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Female genital mutilation in the Canary Islands: A qualitative study on the perspectives of women and healthcare professionals

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ABSTRACT

Introduction: Migration to Western countries is associated with social and health challenges that are difficult to manage. Female genital mutilation (FGM) is a harmful practice that still occurs in the 21st century. According to the World Health Organization, FGM is a ritual procedure involving the partial or total removal of the external female genitalia for non-therapeutic reasons.
Objectives: (I) To explore the experiences of women residing in the Canary Islands, in Spain, who had suffered FGM, and their assessment of the healthcare received. (II) To explore the perspectives of healthcare professionals who had attended to these cases, care pathways, and prevention.
Methods: A qualitative study, phenomenologically oriented based on a pragmatic perspective, was conducted. We conducted open in-person interviews, and written documents were sent via email for data collection. Purposeful and snowball sampling methods were used to select women who had undergone FGM and healthcare providers who had attended to such patients. Nine participants were recruited, five health professionals and four women. Although the sample size was not very large, the data had enough depth and richness to meet the goals of the study. The data were analyzed using the thematic analysis technique.
Results: Six main themes emerged, including the "meaning of FGM," "health consequences," "benefits of treatments," "knowledge about FGM," "experiences of professionals and with professionals," and "recommendations of professionals in improving care."
Conclusions: Professionals and women identified the lack of training to address this problem, and both parties perceived FGM as a negative practice. The women lack knowledge about the relationship between some health problems they suffer and FGM, which poses a challenge for accurate diagnosis and treatment. Therefore, professionals need to know in detail all health conditions related to FGM to diagnose and treat these women more accurately. When affected women arrive in Western countries and receive correct information on the consequences of FGM, they are more likely to reject this practice. The identification of cases of FGM in women born in the Canary Islands urges the need to develop strategies to avoid such situations.

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1. Introduction

According to the World Health Organization [1], female genital mutilation (FGM) is a ritual procedure involving the partial or total removal of the external female genitalia for non-therapeutic reasons, classified as clitoridectomy (type 1), an excision (type 2), infibulation (type 3), and all other harmful procedures to the female genitalia (type 4). Around 200 million women and girls have undergone FGM. These women are mainly from 30 countries in the western, eastern, and north-eastern regions of Africa and some countries in the Middle East and Asia. Additionally, over four million girls are at risk of undergoing FGM annually. However, as schools were closed and preventive programs were interrupted due to the COVID-19 pandemic, this number might increase in the future [1,2]. Moreover, there is an alarming trend in some countries towards the medicalization of FGM, where healthcare providers conduct the procedure. For approximately 52 million women and girls worldwide, FGM was conducted by health personnel, which is very common in countries such as Egypt and Sudan [3]. In Europe, over 578,068 women and girls aged 10 years and above from countries where FGM is documented have suffered it, and approximately 180,000 girls are at risk. More than 15,000 women who have undergone FGM live in Spain [4,5]. Around 4500 women from countries where FGM is performed reside in the Canary Islands, and approximately 200 girls are at risk of undergoing this practice [6]. This makes the Canary Islands the sixth-largest region in Spain in terms of the number of female residents from countries at risk, with a predominant population from Senegal and Mauritania [7]. In 2021, more than 22,000 people arrived in the Canary Islands from Africa by sea, including from countries like Mali and Senegal, where FGM is documented [8,9]. Migration has been associated with escaping FGM or forced marriage [10–12]. Additionally, since February 2012, Spain has reported receiving asylum requests based on FGM [13].

FGM has harmful physical, psychological, and sexual consequences. In the short term, FGM can cause physical problems such as urinary problems, hemorrhage, fever, genital tissue swelling, infections, severe pain, edema, shock, HIV, and even death. Psychologically, many women describe FGM as a traumatic event due to the pain, shock, and use of physical force during the event. In the long term, this practice leads to physical problems such as urinary problems, chronic back and pelvic pain, chronic pelvic infections, HIV, dermoid cysts, abscesses, scar tissue, keloid, obstetric fistula, vaginal problems, menstrual problems, and increased risk of childbirth complications. It can also produce psychological problems such as post-traumatic stress disorder, psychosexual problems, psychiatric diagnosis, anxiety, depression, somatization, phobia, and low self-esteem. Finally, FGM can result in sexual problems, including dyspareunia, anorgasmia, lack of sexual desire, and infertility [1]. Although FGM negatively affects female sexual function, the sexual implications of FGM have remained under-investigated [14]. A recent meta-analysis found 15 studies that reported that women with FGM had lower total and per-domain scores on the Female Sexual Function Index (FSFI) compared to non-mutilated women. However, no investigation has been performed in Spain; only one study has been performed in Europe (Switzerland) [15].

In addition, Almroth et al. [16] found a correlation between primary infertility and severe FGM involving the labia majora, irrespective of the type of mutilation (such as infibulation or type III). Furthermore, a relationship between some forms of FGM and a higher risk of developing endometriosis has been described, leading to chronic pain and infertility [17,18].

Clitoral reconstruction is a good strategy for reducing clitoral pain, improving sexual function, and restoring a vulvar appearance like that of uncircumcised women [19]. A recent study found that reconstructive surgery can improve sexual distress, psychopathology, and genital self-image in these women [20]. Regarding the reconstructive surgery of the clitoris, the Frenchman Pierre Foldès developed a procedure with satisfactory results [21]. Pere Barri was the first surgeon in Spain to perform it in 2007 [22]. This intervention is gradually becoming more accessible in the Public Health System in Spain. It was started in Cataluña in 2015 and in the Valencian Community in 2016 [23,24].

Various qualitative studies have investigated the perceptions of women who suffered FGM and live in Western countries [25–31]. The studies found that these women usually receive poor care due to the lack of empathy, experience, attitudes, and knowledge of health professionals [32]. In Tenerife, a recent study in the Canary Islands assessed the knowledge, attitudes, and practices related to FGM by interviewing 142 health professionals. The respondents lacked knowledge about the practice, its typology, the countries where it is documented, or the reasons for its occurrence. Specific training on the subject increased the rate of detection of cases and knowledge about the practice [33]. Health professionals in the Canary Islands face the challenge of providing adequate care to these women. To overcome this challenge, a comprehensive understanding of the consequences of FGM on these women is required, along with first-hand knowledge about the healthcare attention received. Therefore, our study might help bridge this gap. A similar qualitative study was performed in Switzerland, where the authors examined the relationship between women suffering from FGM and Swiss health services from the perspective of the women affected and that of healthcare professionals [34].

With this background, this research aimed to include two different perspectives: (I) to explore the experiences of women residing in the islands who had suffered FGM and their assessment of the healthcare received, and (II) to explore the perspectives of healthcare professionals who had attended to such patients, care pathways, and prevention. This is the first qualitative study on FGM in the Canary Islands. Before this study, no testimonies had been collected from women who underwent FGM and were born in a Western country.

2. Methods

2.1. Study design and the perspective of women and professionals

We designed a qualitative study, phenomenologically oriented based on a pragmatic perspective, consisting of open in-person interviews and written documents sent via email for data collection [35,36]. The study was conducted in Tenerife, Canary Islands. The data were collected from December 2020 to February 2022. Purposeful and snowball sampling methods were used to select

Table 1
The profiles and FGM status of women participants.

Code	Country of birth	Ethnicity	Age	Residence	Type of mutilation	No. of children	Years in Spain	Age of FGM	Place where FGM occurred
E1	Spain (Canary Islands)	Mandinka	30	Fuerteventura	Type III/ infibulation	–	30	3–4 years	Gambia. No more information provided
E2	Senegal	Soninke	49	Tenerife	Uncertain I or II	4	17	5–6 years	House's bathroom. Pikine, Dakar, Senegal
E3	Guinea Conakry	Mandinka	22	Tenerife	Uncertain I or II	Pregnant	1	5–6 years	Lady's house who performed it. Guinea
E4	Senegal	Peul	25	Tenerife	Uncertain I or II	2	6	3 years	She does not remember, but it was not at her house. Bignona, Ziguinchor in Senegal.

Table 2
The profiles and experience with FGM of the professionals participants.

Code	Profession	Gender	Age	Workplace	Type of FGM observed	Country of origin of women cared	Number of diagnosed cases
P1	Midwife	Female	38	Primary Healthcare in Tenerife	Type I	Nigeria and Senegal	40
P2	Midwife	Female	67	Hospital Materno Infantil in Gran Canaria.	Type II	Nigeria, Mauritania and Senegal	10
P3	Midwife	Female	29	Primary Healthcare in Tenerife	Type I	Senegal and Nigeria	20
P4	Physiotherapist	Female	40	Private Clinic in Fuerteventura	Type II and III	Mali and Mauritania	3
P5	Psychologist	Female	35	NGO in Fuerteventura	Type II	Senegal, Guinea and Mauritania	5

women who had undergone FGM and healthcare professionals who had treated such patients.

To recruit women, contact with the target population was made via migrant associations and informal conversations with professionals who could have attended to these women during their professional activity on the island. To contact these professionals, we selected health centers in Arona, in the south of the island, since it is the second locality with the highest female population from at-risk countries in the Canary Islands [7]. Identifying women who wanted to talk about their experiences was challenging. The snowball technique was used in some cases, so professionals or women interviewed proposed to other women who had suffered FGM, whom they knew either as their patients or as family or friends. Seven women were initially identified for the study. However, one did not answer the invitation to participate, and two declined due to the emotional impact of their experiences. An appointment was made with those women who agreed to participate, and they were requested to sign the consent form at the time of the interview. The inclusion criteria were as follows: female; from a country where FGM is performed; 18 years or older; having undergone FGM; residing in the Canary Islands; and being fluent in Spanish or French (Table 1). The first author conducted the interviews and scheduled them at the most convenient time and place for the participants. Four women aged between 30 and 49 and from the Canary Islands, Senegal, and Guinea Conakry participated in the study. Two of them had given birth at Public Healthcare Services in the region. For **collecting the data,** we conducted open interviews with an interview guide which allowed the women to describe their experiences of FGC, related health issues, and their assessment of the healthcare they received. In Tenerife, three women were interviewed individually in person, and the conversation was audio recorded; non-verbal gestures and observations were annotated in field diaries, and each discussion lasted 40–60 min. One of the women participants lived on another island (Fuerteventura). Thus, her narrative was collected through a semi-structured questionnaire with open-ended questions adapted from the original interview guide sent via e-mail.

For recruiting professionals, we followed the same process as that used for recruiting women. We contacted migrant associations and some primary health centers in the south of Tenerife in Arona. In some cases, healthcare professionals were identified using a snowball approach. Professionals known for often providing care to these women and migrant organizations recommended other health professionals to be interviewed. Finally, professionals from three islands were invited to participate over the phone at their workplaces. We confirmed during the phone conversations that the professionals had experience in providing care to women who had suffered FGM. Six professionals initially agreed to participate in the study, but one participant did not answer the final invitation to participate (Table 2). For **collecting the data**, the professionals participated by filling in a document. For that, the first author sent them the consent form and a semi-structured questionnaire with open-ended questions via e-mail asking about their experiences attending to women who had undergone FGM. The questionnaire included questions about the number of cases attended to, the patient's age and countries of origin, the type of FGM observed, and if they had received training on managing FGM cases. The open-ended questions allowed professionals to freely explain topics, such as pathologies associated with FGM they had observed or treated, the benefits they had observed after treatment, and their opinion on how to improve the care these women receive.

2.2. Data analysis

All interviews were transcribed verbatim by the first author and later translated into English. The identities of all participants were

Table 3
The themes that emerged from the data.

Themes	Subthemes
Meaning of FGM	Definition and Description of FGM by Women The Opinion of The Women on FGM Origin of FGM Beliefs and emotional impact on family members
Health Consequences	Physical consequences Psychological Problems/Emotional Impact Sexual and Reproductive Consequences
Benefits of Treatments	
Knowledge about FGM	Lack of Knowledge about the Causal Relationship between Health Problems and FGM Lack of Knowledge about Existing Treatments and Legislation
Experience of Professionals and with Professionals	Experience of the Women with Professionals Impact of Experience on Professionals and Training Needs
Recommendations of the Professionals in Improving Care	

protected using codes beginning with "P" for the professionals and "E" for the women. The data were analyzed using the thematic analysis technique [35]. The first author coded the data individually and then checked with the second author, constructing the thematic areas through an inductive process, comparing and contrasting constantly recurring themes to respond to the stated objectives [37]. The development of 307 codes showed the richness of the data obtained after the analysis. These codes were finally grouped into thematic areas, always following an emic approach, except for the clinical consequences of FGM described by women where the perspective raised from the point of view of the observer (etic approach) was necessary to analyze. The Atlas.Ti22 software was used to analyze the qualitative data.

2.3. Rigor, combination of perspectives and ethical considerations

To evaluate the rigor of the study, we followed the general criteria of credibility, transferability, dependency, and confirmability described by Guba & Lincoln [38]. Thus, we spent at least 16 months collecting and analyzing the data to understand the participants comprehensively. The data were presented as verbatim quotes and explained according to the interpretation of the authors. The confirmability and credibility of the data were ensured through triangulation. We mentioned the investigation in detail, including descriptions of the perspectives of the participants, the sample, and the context. Finally, this process was systematized, leaving recording each step to facilitate the audit trail. The data had enough depth and richness to meet the goals of the study. The final data analysis included evaluating and consolidating the results obtained from both perspectives to establish areas for improving the care for women.

The Research Ethics Committee of the Hospital Universitario de Canarias in Tenerife approved the study (reference number: CHUC_2021_99). All participants received an information sheet about the study, and they signed the consent form before participation. They were informed that they were free to withdraw from the study at any time, and anonymity and confidentiality of the data would be guaranteed. Permission was requested from the women interviewed in person to audio-record the interview.

3. Results

In the results, we included the perspectives of the women and the professionals interviewed. Because of the sampling techniques used, some women and healthcare professionals interviewed were associated, as the women might have been patients of the professionals. The characteristics of the participants interviewed, and their relation to FGM are presented in Tables 1 and 2. After analyzing the data, the following thematic areas were identified: the meaning of FGM; health consequences; the benefits of treatments; knowledge about FGM; experiences of professionals and with professionals; the recommendations of professionals in improving care. The themes and sub-themes are presented in Table 3.

3.1. Theme 1: meaning of FGM

3.1.1. Definition and description of FGM by women

The women interviewed defined FGM using terms such as "*excision*" (E3), "*cutting*" (E2), "*harmful practice*" (E1), and "*operation or circumcision*" (E4). All of them remembered the moment of the ablation, except for one who only remembered the moments before (E3). They stated that they were told there would be a party and sweets, and thus, they were deceived or manipulated. Then, they reflected on the moments just before the process, with fear or bewilderment, and finally, the moment of the mutilation, with much pain. Some claimed they were mutilated with other girls (E2, E3), and the process can be conducted in the countryside or the city (E1, E3). Usually, it is conducted in the house of the woman who performs it or at her workplace, but sometimes in the house of the girl who will suffer FGM (E2). In one case, the mutilation might have occurred at a midwife's home (E3). The women interviewed described the

process of FGM and its emotional impact as follows:

> "*We did not know anything* (**bewilderment**). *First, they took my sister, I heard that my sister was screaming, and I did not know what was wrong with her because she was older than me. I also started running to see what was happening in the bathroom. It was happening in our house. Then they took me like that and laid me on the ground … there were four ladies, they were strong and big, and you know a child cannot defend herself. One was sitting here (*on her chest*); I remember that then I could not move, I remember I could not move, I could not move until I started pooping* (**fear**) *there in the bathroom. They took it, I do not remember if it was scissors or I do not remember, but they cut it, and it did not go very well because I started bleeding a lot. One of them took one foot; another was sitting here (*on her chest*). I almost died when she was sitting here* (on her chest) *because I could not breathe."* (*E2*).

> "*When they take you to perform the excision, they will tell you, you will see I have chocolates or cookies for you, so we are going to a party. Tomorrow we are going to have a party somewhere … you will see … that was it. And when we are children, we are pleased to go."* (**Deceit/ manipulation**). "*Me, for me, I do not remember it.*" (She does not remember the moment when she was mutilated). (E3).

> "*My grandmother gave me bananas and chocolates and said come with me. We are going to go to celebrate and eat. And I said ok. When they finished* (the excision)*, I saw that all my genitals had blood, and I asked: Grandma, what happened? She said, no, it is nothing; it is a mosquito that bit you."* (**Deceit/manipulation**). "*They took me like that by the hand, and we left. When we arrived, they took a scarf to cover my eyes like that; I remember well, it seems like yesterday. They took the scarf to tie my eyes, and I shouted, and that was it. They tied my eyes like that, and like I was three years old, I had no strength; someone took my legs and eyes like that. They do the treatment like that, without injections and nothing at all. They take scissors or a blade, and then, they cut."*(E4).

3.1.2. The opinion of the women on FGM

When asked about their opinion on FGM, women rejected it and refused to do it to their daughters. However, one woman had ambivalent feelings and described FGM as abuse but also felt pride in following it:

> "*For me, that is abuse. You see, for me, it is abuse. "I do not like it at all; it has to stop; it has to stop*." (E4).

> "*I am proud because I am not the first, you see, I am not the first; my mother did, her sisters, my grandmother, her sisters, all my great-grandmothers did that. So, I am not ashamed because at home we did that … we thought it was a cultural tradition."*(E4).

This woman also changed her attitude toward the meaning of FGM when she contacted the European host country:

> "*Previously, I knew nothing, but when I left my country to come to Europe, I saw how I suffered. It is how we used to live, but now life has changed because we have already discovered that we were doing things I do not know how to explain it … weird things, that is … I do not know how to explain it because it is mistreating people."* (E4).

The women interviewed also considered it as a "harmful practice" (E1), "bad for men" (E3), or "destroying women's health" (E3).

Professionals stated that these women generally reject the practice. However, a professional attended to a pregnant Nigerian patient who supported FGM, considering that she requested information to perform the practice on her daughter (P1).

3.1.3. Origin of FGM

The women interviewed stated that FGM is part of their country's culture and ethnic group.

Although most of them related it to a cultural origin (E2, E3, E4), one of the women claimed that it also has a religious origin.

> "*This is not written in the Koran. We are Muslims. But it is not written in the Koran. When I knew that it was not written in the Koran, I started to hate it."*(E3).

> "*We say it is both* (culture and religion) *because there are Muslims and Catholics among us. So, the Muslims do it, and the Catholics also do it. Some people say it comes from the prophet's time."* (E4). She explained this religious origin through a legend or myth, according to which it started with a married couple who could not have children, so the man married a second woman with whom he had children. The first wife, out of jealousy, mutilated her husband's second wife to avoid them from having a satisfactory sexual relationship and to force her husband to stay by her side (E4).

Other reasons mentioned by women regarding why performing FGM is justified are as follows:

> **Social pressure**: "*At home, we have this mentality, the women, if you do not do it, it seems …, for example, every six or five years we have a ceremony, you see … so if you have a daughter who has not been cut when they are going to do the ceremony you will not be able to join the people, because they will look at you as if you are different. You will not be a part of them."* (E4).

> **A rite of passage***: "If you do not do it, you will not feel like a woman, like a real woman."* (E4).

> **Purity or hygiene**: "*He also says* (her father) *that … you know, previously, parents thought that if a woman does not have it, if she does not cut it, she is not a clean woman. It is what they think, yes. That is what he says."*(E2)

> **To control the sexuality of women**: "*That is the reason. That she will get pregnant without a husband. Outside marriage, this is the cause. It is the reason. That is why we cut. You will be pregnant without a husband, you will not wait until you are 18 or 20, and you will get pregnant before because it makes you want to have sex. For them …*"(E3).

Table 4
Emotional Impact of FGM on family members.

Affected family member	The decision to perform FGM	Emotional impact	Testimonies
Father	Paternal grandmother	Anger	E4: "*When he came back, he stopped talking with his mother because I am his only daughter.*"
		Betrayal/deception	E4: "*You waited until I traveled to do that. If I had known you were going to do that, I would have left out with my daughter. I never would have never left her at home.*"
Mother	Paternal grandmother	Disagreement/betrayal/ deception	E3: "*My mother cried; she told my grandmother, I understand that you do it, but it is too soon; I would have waited until she was six years old to do it. My grandmother said no because, like I was around three years old, it was good.*"
Mother	Father	Sadness/betrayal/ deception.	E2: "*She did not want, my mom did not want, she did not want it. My mom did not want it. When my mother arrived, she started crying.*"

The professionals interviewed also agreed that women justify performing FGM for cultural reasons. However, one professional (P1) stated that some women would also relate it to the sexist customs of their countries, which was not described by the women interviewed. But three women said that men around them would disagree with it, the husband (E2, E3) or the father (E4). Professionals also stated that some women believe there is an association between purity and FGM (P5).

3.1.4. Beliefs and emotional impact on family members

The women interviewed stated that it is a common practice in their families (E3, E4). Usually, their sisters and mothers were also mutilated (E3); however, one woman interviewed was not sure whether her mother suffered it and stated that out of four sisters, only the two eldest suffered the mutilation (E2). Generally, women interviewed were opposed to the beliefs of their families about mutilation. One of them stated that FGM is a part of her family's culture but not her beliefs (E3). However, another interviewee (E4) accepted her family's beliefs.

FGM is usually considered taboo.

> "*She does not know* (her daughter)*; she does not know if they are doing that to women. She does not know. One day, at home, she was watching television and said: Oh look, in Africa, there is a part doing that to women, oh what a shame." "I will never talk about it; I do not like talking to other people, even my children; my daughter is now 20 years old but does not know anything about* it." (E2).

However, some women stated that talking about it relieved them because they consider that it prevents them from feeling resentment or emotional pain or because they think that only those women who have suffered it can speak with certainty on this subject.

> "*For me, it is necessary to speak because if you keep this to yourself in your memory, it hurts. It is necessary to share because when I remember it, it hurts me if I kept it in my heart. So, it is better to express yourself and share the experience with others, to explain how it was done to you."*(E4).

> *"I am going to do everything I can to stop this. Because those women who did not suffer it, that is the chance for them. But we suffered it, even if other people tell me to talk about it. I will talk about it because I am against it."* **"***There are artists who sing this in our country; there are great personalities who say this: stop, stop excision, but they do not understand. So, the fact that you have invited me makes me very, very happy; really, I am delighted.*"(E3).

The decision to perform FGM was not similar among all the interviewees (Table 4), but the father figure or his environment conducted or decided it in all cases. It can be done from six months of age, but the parents decide (E4). There is no specific age, but it is generally done early to avoid opposition from girls. The women in the family are forced to conduct it (E3).

Feelings of disagreement, anger, betrayal, deceit, or sadness among family members are described regarding the experience since, in some cases, the parents are not present when it is conducted or disagree with the process. Hence, family conflicts can arise (Table 4).

3.2. Theme 2: health consequences

FGM led to adverse effects on the health of the women interviewed. The results presented are based on an etic approach in the search for the effects of FGM on the health of the women since, in many cases, the women did not relate their health problems to mutilation.

3.2.1. Physical consequences

The damage caused by FGM significantly affected the physical health of women. These complications might be classified as short-term or long-term.

As short-term consequences, women described much pain, bleeding, anemia (E1), pain while urinating, or inability to walk well for weeks (between two and four weeks). Some women interviewed also claimed to know cases where the girls died during FGM (E2, E3).

> "*I was crying because it hurt. It hurt a lot, and I could not walk well.*"(E2).

Table 5
Pathologies associated with FGM described by professionals.

	Health consequences
Sexual and reproductive	Dissatisfaction in sexual relations (P1) III- and IV-degree tears during vaginal delivery (P2) Anorgasmia (P4) Vaginismus (P4)
Physical	Chronic pain (P4) Recurrent cystitis (P4) Major atrophy in the area (P3)
Psychological	Emotional stress (P1) Difficulty in talking about the subject (P5) They do not accept their body after the cut (self-esteem issues) (P5) Trauma due to people they trusted doing that to them (P5)

"*But when they cut the thing, it did not go very well, and I started to bleed a lot.*"(E2).

"*I could not walk well.*" (E3).

"*When you pee, it hurts … it hurts a lot.*" (E3).

"*When they stopped, I saw that all my genitals had blood.*"(E4).

Women also described difficulty in wound healing, itch, and infections.

"*They put a cream on the wound. For about a month, I could not walk properly, and I could. not put on panties either.*"(E2).

"*You are going to be sick for two or three weeks.*"(E3).

"*The wound took 15 days or more to heal because it itched, so I scratched myself, and the blood came out again. Of course, the wound got infected. I do not know, but I think my infection problems started there.*" "*Sometimes it takes 15 days, or even a month, to heal because what are you going to do? For five days, you put water on the wound, hot water, and then you put a compress or a handkerchief to clean, without soap, without anything, without alcohol, without anything.*"(E4).

In the long term, some women experienced headaches (E3) or urine infections (E2, E3, E4). One interviewee mentioned that the urine infections started when she began sexual intercourse (E4).

The professionals listed chronic pain, recurrent cystitis, and atrophy at the location of the scar (Table 5).

3.2.2. Psychological problems/emotional impact

In the short term, women described the experience as traumatic and painful. They remembered being unable to defend themselves or move. They were held and forced by several women. They also recalled being deceived or manipulated and feeling fear and bewilderment at not knowing what was happening, as mentioned previously in the section on the meaning of FGM, where women described the process of FGM and its emotional impact.

In the long term, some women described suffering from traumatic memories as painful or repetitive memories.

"*What hurts me is just the memory of when I was a child. If I think about it, it hurts.*" "*I just do not want to remember it.*"(E2).

"*It comes to my mind every time. I was three years old; I was only three years old, but till now, it has stayed in my mind. It hurts me when I think about it; that is why I do not want to do that to my daughter.*" "*It remains engraved in my memory; I can never forget it.*" "That is an unforgettable thing because it hurts. It stays in your memory; you see."(E4).

The interviewees also mentioned experiencing self-esteem issues (E1). Specifically, one interviewee expressed feeling incomplete (E2).

"*Sometimes I think that I am a woman, but I am missing something, and that is what I am missing. I do not know because when they removed it* (ablation)*, I was small.*"(E2).

Some women expressed anger, resentment, and impotence.

"*It is something that I did not do myself, it is my father's fault, but I could not do anything.*"(E2).

"*My mom knows that I am very, very, very, very angry with her. I will not forgive her. I tell them that every time. I told her I would not forgive her because it is not written in the Koran.*"(E3).

The professionals stated that the affected women suffer from self-esteem problems, traumatic memories, emotional stress, and difficulty discussing the subject (Table 5).

Table 6
Pathologies associated with FGM, according to professionals, women, or both.

Health Consequences	Both	Only Professionals	Only Women
Sexual and reproductive	-Tears during vaginal delivery - Anorgasmia -Decreased pleasure	- Vaginismus	- Dyspareunia - Menstrual pains - Difficulty in getting pregnant
Physical	- Urine infections	- Chronic pain - Atrophy of the scar	- Anemia - Headaches
Psychological	- Self-esteem issues - Traumatic recall	- Emotional stress - Difficulty discussing this subject	- Anger - Resentment - Impotence

Table 7
Benefits described by professionals after specific treatments.

	Treatment	Treatment benefits
Physical	Behavioral patterns in urination Integration of the vulva into the body scheme Treatment with vulvar moisturizers containing hyaluronic acid	Decrease in recurrent cystitis (P4) Decrease in pain (P4) Improvement of tissue condition after treatment (P3)
Sexual	Perineal massages, self-knowledge, and the use of lubricants, and probiotics	Improvement in sexual intercourse (P4)
Psychological	Talking about what they have experienced Women started exploring themselves. They learned about the type of mutilation they underwent as they had never seen their vulva	Women report feeling relief (P5) Improvement in self-esteem; they have gained self-confidence (P4)

3.2.3. Sexual and reproductive consequences

The women interviewed described problems such as decreased pleasure, anorgasmia, and dyspareunia. One woman stated that she feels pain in each sexual act, assuming that it is a situation that cannot be changed (E4). However, one woman stated that she has no issues during sexual intercourse (E2).

> "*Pain during sexual intercourse*."(E1).
>
> "*It hurts me a lot; it is not good at all.*" (E3).
>
> "*Yes, because the others told us that you do not feel anything if you are cut. I feel nothing; I feel nothing at all. I feel nothing at all during penetration except if my husband uses his hand. Because I am a clitoral woman, I am not a vaginal woman*." (E3).
>
> "*… it hurts me when I make love; it hurts, even now, I feel pain, but what can I do*?" (E4).
>
> **Do you feel pleasure with difficulty? Does it take time for you to feel pleasure? (Interviewer)**.
>
> "*Yes, that is right."*(E4).

Menstrual pain (E1) and complications during childbirth, such as tears, episiotomies, or wound infections, were also described. One of the interviewees claims to have suffered a reopening of the ablation wound during one of her births (E4).

> "*Much pain as soon as the menstruation comes. Every month."* (E3).
>
> "*Childbirth is also difficult for us, for those who have undergone the ablation."*(E3).
>
> "*When I had my first son, I had stitches; with the second one too, but on the third time, I did not have* (stitches)*."* (E2).
>
> "*Yes, in all my deliveries, they did that."*(Episiotomies). (E4)
>
> "*During my second delivery, which I had on the 16th of August of 2021, I almost lost my life … yes, because there was in my genitals, where the operation* (ablation) *was made, there was an infection, you see? So, it was hard; it was really hard."* (E4).

Finally, one woman reported experiencing fertility problems, although she did not attribute it to FGM.

> " *There was something in the pelvis* (lower abdomen, abdomen, or pelvis) *like bubbles or cysts, like a small bubble. That was what hurt me very, very much, and I could not get pregnant. But she* (the gynecologist*) gave me the medicines and injections too. That is how I got pregnant*." (E3).

Professionals described problems such as anorgasmia, decreased pleasure in sexual intercourse, tears during childbirth, and vaginismus (Table 5).

The health problems the women and professionals reported and those which overlapped are presented in Table 6.

Table 8
Experiences of the women with professionals.

Positive experiences	Negative experiences
E4: She described the professionals who have attended to her during her pregnancies and births as pure and generous	E1: She claimed to have not received adequate care and that there were no options for her in Public Healthcare Services.
E3: She was correctly diagnosed during the first visit	E4: She had a bad experience with a midwife during one of her childbirths
E4: She stated that owing to the information received from her midwife, she understood that the complications she had during her births were due to having been mutilated during her childhood	E2: She stated that only some professionals asked her if she had undergone FGM

3.3. Theme 3: benefits of treatments

Only one woman reported having been referred to a specialist by her midwife to receive treatment for pain during sexual intercourse. She received treatment for vaginal dilation to reduce dyspareunia. She continued feeling pain even after treatment during each sexual act (E4). She also received correct family planning information since she was taking oral contraceptives. However, she did not rule out having more children.

The professionals described only one case where the patient had undergone genital reconstruction. Some benefits listed by professionals after treatments are presented in Table 7.

3.4. Theme 4: knowledge about FGM

Only one woman interviewed knew about the type of mutilation she had suffered (E1). One woman also claimed to know of a case of forced marriage in the islands and asylum requests to avoid FGM in their countries of origin, along with three other women who had suffered FGM and reside in Tenerife and Fuerteventura (E1). Two of the interviewed women were aware of the current legislation on FGM in Spain and their countries of origin (Senegal), stating that this practice was prohibited. (E2, E4).

One professional (P1) stated that although most of these patients reject FGM, Senegalese women are the most sensitized and aware of the legislation in Spain and Senegal.

3.4.1. Lack of knowledge about the causal relationship between health problems and FGM

In some cases, the women interviewed knew about the relationship between their health problems and FGM. One of them stated that mutilation destroyed her health by causing severe menstrual cramps every month, headaches, and the absence of vaginal pleasure during sexual intercourse (E3). Another interviewee related FGM to menstrual cramps, painful sexual intercourse, self-esteem problems, and anemia (E1). However, some women did not associate their health problems with mutilation; these problems included complications during their deliveries, such as tears or episiotomies (E2, E4) or recurrent urinary tract infections (E2, E3, E4).

One of the interviewees was also unaware that FGM could cause anorgasmia or difficulty in feeling pleasure during sexual intercourse and dyspareunia.

> "*I had a friend, you know, at home. Only the Diolas, the Peul, and the Mandingue do FGM, but the Wolofs do not, and the Wolofs do not. I had a friend whom I trusted, we talked one day, and I explained my case. She told me she was not cut and that if you are not cut, you feel more pleasure than those who are cut. However, I am not sure; I am not sure if it is true or not.*"(E4).

> "… *it hurts me when I make love it hurts; even now I feel pain, but what can I do*?" (E4).

Another interviewee was unaware of the possibility that FGM might have caused her fertility problems (she conceived via assisted reproductive technology).

> **You have had problems getting pregnant. Do you think there is any relationship with ablation? (Interviewer)** "*I think no, it was not that."*(E3).

One woman interviewed explained that family members are also unaware of the consequences of FGM since parents who favor doing this to their daughters consider that there will be no adverse consequences. They think that their daughters will be fine and in good health (E3).

3.4.2. Lack of knowledge about existing treatments and legislation

Two women interviewed (E1, E3) knew about genital reconstruction, although one did not know that it was done in Spain. The others did not know about this treatment. Although they all showed interest in it, one stated that she would not undergo surgery because she preferred staying that way (E3).

One professional stated that many affected women do not understand the role of a psychologist (P5). Another (P1) said that a pregnant Nigerian patient requested information to do the practice on her daughter, showing a lack of knowledge about the current legislation in our country and hers and also that FGM violates the sexual integrity of women (P1).

Table 9
The recommendations of the professionals in improving care.

P1	Development of a multidisciplinary protocol: This might increase the safety and awareness of health personnel.
P2	Early case detection. Inform and sensitize the population at risk. Include genital reconstruction in Public Healthcare Services. More political involvement: Every region should develop specific health programs. Nursing Colleges should provide specific training, especially to obstetrics and pediatrics staff.
P4	Include physiotherapy as a treatment strategy in Public Healthcare Services, as well as in the action protocol.

3.5. Theme 5: experiences of professionals and with professionals

This section includes specific aspects of the relationship between professionals and women.

3.5.1. Experiences of the women with professionals

The women interviewed generally stated that they had been adequately cared for by health professionals. However, they also related some negative experiences (Table 8).

3.5.2. Impact of the experience on professionals and training needs

All the professionals interviewed had received training in FGM. In one case, the training was not specific to FGM but sexual violence in general. However, they agreed that training in the practice and its consequences must be improved. Sometimes professionals feel helpless and lack preparation in dealing with this situation (P1). This professional also commented that our society was oblivious to FGM and that she had educated herself on this problem to improve the care she provided.

3.6. Theme 6: the recommendations of the professionals in improving care

The professionals suggested various proposals to improve the care provided to these women (Table 9).

4. Discussion

Our study is the first qualitative research on FGM in the Canary Islands. We analyzed the experiences of women who have undergone FGM living on the islands and the perspectives of healthcare professionals who had attended to such patients. The study population of women was originally from Senegal, Gambia, and Guinea, countries from which the Canary Islands assume relevant migratory flows. The prevalence of FGM in these countries is 23.3%, 72.6%, and 94.5%, respectively [7]. One of the women interviewed, born in the Canary Islands, was mutilated during a trip to Gambia. Her experience might represent a more significant problem that has gone unreported and unaddressed. It raises important questions about the prevalence of FGM among women born in Western countries and the need for further research to determine the extent of the problem and identify potential gaps in healthcare and education services to prevent it.

Several misconceptions were identified in this study when some of the women interviewed did not know that their health problems were related to mutilation and were unaware that their quality of life could be improved via proper treatment. Professionals usually feel that they lack sufficient knowledge and resources to deal with these cases adequately.

Our findings also highlight the difficulty of these women in discussing an intimate issue linked to their origins, sometimes leading to conflicting emotions. Thus, culturally sensitive approaches that respect the diversity of the experiences and perspectives of women should be adopted.

Although FGM was considered to be a cultural practice by the women interviewed, they also viewed it as a negative experience. It is related to severe consequences for their health. From a psychological point of view, the women interviewed described self-esteem problems and suffering from traumatic memories. They experienced anger, resentment, impotence, fear, deceit, manipulation, and betrayal [1,26]. The trauma caused by excision has been linked to a “submissive” or “quiet” behavior that can benefit the perpetuation of this tradition [26]. Our study has also documented a similar behavior, such as the rejection of reconstruction in favor of maintaining the current situation or accepting pain during sexual intercourse as normal. The professionals interviewed also noted that many of these women experience emotional stress and difficulty in discussing this subject [1,39].

The physical problems that the women described in the short term after undergoing FGM were pain, dysuria, hemorrhage, anemia, and (of someone else) death [1,40,41]. In the long term, they experienced headaches and urinary tract infections [1,29,42]. The health professionals added chronic pain and atrophy of the scar to the list of long-term problems [1,34,42].

From a sexual and reproductive point of view, the women interviewed described multiple complications such as dyspareunia, tearing during childbirth, anorgasmia, menstrual pain, and fertility problems, as defined by other researchers [16,31,39,41,43]. In our study, the professionals interviewed also reported vaginismus, which was also described by Berg et al. [44]. However, they did not report dyspareunia as a complication that might be related to the lack of knowledge among the affected women about the potential health consequences or the difficulty in discussing FGM, as it is usually considered a taboo subject. However, this issue is not just a taboo for the affected women but also for professionals. One woman interviewed reported that most of the professionals who treated

her did not discuss the issue during the gynecological examination. This silence surrounding FGM in Western countries often leads to dissatisfaction among affected women toward healthcare professionals, as expressed by one woman interviewed who reported a lack of options for her in Public Health Services [25,27,30].

In our study, one interviewed woman underwent specific treatment in an assisted reproduction unit to conceive. Although she did not relate her condition to mutilation, she was diagnosed with ovarian endometriosis. Endometriosis has been described as a possible consequence of FGM [17]. FGM is also related to a higher rate of cesarean section [45], possibly due to the incorrect management of this problem during pregnancy. In Spain, if a patient has undergone infibulation, defibulation (the practice of cutting open the sealed vaginal opening in a woman who has been infibulated) is scheduled between the 20th and 28th week of gestation [46,47]. However, in other countries, such as Switzerland or Belgium, defibulation can be performed during childbirth, in the expulsion phase [34,48].

In Spain and other countries, such as Belgium, FGM is prohibited. However, the law does not explicitly prohibit reinfibulation, which is the procedure to narrow the vaginal opening in women with FGM Type III after defibulation. The same situation also occurs in Switzerland and Denmark, where partial reinfibulation might occur if the patient requests it during or after childbirth [34,47–50]. Some researchers have found that there are cases in Europe where reinfibulation was performed by health professionals after childbirth. In some instances, the women were not previously informed of the intervention [34,51]. Therefore, whether reinfibulation is a criminal offense in certain Western countries is not clear, although some medical organizations oppose it [52,53].

The Spanish Society of Gynecology and Obstetrics (SEGO) has not commented on this issue; however, a study stated that a request for reinfibulation is usually made [54]. Therefore, reinfibulation might be a matter of controversy and ethical problems because professionals might have difficulty distinguishing between reinfibulation and simple suturing after episiotomy. Legislation cannot always resolve these difficulties [55,56].

In some cases, the women interviewed did not relate their health problems to mutilation [29,57]. Three of the four women interviewed were unaware of the type of mutilation they had suffered and that reconstructive surgery was performed in Spain. This might be attributed to insufficient information provided by healthcare professionals [25,27]. The professionals interviewed acknowledged the lack of training in dealing with this problem [58] and concurred that there is a need to provide better training and facilitate access to available resources, particularly among obstetricians and pediatricians. Therefore, providing training to pediatric staff might prevent cases of girls at risk [59]. Professionals interviewed also stated that Public Healthcare Services should provide these women with easy access to reconstructive surgery and physiotherapy as a treatment strategy. In this regard, the first case of an affected woman of FGM receiving physiotherapy treatment in the Canary Health System was described in 2022 [60].

In terms of opinion about FGM, women considered it as an "*abuse,*" "*bad for men*," "*destroying women's health*," a source of "*pride*," or a "*harmful practice*." These results differed from those described in a study by Ballesteros Meseguer et al. [26], where the women interviewed were indifferent to FGM or had no opinion about it.

Regarding the term used to refer to this practice by women, they might reject using words like "FGM" that they feel are imposed outside their community [25,30]. In our study, the Spanish woman used the harshest term, referring to it as a "*harmful practice*," and she was the most aware of the consequences of the practice on her health among all interviewed women. In other cases, FGM was referred to as "*ablation*," "*excision*," or "*operation*." The woman who called it an operation was also proud of being mutilated and did not relate some of her health problems to mutilation. As found by other researchers, we noted that greater education among women could increase the rejection of FGM [57]. Our study also stated that women who emigrate from countries where FGM is practiced might question the practice after settling in Western countries, indicating that cultural exchange and education can change their attitudes toward FGM [27].

Concerning the origin of the practice, the participants stated that FGM is a cultural tradition related to controlling the sexuality of women, a rite of passage, social pressure, and purity or hygiene, as reported by Pastor-Bravo et al. [30]. Sometimes it is associated with religion, although this practice is not mentioned in the Koran. Three of the women interviewed identified as Muslims. However, in a similar study, all participants were Christians, confirming that it is a cultural practice rather than a religious practice [28]. The women interviewed also reported that some men rejected the practice, which might be due to concerns that FGM can reduce sexual pleasure and desire, leading them to prefer non-mutilated women as partners [61].

Although FGM is a deeply ingrained cultural tradition, some women stated that family conflicts occurred when some members opposed the practice. In some cases, manipulation, deceit, or betrayal of family members are used to conduct the practice. These factors suggest that the roots of FGM might not be as firm now as they once were or that changes might be occurring within communities that practice it. For example, alternative practices, such as rituals that do not involve cutting, are being adopted in some societies [62].

Finally, based on the description of one of the women participants, it is concerning that there are cases of forced marriage in the islands, suggesting its possible relationship with FGM [48].

4.1. Limitations of the study

Finding women with FGM residing in the islands who would agree to participate in the study and professionals who had attended to such women was difficult. This difficulty occurred probably because of the under-diagnosis of cases due to a lack of specific training of the professionals or because they decided not to intervene as they probably consider it to be a cultural tradition. Similarly, women often consider FGM a taboo subject, making it difficult to discuss the problem openly, or the emotional impact of the experience can be so intense that many women avoid remembering their experience. Another limitation is the geographic dispersion of the islands.

Table 10
A summary of the implications for the clinical practice.

What to do?	Recommendations
For prevention and awareness	1. The use of excessively critical terms in the first contact should be avoided. The term FGM should be replaced with ablation or excision, or the patient's terminology might be used. 2. The women and their families should be informed about the severe health consequences (including the possibility of death) and current legislation in Spain and their countries of origin. 3. Exposing certain myths: FGM is not mentioned in the Koran, so the religion does not suggest it, and there is no relationship between purity or hygiene and FGM. 4. The women and their families should be informed about the association between FGM and decreased sexual pleasure and desire to have sex and the possibility of infertility. 5. An ally in the family should be identified to avoid reproducing this action among other family members (some family members oppose the practice of FGM). Having an ally in the family can facilitate a change within the family's culture and prevent them from feeling questioned by external cultural perspectives. 6. Husbands and fathers should be sensitized as they might help in changing the opinion of others. 7. Alternative practices to FGM should be informed about (rite without cut). 8. In pregnant women with FGM, mutilation of the daughter should be prevented. The mother should be asked about her beliefs concerning FGM and the pediatric service should be notified if necessary.
To attend women with FGM.	1. The beliefs of each woman should be addressed individually. They should be asked about the meaning, value, and consequences of FGM, considering their cultural context. 2. Although FGM is a cultural practice, women usually perceive it negatively. We share the same negative vision, which can help to break down the barrier between cultures. 3. If women do not want to talk about their experiences (a taboo subject or painful memories), successive appointments should be made to earn their trust, and discussion regarding the issue should be avoided at the first consultation. 4. The women should be informed about the type of mutilation they have suffered 5. The use of excessively critical terms should be avoided in the first contact. The term FGM should be replaced with ablation or excision, or the patient's terminology might be used (some women might have ambivalent feelings). 6. The women should be informed about possible treatments such as genital reconstruction and referred to a gynecologist, psychologist, or physiotherapist. 7. The health consequences should be fully explained, focusing on those issues that are least known to the women, such as issues affecting their sexual and psychological health, or those that affect their physical health, such as repeated urinary tract infections. 8. If pregnant women have infibulation, defibulation should be performed (between the 20th and 28th week of gestation) and they should be informed that reinfibulation after delivery will not be performed.

5. Conclusions

We provided an opportunity to women who experienced FGM and were living with its consequences and to professionals who attended to these cases to share their experiences and perspectives. Both parties identified the lack of training concerning this problem, highlighting the urgent need to improve the diagnosis and treatment. Our findings indicate that when qualified professionals attend to such women, they receive accurate information, which increases their chances of rejecting FGM. These women also benefit from treatments that improve their quality of life. Although they are often overlooked, these women suffer from significant sexual and reproductive problems, including infertility. Therefore, obstetricians and gynecologists must be aware of these consequences and receive training in defibulation and genital reconstruction techniques. Additionally, reconstructive surgery should be easily accessible in Public Health Services. Clear instructions should also be provided regarding the non-recommendation of reinfibulation after birth.

Finally, we found that being born in Europe does not protect these women from FGM. In such cases, they must confront the cultural shock of being born in a Western country and suffering FGM outside of any cultural context, along with the severe sequelae. This highlights the importance of training pediatric staff to prevent cases. The identification of cases of FGM among women born in the islands, the requests for asylum to escape from FGM, and cases of forced marriage, which might be linked to FGM, highlight the need for urgent action from institutions in the Canary Islands. This includes developing training and awareness programs for health professionals, including those in university degree programs, and also for society, in general, and those at risk, in particular.

5.1. Implications for care practice

Some recommendations that might enhance the quality of care provided to these women are presented in Table 10.

Author contribution statement

Nieves Correa-Ventura: Conceived and designed the study; Performed the study; Analyzed and interpreted the data; Wrote the paper.

Vinita Mahtani - Chugani: Analyzed and interpreted the data; Contributed analysis tools or data; Wrote the paper.

Delia Báez -Quintana: Conceived and designed the study; Contributed analysis tools or data.

Data availability statement

Data will be made available on request.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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