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'I want what every other woman has': reasons for wanting clitoral reconstructive surgery after female genital cutting – a qualitative study from Sweden

Malin Jordal^a, Gabriele Griffin^a and Hannes Sigurjonsson^{b,c}

^aCenter for Gender Research, Uppsala University, Uppsala, Sweden; ^bDepartment of Plastic and Reconstructive Surgery, Karolinska University Hospital, Solna, Sweden; ^cDepartment of Medicine, Karolinska Institute, Karolinska University Hospital, Solna, Sweden

ABSTRACT

Female genital cutting (FGC) involves the removal of women's external genitalia for non-therapeutic reasons. An estimated 38,000 women living in Sweden have undergone some form of the procedure. These women often belong to marginalised minorities of immigrant women from countries where FGC is widespread. Clitoral reconstructive surgery following FGC has recently been introduced in Sweden. This study investigates women's perceptions of FGC and clitoral reconstructive surgery with a particular focus on: (1) reasons for requesting reconstructive surgery, and (2) FGC-affected women's expectations of the surgery. Seventeen women referred for clitoral reconstructive surgery at the Department of Plastic and Reconstructive Surgery, Karolinska University Hospital, Stockholm, participated in the study. Findings revealed five factors motivating women's request for clitoral reconstruction (CR): (1) symbolic restitution – undoing the harm of FGC; (2) repairing the visible stigma of FGC; (3) improving sex and intimacy through physical, aesthetic and symbolic recovery; (4) eliminating physical pain; (5) and CR as a personal project offering hope. These factors were highly interconnected, suggesting that the reasons for seeking surgery were often multiple and complex.

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Introduction

Female genital cutting (FGC)¹ refers to the partial or total removal of women's external genitalia for non-therapeutic reasons (WHO 2017). It can involve the cutting of the clitoris, labia minora and majora and/or infibulation (narrowing of the vaginal orifice). The World Health Organization (WHO) has identified four types (I–IV) of FGC: Type I involves cutting the clitoris, Type II cutting the clitoris and labia minora (and/or majora), Type III infibulation (narrowing of the vaginal orifice) with or without cutting the clitoris and Type IV 'other' procedures, for example pricking and piercing the clitoris (WHO 2017).

CONTACT Malin Jordal  Malin.Jordal@gender.uu.se

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FGC is mostly carried out on girls between infancy and adolescence, usually without their consent. Diverse societies justify, time and organise FGC differently (Ahlberg et al. 2004; Hernlund and Shell-Duncan 2007). Their rationales may involve FGC being a *rite de passage* or ritual conferring a sense of ethnic and gender identity, safeguarding women's virginity or enhancing girls' marriageability (Johansen 2016; WHO 2016). There is also a widespread belief that Islam requires girls to be cut (Berg and Denison 2013; Johnsdotter and Essén 2005). The social acceptance of girls who have undergone FGC can be an important factor for the practice (WHO 2016).

The health consequences of FGC are often divided into immediate and long-term, where long-term negative health effects include problems with urinating and menstruating (particularly if infibulated), chronic vulvar pain, cysts, infertility, sexual problems, post-traumatic stress disorder, depression and obstetric complications (WHO 2016). Not all FGC-affected women experience these health complications, or to the same degree. Particularly when it comes to sexual problems, current evidence seems conflicted, as sexuality is affected by a large range of physiological, socio-cultural and psychological factors (Johnson-Agbakwu and Warren 2017). Thus, complications vary depending on factors such as the type of FGC undergone and the conditions around the cutting.

FGC is widespread: estimates suggest that up to 200 million women and girls worldwide may have undergone it in some form (UNICEF 2016a). FGC is largely seen as an African phenomenon but is also practised in several Middle Eastern and Asian countries (Alkhalaileh et al. 2017; Rashid, Patil, and Valimalar 2009), even if attitudes and practices regarding FGC are changing (Van Bavel, Coene, and Leye 2017; Graamans et al. 2018). Migration has turned FGC into a global phenomenon, with more than half a million cut women and girls living in Europe, for example (Van Baelen, Ortensi, and Leye 2016). The prevalence of FGC seems to have reduced after years of preventive campaigns, but progress towards eradication is slow. The actual number of women and girls cut is thought to be rising due to the general population growth (UNICEF 2016b).

Much health care attention regarding FGC-affected women centres on surgical defibulation (Johansen 2016; Nour 2006). However, in recent years, the surgical practice of clitoral reconstruction (CR) for women who have undergone FGC has emerged in Europe, USA and Africa (Jordal and Griffin 2017). CR was developed by the French urologist Pierre Foldès. It was initially performed on women with FGC-related vulvar and clitoral pain but later extended to improve their sex lives and physical appearance (Foldès, Cuzin, and Andro 2012). Despite this, there are few studies on CR, particularly on what motivates women to seek CR surgery, and how they experience CR. The few published studies investigating motives, expectations and outcomes of CR are mostly quantitative in nature (Foldès, Cuzin, and Andro 2012; Merckelbagh et al. 2015; Vital et al. 2016) and/or written in French (Ouedraogo et al. 2013; Villani 2015; Villani and Andro 2010). A recent systematic review shows that women report 'improve[ing one's] sex life, recover[ing one's] identity and decrease[ing] pain' as the most common reasons for CR surgery following FGC (Berg et al. 2017, 983). Still, little is known about what this entails. There continues to be a dearth of knowledge regarding what motivates women to seek CR surgery, what they expect of the surgery and how they

experience surgery, particularly in socio-cultural, bodily and socio-political terms (Jordal and Griffin 2017).

Migration to Sweden from FGC-practising countries such as Somalia, Eritrea and Ethiopia in the 1980s and 1990s has resulted in an estimated 38,000 FGC-affected women and girls living in Sweden (Socialstyrelsen 2015). This means that Sweden has one of the highest prevalence figures of FGC-affected women in Europe. Almost half of these women in Sweden are from Somalia (Socialstyrelsen 2015). Studies indicate that the health care system in Sweden is largely unprepared to provide quality care for cut women (Jordal and Wahlberg 2018). Continued immigration to Sweden from FGC-practising countries is also likely to make rising demands on the Swedish health care system when it comes to dealing with FGC-affected patients.

CR was introduced in Sweden in early 2015 (Hallberg 2015), and the cost is covered by the national health insurance. Psychosexual counselling is part of the treatment (Werner 2016). The latter is becoming customary in public clinics offering CR in Europe, but less so in the USA (Chang, Low, and Percec 2017). This may be associated with the very different welfare and public health care regimes in these two world regions. Sweden is still the only Nordic country offering CR surgery. At present (in 2018) CR is practised by a small number of surgeons in very few hospitals, including the Karolinska University Hospital. Here, Foldès's original technique is used, often with modifications (Sigurjonsson and Jordal 2018). Since the procedure itself is very recent and data are still scarce, there has been limited public discussion about CR in Sweden. Discussion among academics include concerns about the effectiveness of CR (no long-term studies on this are available yet), and the degree to which context promotes a demand for CR which might not otherwise be there (Johnsdotter and Essén 2017; Johnsdotter and Mestre 2017).

FGC and CR surgery are complex issues, not least because recent research has established that the clitoris does not just consist of the tip visible at the top of the vagina but extends way beyond that in its roots (O'Connell et al. 1998). FGC and CR have medical, social, gendered and psychosexual implications (Abdulcadir, Rodriguez, and Say 2015). As gender identity and body image play a determinant role in sexuality, health and well-being (Parker 2009), these complex issues need to be addressed and investigated within the context of such surgery. Contextual research on women's motives and expectations of CR surgery can contribute to informing guidelines for optimising care for women who have undergone FGC. This paper explores women's reasons for seeking CR surgery as well as what they anticipate the surgery to accomplish, from the perspective of FGC-affected women in Sweden. The underlying study was inspired by, but did not seek to replicate, existing studies on CR, particularly regarding the reasons for requesting surgery (Berg et al. 2017; Foldès, Cuzin, and Andro 2012), and the methodology (Andro et al. 2009; Villani 2017).

Methods

A qualitative approach was used since the goal was to provide an in-depth picture of people's multifaceted, articulated perspectives and experiences on a sensitive and under-researched area with few available participants (Kvale and Brinkmann 2009).

Study participants were purposively recruited at Karolinska University Hospital, with the key inclusion criterion of having undergone FGC and seeking CR surgery. All women ($n=26$) requesting CR during the research period (November 2015–April 2017) were asked to participate in the study by the operating surgeon, who acted as a gatekeeper facilitating access to the participants. If their response was affirmative, they were contacted by the first author and provided with more information about the study. If they then continued to be willing to participate, an interview was arranged. Of the 26 women asked to participate, nine declined or could not be contacted. In total, 17 women agreed to be interviewed for this study. The interviews took place on the hospital premises in a private room, in a café, in the women's home or outside in a park, depending on participants' preferences. None of the women had undergone CR at the time of their interview, and therefore the degree of the excision of their clitoris was not known then. This paper consequently focuses on their expectations and views.

All the women were interviewed individually using a semi-structured topic guide (Kvale and Brinkmann 2009). The interview focus was on the women's memories and perception of undergoing FGC; their views of their pre-operative genital, mental or sexual situation, particularly in relation to pain, sexual function, body image and identity; relational factors; their reasons for requesting surgery; and their expectations of the surgery. Fourteen interviews were conducted in Swedish, two in English, and one in Somali using an interpreter. Sixteen interviews were carried out face-to-face in person, and one over the phone. The interviews lasted between 30 and 90 minutes. Fifteen interviews were tape-recorded and later transcribed. In the remaining two, notes were taken because the woman refused tape recording or because the recorder did not work.

The fact that the interviewees were invited into the study by the operating surgeon is likely to have influenced the women's decision to agree to participate. However, while all the women agreed to be contacted by the first author/interviewer, not all of them responded to her subsequent attempt to contact them. On the other hand, many did agree to participate, despite having to discuss a difficult and sensitive topic, perhaps partly because the interviewer (MJ) highlighted her professional background as a nurse and researcher when contacting the potential interviewees for the first time. This meant that she could also be identified as being part of the 'care institution'. Simultaneously, her status as university-educated, white and non-cut is also likely to have affected how she was perceived by the participants (Peeck 2016, 114), even if it is difficult to say exactly how. She tried to balance out the differences between herself and the interviewees by emphasising aspects of herself she perceived to be similar to them (cf. Liangputtong 2010) – including her immigrant status in Sweden (she is from Norway), her gender and her nursing background (importantly, many of the informants were themselves nurses). The interviewer always sought to display an empathetic, non-judgemental attitude, whilst encouraging women to express their opinions, feelings and experiences (Peeck 2016, 116–119). The interviews had a conversational character, co-created between the interviewer and the informant. In most of the interviews, the interviewer felt that the women experienced a sense of relief talking about a sensitive topic in a non-judgemental setting. However, some women also sometimes demonstrated difficulties in talking about the subject, for instance by remaining silent, by

crying or by articulating or bodily manifesting sadness and embarrassment. Their treatment-related counselling offered opportunities to deal with such feelings beyond the interview situation, and they were encouraged to make use of this.

The data were analysed using a grounded-theory approach, whereby core themes were identified from repeated close readings of the transcripts looking for patterns in the responses (Braun and Clarke 2006). Data extracts were selected and coded based on the thematic concerns as these emerged from the data. The codes were then collated and organised into core themes. This process was not linear, but a 'back and forth' movement between the entire data set, data extracts, codes and preliminary themes, until the final themes captured the substance of the data set (Braun and Clarke 2006, 86).

This study received ethical approval from the Regional Ethical Review Board in Stockholm (2015/1188-31). Each participant was provided with an information letter about the project that emphasised that they did not have to take part in the study, that their decision to take part or not would not affect their treatment in any way, that they had the right to withdraw at any point and that all data would be treated confidentially and anonymised in any use. Informed consent was obtained from each woman. Permission to recruit informants was given by the Head of the Department of Plastic and Reconstructive Surgery at the Karolinska University Hospital. The content of the interviews was anonymised for all use and authors besides the first author. Pseudonyms are used for all the interviewees throughout this paper.

Research participant characteristics

The interviewees were aged between 19 and 56 years and had migrated from Somalia (n = 11), Eritrea (n = 2), Gambia (n = 2), Sierra Leone (n = 1) and Iraq (Kurdistan) (n = 1). They had come to Sweden through family reunification, or alone, many as young adults or children. Some had lived in other migratory contexts before coming to Sweden. The majority had lived in Sweden for more than 10 years at the time of the interview (Table 1). Many worked in the health care sector (10 out of 17), primarily as nurses or nurse assistants. This meant that they were familiar with the Swedish health care system, which may have facilitated their knowledge of and asking about CR surgery. The remaining women worked as personal assistants or as cleaners, were studying or unemployed. Four women were currently married, six were divorced and seven were unmarried. Two of the unmarried and one of the divorced women had a boyfriend at the time of the interview. The fact that 13 women were divorced or unmarried suggests that they had gained a degree of independence from partnership ties that might have influenced their decision to request CR. Seven women had children, and one had grandchildren. All the women had permanent residency in Sweden.

The women reported having been cut at different ages, ranging from two months to 9–10 years of age; some could not remember how old they had been. Eleven had undergone FGC Type III (infibulation), but only two were fully infibulated at the time of the interview (the rest had previously been opened, at least partly, due to childbirth or previous surgical defibulation for other reasons). Five had undergone FGC Type II, and one Type I. They reported different experiences regarding pain and the use of

Table 1. Characteristics of the interviewed women opting for CR in Sweden.

Fictive name	Age	Country of origin	Years in Sweden	Current employment	Civil status	FGC Type
Barni	33	Eritrea	28	Health care	Unmarried	Type II
Ami	37	Gambia	27	Health care	Unmarried	Type II
Aisha	56	Somalia	25	Unknown	Divorced	Type III
Anna	38	Eritrea	25	Unskilled	Divorced	Type II
Sara	32	Somalia	24	Student	Divorced	Type III
Soheila	32	Somalia	21	Health care	Married	Type III
Ruquia	37	Somalia	18	Health care	Divorced	Type III
Leila	31	Somalia	18	Health care	Divorced	Type III
Natalie	22	Somalia	14	Health care	Unmarried	Type III
Behar	46	Iraq	14	Health care	Married	Type I
Patricia	23	Sierra Leone	13	Health care	Unmarried	Type II
Ilham	20	Somalia	12	Unskilled	Unmarried	Type III
Lemma	32	Somalia	10	Health care	Unmarried	Type III
Ayaan	33	Somalia	9	Health care	Divorced	Type III
Amina	46	Somalia	5	Unknown	Married	Type III
Fatou	30	Gambia	5	Unskilled	Married	Type II
Imtesam	24	Somalia	2.5	Student	Unmarried	Type III

sedatives during the actual cutting. Eleven, the majority, remembered the cutting or the immediate period afterwards as traumatic and painful. Three had been given sedation and did not experience the cutting as painful, and three had been too young to remember. Table 1 shows an overview of the interviewed women's key characteristics.

Findings

Five core themes emerged from the interview data as the key reasons why the interviewees requested CR surgery. These were (1) what we termed 'symbolic restitution' – undoing the harm of FGC; (2) repairing the visible stigma of FGC; (3) improving sex and intimacy through physical, aesthetic and symbolic recovery; (4) eliminating physical pain; and (5) CR as a personal project offering hope. These core themes figure as subheadings in the analysis below. Although we have separated these themes out for analytical reasons, they were not mutually exclusive, but highly intertwined. At times there was, however, greater emphasis on particular themes.

Symbolic restitution: undoing the harm of FGC

The interviewed women had perceived FGC as something normal during childhood and early adolescence, even if they had experienced severe pain, confusion and fear during the actual cutting. At a later point in time, however, they had come to think of FGC as negative and harmful, a violation of their bodies and rights. It was not always clear when or why this had occurred. The interviewed women's own perception of FGC as negative often occurred during adolescence, as this was a period in life associated with an increased interest in bodily and sexual issues. It was also a time when many started to seek information about FGC or became exposed to anti-FGC messages. Several women talked of this as becoming more conscious of women's rights, or developing feminist attitudes, and of experiencing feelings of anger and rage towards the injustice they felt they had been subjected to. Sara, a 32-year-old woman from Somalia said:

I think that [being against FGC] is something that comes naturally when you get more liberal thoughts. There's no woman who stands up for women's right to bodily integrity who does not think that she should also have that. So, I feel it's more of a feminist idea that exists all over the world. (Sara)

While many had started to reflect on FGC as negative prior to migration, living in Sweden had significantly influenced how the women saw FGC, as they were exposed to anti-FGC messages and new ideals regarding body image and female sexuality there. The women were also very aware of the fact that FGC was illegal in Sweden. They felt that in Sweden they did not have to accept their condition any longer. When asked about how she believed growing up in Sweden had affected how she perceived her condition as cut, a 33-year-old woman from Eritrea said:

It is difficult for me to depict how it would be otherwise, but I suspect that I would have, I don't know, accepted the condition in another way. That I do not have to do now. (Barni)

Ahmadi (2003) has highlighted how migrants' exposure to the individualistic ideology and lifestyle in Sweden often results in revisions of previous thinking and an increased emphasis on the prospect of realising one's desires, goals and personal life project. But participants in this study had sometimes already experienced such revisions before they came to Sweden because of anti-FGC campaigns in their countries of origin. A 24-year-old woman from Somalia said:

Imtesam: I was 14–15 years old when I started to feel that something was wrong. When I got my first menstruation. When I started to get pain, and when I heard that one talked about FGC as something wrong. That was in Somalia. The pain came with menstruation and peeing (...) In Somalia I met people who talked about the disadvantages of FGC, about the reasons for doing it, and about the complications.

Interviewer: How did you feel then?

Imtesam: I felt like I had been violated, that what had happened was not good. I thought a lot about it and that made me feel sad.

Imtesam's original views of FGC were challenged by the combination of experiencing physical pain and being exposed to anti-FGC messages. This negatively affected how she perceived her health, body and genitals as will become evident later in this text. It also evoked sadness.

Almost all the women understood FGC as having deprived them of something important for their sexuality. They came to see the clitoris as an important part of their body for their capacity to experience sexual pleasure. A 30-year-old woman from Gambia said:

Before I didn't know, why it's so important for you to have your clitoris, I didn't know it before, because I was like ... You know in my country they don't talk about sex in public (...) So I didn't know the importance of the clitoris, until I started having sex, and then ... (Fatou)

The clitoris thus became important to these women. Recognising it as being cut troubled their sense of womanhood and made them feel incomplete; several women said they did not feel like 'full' or 'real' women.

Some women also said that being cut affected their ability to engage with the world and their sense of freedom. When asked about how she felt the cutting had affected her, Amina, a 46-year-old Somali woman, said: 'I feel I wasn't brave enough in the world, haven't embraced the world as I should have, as a free person'. Living with FGC hence involved feelings of constraint. Thus, one important aspect of the CR surgery was the symbolic act of reclaiming one's body. A 33-year-old woman from Eritrea said:

When I say that it has a symbolic value it means that, to me at least, that I more or less reclaim my body. I do what they did to me, like undone, and that is, yes, I don't know, it becomes mine again. Do you understand what I mean? Mine to do what I want with ... And this whole process, from beginning to end has been, I don't know, it has been me who has decided for it, it has been a decision that I have made, that is about me, not ... Yes, I think that's why it's so important to me. (Barni)

For Barni, as for many of the interviewees, this symbolic reclamation of self-determination regarding her body was a significant motivation for CR. Through surgery they wanted to undo what had been done to them. It was a way of gaining restitution for the harm done to them as children without their consent, creating a sense of taking control over their lives.

Repairing the visible stigma of FGC

Related to feeling violated by FGC, many participants viewed their genitals as damaged, deformed and 'ugly'. This invoked feelings of shame. Their visibly cut genitals thus became a sign of stigma (Goffman 1963, 5). Women reported that looking at their cut and often scarred genitals evoked negative emotions. Living with FGC in the context of Sweden thus created awareness of themselves as 'different'. When asked about what she meant by feeling 'different', a 37-year-old woman from Somalia replied:

Interviewer: What you say about 'other' women, when you were in Somalia you were a little like everybody else, did you then still think that something was wrong ... ?

Ruquia: No. [It is] here in Sweden, I have work colleagues, fellow students, acquaintances that I meet outside, I have friends that I exercise with, I go to the sauna ... And then I know that I am not like everybody, I am not like them.

Ruquia, like other interviewed women, was very aware that FGC is not approved of in Sweden, as in many non-cutting contexts (Pedwell 2010; Pred 2000). Being cut, the women therefore felt different – not only from native-born Swedes, but also from many peers from their own country, particularly when these were born in Sweden or had 'modern' parents who no longer supported FGC. As Natalie, a 22-year-old woman from Somalia, said during an interview:

Interviewer: Have you ever talked to anybody about this? The circumcision. With other Somali girls or ... Have you done that?

Natalie: It has happened that they have, where they have asked, they ask 'you then, have you, are you also like that, down there?' Because they say, 'my mum didn't do that on me because she didn't want to' and like that. So, I said, actually I lied, I said 'no, I am totally normal'. Yes, in school when they asked, I lied.

Such unwillingness to reveal their cut condition entailed a degree of secretiveness for women like Natalie. This affected their social relationships. Goffman (1963) writes that stigma invokes feelings of inferiority, which can lead to self-isolation, anxiety and depression. Because of the social advantages of being considered normal, stigmatised persons may try to 'pass as normal' whenever possible (Goffman 1963, 73). The interviewees in this study could hide their stigma from public view, but only at the price of anxiety and the fear of being 'found out'. Passing as 'normal' was more difficult in intimate and sexual relations, resulting in the women feeling particularly vulnerable in such situations. CR surgery was expected to remove the visible sign of stigma at least partly.

Nonetheless, many women were aware of the limitations of CR surgery in being able to restore their genitals to resemble uncut genitalia fully, not least because at present such surgery cannot restore cut labia. Many regretted this. Yet, for the majority of the women, opting for CR remained an attempt to achieve 'normal'-looking genitalia to the greatest possible degree. When asked about her reasons for wanting CR surgery, Ayaan, a 33-year-old woman from Somalia, said: 'First and foremost that my genitals will look normal, that is the first hope that I have'.

Through CR surgery, the women wanted to repair the damage done to their genitalia through the act of FGC. They hoped that this would lead to less anxiety when looking at their genitals, and that they would 'pass as normal' in social, intimate and sexual relations.

Improving sex and intimacy through physical, aesthetic and symbolic recovery

All the women had come to understand the intention underlying FGC as controlling women's sexual desire and preventing them from being promiscuous. For the majority of the interviewees, this was also the effect: they experienced sex as undesirable, uncomfortable or directly painful. They ascribed their sexual problems, which included lack of sexual desire and enjoyment, little sensitivity in the genital area and difficulties in lubricating and achieving orgasms, to being cut, even if they were aware that some cut women did enjoy sex and some non-cut ones did not.

The interviewees perceived the ability to enjoy sex as healthy and normal; consequently, they viewed their inability to enjoy sex as a handicap. Regarding FGC as a handicap has been identified in other contexts such as France (Andro et al. 2009). The interviewees in our Swedish study viewed their lack of sexual enjoyment as threatening their intimate relationships, since mutual pleasure was considered important for closeness and intimacy. They also experienced feelings of inadequacy and shame. A 37-year-old woman from Gambia said:

And then I am ashamed, and I feel sorry for the boy as well (laughs a little), in that I ...
Yes, I believe both parts should enjoy [sex] for it to be good, and ... (Ami)

While ascribing poor genital sensitivity largely to the physical removal of the clitoris, many expressed awareness of the recent understanding of the clitoris as a much larger organ than previously assumed (O'Connell et al. 1998). This was either because they had 'discovered this for themselves' and could sense the clitoris under the scar, or because they had learned about the anatomy of the clitoris in their psychosexual therapy (a prerequisite for the surgery). This involved learning that not the entire

clitoris had been removed during the cutting. This is also the basis for CR surgery, since it brings to the surface underlying clitoral tissue and ‘puts it in its right place’ (Villani 2015, 98). The women hoped that surgery would bring back sensitivity to the genital area and that this would have positive effects on their experience of sexual pleasure and ability to reach orgasm.

The interviewees’ experiences of sexual problems were not uniform. Some interviewees said that they could enjoy sex and reach orgasm, especially if they were with a loving and caring partner or if masturbating alone. Still, they believed that for them sexual arousal and orgasming took longer due to the FGC. Furthermore, the women associated their sexual difficulties with certain non-physical aspects of the cutting. They described sexual and intimacy problems as related to the aesthetic effects of FGC; perceiving their genitalia as ‘ugly’ affected their genital self-image negatively. This, as already indicated, caused shame and uneasiness in sexual relations. Previous research has highlighted the detrimental impact of a negative genital self-image on body image, sexual health and well-being (Berman et al. 2003; Schick et al. 2010). The women’s negative genital self-image made them self-conscious during sex, they avoided certain sexual practices otherwise associated with pleasure, or avoided sex and intimate relationships altogether. The women thought that their sense of being ‘damaged’ and ‘not whole’ contributed to sexual and intimacy difficulties. A 33-year-old woman from Eritrea said:

On a purely physical level, when it comes to the sensation, I still have that: I can have an orgasm. That I have known since I was 15–16 and started experimenting with myself (laughs a little). But it becomes a problem when there is another person in the picture. First and foremost, it is more in my head I think, mostly because I don’t feel whole, I don’t feel ... Yes, I feel damaged, or like ... And because of that it doesn’t work, no, I don’t know how to explain ... (Barni)

For Barni, it was the interconnection of the relational and psychological dimensions of engaging in sex with another person that created difficulties in her sexual relationships. She, like other women, hoped that surgery would result in better genital self-esteem which would improve their intimate and sexual relations.

Others ascribed the meaning attributed to FGC of containing women’s sexuality as impacting detrimentally on their ability to feel sexually free. Sara, a 32-year-old woman from Somalia explained:

When one feels that one is in a wrong body, it becomes difficult to have sex with that body, taking pleasure without feeling guilt or thinking about it ... It feels wrong to have sex with the cut genitalia. (Sara)

Both Barni and Sara had lived in Sweden since childhood. In their upbringing and particularly during adolescence, it was common to discuss sex and pleasure among their peers. In the Swedish context, their cut genitals put physical, symbolic and aesthetic constraints on their ability to feel sexually free. Sweden is often upheld as a global leader when it comes to liberal attitudes regarding sexual freedom and gender equality (Sherlock 2012). Furthermore, in the West more generally, the clitoris has become a symbol of women’s sexual emancipation, of sexual satisfaction and orgasm, prompted in part by the assertion of ‘the myth of vaginal orgasm’ in the 1970s (Gosselin 2000; Koedt 2010). This led to a renewed focus on women’s sexuality, including the positive valuation

of masturbation, clitoral orgasm and lesbian sex, as part of a larger struggle for women's sexual liberation (Gosselin 2000, 46). Both Barni and Sara articulated liberal sexual ideals and raised the importance for women to feel sexually free, something that could indicate integration into Swedish society, or at least to its cultural ideals.

Eliminating physical pain

Although not the most common reason for seeking surgery, some interviewees said that they experienced physical pain in their genital area, either unprovoked or when having sex. They thought that the pain was related to scar tissue in the area, oversensitivity of the clitoris, cysts or ingrowths of pubic hair as a result of the cutting. The pain could be triggered by walking, wearing underwear or by sitting down too quickly. Pain during sexual intercourse was more common than unprovoked pain and was thought to be related to scar tissue and infibulation, which even after partial defibulation had left the vaginal opening less elastic and sore. For these women, becoming pain-free was the most important reason for seeking surgery, although often combined with other reasons. A 37-year-old woman from Somalia said during an interview:

Interviewer: When did you become conscious that you had pain?

Ruqia: Eh, I have always had pain, but I ignored it ... But now it felt like, 'Why? If I can get help, why don't I seek help?' Then perhaps I can become pain-free one day (...)

Interviewer: What are your expectations [for CR]?

Ruqia: Pain-free, first of all. And then to feel like a whole woman.

CR as a personal project: offering hope

As the last quote above shows, the women had often lived for years with suffering and distress related to their FGC. This had reduced the quality of their life and affected their social and intimate relations. FGC-affected women are often portrayed as passive and ignorant victims without agency (Boddy 1998; Silverman 2004). We think that opting for CR meant refusing this sense of 'victimhood'. CR was thus an act of self-care and responsibility, of taking action and 'correcting a mistake'. Amina, a 46-year-old woman from Somalia, said:

I just want to feel different, want to feel that I have done, I have undone something that was done to me and I have corrected a mistake ... (Amina)

Opting for surgery was largely a personal project. This meant that the majority of the women were not prepared to stand up against FGC in public. They explained this as partly due to considering FGC and CR as 'private', and partly due to not wanting to further stigmatise their ethnic group who already have negative media images associated with 'carrying out FGC on their children'. Some admired fellow citizens who publicly condemned FGC, but others, particularly Somalis, described feeling uncomfortable when hearing Somalis speak out against FGC publicly. Nonetheless, many expressed anger towards the tradition of perpetrating FGC, although in most cases not towards

their parents who were seen as doing their best for their daughters in cutting them, which was a way of securing social acceptance. Some parents were also described as unable to prevent their daughters from being cut.

The women had learned about the possibility of CR surgery in Sweden in various ways: the radio, TV, newspapers, the Internet, at a specialist FGC clinic, through their GP or through friends. Many had been thinking of such surgery for some years. Amina said:

Amina: I was stitched up so much that I had to go to a doctor to have the opening, the stiches taken out, so then I became more exposed, and also came across women who were anti female-circumcision. And I remember trying to find a doctor or trying to find ways of having this whole surgery done.

Interviewer: Clitoral reconstructive surgery?

Amina: Yes, and that was almost like about 10, 15 years ago. I tried to find out, and I asked specifically a doctor that I met who removed some of the stiches, if she can do more than just remove the stiches, if she can do the whole reconstruction ... And she said 'no, no, no, we just do the stiches for now', because I think I was a little bit ahead of my time then ... Yeah.

Finding out about CR in Sweden created feelings of hope which in some cases also influenced the ability to open up to others about their FGC. A 22-year-old woman from Somalia said:

Natalie: I remember when I read the news about this thing.

Interviewer: The clitoris reconstruction?

Natalie: Yes. Then I felt a little hopeful. I became very happy, and I thought, 'now I can finally get help'. So, then I became open with those that I lived with, and I told a friend that I have known for many years. So, I feel that I can actually talk about it now. Before I couldn't talk at all ...

Natalie was not the only woman who felt relieved when learning about the possibility of CR. The majority of the interviewees described being filled with hope, relief and happiness when finding out about this surgery. At the same time, they were aware of its limitations in 'fixing their lives'. Several women emphasised their own role in improving their lives, and perceived reconstructive surgery as one element in a larger process of regaining self-confidence and control over their lives (see also Villani 2015; Villani and Andro 2010). But even if aware of these limitations, they hoped that the surgery would give them a sense of having regained something. Amina expected improved self-confidence, body image and sense of normality when asked about what she hoped surgery would accomplish:

My expectation is to feel more confidence, to feel more like a normal person again, to be able to relax with my own body and not be embarrassed about it. (Amina)

Conclusions

This study has explored some of the reported complexities involved in living as a cut woman and requesting CR surgery in Sweden. Interviewees frequently gave multiple

reasons for their aspiration to undergo CR surgery: they hoped that surgery would give them a sense of restitution, of 'normal' womanhood, and that it would remove the visible signs of the cutting. They also hoped for an improved genital self-image, thus enabling them to feel better about their own bodies and relax in intimate and sexual relations. They hoped, finally, to feel 'whole' – as women and as human beings. This they anticipated would create a sense of feeling more 'equal' with other women in Sweden.

Since CR surgery remains a fairly new procedure, and this study explores cut women's motivations and expectations regarding that surgery only, little is known about CR's medium- to long-term effects. We therefore do not know to what extent CR meets FGC-affected women's hopes and expectations. Further longer-term follow-up studies are required to explore these issues more fully.

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Notes

1. FGC is also commonly referred to as 'female circumcision' or 'female genital mutilation' (FGM). Female circumcision, the term first used to describe the practice, is often used by practising communities. However, the term has been criticised for not sufficiently reflecting the severity of the procedure and likening the practice to male circumcision, often perceived to be less harmful than the circumcision of girls. In the 1970s, the term 'female genital mutilation' was introduced (Hosken 1979), and later also adopted by governments, the World Health Organization, non-governmental organisations (NGOs) and many researchers. However, this term has also been critiqued by many scholars, particularly outside the West, for giving the impression that practising communities intended to *mutilate* their daughters. Consequently, the term 'female genital cutting' was introduced as a less judgemental descriptor, but without indicating the procedure to be harmless or done with a malevolent intent. FGC is used throughout this paper.

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