# THE EXPERIENCES AND PERCEPTIONS OF GENITALLY MUTILATED FEMALES AND HEALTHCARE PRACTITIONERS IN SOUTH EASTERN NIGERIA

**OLUCHUKWU LOVETH OBIORA**

**A thesis submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in fulfillment of the requirements for the degree of Doctor of Philosophy.**

**Johannesburg, 2020**

## DECLARATION

**I, Oluchukwu Loveth Obiora, declare this thesis is my own work. It is submitted for the degree of Doctor of Philosophy at the University of the Witwatersrand, Johannesburg. It has not been submitted for any degree or examination at this or any other university.**

**Signature:**

**Date: 31/01/2020**

## DEDICATION

This work is dedicated to females and families who may have suffered morbidity and/or mortality as a result of female genital mutilation/cutting (FGM/C). I pray that this work would contribute to evidence that would be used to develop interventions that could accelerate the ending of this practice, empower genitally mutilated females towards improved self-care, and then create a society where FGM/C and its complications will only be history.

**ACKNOWLEGMENTS**

With a deep and profound gratitude, I express my heartfelt appreciation to God Almighty for his love, grace, provision, guidance and protection, and for bringing me this far in this noble profession.

I am deeply grateful to the community leaders, healthcare practitioners and females in South Eastern Nigeria for allowing me entrance into their communities, and the latter for sharing their FGM/C experiences with me. I salute your courage.

I remain grateful to my supervisors, Prof. JE Maree and Dr Nokuthula Nkosi-Mafutha for their patience in reading this work, making necessary corrections and suggestions to ensure this work met the required standard. My sincere gratitude also goes to the entire staff of the Department of Nursing Education, University of the Witwatersrand whom I had the opportunity of working with during my doctoral study in this great institution.

I want to say a big thank you to my husband Engr. CN Obiora, and our children - CJ and CM without whose patience and support, I would never have reached this milestone. Finally, I want to thank my dad, relatives and senior friends who always supports me despite all the odds. May God bless you all.

## ABSTRACT

**Background:** Female Genital Mutilation (FGM), also referred to as Female Genital Cutting (FGC) or female circumcision (FC), remains a contributor to the high morbidity and mortality among females in Africa. Despite concerted efforts to curb it, the practice continues among many ethnic groups, especially in Africa. Various studies have been conducted, focusing on this practice. However, in Africa, there is a paucity of literary work on the experiences of females who underwent FGM/C, and the experiences of healthcare practitioners who care for these genitally mutilated females is also unknown.

**Aim of the study:** The aim of this study was to obtain insight into the Female Genital Mutilation/ cutting (FGM/C) experiences of females and healthcare practitioners in South Eastern (SE), Nigeria where the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) Nigeria (2016) reported a steady rise in their FGM/C prevalence; and also to develop a comprehensive, context-specific health education pamphlet (HEP) for the females based on the identified health information needs. The study was underpinned by the self-concept theory and the theory of ethical relativism.

**Methods:** This was a multi-method study which employed a scoping literature review, a qualitative descriptive method, and a methodological triangulation for the development of a HEP for the genitally mutilated females. Therefore, the study had three phases. Phase one was the scoping literature review of FGM/C in Africa, Phase two was a qualitative description of the FGM/C experiences of genitally mutilated females, mothers of genitally mutilated girls and the healthcare practitioners in SE Nigeria, while Phase three was the development of a health education pamphlet (HEP) for use by the genitally mutilated females.

**Findings:** The first phase of the study revealed FGM/C was still being practiced widely in Africa despite interventions such as anti-FGM/C laws and campaigns. Evidence found has also revealed there might have been an increase in "early-age" (0 to 10 years) FGM/C in some communities, and that the FGM/C studies done between 1 January 2007 and 31 December 2016 were mostly quantitative studies focused on the prevalence, attitude, perpetrators and health consequences of FGM/C. Studies investigating the experiences of all the role players involved in this practice and how to prevent it were absent. Understanding these phenomena could guide efforts to curb this harmful practice. In the second phase of the study, the participants equated FGM/C to male circumcision and noted that culture was mostly responsible for the continuation of the practice over the years. Regardless of the pain associated with this practice, some of the participants were forcefully circumcised to ensure adherence to their culture. Among the female participants, feelings of uncertainty, fear, and

helplessness were experienced. Moreover, healthcare practitioners reported feelings of not being adequately equipped with the advanced skills required in the care of genitally mutilated females, especially during childbirth. Also reported were cases of child mortality and other healthcare challenges owing to FGM/C. In the third phase, three synthesized findings were generated from the methodological triangulation of conclusions from Phases one and two: “FGM/C: past and present situations,” “factors that sustained FGM/C” and “health information needs.” In response to the health information needs identified, a health education pamphlet (HEP) was developed to improve self-care among the females.

**Conclusion**: This study provided evidence that FGM/C is ongoing in Africa. Although it is illegal in many countries, females and healthcare practitioners still support this procedure as it is seen as a part of the culture. Some women were forcefully circumcised. Feelings of uncertainty, fear and helplessness were reported among the females. Cases of child mortality and other healthcare challenges due to FGM/C were also experienced. In response to the information needs that emerged from the scoping review and the qualitative investigation, a health education pamphlet was developed to inform the genitally mutilated females on what FGM/C was all about, self-care after FGM/C, and what to do when under pressure to circumcise their daughters.

**PRESENTATIONS ARISING FROM THIS STUDY**

Obiora, O.L., Maree, J.E. & Mafutha, N.G. 2019. Female Genital Mutilation in Africa: Scoping the landscape of evidence. The 26th Cochrane Colloquium. Santiago, Chile, South America**.** October 22-25, 2019.

Obiora, O.L., Maree, J.E. & Mafutha, N.G. 2019. Experiences of young girls who underwent female genital mutilation/cutting. School of Therapeutic Sciences Research Day, University of the Witwatersrand, Johannesburg**.** September 10, 2019.

Obiora, O.L., Maree, J.E. & Mafutha, N.G. 2019. "…Most women who come to us are circumcised…" experiences of healthcare practitioners who care for genitally mutilated females. Department of Nursing Education Research Day**.** September 20, 2019.

Obiora, O.L., Maree, J.E. & Mafutha, N.G. 2019. Female Genital Mutilation in Africa: Scoping the landscape of evidence. Cross-Faculty Postgraduate Symposium, University of the Witwatersrand, Johannesburg**.** September 3, 2019.

Obiora, O.L., Maree, J.E. & Mafutha, N.G. 2019. Female Genital Mutilation in Africa: Scoping the landscape of evidence. Sigma Theta Tau International: Chi Xi-at-Large Chapter: Second Biennial Conference, Malawi. August 14-16, 2019.

Obiora, O.L., Maree, J.E. & Mafutha, N.G. 2019. Experiences of young women who underwent Female Genital Mutilation. Sigma Theta Tau International: Chi Xi-at-Large Chapter: Second Biennial Conference, Malawi. August 14-16, 2019.

Obiora, O.L., Maree, J.E. & Mafutha, N.G. 2019. Female Genital Mutilation in Africa: Scoping the landscape of evidence. African Epidemiological Association Conference, Maputo, Mozambique. April 14-17, 2019.

**ACRONYMS AND ABBREVIATIONS**

| | |
|---|---|
| CHEW | Community Health Extension Workers |
| FC | Female Circumcision |
| FGC | Female Genital Cutting |
| FGM | Female Genital Mutilation |
| FGM/C | Female Genital Mutilation/Cutting |
| MICS | Multiple Indicator Cluster Survey |
| NDHS | National Demographic and Health Survey |
| NPC | National Population Commission |
| SE | South East |
| TBA | Traditional Birth Attendants |
| UNICEF | United Nations Children Fund |
| UNFPA | United Nations Population Fund |
| VVHW | Voluntary Village Health Workers |
| WHO | World Health Organization |
| HEP | Health education pamphlet |

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

# CHAPTER ONE
# OVERVIEW OF THE STUDY

## 1.1 INTRODUCTION

This chapter introduces the study, gives the background, the problem statement, aim of the study, the research questions and objectives, significance of the study, research design and the clarification of concepts used. The chapter concludes with an outline of the overall study.

## 1.2 BACKGROUND TO THE STUDY

Female Genital Mutilation (FGM) also referred to as Female Genital Cutting (FGC) or Female Circumcision (FC), has drawn considerable attention from many organizations and researchers worldwide. This is a harmful practice that has both short and long-term complications, and it continues among many ethnic groups, especially in Africa, as it is based on myths and religion passed from generation to generation (Onuoha, 2018; UNICEF & UNFPA, 2018). Although widely recognised as a violation of human rights, FGM/C is believed to be an ancient practice originating from communities who wanted to control female sexual behaviour and ensure women's virginity by reducing their sexual desire (Rafferty, 2013; Berg & Denison, 2013; WHO, 2017). Key among these myths is that some communities believe the clitoris contains powers strong enough to cause harm to a male penis, or to kill a baby during child birth. Other reasons why FGM/C is practiced include sexual purity, marriageability, economic empowerment - as it is a means of income generation for the circumcisers, and rite of passage into womanhood (UNICEF & UNFPA, 2016).

According to the World Health Organization (WHO) (2018), FGM/C includes all procedures involving partial or total removal of the external female genitalia and/or injury to the female genital organs, whether for cultural or non-therapeutic reasons. The WHO (2017) classified FGM/C as follows:

- Type I: Partial or total removal of the clitoris, and in very rare cases only the prepuce is removed (clitoridectomy).
- Type II: Partial or total excision of the clitoris and the labia minora, with or without excision of the labia majora. It is often referred to as excision.
- Type III: Often referred to as infibulation, this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning of the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoris. Infibulation is also known as the Pharaonic form of genital circumcision.

- Type IV: This includes all other forms of non-therapeutic genital alteration, such as pricking, piercing, incising the clitoris or labia, stretching the clitoris or labia, cauterizing the clitoris and surrounding tissue, scraping the vulvar vestibule, cutting the vagina and introducing caustic substances, poultices or herbs into the vagina to create tightening or narrowing of the vaginal vault.

From a health perspective, FGM/C can lead to immediate post-surgery complications, such as haemorrhage, genital tissue swelling, shock, infection and death; as well as some severe long-term effects such as increased risk of childbirth complications, sexual problems, scar tissue and keloid formation, and a need for de-infibulation (Ekenze et al., 2007; Kaplan, et al., 2013; Bogale, Markos & Kaso, 2014; WHO, 2017; WHO, 2018). From a psychosexual perspective, mutilation can lead to dyspareunia (Anis, AboulGheit, Awad & Saied 2012), which can lead to crises among couples. FGM/C could have a detrimental impact on the economic and social development of females and prevents them from realising their full personal potentials (UNICEF, 2006). This is because the moment a girl is circumcised, it indicates she has gradually transited from being a girl to a woman and is now marriageable, thereby predisposing the girl to early marriage with the attendant consequences of dropping out of school (Njogu, 2018) and adolescent pregnancy.

However, even with the knowledge of the harmful consequences, the practice continues to be valued for a variety of culturally “good” reasons, which contribute to people’s social standing and ultimately, the social fabric of a community (Chege., Askew, Igras & Mutesh, 2004). This is in tandem with the statement of Fund and Gupta (2013) that the practice of FGM/C has proven remarkably tenacious despite attempts spanning over nearly a century to eliminate it.

Although the exact number of girls and women affected is unknown, it is estimated that more than 200 million females alive today have undergone some form of FGM/C with another 30 million at risk of being mutilated in the next decade (WHO, 2017; WHO, 2018). FGM/C is most commonly practiced in a swath of 29 countries across Africa and the Middle East, stretching from the Atlantic coast to the Horn of Africa.

The practice is found to a lesser degree in other parts of the world (Fund & Gupta, 2013), such as in certain ethnic groups in Central and South America (WHO, 2008). This is due to the rise in international migration, which has increased the number of girls and women living in the various diaspora populations, including in Europe and North America, who have

undergone or may undergo this practice (UNICEF, 2016). In addition, Davis and Jellins (2019) reported a rise in the number of women who underwent FGM/C in Australia.

According to UNICEF (2016), eight African countries have an FGM/C incidence of more than 80%; Somalia has the highest incidence of 98%, followed by Guinea, Djibouti, and Egypt with an incidence of more than 90% and Eritrea, Mali, Sierra Leone and Sudan with an incidence of more than 80%. However, FGM/C is widely practiced in Nigeria, where an estimated 21.6 million women of childbearing age have undergone the procedure (UNFPA & UNICEF, 2016); this accounts for 24.5% of the practice globally (Nigeria Demographic Health Survey, [NDHS] 2013). According to 28 Too Many (2018), of the 55 million girls (aged 0 to 14) who have experienced or are at risk of FGM/C in Africa, 50% of them are from three countries: Egypt, Ethiopia and Nigeria. However, since Nigeria is the most populous of these countries (NDHS, 2013) it may also have a larger share of the 50%.

In 2008, a global UNFPA/UNICEF joint programme on the abandonment of FGM/C was launched and is currently implemented in 17 countries. Nigeria joined this global programme in December 2013, but the actual implementation commenced in 2014 in Imo, Ebonyi, Osun, Ekiti, Oyo and Lagos States, with a joint FGM/C Situation Assessment (UNICEF & UNFPA, 2016). These states were chosen because of their high prevalence of FGM/C compared to other states, such as Delta and Akwa Ibom, where FGM/C is also practiced. According to the baseline situation analyses conducted by the Nigeria Demographic Health Survey (NDHS) (2013), the FGM/C prevalence rate in Southwest Nigeria was the highest in the country and little progress has been made in terms of eradicating this practice since the prevalence rate of about 57% in 2003 only decreased to 48% in 2013.

Conversely, the South Eastern region, where this study was conducted, experienced a steady increase in the practice from 40% in 2003 to 48% in 2013 (NDHS, 2013). Despite the reported increase in awareness resulting from the campaign of UNFPA and UNICEF in this region (UNICEF & UNFPA, 2016). This evidence indicates that if this practice is to be eradicated, the FGM/C culture and belief system of the practitioners which includes their experiences, perceptions and motivators for the practice, must be understood. Specific community-led interventions can then be designed to deliberately and effectively bring an end to the practice, while context specific measures can be developed to improve self-care among the females who are already genitally mutilated.

## 1.3 Statement of Problem

The research problem for this study relates to female genital mutilation/cutting (FGM/C). It is internationally recognized as a violation of the human rights of women and girls, as well as a violation of the human rights of children, as minors are sometimes subjected to this cruel, discriminatory procedure (WHO, 2017). It is estimated that about 200 million women and girls who are currently alive have undergone some form of FGM/C, with Nigeria responsible for 24.5% of this population (WHO, 2017; NDHS, 2013). According to UNICEF and UNFPA (2016), Nigeria being the most populous country in Africa currently has the third largest number of women and girls globally who have undergone some form of FGM/C (21.6 million); this implies one in four women aged 15 to 49 years in Nigeria have been genitally mutilated (UNICEF & UNFPA 2016).

Onuoha (2018) wrote that despite the efforts of human right activists in the country, or the bill passed by National Assembly in 2015 in Nigeria, the spiritual and traditional attachment to FGM/C by the practitioners has made it impossible to eliminate, while some traditionalists believe it will bring loss of cultural identity. On paper, FGM/C is acknowledged as a form of oppression towards women and girls in Nigeria, but in reality, many value the tradition (Edeh, 2017), and some communities have even medicalised the practice (UNICEF & UNFPA, 2016). In addition, the ban on FGM/C could lead to an increase in maternal and child morbidity and mortality in these communities because adherents of FGM/C might not seek health care when experiencing complications in order to avoid prosecution. Evidence has shown that the reasons for continuing FGM/C are culturally and religiously based (WHO, 2017), thus the practice is grounded in peoples' belief system.

UNFPA and UNICEF (2016), in their campaign fliers to end FGM in Nigeria verbalised that FGM/C puts a woman's reproductive health at risk, makes her 30% likely to lose babies during labour, 40% likely to suffer and eventually die from health complications, 70% more likely to suffer from haemorrhaging during child birth, and two times more likely to die during childbirth. Also, various studies have been conducted in Africa focusing on this practice. When exploring the literature of the past 10 years, the researcher found these studies primarily investigated the prevalence of FGM/C and the health consequences associated with the practice (Bogale, Markos & Kaso, 2014; Kaplan, et al., 2013; Rodriguez, et al., 2016) and to a lesser extent, intention to continue FGM, motivators and perpetrators for this practice and the association of FGM/C with intimate partner violence (Salihu et al., 2012; Bogale et al., 2015; Abathun et al., 2016). However, the experiences of women and girls living in Africa, who underwent this procedure and must live with its consequences, are not known due to paucity of literature. In addition, the experiences of healthcare

practitioners, such as nurses, midwives and nurse aids who care for these genitally mutilated females, also seem to be unknown.

This study was therefore an attempt to address the identified knowledge gap, by obtaining insight into the experiences of women, girls and mothers of girls who underwent FGM/C, and the FGM/C experiences of the healthcare practitioners in communities of South Eastern, Nigeria where UNICEF and UNFPA (2016) reported a steady increase in FGM/C prevalence. Understanding the FGM/C experiences of these females and the healthcare practitioners is essential in the designing of effective community - led interventions to curb this practice, and in the development of a health education pamphlet to improve self-care of the genitally mutilated females.

## 1.4 AIM OF THE STUDY

The aim of a study is defined as the broader, more abstract proposal of what the research should contribute to the current body of knowledge, whereas the objectives are referred to as the more tangible, more promptly attainable plans (de Vos et al., 2011). Therefore, this study aimed to obtain insight into the experiences and perception of women, girls and mothers of girls who underwent FGM/C; the FGM/C experiences of the healthcare practitioners caring for these females, and to develop a health education pamphlet (HEP) for use by the genitally mutilated females.

### 1.4.1 Research Questions

To achieve the aim stated above, this study was guided by the questions below:

- What is the documented research evidence on FGM/C in Africa over a period of ten years?
- What are the FGM/C experiences and perception of genitally mutilated females and healthcare practitioners caring for these females in South Eastern, Nigeria?
- What health education pamphlet (HEP) can be developed to improve self-care of the genitally mutilated females?

### 1.4.2 Research Objectives

In line with the aim and the research questions stated above, the objectives of this study were to:

- Explore the documented research evidence on FGM/C in Africa over a period of ten years

- Describe the FGM/C experiences and perception of females living in South Eastern Nigeria
- Describe the FGM/C experiences of healthcare practitioners caring for these females in South Eastern Nigeria.
- Develop a health education pamphlet (HEP) to improve self-care for the genitally mutilated females.

The objectives of the study were achieved through the phases presented in Figure 1.

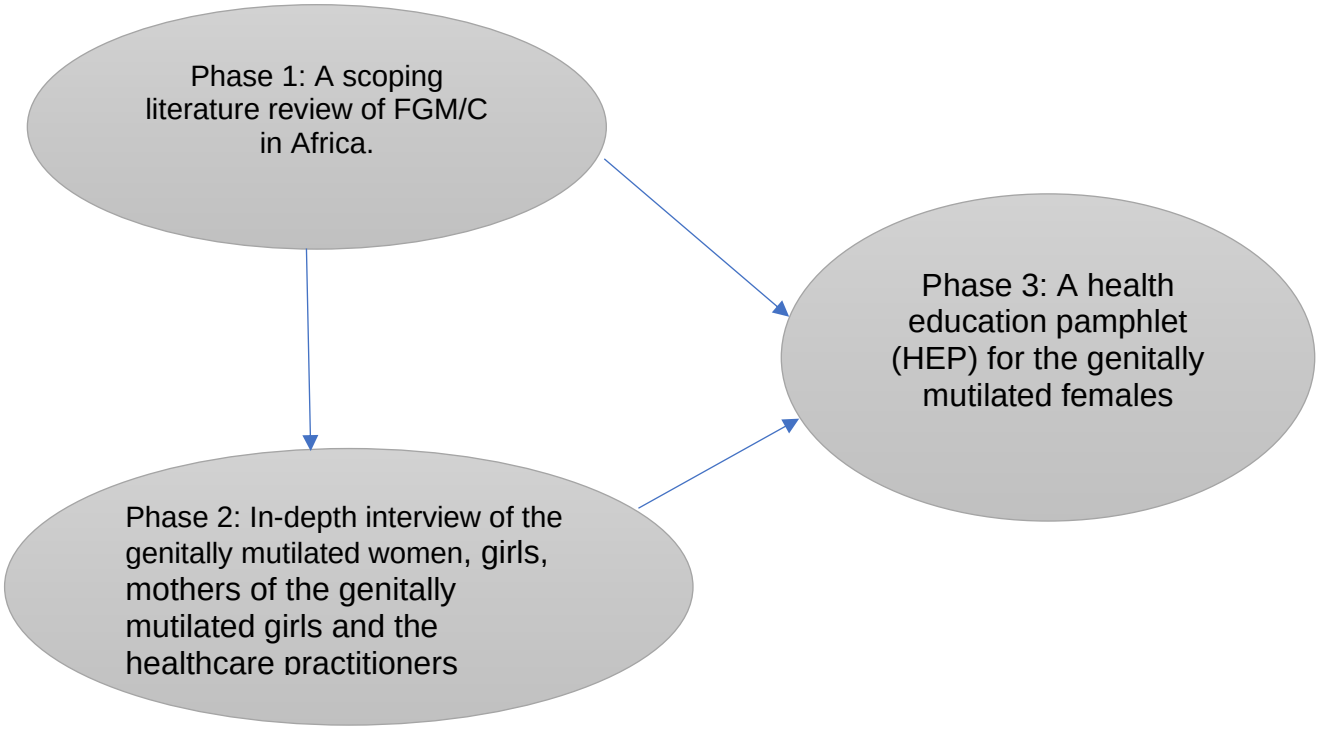



**Figure 1.1: Phases of the study**

### 1.5 SIGNIFICANCE OF THE STUDY

Heather (2013) suggested the belief systems of Africans affect their traditional practices. Culture remains an important aspect of the people's identity, and the practice of FGM/C is deeply rooted in cultural and social myths; therefore whatever the community validates and embraces as their culture is often imbibed and thus provides a strong opposition to change (UNICEF & UNFPA, 2016). The researcher is of the opinion that experiences of those who underwent this procedure may appeal to the conscience of the custodians of the FGM/C culture in various communities, thereby contributing positively in reducing the support for the

continuation of the practice. This could lead to a significant reduction in morbidity and mortality as a result of the decrease or abandonment of FGM/C.

Understanding the experiences of the genitally mutilated females and their healthcare practitioners, who might be perpetrators but also caretakers for these females, would create awareness of the lives of these females. The findings could therefore be used to strengthen, national and international attempts to eradicate this practice.

A better understanding of the experiences of the study population might inform healthcare practitioners and researchers in developing evidence-based practices that would ensure high quality care and management of FGM/C in various Nigerian communities, and especially in countries such as South Africa - which has a high influx of women from Somalia, Egypt, Zimbabwe, Nigeria and other African countries - where FGM/C is reported as not being concentrated in any specific province, and so the prevalence has not been determined (Isilo, 2011; eNCA, 2015; UNICEF & UNFPA, 2016).

Finally, to the best of the researcher's knowledge, this is the first multi-method study into the FGM/C experiences and perception of mothers of genitally mutilated girls regarding their daughters' FGM/C and that of healthcare practitioners working in the FGM/C practicing communities, while still taking into account the FGM/C experiences of genitally mutilated girls and women in a region. Triangulating the findings from these data sources might contribute to literature to inform future programme designs of FGM/C eradication activities operating at community levels in Nigeria, Africa and the World at large. The findings could also contribute to the achievement of the sustainable development goals (SDG) that are geared towards the reduction of maternal and child morbidity and mortality, gender equality and the empowerment of girls and women.

### 1.6 RESEARCH DESIGN

This is a multi-method study which involved a scoping literature review and a qualitative descriptive method, with the development of a health education pamphlet as an outcome. This is justified by the statement made by Polit and Beck (2014) that descriptive qualitative studies tend to be eclectic in their designs and methods and are based on the general premises of constructivist inquiry. Phase one of the study was the scoping literature review, Phase two was a qualitative description of the experiences of the mutilated females and their healthcare practitioners, while Phase three was the development of a practice guide for high quality health care of the genitally mutilated females. Each phase, with the corresponding research design, was discussed fully in the method chapter of this study.

## 1.7 CLARIFICATION OF CONCEPTS

For the purpose of clarity, the meanings of certain concepts as used in the study are presented below:

**Experiences**: The way the study participants underwent FGM/C and how it made them feel (Cambridge University Press, 2019). The feelings may be physical, emotional, cultural, sexual, or social. It is a process that influences the entire life of an individual or group and might lead to a change of behaviour and way of thinking toward life (Boud, Keogh & Walker, 2013).

**Perceptions**: The way people think about FGM/C, what they believe and understand it to be.

**Females**: These are genitally mutilated girls, genitally mutilated women and mothers of genitally mutilated girls.

**Girls**: Females within the age bracket of 10 to 19 years of age (WHO, 2017) in this study.

**Women**: Females up to 20 years of age and above in this study.

**Healthcare practitioners**: Members of the health care team - Registered Nurses, Registered Midwives, Community Health Extension workers (CHEWs) and Voluntary Village Health Workers (VVHWs) - who work and reside in the FGM/C practicing communities. However, the participants in our study referred to all female healthcare practitioners as nurses during the interviews. In Nigeria, healthcare is provided by professionals such as registered nurses, midwives and medical doctors, semi-skilled community health extension workers (CHEWs) who also have some formal training which enables them to render healthcare services, and unskilled voluntary village health care workers (VVHW). In addition, the unskilled traditional birth attendants (TBA) who have also go round the villages to assist women during childbirth, while some of them use some spaces in their houses as their clinics where they render health care assistance to the women who consult them. However, in most rural communities in Nigeria, the VVHW and CHEWs seems to form a larger population of the health care practitioners, followed by the registered nurses and midwives who primarily man the health facilities, with the medical doctors visiting the health facilities on some specific days. Although not certified for such procedures, CHEWs and VVHWs often perform episiotomies and vaginal suturing when delivering babies (Aluko, Anthea & Marie Modeste, 2019).

**Motivators of FGM/C**: Factors that promote FGM/C in the communities.

**Medicalisation**: A situation where FGM/C is performed by any healthcare practitioner in the home, private or public health facility (WHO, 2010).

**Infibulation**: This refers to the narrowing of the vaginal orifice by removing the clitoris and labia, after which the remaining edges of the vulva are sutured (Mackie, 1996).

**De-infibulation**: This is a surgical procedure that is done to re-open the vaginal orifice of a woman who has been infibulated, to enable her to have less painful sexual intercourse or to facilitate childbirth (WHO, 2018).

### 1.8 OUTLINE OF THE STUDY

The following is an outline to the rest of the study:

**Chapter Two**: Literature review and philosophical underpinning of the study

**Chapter Three**: Research design and methods

**Chapter Four**: Scoping literature review

**Chapter Five**: FGM/C experiences of females and healthcare practitioners
A: In-depth interview of genitally mutilated women
B: In-depth interview of genitally mutilated girls
C: In-depth interview of mothers of genitally mutilated girls
D: In-depth interview of healthcare practitioners

**Chapter Six**: Discussion and interpretation of findings

**Chapter Seven**: Development of a health education pamphlet (HEP) to meet the health information needs of the genitally mutilated females

**Chapter Eight**: Recommendations, limitations, researcher's reflection and conclusions.

## 1.9 SUMMARY OF CHAPTER ONE

This chapter provided an overview to the study, including the clarification of concepts used in this study. Chapter Two provides an in-depth review of literature on Female Genital Mutilation/Cutting, as well as the philosophical underpinning of the study.

# CHAPTER TWO
# LITERATURE REVIEW

## 2.1 INTRODUCTION

The previous chapter gave an overview of the study, which included the background to the study, the problem statement, significance, objectives, aim, research questions and clarification of some words used in the study. A brief overview of the research methodology was also presented. This chapter begins with a brief history of FGM/C and the reason for using the term “FGM/C”, discusses in detail the conceptual framework for FGM/C, and then closes with philosophies underpinning the study.

## 2.2 HISTORICAL PERSPECTIVE OF FGM/C

There is no ascertained origin for FGM/C; however, Knight (2001) argued that FGM/C was practiced in ancient Egypt. He explained that a Greek geographer named Strabo wrote about FGM/C after visiting Egypt around 25 B.C.E, "*This is one of the customs most zealously pursued by them [the Egyptians]: to raise every child that is born and to circumcise the males and excise the females*" [p. 318].

According to Knight (2001), Philo Judaeus also referred to this practice, "*The Egyptians by the custom of their country circumcise the marriageable youth and maid in the fourteenth (year) of their age, when the male begins to get seed, and the female to have a menstrual flow*" [p. 333].

Another Greek physician, Aetios of Amida (mid-5th to mid-6th century CE), according to Knight (2001) offered more details in Book 16 of his *Sixteen Books on Medicine*. Aetios wrote that FGM/C procedure was performed in case the clitoris grew too large or triggered sexual desire when rubbing against clothing. "…*On this account, it seemed proper to the Egyptians to remove it before it became greatly enlarged, especially at that time when the girls were about to be married…*" [p. 327]

Mackie (1996) explained that a Portuguese missionary Dos Santos (1609) described a group near Somalia, who had a "*custom to sew up their females, especially their slaves being young to make them unable for conception, which makes these slaves sell dearer, both for their chastity, and for better confidence which their Masters put in them*" [p. 1003] . Thus, Mackie argues, FGM/C that was formally associated with female slavery has come to stand for honour in several communities today.

Furthermore, in the 19th-century, gynaecologists in Europe and the United States removed the clitoris to treat insanity and masturbation (Rodriguez, 2008). Later in the 19th century, A. J. Bloch, a surgeon in New Orleans was said to have removed the clitoris of a two-year-old girl who was reportedly masturbating (Hoberman, 2005). Cutner, (1985) also reported that clitoridectomy was performed in the United States into the 1960s to treat hysteria, erotomania and lesbianism.

From the mid-1950s, James Burt, a gynaecologist in Dayton, Ohio, performed non-standard repairs of episiotomies after childbirth, adding more stitches to make the vaginal opening smaller. From 1966 until 1989, he performed what was called "love surgery" by cutting women's pubococcygeus muscle, repositioning the vagina and urethra, and removing the clitoral hood, thereby making their genital area more appropriate, in his view, for intercourse in the missionary position (Rodriguez, 2014). All these point to the fact that FGM/C is a global concern, not just a problem conceived in Africa.

### 2.3. WHY USE THE TERM "FEMALE GENITAL MUTILATION/CUTTING (FGM/C)"?

There have been debates on the terminology with which to refer to the practice of FGM/C. This practice was widely known as female circumcision (FC) and some people, especially those from the practicing communities still use the term FC to date. However, in 1929, the Kenya Missionary Council referred to it as sexual mutilation of women (Karanja, 2009) while Hayes (1975), an American anthropologist, used the term FGM in the title of a paper in American Ethnologist. In 1990, the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children referred to this practice as FGM, while the WHO followed suit in 1991 (UNICEF, 2013). It was from this trajectory that other English terms such as female genital cutting (FGC) and female genital mutilation/cutting (FGM/C) are in use today (WHO, 2008).

Over-the years, some anthropologists have accused the anti-FGM/C crusaders of cultural colonialism. They argued that the failure of the anti-FGM/C crusaders to appreciate FGM/C's cultural context serves to discriminate the practitioners and invariably undermine their agency – particularly when parents are referred to as 'mutilators' (Kirby, 2005). The feminist theorist Obioma Nnaemeka who is strongly opposed to the term FGM (as she prefers FC) argues that renaming it FGM introduced "*a subtext of barbaric African and Muslim culture, and the West's relevance in purging it.* "[p. 34] (Nnaemeka, 2005).

This study's researcher, being familiar with the practice in question because she is a citizen of a country practicing it, chooses to use the term FGM/C because the term FC simplifies the practice, by making it sound equal in all respects to male circumcision; and this is exactly the belief of the perpetrators of the practice. The researcher feels the term FC implies that whatever cost and benefits male circumcision has is the same for female circumcision, thereby indirectly encouraging FGM/C.

The WHO (2018) stated there is no known health benefit of FGM/C but rather possible complications and risks. This is unlike male circumcision, which the WHO (2018) stated was recommended by UNIAIDS in 2007 as an intervention package in services aimed at reducing men's risk of heterosexually acquiring HIV. Several other studies in various countries have also attested to the benefits of male circumcision outweighing the risks (Moses, Balley & Ronald, 1998; Bailey, et al. 2007; Gray, et al. 2007). This evidence points to the fact that FGM/C cannot be compared to male circumcision. Thus, the researcher chooses to use the term FGM/C, not because she intends to discriminate/derogate the practitioners but rather to "call a spade a spade."

However, to ensure cultural competence, since the word "circumcision" is the terminology culturally acceptable among the study communities, when referring to the different forms of FGM/C they practice, the researcher used the word "circumcision" during the interviews. It was also written as this when transcribing the interviews as raw as possible to preserve the meaning of their experiences and for the readers to evaluate the credibility of the interpretations the researcher gave to the findings.

## 2.4 PROCEDURES AND REASONS FOR FGM/C

The WHO (2017) classified the types of FGM/C into four major categories as stated in the previous chapter. However, the procedure varies considerably according to geographical locations, tribes, families, choices, ethnicities, and circumcisers' method/choice. According to a study by Cappa (2013) in Niger, women responded with over 50 different descriptions when asked what exactly was done to them. Language translation is another challenge that affects how women describe the type of FGM/C they had (Yoder et al., 2013), thereby making the many studies/reports on the type of FGM/C prevalent in communities somewhat unreliable. There have been cases of research evidence where the participants reported they were circumcised or had a less severe type of FGM/C, but medical examinations of the

same participants proved their answers to be wrong (Elise et al., 2005; Elmusharat 2006). **Figure 2.1** below shows normal female genitalia and the three major classifications/types of FGM/C according to the WHO (2017).

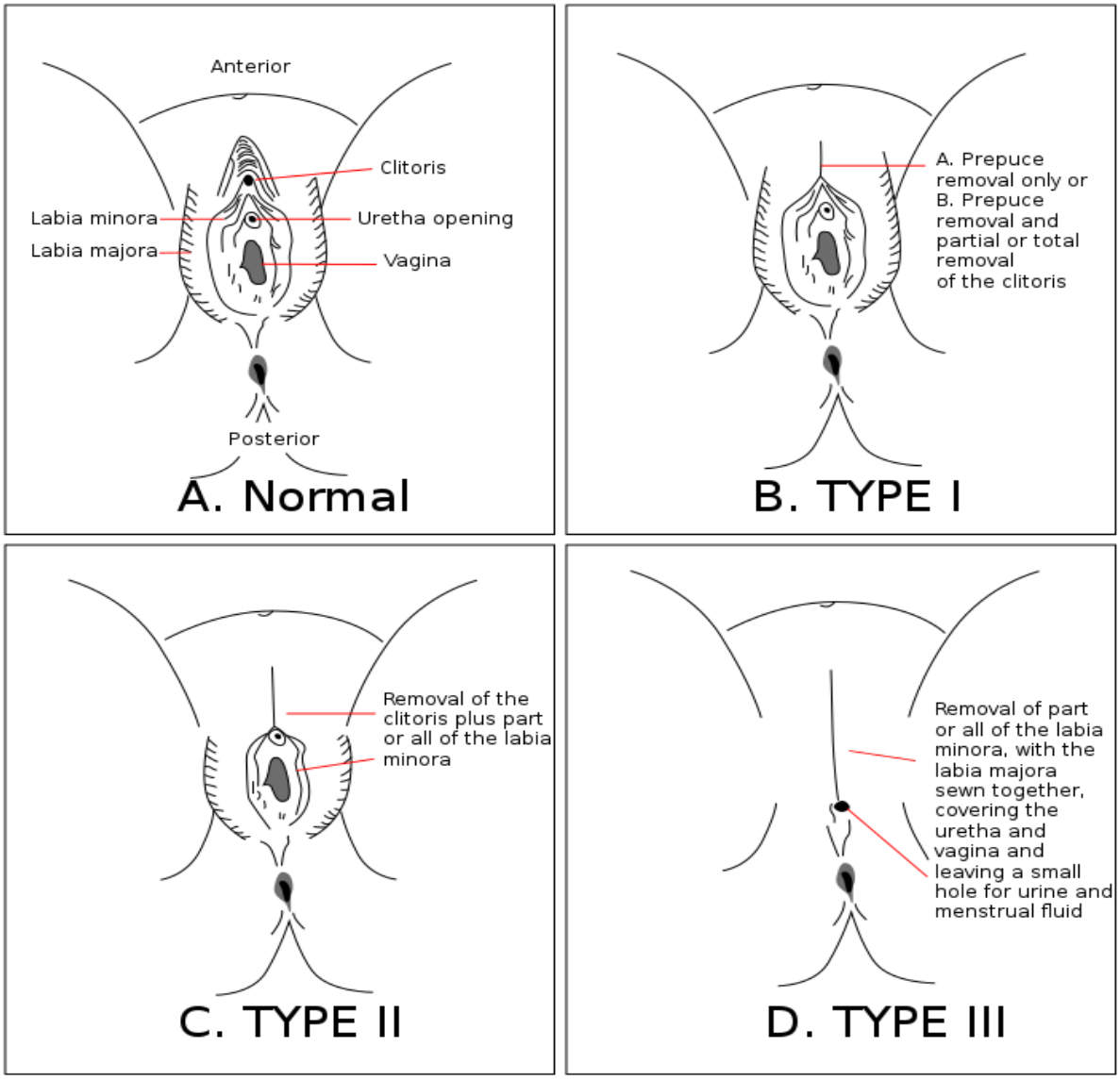



**Fig 2.1: Diagram of the normal female vulva and first three classifications/types of FGM/C**

**Source: WHO (2017)**

The age at which FGM/C is done also varies according to different communities, tribes/ethnic groups, religions and different geographical locations. Yoda et al (2004) reported that in Eritrea, Ethiopia and Yemen, most girls will have been cut before their first birthday, whereas in Egypt, 90% of girls are circumcised between 5 and 15 years of age. According to their findings, very few women undergo FGM/C as adults. In line with these

findings, Cappa et al. (2013) reported that in countries such as - Nigeria, Mali, Ghana and Mauritania where FGM/C is performed, more than 80% of cut girls experienced FGM/C before their fifth birthday. Thus, the average age of cutting can be placed at about 10 years old, spanning from infancy to about 15 years of age. Some socio-demographic factors, such as urban or rural residence, educational status, economic status and mothers' FGM/C status have also been linked to the practice and procedure of FGM (Cappa et al., 2013).

According to multi-cultural studies by Cappa et al. (2013) and the WHO (2018), the most reported benefits or reasons for FGM/C practice was to gain social acceptance; other benefits/reasons include cleanliness, hygiene, better marriage prospects and preservation of virginity, more sexual pleasure for men and as a religious requirement. It is an age-long practice not peculiar to any religion and the WHO (2008) and UNFPA (2006) reported that FGM/C practice predates both Islam and Christianity. However, they also reported that in most FGM/C practicing countries, especially Kenya (57%), Benin (48%), Burkina Faso (47%) and Nigeria (37%), many of the circumcised girls and women (15-49 years) reported they see no benefits to FGM/C.

Furthermore, data from the same multi-country studies by Cappa et al., (2013) revealed that males between the ages of 15 to 59 years mirrored similar reasons or benefits which women and girls gave for FGM/C with social acceptance and preservation of virginity being the most commonly cited. This proves FGM/C is supported by both males and females in the practicing countries, thus people born into such communities would want to be accepted by their community members.

Another major reason or benefit revealed by FGM/C surveys was tradition (Yoda et al., 2004; Getachew, 2006; Jacobson et al., 2018; Muraya, 2015; Van Bavel, Coene & Leye, 2017; Edeh, 2017), which appears to be the summary for the benefits of FGM/C. This reason affirms that FGM/C is deeply rooted in the practitioners' culture and belief system in so much that even after confessing they see no benefits to it, the people still do it, thus esteeming the perceived social benefits (tradition) of higher importance than whatever pain or disadvantages FGM/C may expose them to.

In some societies, the practice is embedded in coming-of-age rituals, sometimes for entry into women's secret societies, which are considered necessary for girls to become adults and responsible members of the society (Johnsen, 2007). Girls themselves may desire to undergo the procedure due to social pressure from peers and fear of stigmatisation and rejection by their communities if they do not follow the tradition (WHO, 2008). In some places

girls who undergo the procedure are given rewards such as celebrations, public recognition and gifts (United Nations Children's Fund and Gupta, 2013), thus, imparting a sense of pride and good self-worth to the girl and her family. According to Gruenbaum, (2006), some communities believe that FGM/C helps to restrain sexual desire, thereby ensuring marital fidelity and preventing sexual behaviour that is considered immoral.

In many communities, older women, who themselves have been genitally mutilated often become the custodians of the practice, seeing it as essential to the identity of women and girls (WHO, 2008). This is probably one reason why women, and more often older women, are more likely to support the practice and tend to see efforts to combat the practice as an attack on their culture (Johnsen, 2007). In the bid to preserve this cultural practice, FGM/C is mostly performed in the home of the girl by these older women (WHO, 2008) who are considered specialists in the procedure. These practitioners often play other roles in the communities such as attending to childbirths and treating some ailments using crude and unhygienic instruments such as knives, razor blades, scissors, glass, sharpened rocks and fingernails (Kelly & Hillard, 2005).

Health professionals are also often involved, and this is termed "Medicalisation". In Egypt, about one third of the procedures take place at a doctor's office, hospital or clinic (Cappa et al., 2013). The phenomenon of medicalisation of FGM/C was reported to be more acute in Egypt where Cappa et al. (2013) reported that 77% of FGM/C procedures were performed by medical doctors. This is unlike other countries where a significant proportion of other medical personnel such as nurses, midwives and other cadres of trained healthcare practitioners carry out the procedure. Yoder et al. (2004) documented evidence showing that the trend of medicalisation was increasing in several countries. Countries that had a significant number of FGM/C reportedly performed by medical personnel were Kenya, Nigeria, Yemen, Djibouti, Guinea, Chad, Sudan, Iraq and Ghana (Cappa et al., 2013).

There are various reasons why healthcare practitioners perform FGM/C, including prospects of economic gain, pressure and a sense of duty to serve community requests (Berggren et al., 2004). They seem to neglect the fundamental medical ethics to "do no harm." Some educated parents and healthcare practitioners believe that medicalisation is a harm reduction strategy, and support the notion that when the procedure is performed by a trained healthcare practitioner, some of the immediate risks may be reduced (Christoffersen-Deb, 2005). However, there is no evidence that medicalisation reduces the documented obstetric or other long-term complications associated with FGM/C; and as a matter of fact, Budiharsana (2004) stated there are serious risks associated with medicalisation of FGM/C.

He argued it may wrongly legitimise the practices as medically sound or beneficial to girls and women's health. It can also further institutionalise the procedure, as healthcare practitioners often hold power, authority and respect in the society. It also encourages disparity in medical ethics globally.

## 2.5 FGM/C: A GLOBAL CONCERN

Globally, FGM/C is recognised as a violation of human rights. It is believed that FGM/C is an ancient practice originating from primitive communities who wanted to control female sexual behaviour and ensure women's virginity by reducing their sexual desire (WHO, 2017). FGM/C violates a series of well-established human rights principles, norms and standards, including the principles of equality and non-discrimination based on gender, the right to life when the procedure results in death, and the right to freedom from torture or cruel, inhuman or degrading treatment or punishment, as well as the rights of the child (WHO, 2008). Many females are circumcised before they come of age to give their assent/consent, while some submit themselves to be circumcised out of fear of being discriminated against by their society. **Figure 2.2** presents the percentage of girls and women by country aged 15 to 49 years who have undergone FGM/C according to UNICEF (2013).

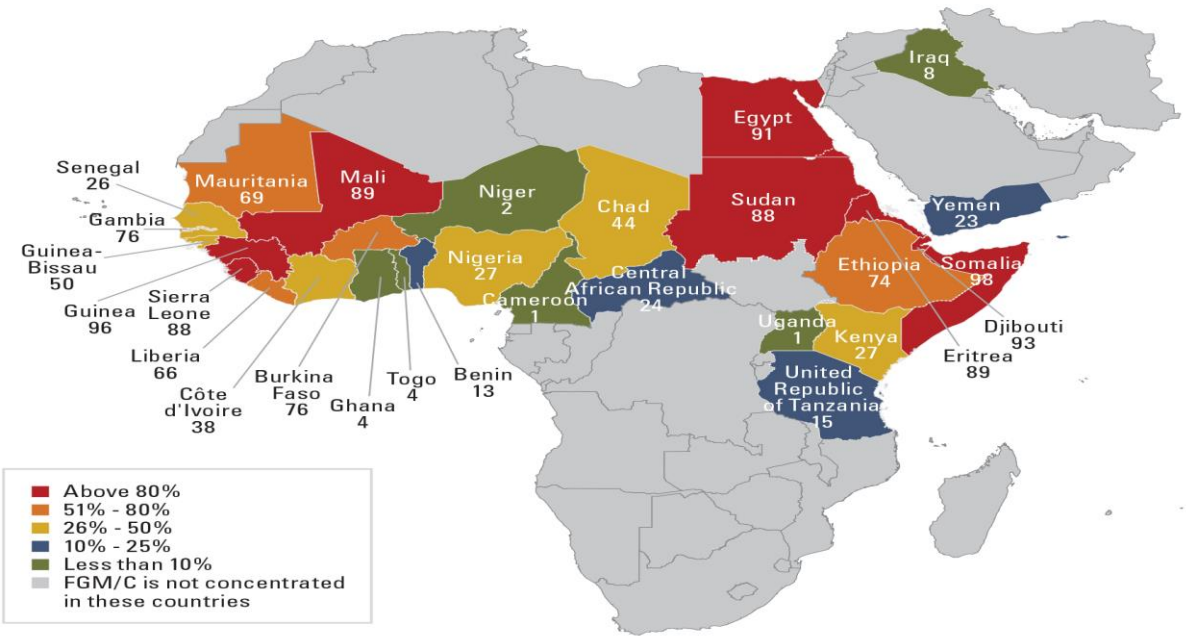



**Fig 2.2: Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, by country. Source: UNICEF (2013).**

More than 200 million girls and women alive today have undergone some form of FGM/C in a swath of 29 countries across Africa and the Middle East (WHO, 2017); another 30 million girls are at risk of being cut in the next decade. The practice is found to a far lesser degree in other parts of the world, although the exact number of girls and women affected is unknown (Fund and Gupta, 2013). As of 2013, 27.2 million women had undergone FGM/C in Egypt, 23.8 million in Ethiopia, and 19.9 million in Nigeria (UNICEF, 2013). Indonesia also has a high concentration, but as the Indonesian Ministry of Health and the Indonesian Ulema Council both said that the clitoris should not be cut, Type I (clitoridectomy) and Type IV (symbolic nicking) are practiced. The prevalence rate for the 0–11 age group in Indonesia is 49 percent (13.4 million) (UNICEF Indonesia, 2013). Smaller studies, or anecdotal reports, suggest that FGM/C is also practiced in Colombia, the Congo, Malaysia, Oman, Peru, Saudi Arabia, Sri Lanka, the United Arab Emirates, and by the Bedouin in Israel (UNICEF, 2013; UNICEF, 2016).

It was also reported that some forms of FGM/C have also been conducted in other countries, including among certain ethnic groups in Central and South America (WHO, 2008). The rise in international migration has increased the number of girls and women living in the various diaspora populations, including in Europe and North America, who have undergone or may undergo the practice (UNICEF, 2016). Jones et al. (1997) documented that the Centre for Disease Control (CDC) in the United States' estimated the number of FGM/C cases was 168,000 in 1990. However, in 2016 Turkeweiz (2015) reported that according to the preliminary report of the Centre for Disease Control and Prevention, half a million women and girls in the United States had undergone FGM/C or were at risk of being exposed to it. He explained further that this figure (500,000) is about three times the number of women and girls reported to have undergone or be at risk of FGM/C in the United States in 1997. Yoder, Wang and Johansen (2013) reported that according to the European Parliament, by the year 2009 about 500,000 women in Europe had undergone FGM/C while France despite its tough stance against FGM/C had up to 30,000 women who were thought to have undergone FGM/C by 1995 (Kool & Wahedi, 2014). This implies that FGM/C is not just a problem for Africa and some developing countries; its elimination is a global concern.

Most national governments around the world have recognised the problem of FGM/C and its medicalisation. Several countries have passed a law prohibiting FGM/C, and some have a special article on penalties if the practice is carried out by a healthcare practitioner. Some countries have also taken other important steps, such as the development of national action plans against FGM/C, inclusion of FGM/C in training of healthcare practitioners and close

cooperation with various national and international organisations and agencies, with the aim of bringing an end to FGM/C (WHO, 2010).

However, UNICEF (2014) emphasised that "*the total number of girls and women cut will continue to increase due to population growth; and if nothing is done, the number of girls and women affected will grow from 133 million today to 325 million in 2050. However, if the progress made so far is sustained, the number will grow from 133 million to 196 million in 2050, and almost 130 million girls will be spared this grave assault to their human rights*" [p. 3]. Thus, FGM/C is a global concern.

## 2.6 CONSEQUENCES ASSOCIATED WITH FGM/C

FGM/C has no known health benefits, and it harms girls and women in many ways. It involves removing and damaging the normal female genital tissue and interferes with the natural functions of girls' and women's bodies. Generally, risks increase with increasing severity of the procedure (WHO, 2018) and, the expertise and hygienic practices of the circumciser during the procedure plays a role in determining the possible consequences that might result from the procedure. The consequences of FGM/C range from immediate, to long term post-procedure consequences. A 2014 systematic review of 56 FGM/C studies by Berg and Underland suggested that more than one in 10 girls and women undergoing any form of FGM/C, including symbolic nicking of the clitoris (Type IV), experience immediate complications, although the risks increased with Type III. The review also suggested that there was under-reporting of the consequences associated with FGM/C.

### 2.6.1. Immediate Consequences of FGM/C

The WHO (2018) gave a list of possible consequences of FGM/C based on reviews of many research evidences. The consequences are:

- **Severe pain**: cutting the nerve ends and sensitive genital tissue causes extreme pain and the FGM/C practitioners rarely use anaesthesia (Khazan, 2015; UNFPA & UNICEF Nigeria, 2016). Type III FGM is a more extensive procedure of longer duration; hence the intensity and duration of pain may be more severe. The healing period is also prolonged and intensified accordingly.
- **Haemorrhage**: can result if the clitoral artery or other blood vessel is cut during the procedure.
- **Shock**: can be caused by pain, infection and haemorrhage.
- **Genital tissue swelling**: due to inflammatory response or local infection.

- **Infections**: may spread after the use of contaminated instruments (e.g. use of same instruments in multiple genital mutilation operations), and during the healing period.
- **Fever**: this can be a sign of possible infection.
- **Human immunodeficiency virus (HIV)**: the direct association between FGM/C and HIV remains unconfirmed, although the cutting of genital tissues with the same surgical instrument without sterilisation could increase the risk for transmission of HIV between girls who undergo female genital mutilation together.
- **Urination problems**: these may include urinary retention and pain passing urine. This could be due to tissue swelling, pain or injury to the urethra.
- **Impaired wound healing**: can lead to pain, infections and abnormal scarring
- **Death**: can be caused by infections, including tetanus and haemorrhage. Haemorrhage can lead to shock.
- **Psychological consequences**: the pain, shock and the use of physical force by those performing the procedure are mentioned as reasons why many women describe FGM/C as a traumatic event.

### 2.6.2. Long-term Consequences

According to the WHO (2018), Ekenze et al., (2007), Kaplan, et al., (2013), Bogale, Markos & Kaso, (2014), the following are some of the long - term consequences of FGM/C:

- **Pain**: due to tissue damage and scarring that may result in trapped or unprotected nerve endings.
- **Chronic genital infections**: with consequent chronic pain, and vaginal discharge and itching. Cysts, abscesses and genital ulcers may also appear.
- **Chronic reproductive tract infections**: may cause chronic back and pelvic pain.
- **Urinary tract infections**: If not treated, such infections can ascend to the kidneys, potentially resulting in renal failure, septicaemia and death. An increased risk for repeated urinary tract infections is well documented in both girls and adult women.
- **Painful urination** due to obstruction of the urethra and recurrent urinary tract infections.

- **Menstrual problems** result from the obstruction of the vaginal opening. This may lead to dysmenorrhea, irregular menstruation and difficulty in passing menstrual blood, particularly among women with Type III FGM/C.
- **Keloids**: there have been reports of excessive scar tissue formation at the site of the cutting.
- **Human immunodeficiency virus (HIV)**: given that the transmission of HIV is facilitated through trauma of the vaginal epithelium, which allows the direct introduction of the virus, it is reasonable to presume that the risk of HIV transmission may be increased due to increased risk for bleeding during intercourse, as a result of FGM/C.
- **Female sexual health problems**: removal of, or damage to highly sensitive genital tissue, especially the clitoris, may affect sexual sensitivity and lead to sexual problems, such as decreased sexual desire and pleasure, pain during sex, difficulty during penetration, decreased lubrication during intercourse, reduced frequency or absence of orgasm (anorgasmia). Scar formation, pain and traumatic memories associated with the procedure may also lead to such problems.
- **Obstetric complications**: FGM/C is associated with an increased risk of Caesarean section, post-partum haemorrhage, recourse to episiotomy, difficult labour, obstetric tears/lacerations, instrumental delivery, prolonged labour, and extended maternal hospital stay. The risks increase with the severity of FGM/C.
- **Obstetric fistula**: a direct association between FGM/C and obstetric fistula has not been established. However, given the causal relationship between prolonged and obstructed labour and fistula, and the fact that FGM/C is also associated with prolonged and obstructed labour, it is reasonable to presume that both conditions could be linked in women living with FGM/C.
- **Perinatal risks**: obstetric complications can result in a higher incidence of infant resuscitation at delivery and intrapartum stillbirth and neonatal death. These might be due to prolonged second stage of labour and difficult child delivery. The WHO estimated in 2006 that an additional 10 to 20 babies die per 1,000 deliveries due of FGM/C. The estimate was based on a study conducted on 28,393 women attending delivery wards at 28 obstetric centres in Burkina Faso, Ghana, Kenya, Nigeria, Senegal and Sudan. In those settings all types of FGM/C were found to pose an increased risk of death to the baby: 15% higher for Type I, 32% for Type II, and 55% for Type III (Abduladir et al., 2011).

- **Psychological consequences**: some studies have shown an increased likelihood of post-traumatic stress disorder (PTSD), anxiety disorders and depression among genitally mutilated females. Feelings of shame and betrayal can develop when women leave the culture that practises FGM/C and learn that their condition is not the norm; whereas within the practising culture they may view their FGM/C with pride, because for them it signifies beauty, respect for tradition, chastity and hygiene (Reisel & Creighton, 2015). The cultural significance of FGM/C might not protect against these possible psychological complications.
- **Need for later surgeries**: for example, the FGM/C procedure that seals or narrows a vaginal opening (type III) needs to be cut open later to allow for sexual intercourse and childbirth (de-infibulation). Sometimes genital tissues are stitched again several times, including after childbirth, hence the woman goes through repeated opening and closing procedures, further increasing both immediate and long-term risks.

## 2.7 INTERVENTIONS TO CURB FGM/C

Global campaigns and other efforts to eliminate FGM/C initially focused on the adverse health consequences of the practice. However, in the early 1990s, this emphasis became less popular for several reasons, – primarily because the campaigns did not result in significant reductions in prevalence, but also because the focus on health may have inadvertently promoted the 'medicalisation' of the practice (Shell-Duncan, 2008). It was during this period that FGM/C was re-conceptualised as a human rights violation (UNICEF, 2013).

In December 1993, the United Nations (UN) General Assembly included FGM/C in resolution 48/104, the Declaration on the Elimination of Violence Against Women, and from 2003 sponsored International Day of Zero Tolerance for Female Genital Mutilation, held every year on 6 February (Friedman-Jacobs, 2009). Also, in 2008, several United Nations bodies recognised FGM/C as a human-rights violation (WHO, 2008) and in 2010 the UN called upon healthcare practitioners to stop carrying out the procedures, including re-infibulation after childbirth and symbolic nicking (Askew et al., 2016). In 2012, the General Assembly passed resolution 67/146, titled Intensifying Global Efforts for the Elimination of Female Genital Mutilations (Bonino, 2012). Since then, much effort has been made to counteract FGM/C through research to generate further evidence on which to base interventions by involving communities, and through advocacy and passing laws (WHO, 2008).

According to the WHO (2010), the condemnation of medicalisation has been and was again emphasised in the interagency statement on the elimination of FGM/C that was co-signed by 10 United Nations agencies in 2008. Furthermore, several United Nations Treaty Monitoring Bodies, inter alia the Committee on Elimination of all forms of Discrimination against Women, called on countries to eliminate the medicalisation of FGM/C.

The WHO (2008), in their interagency calling for the elimination of FGM/C, stated some communities that have employed a process of collective decision-making have been able to abandon the practice. They further reiterated that if the practising communities decide to abandon female genital mutilation, the practice can be eliminated rapidly. Several governments have passed laws against the practice (anti-FGM/C law), and if these laws are complemented with culturally sensitive education and public awareness-raising activities, the practice would decline. National and international organisations have played a key role in advocating against the practice and generating data that confirms its harmful consequences. The African Union's Solemn Declaration on Gender Equality in Africa, and its Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa constitute a major contribution to the promotion of gender equality and the elimination of female genital mutilation (WHO, 2008).

According to a press release by the executive directors of UNICEF and UNFPA (2018), more than 25 million people in some 18,000 communities across 15 countries have publicly denounced FGM/C since 2008. Globally, its prevalence has declined by nearly a quarter since around 2000. However, they reiterated that despite these successes, the overall rate of decline in the prevalence of female genital mutilation has been slow compared to the population explosions in the FGM/C practicing countries. Given the rising number of girls at risk, it is therefore a global imperative to strengthen work for the elimination of this practice, which is essential for the achievement of many of the Sustainable Development Goals by 2030.

## 2.8. PHILOSOPHICAL UNDERPINNING FOR FGM/C

### 2.8.1. Self-concept theory

Self-concept may be defined as the totality of a complex, organised, and dynamic system of learned beliefs, attitudes and opinions that each person holds to be true about his or her personal existence, and it is quite different from self-esteem which refers to the feeling of personal worth and the level of satisfaction regarding one's self (Purkey, 1988). There is a

growing awareness that of all the experiences individuals encounter in the course of living, none has more profound significance than the perceptions they hold regarding their own personal existence - their concept of who they are and how they fit into the world both as individuals, family or a community.

By far the most influential and eloquent voice in self-concept theory was that of Carl Rogers (1947) who viewed the self as the central ingredient in human personality and personal adjustment. Rogers described the self as a social product, developing out of interpersonal relationships and striving for consistency. He maintained there is a basic human need for positive regard both from others and from oneself. He also believed that in every person there is a tendency towards self-actualisation and development so long as this is permitted and encouraged by an inviting environment (Purkey & Schmidt, 1987).

According to Purkey (1988), self-concept theory has at least three major assumptions: (1) it is learned, (2) it is organised and (3) it is dynamic. A description of each of these assumptions follows.

**2.8.1.1. Self-concept is learned**: As far as we know, no one is born with a self-concept. It gradually emerges in the early months of life and is shaped and reshaped through repeated perceived experiences, particularly with significant others (Purkey, 1988). The fact that self-concept is learned implies that no girl is born with the intuition to practice FGM/C or any particular culture. The belief of FGM/C to be an aspect of one's culture, with the many reasons for which it is upheld, is learned as the child grows up into an adult. The girl's experience of her own genital mutilation and that of her significant others, as well as the possible celebrations and seeming benefits from the practice, adds to her self- concept; this therefore forms her beliefs and practice. Consequently, when a girl learns that FGM/C has many benefits, she will willingly submit herself for the procedure and even subject her daughters to it, not minding the physical discomfort and pain that come with the procedure.

**2.8.1.2. Self-concept is organised**. It is believed that self-concept has a generally stable quality, characterised by orderliness and harmony. Self-concept requires consistency and stability, and tends to resist change (Purkey, 1988). If self-concept changed readily, the individual would lack a consistent and dependable personality. The more central a particular belief is to one's self-concept, the more resistant one is to changing that belief (Purkey, 1988).

Therefore, individuals in communities where FGM/C confers some identity or an air of acceptance/ responsibility on an individual might vehemently resist any attempt to stop the practice. This is because FGM/C has become an organised and intricate part of their lives, belief and culture (Muraya, 2015). It seems to add to their sense of self -worth and maybe also their peculiarity which they believe differentiates and makes them special from people from other culture, tribes and communities. Self- concept, just like Rome is not built in a day.

**2.8.1.3. Self-Concept is dynamic.** This implies that self-concept development is a continuous process. In the healthy personality there is constant assimilation of new ideas and expulsion of old ideas throughout life. Individuals strive to behave in ways that are in keeping with their self-concept, no matter how helpful or hurtful to oneself or others. Self-concept usually takes precedence over the physical body (Purkey, 1988). Individuals will often sacrifice physical comfort and safety for emotional satisfaction. Self-concept continuously guards itself against loss of self-esteem, for it is this loss that produces feelings of anxiety (Purkey, 1988).

Thus, there is hope that individuals from communities where FGM/C is practiced can assimilate new ideas of the numerous health risks of FGM/C, and the view that the practice is a violation of the rights of women and girls irrespective of whatever beliefs they and their ancestors had about FGM/C. If they understand that the practice, despite having lasted for decades, causes more harm than good for women and girls, there is a great possibility that they will start questioning the practice in their minds and gradually people will begin to refuse the practice. This is because individuals have relatively boundless potential for developing a positive and realistic self-concept, by making some adjustments and modifications based on new ideas imbibed. This potential can be realised by people, places, policies, programmes, and processes that are intentionally designed to initiate the realisation of this potential (Purkey, 1988).

### 2.8.2. Ethical relativism

Evidence has shown that FGM/C is deeply rooted in cultural beliefs of the people practicing it. Hence, the theory of Ethical Relativism was also used to underpin this study. This theory postulates that morality is relative to the norms of one's culture (Velasquez et al., 1992), which implies that whatever a culture approves to be good or morally acceptable may not be judged as unethical by another society or cultural group. Communities practicing FGM/C generally consider the practice as an important part of their cultural tradition and social

requirements, as sometimes as part of their religious duty. In migrant populations, this perception often remains valid, even when relocating to a society where women have more freedom of choice, including in their sexuality. They believe FGM/C is accepted to be morally right in their culture for reasons peculiar to them. The younger women in such communities who might have interacted with people from other communities that do not practice FGM/C might begin to have doubts or question the so-called benefits of FGM/C in their minds. However, because of the desire to be recognised as morally good in their society of origin, they submit themselves, and maybe their daughters to undergo the procedure, irrespective of the pains and possible complications that go with the experience.

From the aforementioned, it can be concluded that the basis on which an action or procedure is judged as right or wrong depends on the moral norms of the society in which it is practiced. FGM/C can therefore only be conquered through community-led interventions, otherwise the people might understand the anti-FGM/C activities to be an imposition of another culture on them or an interference with the beliefs handed to them by their forefathers, and so reject the anti-FGM/C activities. However, community–led interventions cannot be designed nor carried out effectively without a good understanding of the FGM/C experiences of the members of that society, their perception about FGM/C and factors that promote/motivate it. This therefore forms the philosophical underpinning for this study.

### 2.9. SUMMARY OF CHAPTER TWO

This chapter provided a brief history of FGM/C, the reason for using the term ‘FGM/C” and discussed in detail the conceptual framework for FGM/C. It closes with philosophies underpinning the study.

The next chapter describes the methodology and research design used in the study.

# CHAPTER THREE

# RESEARCH DESIGN AND METHODS

## 3.1 INTRODUCTION

The previous chapter dealt with the review of literature related to the topic. This chapter describes the research methods used in this study and includes the research design, the research setting, the research methods (population, sampling method, data collection and data analysis), rigour, as well as the ethical considerations for the study.

## 3.2 RESEARCH DESIGN

This was a multi-method study which involved a scoping literature review, qualitative descriptive inquiries and the development of a health education pamphlet (HEP), thereby making the study consist of three phases. According to Hunter and Brewer (2015), multi-method research design has some similarities with a mixed-method design. The data from a mixed-method study, which involves the collection and analysis of both qualitative and quantitative data to answer a single research question, must be combined during the study (Cameron, 2010; Gunasekare, 2013). However, according to Hunter and Brewer (2015), multi-method designs also involve the mixing of two or more methods whether qualitative or quantitative, but each method in the multi-method study is complete in itself and is used to answer a specific research question within the multi-method study (Byrne & Humble, 2007). In a bid to answer the research questions for this study, a multi-method study design-was employed. Each phase of the research stood alone and provided the background or data for the next phase; thus, it employed a progressive multi-method study design. **Table 3.1** provides an overview of research methods used in this study.

**Table 3.1. Quick overview of the research methods**

| Phases | Stages | Objective | Data collection | Sampling and sampling techniques | Data analysis |
|---|---|---|---|---|---|
| 1 | A | Explore the documented research evidence on FGM/C in Africa over a period of ten years. | Scoping literature review of all research articles on FGM/C in Africa (2007-2016) | Purposive sampling (n=28) | Content analysis |
| 2 | A | FGM/C experiences of genitally mutilated women | In-depth interview | Snow-ball sampling technique (n=20) | Qualitative content analysis |
| | B | FGM/C experiences of genitally mutilated girls | In-depth interview | Snow-ball sampling technique (n=18) | Qualitative content analysis |
| | C | Experiences of mothers of genitally mutilated girls about their daughters' FGM/C | In-depth interview | Snow-ball sampling technique (n=18) | Qualitative content analysis |
| | D | Experiences of healthcare practitioners taking care of the genitally mutilated females | In-depth interview | Purposive sampling using a sample grid (n=17) | Qualitative content analysis |
| 3 | A | Development of a health education pamphlet | Conclusions drawn from Phases 1 and 2 | All the conclusions from Phases 1 and 2 | Methodological triangulation approach |

### 3.2.1 Phase 1: Scoping literature review

This refers to the first objective of the study. Scoping reviews use systematic and explicit processes in defining the area under study, searching for the studies within the area, assessing the studies retrieved and analysing the findings qualitatively or quantitatively (Arksey & O'Malley, 2005; Peters et al., 2015). The review method focuses on complex and broad topic areas that lack comprehensive reviews. The scoping review searches for all research conducted within the specific field without paying attention to the research design

(Arksey & O'Malley, 2005). The objective of this review was to conduct a scoping review to explore the documented research evidence on FGM/C in Africa over a period of 10years.

The approach for this scoping review was underpinned by Arksey and O'Malley's (2005) five-stage framework, which adopts a rigorous process of transparency, enabling replication of the search strategy and increasing the reliability of the study findings. The five stages of Arksey and O'Malley's framework are: (1) identifying the initial research questions, (2) identifying relevant studies, (3) study selection, (4) charting the data, and (5) collating, summarising and reporting the results utilised in this review of FGM/C in Africa. Grant and Booth (2009) suggested that lack of a quality assessment in scoping review limits its uptake into policy and practice, therefore, in order to facilitate the uptake and relevance of the scoping study, the researcher also conducted a quality assessment of the selected articles using the Mixed Method Appraisal Tool (MMAT) Version 2018, (Hong et al., 2018).

A scoping review of both qualitative and quantitative evidences about FGM/C in Africa was conducted**.** Initial research questions were identified based on the objective of the study. Also, being fully aware that the topic under study is not only limited to the health field, a Boolean combination of key words, – "female genital mutilation," "female genital cutting," "female circumcision" and "Africa," were used to search electronic databases representing biomedical fields, nursing, and allied health. Databases: PubMed, Cumulative Index to Nursing and Allied Health Literatures (CINAHL), Web of Science, and Scopus, were searched for FGM/C studies conducted from 1st January 2007 to 31st December 2016 in Africa and reported in English with full texts available. Non-peer reviewed articles and grey-literatures were excluded. Reference lists of tracked articles were also used to track other relevant studies. To prevent the risk of bias, the researcher extracted the data while her two supervisors reviewed, where after a consensus meeting was held. A data extraction sheet was developed and only articles that met the inclusion criteria were analysed using content analysis method.

### 3.2.2 Phase 2: The FGM/C Experiences of Females and Healthcare Practitioners.

This phase refers to the second and third objective of the study. The phase was non-sequential and represented the multiple sources of data - gathering used for the study. The design, setting, study population, sampling, data gathering and data analysis for this phase were discussed.

#### 3.2.2.1 Design

A qualitative method of inquiry was used to generate rich descriptive data. Qualitative description (Sandelowski, 2000) was used to describe the FGM/C experiences of the genitally mutilated girls and women, as well as the experiences of mothers as regards their daughters' genital mutilation, and finally, the experiences of the healthcare practitioners who care for these genitally mutilated females. According to Creswell (2012), there is an explosion in qualitative methodologies among health science researchers, because social problems lend themselves toward thoughtful exploration, such as when issues of interest are complex, have variables or concepts that are not easily measured, or involve listening to populations who have traditionally been silenced. Polit and Beck (2014) stated that descriptive qualitative studies tend to be eclectic in their designs and methods and are based on the general premise of constructivist inquiry.

According to Sandelowski (2000) and Polit and Beck (2014), qualitative description is especially amenable to obtaining straight and largely unadorned answers to questions of special relevance to practitioners and policy makers. It uses naturalistic enquiry without pre-selected variables and a predetermined commitment to a specific theoretical view. Qualitative descriptive studies are arguably the least "theoretical" of the spectrum of qualitative approaches, in that researchers conducting such studies are the least encumbered by pre-existing theoretical and philosophical commitments (Sandelowski, 2000). This contrasts with the phenomenological, grounded theory, ethnographic, or narrative studies, which are based on specific methodologic frameworks emerging from distinctive disciplinary traditions (Sandelowski, 2000).

However, although qualitative descriptive studies are different from phenomenological, grounded theory, ethnographic, and narrative studies, they may, have hues, tones, and textures from these approaches. Any qualitative approach can have the look, sound, or feel of other approaches (Sandelowski, 2000). This second phase of the study was therefore a qualitative descriptive study that had phenomenological hues as the researcher attended to the FGM/C experiences of females in South Eastern Nigeria, and the healthcare practitioners who take care of them in their various communities. It is important to note that variously hued, toned and textured studies are not to be confused with erroneous references to, or misuses of methods or techniques. Qualitative work is produced not from any "pure" use of a method, but from the use of methods that are variously textured, toned, and hued (Sandlelowski, 2000).

#### 3.2.2.2 Setting

The research setting refers to specific places where information is gathered. According to Creswell and Creswell (2018), qualitative data is collected in the field at the site where participants experience the issue or problem under study. Nigeria which is the most populous country in Africa and the seventh most populous country in the world, has a population of approximately 182 million inhabitants, with more than half of its population under the age of 30, noting a rapid increase of youths (National Population Commission [NPC], 2016). Nigeria is viewed as a multinational, multi-cultural state as it is inhabited by over 250 ethnic groups and dialects, of which the largest are the Igbo, Hausa and Yoruba. The Hausa- Fulani tribe is predominantly in the North, the Igbos are predominantly in the South East, while the Yoruba are predominantly in the south Western parts of the country; the rest of the ethnic groups are found throughout the country. The Hausa tend to be predominantly Muslim, the Igbos are predominantly Christians, the Yoruba have a balance of members that are adherent to both Muslim and Christianity, while a significant proportion of Nigerians still holds to their indigenous traditional religion. However, economic factors cause a significant mobility of Nigerians of various ethnic groups and religious background to reside in territories that are outside their religious or ethnic backgrounds which results in the intermixing of the various ethnic groups. English language became the lingua franca in Nigeria since the coming of the British to the country (Blench, 2014).

Nigeria has a maternal mortality rate (MMR) estimate of 814 per 100,000 births (WHO, 2015), while the under-five mortality rate (NMR) is 109 per 1,000 live births (UNICEF, 2015). The country has FGM/C prevalence of 24.8% ( for women of child bearing age), which makes up about 10% of the global total (Nigeria28 Too Many, 2019). The country is divided into six geopolitical zones which consist of states with similar culture, history and background, and are close in terms of proximity to each other; and the economic, political and educational resources are often shared across the zones.

FGM/C is a practice that transcends age, status, and geography in Nigeria. The categories of females cut are mainly infant girls, then girl children, teenagers, brides and pregnant women (UNFPA & UNICEF, 2016). The four classifications of FGM/C according to the WHO, are all practiced in Nigeria (NDHS, 2013). According to Nigeria Demographic Health Survey (NDHS) (2013), the prevalence of FGM/C in Nigeria is highest in the South West geopolitical zone and little progress has been made from a prevalence rate of 57% in 2003 to that of 48% in 2013. Quite disturbing was the discovery that there is a steady rise in the prevalence of FGM/C in the South Eastern geographical zone from a prevalence rate of 40 % in 2003 to

48% in 2013. This calls for immediate action and thus informed the rationale for this study to be conducted in South Eastern Nigeria.

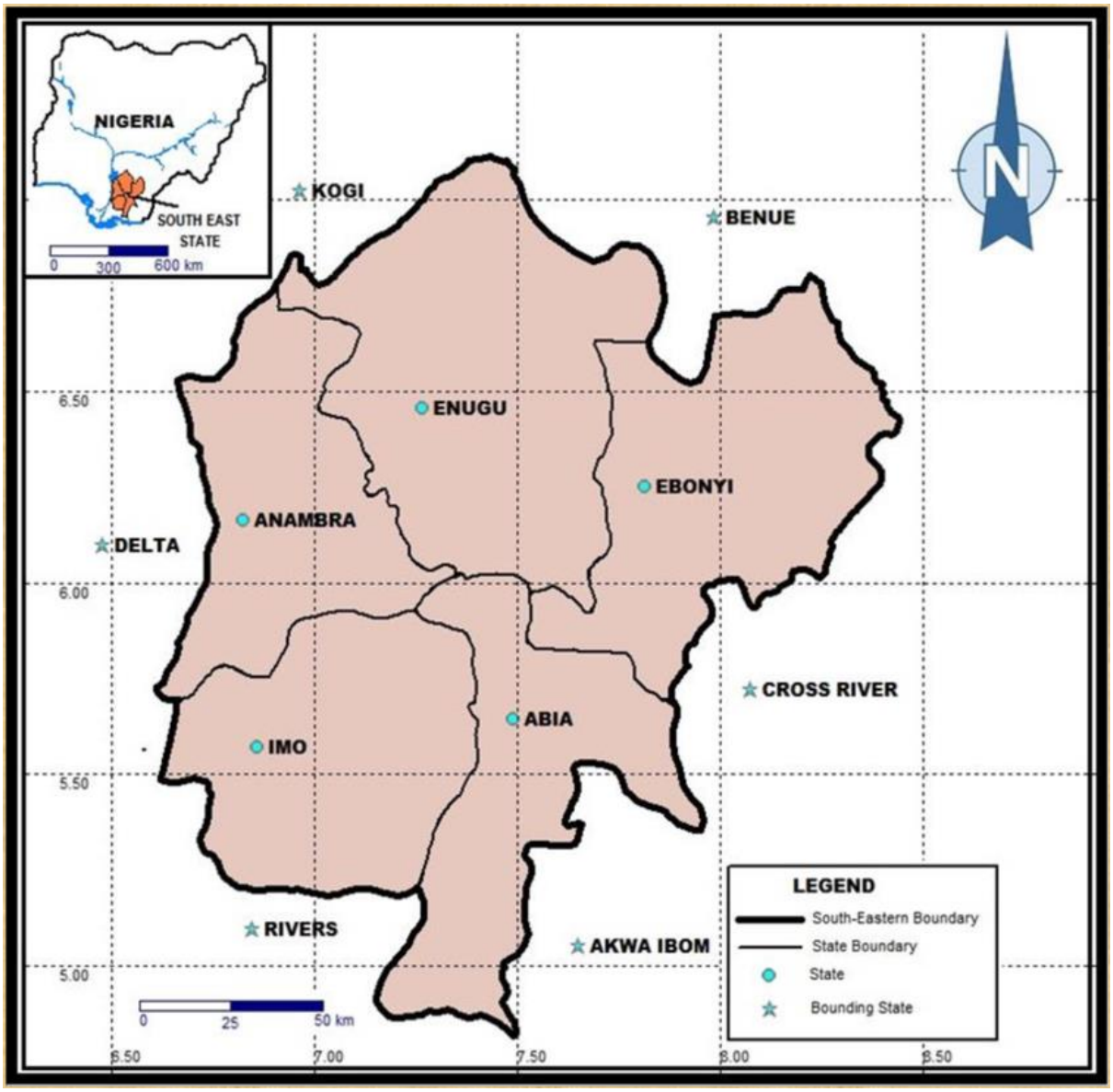



**Figure 3.1**. **Map showing South Eastern Nigeria**
**Source:** Onoja et al. (2015)

South Eastern Nigeria (**See Figure 3.1**) which is one of the geopolitical zones consists of five states: Abia, Anambra, Ebonyi, Enugu and Imo. This zone is divided by the lower Niger River into two unequal sections and is characterised by the diverse Igbo culture and the equally diverse Igbo language. More than 30 million people inhabit the zone with a population density ranging from 140 to 390 inhabitants per square kilometer (Ezeokana,

1999). The major occupation of the Igbos is trading, while some groups are civil servants, and farmers.

Analysis of data from NDHS (2013) revealed that Ebonyi and Imo States had the highest prevalence of FGM/C in SE Nigeria, with prevalent rates of 74.2% and 68.0% respectively (**see addendum 1**). Further assessment of the prevalence rate by local Government Area (LGA) in Ebonyi state indicated that Ohaukwu LGA had the highest prevalence rate of 72.6%, while Orlu LGA with a prevalence rate of 71%, was the highest in Imo State. This again informed the decision for this study to be conducted in Ohaukwu LGA, Ebonyi State and Orlu LGA in Imo State, SE Nigeria. Studies conducted by Okemgbo, Omideyi and Odimegwu, (2002) and Ibebuike, et al. (2018) revealed that FGM/C is common in Orlu LGA. According to Okemgbo, Omideyi and Odimegwu (2002), more than half of the respondents supported the practice of FGM/C and about 73% of them have undergone FGM/C. Their reasons for supporting the practice were mostly – for good health, the tradition and to prevent promiscuity. They also reported that in Imo state, children are circumcised when they are still at a very tender age so that they would not feel the trauma of the heinous practice.

A study carried out in Ebonyi state by Odimegwu, Okemgbo and Bisiriyu, (1998) revealed that women and TBAs are the major perpetuators of FGM/C in the state. This was confirmed by the UNICEF and UNFPA (2016) who did a study on FGM/C in Ohaukwu LGA. However, it is noteworthy that a news agency in Nigeria, known as the Nigerian Observer news, posted on 21$^{st}$ June 2017 that traditional rulers in Abakiliki which is the capital of Ebonyi state as well as a LGA have publicly declared a ban on FGM/C in their communities. Local Government Areas (LGAs) such as Ohaukwu which have been reported to have a high prevalence of FGM/C are yet to join this move as they held tenaciously to the FGM/C practice, despite the ban by the rulers in the State capital under the Support of the state government (Martins library, 2014). Harrison (2010) opined that traditional and religious customs such as FGM/C for pregnant women conducted in these communities put the women under a huge risk of serious complications.

The NPC (2006) documented the population projection for Ohaukwu LGA to be about 195,555, with an area of 517km$^2$. Ohaukwu's headquarters are in a town called Ezzamgbo. and it is one of the 13 LGAs in Ebonyi State. Ohaukwu is popularly known as the seat of the permanent site of Ebonyi State University. The common language is Igbo and most of the people are farmers producing foods such as yam and cassava in large quantities. A significant number of the population rear livestock, some are traders while a few are on the government pay roll as civil servants. Many civil servants from Ohaukwu occupy mainly the

lowest ranks in civil service due to their low literacy/education level when compared with other states in the SE geopolitical zone. However, they also have doctors, engineers, architects, lawyers and technicians among them. The major religion in this area is Christianity, however some still hold tenaciously to the traditional religion of their forefathers, while a small percentage practice Islam.

The people of Ohaukwu have a rich cultural heritage which they are proud of and includes festivals such as the Itukwe festival, Ofie Obodo and many others. The lives of the people are socially inclined. They have community chiefs that oversee the activities of the traditional rulers. There is also the presence of age grades (Ndi Ogbo) who maintain law and order in the community, organise communal work and carry out assignments as directed by the traditional ruler and the village cabinet.

Orlu LGA in Imo State is an urban city compared to Ohaukwu LGA. It is the second largest city, after Owerri, in SE Nigeria's Imo State, with an estimated population of about 420,000. It has a long history and has played a critical role as the headquarters for the Organisation of African Unity (OAU) Humanitarian Relief Agencies during the Nigeria/Biafra civil war (Egbokhare & Oyetade, 2002). The Nigerian headquarters of the British Cheshire Home is in the city. Orlu is the permanent site for various industries, state and federal agencies, such as the Imo State University Teaching Hospital, the state owned Cardboard Industry in Owerri-Ebeiri, the newly built Imo State School of Nursing and Health Technology at Okporo and a host of small and medium size chemical and pharmaceutical companies, the multipurpose Imo International Market, which houses one of the three most influential pharmaceutical markets in West Africa, due to the high number of Orlulites in the pharmaceutical and chemical industry. The local government consists of more than 33 Autonomous communities. The towns in Orlu urban have different cultural masquerade heritages through which they express their communal attributes, descents and heritages such as Mmuowu (Egbokhare & Oyetade, 2002). Since all the states in SE Nigeria have a similar culture and language (NPC, 2006; NDHS, 2013) the findings from this study may be generalised to them.

#### 3.2.2.3 Study population

A population refers to an entire group about which information is required to be ascertained (Brink, 2007; Banerjee & Chaudhury, 2010; Polit & Beck, 2014). In addition, a population can be a complete set of people with a specialised set of characteristics (Banerjee & Chaudhury, 2010). Therefore, the population for this study included: all genitally mutilated girls, genitally mutilated women, mothers of genitally mutilated girls and healthcare practitioners who reside

in Ohaukwu LGA, Ebonyi State and Orlu LGA, Imo State, Nigeria. This population was chosen for the study because of the increasing prevalence of FGM/C recorded among them (UNICEF & UNFPA, 2016). The inclusion criteria were:

- For the girls: adolescent between the ages 14 and 19years, who assented to participate in the study, had consent from her parent or guardian and had undergone FGM/C.
- For the mothers: their daughter(s) must have been genitally mutilated
- For the women: 20 years and older and to have undergone FGM/C.
- For the healthcare practitioners: currently working in any of the communities of study and must have worked there for at least one year.

#### 3.2.2.4 Sampling

A sample is a subset of a population (Banerjee & Chaudhury, 2010), and must be representative of the whole population. It is a portion of the population that is used in a study to describe the characteristics of interest in a whole population (Banerjee & Chaudhury, 2010). Although purposive sampling is the method of choice for qualitative studies (Sandelowski, 2000; Etikan et al., 2016), due to the social structure of the communities in which the study was done and also the sensitive nature of the topic studied, a purposive sampling method was used to select participants among the healthcare practitioners, while the Snow - ball technique, which involved asking the initial/early participants to make referrals or recommendations for other potential participants (Banerjee & Chaudhury, 2010), was used to select the female participants. Purposive sampling allows the researcher to select participants who are typical of the population under investigation, because of their knowledge and experience of the phenomenon (LoBiondo-Wood & Haber, 2010; Sandelowski, 2000).

According to Fusch and Ness (2015), data saturation defines the sample limit in qualitative studies, as adding more participants after data saturation does not add any value to the research results. Creswell and Creswell (2018) explained in qualitative data collection, the researcher stops collecting data when fresh data no longer sparks new insights or reveals no new properties. Therefore, the sample size for this study was determined by data saturation. The researcher became acquainted with the healthcare practitioners whom after being informed of the research study, recommended some potential participants, namely: women who had experienced FGM/C and mothers of girls of girls who had experienced FGM/C who were at the health facilities for various reasons that day. The researcher met with these participants and recruited those who met the inclusion criteria. Some of these participants

then recommended other potential participants and even went with the researcher to introduce her to them. This pattern was continued for the three groups of females under study simultaneously, until there was evidence of data saturation in each of the female groups. The participants chose their convenient place and time for the interview without having to wait for data collection for one group of the females to be completed before they could be interviewed. This method of collecting the data for the three groups of females simultaneously saved transportation costs and time for the researcher, as there was much flexibility with time and fewer disappointments from the potential participants since the interviews were mostly done in the participants' preferred venues, at their chosen time, and they could easily recommend their neighbours for possible participation in the study.

For the healthcare practitioners, the sample grid below was used to ensure equal representation of all the cadres of healthcare practitioners found in the communities. Each of the study participants met the inclusion criteria and data saturation (Carnevale, 2016) was also applied to this group.

**Table 3.2: Sampling grid for in-depth interview of the healthcare practitioners**

| **No** | **Cadres of Healthcare practitioners** | **Sampling pattern** | | |
|---|---|---|---|---|
| **Ohaukwu LGA, Ebonyi State** | | | | |
| 1 | Registered Nurses/midwives (RN/RM) | 1 | 4 | 7 |
| 2 | Community health Extension workers (CHEW) | 2 | 5 | 8 |
| 3 | Voluntary village healthcare practitioners/health assistants | 3 | 6 | 9 |
| **Orlu LGA, Imo State** | | | | |
| 1 | Registered Nurses (RN/RM) | 1 | 4 | 7 |
| 2 | Community health Extension workers (CHEW) | 2 | 5 | 8 |
| 3 | Voluntary village healthcare practitioners/health assistants | 3 | 6 | 9 |

#### 3.2.2.5 Procedure for data gathering

The data gathering entailed the following:

- The researcher obtained approval for this study from the Research Ethics Committee of the University of the Witwatersrand (**see addendum 2**).
- Approval was also obtained from the rulers of Ohaukwu and Orlu LGAs, through the Directors of Primary Health Care in the two local governments in order to gain entrance into the communities for the data collection.
- The first set of females were recruited based on the recommendation of the healthcare practitioners in the community, where after, a Snow - ball sampling method was used to recruit all the other females. The healthcare practitioners were recruited purposively using the sample grid to ensure equal representation of all the cadres of healthcare practitioners.
- The study information leaflet (**see addendums 3 to 7**) was explained to the recruited females (as some could not read). During discussion of the information leaflet, the recruited females were informed on the possible duration and topic of the interview. They were informed that the interview would be audio taped with their permission.
- Having been properly informed, the recruited females were then allowed to voluntarily consent and/or assent to participate in the study.
- After obtaining informed consent and/or assent, an appointment was made for the interviews at a private venue selected by each participant.
- The researcher conducted in-depth interviews to allow the genitally mutilated girls and women to share their FGM/C experiences, while the mothers of the genitally mutilated girls shared their experience of their daughter's genital mutilation and obtained information from the healthcare practitioners who take care of these females.
- The interviews were conducted in the preferred language of the participants. As the researcher is not fluent in the peculiar dialect of the Igbo Language spoken by the two different communities used for the study, a community member was recruited to assist with language issues. This person consented to a confidentiality agreement (**see addendum 8**).
- The girls were interviewed individually without the presence of their parents or guardians, to ensure privacy and allow them to express their feelings about FGM/C.
- Knowing that the topic for the interview was a sensitive one, the researcher was cautious around the use of the word "why" as it could sound judgmental.

- To deepen the trust and confidence of the participants, the researcher explained to them that even though she was a nurse carrying out a postgraduate study, they, as the participants were the experts of their own experiences. Therefore, they were free to share their experiences as they deemed fit.
- Follow-up interviews were conducted, and additional information was obtained from the participants' experiences that might have not been told in the first interview, to ask probing questions that arose during data analysis and to confirm the credibility of the findings and interpretation.
- For the HCPs, data saturation was achieved after 13 interviews and an additional four to clarify issues, recruitment was discontinued.
- For the women, girls and mothers whose daughters had experienced FGM/C, data saturation was reached after 17, 12 and 14 interviews respectfully, but additional four interviews were also done for each group of females in order to clarify issues.
- Data analysis commenced alongside data gathering. Recordings were numbered and participants' preferred names were used during the interviews but were replaced with pseudonyms during data analysis.
- Although none of the participants showed signs of emotional discomfort during the interviews, the researcher had planned to refer any participant who experienced emotional discomfort that required referral for further intervention to a counsellor in the community's primary health care centre.

#### 3.2.2.6. Instruments for data gathering

Data gathering is about processes and instruments used to gather information from the participants in a study (Polkinghorne, 2005; Polit & Beck 2014). The data provides evidence for the experience being investigated and forms the pillars on which findings are based (Polkinghorne, 2005). There are various of methods used for data gathering in qualitative research including observation, focused group discussion, field work, interviews, textual and visual analysis. Due to the sensitive nature of the topic under study, in-depth, face-to-face interviews were conducted for the women and girls who had experienced FGM/C, mothers of girls who had experienced FGM/C and for the healthcare practitioners in order to obtain general information and ask the main question as well as probing questions. According to Carter et al. (2014), "*In-depth interviews allow for spontaneity, flexibility, and responsiveness to individuals; however, conducting the interviews, transcribing the discourse, and analysing the text often require considerable time and effort*" [p. 545].

The researcher used semi-structured interview guides (**see addendums 9 to 12**) to conduct in-depth interviews about the FGM/C experiences of the study participants. This was because, according to Leech (2002), an unstructured interview is used when very little information is known about the area of study and so is best used as source of insight, while structured interview guides are used when the researcher has a lot of knowledge about a subject matter, but just wants specific answers for specific questions. However, unlike the structured and unstructured interview guides, a semi-structured interview guide provides the researcher with a set of predetermined questions which were used while the researcher allows the participants to lead the conversation instead of focusing on getting the questions answered (Greeff, 2011; de Vos, et al., 2011). Therefore, the predetermined probes for this study were not used line by line, rather, the researcher listened more and allowed the probes to naturally emanate from, but not be limited to the information the interviewee provided. Also, to make the interview more natural, paraphrasing, passive and indirect probes were used to avoid limiting the flow of information from the participants.

One broad opening question also known as the grand tour question (Leech, 2002), was asked of the genitally mutilated girls and women, *"Please tell me about your experience of FGM/C from the day you were cut up to now"* **(see addendums 9 and 10)**.

The grand tour question used to guide the interview for the mothers of the genitally mutilated girls was, *"Please tell me how you experienced your daughter (s) genital circumcision, from the day she was circumcised up to now"* **(see addendum 11)**.

For the healthcare practitioners, one broad question was asked, "*Please tell me your experiences about FGM/C in this community and the reasons why healthcare practitioners assist them with the procedure.*" Themes that were explored were the motivators of the practice and their opinion about the practice of FGM/C **(see addendum 12)**.

According to Leech (2002), the grand tour question when used in combination with probes/prompts, is sometimes enough to elicit almost all the information needed in a semi-structured interview.

#### 3.2.2.7. Data analysis

The interviews were done in the preferred language of the participants and their preferred names were replaced with pseudonyms. Data analysis was commenced alongside data gathering, therefore, the interviews were audio recorded and translated into English, and clarifications about words which the researcher was not sure of their meanings were

obtained from the language assistant and the study participants to ensure meaning was not lost, thereby enhancing the rigour and validity of the research study. According to Lopez et al. (2008); Maneesriwongul and Dixon (2004), although standards of rigour exist for other aspects of the research process such as data collection and data analysis, there is no standard for translation in qualitative research. Some qualitative researchers have used different methods including adaptation of Brislin's 7-step translation method (Lopez et al., 2008) and back translation for their studies (Chen & Boore, 2010; Wu, 2006). Although back translation is used by many researchers (Chen & Boore, 2010), some authors, like Birbili (2000) reported that back translation can be very helpful, but like other methods, it is imperfect. Therefore, the goal of any method used for translation should be to ensure that meaning originating from the data in the source language is not lost (Maneesriwongul & Dixon, 2004; Lopez et al., 2008; Chen & Boore, 2010; Oxley et al., 2017).

General information of the participants was entered onto a spreadsheet. Qualitative content analysis which is the analysis strategy of choice in qualitative descriptive studies (Sandelowski, 2000), was used to analyse the data from the in-depth interviews. It was used to break down the findings of the studies into codes, then group similar codes to form sub-themes and then group the sub-themes into themes. This involved breaking down the content of the articles into smaller units, coding and naming the units according to the content they represent, and grouping the coded materials based on shared concepts (Polit & Beck, 2014).

In contrast to quantitative content analysis, in which the researcher systematically applies a pre-existing set of codes to the data, qualitative content analysis is data-derived, that is, codes were also systematically applied, but they were generated from the data garnered during the study (Sandelowski, 2000). The study was characterised by the simultaneous collection and analysis of data, whereby both mutually shaped each other.

According to Sandelowski (2000), qualitative content analysis is similarly reflexive and iterative as researchers continuously modify their treatment of data to accommodate new data and new insights about those data. It involved, developing significant phrases or sentences from each transcript that pertained to the FGM/C experiences of the females and the healthcare practitioners who take care of them (Creswell, 2012). Codes were formulated from these significant phrases and statements. The formulated codes were clustered into sub-themes, and similar sub-themes were grouped under themes (ideas) common to participants' transcripts **(see figure 3.2)**. The researcher discussed her findings freely with

her colleagues so that they could help her develop analytic questions for the discussions. Iterative check was ensured throughout the study and the results were later integrated into an in-depth, exhaustive description of the data gathered.

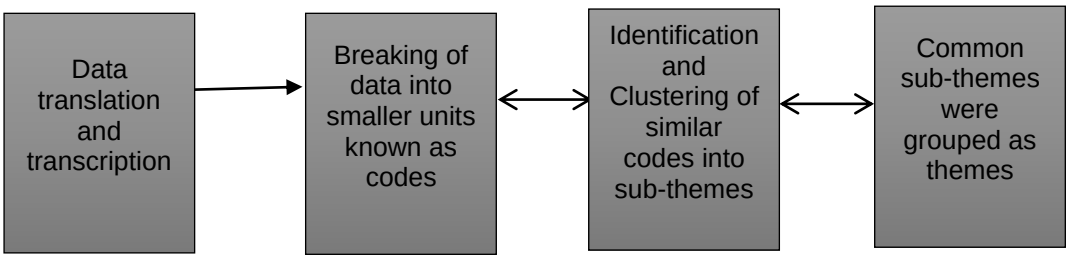



**Figure 3.2: Process of the qualitative content analysis**

### 3.2.2.8. Reflexivity

Unlike in quantitative studies, the researcher can be said to be a significant part of the instrument for data collection in qualitative studies, and such has so much influence on the credibility and authenticity of the research process and outcome. Polit and Beck (2014) explained that reflexivity involves the awareness that the researcher as an individual brings to the inquiry a unique background, set of values, and a social and professional identity that can affect the research process. Reflexivity involves attending continually to the researcher's effect on the collection, analysis and interpretation of data. This implies that the experiences the researcher brings into research can inherently influence decisions such as the selection and wording of the questions before during and after the interviews or what aspects are emphasised in the notes and reports of findings. According to Creswell and Creswell (2018), sufficient reflexivity occurs when researchers record notes during the process of research, reflect on their own personal experiences, and consider how their personal experiences may shape their interpretation of results. However, the authors further cautioned about the need for qualitative researchers to limit their discussion about personal experiences so that they do not over-ride the importance of the content or methods in their study.

In order to ensure sufficient reflexivity, and thus enhance the trustworthiness of the study, the researcher had a reflexive journal and a summary of it follows.

The researcher is a registered public health nurse in Nigeria. She has lived and worked for the greater part of her life in SE Nigeria, but not in these communities with the high prevalence of FGM/C. She attended a conference for midwives where some representatives from UNICEF and UNFPA did a presentation on FGM/C and informed the participants on the

high and escalating prevalence of such practice in SE Nigeria. They also used pictures and case reports in their presentation. The researcher, - although having heard about FGM/C and it's risks as announced on international media, - was taken aback because although residing and working in this part of the country, she never knew this was happening to such an extent only a few hours' drive from her home.

The researcher began to ask questions about FGM/C from people she knew were from those communities and was surprised to hear them speak in favour of FGM/C and that it was a must for every girl, and even boasted about it. This information triggered interest in the researcher to read and ask more questions about FGM/C. She came to understand from the literature that FGM/C has great risks and even saw some pictures with terrifying reports of girls and women said to hail from these FGM/C practicing communities. The researcher, being a healthcare practitioner, felt concerned about what clinical practice would look like for her colleagues working in such communities with all these distressing FGM/C reports on the international media. She then decided to focus her PhD study on unravelling the truth about FGM/C in the communities in SE Nigeria.

Her research process began with a scoping literature review of FGM/C research evidence, with Africa as the study site to find out what evidences was available about FGM/C in Africa. It was from this literature review that she discovered the research gap, which led to the planning, designing and implementation of this present study, with SE Nigeria as the site for the study.

During sample selection, participants from the healthcare practitioners were purposively selected because of their experiences related to the study while the female participants were selected using the Snow-ball sampling technique. The researcher went to her colleagues who worked in these communities, and easily familiarised herself with them. They then helped her gain access into the communities and recommended her to the community members, thereby creating confidence and a relaxed atmosphere to talk with her. The healthcare practitioners recommended her first female interviewees who then recommended other participants from their communities (Snow - ball technique) until the researcher confirmed data saturation (Carnevale, 2016).

Prior to the commencement of the interviews, the researcher learned from the healthcare practitioners that they were careful about any discussion relating to FGM/C because of the ban the government of Nigeria has declared on the practice. Thus, the researcher had to provide a clear explanation to convince first the healthcare practitioners and then the

community members that she was doing a study on FGM/C and would keep their information anonymous and confidential. To retain the trust of the participants all through her interactions with the communities, the researcher wrote down her objectives for the study, which was to obtain the FGM/C experience of the people and the relevant healthcare practitioners, and not to campaign against the practice.

The researcher was very cautious around the use of the word “why” and any other word or expression that would seem judgmental. She used paraphrasing, silent and indirect probes to ensure the interviewee was relaxed during the interview, without having any fear since many of them were aware of the ban on the practice. It appeared the ban on FGM/C made conducting studies on the practice more sensitive, as the communities did not see FGM/C as an issue private to them, but something that might put them in trouble with the law of the country.

Although the researcher defined the focus of the interview, there was no fixed sequence of questions. The questions were addressed and tended to change slightly as the researcher gained insight from previous interviews. Participants were encouraged to raise important issues not addressed by the researcher. In this manner, the researcher and the participants were actively engaged in constructing a version of their world view with FGM/C as a common goal and making a sense of the interview experience.

The researcher conducted interviews and analysis concurrently and for her to become familiar with the data, she read and re-read the transcripts while recalling the experiences to become immersed in the data. This did not only enhance an understanding of the phenomena, it also enabled a dynamic interaction between the researcher and experiences shared by the interviewees. Finally, as the relationships among the participants, actions and events began to emerge, the researcher offered a description of what was transpiring by understanding and explaining the findings from the participants’ perspective.

### 3.2.3. Phase 3: Development of the health education pamphlet (HEP) for the genitally mutilated females

This phase refers to the fourth objective of this study which was to achieve the development of a health education pamphlet (HEP) to meet the identified health information needs of the genitally mutilated females. In this phase of the study, a methodological triangulation approach was applied. According Fusch, Fusch and Ness (2018), a methodological triangulation is the most frequently used triangulation method utilised by students. It refers to

the employment of multiple data collection techniques to study a single problem (Konecki, 2008). Methodological triangulation has been found to be beneficial in providing confirmation of findings, more comprehensive data, increased validity and enhanced understanding of the studied phenomenon (Bekhet & Zauszniewski, 2012).

An outline of the conclusions drawn from Phases 1 and 2 of the study were presented, categorised and then clustered into synthesised findings. According to Jordan et al., (2011) these synthesized findings can be used as the basis for evidence - based practice. Finally, in response to the synthesised findings, a health education pamphlet (HEP) was developed to meet the identified health information needs of the females who had experienced FGM/C.

## 4. TRUSTWORTHINESS

Trustworthiness is the term used to evaluate the quality of qualitative data (Polit, Beck & Hungler, 2001). Lincoln and Guba's criteria for trustworthiness, as discussed in Shenton (2004), was used to ensure trustworthiness in this study. These criteria and the application thereof are discussed below.

**Credibility** is the ability of the researcher to establish confidence in the true value of the data and findings of an inquiry with reference to the participants and the context in which the study is carried out (Polit & Beck 2014; Shenton, 2004). Credibility was enhanced in this study by:

- Prolonged engagement in the field (Shenton, 2004). Prolonged engagement according to Polit and Beck (2014) helps the researcher gain an in-depth understanding of the culture, language, or views of the people or group under study, to test for misinformation and distortions, and to ensure saturation of important categories. This was achieved in that the researcher was and continues to be a public health nurse and midwife who lives and works in SE Nigeria. She has a good relationship with the healthcare practitioners in the communities of study as they knew her as a colleague while the community people called her as one of the nurses and so were relaxed with her. Prolonged engagement with the participants was also maintained in that the researcher stayed in the field until data saturation occurred.
- Triangulation was achieved as the study used a multi-method approach involving different communities, females of various ages and healthcare practitioners. Methodological triangulation and triangulation of data sources (Shenton, 2004; (Carter et al., 2014) were done at various points during the study to enhance the credibility of the study findings.

• The researcher wrote extensive field notes and memos to supplement the findings as a form of ensuring referential adequacy (de Vos et al., 2011). These notes were used in the results section to explain the activities and participants actions during the interview that could have reflected their reaction to a response such as laughing, silence, grimacing among others. An example of the field note is added as **addendum 13**.

- Reflexivity was ensured as the researcher's assumptions and preconceptions about FGM/C were acknowledged and written down to ensure more effective and impartial analysis of the data gathered.

- Searching for disconfirming evidence, which according to Polit and Beck (2014) is a powerful verification procedure, was done in order to challenge a categorisation or explanation that arose earlier in the analysis. This was possible because the researcher used purposive and snow - ball sampling methods.

**Transferability** also referred to the possibility of the results of the study to be applied to other settings and wider populations (Shenton, 2004; Polit & Beck, 2014). The following strategies were implemented to enhance transferability of the study:

- A thorough, vivid and rich description is provided of the area where the study was done, participants' eligibility criteria and the process of data collection with sufficient detail to allow judgements about transferability to be made by the reader.
- The researcher also maximised the range of specific information that could be obtained from the context by purposively selecting participants and locations that were reported to have the high burden of FGM/C, to fulfil the study needs.

**Dependability** refers to the reliability of the data over time (Shenton, 2004). It can be explained as the extent into which another researcher can clearly follow the decision trail used by the researcher and get similar data over time. Dependability was achieved by:

- Providing the reader with a clear description of the research methodology, justification of the procedures, and decisions and choices throughout the research process to ensure dependability of the study.
- Using a voice recorder to record the interviews, followed by verbatim transcription and translation of all the interviews.

- Storing data safely in a pass - worded protected computer to ensure retrieval when needed.
- Taking field notes and memos during, and sometimes immediately after each interview to enrich the voice recorded data and to record impressions of the context.

**Conformability** refers to the potential for congruence between two or more independent people about the data's accuracy, relevance, or meaning (Shenton, 2004). The following strategies were implemented to enhance transferability of the study:

- Evidence from literature was utilised throughout the process of developing themes and discussing the data to examine whether themes and concepts extrapolated from the data agreed with the available literature.
- The researcher had accurately documented the strategies and process of the study to provide the reader with the opportunity to audit the study.
- Samples of analysed transcripts have been provided in the appendix section. These include: one transcript from each participants group for auditing purposes (see **addendums 14 to 17**).
- A non-judgmental neutral stance was retained during interviews by asking open-ended questions to facilitate the expression of the participants' own subjective experiences as much as possible. The predetermined probes were not used line by line, rather, the researcher listened more and allowed the probes to emanate naturally from, but not be limited to the information the interviewee provided. To make the interview more natural, much paraphrasing, passive and indirect probes were used to avoid limiting the flow of information from the interviewees.
- Before the end of an interview, the participant was requested to confirm that the responses given throughout the interview were an accurate reflection of the conversation and was given an opportunity to further expand if need be until his or her view had been adequately expressed.
- An inquiry audit was done to enhance the conformability of the data and the meanings attached to them.
- Peer evaluation: several presentations were made before the project was approved; conference presentations of the findings were also done and research manuscripts are being prepared for possible publications in peer reviewed journals.

**Authenticity** is closely linked to credibility, and it refers to the extent to which researchers fairly and faithfully show a range of realities (Whittemore, Chase & Mandle, 2001). This was achieved by:

- Describing the participants' experiences as they were lived in order to invite the readers into a vicarious experience of the lives being described, as well as enabling them to develop a heightened thoughtfulness to issues being illustrated.
- Themes were formulated using words of participants.
- Description of the limitations of the study in this thesis was ensured.
- Rich and in-depth data description was presented in this thesis.

## 5. ETHICAL CONSIDERATIONS

Ethical procedures in research start with the researcher's plan being reviewed by the Internal Research Board of a university to ensure the enforcement of federal regulations that protects research participants (Creswell, 2012) . The following ethical considerations were ensured:

- The research proposal was presented and peer - reviewed for input from the Department of Nursing Education, School of Therapeutic Sciences, Faculty of Health Sciences, University of Witwatersrand.
- Proposal was reviewed by Postgraduate Committee, University of the Witwatersrand for approval.
- Ethical Clearance was obtained from Wits Human Research Ethics Committee.
- Permission for access into the communities was obtained from the traditional rulers through the directors of the Primary Health Care facilities of Ohaukwu and Orlu local government areas.
- Each adult participant gave an informed consent, while the young girls gave their assent in addition to the consent given by their parents or guardians.
- Participants were informed and allowed to withdraw from the study at any point in time.
- The research assistant consented to a confidentiality agreement.
- Field notes, transcriptions and memos were numbered, and pseudonyms assigned to ensure anonymity.
- Recorded materials were kept under lock and key on completion of transcription and will be erased after a specified period.
- Interviews were conducted in the privacy of the participants home.

- Although no harm was intended, any emotional discomfort experienced due to the sensitive nature of the phenomenon under study were referred to the counsellor in the community who had already consented to assist in the study whenever necessary.
- Only participants meeting the criteria were approached and invited for the study
- Data were gathered until saturation was reached.
- All records were saved anonymously in a password protected computer.

## 6. SUMMARY OF CHAPTER THREE

In this chapter, the overall research design and method for Phases I, 2 and 3 were described. These three phases reflect the processes necessary in the development of the HEP. Common aspects in the different phases of the study such as research setting, researcher's reflections, measures used to ensure trustworthiness and ethical considerations, were also discussed in detail.

The next chapter presents a detailed research design and methods including the findings and discussions from the scoping review conducted in Phase 1 of the study.

# CHAPTER FOUR

# SCOPING LITERATURE REVIEW

## 4.1. INTRODUCTION

In the previous chapter, the overall research methodology and research design of the study was described. This chapter refers to the Phase 1 of the study and it starts with providing a detailed research process for this phase. Thereafter, the results of the scoping literature review were presented and discussed. The results from this chapter contributed to the development of the health education pamphlet (HEP) in Chapter Seven of this study. **Figure 4.1** is a summary of the presentation of this chapter.

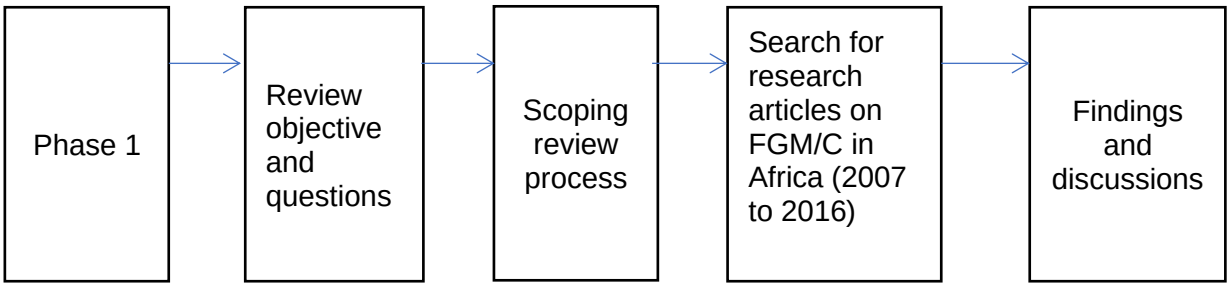



**Figure 4.1: Summary of the presentation of Chapter four.**

## 4.2. REVIEW OBJECTIVE AND QUESTIONS

The objective of this review was to describe the publication output on FGM/C conducted in Africa over a period of 10 years and to identify trends and gaps to guide the future scope of research into FGM/C. To achieve the above-stated purpose, the following questions guided the review:

- What are the FGM/C research outputs in Africa over a period of 10 years (1 January 2007 to 31 December 2016)?
- What are the trends and knowledge gaps in FGM/C studies in Africa in the last 10 years (1 January 2007 to 31 December 2016)?
- What is the guide for the future scope of research into FGM/C in Africa?

## 4.3. SCOPING REVIEW PROCESS

Scoping reviews can be conducted to map a body of literature with relevance to time, location, source, and origin (Peters et al., 2015). As stated in Chapter Three of this study, Arksey and O'Malley's (2005) five-stage framework underpinned the approach for this scoping review. The framework adopts a rigorous process of transparency, enabling replication of the search strategy and increasing the reliability of the study findings. To

adhere to the framework, the researchers identified the initial research questions, identified relevant studies, selected studies, charted the data, and collated, summarized, and reported the results. It is therefore essential that the process of literature retrieval and inclusion be documented in detail, to ensure the rigour of the scoping reviews findings.

### 4.4. SEARCH STRATEGY

The keyword “Africa” in combination with the terms “female genital mutilation,” “female genital cutting” and “female circumcision,” were used to search the databases - PubMed, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Web of Science and Scopus. Reference lists of tracked articles were used to track other relevant articles. Studies were included if they were conducted in an African country, written in English and published between 1 January 2007 and 31 December 2016 in peer-reviewed journals. Literature reviews, dissertations, editorials and letters to the editor, case reports, discussion papers, and grey literature were excluded as the researchers wished to include only peer-reviewed publications.

Data gathering started in March 2017 and ended in August 2017. The list of publications obtained from the databases was printed and reviewed to exclude articles that did not meet the inclusion requirements. The titles were reviewed first to ensure the work investigated some aspect of FGM/C, while the abstracts were reviewed for articles whose titles were not clear. The researcher also used the abstracts to investigate the authors and country in which the study was conducted, while full texts were used to investigate the latter if the abstracts did not provide the necessary information.

The first search yielded 332 articles, while 69 articles came from reference lists, totaling 401articles. One hundred and sixty-four (164) articles were removed as duplicates and 40 articles were excluded because despite efforts made to retrieve their full texts, only their abstracts were available; 197 articles remained. Thereafter, those that did not meet the inclusion criteria (169) were excluded, leaving 28 articles for the review. **Figure 4.2** is a PRISMA flow diagram showing how the search was conducted.

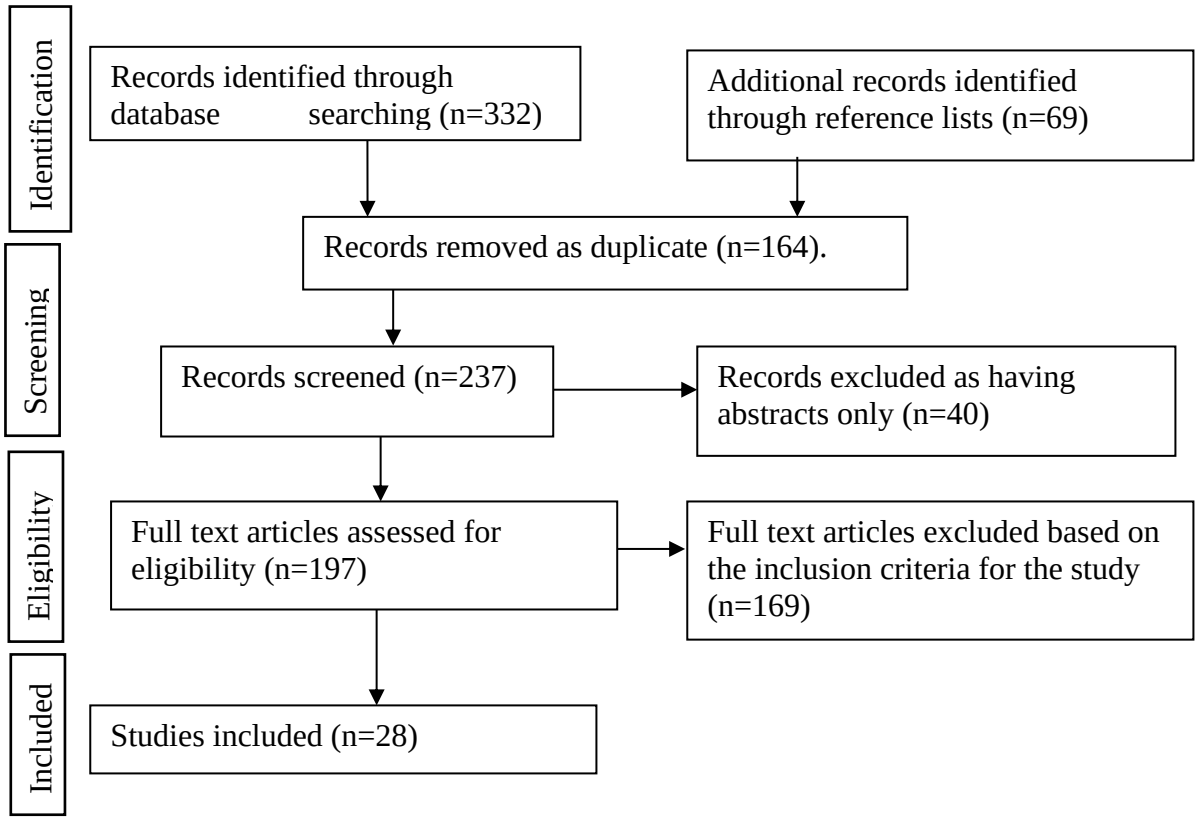



**Figure 4.2. PRISMA flow diagram of the review search process**

To handle the data and combine the results effectively, a data extraction sheet was developed for documentation. This captured the author, date of publication, country of origin**,** purpose, study design, population and sampling, data collection and instrument and the major findings (**see addendum 18**). The Mixed Method Appraisal Tool (MMAT) Version 2018, (Hong et al., 2018), was used to appraise the quality of the review articles (**see addendum 30**). Content analysis (Polit & Beck, 2014; Bengtsson, 2016), a process of integrating and organising information, was used to categorise the focus of the studies and group the categories into themes. To minimise the risk of bias, the researcher extracted the data iteratively, while the research supervisors compared the table containing the provisional titles with the extracted data. The titles were finalised during a consensus meeting.

### 4.5. RESULTS

In addition to the general information referring to the characteristics and focus of the studies, two themes and six subthemes arose from the data **(see Table 4.1)**. Tables, graphs, and percentages were used to support the general information.

### 4.5.1. General Information

#### 4.5.1.1. Characteristics of the studies.

The studies originated from various countries: Ethiopia, Senegal, Cote d'Ivoire, Kenya, The Gambia, Egypt, Mali, Burkina Faso, Ghana, Nigeria, Togo, Guinea-Bissau, Mauritania, Niger, Sierra-Leone, Rwanda, and Tanzania. Six studies (21%) were conducted in Egypt, followed by Ethiopia, The Gambia, and Nigeria, which had four studies (14%) conducted in each. **Figure 4.3** provides the details.

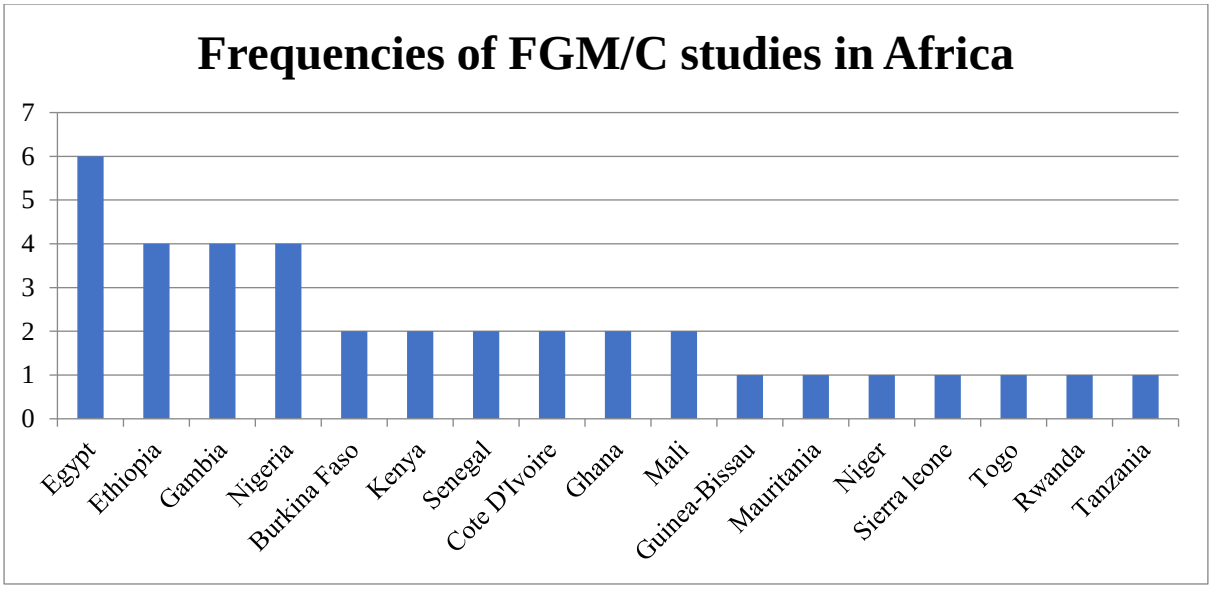



**Figure 4.3. Countries where the studies were conducted.**

Most of the studies were non-experimental (93.0%; n=26), 53.6% (n=15) were quantitative, 32.0% (n=9) were qualitative while 7.0% (n=2) used mixed methods and quasi-experimental methods respectively. More than one instrument and source were used to collect data in most of the studies; these included a combination of questionnaires, interviews, focus group discussions and direct observations.

The study population comprised mainly women aged between 18 and 65 years (50.0%, n=14), followed by those aged between 15 and 49 years (39.0%, n=11), males (21.0%, n=6), young females aged between 1 and 14 years (14.0%, n=6), healthcare providers (11.0%, n=3), infants (7.0%, n=2), schoolgirls (4.0%, n=1) and government officials (4.0%, n=1).

When appraising the quality of the studies, it was found that most of the studies (n=26; 92.9%) did not provide clear research questions and therefore the researchers were unable to tell whether the data collected answered the research questions. One of the six qualitative studies (16.7%, n=6) provided a research question and met all five methodological quality

criteria. Similarly, one of the 16 descriptive qualitative studies (6.3%, n=16) presented a research question and met all five quality indicators. Only one of the two non-randomized qualitative studies (50%, n=2) met all the quality indicators. As none of the four mixed methods studies had a research question, none met all the quality indicators.

#### 4.5.1.2. The focus of the studies

Most of the studies (29.0%, n=8) focused on finding the prevalence of FGM/C, attitudes/intention to continue the practice and the health consequences associated with the practice as part of their objectives**.** Studies also focused on determining the effectiveness of anti-FGM/C laws (18.0%, n=5), motivations for FGM/C (18.0%, n=5), perpetrators of FGM/C (11.0%, n=3), testing the effectiveness of programmes to end FGM/C (7.0%, n=2), the role of male and female sexuality about FGM/C (4.0%, n=1), perceptions of sexual consequences of FGM/C (4.0%, n=1) and risk for intimate partner violence (4.0%, n=1). None of the studies focused on the experiences of girls and their mothers before, during and after an FGM/C procedure.

### 4.5.2. Themes elicited from the data

**Table 4.1. Themes and categories arising from the study**

| Nos | Themes | Categories |
|---|---|---|
| 1. | The practice of FGM/C | • Prevalence and types of FGM/C<br>• Age at FGM/C<br>• Consequences of FGM/C |
| 2. | Attempts to end FGM/C | • Attitude and motivators of FGM/C<br>• Effectiveness of interventions to end FGM/C<br>• Perpetrators and medicalization of FGM/C |

#### 4.5.2 1. Theme one: the practice of FGM/C

- **Prevalence and types of FGM/C**

Twelve studies (n=12) reported the prevalence of FGM/C in various African countries, while five studies (n=5) reported findings on the types of FGM/C prevalent in their study areas. Bogale, Markos and Kaso (2014) reported a prevalence rate of 78.5% for FGM/C in the Bale zone, Ethiopia, which is in line with the findings of Yirga, Kassa, Gebremichael and Aro (2012) in the Karsa district, Oromia region of Ethiopia, where 88.1% of the mothers reported circumcising their daughters. In Egypt, Zayed and Ali (2012) reported that 63.9% of the sample of females between the age 5 and 30 years had undergone FGM/C, which agrees

with the report of Rasheed et al. (2011), who reported that 89.2% of young girls and women in Egypt, as of the year 2011, had undergone FGM/C.

Concerning the types of FGM/C, Ekenze, Ezeugwui, and Adiri (2007) reported a prevalence of 57.1% for Type I and 42.9% for Type II in Nigeria. Kaplan, Hechavarria, Martin and Bonhoure (2011) reported 66.2% for Type I, 26.3% for Type II and 7.5% Type III FGM/C in The Gambia, whilst Kaplan, et al. (2013) reported a prevalence of 75.6% for Type I FGM/C and 24.4% for Type II. According to Kaplan, et al. (2013), 78.9% of the Ethiopian women included in the study, claimed their clitoris was removed during circumcision.

- **Age at FGM/C**

Not all the studies reported on the ages of girls and women at the time of FGM/C. However, most of the studies (n=23; 82.1%) included women between 15 to 65 years, while two studies (13.3%) included girls below 14 years of age. In a prospective evaluation of girls with genital complications of FGM/C in Nigeria, Ekenze et al. (2007) reported that the average age at presentation was 3.5 years and the genital cutting procedures were performed eight to 90 days after birth. This report agrees with the Tanzanian report of Galukande et al. (2015) who, when comparing the 2005 district health survey to that of 2010, found that cutting of young girls under or equal to one year had increased from 18.4 to 31.7 %. The same authors also reported that a significant number of respondents indicated that more girls younger than 10 years, and in some instances, neonates were being circumcised. In Cote d'Ivoire, Plo et al. (2014) reported that 87% of their patients had FGM/C when they were below 5 years of age. In Egypt, Tag-Eldin et al. (2008) reported that the mean age of the time of FGM/C was 10.1, ± 2.3 years, while Zayed and Ali (2012) reported that the mean age was 10.846 ± 1.9 years.

- **Consequences of FGM/C**

Some of the studies reported the physical consequences of FGM/C with only a few reporting psychological and sexual consequences. Bogale, Markos and Kaso, (2014) elucidated the immediate consequences of FGM/C as excessive bleeding during the procedure, infection, urine retention and swelling of the genital organs. Ekenze et al. (2007) concurred with these findings and reported post-surgical complications such as infection, labial adhesion and genital lesions complicated by clitoral dermoid cysts and labia fusion. Kaplan et al. (2013) in their study conducted in The Gambia, found that women with Types I and II FGM/C had a significantly higher prevalence of long-term health problems such as dysmenorrhea, vulva or vaginal pain, problems related to wound healing such as fibrosis, keloid sexual dysfunction, and complications during childbirth, compared to those who were not circumcised.

Other consequences reported included a reduction of all aspects of sexual function (Anis, AboulGheit, Awad & Saied 2012), higher odds of being HIV positive (Smolak, 2014) and emotional trauma (Zayed & Ali, 2012). In addition, Salihu et al. (2012) reported an association between FGM/C and intimate partner violence with the odds of this kind of violence increasing with the increase in the FGM/C severity. This may be because of possible dyspareunia, which might hinder the female partner from enjoying sex.

Some studies revealed the possible under-reporting of the consequences of FGM/C due to ignorance. For instance, Yirga et al. (2012), in a study conducted in Ethiopia, found that 68.8% of the 858 women included in their study were unaware of any health problems associated with FGM/C and would therefore not be able to report any post-FGM/C complications. The same trend was not found in Egypt, where sexual problems were reported by 72.7% of the women who were sexually active (Zayed & Ali 2012).

#### 4.5.2.2. Theme two: attempts to end FGM/C

- **Attitude and motivators of FGM/C**

Various studies found that women supported the continuation of FGM/C. For instance, in a study conducted by Akinsanya and Babatunde (2011) in South West Nigeria, it was reported that 86% of the 84 respondents included in their study believed in the continuance of the practice. A similar trend was found in South Eastern Nigeria, as Ekenze et al (2007) reported that, out of all the circumcised mothers they interviewed (n=21), 61.9% (n=13) stated they would circumcise their daughters for socio-cultural reasons. This is not unique to Nigeria, as there were similar reports in studies from other countries such as Egypt, Ethiopia, The Gambia and Burkino Faso. In a study conducted by Anis, AboulGheit, Awad, and Saied (2012), it was found that 46.0% of the women in Egypt had a re-infibulation after childbirth or planned for their daughters to undergo FGM/C. It was interesting to note that Sipsima et al. (2012) reported a dramatic reduction in FGM/C prevalence from mothers (74%) to daughters (25%) in Burkina Faso but explained that 14.2% of the women still affirmed the belief that the practice should be continued. Support for FGM/C continuation is however not limited to women, as according to Kaplan, Hechavarria, and Bonhour (2013), in a study conducted in The Gambia, a significant proportion of healthcare practitioners in the rural areas embraced the continuation of FGM/C.

Various reasons have been documented for continuing this practice. Refaat (2009) found that cultural influences (81%) were the highest determinants of FGM/C, followed by a lack of knowledge (35%). According to Jirovsky (2010) and Fahmy, El-Mouelhy, and Ragab (2010), communities are motivated to continue this practice to increase women's chastity and to

ensure morally acceptable behavior. Other socio-cultural reasons that motivate the continuation of FGM/C are the rite of passage from girlhood to womanhood, religion, safeguarding virginity, and fear of the clitoris being similar to the male penis. In addition, FGM/C is also perceived as giving a good and acceptable body image (Bogale, Markos & Kaso, 2015; Plo, Asse, Sei & Yenan, 2014; Rasheed et al., 2011).

- **Effectiveness of interventions to end FGM/C**

Interventions against FGM/C comprise of anti-FGM laws and campaigns. However, laws forbidding FGM/C do not seem to be effective as various studies (18%, n=5) reported the ineffectiveness of these laws. Kandala and Komba (2015), in a study conducted in Senegal, found that this strategy had both advantages and vulnerabilities in relation to its enforcement, as the legislation failed to offer adequate protection to potential victims of FGM/C in Senegal. Rasheed et al. (2011) supported this finding by stating that irrespective of the fact that FGM/C was criminalised in Egypt, the incidence of the practice was still high in Upper Egypt. In addition, Ako and Akweongo (2009) reported that although this practice had been criminalised in Ghana, the political will to enforce the law was lacking because support for FGM/C in the communities was clearly in variance with the law. The communities are determined to maintain the practice because of tradition, thereby posing a huge challenge for effective intervention by the state.

Diop and Askew (2009), in their quasi-experimental study in Senegal, reported that the post-intervention prevalence of FGM/C among girls aged 10 years and below decreased significantly over time. An eighteen months long anti-FGM/C campaign in a rural community in Tanzania (Galukande, Kamara, Ndabwire, Leistey, Valla & Luboga, 2015), revealed the post-intervention prevalence of FGM/C to be 69.2%, while a third of the FGM/C practitioners denounced the practice and formed an anti-FGM/C peer group. In addition, knowledge of the health risks of this practice increased from 16% to 30%. However, when the authors did a post-intervention physical obstetric examination of the women in labor, they found that more than 95% of the women had undergone FGM/C (Galukande et al., 2015).

- **Perpetrators and medicalisation of FGM/C**

According to the available evidence, perpetrators of FGM/C include traditional healers as well as nurses and medical practitioners. In addition, the procedure is conducted both at home and in health care facilities. Yirga et al. (2012) found the majority (76.1%) of their respondents living in Ethiopia were circumcised by traditional healers. In contrast, Zayed and Ali (2012) did not find the same trend in Egypt, as medical personnel performed the majority of FGM/C, with 38.5% of the circumcisions done in private clinics and hospitals and 6.5% at

home. Rasheed et al. (2011) supported this finding by reporting that general practitioners performed most of the procedures in Egypt, with nurses being overwhelmingly in support of this practice, as 88.2% of the nurses in their study were in favour of FGM/C in contrast to the 34.3% of young physicians and 14.9% senior physicians.

Refaat (2009) reported support for FGM/C in Egypt, as 18% of physicians approved of FGM/C, while 19% practiced it mostly due to conviction or for profit. Support for the continuation of FGM/C was also found in The Gambia, as documented by Kaplan et al. (2013) who reported that 42.5% of healthcare professionals indicated support for the continuation of FGM/C, 47.2% indicated they would circumcise their daughters, and 7.6% reported they have performed the procedure during their professional practice. In Nigeria, Ekenze et al. (2007) documented that their study participants were circumcised by traditional practitioners (66.7%) and to a lesser extent (33.3%) by nurses.

### 4.6. DISCUSSION

This scoping literature review provided evidence that most of the studies focusing on FGM/C in the last 10 years were done in Egypt, followed by Ethiopia, The Gambia, and Nigeria. Whether this research output represents the prevalence of this practice in Africa is debatable. According to UNICEF (2013), the prevalence of FGM/C is more than 80% in countries such as Egypt, Somali, Mali, Sierra Leone, Guinea, Eritrea, and Djibouti. Evidence of at least one peer-reviewed study on FGM/C conducted in Egypt, Sierra Leone and Mali was found during the search process.

The reason for the limited number of FGM/C studies in these countries with the highest estimated prevalence is unknown. As is common with many developing countries, it could be possible they do not have a high research capacity and thus lack the manpower or enabling environment to conduct indigenous health research (Dye, Reeder and Terry, 2013). In addition, despite the anti–FGM/C law in these countries, FGM/C could be acceptable amongst a large number of the population. Therefore, indigenous health researchers may not have the will to conduct research on such sensitive topics as FGM/C against the wish of the governing authorities. This possibility is supported in the statement of Motaung (2015), that in Eritrea, the authorities control all sources of information, a situation that is in tandem with a culture of silence (Jacobson et al., 2018) and enables the practice of FGM/C to continue. This could discourage any indigenous research on FGM/C in those communities, as indigenes may not want to expose their culture to criticism.

The attitude of not exposing one's culture for possible criticism is supported by the Theory of Ethical Relativism, which states that morality is relative to the norms of one's culture

(Velasquez et al., 1992). Notwithstanding, there is still need for communities with higher FGM/C prevalence to give greater priority to the efforts to curb the practice, and this cannot be done without obtaining research evidence, which would be a guide for planning and designing interventions that would address the peculiarities of FGM/C practices in these countries.

Most of the studies focused on women between 15 to 65 years, with only two studies (13.3%) including girls younger than 14 years of age. This could be because this age group (15 to 65) is easily available and accessible for the studies or that parents control access to their daughters who were below 14 years of age. In addition, the current study revealed that in various countries, some girls were cut before they reached 10 years of age. This agrees with the statement of Fund and Gupta (2013), that in half of the countries with available data, many girls were cut before the age of five. This might be linked with key motivations for FGM/C among the respondents, which were marriageability, sexual chastity and other traditional beliefs (Yirga et al., 2012, Abeer & Ali, 2012). It can be assumed that mothers subject their daughters for FGM/C at an age when they still decide for them to ensure they grow up to be sexually chaste, have a good body image and thus be fit for marriage. Galukunde et al. (2015), who reported an increase in early-age FGM/C in Tanzania, explained strategies such as the anti-FGM/C law and campaigns could be responsible for this practice.

Interventions, such as anti-FGM/C laws and awareness campaigns against FGM/C, had both positive and negative effects in the bid to end the practice (Kandala & Komba, 2015). These interventions led to an increase in knowledge about FGM/C and its consequences, brought about the public denunciation of the practice, but still led to the continuation of FGM/C in secret (Galukande et al., 2015; (Van Bavel, Coene & Leye, 2017). In addition, anti-FGM/C laws could result in women who had complications from FGM/C not presenting themselves or their affected children for health care for fear of apprehension by the law, thereby silently increasing morbidity and mortality.

This study's findings re-echoed the surge in the medicalisation of FGM/C in Africa. This is in tandem with the report of UNICEF (2013) that in Egypt, the medicalisation of FGM/C is acute, and the percentage of girls circumcised by health personnel increased from 55 % in 1995 to 77 % in 2008. UNICEF and UNFPA (2016) also reported medicalisation of FGM/C in Nigeria, which could be due to the increase in the awareness of the campaign regarding the health consequences of FGM/C.

Families, in a bid to meet their societal demands or traditions while still protecting the health of their girls and women, resort to medicalisation. Nurses and young medical doctors, as part of the healthcare professionals, were mentioned specifically as the major perpetrators of FGM/C (Rasheed et al., 2011). This might be possible, because in many African countries, nurses and midwives form the bulk of healthcare practitioners in the communities (Dovlo, 2007). Unfortunately, they, along with other healthcare practitioners, are also perpetrators of this practice and perform FGM/C for cultural and financial reasons, as well as to prevent women from visiting a traditional healer to have the procedure (Anis et al., 2012). Whatever the reasons or methods by which FGM/C is done, it is condemned by international organisations as a violation of females' human rights (WHO, 2013). It is, therefore, necessary to emphasise the fact that medicalisation of FGM/C is not a guarantee or shield from all the long-term sexual, health and psychological consequences related to the procedure (WHO, 2010).

Finally, most of the studies were quantitative and used questionnaires to collect data. Although the studies provided valuable evidence, studies on the experiences of females who must live with the consequences of this procedure were absent. In addition, the experiences of the traditional circumcisers in recent years, and what would motivate them to abandon this procedure were also not found.

### 4.7. LIMITATIONS

This study was a traditional scoping review and focused only on peer-reviewed articles. There might be some work on FGM/C in African countries which has not been published or have been disseminated through other venues. In addition, citations that might be in the reference lists of the excluded studies could have been missed. It could also have been possible that articles were missed because keywords such as infibulation and medicalisation were not included in the search terms.

### 4.8. CONCLUSION

The study provided evidence that the FGM/C research output in Africa over the 10 - year period, 1 January 2007 to 31 December 2016, was not high. It was found that despite the anti-FGM/C law, the practice of FGM/C was still widely practiced in Africa, and there might have been an increase in early-age FGM/C in some communities. The studies focused primarily on prevalence, attitude, motivators, consequences, perpetrators, and effectiveness of anti-FGM/C interventions. Studies investigating the experiences of women and children who underwent this procedure in different cultural groups were absent. Studies focusing on

the experiences of those who conduct FGM/C and how this could be prevented in recent years were also absent.

There is a need for research into the experiences of the females who have been affected directly or indirectly by FGM/C in each community, especially in the countries with a high prevalence of FGM/C. The experiences and suggestions of these females contribute to literature to inform future programme designs of FGM/C eradication activities operating at community levels in Nigeria, Africa and the World at large. The fact there has been a recent increase in early-age FGM/C, as revealed in this study calls for further research on this subject as early-age FGM/C can cause an increase in morbidity and mortality, which could drive the practice further underground.

### 4.9. SUMMARY OF CHAPTER FOUR

This chapter presented the scoping literature review on FGM/C in Africa, and identified research gaps in FGM/C. The knowledge gaps identified by means of this scoping review led to the following research questions, as stated in Chapter One of this study:

- What are the FGM/C experiences of genitally mutilated females and healthcare practitioners caring for these females in South Eastern, Nigeria?
- What health education pamphlet (HEP) can be developed to improve self-care by the genitally mutilated females?

The next chapter presents the findings of the FGM/C experiences of females and healthcare practitioners in SE Nigeria.

# CHAPTER FIVE

# FGM/C EXPERIENCES OF FEMALES AND HEALTHCARE PRACTITIONERS

## 5.1. INTRODUCTION

The previous chapter focused on the scoping literature review, which was the first phase and first objective of the overall study. This chapter refers to the second and third objectives of the overall research study, which were to describe the FGM/C experiences of females and the healthcare practitioners caring for these women and girls in South Eastern Nigeria. There are four non-sequential stages in this phase of the study (**See Figure 5.1**). The general information of the participants, as well as findings of the themes that arose from each stage of the study were presented while a summary of the findings ended this chapter. The findings from this study formed part of the evidence for the development of health education pamphlet (HEP) for genitally mutilated females.

.

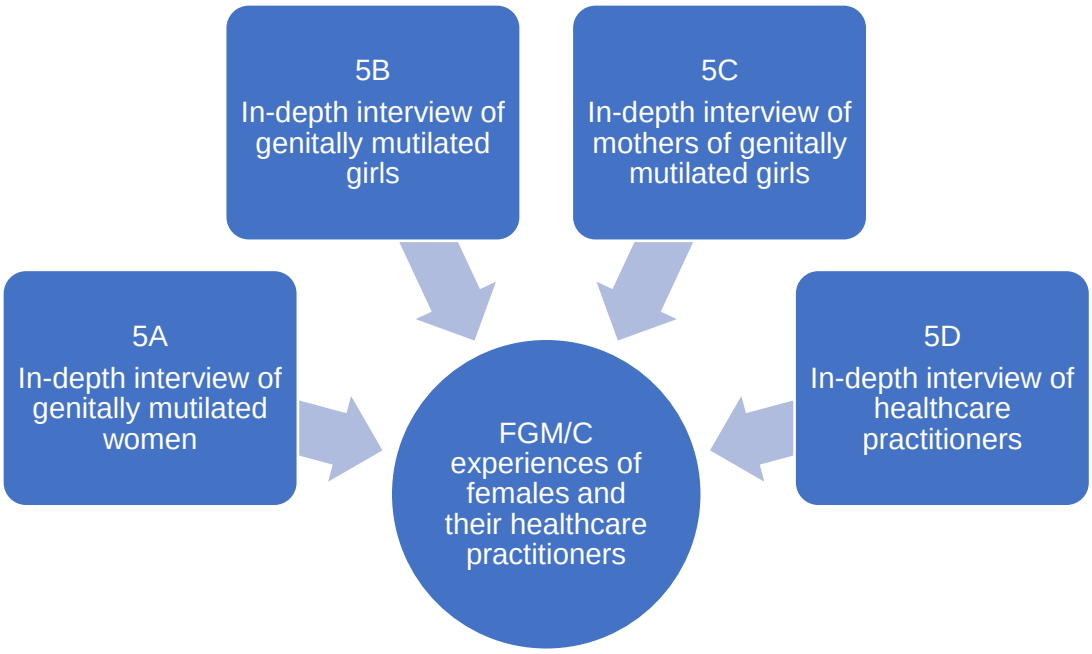



**Figure 5.1. A quick presentation of the second phase of the study**

## 5.2. PRESENTATION OF FINDINGS

Findings from the interviews were presented in this section. Sub-themes identified were then used to further explain the major themes. Narratives from the transcribed interviews were cited to illustrate the findings and to allow the reader to evaluate the responses and the credibility of the findings. Each citation was followed by a code, for example “W” indicated that the statement was made by a woman participant during the individual interviews. The codes were followed by a subscript number to indicate which of the participants made the statement, for example, $W_3$ indicates the third woman interviewed made the said statement.

## 5A. Findings arising from the Interview with the Genitally Mutilated Women

The participants will first be described followed by the themes and sub-themes that were elicited from the data.

### 5A.1. The participants

The participants consisted of 22 (n=22) genitally mutilated women. The ages of the participants ranged between 20 and 40 years with three participants indicating that they were not sure of their ages. The participants were all women of childbearing age. The mean age was 28.6 (SD ±5.1). All the participants were from the Igbo cultural group, married and had at least a primary school education; six of the 22 participants did not declare their highest educational level. Their ages at circumcision ranged from infancy to 15 years. Half of the participants (11 of 22) were circumcised by traditional birth attendants (TBA), six by traditional circumcisers, three by a female relative (grandmother, aunt or step mother) and two by nurses. Most of the women (14 of 22) were not sure of which anatomical structure was removed during their circumcision, the rest indicated that their clitoris was removed. Most of the participants had given birth to at least one child; one participant said she is yet to have a child and one participant didn't disclose how many children she had. **Table 5A.1** provides the details.

**Table 5A.1. General information of the genitally mutilated women** **n = 22**

| Women | Age (Years) | Cultural group | Marital status | Highest educational level | Age at circumcision | Agreed to the procedure? | Circumciser | What was removed? | No of children |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 40 | Igbo | Married | Secondary | 15 years | No | TBA (Traditional Birth Attendant) | Clitoris | 6 |
| 2 | Not sure | Igbo | Married | No answer | Infant | Not applicable | TBA | Not sure | 5 |
| 3 | 35 | Igbo | Married | No answer | Infant | Not applicable | TBA | Not sure | 3 |
| 4 | 23 | Igbo | Married | No answer | Infant | Not applicable | TBA | Not sure | 1 |
| 5 | 36 | Igbo | Married | Secondary | Infant | Not applicable | TBA | Not sure | 6 |
| 6 | 31 | Igbo | Married | Secondary | Infant | Not applicable | TBA | Not sure | 5 |
| 7 | Not sure | Igbo | Married | No answer | Infant | Not applicable | TBA | Not sure | 1 |
| 8 | 25 | Igbo | Married | No answer | Infant | Not applicable | TBA | Not sure | 1 |
| 9 | 30 | Igbo | Married | Tertiary | Infant | Not applicable | TBA | Not sure | 1 |
| 10 | 28 | Igbo | Married | Secondary | Infant | Not applicable | Healthcare practitioner | Not sure | None yet |
| 11 | 30 | Igbo | Married | Tertiary | Infant | Not applicable | TBA | Not sure | 6 |
| 12 | 22 | Igbo | Married | Secondary | 9 years | Not applicable | Traditional circumciser | Clitoris | 4 |
| 13 | 35 | Igbo | Married | Secondary | 10 years | No | Traditional circumciser | Clitoris | 5 |
| 14 | Not sure | Igbo | Married | Primary | 6 years | No | Traditional circumciser | Not sure | 3 |
| 15 | 20 | Igbo | Married | Primary | 10 years | No | Grandmother | Clitoris | 1 |
| 16 | 28 | Igbo | Married | No answer | 3 years | Not applicable | Traditional Circumciser | Clitoris | 3 |
| 17 | 28 | Igbo | Married | Primary | 7 years | No | Traditional circumciser | Not sure | No answer |
| 18 | 30 | Igbo | Married | Primary | 10 years | No | Maternal aunt | Clitoris | 3 |
| 19 | 25 | Igbo | Married | Secondary | 8 years | No | Step mother | Clitoris | 5 |
| 20 | 26 | Igbo | Married | Secondary | 6 years | No | TBA | Not sure | 4 |
| 21 | 25 | Igbo | Married | Secondary | 8 years | No | Traditional circumciser | Clitoris | 5 |
| 22 | 27 | Igbo | Married | Tertiary | Infant | Not applicable | Healthcare practitioner | Not sure | 1 |

### 5A.2. Themes and sub-themes elicited from the data

Three themes and seven sub-themes were elicited from the data. The themes were: cultural issues, life as a circumcised woman and the future with FGM/C. A summary of the themes and sub-themes identified in this step of the study are presented in **Table 5A.2**.

**Table 5A.2 Themes and Sub-themes emerging from the data**

| Themes | Sub-themes |
|---|---|
| Cultural Issues | • FGM/C is culturally embedded<br>• Fear, force and obedience<br>• The cutting experience |
| Life as a circumcised woman | • Coping with the pain and wound healing<br>• Experiences of problems following FGM/C |
| The future with FGM/C | • The future for our daughters<br>• Factors that influence the practice of FGM/C |

**Theme One: Cultural Issues; *"…it is our tradition…"***

This theme consists of three sub-themes. The sub-themes are: FGM/C is culturally embedded, fear, force and disobedience, and the cutting experience.

**Sub-theme one: FGM/C is culturally embedded**

Most of the participants believed FGM/C had its root in their culture. They claimed it has been in practice before they came into existence and was handed over to them by their ancestors. Some also considered that uncircumcised women were not indigenes of their communities and that a woman must be circumcised to be qualified to circumcise her daughter. The participants explained:

"… *It is our culture. Every girl must be circumcised before she gives birth to a child. It has been in practice before I was born. Even my grandmother and mother were circumcised*…" ($W_{12}$)

*"…they also said that a girl is not an indigene of our community if she is not circumcised*…" ($W_{13}$)

"…*They did not tell me any reason for the circumcision except that it is our culture. My mother was circumcised, so she insisted on circumcising me".* ($W_1$)

"…*All my mother told me which I also saw with my eyes is that FGM is a tradition handed over to us by our ancestors. So, every true daughter of this land must be circumcised. My mother was circumcised, so also my grandma and so they circumcised me."* ($W_{17}$)
*"My grandma said it is our tradition. She said my mother was circumcised hence I must be circumcised to qualify to circumcise my own daughters."* ($W_{15}$)

The participants were divided about the benefits of FGM/C. Most believed FGM/C has various benefits whilst a few participants did not view this practice beneficial at all. Those who believed the procedure held benefits were of the opinion FGM/C qualifies a woman for marriage, beautifies the genitalia and prevents promiscuity. Some participants also believed that uncircumcised women experience genital itching. They said:
*"…She also said that during their youthful age, all women were circumcised to qualify for marriage… "(*$W_{16}$)
"*They say that uncircumcised girls always feel sexy and prickling sensation which makes them promiscuous…the genitals are ugly if you don't do FGM/C. … I had a neighbour who refused to do FGM/C for her daughter. The girl is about two years old now and her genital is ugly. As a result, the girl wears pants always."* ($W_6$)

In contrast, those who believed this practice holds no benefits said:
"*I believe promiscuity is in people's lineage. FGM/C does not stop promiscuity…"* ($W_{22}$)
"*I don't know any benefit of FGM/C. I participated in it because others were doing it.*" ($W_{21}$)

The participants reported their fathers supported the tradition and were aware of the arrangements made for their FGM/C. They elucidated:
"…*My father told me that it will one day be my turn to be circumcised.*" ($W_1$)
"… *He was aware. He was in the house that day*." ($W_{13}$)
"…*he (father) was aware but it was my grandmother that arranged for the circumcision. My mother was late (dead) when I was circumcised*…" ($W_{12}$)

**Sub-theme two: Fear, force and obedience**
Most of the participants said that they were afraid, scared or anxious when they were told to go into the yam barn for the procedure. However, they subjected themselves to the procedure in order to be obedient to their parents. They felt they had no choice since their caregivers wanted them to be circumcised. They feared they would be labelled as stubborn or disobedient if they refused the circumcision, and this might spell doom for them since they were still wholly dependent on their caregivers for their livelihoods. This was described as follows:

"… *I was a child then and so had no choice than to obey or undergo whatever my parents choose for me… I was afraid*…" ($W_{14}$)
"… *I was so afraid because I have never witnessed it, and I don't really know what it means…. I was so afraid, and my heart was racing fast 'kpim, kpim, kpim…', but I obeyed my mother and entered the yam barn when it was my turn…*" ($W_1$)

Some of the participants reported they did not know what to expect with regards to FGM/C until they were cut. Although FGM/C is a common practice in these communities, the details of the procedure were not divulged to uncircumcised girls and they had to learn from their personal experience of circumcision.
"…*FGM /C is a common practice in our community, but I didn't know what the practice entails until I had the experience myself*…. *They told me to go in, that it is a small thing that will be done to me.*" ($W_{12}$)
"…*Nothing, she (mother) didn't tell me anything. She woke me up one early morning and said I would be circumcised that day. … I just obeyed her and went into the Oba (yam barn). I didn't actually know what awaited me there."* ($W_{18}$)

Some of the participants explained that not telling a girl what FGM/C procedure entailed before putting her through it was not a bad practice. They were of the opinion that children do not have choices and maybe the parents did not want to instigate fear in their daughter, seeing that FGM/C must be done for the girl as tradition demands.
"…*That is how many mothers do it so that the girl will not run away because of pain…a child is totally dependent on the parents and has no choice but to do whatever the parents chooses for her. So, the parents do not need to start begging her or do unnecessary explanation to her. She may never understand whatever reasons you give because she is still too young."* ($W_{17}$)
"*Well, I don't know what to say, but maybe she did not want me to be afraid. FGM/C is a tradition in our community.*" ($W_1$)

One participant said she was "deceived" into undergoing the procedure. She was given some information to ease her fear and encouraged to go into the yam barn for the procedure. However, she opined that her experience of the procedure was different from the information she was given. However, just like the other participants who were not given any information about the procedure before they were made to go through it, the participant explained that her parents "deceiving" her into being circumcised was the only way they could get her to submit herself for FGM/C. She explained:

"…*I did not want to be circumcised, but my people tactfully convinced me. The pain that I had was much. They deceived me by saying that if I didn't get circumcised, I would not circumcise my children whether girl or a boy. They also said that my mother was circumcised, therefore I must be circumcised too… I didn't know how the circumcision will be done. I wanted to obey my mother. It was when my grandmother did the cutting that I cried out… In my opinion, I believe that they used the only option they had to make me go in for the procedure. Since it is a must for a girl to be circumcised in our culture, they did what they thought was best for me. That's the way I see it."* ($W_{15}$)

Some of the participants said that they were forcefully circumcised. One was even forced to go into the yam barn despite refusing to have the procedure. She said:
"…*A woman held me to a place before the circumciser cut off my clitoris*. *Somehow, I was forced. I was not sure of what will happen inside the yam barn, but my mother told me to enter the yam barn for the circumcision*…" ($W_{13}$)

Despite not being prepared for the cutting, the participants accepted it as part of their tradition. They felt there was nothing they could do about it, and some even felt they were not harmed.
"I*t was not a sweet experience I must confess. I was so scared when the woman held me in the yam barn. My fear gave way to real crying when the woman that did the circumcision brought out the razor blade and then the pain of the cutting. It was so painful. But it is our tradition. There is nothing anyone can do about it".* ($W_{13}$)
"*But as an adult now, I think my mother and grandma did me no harm. They did what everyone was doing at that time for me. FGM/C is a must in this village. If they didn't do it the way they did it, I will never have agreed to undergo the circumcision because of fear."* ($W_{17}$)

**Sub-theme three: The cutting experience**

The majority of the participants were able to recall and share the experience of their circumcision procedure. Most mentioned they were circumcised in the morning. The cutting experience was traumatic, apart from not being prepared, the participants were held down to be cut. They experienced the procedure as extremely painful and had to live with the pain afterwards; nobody mentioned they received anything to relieve their pain.
"*My mother woke me up one early morning and said that I should enter the yam barn to be circumcised. I didn't understand what they meant until I entered the yam barn and saw that my grandmother was there with another woman from our village. Grandma told me to sit down with my legs thrown apart in front of a small hole. I had mixed feelings but still obeyed*

*her. She then bent down and held me so tight that I couldn't move my body anymore. Like a flash, the woman brought out a razor blade from the packet and cut some flesh from my genitals. Some blood came out and dripped into that hole she dug. I struggled to free myself because of the intense pain but my grandmother's grip on me was so strong. I wept so much. Finally, she released me and told me to go into the house and lie down". … It was so painful, believe me.*" ($W_{17}$)

"*…Hmm…. I felt as if I will die. It was a mixture of fear and pain when the woman did the cutting. If not for my grandmother's grip on me, I would never have been able to sit for the circumcision…I can't say if I was angry at anybody. I was too scared and in great pain when grandma released me. I wanted to get out of the place as fast as I could."* ($W_{17}$)

While some of the participants were aware of their cutting experience because they were circumcised at an age when they could recall their experience, some were not aware of their circumcision until they went to the hospital or clinic for childbirth. They grew up thinking that their genitals were the way they looked at birth. One of the women who, according to her story and description seemed to have had an infibulation was circumcised before she became conscious of her environment and so had to undergo a de-infibulation when she went to the village health centre for the birth of her first child.

*"I was circumcised as an infant. I had a tear in my vagina when I had my first baby and it has not healed. The nurses say I was circumcised so my vagina is narrow. After my second child, I had no tear as they left open the initial tear. I have never had postpartum haemorrhage or caesarean section. My problem is the tear.*" ($W_{20}$)

"*I was circumcised as an infant. Nobody told me I was circumcised until I went to deliver my first baby. It was there they said I was circumcised.*" ($W_6$)

"*I was circumcised as an infant…When I went to give birth to my baby, the midwife told me my clitoris was cut off during circumcision.*" ($W_7$)

In summary, the participants believed FGM/C has its root in their culture with some myths surrounding it. The participants were not prepared for the circumcision and some were forcefully circumcised, while some were circumcised when they were too young to recall their experiences. Additionally, fathers were in support of their circumcision and the experience was traumatic.

**Theme two: Life as a circumcised woman; *"I endured the pain"***

The second theme in the findings from the women participants had two sub-themes, which were coping with pain and wound healing and the experiences of problems following FGM/C.

**Sub-theme one: Coping with the pain and wound healing**

The participants had to go into their houses and lay down after the FGM/C procedure, and they were exempted from doing house chores. Their family members assisted them with some self-care needs until the pain subsided, while some said special meals were cooked and a ceremony organised to celebrate their new FGM/C status.

"*After the circumcision, I went and lay down in a room…I endured the pain. I went and lay down in the house after the circumcision. I did not go away from the house. I did not do any strenuous activity*…" ($W_{18}$)

"*As for me, pain continued after I urinated. But it was reducing gradually ... I had no option than to endure it. My mother helped in any way she could to help limit my movement because it pained me a lot when I move my legs fast… No special food was cooked for me, it was a normal day, just like every other day in the house."* ($W_{17}$)

"*They cooked special food for me. I ate my favourite dish that day. I was not allowed to do any work in the house. That is our culture… It took about a day for the pain to subside. I endured the pain…"* ($W_{15}$)

"*I walked the same day. I was helped to stand on my feet and walk into the house. It pained me much the first time I urinated after the circumcision. After that first urination, the pain subsided. Meanwhile, my grandmother and other women cooked special food for me to mark the occasion as it is the norm in our community…Yes, I ate. It was my favourite dish with plenty meat. I was specially served that day. Such opportunity to eat sumptuously rarely comes, so I did not miss eating the food irrespective of the pain."* ($W_{12}$)

The majority of the participants, who could recall their circumcision experiences, reported that their wounds healed without any treatment, while a few said their mothers applied some mixture to the wound to aid healing. Also, another participant mentioned that she had rashes and itching on her genitals before the wound closed; but still maintained that no treatment was applied on the wound before it finally healed.

"… *but the wound healed neatly on its own some days after the circumcision.*" ($W_{15}$)

"*It was the problem of rashes. The wound started scratching me before it dried up...they left after some time.*" ($W_{19}$)

*"… yes, but I cannot say what was applied.*" ($W_{14}$)

**Sub-theme two: Experiences of problems following FGM/C**

Some of the women told stories of immediate complications that other girls in their community suffered after their FGM/C. However, none of these women confessed to having any immediate complication from their circumcision.

"*I do not have problem…but you know people's body are different, some girls do have a big thing form on the circumcision wound site, when they go to give birth, they complain that they suffer much because of that thing that formed on their genital. Had it been they were not circumcised, that won't have happened to them.*" ($W_{13}$)"
"*…I did not bleed much…a big clot formed on one of my sister's genital. She went to urinate and was having pains. She then noticed the clot, so she ignorantly removed the clot, immediately blood started gushing out of that place. She was taking to hospital and had; some treatment and the bleeding stopped, and never happened again*…" ($W_1$)

Although some of the participants mentioned that since after their FGM/C experience, they never had problem caused by their FGM/C status, later during the interviews some described some challenges they had. These participants had little or no sexual feeling, experienced dyspareunia and difficulties in childbirth. The participants said:
"*I don't have sexual arousal and it causes problem between me and my husband...To me, female circumcision is simply to dis-virgin a girl before she meets a man.*" ($W_7$)

Another participant explained:
"*I desire for my husband to be around often, but that aspect of having sexual intercourse I hardly desire it. Many times, it's my husband that forces me to have sex with him…*" ($W_{13}$)

Another participant added:
"*…I have been fine since that time (post –FGM/C) only that I don't have what they call sexual feelings. I heard that when a girl grows to a certain age, she will begin to desire for a man, but I have never experienced it. Not even for my husband and I don't like it … I experience a lot of pains whenever I am having sexual intercourse with my husband. I have discussed this problem with my friend, and she advised me to visit the hospital. When I visited the hospital, they checked me and said that my problem is a result of the circumcision I did.*" ($W_{17}$)

As already mentioned, the participants experienced child birth issues which included postpartum haemorrhage, excessive perineal tears, prolonged labour and even foetal death. This was described as follows:
"*My perineum usually tears in a large proportion like rags. My body usually burst like balloon once my baby has crowned fully, and the child will pop out. But the tears are usually in the direction opposite the circumcised part of my genitals…*" ($W_1$)

"*When I had my second baby, a lady came later than me and gave birth before me. I asked the doctor the reason for that. He told me that FGM/C has narrowed and caused scar on my vagina*…" ($W_6$)
"…*I bleed so much during the birth of my second child… I had one prolonged labour that lasted more than one week. It started gradually and continued until after one week. I lost that baby."* ($W_{21}$)

In summary, the participants agreed that the cutting was painful, however they were able to cope with the pain and the wound healing process. The procedure was not without complications and had a negative influence on their sexual functioning and childbirth.

**Theme Three: The Future with FGM/C; "*I see no wrong in it*"**
Theme three consisted of two sub-themes: the future for our daughters and the factors that influence FGM/C in the communities.

**Sub-theme one: The future for our daughters**
Although the participants were aware of the government's warning against FGM/C, some reported that their daughters had already undergone the procedure, others planned to have their daughters circumcised, while some explained their daughters only had Type IV FGM/C. They said:
"*I have circumcised one, it remains only one …We still have traditional attendants who secretly do the job.*" ($W_3$)
"*Yes... The nurse simply took them in, circumcised them and brought them out.*" ($W_7$)
"*Well, I only did the mild method (Type IV FGM/C) for my four girls from birth.*" ($W_5$)
"…*I will circumcise them …Some healthcare practitioners still do circumcision in the secret due to the threats of the government. They go to people's house to do it, but before now, they did it openly.*" ($W_3$)

The participants were divided as to whether FGM/C should be continued or stopped. Many of them wanted the practice to be continued; some preferred it done as required by their culture while others preferred a "mild form" of FGM/C. A few of the participants were neutral and did not support the continuation or discontinuation of the practice whilst the others wanted the practice to be abandoned. The participants explained:
"*Yes, I strongly support the continuation of FGM/C.*" ($W_3$)
"*Yes, because I see no wrong with it. …There are places where you can still do FGM/C. It can't be stopped*..." ($W_{22}$)

"…*Bleeding (post-partum haemorrhage) is likely to occur with circumcised woman. I prefer the mild method…my daughter was not circumcised until she was two years old. Then, she started itching on her genitals, so I did the mild method for her."* ($W_6$)

Those who wanted the practice to be abandoned or had no specific preference said:
"*No, let the government ban female circumcision. I see no reason for such suffering.*" ($W_{17}$)
"*The government is already against it. They said it's bad. So, I better follow the government decision."* ($W_{15}$)
"*I don't know what to say, if everybody decides to stop it, fine. I think it's just culture.*" ($W_{12}$)
"*It is our tradition. I cannot say. But it was very painful.*" ($W_{14}$)

**Sub-theme two: Factors that influence the practice of FGM/C**
Several factors influenced the practice of FGM/C in the participants' communities. These factors were relatives, husbands, healthcare practitioners, government warnings against FGM/C and confusion.

Some of the women who had subjected their daughters to FGM/C had felt pressurised by their relatives to support this practice, and they yielded to the pressure, but only allowed their daughters to undergo a "mild" form of FGM/C.
"…*in antenatal clinic, they taught us that female circumcision affects women during childbirth…But when my mother-in-law insisted that I should circumcise my daughters, I did a mild method on them.*" ($W_6$)
"*My mother did the mild method on my daughters.*" ($W_{11}$)

Some of the participants believed it was the prerogative of the husband to decide whether their daughters would or would not have FGM/C. A participant said:
"*It is my husband that will decide if our daughters would be circumcised or not, but I don't think there are negative effects of the circumcision.*" ($W_{12}$)

Healthcare practitioners also played a role in the practice of FGM/C. Some of the participants learnt from healthcare practitioners that they should not subject their daughters to FGM/C and that the practice was disapproved of by the government. However, some participants also reported that the government's anti-FGM/C warnings did not deter them as they patronised some healthcare practitioners who performed the procedure secretly.
"*No…We were taught in antenatal clinic that FGM/C causes problems. They also announced same on radio…"* ($W_9$)

"*…The fourth and fifth girls are not circumcised. I was afraid of the police, but I have now discovered that the nurses still do it secretly.*" ($W_{11}$)
"*I was circumcised and will also do it for my baby girls. The nurses will do it for me.*" ($W_{10}$)

Government warnings and healthcare practitioners also influenced the practice of FGM/C. Almost all the participants were aware of the government warnings against FGM/C. Some said they do not support the practice of FGM/C because of the anti-FGM/C warnings, whilst others sad that the procedure is now done secretly because of the anti-FGM/C warnings.
"… *I don't support FGM/C. It is because government has told us the dangers associated with it; although I don't have any complications as a result of it as a person."* ($W_7$)
"*Some healthcare practitioners do FGM/C in the secret due to the threats of the government…but before now, they do it openly*" ($W_4$)
"*…No, government has said it is not good*". ($W_{20}$)

Deciding what was right and wrong was not so easy and some of the participants were confused. One participant said:
"…*many parents are confused. They are in a fix whether to continue FGM/C or not*…." ($W_6$)

In summary, despite being aware of the anti-FGM/C warnings by their state governments, some of the participants have subjected their daughters to FGM/C, while some said they plan to have their daughters undergo the procedure. The participants who indicated support for various forms of FGM/C to be continued were more than those who said they wanted it to be stopped. Finally, healthcare practitioners, relatives, government warnings and confusion were some of the factors that influenced the practice of FGM/C in these communities.

**5B. Findings arising from Interviews with the Genitally Mutilated Girls**
An overview of the participants will first be presented followed by the themes and categories that emerged from the data.

**5B.1. The participants**
The participants consisted of 16 (n=16) genitally mutilated girls. They were between the ages of 12 and 19 years, their mean age was 16.3 (SD ±2.2). Most of the girls were under the care of their parents at the time of the interview, while two girls were under the care of some guardians. All the girls were unmarried and had acquired at least a primary school education for six years. Half of the participants (8 of 16) were not sure how old they were when they were circumcised, and some did not know where they were circumcised or who performed the procedure. However, two of the 16 participants indicated they were

circumcised in a health centre by healthcare practitioners, while eight were circumcised in an Oba (their father's Yam barn) by a traditional circumciser. Only four of the participants knew which anatomical structure was removed during the procedure. Most of the participants (11 of 16) supported the continuation of FGM/C, four opposed the practice and one neither supported nor opposed the practice. The details are presented in **Table 5B.1**.

**Table 5B.1. General information of the genitally mutilated girls** **n = 16**

| Nos | Age (Years) | Caretakers | Cultural group | Marital status | Highest educational level | Age at circumcision (Years) | Venue of circumcision | Circumciser | What was removed? | Support for FGM/C |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 18 | Parents | Igbo | Single | Primary | Not sure | Health centre | Healthcare practitioners | Don't know | Yes |
| 2 | 18 | Parents | Igbo | Single | Primary | Not sure | Oba (Yam barn) | Traditional circumciser | Not sure | Yes |
| 3 | 18 | Parents | Igbo | Single | Primary | 10 | Oba (Yam barn) | Traditional circumciser | Clitoris | No |
| 4 | 18 | Guardian | Igbo | Single | Primary | 7 | Oba (Yam barn) | Traditional circumciser | Clitoris | No |
| 5 | 17 | Guardian | Igbo | Single | Primary | 11 | Oba (Yam barn) | Traditional circumciser | Clitoris | Neutral |
| 6 | 19 | Parent (Father) | Igbo | Single | Primary | 10 | Health centre | Healthcare practitioners | Not sure | No |
| 7 | 18 | Parents | Igbo | Single | Primary | 10 | Oba (Yam barn) | Traditional circumciser | Not sure | Yes |
| 8 | 17 | Parents | Igbo | Single | Primary | 9 | Oba (Yam barn) | Great grandmother | Not sure | Yes |
| 9 | 19 | Parents | Igbo | Single | Primary | 15 | Oba (Yam barn) | Grandmother | Don't know | No |
| 10 | 13 | Parents | Igbo | Single | Primary | Not sure | Don't know | Don't know | Don't know | Yes |
| 11 | 12 | Parents | Igbo | Single | Primary | Not sure | Don't know | Don't know | Don't know | Yes |
| 12 | 14 | Parents | Igbo | Single | Primary | Not sure | Don't know | Don't know | Don't know | Yes |
| 13 | 15 | Parents | Igbo | Single | Primary | Not sure | Don't know | Don't know | Don't know | Yes |
| 14 | 14 | Parents | Igbo | Single | Primary | Not sure | Don't know | Don't know | Don't know | Yes |
| 15 | 15 | Guardian | Igbo | Single | Primary | Not sure | Don't know | Don't know | Don't know | Yes |
| 16 | 16 | Parents | Igbo | Single | Primary | 9 | Oba (Yam barn) | Traditional circumciser | Clitoris | Yes |

### 5B.2. Themes and sub-themes elicited from the data

Four themes and 10 sub-themes were elicited from the data. The themes were: a game of conscience, the cold circumcision morning, life after FGM/C and FGM/C is ongoing. A summary of all the themes and sub-themes identified in this step of the study are presented in **Table 5B.2**.

**Table 5B.2 Themes and Sub-themes emerging from the girls' participants**

| Themes | Sub-themes |
|---|---|
| A game of conscience | • FGM/C is our culture and father was in support<br>• A stubborn girl<br>• Beliefs and benefits of FGM/C |
| The cold circumcision morning | • Circumcised against my wish<br>• The circumcision procedure<br>• Fear, pain and maturity |
| Life after FGM/C | • Recovery and returning to school<br>• Stories of other circumcised girls |
| FGM/C is ongoing | • Should we continue with this practice?<br>• Perpetuators of FGM/C |

**Theme One: A Game of Conscience; "*They wanted me to be circumcised*"**

This theme consists of three sub-themes: FGM/C is our culture and father was in support, a stubborn girl and threats and benefits of FGM/C.

**Sub-theme one: FGM/C is our culture and father was in support**

The girls believed that FGM/C was part of their culture and it was expected for every girl to be circumcised, because their mothers and grand-mothers were circumcised, so it was only natural for them to undergo the same procedure. They believed they had to be circumcised because boys in their communities were also circumcised. The participants said:

"…*they said circumcision is our culture, so I felt it was compulsory for every girl.*" ($G_3$)

"*Yes of course, female circumcision is an age-long tradition in this village, and I think that almost all the mothers in this village are circumcised*…." ($G_4$).

"…*Yes, all of us were circumcised including my younger sister… my mother told us all that we were all circumcised so we can look like other girls.*" ($G_1$)

"*Everyone must be circumcised… circumcision is our culture…boys are circumcised, girls are circumcised…"* ($G_2$)

The FGM/C culture was so strong in these communities that uncircumcised girls who become pregnant, whether married or not, were circumcised before they gave birth to their babies. A participant explained:
"*It is an abomination for a girl to give birth without being circumcised. That is what they said, so I had to go through it*" ($G_9$)

The participants believed their fathers were in support of the circumcision practice as their fathers believed that both males and females must be circumcised. None of the participants were circumcised or held down for the circumcision by a male, yet their fathers were aware of the procedure. The participants shared the following:
"…*so, my father told me that I will be circumcised alongside my elder sister*". ($G_7$)
"…*my father was also in the house and in full support of the procedure*" ($G_4$)
"*…Yes, he was fully in support of my being circumcised. He also believes that it is the culture in our community, and they have always done it successfully*". ($G_5$)

**Sub-theme two: A stubborn girl**
None of the girls subjected themselves for FGM/C procedure willingly. Some were merely told they were circumcised whilst others surrendered themselves to the FGM/C as they were helpless and had no option other than to accept this prevalent practice in their community. They went for the procedure in obedience to their parents' wishes. They did not want to argue nor appear as if they were questioning their parents' choices for them; as such attitude can cause a girl to be termed "stubborn"; and might negatively influence a girl's reputation in the community.
"*…yes, you see, the woman was already there to do the job and it will not be good for her to see me disobey my mother nor question her instruction…. I did not want to be labelled a stubborn girl especially by people outside my immediate family.*" ($G_5$)
"…*I entered the yam barn in obedience to my mum…. I was afraid but I wanted to obey my mum and also be a proud girl* (laughs)…" ($G_{16}$)
"… *I did not argue with them … mother woke me up with the instruction to get ready for the circumcision, I just obeyed. Meanwhile, the woman that did the circumcision was already waiting for me that early morning to carry out the procedure*. (Silence for some seconds) …. *I did not say yes or no to my parents. I knew they wanted me to be circumcised*…" ($G_3$)

In addition, some of the participants did not think they had an option and felt they were expected to obey. They just subjected themselves to what they thought was their fate. The participants explained:

"…*well, I don't know whether to say that I wanted to undergo it. I knew I had no option than to obey my parents and endure it. It is what every female in this community experiences once in a life time. I had no option than to be circumcised.*" ($G_9$)
"…*one thing I was sure of is that I knew that they wanted me to be circumcised…I didn't think I had any option than to just do as they said, especially when they went further to explain to me that it is our culture and so needs to be done for my good…. I just obeyed them and went in for it. It was not as if I had a choice of refusing or accepting to be circumcised. Remember that I was a small girl then…"* ($G_3$)

Even though FGM/C was a common practice in their communities, the participants did not know what the procedure would entail until they were circumcised. The participants said:
"*I didn't know exactly how it will be done, so I was not sure of what to expect*" ($G_9$)
"… *Although I knew that girls are usually circumcised…I didn't know exactly how the circumcision will be… I obeyed my mother*…" ($G_8$)

**Sub-theme three: Beliefs and benefits of FGM/C**

Some of the participants described the reasons for FGM/C they learnt from their parents and neighbours. Some believed they would have difficulty during childbirth if they were not circumcised, whilst others believed it is the price you must pay to be like other girls. These beliefs were described as follows:
"…*she* (mother) *said that if a girl is not circumcised, she will have difficulty with childbirth. She said it is a type of crucifixion; that a girl is supposed to be circumcised so she can be like other girls.*" ($G_1$)
"…*ehmm, in our village, girls are circumcised so that they will not have* difficult labour, *when they go to give birth. Like me, I gave birth to this my daughter about a year ago, and I did not have difficult labour. I delivered her myself with the help of my mother. I was strong and fine after the childbirth. My daughter is fine as you can see. That was because I was circumcised before the childbirth experience. That is the benefit of circumcision. No one knows the future. I didn't wish to have a child without being married but though it happened to me, I did not have problem in childbirth…*" ($G_8$)

Some participants even believed it is a disgrace for a girl to give birth to a child if she is not circumcised. Not only would she have severe pain during labour but would also not have her son or daughter circumcised. One participant said:
"*Yes now, ask the women in our community, they will tell you the same thing I am telling you. It is an abomination for a girl to give birth to a child without herself being circumcised, whether she is married or not. That is the practice here. If she gets pregnant without being*

*circumcised, she will be circumcised before she gives birth to that child so that she will not have difficulty during childbirth. So, you see, the girl will have double pain during childbirth.... In fact, if a girl succeeds in giving birth to the child without being circumcised first, that child will not be circumcised whether male or female, and so it will continue in their generation."* ($G_8$)

Preventing promiscuity was also mentioned as a reason for being circumcised, and this would prevent an unplanned pregnancy.

"…*she* (mother) *said that said that if a girl is circumcised, she will not be promiscuous and so will not have 'ime mkpuke* '(unwanted pregnancy), *and even if she gets pregnant outside wedlock, it won't be called ime mkpuke because a circumcised girl is seen as a full woman and so can get married and have children. Also, childbirth will be easier for the person because she is circumcised*. "($G_6$)

To support their beliefs about FGM/C, some of the participants hinted that their mothers and grand-mothers were circumcised too.

"…*My mother said that herself was circumcised, so also my grand-mother. So that makes me think that it might be their cultural belief that circumcision makes a woman to deliver her baby faster during childbirth.*" ($G_4$)

"*…my mother believes strongly that circumcision is good for every girl. Even herself was circumcised by her parents before she married my father.*" ($G_1$)

In summary, the participants believed that FGM/C was part of their culture; some believed it was the price to pay to be like the other girls and not have difficulty during childbirth. The participants were never allowed to decide if they wanted to undergo the procedure or not, neither were they briefed on the procedure before they entered the barn where the cutting was done. They felt their parents wanted them to undergo FGM/C and to be seen as a good girl, they always had to obey their parents.

**Theme Two: The cold circumcision morning; "…*it was so painful…*"**

This theme consists of three sub-themes: circumcised against my wish, circumcision procedure, and fear, pain and maturity.

**Sub-theme one: Circumcised against my wish**

Some of the participants reported that much anxiety and fear enfolded them on the circumcision morning. Despite persuasions and reassurances from their parents, they could

not help but be afraid, as some other circumcised girls had told them the procedure was usually painful, hence the reason for the fear and anxiety. The participants said:

"*I did not run away, but I was so scared… I was afraid and crying*…" ($G_{16}$)

"*In fact, my mother really tried to make me see reasons with her for the circumcision, but I was still very scared in my mind. I had elder sisters and girlfriends that have been circumcised, and they already told me that me that it is very painful*…" ($G_6$)

One of the girls felt she was "deceived" as her mother and elder sisters told her the circumcision was not painful. She felt betrayed when she realized some flesh had been removed from her genitals, leaving her with much pain.

"*My mother was the one that woke me up. I asked her to know what the experience is in details, but she told me not to worry, that it won't harm me. My elder sisters also reassured me that the experience was not painful and won't take a long time. So somehow in my mind, I believed them… after all, my elder sisters had gone through it before me… madam, it was so painful. Chai!!! Don't mind them o. They deceived me so that I will not run away. It was really painful. It was a swift, but very painful cut…I am not sure I will be brave enough to submit myself for the procedure if I had knowledge of how painful it is*…" ($G_2$)

Some of the girls did not easily yield themselves for the circumcision. Some knew that FGM/C was not favoured by the health care system and refused to be circumcised, but to no avail. One participant explained,

"*I was circumcised in year 2012 with my younger sister. Before that day, my mother told me that I will be circumcised but I refused because I heard over the radio that FGM/C is not good and that the government and people in health services are preaching against it. However, one early morning, my mother woke me up with the news that the woman that will circumcise me and my younger sister has arrived. She told me to get up, take my bath and get into the yam barn for the circumcision. I refused but she was annoyed and warned me not to dare challenging her…she dragged me to the yam barn…she thought I just wanted to disobey her or be naughty."* ($G_5$)

Despite being circumcised against her wishes, the participant considered her mother's behaviour as normal given the community they lived in. She said,

"*…I am a young girl and didn't have much opinion…I was not happy when my mother dragged me to the yam barn, but I was not surprised at her because that is what I think any other mother in this community will do*…" ($G_5$)

**Sub-theme two: The circumcision procedure**

Some of the participants reported healthcare practitioners as their circumcisers while some did not know who circumcised them because they had FGM/C as infants or toddlers, and so could not recall the experience. One of the girls said the nurse put her to sleep by injecting some drug into her body. She woke up later in the day and felt some pain in her genitals, and then her mother told her that she had been circumcised.

"*… later that morning, my mother's sister came to our house and she took me to a health center and there they gave me drug which made me to sleep. I woke up later in the day with pains in my genitals. I looked around and saw that I was on the hospital bed with my mother beside me. Later in the evening that day, we went back to our house…I was given an injection which I think made me to sleep.*" ($G_6$)

When describing how she felt when she woke up and saw that she has been circumcised, she replied, *"Well, I don't know exactly how I felt, but I saw my mother beside me and recalled that we were in the clinic. I was afraid of the pain of the procedure, but that one is now gone. I was having some pains in my genitals, so my mother gave me some pain killer drugs which I took and soon I was relieved to a large extent and we went home. I think I was happy that I didn't have to bear the pain of the circumcision being done in our house.*" ($G_6$)

The participants who were not circumcised in a health care facility agreed they were circumcised early in the morning, in their father's yam barn, and that the cut was swift. None of them were sure which anatomical part was removed, nor the type of FGM/C they had undergone. Some guessed their clitoris had been removed. Those circumcised by a traditional circumciser believed them to be experts in FGM/C.

"…*she is a traditional circumciser. My mother said that she does circumcise other women. That she is an expert with the job…my heart was beating very fast* (in a low tone)*. The woman asked me to sit on the floor and remove my pant. I did so. She then asked me to spread my legs apart. I obeyed. She went on to dig a small hole on the ground in front of my genitals, in between my legs. After that, she brought out a razor blade, held my flesh pulled it a little and then cut it off swiftly…*" ($G_2$)

Some of the girls were held down by an adult so they would not be able to move their bodies during the circumcision procedure. Many were afraid and wept at the sight of the instrument (most commonly a razor blade) that was used to do the cutting. Blood that oozed from the cutting was buried in a hole dug into the ground in the yam barn. They all confirmed that it was a very painful experience, as explained below,

"*Hmm, I was so afraid and was even crying especially when the woman was about to cut off my flesh. So, my mother held me so tight such that I could not move my body. The woman also used her strength to immobilise my legs so that I was not able to move my legs and thigh while she did the cutting. I really wept. It was so painful… I bled for a short time, and the blood stopped coming out. She dug a small hole into the ground in between my legs before she did the cutting. So, the blood that came out of the wound dripped into the hole. She then buried the flesh she removed in the same hole…I was in much tears. I can't say I saw or can describe what she removed. But they say that it is only the excess flesh that is removed during circumcision.*" ($G_4$)

When explaining her experience of being held down, she was silent for a while and then said "… (silence)…*I think that was the only thing they could do then so that I will be circumcised. If they did not hold me like that, I don't think I would have stayed for that procedure because I was scared beyond imagination…I think I might have run away even. So, they had no option than to hold me like that for me to be circumcised. I wept so much, but that is past tense now. Am fine and strong*…" ($G_4$)

Another participant described her experience as:
"*…I didn't like the way she held me down despite the terrible pain of the cutting. I really struggled to get away from her, but she was too strong for me to push away. However, I think she did what my parents and every other person in this community approves of… My great grand-mother even encouraged her not to allow me move my legs till she* (great grand-mother) *was done with the cutting…*" ($G_9$)

**Sub-theme three: fear, pain and maturity**

Although the participants feared the circumcision and especially the razor blade, some tried to conceal their fears in order to show some level of maturity and to act strongly.
"*Hmm, sincerely, I was afraid within me. I was so afraid but was trying to act strong before my family. I also tried to believe that it won't be painful, after all, my elder sisters have gone through it before me.*" ($G_2$)

In addition to the pain they experienced, some were afraid of friction on the wound and tried to avoid increasing the pain intensity; this also involved urination.
"*Another thing that became a torment to me that day was when I had the feeling to urinate. I was so afraid to do so because I felt the urine will touch the fresh wound… When I could no longer bear the pressure of the urine in my body, I moved as fast as I could to urinate and oh, it was so painful that I began to cry again. My mother and sisters said that the wound*

*pain will stop and the wound will heal when the urine touch it, but it was not so for me. I still had pains on the wound for about two or three days after the procedure. I was then able to start moving about…*" ($G_4$)

"*…I walked gently with my legs somehow apart after the procedure till the wound healed. Also, the fear to urinate was there. This was because of the pain I thought I will feel when urine touches the wound site…"* ($G_3$)

One of the participants went into shock after undergoing the procedure. She began to feel very cold, shook for a short while after the circumcision, and wanted to sit close to the fire place to have some warmth, but for some unknown reason, her parents did not allow her to stay close to the fire.

"*When they released me, my mother helped me to stand up… I was feeling cold, so I wanted to stay close to the fire place so I can have warmth, but my parents told me not to go close to the fire till the wound healed…they asked me to go and lie down and never to go close to the fire for reasons best known to them…but the morning was not a very cold one. I can't really say the exact cause of that severe cold, but I just realised that my body was shaking vividly with cold when I entered my father's house after the circumcision. Maybe the intense pain and crying triggered the cold. I don't know the exact cause.*" ($G_4$)

The participants also experienced emotional blackmail to prevent them from acknowledging the pain they had to endure. They were told not to cry out when they felt pain during the FGM/C procedure, as this was seen as a sign of strength, and those who cried out were mocked by the other girls who were circumcised. A participant explained:

"*…I was crying… but I did not shout while crying because my mother said that if the other circumcised girls get to know that I cried out during the procedure, they will collect a penalty from me… they will come to our house in a group and request me to pay a penalty to them for disgracing other girls when I was circumcised. Also, people can use that to mock me that I can't endure pain…it is a sign of strength and courage for a girl not to cry during circumcision. It is a thing girls boast of when they are with their peers. So, my mother told me not to cry so that other circumcised girls will not hear me and then come and make mockery of me and then collect penalty from my mother. I still cried so much but with a low tone.*" ($G_7$)

In summary, all the participants were circumcised on a cold morning. The circumcision was done by various people, including traditional circumcisers, relatives and healthcare practitioners. Some participants were not willing to have the circumcision but were

circumcised forcefully against their wishes. The majority found the procedure very painful and endured much pain.

**Theme Three: Life after FGM/C; "Mother cooked special food…"**

Two sub-themes emerged from the data - recovery and returning to school, and stories of other circumcised girls.

**Sub-theme one: Recovery and returning to school**

In addition to sheer will to endure the circumcision pain, the participants experienced their family as very supportive after the circumcision. They were not allowed to do house chores until their wounds were healed, while some said their mothers cooked special food for them. These gestures helped them to cope with the pain.

"*My family members were very supportive during the period. They were so happy that I was circumcised, and they tried to render every assistance they could to me. My siblings ran errands for me while I laid down to rest. My mother cooked special food for me the day I was circumcised, so I was able to eat that day despite the pain because my favourite food was served. "(*$G_4$)

Participants who were already attending school had to wait for their wounds to heal before they resumed schooling, the duration of recovery varied. They were not sure of how long they stayed at home before they resumed schooling, however, some of the participants rationalised that FGM/C did not affect their learning. One participant explained:

"*No, normally our parents will tell our class teacher that we are sick and so won't be in school till we recover. They can also send a sibling or a neighbour's child who lives close by to go tell our class teacher to excuse us from school because of ill health. The teachers don't complain about that. The best they can do is to send a message that the pupil should take enough rest and recover fast. We don't tell them exactly what happened. I wasn't absent from school for a long time.*" ($G_5$)

However, another participant who had challenges when returning to school reported:

"*Well, it does sometimes as I have to be scratching my body secretly when a teacher is in class or when am alone. It makes me worried and uncomfortable…I try to take my bath as often as possible and good smelling cream. I go to a secluded corner to scratch the place when the itching becomes intense. I have been coping with it, though it has not been so easy for me. I also take the medications my mother got for me, both herbal and modern ones. Some of them bring temporal relief.*" ($G_9$)

Unfortunately, some of the girls experienced fever and some had genital infections resulting in foul smelling genital discharge shortly after their circumcision. The participants explained: "*…I later had fever for some days, was treated with some natural herbs and it later stopped…my body temperature was so high, and I was having cold…"* ($G_7$)
"*My wound lasted longer than was expected because of that dirty discharge that started coming out from it then…it was a white capsule with white powder inside it. So, I use to open the capsule and apply some of the powder on the wound daily till it dried up...*" ($G_9$)

**Sub-theme two: Stories of other circumcised girls**
Some of the participants shared the FGM/C stories of other girls. One participant explained: "*…I went to stay with my mother in the city…one day, the woman's daughter who is also my friend but much younger than me began to yell and scream for pain. Neighbours rallied round to know what the problem was. They now saw that she was bleeding from her genitals. She held her tummy and was crying from pain. She was then rushed to the hospital where they succeeded in controlling the bleeding and her life was saved. Later, her mother told mum that the girl just got circumcised at a health clinic a day before the bleeding incidence. She said that such use to happen to girls who have known a man before circumcision…They said girls of this generation get exposed to sexual intercourse early, so they should be circumcised at an earlier age. My mother was so scared with the incidence, she said she will not get my younger sister circumcised since she is not sure if she has known a man or not…. I was very scared that day.*" ($G_6$)

In summary, life after FGM/C has been eventful for some of the participants. Factors such as supportive family, fever, infections on the circumcision site, and ill health influenced the life of the participants after they undergone FGM/C. Most of them reported they resumed schooling after their wounds healed while some went further to tell stories of other circumcised girls in their communities.

**Theme Four: FGM/C is ongoing: "*A bag of excess flesh*"**
Theme four consists of two subthemes: should we continue with FGM/C? and perpetuators of FGM/C.

**Sub-theme one: Should we continue with FGM/C?**
The participants were divided in terms of the continuation of FGM/C. Some heard that FGM/C was not good or should be stopped whilst others still believed this practice should be continued. In addition, efforts to end FGM/C were on going in these communities by means

of some healthcare practitioners, teachers, churches and anti-FGM/C government announcements over the radio. The participants said:

"*I was circumcised in the year 2012 alongside my younger sister. Before that day, my mother told me that I will be circumcised, but I refused because I heard over the radio that FGM/C is not good and that the government and people in health services are preaching against it… I don't really know the reasons, but I heard it with my own ears…*" ($G_5$)

"…*I have heard a male teacher say something like that to us in school…I think he said that FGM/C is not good and that the government said that people should stop it…All I know is that my mother said that a girl must be crucified …I don't know what the teacher was talking about* (she said with a mean face)." ($G_1$)

"*…They are now saying that people should stop FGM/C. I have heard it from some teachers and students…*" ($G_3$)

Concerning the personal opinion of the participants on the continuation of FGM/C, it was interesting to see the same girls who shared experiences of uncertainty, pain and even some health challenges which they attributed to FGM/C, say boldly that they supported the continuance of the same practice. Their opinions about the continuation of FGM/C, as well as their reasons were described as follows:

"*Oh yes. It is our culture and for our good. I have told you the reasons I know why it is done. My mother was circumcised, so also my grandmother. It will not stop in my time… It is a must for every girl in our community.*" ($G_7$)

"*Yes now. FGM/C is our culture. It is not a bad thing. I am circumcised and I have no problem, so I will circumcise my daughters when I have them. Meanwhile, I don't want myself or my daughters to have difficulty in childbirth. There is no harm in FGM/C* (she said with an air of finality and partially stood up to leave)." ($G_1$)

A few indicated they do not want FGM/C to continue, while one of the girls was neither in favour of the practice nor against it. Her reason was that although she had heard FGM/C was not good. She said: "… *and will not like to pitch my tent against all other people.*" ($G_5$)

Some explained they will circumcise their daughters later in life. One participant said:

"*Everyone in our community gets circumcised. So, it is only normal and good for them to be circumcised too. I will not harm my children. It's just our culture for boys and girls to get circumcised. My mother did it for me and I will do it for them…*" ($G_2$)

"*Yes. Even my daughter here will be circumcised when she comes of age. It is our culture here, so no one can run away from it*". ($G_8$)

"*…since they said it is our culture, when I get married and have a daughter, I will circumcise her just like my mother circumcised me… I have not suffered any problem because of circumcision.*" ($G_{16}$)

**Sub-theme two: Perpetuators of FGM/C**

Various factors contributed to the perpetuation of FGM/C. These factors were: peer pressure, circumcised mothers, circumcised relatives, fathers and some healthcare practitioners. Peer pressure seems to be one of the greatest perpetuators of FGM/C. Some of the participants mentioned it was a thing of pride to be counted as a circumcised girl in these communities. One participant said:

"*Infact the reigning thing now is that circumcised girls make mockery of the uncircumcised girls. We tell them that they are carrying 'akpa api'* (bag of excess flesh)*. We sometimes move away from an uncircumcised girl or make sure that she is not in our circle of close friends. Circumcised girls are happy and proud you know…* (laughs). *Api is what we call that excess flesh that is usually removed during circumcision. So, when a girl is not circumcised, we know she still has that natural flesh which ought to be removed from every girl. It is a shame for a girl to be called "akpa api". There was a girl that the parents attend a church where they tell them not to circumcise their daughters. The mother was too religious and so refused circumcising her. We made mockery of her such that she went to plead with her mother to circumcise her, but her mother still refused. There are other girls too who get convinced to request for circumcision so that they can be like us. It is a thing of pride to be a circumcised girl…* (laughs)." ($G_2$)

Being birthed by a circumcised woman was another high-risk factor for FGM/C.

"*Yes now. My mother was circumcised; she also gave birth to me and circumcised me. Some of my elder sisters are now married with children and they were all circumcised too. So, for me, I will circumcise my children so that they can circumcise their own children later in life*". ($G_2$)

"*She said FGM/C is our culture and that herself was circumcised by her mother with no consequence up to date. She said I just had to undergo it for my good…She insisted that I must be circumcised*". ($G_5$)

Furthermore, some of the participants were circumcised or persuaded to get circumcised by their relatives especially their elder sisters, aunties, grand-mothers and great grand-mothers. The participants explained:

"*…and entered the yam barn only to see my great grand-mother getting ready her tools for the circumcision, and my dad's sister was there too…*" ($G_8$)

"*I have three elder sisters and they were all circumcised…My elder sisters also reassured me that the experience was not painful and won't take a long time. So somehow in my mind, I believed them.*" ($G_2$)

Although none of the participants reported the father to have circumcised or actively participated in ensuring their circumcision, they still opined their fathers were aware of the circumcision plan and were in support of it. They therefore appeared to have a quiet support for the practice. Some of the participants said:
"*My father told me that I will be circumcised alongside my elder sister. He said that they don't want to delay my circumcision so that what happened to my elder sister* (unwanted pregnancy) *will not happen to me.*" ($G_7$)
"*…I think that he knew that I was going to be circumcised. It was not a secret thing in our house, but he did not go with us to the health centre where it was done.*" ($G_6$)

In addition, some of the participants mentioned that some healthcare practitioners teach against FGM/C, however, other participants reported they were circumcised by healthcare practitioners. One participant said:
"*…my mother's sister came to our house and she took me to the health centre, and there they gave me a drug which made me sleep… I think she was a nurse, she was not wearing any uniform that day. Sometimes when you go there, they will attend to you without wearing uniform…*" ($G_6$)

In summary, FGM/C is ongoing in the communities of the participants, despite the efforts to end the practice. More than half of the study participants indicated a positive support for the continuation of FGM/C with various reasons. Uncircumcised girls were mocked and segregated from circumcised girls. Peer pressure, circumcised mothers, circumcised relatives, father's attitude and some healthcare practitioners were reported to be the perpetuators of FGM/C.

## 5C. Findings arising from the Interviews with the Mothers of Genitally Mutilated Girls

An overview of the participants will first be presented followed by the themes and categories arising from the data.

### 5C.1. The participants

Eighteen (n=18) mothers of genitally mutilated girls were interviewed. Their ages ranged between 25 and 56 years, with a mean age of 37.8 (SD ± 9.9). All the participants belonged to the Igbo cultural group and were married. Their educational level ranged from not declaring (7 of 18) to primary school (1 of 18) to tertiary education (4 of 18). Four of the mothers said their daughters were already married with children. The ages at which their daughters were circumcised ranged from a few days after birth to 17 years of age; however, most of the mothers (10 of 18) circumcised their daughters at infancy. None of the mothers obtained their daughter's consent for the FGM/C procedure. Relatives including the grandmother or mother-in-law, traditional circumcisers and traditional birth attendants conducted the circumcisions. Half of the mothers (9 or 18) were not sure which anatomical part was removed from their daughters during the FGM/C procedure whilst a few (5 of 18) said nothing was removed because they had an FGM/C method that does not involve the removal of flesh. Three of them claimed their daughters' clitoris was removed, one said her daughter's labia majora was removed, while five mothers said nothing was removed from their daughters. When asked about the year their daughter (s) had the procedure, seven (7 of 18) couldn't recall which year, although they could recall the experience, while others were able to recall the various years as well as their experiences of one or more of their daughters' FGM/C. According to the mothers, eight (8) of their daughters had FGM/C between the years 2010 to March 2018, six (6) of the daughters underwent FGM/C between the years 2000 and 2009, while two (2) had the procedure in 1999. **Table 5C.1** provides the details.

**Table 5C.1. General information of the mothers of genitally mutilated girls n = 18**

| Mother | Age (Years) | Cultural group | Marital status | Highest education level | Number of girls | Age of girls (s) | Girls' Marital status | Girls' Highest education level | Girls' age at FGM/C | Girl (s) assented | Mother consented | Girls' circumciser | What was removed | Year of girl's FGM/C |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Not sure | Igbo | Married | Secondary | 4 | Young adult | Married | Don't know | 6 years | No | Yes | Traditional circumciser | Not sure | Can't recall |
| 2 | 30 | Igbo | Married | Secondary | 2 | Early adolescent | Single | Primary | 9 years | No | Yes | Nurse (not a Registered Nurse) | Not sure | Can't recall |
| 3 | 50 | Igbo | Married | Don't know | 2 | Don't know | Married | Secondary | Early adolescent | No | Yes | Traditional circumciser | Not sure | Can't recall |
| 4 | 55 | Igbo | Married | Don't know | 3 | 19 years | Single | Secondary | 15/17 years | No | Yes | Traditional circumciser | Not sure | 2014/ 2016 |
| 5 | Not sure | Igbo | Married | Primary | 2 | Don't know | Married | Primary | Can't recall | No | Yes | Mother-in-law | Not sure | Can't recall |
| 6 | 36 | Igbo | Married | No answer | 1 | 17 years | Single | Secondary | 14 years | No | Yes | Nurse | Clitoris | 2015 |
| 7 | 56 | Igbo | Married | No answer | No answer | Don't know | Married | Don't know | Adolescent | No | Yes | Nurse | Clitoris | Can't recall |
| 8 | 42 | Igbo | Married | Secondary | 1 | 17 years | Single | Secondary | Infant | No | Yes | TBA (traditional birth attendant) | Clitoris | 2000 |
| 9 | 30 | Igbo | Married | Secondary | 1 | 6 years | Single | Primary | Infant | No | No | Midwife | Not sure | 2011 |
| 10 | Not sure | Igbo | Married | No answer | 1 | 9 years | Single | Primary | Infant | No | Yes | Midwife | labia majora (type II identified) | 2008 |
| 11 | 42 | Igbo | Married | Secondary | 1 | 18 years | Single | Secondary | Infant | No | Yes | Mother | New method | 1999 |
| 12 | Not sure | Igbo | Married | No answer | 1 | 18 years | Single | Secondary | Infant | No | Yes | TBA | Not sure | 1999 |
| 13 | 34 | Igbo | Married | Tertiary | 2 | No answer | Single | Primary | Infant | No | Yes | Mother | New method | Can't recall |
| 14 | 31 | Igbo | Married | Secondary | 2 | 10/4 years | Single | Primary/ pre-school | 2 years | No | No | Mother | New method | 2007/ 2013 |
| 15 | 30 | Igbo | Married | Tertiary | 2 | 5/3 years | Single | Pre-school | Infant | No | Yes | Nurse | Not sure | 2012/ 2014 |
| 16 | 25 | Igbo | Married | No answer | 2 | 2 years/ 8months | Single | Pre-school | Infant | No | Yes | Mother | New method | 2015/ 2017 |
| 17 | 30 | Igbo | Married | Tertiary | 3 | 14/12/10 years | Single | Two in secondary, One in primary | Infant | No | Yes | Grand mother | New method | 2003/ 2005/ 2007 |
| 18 | 38 | Igbo | Married | Secondary | 1 | No answer | Single | Primary | Infant | No | Yes | Traditional circumciser | Not sure | Can't recall |

### 5C.2. Themes arising from the data

Two themes and six sub-themes were identified. The themes were: Trends of the practice and Perceptions about FGM/C continuation (see **Table 5C.2**).

**Table 5C.2 Themes and Sub-themes emerging from the interviews with mothers of genitally mutilated girls**

| Themes | Sub-themes |
|---|---|
| Trends of the practice | • Age at circumcision<br>• The cutting method<br>• The new method<br>• Caring for daughter after FGM/C |
| Perception of FGM/C continuation | • Anti-FGM/C activities<br>• Motivators of FGM/C |

**Theme one: Trends of the practice: "*circumcision is not a sickness*"**

This theme consists of four sub-themes: age at circumcision, the cutting method, the new method and caring for daughter after FGM/C.

**Sub-theme one: Age at circumcision**

The participants had their daughters circumcised at various ages. Some daughters were circumcised a few days after birth while some were circumcised during early childhood and others during their teenage years.

"*My daughter was not circumcised until at the age of two when she started itching.*" ($M_{14}$)

"…*Girls are circumcised once they start developing breast and menstruating…My daughter was circumcised when she was in college. She is now married with children. She stays with her family in the city.*" ($M_3$).

"*She was circumcised seven days after birth… it was done in the hospital by a midwife.*" ($M_9$)

Despite the fact the initial age for circumcision in these communities was before marriage, the mothers circumcised their daughters at any age they were comfortable with. Some believed the post-cutting bleeding was less when a girl was circumcised at a later stage.

"*…You know there is no specific age for a girl to be circumcised. We usually circumcise girls when the mother sees that she has started going into puberty… when a girl is circumcised few days after birth, she bleeds more, but when she is circumcised later in life, she bleeds less.*" ($M_2$).

"*…for me, I circumcised my daughters when they were still small girls. They were about six years of age then…but in our community, girls are circumcised when they start developing into womanhood. When they start forming breast and can now menstruate. Then they can get pregnant and bear children, so they are marriageable. There is no specific age for that…"* ($M_1$)
"*…It is our custom that everybody must be circumcised whether male or female. The only difference is that males are circumcised about eight days after birth, while females are circumcised when they grow up, before marriage…*" ($M_6$)

The mothers decided to circumcise their daughters before puberty due to fear the girls might refuse to be circumcised once grown up. In addition, the mothers believed FGM/C was part of their culture and females had no option but to undergo the procedure. The participants explained:
"*…As we all know, the world is changing and some children today when you allow them to get into the age of developing into womanhood, they will become so bold and refuse circumcision which is our tradition. There were cases of girls in this community who grew up and kicked against circumcision. They vehemently disobeyed their parents' desire for them to be circumcised. So I decided to circumcise my girls early in their lives… if you go round the village more, you will discover that some mothers also circumcised their daughters at tender ages for this same reason I told you…The children of this age are not obedient like us when we were their age, so instead of the girl bringing shame to the family, we circumcise her early in life.*" ($M_1$)

Uncircumcised girls can also be circumcised by their husband's parents before they give birth to children. Should the FGM/C be done by the suitor's family, the procedure will be more expensive. The participants explained:
"*The husband's family might decide to circumcise girl by themselves and a big ceremony will follow that. It is still done in our culture.*" ($M_5$)
"*…If a girl was circumcised by the family of her suitors, they will spend more money and do bigger ceremony…*" ($M_2$)

Since FGM/C is a culture and so compulsory according to the participants, females had no option than to undergo the procedure. One of the participants reported: "*…they have no option than to go in for it. They have been hearing of circumcision from other girls. They know that it is our culture for every girl to be circumcised before she gets pregnant…That is our culture. They knew I will never do anything to hurt them…*" ($M_1$)

**Sub-theme two: The cutting method**

The family of the uncircumcised girls made the preparations and decided on the when and who will do the FGM/C for the girls. The mothers reported they actively made arrangements for their daughter's circumcision, while some younger women reported their mothers-in-law made the preparations. The participants reported: "*…A woman who is an expert in circumcision came to our house and did it for her… I invited the woman that did the circumcision. Then I went to the market and bought many things that I used to cook for her that day. The morning of the circumcision, all I did was to wake her up and encourage her to go into the yam barn because the woman that did the circumcision came very early that morning and was ready for the procedure. Some women friends came around and helped me with the cooking while one of them helped in holding her in position while the circumciser did her job.*" ($M_3$)

"*My mother-in- law drew my attention to the fact that my daughter was old enough to be circumcised according to our custom…So we agreed on a day and got things ready. My mother-in-law knows how to do circumcision, so she offered to do it for my daughter and that was it…*" ($M_5$)

Most of the mothers consented to their daughters being circumcised. However, some mothers were forced into circumcising their daughters by their mothers-in-law. They said:

"*My mother-in - law was in charge of my baby at that time* (7 days after child birth)*, she forced me to circumcise my daughter. I was not happy*". ($M_9$)

"*…my mother-in-law insisted that I circumcise my daughter, so I was compelled to circumcise them…*" ($M_{14}$)

The majority of the daughters were circumcised in their father's yam barn, as tradition demands by traditional circumcisers or relatives who knew how to do the job. However, some mothers, in a bid to "give the best to their daughters", invited healthcare practitioners to circumcise their daughters in their yam barn, while some had the daughters circumcised in the hospital by the same cutting method. The participants explained:

"*…These people are circumcised women and they have done it over the years. How much more healthcare practitioners? ...It depends on the personnel you choose to do the job. It was a nurse who did my own girl's circumcision. Also, my neighbour was inside the yam barn with them to help restrict the girl for the nurse to do the circumcision.*" ($M_2$)

"*Okay, my daughter was circumcised in the hospital by a nurse there in 2014…because I believe the nurses are experts and are educated unlike the traditional circumcisers we have in the village. I wanted to give my daughter the best I can afford. So, she was circumcised in*

*the hospital. I am not the only woman that did that, some other women are doing it too. What matters most is that the girl is circumcised*" ($M_6$)

The participants agreed some people were seen as experts in FGM/C and they go to the villages in the communities on invitation to do FGM/C for females.

"*Well, some women are gifted with the skill of doing circumcision and some families are known to have their daughters grown up to be good with doing the procedure. They may have other things they like doing like farming, selling things in the market…"* ($M_3$)

"*…the person that did the circumcision has done it over the years. She is an expert…*" ($M_2$)

"*…some women do it like their occupation, while some have other means of livelihood*" ($M_4$)

These FGM/C experts do not just do the procedure without remuneration. The mother of the girl to be circumcised usually meets with their preferred FGM/C expert and they agree on what will be given for the procedure; mostly they are given some farm produce and money.

"*Well, I gave her water and soap to wash her hand according to the tradition. Then I gave her small money and some farm produce just to appreciate her for the job she did. So, it depends on what you agreed with the circumciser before she does the job. Some circumcisers will tell you what exactly to pay them, while some, especially if they are your relatives might tell you to give them whatever you have. But the minimum money is 500 naira* (about 1.39 USD) *and any other farm product such as yam.*" ($M_4$)

As was the custom, the participants did not witness their daughter's circumcision. This they said was the standard cultural practice. Irrespective of where the girl was circumcised, the mother was not allowed to witness her daughter's FGM/C, nor do the procedure even if she was an expert in the procedure. Some of the participants explained that some women might be emotionally strong enough to watch their daughters being circumcised.

"*No, it is not the custom for a mother to witness her daughter's circumcision. Normally, women such as the mother-in-law, relatives or even friends of the woman whose daughter is being circumcised will go in with the girl and hold her in position for the circumcision.*" ($M_1$)

"*No, the nurses there are our people too, so they know the culture. It is not allowed for a woman to witness her daughter's circumcision. The nurses did the circumcision by themselves… I believe our ancestors have good reasons why a mother should not witness her daughter being circumcised. Some women's heart may not be strong enough to stay and watch their daughters get circumcised.*" ($M_6$)

Concerning how they felt while waiting for their daughters to come out of the FGM/C procedure, some said they prayed quietly, some said they were fine since it was usually a short procedure where the FGM/C expert just grabbed the excess flesh and cut it off swiftly,

while others said their relatives went in with the daughter during the circumcision and they trusted the relative's experience on what should be done for the girl.

"*For me, I was not afraid, my heart was strong. I was not afraid because it is a common practice in our land and a thing of pride. I only prayed that my daughter will not bleed much and that the wounds will be fine, but also, I was busy preparing for the celebration too. God did it for me that way.*" ($M_1$)

"*I was not afraid. I told you FGM/C is a common practice in our community. It did not take a long time too before they finished the circumcision.*" ($M_6$)

Also, all the participants mentioned their daughters had FGM/C early in the morning.

"*…the circumcision is done early in the morning or in the evening when the weather is cold. My daughter was circumcised early in the morning…we prefer to do the circumcision when the weather is cool as hot environment can cause more pain and bleeding for the girl. But if you do it in the cool of the day, the girl can go in and relax and maybe even sleep off after the circumcision because her body is relaxed. That's why circumcision is done early in the morning or in the evenings, but preferably, very early in the morning.*"

**Sub-theme three: The new methods**

Various new methods of circumcision were used to reduce the clitoris to a desired shape and size (small and flat) without cutting. The participants explained this was a modern way of doing FGM/C and to avoid the risk of haemorrhage and infection commonly associated with the cutting method. The promoters of this new method were mostly young literate mothers who explained they do not want their daughters to undergo the traditional FGM/C procedure because they have heard of the possible health complications associated with the practice. They therefore, believed that these new methods would achieve the same purposes as the proper cutting method, without the associated side effects. The participants explained:

"*…I used a new method. It doesn't involve cutting hence nothing like bleeding. I just applied Vaseline and massaged the clitoris until it flattened and reduced in size…it lasts between 3 to 6 months.*" ($M_{11}$)

"*You apply dusting powder there. You then use the thumb to massage it; putting the legs together to be rubbing the clitoris. You do it for up to three months until the clitoris goes inside. When the girl goes to give birth, the place will open on its own.*" ($M_{15}$)

"*…you don't cut off the excess flesh. I applied hot water to the genitals after I used Vaseline and mentholin to rub and press the clitoris to take the desired shape. It was done twice daily for up to 6 months. This will flatten and make the clitoris small, not hanging out like a man's penis…if you see my daughters, you would think they are circumcised… The genitals are ugly if you don't do FGM/C. So, I take good care of my daughters' genitals.*" ($M_{14}$)

"*The clitoris is usually soft after birth and so it's easier to get it flattened at this stage before it gets strong…we push and massage the clitoris using Vaseline to get it flattened and reduced in size. It appears good at the end…it took me about three months.*" ($M_{13}$)

Another benefit of this new method is that the mother does not have to pay a circumciser to perform the FGM/C, and she also does it at her convenience. Also, no ceremony or special cooking is needed as the procedure is repeated daily over a period. They perceived the pain their daughters undergo while they perform the new method as temporary. They explained:
"*The pain is for good and it stops as soon as you finish the massage.*" ($M_{11}$)
"*I was touched but it was for a short time and for a purpose.*" ($M_{14}$)

One of the participants reported that the state government and some healthcare practitioners have started preaching against these new methods.
"*Yes, the government started kicking against the new method recently, but I see nothing wrong with it. Some of the nurses that were teaching us to do it are now telling us to stop because the government does not want it done for reasons I don't remember. They said it is also similar to FGM/C, but this method does not involve cutting or bleeding. It only requires genital massaging of the baby's clitoris until it becomes flat and smaller in size, thereby looking neat and fine.*" ($M_8$)

**Sub-theme four: Caring for the daughters after FGM/C**
Concerning the participants' experience after their daughters' circumcision procedure, some mentioned that FGM/C was not a sickness, so the daughters recuperated fast and they had no stress taking care of them. They explained:
"Hmm, *I had no problem. The girl was no more a baby. She ate food and was calm throughout the day. I didn't assign house chores to her. I helped her as much as I could so that she will have less movement of her legs to reduce pain and promote healing of the wound. I did not have to sit down with her all day long. Then the next morning after urinating, the pain stopped and she was a little more relieved. She was able to eat by herself that day. Circumcision is not a sickness. The pain is just for a short while.*" ($M_2$)

One participant said the pain the daughter had post-FGM/C was a good pain, while another said the daughter was old enough to endure some pain.
"*A girl is not expected to be jumping up and down immediately after circumcision because of the wound in between her legs. So, my daughter went into the house and laid down. We were rejoicing and cheering her up…she was no more a kid. She could endure some pain and do somethings for herself…*" ($M_3$)

*"The pain is for good…*" ($M_{11}$)

Furthermore, some of them said they cooked special meals or had some ceremony to mark their daughter's FGM/C. This was only done by mothers whose daughter had the cutting method of FGM/C and whose daughters were not circumcised at infancy. This was described as follows:

"*Yes. That is the tradition. I didn't even do much celebration for her like my parents did for me, because my husband does not have much money like my parents. But I made sure different dishes were prepared that day with assorted meat. I applied local powder on her body when she came out. Friends and family were there to cheer her up and congratulate her. She ate the food of her choice and was specially served that day."* ($M_3$)

The mothers whose daughters had the cutting method a few days after birth reported that their relatives (mother or mother-in-law) took care of their daughters during and after the FGM/C procedure, and so they only breastfed their babies when the relatives brought them. One participant explained:

" *…My mother took care of my daughter during and after the circumcision. I only breastfed her whenever my mum requested me to do so. So, I may not have many details if there was any. All I know was that my daughter was brought to me fine and healthy. She had pains after urinating due to the circumcision, but she stopped crying like that after about two days. She ate and slept normally like other girls of her age.*" ($M_8$).

Some mothers reported their daughters were afraid to urinate post-FGM/C due to fear of pain as the urine touches the wounds. However, they went on to explain that the wound heals when the urine touches the wound site, therefore they encouraged their daughters to urinate after FGM/C as the intense pain that ensues when the urine comes in contact with the wound is the end of the FGM/C pain. Some mothers even advocated for the urine of a circumcised infant to be poured on the wound site to cause the wound to heal fast.

"*She was a small girl then. So, after the circumcision, she was so scared that she will have more pains when she urinates, but by the next morning, she could not resist the urge to urinate and the circumcision pain stopped. That is how it was for me too, after I was circumcised, as soon as my urine touched the wound, it pained me so much and then the pain stopped. That was all…*" ($M_2$).

Concerning the management of possible immediate FGM/C complications, some participants opined that the circumcisers were experts so such would not happen, while some said it depends on the girl's body make up, as some girl's bodies might have more

tendency to bleed or have delayed wound healing. However, one of the participants gave the following explanation about immediate FGM/C complications:

"*That of bleeding much is very dangerous o. It is very dangerous. Every mother prays and hopes that such will not be the fate of the daughter. We have a particular leaf that stops bleeding from wounds. It is always applied by the circumciser immediately after cutting off the excess flesh so as to stop blood flow from the wound. Sometimes, the blood loss becomes too much, the circumcisers have other measures they employ to stop it and in the worst scenario, the girl will be taking to the health centre or hospital where they will use white man's method to stop the bleeding…I told you it depends on the girl's body make up. Some girls body might become hot and they will be shaking due to cold some hours after the circumcision, but they soon recover with some treatment. Some might have headache too or start vomiting and feel weak. It all depends on girl's body make up. But my daughters were all fine and never had any sickness or complaint after their circumcision.*" ($M_1$)

Although some of the participants reported their daughters had no problems post-FGM/C as their wounds healed fast, one reported her daughter had delayed wound healing and was treated for it, another reported her daughter had a fever and cold shortly after the FGM/C procedure and was given some anti-pyretic until the fever subsided, while another participant reported that her five year old daughter still had pain in her genitals from the FGM/C wound site to date, even after several years of FGM/C. They said,

"*Yes, my five years old daughter still complains of pains in her genitals, especially when I am bathing her, as a result of the circumcision she underwent.*" ($M_{15}$)

"*…One of my daughters did not stay for long before her wound healed completely, but one continued having discomforts from her wound and it took up to about one month for her wound to heal completely. The wound proved stubborn but later dried up and she was able to resume her normal life…we applied some herbal treatment on the wound… like every mother I was anxious for the wound to heal…but I was confident that the wound will heal. It is common in our community that people's body are different in response to wound healing…she never got sick as a result of the circumcision. She was fine only that her wound did not heal very fast."* ($M_3$)

"*She had fever, but I gave her paracetamol and hot bath. It then stopped.*" ($M_{12}$)

In summary, even though most of the participants consented to their daughter's FGM/C, none of them could witness the cutting procedure. The report from the participants revealed there have been some modifications in the practice in these communities over the years. The participants had their daughters circumcised at various ages. A non-cutting method of FGM/C, referred to as a new method, was being promoted by some of the participants, while

some of them held on to the traditional cutting method. Finally, the participants did not experience difficulty taking care of their daughters after the FGM/C procedure, as some daughters were deemed old enough to endure the circumcision pain, while some participants whose daughters were circumcised during infancy had some assistance from their mothers-in-law in taking care of their daughters' post-circumcision.

**Theme two: Perception about FGM/C continuation; *"why didn't the government tell everyone to stop male circumcision too?"***

This theme consists of two sub-themes, anti-FGM/C activities and motivators of FGM/C.

**Sub-theme one: Anti-FGM/C activities**

The participants agreed they were aware of the anti-FGM/C warnings and teachings; some had heard it from healthcare practitioners, others from other women in the communities. However, some of the participants expressed unhappiness towards the anti-FGM/C activities as they felt the healthcare practitioners were working for the government who wants to change their culture and its values. One participant explained:

"*Hmm. I will tell you the truth, I don't care. FGM/C is an age long tradition in this community. Our parents handed it down to us. They did it and did not die, now some people are looking for flimsy excuses to take away our culture from us. Why didn't the same government tell everyone to stop male circumcision too? They should stop circumcision for male and female not just telling us to stop female circumcision. As for healthcare practitioners, they are working for the government, but everybody in the community knows the truth that FGM/C is not dangerous. I am a member of this community, but I live in the northern part of the country with people from different ethnic groups and I was surprised to discover that some of them do FGM/C too. So it's not even peculiar to our community. This is our culture and I will come back to the village and get my daughter circumcised at the right time…I am not an illiterate…So I am not saying that FGM/C will make a girl to get infection. If it is so, then circumcision should make boys get infection too (laughs)."* ($M_2$)

Most of the women who practiced and advocated for the new FGM/C method, did so partly to avoid being prosecuted according to the anti-FGM/C law which the healthcare practitioners preached to them. Unfortunately, the healthcare practitioners who preached against the cutting did it secretly. The mothers said:

"*…it is because of the new teaching; my husband is in support of our daughter being uncircumcised…I did hot water compress on my daughter's genitals after which I used thumb to gently massage the genitals to have good shape and then put her legs together.*" ($M_{16}$).

"*…My mother did new method for my first three daughters. The last two are yet to undergo the procedure. I was afraid of the police if they discover it, but I later realised that the nurses are doing it secretly.*" ($M_{17}$)

Some of the participants were unhappy with the behaviour of the young generation as they were of the opinion this generation was trying to turn the world upside down by trying to stop FGM/C, which has been in existence long before they were born. One participant said,
"*…You young people now want to stop it; it concerns you people… why did you people not kick against male circumcision? The reason why we do male circumcision is the same reason why we do female circumcision. I am proud I circumcised my daughter. You people want to stop our tradition given to us by our ancestors. Let me tell you, female circumcision is not bad. That is all I want to tell you…Don't ask me any question because I will not answer you. The government and you young people want to turn the world upside down. Go and tell them what I said* (angrily)." ($M_6$)

The participants were divided in terms of the continuation of FGM/C. Those who wanted the cutting to be stopped based it on the teachings they heard from nurses about the possible complications of FGM/C. However, they were in favour of the new method being continued as it makes the clitoris appear neat and in good shape. This was explained as follows:
"*Women have been reported to have big tear and difficult labour during childbirth…That is why I didn't circumcise my daughter. I only did the new method that does not involve cutting… Ignorance is the reason behind the FGM/C. I encourage the new method that does not involve cutting.*" ($M_{11}$)
"*I don't support FGM/C because…bleeding* (postpartum haemorrhage) *is likely to occur for circumcised women. I prefer the new method that takes about six months to complete.*" ($M_{14}$)

Some of the participants neither supported nor opposed the continuation of FGM/C, but they still reiterated that FGM/C was their culture and caused no harm:
"*The world is changing, and children of this generation are trying to be like the western world. The white men know better. If they want us to stop FGM/C* (cutting method)*, I am not in support of or against it… But for me FGM/C is not dangerous and causes no harm.*" ($M_3$).

In contrast, a few participants reiterated they want the practice to be stopped. One participant said,
"*No, government is campaigning against it…they must have seen something wrong with it. So, I agree with them.*" ($M_{12}$)

**Sub-theme two: Motivators of FGM/C**

The participants reported the practice of FGM/C has been in existence long before they were born; their mothers and grandmothers were circumcised. They believed circumcised girls were happy and proud, thus they themselves were happy and proud to have circumcised their own daughters too. In addition, circumcision guaranteed marriage, as no uncircumcised girl would be allowed to get married. Getting pregnant before marriage was also not a crime if the girl was circumcised. They explained:

"*FGM/C is our culture…The practice has been in existence before I was born...My daughter is already circumcised, she is now married with children and she has had no problem since then. I was circumcised, so also my mother, grandmother and all responsible women in this village… I am proud I circumcised my daughters. It is an honor for a girl to be circumcised…*" ($M_7$)

"*All my daughters were circumcised…It was a big day for me. I was very proud and happy as a mother…yes, FGM is our culture. Our fathers handed it down to us. It is a great thing for a mother to have her daughters circumcised. That means that the daughters are grown up now and can be married or will soon be married. It is a mother's joy and pride…My mother was circumcised too and so my grand and great grand-mother. My mother-in-law was circumcised. Every woman undergoes it. It is a tradition we don't joke with.*" ($M_1$)

"*It is compulsory to get circumcised… You are free if you get pregnant outside wedlock as long as you have been circumcised…It is our custom here to get our girls circumcised before marriage. We take pride in it. It then means that no marriage will take place unless the girl that intends to marry gets circumcised first.*" ($M_4$)

The circumcision procedure differed when a girl was pregnant compared to that performed under normal circumstances. One participant explained:

"…*During pregnancy, the girl will be circumcised and the flesh that was removed will be put in this type of container* (she brings something like a coconut shell) *and the blood that will come from the wound will be put into the container too. The blood from that wound must not touch the ground. This is unlike when a non-pregnant girl is circumcised. The container with the pregnant girl's excess flesh will be thrown into the evil forest at night and no male must see it*" ($M_3$)

The involvement of family members was also a motivator as both parents were involved in getting their daughters circumcised.

"*…I told my husband and we agreed on who to invite for the circumcision and the things needed to be gotten for the ceremony that follows the circumcision…It was not a secret affair. The king was there for the ceremony of my daughters' circumcision.*" ($M_1$)

"*Yes, he was fully informed. He knows the culture and was part of the celebration that day. He was happy.*" ($M_3$)

Another participant explained that her father-in-law was actively involved in her daughter's circumcision.

" …*My father-in-law held my daughter while the wife (mother-in-law) did the circumcision.*" ($M_5$)

This participant was not the only mother who reported the involvement of relatives as motivators for their daughter's FGM/C. Some mothers reported their relatives reminded them or forced them to circumcise their daughters.

"*I had a baby girl in 2012. My mother-in-law oversaw my baby at that time. She forced me to circumcise my daughter. I was not happy.*" ($M_9$)

"…*I refused to circumcise my daughter because of the dangers of FGM/C we were taught during antenatal clinic. My mother-in-law insisted that I circumcise my daughter*…" ($M_{14}$)

Some healthcare practitioners also motivated the people to have their daughters circumcised. It was somewhat surprising when one participant reported that a nurse motivated her to circumcise her daughter, and even did the circumcision. The quote below illustrates this evidence:

"*…A nurse told me that a girl in the university was not circumcised, then her genitals grew so long and was itching. She came to her and got circumcised. She was 20 years old as at the time of her circumcision. I think it was because the genitals were not well taken care of, so it grew like that.*" ($M_{15}$)

According to the participants, there are perceived benefits of FGM/C that motivates mothers to ensure their daughters are circumcised. Some mothers said that FGM/C prevents promiscuity, though other participants doubted if this belief was true. However, many participants agreed that circumcision reduces sexual urge, makes genitals beautiful and prevents ime mpuke (pregnancy of an uncircumcised girl whether she is married or not). This is illustrated in the following statements "*It prevents scratching of the genitals. It also prevents flirting.*" ($M_9$)

"*It makes the genitals good and reduced in shape*" ($M_{10}$)

"*…The only gain is that the clitoris will not be hanging like that of a man.*" ($M_{18}$)

"*If a girl gets pregnant without being circumcised, it is called ime mkpuke which is a big shame to the family. A girl is seen as a full-fledged female after being circumcised. Also, FGM/C will help prevent her from running after men so that she will be a responsible mother*

*and wife when she gets married… Excess flesh in a girl's genital is what makes her have sexual urge and so desire to be with men. During circumcision, the excess flesh is removed and so the girl's urge will be tamed…not running after different men to satisfy her urge.*" ($M_1$)

Another perceived benefit of FGM/C was giving birth to strong children. One participant explained: "*A circumcised girl becomes strong and gives birth to strong children. In fact, I have noticed that giving birth to deformed and weak children is common these days. You see, all these children born by uncircumcised girls usually look weak and behave like imbeciles. But that was not so when every girl was circumcised as a must before she gives birth to a child…*"

Furthermore, the perceived consequences that awaited any girl that refused FGM/C could be a motivator to undergo FGM/C. One of the participants explained some of the many consequences that await a girl who refuses FGM/C. She said,
"*If a girl gets refuses to be circumcised, she will never progress martially, even if she gets married. Such girls are referred to insultingly… they still have the extra flesh which ought to have been removed. If a girl gets pregnant without being circumcised, whether married or not, she must be circumcised before she gives birth to her baby, else that child will not be circumcised when she grows up. It is a taboo for a girl to give birth to her child with her excess flesh intact…*" ($M_3$)

In summary, the participants were aware of the anti-FGM/C warnings by their state governments and the teachings from some of the healthcare practitioners. Some of them expressed unhappiness about the anti-FGM/C activities and they equated FGM/C to male circumcision**.** Some advocated for and practiced the new method to avoid being prosecuted by the anti-FGM/C law while some advocated for the new method because they believed it did not cause the possible FGM/C complications which the healthcare practitioners taught them, but the new method still makes the clitoris appear neat and in a good shape. However, the majority of participants supported the continuation of FGM/C for reasons such as culture, perceived benefits about FGM/C, influence of their relatives, and the perceived consequences for refusing FGM/C.

**5D. Findings arising from the Interviews with the Healthcare practitioners**

An overview of the participants will first be presented followed by the themes and categories arising from the data.

### 5D.1. The participants

The participants consisted of 17 healthcare practitioners, between the ages of 25 and 51 years old; their mean age was 35.7 (SD ± 7.2). The majority (12 of 17) were married, while some (five of 17) did not disclose their marital status. Only a few (four of 17) of the participants were registered nurses or midwives, or both, seven (seven of 17) were Community Health Extension workers (CHEW), while six (six of 17) were Voluntary Village Health Workers (VVHW). Only healthcare practitioners who have lived in and served the communities for at least one continuous year were interviewed. **Table 5D.1** presents the summary of the general information of the healthcare practitioners.

**Table 5D.1. General information of the healthcare practitioners n = 17**

| Health care practitioners | Age (Years) | Cultural group | Marital status | Professional qualification | Years of practice in the communities | Years of residency in the communities | Support for FGM/C continuation |
|---|---|---|---|---|---|---|---|
| 1 | 49 | Igbo | Married | CHEW | 11 | Many | No |
| 2 | 40 | Igbo | Married | B.N. Sc., RN | 2 | 2 | No |
| 3 | 25 | Igbo | Married | RN/RM | More than 2 | 25 | Yes (New method) |
| 4 | 51 | Igbo | Married | RM | 7 | 7 | Yes (New method) |
| 5 | 42 | Igbo | Married | VVHW | 10 | 10 | Not sure |
| 6 | 34 | Igbo | Married | VVHW | 16 | 16 | Yes |
| 7 | 32 | Igbo | Married | VVHW | More than 1 | More than 1 | Yes |
| 8 | 26 | Igbo | Not disclosed | CHEW | More than 1 | More than 1 | No |
| 9 | 38 | Igbo | Married | VVHW | More than 1 | More than 1 | Yes (New method) |
| 10 | 30 | Igbo | Married | CHEW | 8 | 8 | No |
| 11 | 38 | Igbo | Married | CHEW | 9 | 9 | No |
| 12 | 32 | Igbo | Married | CHEW | 4 | 20 | No |
| 13 | 28 | Igbo | Not disclosed | CHEW | 7 | More than 4 | No |
| 14 | 35 | Igbo | Not disclosed | RN/RM | 8 | More than 5 | No |
| 15 | 32 | Igbo | Not disclosed | CHEW | 15 | Many years | No |
| 16 | 35 | Igbo | Not disclosed | CHEW | 10 | Many years | No |
| 17 | 40 | Igbo | Not disclosed | VVHW | 4 | Many years | No |

**Key**

CHEW: Community Health Extension Workers

VVHW: Voluntary Village Health Workers

B.N.Sc: Bachelor of Nursing Science

RN: Registered Nurse

RM: Registered Midwife

### 5D.2. Themes elicited from the data

Two themes and five sub-themes emerged from the data. These themes were: an ancient tradition and health care for circumcised females (see **Table 5D.2)**.

**Table 5D.2 Themes and Sub-themes emerging from the health care participants**

| Themes | Sub-themes |
|---|---|
| An ancient tradition | • The practice of FGM/C<br>• Factors that promote FGM/C<br>• Do we continue with FGM/C |
| Health care for circumcised females | • Complications associated with FGM/C<br>• Challenges to high quality care for circumcised females |

**Theme One: An ancient tradition; "FGM/C won't stop overnight"**

The sub-themes for this theme were: The practice of FGM/C, Factors that promote FGM/C, and Do we continue with FGM/C?

**Sub-theme one: The practice of FGM/C**

All the participants were natives of either the study communities or nearby communities. They re-iterated that FGM/C was part of their culture and had been in existence since before they were born. Most of them reported they were circumcised just like other women in the communities. According to them, almost all the women in the villages were circumcised and FGM/C was highly esteemed.

"*FGM/C has been in existence by the time I was born…I am circumcised hence I also talk out of my own experience.*" ($H_9$)

"*…FGM/C is an age long tradition in this community…To the best of my knowledge, almost all the women in this village are circumcised. It is a way of life that has lasted for years and people see no wrong in it…This is a maternity home …From my experience here, if three women come for childbirth, there is a high chance that two or all of them are circumcised. Also I grew up in this village and know how seriously the belief about FGM/C is…Even we that are now teaching against FGM/C were circumcised before the government started intense campaign against FGM/C…FGM/C is highly esteemed in this community*" ($H_{12}$)

"*Myself was circumcised as a teenager. I told you that FGM/C is an age long tradition in this community. Most women of my age are all circumcised.*" ($H_{13}$)

Some of the participants explained they have never assisted uncircumcised woman during childbirth, despite many years of working as healthcare practitioners in these study communities.

"…*I have never assisted in childbirth for an uncircumcised woman so I cannot talk about them…*" ($H_{17}$)

"*…the thing is that most of the women that present for childbirth here always have a form of circumcision…*" ($H_{13}$)

The participants also reported that FGM/C was previously done when girls reached the age of marriage, however, it is now done during infancy, especially a few days after the birth of a baby girl. The participants explained:

"…*Once a girl is up to the age of marriage, they will circumcise her…After the circumcision, the girl will bath, and then go to her husband house…At infancy stage* (current circumcision age)*. Before, it was when they reached the age of marriage.*" ($H_{10}$)

"*I am the head in this facility presently and also an indigene of this community. Few years back, it was a must that every girl in this land that is up to 18 years of age must be circumcised. It was seen as a transition into womanhood…Since the government began the campaign against FGM/C, some mothers now prefer to circumcise their female children at infancy just like the male children are circumcised at infancy. It is believed that FGM/C prevents promiscuity and no mother wants her child to be promiscuous.*" ($H_{16}$)

"*I think they used to do so when the girl goes into puberty and so can get pregnant, but these days, some women even circumcise their daughters at infancy while some do so when the girl is still a child…*" ($H_{14}$)

Furthermore, some of the participants described how FGM/C was usually done. They likened FGM/C to male circumcision and were of the opinion it took less than a week for complete healing of FGM/C wound. Some of them described how they used to conduct FGM/C but have stopped since the government started campaigning vigorously against it, while some described the way traditional circumcisers do the procedure:

"*When we cut off the excess flesh, we get a particular herb and squeeze it so that the liquid from it drops on the wound, then it will stop bleeding. Healing time is similar to the time for healing of male circumcision. It takes less than a week for healing to be complete.* " ($H_1$)

"*The circumcision wound heals between 5 to 7 days.*" ($H_6$)

"*Okay, it is usually done early in the morning before sunrise or in the evening when the sunsets, but most commonly, it was done early in the morning. The girl comes in, sits or lies down with her legs thrown apart. Strong women might be there to hold her in position if she seems fearful. The circumciser then uses a sharp object… to swiftly cut off the clitoris*

*depending on what the girl's mother agreed with the circumciser. The sharp object is a type of razor blade that can be washed and reused. It is used for both male and female circumcision. After the cutting, they use a herb which is popularly known to stop bleeding from injuries. They squeeze the liquid from the herb onto the wound site to stop the bleeding. Then the girl is allowed to go and rest while the wound gradually heals by itself.*" ($H_{16}$)

However, some of participants explained a method they referred to as being new and safe when compared with the 'traditional/cutting' method of FGM/C in these communities.
"*Yes…our old healthcare practitioners believe in FGM/C so when the government banned it, they adopted this new method…In this method, they apply menthol and Vaseline cream on the girl-child's clitoris at infancy stage. This method reduces the shape and size of the clitoris from birth… It takes between 3 and 6 months from birth to perfect it…*" ($H_3$)
"*The new method is good. It gets the clitoris flattened as you push and massage it with Vaseline, so it looks good…The new method takes about 3 months to complete and it looks good. The clitoris is usually soft after birth, so you force it to flatten before it gets strong.*" ($H_6$)
"*The new method makes the clitoris flat with good shape; not hanging out like male penis.*" ($H_9$)

**Sub-theme two: Factors that promote FGM/C**
The participants mentioned various factors that promoted FGM/C including culture, circumcised mothers, ignorance and genital beauty
"*They insist on circumcising their daughters because they were circumcised themselves… Ignorance is the reason behind FGM/C.*" ($H_5$)
"*Well, the major reason I know is that it is a long age tradition which our fore-fathers and mothers have successfully practiced…It is not so easy to stop an age long practice. So you will not be surprised to see some women tell you that they were circumcised, so also their mothers, grandmothers, great grandmothers… so they will circumcise their own daughters. The tradition of the elders will not stop with them.*" ($H_{12}$)

Also, some participants reported that several myths were held by these communities which promoted FGM/C. The participants explained:
"*…It is believed that a girl is not supposed to sleep with a man with her clitoris intact, talk less of getting pregnant or giving birth to a child without being circumcised. That child will never be circumcised whether male or female. If a girl gets pregnant uncircumcised, she is said to have unwanted pregnancy even if she is married. This is because circumcision is part*

*of the preparation a girl was supposed to have before she goes to her husband's house. It is part of the ceremony done to show transition to womanhood…*" ($H_{15}$)
"*…It is believed that FGM/C reduces prostitution by making the girl not to have sexual feelings. Our elders believe that the clitoris which is the part mostly removed during circumcision is the thing that makes a girl to be having feelings to meet a man. It is believed that a man should be the one to get attracted to a woman. So, when the clitoris is removed, the young girl will grow up into a responsible woman. She will be able to stay married to one man and not be running up and down looking for satisfaction from different men.*" ($H_{14}$)
"*I think FGM/C prevents promiscuity in women. It also stops the scratching of genitals in males.*" ($H_5$)

**Sub-theme three: Do we continue with FGM/C?**

The participants reported that the government currently warns against FGM/C and they as healthcare practitioners also teach the women to stop FGM/C. They also reported that FGM/C is now done secretly, and that FGM/C is neither done nor allowed in the health facilities since the government started campaigning against it. The participants said,
"*…It is recently that the government started giving serious warning against it. We have also joined the government to tell the women to stop circumcising their female children. We don't encourage any form of FGM/C in this facility.*" ($H_{12}$)
"*It was a tradition strongly held unto and believed to be our lifestyle till the present government started to campaign against it on the radios…I suppose it is possible that some healthcare practitioners might be doing FGM/C secretly. Not quite long, a man who is not an indigene of this community but lives in our village came to me with his wife who was pregnant and in her last trimester. He wanted her to register in our facility so that she will give birth to her child in our facility. The man then inquired if we circumcise female children too after they are born, and we answered him in the negative. He then told us that he will go to another facility where his child will be circumcised after birth whether male or female. I tried persuading him against FGM/C but he insisted on going to another facility and left us. I later saw the woman with a baby girl and truly, the girl was circumcised. So that gave me the impression that some healthcare practitioners might still be doing FGM/C secretly.*"
($H_{16}$)
"*I cannot say for others because these things are done in the inner room, but it is against the law for healthcare practitioners to do FGM/C.*" ($H_2$)

Not all the participants were willing to tell what they teach the women about stopping FGM/C. Most of the participants declined stating it was the healthcare practitioner in charge

of their facilities that can teach about FGM/C, while some said they tell the women that the government is warning against FGM/C.

"*Well, it is our chief here who is a registered nurse that use to give them those talks and teachings during antenatal classes. She also attends the meetings against FGM/C being organised by some organisations in this state.*" ($H_{12}$)

"*…we now teach them to stop FGM/C and also go on to tell them that the government will punish anybody reported to be doing it, as well as the parents of the girl or girls involved.*" ($H_{16}$).

Concerning their perception on the possibility of the community accepting their teachings about stopping FGM/C, some of them replied,

"*Well, I can say yes because many of the young mothers ask questions that show they are interested in what you are telling them and some even verbalize it that they will not circumcise their daughters for any reason.*" ($H_{14}$)

"*I think some of them are agreeing to it especially the younger women. But the truth is that not everyone will agree with the warning immediately. But presently, they don't do open ceremonies to mark FGM/C in the community. So, it depends on family decisions now.*" ($H_{12}$)

"*With this new government warning against FGM/C, the awareness of the need to stop FGM/C is spreading…and young girls are getting more courage to refuse circumcision. You can now see a girl of 17 years who is not circumcised, and she lives happily and associates with other members of the community.*" ($H_{13}$)

The participants were divided in terms of the continuation of FGM/C. Some were in favour of abandoning this practice while others supported its continuation; the majority said they do not support the continuation of FGM/C. However, some of the participants who stated that they did not support the continuation of the practice likened FGM/C to male circumcision, and had their reasons for indicating no support to be mostly because the government was against FGM/C.

"*I don't do it. The government is against FGM/C. I can't answer for other healthcare practitioners if they do it secretly or not…I don't support FGM/C. We teach women to stop it.*" ($H_{12}$)

"*No, it is dangerous and has many consequences as I have told you*." ($H_{16}$)

Among those participants who said no to the continuation of FGM/C were those who explained that FGM/C was beneficial and should not be seen as a problem. However, when they were asked directly if they supported the continuation of FGM/C, they said no.

"*I think FGM/C prevents promiscuity in women. It also stops scratching of genitals in girls*" ($H_5$)

"*…Even though I told you some complications associated with it, yet many women and girls in this community are circumcised, and they have lived and are living their lives without complaint. Some circumcised women have given birth to up to seven children and more per vagina. Some of our women who are highly educated and are occupying big positions in the cities were also circumcised. But since the government started campaigning against FGM/C, we don't do it at all, and we also teach women to stop doing it…*" ($H_{16}$)

"*…It is not every girl that is circumcised that do develop complications. It is usually very few. The people that do these circumcisions for them have been on the job for many years and it is not even a hard thing to do. So, don't see it as if every circumcised woman or girl is in trouble. All our mothers were circumcised, and they lived long and had many children, and we are here today. We also were circumcised, and we did not die. We have our daughters circumcised who are themselves married with many children too. So please, it does not mean that every circumcised girl or woman will have problem or is to be pitied, or that circumcision will make the girl to die. People get sick for several reasons and die for several reasons. So, it is with childbirth too.*" ($H_{17}$)

In addition, among the participants who indicated no support for FGM/C were some who explained they only supported the new method and stated they did it for their daughters. They also encouraged other women to do it despite being aware that the government was against the new method too, but when asked if they support the government campaign to stop FGM/C, they were among those who said yes.

"*…I have tried all I could to persuade them to abandon the old types of FGM/C and embrace the new method…I did it for my baby girl…the new method I descried earlier helps to make the size and shape of the clitoris look good…No, I only support the new method.*" ($H_3$)

Some of the participants boldly indicated strong support for the continuation of FGM/C. They supported the cutting method and gave reasons why they have continued to perform it for different families. One of the participants said, "*In my opinion, I love FGM/C as it reduces sexual urge/libido…I don't believe FGM/C causes difficult labour as big babies can equally cause difficult labour.*" ($H_6$)

Another added:

"*Female adolescents can decide to get FGM/C. But mostly, I circumcise babies 8 or 9 days after birth at which time the cord has fallen… I apply adrenalin to stop the bleeding…I don't support the new method as it hurts the baby for long. It takes between 3 to 6 months to*

*complete the procedure. It is better to do the circumcision once… I cut off the clitoris mainly and sometimes cut also little labia… No, I circumcise females; I can't stay with an uncircumcised female…The clients don't come to the hospital to have FGM/C. We go to their houses to circumcise them."* ($H_7$)

In summary, the participants reiterated that FGM/C was part of their culture and had been in existence for many years and that almost all the women in the village were circumcised**.** The majority of healthcare practitioners indicated they were circumcised. In addition, FGM/C was previously done when the girls reached the age of marriage, but is now done during infancy They likened FGM/C to male circumcision. Also, some of the participants indicated they used to do FGM/C but have stopped since the government began campaigning against it. Some of the participants were in support of various forms of FGM/C while some said that they want FGM/C to be stopped because government is warning against it.
However, FGM/C is done in secret despite government warnings against it. Factors like culture, circumcised mothers, genital beauty, myths and ignorance promotes the practice of FGM/C.

**Theme Two: Health care for circumcised females; "…*Most women who come to us are circumcised*"**

The theme consisted of two sub-themes. The sub-themes were: complications associated with FGM/C and challenges to high quality care for genitally mutilated females.

**Sub-theme one: Complications associated with FGM/C**

The participants reported that circumcised women almost always have lacerations during childbirth. From the description of the type of genital laceration the participants reported, it would appear that circumcised women usually have third degree perineal lacerations during child birth. This was described as follows:

"*…The truth is that a lot of them do have scary tear during child delivery here.*" ($H_2$)

"*…I have worked in this community as a nurse-midwife for some years now…circumcised women have this peculiar tear on the anterior/roof of the vagina through the place where the clitoris was supposed to be. There was the case of a woman that came in to have her baby born here…Before I could give a quick episiotomy, the baby pushed its head out with the perineum tearing apart almost to the anus and another tear on the anterior part of the vulva through the place where the circumcision scar was. Then we hurriedly completed the delivery of the baby and placenta, but already the woman was already having intra-partum haemorrhage which later proceeded to PPH. It was like a battle saving that woman's life, but we finally succeeded in getting all the torn pieces sutured and stopped the bleeding. It was*

*a terrifying experience. So, whenever these circumcised women present for childbirth and we notice tight perineum, I don't wait to do manipulations using hand because the scar will never expand… I simply give a quick episiotomy…Am not trying to say that uncircumcised women don't have perineal tears … but for circumcised women…it's almost a norm for them. Then this anterior tear is what I can say is peculiar to some, not all please, circumcised women…and in few occasions even after you give a mediolateral episiotomy. I never knew it was possible till I started working in this community with a very great percentage of women who come for childbirth circumcised.*" ($H_{14}$)

Circumcised women are also prone to intra-partum and post-partum haemorrhage due to perineal laceration. Other complications common with the community women, which some of the participants associated with FGM/C, were foetal still birth, infections, stool incontinence, vesico-vaginal fistula (VVF), much pain post-partum, prolonged labour and genital keloid. The participants said,

"*…Some of these women have foetal still birth due to narrowed vaginal wall. Some have stool incontinence, infections and VVF. I have seen a circumcised woman who had perineal tear during childbirth and was divorced by her husband because she ended up having VVF. The man was afraid to remarry because he thought that all women have VVF after child birth…I referred them to a hospital where she had a surgery to repair fistula… I have also seen a circumcised woman who later had keloid formed in her genitals, and thus made her vagina narrow.*" ($H_1$)

"*VVF can be a consequence of FGM/C. One of the clients told me this morning that her daughter urinates abnormally as urine doesn't flow well. During history taking, she said she just circumcised the daughter.*" ($H_4$)

"*I have assisted women with childbirth severally and have noticed that circumcised women usually have tight perineum during childbirth…they do undergo much pain when they have those big tears because it is more difficult to suture those sudden tears. So, the woman will still undergo real pain after childbirth when you will be trying to suture the tears…*" ($H_{13}$)

Child mortality also due to FGM/C was reported by some of the participants.

"*When I was training to be a CHEW, the chief midwife in my institution of training had a private clinic in her house. One day, the midwife ran to work after circumcising a baby girl in her private clinic. She never knew that the girl was bleeding heavily, and her assistants tried the much they could to stop the bleeding, but with no success. The baby was then rushed to our hospital, but she was already so weak and so died.*" ($H_1$)

"*I have witnesses three (3) babies that bled to death after being circumcised…*" ($H_5$)

"*My step-mother's children (a boy and a girl) got HIV/AIDS infection through circumcision. They are now dead. There was no other invasive procedure done on them before they died aside the circumcision, so it was believed that they got the infection through circumcision. They became sick and later tested positive for HIV/AIDS before they died… In fact, there was the case of another baby girl that bled to death after she was circumcised. I saw the girl, but we didn't succeed in saving her life. That was about two years ago. She had bled so much before our attention was drawn to her and we couldn't save her life.*"($H_{16}$)

Due to the complications described above, the participants reported they always prepared for a quick episiotomy during childbirth for their clients who were mostly circumcised women.
"*…So, what we do for them is that once we discover that the perineum is very tight, we give them episiotomy cut to aid delivery of the foetal head and also prevent those big tears (laceration) which can cause the woman to lose more blood than is supposed.*" ($H_{13,}$)
"*…to prevent this, I do have my scissors ready to give quick episiotomy cut to aid the delivery of the baby. When they have the tear, it makes some of them to bleed too much and that is dangerous. After, I suture the cut and the woman will be fine with her baby.*" ($H_{17}$)

**Sub-theme two: Challenges to high quality care for genitally mutilated females**
Some of the participants reported challenges they had in rendering high quality care to the genitally mutilated females. One of these reported challenges was shortage of skilled staff, such as registered nurses and registered midwives. This was because most of the health facilities in these communities were manned by CHEWs and VVHWs.
"*Yes, we need more skilled staff here. Midwives are really needed in this community and the various villages in it. Remember I told you that some villages in this community have their clinics being manned by TBAs and VVHWs. Majority are manned by CHEWs…*" ($H_{14}$)

They also complained of the shortage of basic consumables and equipment in their facilities. The participants explained:
"*…Also, we need to have regular supply of consumables and other reusable equipment needed for the care of these patients. Many village facilities don't have electricity and good/nearby source of water supply. These really affect our activities. They should create a link between us and the hospital in town so that when we refer women, they will be readily attended to in the hospitals...*" ($H_{14}$)

The participants also lacked continuous education and training in order to be updated on current health care practices practiced in the cities. Only a few RNs or RMs are sent to the

cities for training and they come back without being equipped to pass the knowledge on to the other healthcare practitioners. Hence, many healthcare practitioners could not give health education, counselling, do home visits or advocate for stopping of practices like FGM/C. Thus, some healthcare practitioners ignorantly continued with FGM/C secretly, while some could be doing it to please the community. This was explained as follows:
"*We need more training on better ways to care for these women. They usually pick one or two staff from this big community and they go to the city when they want to do seminars and trainings for staff. There is no way one midwife will be able to impart the knowledge gained to all the healthcare practitioners in all the health centres in this community. Sometimes too they come back without the tools for all of us to learn and practice what they have been taught.*" ($H_{16}$)

The participants complained that the government warnings about stopping FGM/C had resulted in the community women doing FGM/C secretly and not referring females who have complications from the procedure to the hospital for proper management; they have also never heard of anyone prosecuted for FGM/C.

"*We live in this community and if they have any problem, they are meant to come to us, and we will help them. But the issue is that since the campaign against FGM/C started, people do it secretly without telling us. They don't come to us for counselling or anything about FGM/C. We only see that they have circumcised their daughters when they bring them for treatment of illnesses like fever, diarrhoea or when they present the children for immunisation.*" ($H_{16}$)
"*You know, some of these women have Type III FGM/C… some of those women will be ashamed to have vaginal examination* (during antenatal services)." ($H_3$)
"*Remember that I told you that since the government began the campaign against FGM/C, some adolescents now resist circumcision boldly. Therefore, some mothers now prefer to circumcise their female children at infancy just like the male children are circumcised at infancy.*" ($H_{16}$).
"…*No o* (have never heard of anyone prosecuted due to FGM/C)." ($H_{12}$)

The participants experienced some women being so mutilated that they have difficulty identifying the parts of the genitals. These women were at high risk for PPH. The participants said: "*…Sometimes they will so much cut off the clitoris that you won't even know it was ever there or you might sometimes get confused identifying the different parts of the vulva.*" ($H_{13}$)

"*There was a particular case of a woman who came in for childbirth and we saw that she had infibulation. We had difficulty identifying the different parts of her vulva. It was just holes that were left for her. We were so surprised because FGM/C is a practice in our community, but we remove mainly the clitoris here. We enquired from her to know who did her circumcision and she said that it was her father who circumcised her.*" ($H_{17}$)
"*You know, some of these women have Type III FGM/C. So, during delivery, they experience PPH…some of them will be ashamed to have a vaginal examination.*" ($H_3$)

Finally, some of the participants advised that increased understanding of the dangers of FGM/C, as well as the government providing alternative sources of income for the traditional circumcisers, could contribute effectively in eradicating FGM/C in the communities.
"*Yes, knowledge they say is power. If the government can send people to the more interior villages to explain to the people the dangers of FGM/C, it will really help to stop FGM/C. Also, if the government can provide alternative means of employment to the traditional circumcisers and also include training of unskilled healthcare practitioners in their FGM/C training sessions, I believe that it will also help to stop FGM/C.*" ($H_{14}$)
"*…FGM/C cannot be stopped overnight as it has to do with people's belief and tradition, but with continual creating of the awareness of the need for it to be stopped especially in the villages, … a time will come when people will rarely allow their daughters to be circumcised.*" ($H_{13}$)

In summary, the participants' reported that most of the women who present at their health facilities were circumcised women. They reiterated that FGM/C has been a revered cultural value in the communities and that much skill is needed to be able to render efficient health care to genitally mutilated females due to their high risk for morbidity and mortality especially during childbirth. Childhood morbidity and mortality due to FGM/C were also reported, but despite the complications caused by the practice, some of the participants supported its continuation.

### 5.3. SUMMARY OF CHAPTER 5

This chapter presented the findings of the FGM/C experiences of females in SE Nigeria. Findings for the women participants had three themes and 11 sub-themes emerge from the study. Despite the majority of the women being literate and aware of the government ban on FGM/C, the practice was still on-going with some level of secrecy. Some participants had early-age FGM/C, some were forcefully circumcised; some attributed their sexual and childbirth problems to their FGM/C status; while some indicated support for the continuation of the practice.

In the findings from the girl participants four themes and 10 sub-themes emerged from the study. A critical look at the general information of the participants revealed that the girls who could recall their FGM/C procedure experience were circumcised between years 2007 and 2015, and some of these reported their younger sisters have or will be circumcised. Participants reported fear, uncertainty, pain and a feeling of helplessness to be associated with the practice, while the preservation of their culture was the major motivation for FGM/C. Many of the participants submitted themselves to FGM/C just to obey their parents, while some indicated support for the continuation of the practice.

Findings from interviews with mothers of genitally mutilated girls revealed two themes and six sub-themes. FGM/C was ongoing as many of the participants reported in the general information that their daughters were circumcised in the recent years. Modifications in the practice of FGM/C in these communities over the years were reported. This was seen in the age at which circumcision was done, the method of conducting FGM/C and the care of the girls after FGM/C. Also, the participants' awareness of the anti-FGM/C campaigns, their opinion about the continuation of the practice and the factors that motivated the continuation of the practice were presented.

The interviews with healthcare practitioners on their experiences about FGM/C in SE Nigeria revealed two themes and five sub-themes. Most of the participants were indigenes of the study communities and they reported they also had undergone FGM/C, and that medicalisation of FGM/C had been ongoing until the present government began to campaign against it. They reiterated that FGM/C has been a revered cultural value in the communities and that much skill was needed to be able to render efficient health care to genitally mutilated females due to their high risk for morbidity and mortality especially during childbirth. Childhood morbidity and mortality due to FGM/C were reported, however, some of the participants indicated support for the continuation of FGM/C.

The next chapter presents the discussions and interpretations of the findings on the FGM/C experiences of females and healthcare practitioners in SE Nigeria in the context of the available literature.

# CHAPTER SIX

# DISSCUSSION AND INTERPRETATION OF FINDINGS

## 6.1. INTRODUCTION

The findings from the in-depth interviews on the FGM/C experiences of females in SE Nigeria and their healthcare practitioners were presented in the previous chapter. This chapter presents the discussion and interpretation of the findings on the experiences of females and healthcare practitioners in SE Nigeria compared to available literature on FGM/C. This evidence contributed to the development of the health education pamphlet (HEP) for genitally mutilated females.

For the purpose of this discussion, triangulation of data sources (Shenton, 2004; Fusch, Fusch & Ness, 2018) was conducted in order to synthesise the findings from the four data sources (genitally mutilated women, genitally mutilated girls, mothers of genitally mutilated females and healthcare practitioners) presented in Chapter Five. This will allow a more comprehensive view of the reality about the FGM/C experiences of females in South Eastern Nigeria (Shenton, 2004), increase the credibility (Shenton, 2004; Carter et al., 2014; Fusch, Fusch & Ness, 2018) of the findings and avoid unnecessary repetition of findings that were similar across the four data sources.

## 6.2. TRIANGULATION OF THE DATA SOURCES

According to Shenton (2004) and Carter et al. (2014), during data source triangulation, individual viewpoints and experiences can be verified against others and, ultimately, a rich picture of the experiences of those under scrutiny may be constructed based on the contributions of a range of people. However, where similar results emerge at different sites, findings may have greater credibility (Shenton, 2004). Therefore, using inductive reasoning (Bradford, 2017; Copi, Cohen & Flage, 2016), sub-themes that emerged from the findings presented in the Chapter Five were carefully reviewed, and clustered together based on similarity of the findings. According to Bradford (2017) and Copi, Cohen & Flage (2016), inductive reasoning allows broad generalisations from specific observations by drawing conclusions from the data. Statements that adequately represented the clustered sub-themes were referred to as synthesised themes and sub-themes and used as headings for discussing and interpreting the findings from the FGM/C experiences of the genitally mutilated females and their healthcare practitioners in SE Nigeria. **Table 6.1** shows the synthesised themes and sub-themes of the FGM/C experiences of females and healthcare practitioners in SE Nigeria.

**Table 6.1 Synthesised themes and sub-themes of the FGM/C experiences of females and healthcare practitioners in SE Nigeria.**

| Nos | Synthesised themes and sub-themes | Sub-themes from the four sources of data | | | |
|---|---|---|---|---|---|
| | | **Genitally mutilated women** | **Genitally mutilated girls** | **Mothers of genitally mutilated girls** | **Healthcare practitioners** |
| **1.** | **FGM/C: Past and present.**<br><br>1.The cutting experience<br><br>2. Life after FGM/C<br><br>3. Trends of the practice | 1. FGM/C is culturally embedded<br><br>2. Fear, force and obedience<br><br>3. The cutting experience<br><br>4. Coping with the pain and wound healing<br><br>5. Experiences of problems following FGM/C | 1. FGM/C is our culture and father was in support<br><br>2. A stubborn girl Circumcised against my wish<br><br>3. The circumcision procedure<br><br>4. Fear, pain and maturity<br><br>5. Recovery and returning to school | 1. Age at circumcision<br><br>2. The cutting method<br><br>3. The new method<br><br>4. Caring for daughter after FGM/C | 1. The practice of FGM/C |
| **2.** | **The future for our daughters**<br><br>1. Factors that influence the practice of FGM/C<br><br>2. Challenges to high quality care of circumcised females | 1. Factors that influenced the practice of FGM/C<br><br>2. The future for our daughters | 1. Perpetuators of FGM/C<br><br>2. Threats and benefits of FGM/C<br><br>3. Should we continue with this practice? | 1. Motivators of FGM/C<br><br>2. Anti-FGM/C activities | 1. Factors that promote FGM/C<br><br>2. Do we continue with FGM/C<br><br>3. Challenges to high quality care for circumcised females<br><br>4. Complications associate with FGM/C |

### 6.3. FGM/C: PAST AND PRESENT

#### 6.3.1. The cutting experience

The findings from the current study agrees with those from previous studies, that the practice of FGM/C is rooted in culture and traditions (WHO, 2017; Bogale, Markos & Kaso, 2015; Alo & Gbadebo, 2011). It is also in tandem with the report of Edeh (2017) that in many communities, the practice continues simply because it is tradition. Thus, this social value dwarfs the pain or denial of rights associated with FGM/C (Edeh, 2017). These reports reiterate the statement from UNICEF and UNFPA (2016), that whatever the community

validates and embraces as their culture, is often imbibed and provides a strong opposition to change.

This was illustrated in the study as the participants repeated, in various ways, that FGM/C is part of their culture, and it seems that none of the practitioners dared to question it. According to Siddhanta and Sinha (2016), in communities where FGM/C is practiced, men and women obey it without questioning. If the adults obey without questioning, the children are expected to obey to a greater extent, else they will be termed stubborn or disobedient. Hence, it would only be normal for a girl to obey her parents even in subjecting herself to FGM/C. The need for social acceptance and a good reputation outweighed the fear, uncertainty and pain of FGM/C. According to Bogale, Markos & Kaso (2015), conformity meets with social approval, and also brings respect and admiration. This is supported by the finding that circumcised girls mocked and segregated against non-circumcised girls.

Similar to a report by UNFPA & UNICEF Nigeria (2016), the parents of the female participants assumed they were too young to understand FGM/C traditions that preceded their birth and so did not inform them of the details of the procedure before putting them through it; they talked less of requesting their assent for the procedure. However, Jean Piaget's Theory of Cognitive Development explained that children between the ages 7 of and 12 years are capable of inductive concrete reasoning (Kendra, 2018), therefore, they would have been able to give or withhold assent to undergo FGM/C. One of the participants even said that if she had known the procedure would be so painful, she would not have agreed to undergo it.

The participants explained there is a culture of silence with regards to FGM/C in their communities. The study provided evidence that FGM/C was scarcely discussed among the practitioners, despite it being a common practice. Many of the participants did not know what the practice entailed until they experienced it, although some had a priori hint from their friends that the practice was associated with much pain; this is supported by Jacobson et al. (2018) and Nour (2008) who reported that FGM/C was not openly discussed within communities where it is practiced  Therefore, fear, uncertainty and pain marked the circumcision morning.

Similar to reports by Nour (2008), none of the participants desired to be circumcised, but were rather coerced into it or forcefully circumcised by their parents who believed they were doing good to their daughters. This is a violation of the right of children to protection, health, life and physical integrity (Centre for Reproductive Rights, 2006; Yaya & Ghose, 2018). It

was also not surprising when one participant said that she was "*deceived*" into undergoing FGM/C. Her mother and circumcised elder sisters told her that the procedure was not painful, but she was disappointed when she experienced terrible pain from the cutting. However, she explained that deception was the way mothers and relatives convinced the girls to subject them to the procedure, which illustrates that her experience was not an exception. Irrespective of being deceived, the FGM/C culture is so embedded that the same participant was of the opinion that every female must experience FGM/C.

In addition, it can be deduced that families devised various means, including deception, to convince females to go for FGM/C. This attitude raises questions as to whether the beliefs and perceived benefits of FGM/C are real or just one of the means by which the practice is sustained from generation to generation. This idea might create a good argumentative strategy to be used by the anti-FGM/C campaigners in dissuading young people about the long-held beliefs about FGM/C.

Furthermore, there were reports of FGM/C being done by "nurses." The professional qualifications of the healthcare practitioners who did the circumcision were not clear, as the people in these communities refer to their female healthcare practitioners as "nurses." However, these reports provide evidence that medicalisation of FGM/C exists in these communities. According to the healthcare practitioners who were interviewed, medicalisation of FGM/C was routine until the anti-FGM warnings by their state governments, which started few years ago. This finding is in tandem with the report of Ekenze et al. (2007) that 33.3% of their respondents in South Eastern, Nigeria said they were circumcised by nurses. Also, Cappa et al. (2013) in their multi-method study also mentioned Nigeria as one of the countries with a significant prevalence of FGM/C medicalization.

It was interesting to find that one of the girl - participants was somewhat sedated in the health centre in their community to reduce the pain associated with FGM/C procedure. A similar experience was also reported by Jacobson et al. (2018) among Somalian-Canadian women of whom six underwent FGM/C under local anaesthesia. However, irrespective of the reason for which FGM/C was done medically, it is strongly condemned globally as a violation of human rights (WHO, 2013). This also raised the question about their ethics and scope of practice.

In tandem with the report of UNFPA & UNICEF Nigeria (2016), some of the participants opined that the FGM/C circumcisers were experts, therefore no complications would arise due to FGM/C. Thus, mothers entrusted their daughters to the traditional circumcisers for the procedure. According to the participants and some previous studies, some families were

gifted to perform FGM/C and these circumcisers went about the communities to conduct FGM/C (Nour, 2008). Healthcare practitioners who do FGM/C were also referred to as experts. Consequently, the participants were optimistic that their daughters' FGM/C would not result in any complications. However, according to Ekeanyanwu (2017), it is always difficult to explain the possible complications of FGM/C to its believers as they quickly allude the cause of the complications to other reasons.

The participants also experienced helplessness, though they tried to defend the actions of the adults forcefully restraining them during the circumcision with the excuse that what those adults did was the norm in their communities. This is vivid evidence of the power of culture. According to the theory of ethical relativism, morality is relative to the norms of one's culture (Velasquez et al., 1992).

The participants experienced fear and severe pain during the circumcision. Some of them mentioned it was a sign of maturity for a person to conceal/endure pain. One participant even reported that her peers would make her mother pay some penalty if she was heard crying out during or after the circumcision, which relates to emotional blackmail. She was expected to endure and conceal the pain so as not to disgrace her peers and to prove she was mature. According to Khazan (2015), the pain of FGM/C was seen as a "good" pain, and so the girl was expected to endure it. Also, Morison et al. (2001) reported that in the Gambia, girls were told to be brave and not to cry during the FGM/C as crying would bring shame to their family.

The cutting experiences shared by the participants were similar in many ways. There was a similar process in the way the circumcision was conducted in the different communities; also, acute pain was associated with the cutting procedure. Gele et al. (2012) reported that Somali women mentioned FGM/C was a very painful experience, while Jirovosky (2010) reported that in Burkina Faso, the women also mentioned FGM/C was painful, especially if the girl was old enough to remember it.

It was evident from the experiences of the participants that FGM/C was done by women on younger females, some of whom were relatives to the client brought for the procedure. This was despite the fact that it is females that bears the direct consequences of this procedure. According to Muraya (2015), the majority of the women were circumcised by women themselves. Abathun, Sundby and Gele, (2016) also reported that in Eastern Ethiopia, FGM/C was performed mainly by female traditional circumcisers. Since one of the perceived benefits of FGM/C, as reported by the participants was to preserve chastity, it might seem

awkward in a traditional setting for males to be allowed to circumcise the females (Muraya, 2015). The apparently conservative women of these FGM/C practicing communities therefore do the cutting by themselves. This finding is also supported by the statement of the WHO (2008) that older women who have had FGM/C now become the custodians of the FGM/C culture; they are more likely to support the practice and tend to see efforts to combat it as an attack on their culture (Johnsen, 2007). This finding re-emphasises the fact that contextualised health education of women about FGM/C might be one of the important steps to eradicating FGM/C.

As seen in the current study, some participants reported the cutting was done with a razor blade, but they were not sure if the blade was a new one before it was used to cut them. This could pose a great risk for the spread of infectious diseases in the community if razor blades were re-used for cutting different clients. This finding concurs with the statement of (Biglu et al., 2016) that a blade or straight razor is usually used for FGM/C.

In line with reports from previous studies (Cappa et al., 2013; Obi & Igbinadolor, 2018), most of the study participants was sure of what was removed from them during the circumcision. but some of them claimed it should be the clitoris. Since all the participants had FGM/C in the early years of their lives (as children), it might be assumed they were not yet familiar with what their genitalia looked – like before they had FGM/C, therefore, they were not sure of what was missing after they had FGM/C. Also, it may not have been possible for someone under restraint and having much pain mixed with fear to see exactly what was cut off before it was buried in the small hole at the circumcision site. This assumption was supported by the statement of one of the participants ($W_{17}$), all she wanted to do was to run away as soon as her grandmother released her grip on her after the cutting. Also, available evidence from our scoping review of FGM/C in Africa (See Chapter 4) revealed that clitoridectomy, which is a Type 1 FGM/C, was the most common in the communities where FGM/C was done (Ekenze, Ezeugwui & Adiri, 2007; Kaplan, Hechavarria, Martin & Bonhoure, 2011; Kaplan, et al. 2013). This might also apply to our participants in this study as some of them said the clitoris might have been what was removed from them. As the participants lacked knowledge of the anatomy of the female genitalia, they believed FGM/C removes the excess flesh in the genitalia to make it small and flat, thus beautiful according to their expectation. According to, (Onyima, 2015) they did FGM/C because of their search for some beauty in the external female genitalia.

Concerning the reports that the circumcision was done in the fathers' yam barn, with a hole dug in the ground into which the removed flesh and oozing blood was buried, this seems to

be a mere cultural routine as none of the participants could say the reasons for these aspects of the FGM/C procedure. This supports the notion that FGM/C was basically a cultural issue (WHO, 2017).

It was interesting to note that some of the women participants said they never knew they had FMG/C until they went for childbirth; their parents did not tell them they had undergone FGM/C, so they heard it from healthcare practitioners. However, based on the experiences garnered from the participants, the state government of both states (Imo and Ebonyi) were announcing regularly on the radio and television against FGM/C (Ogbugbuaja, 2018), and all the participants claimed to be aware of the warnings, although according to them and in tandem with the report of (Nigeria28 Too Many, 2019), no one had ever been arrested for FGM/C. It was observed that all the participants who said they were circumcised as infants were from “urban” communities (Orlu LGA in Imo State), while the others were from rural communities (Ohaukwu LGA in Ebonyi State). It is therefore possible that despite the government warnings against FGM/C in both states, those in the urban settings, being supposedly more literate (as some of them claimed to have attended tertiary institutions) (NDHS, 2013), might be more afraid of the government campaign against FGM/C. The fear of a possible prosecution might have also contributed to the already-reported culture of silence among the FGM/C practicing communities in SE Nigeria. This was observed among our participants as many of them, despite being educated (for those in the urban communities), struggled to find words to share their experiences. This was despite the fact the interview was done in their local language. Therefore, the parents of this group of participants might have found it difficult to tell these females of their FGM/C status.

### 6.3.2. Life after FGM/C

Regarding the participants’ experience of caring for their daughters after FGM/C, the participants explained their daughters had pain. Reduced movement, good family support and a sheer will to endure the pain were the pain-coping mechanisms used by the participants, post-FGM/C. The coping mechanisms reported by our participants were similar to the FGM/C report in Kenya as described by Shell-Duncan in Khazan (2015), that a young girl endured the post-FGM/C pain by sheer will and partook in her post-FGM/C ceremony. Thus, in line with the findings of the current study, the post-circumcision pain was seen as a “good, temporary pain,” which every girl must endure as she transits into womanhood (Khazan, 2015).

The mothers of the genitally mutilated girls reported they did not experience stress taking care of their daughters after the FGM/C procedure. According to the participants, it was not

as though the daughters were sick, hence, their daily routines were not negatively affected. The participants (mainly from the rural communities) whose daughters were circumcised “not too early in life” explained that their daughters were not babies at the time of circumcision and so could endure some pain. This is also similar to the report about commendation for enduring pain among FGM/C practicing communities by Khazan (2015). In tandem with reports from other FGM/C studies (Klein et al., 2018), some participants explained they cooked special meals for their daughters on their circumcision day, and the girls were able to eat the food despite the post-FGM/C pain. This could have been a type of diversional therapy for the newly circumcised girl. This report agreed with the findings of the interviews with circumcised girls and women in these communities.

However, participants whose daughters were circumcised a few days after childbirth had their mothers or relatives take care of their daughters, post-FGM/C. Similar to the report from circumcised girls and women in these communities, the mothers explained their daughters were afraid to urinate shortly after the FGM/C procedure as the urine increased pain on the wound when it came in contact with it (Jacobson et al., 2018). However, the participants still believed that urine would enhance wound healing. Therefore, they encouraged the girls to urinate post-FGM/C, and some whose daughters were circumcised at infancy sprinkled the baby’s urine on the fresh FGM/C wound.

According to Nour (2008), post-circumcision wound care depends on the type of FGM/C done. There was no detailed documentation in literature concerning FGM/C wound healing, however, available evidence about FGM/C mentioned that the circumcised girls were kept housebound until their wounds healed (Nour, 2008; Van Bavel, Coene & Leye, 2017).
In line with reports from other studies, some of the participants explained that if any complication occurred shortly after the FGM/C, they treated it with herbs and if it persisted, they administered allopathic drugs or took the girl to the hospital or health clinic for further management (Nour, 2008). Some of the common immediate complications reported were haemorrhage, fever, headache, shock and delayed wound healing. However, how often these complications occurred and how long it took for them to confirm that the herbs were not resolving the complications before the girls were taken for medical treatment was not ascertained, as most participants claimed their daughters - just like themselves - had little or no FGM/C complication. However, this study re-echoes the report from WHO (2018) about the possible immediate complications of FGM/C.

Furthermore, all the participants who shared their circumcision experiences mentioned they stayed indoors until their wounds healed. The length of time it took the wounds to heal,

ranged from few days to about one to two weeks post-FGM/C. Having reported none of the participants was sure of the type of FGM/C they had undergone, it may be assumed that those whose wounds healed faster had a less degree of FGM/C than those whose wounds took longer time to heal. This finding concurs with the report of Nour (2008) that wounds from Type I FGM/C heals faster than wounds from Type III FGM/C.

Most of the girl participants explained that FGM/C did not affect their schooling. This was because most of the girls from the urban communities were circumcised at infancy, while those from the rural communities explained that their parents informed the teachers, they were sick, in order that they would never know the girls had undergone FGM/C. This seems to portray the low importance parents and people in these rural communities placed on education in comparison to their cultural rituals. In contrast, to the report of UNFPA (2017) that school holiday seasons are mostly FGM/C periods in Somali, communities in South Eastern Nigeria performed FGM/C any time the parents decided on, not minding the impact of the days of absence from school on the learners. According to Njogu (2018), FGM/C could hinder the girls from participating actively in education due to chronic absenteeism from school which might cause dismal academic performance in class and eventually compound to high dropout rates from school as a result of this vice. Again, the strong power of culture is showcased.

Conversely, some of the girl participants had hyperpyrexia post- circumcision, while some had foul smelling discharges from the wounds after the FGM/C procedure and some recurring infections over the years, of which they were not sure if FGM/C contributed. These also might have increased the duration of their absence from school, as they reported they stayed at home until their wounds healed properly before resuming schooling. These symptoms reported by the participants have been mentioned in previous studies as complications of FGM/C (WHO, 2018). Also, in tandem with this finding is the report from Njogu (2018), that FGM/C has a devastating effect on the education of young girls in school. Njogu (2018) also explained that FGM/C causes some girls to drop out of school as it gives the impression, they are now complete women and can get married and raise their own children; while those girls who did not marry immediately may have suffered some setbacks in their academics due to numerous days of absence from school during the recovery period, and for the possible recurrent or chronic infections that characterised life after FGM/C in these communities.

Some of the participants recounted the FGM/C experiences of other persons. It might be possible that some participants insisted their FGM/C experience was not so bad to show

strength or maturity as the tradition in these communities demands. This could be because, as previously discussed, the ability to endure pain is a sign of maturity and is applauded in their community. There might also be a recalling bias (Jacobson et al., 2018) because these participants were circumcised years before this interview and at a young age. Therefore, the females might not be able to recall nor link some immediate complication from their circumcision but would easily share stories of current sufferings due to FGM/C that they had seen in other females.

From the report of the women on how FGM/C affected their sexuality, it would appear that "controlling of female sexuality," - thereby preserving chastity - (Fahmy, et al., 2010; Yirga, et al., 2012; Ekeanyanwu, 2017), which was one of the major reasons why FGM/C has persisted through the years, is indeed true. It appears that removing some parts of the female genitalia actually controls her chastity by causing her to have little or no sexual feelings, or causing dyspareunia, and so the female lives her life avoiding any form of sexual intercourse, except when mandatory. This provides evidence that FGM/C was instituted by rational human beings, the creators of the practice had their reasons and so deliberately ensured they passed it down to succeeding generations.

Therefore, to scale up the initiatives against FGM/C, it might be necessary to avoid arguing with the practicing communities/individuals on whether FGM/C affects sexuality or not. This is because the reports from the circumcised females in the current study, and even from previous studies, suggests that FGM/C can result in a female being less active sexually by causing dyspareunia, reduced or no sexual feelings, infections, and scars/keloids (Nour, 2008; WHO, 2018; ). The anti-FGM/C crusaders should rather emphasise the long and short-term consequences of FGM/C and its violation of the rights of the female child. In this way, the females can acknowledge some of the consequences they have suffered and decide not to subject the younger generation to FGM/C.

A contrasting opinion on women's views of sexuality was reported by Fahmy, et al., (2010) in Egypt. These authors found that sexual problems were widespread among their circumcised female participants. However, unlike their male counterparts, the women considered themselves to be sexually satisfied if there was marital harmony and a satisfactory socio-economic situation in their homes; they referred to sex as a duty and religious requirement they owed their husbands. Conversely, the women in this study regarded sexual satisfaction in marriage as a necessity for a good relationship with their husbands. This is evidenced in the statements that their poor sexual desire/ performance caused problems between them and their husbands and they were not happy about it. Therefore, the difference in the

paradigm of sexual satisfaction among the women in the current study and those reported in the study done by Fahmy, et al., (2010) could be explained with the report of Esho, et al., (2010) that sexual function is a highly complex phenomenon whose optimisation is dependent on influences from various factors. For example, women from a conservative, FGM/C- practicing culture might not be bothered about sexual problems such as reduced sexual desires or feelings, and dyspareunia as long as they believed they have marital harmony. Although this study was done in both rural and urban communities, the participants may have been influenced greatly by the advancement in science and technology, and so might not view sexuality like they would have done nine years ago (2010) when Fahmy, et al, did their study.

It is true that many other factors could contribute to complications during childbirth, however, the reports of some of the participants that FGM/C was the reason why they had these complications cannot be totally disregarded. Those who experienced complications said they gave birth to their children in health care facilities, and some mentioned the health care practitioner who assisted them told them they had the complications due to the FGM/C they had undergone. As can be seen in the findings of the study, a participant explained she was told by the doctor that her vaginal opening had become narrowed due to her FGM/C. This finding about FGM/C as a possible cause for childbirth complications agrees with the statement of the WHO (2018), and other studies (Morison et al., 2001; Yirga, et al. 2012; Kaplan, et al. 2013; Morison et al., 2001; Klein et al., 2018), that FGM/C causes an increased risk for childbirth complications.

### 6.3.3. Trends of the Practice of FGM/C

Findings from the participants revealed there have been some modifications in the practice of FGM/C. Despite the numerous publications about FGM/C being a cultural norm and so are upheld tenaciously by some practicing communities, the current study in SE Nigerian urban and rural communities shows the practice has also undergone some modifications. This agrees with the three assumptions of the self-concept theory which explained that self-concept is learned, organised and dynamic (Purkey, 1988). None of these participants created the practice of FGM/C, they learned the practice from their ancestors, and accepted the how, when and why behind it which makes the practice somewhat organised. They have imbibed FGM/C as an intricate part of their lives as it confers some identity and self-worth. However, the self-concept is also dynamic (Purkey, 1988).

The dynamism of self- concept implies that although the participants believed in, and upheld the tradition of their ancestors, and even resisted any external change to it, they still have

the tendency of constant assimilation of new ideas and behaviours that are in keeping with their self-concept. Therefore, in an era where the campaign against FGM/C, which the participants have imbibed as part of their lives, is building momentum, there is a tendency for the FGM/C practitioners to also absorb new ideas and behaviours that agree with their self-concept. This also infers that since these firm FGM/C believers can accept changes in the organised practice of FGM/C for whatever reasons, there is hope that with the correct strategies being implemented, especially from within the community, they could have a rethink and accept a total abandonment of the practice for necessary reasons that would benefit their self-esteem. This is because self-concept always guards loss of self-esteem (Purkey, 1988). The modifications were seen in the age at which FGM/C was done, method of FGM/C and the care of the girls after FGM/C.

According to the findings, FGM/C was originally conducted when the girls started showing signs of puberty in order to prepare them for marriage and child birth. However, the present generation of FGM/C practitioners perform FGM/C whenever it is convenient for the parents, with most of the participants reporting they subjected their daughters to FGM/C during infancy or early childhood. In tandem with the findings of this study, Onyima (2015) explained that parents presumed their daughters might resist FGM/C when they grow up, and so imbibed the idea of early –age circumcision to avoid the stress of having to convince a grown-up girl to be circumcised, especially with on-going anti-FGM/C activities.

It was observed that all the interviewed women and mothers from the urban communities had their daughters circumcised at infancy or toddler age. This report also agreed with the findings from the girl group of participants, as all the girls from the non-rural communities could not recall their FGM/C procedure because they had infant FGM/C. It would appear that early-age FGM/C is thriving in those urban communities. These girls grow up without any remembrance of their circumcision experience. According to Nigeria28 Too Many (2019), the age for FGM/C in Nigeria is mainly between 0 to 14 years and globally 0 to 15 years, however, Onyima (2015) opined that in Nigerian cities, FGM/C is done mainly at infancy especially after eight days of birth. This report (Onyima, 2015) strongly agreed with our study findings because most of the girls that had early-age FGM/C in this study were from a urban community (Orlu LGA). It can therefore be deduced that currently in SE Nigeria, people in the rural areas are still practicing pre-puberty or puberty FGM/C, while those in cities are practicing early-age FGM/C. However, it is also possible that the supposed increase in early-age FGM/C could be partly due to the fear of the anti-FGM/C law and awareness campaigns in Nigeria. Though there is no report of anyone being arrested for FGM/C (Nigeria28 Too Many, 2019; Daly and Carson, 2016), people might have a silent fear for the law, especially

people living in cities. Early-age circumcision is dangerous as it can lead to an increase in underground FGM/C; since the child cannot resist or report her experience. It is a threat to the anti-FGM/C initiatives and requires more research that will lead to evidence-based interventions to stop this practice. Else, such practice could also be an alternative for rural dwellers who might try to preserve their culture, even if it means doing so in secrecy.

As previously explained, literacy is high among women in the urban communities (Orlu LGA) compared to the rural communities (in Ohaukwu LGA) where this study was done (NPC [Nigeria] & ICF International, 2014). Therefore, awareness of the anti-FGM/C campaigns and government warnings might be higher among the residents of the urban communities, thereby instigating them to devise means of keeping to their culture without being caught by the law. It would also appear that with an increase in the awareness of anti-FGM/C activities among rural dwellers, they are now liberal with the age at which FGM/C is performed and are gradually imbibing the idea of early-age FGM/C probably from or like the urban communities. Therefore, it was not a surprise that participants from one of the rural communities said the most important thing is to ensure the girl had FGM/C. These findings agree with the report of Galukande et al. (2015), that in Tanzania, the cutting of young girls under or equal to one year has increased.

This might be a good explanation for the reason behind the report of (NPC [Nigeria] and ICF International, 2014), that SE Nigeria which had the highest percentage (90%) of literate women in the country - with Imo State which has Orlu LGA in it having the highest percentage (87%) of educated women in SE Nigeria, also having 82% of her circumcised women undergoing the procedure before they reached the age of 5 (Nigeria28 Too Many, 2019). This was unlike the other five geographical zones of the country, where majority of the circumcised women had it before or during puberty (NPC [Nigeria] & ICF International, 2014). Thus, a change in trend as regards the age at circumcision occurred in SE Nigeria.

The findings from the current study revealed that another type of FGM/C is now being practiced by some of the participants instead of the seemingly organised FGM/C procedure which involved cutting some flesh from the female genitalia. This new method of FGM/C was reported only by participants in the urban communities. According to them, the new method was a good alternative to the cutting method, as it does not expose the girl to the many health complications associated with FGM/C, but still ensured the clitoris appeared in good shape and size. It therefore appears there is a sense of genital beauty, which the FGM/C practitioners have and wish to achieve for their daughters. This new method of FGM/C was reported in a study by Onyima (2015) in Awka, the capital of Anambra State, SE Nigeria,

where some women during a focus group discussion began to advise and educate other women on the new method. This new method can be likened to Type IV FGM/C, according to the WHO's classification (WHO, 2018). Therefore, there was a change in trend from the cutting methods of FGM/C to a non-cutting method among some of the study participants.

### 6.4. THE FUTURE FOR OUR DAUGHTERS

A critical look into the ages and years in which the participants were circumcised reiterates the practice of FGM/C persists in SE Nigeria. This was because, according to the mothers who could recall the year of their daughter's FGM/C, eight of their daughters had FGM/C between the years 2010 to 2018, while six were cut between 2000 and 2009. The girls interviewed were all circumcised between the years 2009 and 2015, with some of them reporting their younger sisters were circumcised years later. UNICEF and UNFPA (2018) announced a global decline in FGM/C, however, from the findings of this study in SE Nigeria, it would appear that although FGM/C prevalence may have declined globally, the practice persists with no sign of eradication in some African countries. It is likely these communities were among those referred to by UNICEF and UNFPA (2018), where FGM/C persists, and they seem to be having a population boom. This is because a significant percentage of the participants confessed support for the continuation of the practice. Additionally, some of the young women (mean age 28.4) interviewed, have already subjected their daughters to some form of FGM/C, while some boldly said they intend to do it for their daughters; this, despite the heart-rending experiences some of them shared about their FGM/C and the long-term complications, from which some were still struggling. Most of these women also claimed to have had some formal education, which concurs with the report of Ekenze, Ezegwui and Adiri (2013) that in South Eastern Nigeria, most of the women who encourage FGM/C are literate and are aware of some of the dangers of FGM/C.

#### 6.4.1. Factors that Influence the Practice of FGM/C

Several reasons have been documented for FGM/C in literature (Cappa, et al., 2013; WHO, 2018; Obi & Igbinadolor, 2018); however, from the current study, factors identified were relatives, fathers, healthcare practitioners, government warning/anti-FGM/C law and ignorance. These factors are discussed below:

- **Culture:**

According to the study participants and in line with findings from other studies (WHO, 2018; UNFPA and UNICEF Nigeria, 2016; Onuoha, 2018; Edeh, 2017; Yaya and Ghose, 2018), culture is the major reason that has sustained the practice of FGM/C to date. Some practitioners of FGM/C simply claim that FGM/C is their culture and so they adhere to the

practice irrespective of any harm it might have caused them or their loved ones (UNFPA and UNICEF Nigeria, 2016), thus the principle of ethical relativism applies here (Velasquez et al., 1992). People judge behaviours or values to be good based on whether it is acceptable in their community and culture, otherwise, there is no reason why a human being would wilfully support the continuation of what causes obvious pain and harm. This again shows the power of culture/ tradition (Onuoha, 2018). According to UNFPA (2017), even parents from FGM/C practicing communities who live in western countries and are literate spend a lot of money to send their daughters back to their local communities to have FGM/C.

Some of the FGM/C myths and beliefs were more like threats for anyone who refused FGM/C. Of interest, was the report that FGM/C prevents difficult labour and was a type of crucifixion. According to the study participants, this reason explained why uncircumcised pregnant girls and women were circumcised before they gave birth to their babies. This finding is again similar to the report of one participant who was circumcised during pregnancy in a previous study (UNFPA & UNICEF Nigeria, 2016). Unlike the report in UNFPA and UNICEF Nigeria (2016), a participant in the current study, who said she was circumcised during pregnancy, asserted "*… I delivered her myself with the help of my mother. I was strong and fine after the childbirth…*" She therefore attributed her uneventful childbirth experience to the circumcision she had during pregnancy.

Worthy of note was the finding that many of the participants believed FGM/C made the genitals beautiful. This belief was reported also by Siddhanta and Sinha (2016), who stated the procedure is done for aesthetic reasons by some ethnic groups that practice FGM/C. These FGM/C practitioners believe that when the supposedly unclean part of a female's body is removed, it makes her clean and beautiful (WHO 1997).

Furthermore, preventing promiscuity was one of the myths for which FGM/C was done. This report from the participants are in agreement with the claims of Edeh (2017) and Siddhanta and Sinha (2016) that the need to control a woman's sexuality and pleasure was the principal reason for the practice of FGM/C. The practicing communities also believed that a circumcised woman would be less promiscuous and thus more suitable for marriage, since it is presumed, she will be able to be faithful to one husband because she is circumcised. This is because a woman is expected to keep herself only to her husband in order not to bring shame to her father's house, while the man may or may not be faithful to only his wife. Therefore, in a bid to ensure the woman's sexual urges are brought under control, her family circumcises her before she gets married (Bogale, Markos & Kaso, 2015).

Other FGM/C myths and beliefs which were reported by the participants were the fear of the clitoris growing long and large as the girl grows up, the need to prevent genital itching, the belief that FGM/C indicates transition to womanhood, and the fear of giving birth to weak imbecile children and having no progress in marriage if they refuse FGM/C

Even those participants who claimed they did not believe or know of any benefit of FGM/C adhered to this practice. The reason being other people in their communities were doing it, therefore they decided to follow the norm. This confirms the statement by Althaus (1997) that sometimes females desire to conform to peer as well as societal pressure. They accept the practice of FGM/C as a necessary and normal part of their lives. They would rather go through the pains and the outcome of the FGM/C procedure than to feel stigmatized or unaccepted in their community (Abathun, Sundby & Gele, 2016; Setegn, Lakew & Deribe, 2016). This supports the notion that the battle against FGM/C might not be short term. The minds of these FGM/C practitioners have been trained to believe that FGM/C is compulsory for several reasons; therefore, a community-based and convincing anti-FGM campaign is very important to disabuse the minds of these community members about the practice.

- **Fathers:**

Some of the participants reported their fathers were aware of their circumcision as they were in the house the day they were circumcised, though they were not the ones that arranged for the cutting. In line with the reports of Howard and Gibson (2017), the girls' mothers or female relatives arranged for the circumcision without any resistance from the fathers of the girls. This therefore gives the impression that the father permitted or supported his daughter's circumcision. This is similar to the report of Bogale, Markos and Karso (2014), that even if only the mother was present during a girl's circumcision, the father must have facilitated things beforehand.

In a patriarchal country such as Nigeria (Edeh, 2017; Gele, Bø & Sundby, 2013), despite influences and suggestions from a man's wife, relatives or neighbours, a man is seen as the head of his house and ideally has the final say as regard what happens in his home, including the circumcision status of his daughters. Therefore, it will be unlikely that a girl in Nigeria would be circumcised against her father's wish. This provides evidence that for the campaign against FGM/C to be effective in Nigeria, health education of males about FGM/C should be one of the key targets.

- **Circumcised mothers:**

It was clear from the interviews and confirmed by previous studies, that daughters of circumcised mothers and relatives are at the highest risks for FGM/C (Obi and Igbinadolor, 2018). This is because some of the female participants emphasised, they have no problems due to their circumcision, despite saying they were taught that FGM/C is not good during antenatal classes and in the hospital. These circumcised women's daughters could therefore be at a higher risk for FGM/C (Ekenze, Ezegwui & Adiri 2013), since their mothers believe FGM/C caused them no harm.

- **Circumcised relatives:**

It would appear parents are influenced by the decisions of the extended family in bringing up their children. The extended family can insist that a girl be circumcised, and the parents of the girl will yield to that (Ekenze, Ezegwui & Adiri, 2013). These findings support the report of Ekeanyanwu (2017) that Nigeria is a patriarchal society where the extended family is allowed to interfere with a girl's upbringing, including her circumcision status.

- **Government warnings/ anti-FGM/C laws:**

It was also revealed, in line with the findings of the scoping review in Chapter Four, that the anti-FGM/C law had a dual effect as it led to FGM/C being conducted secretly, to an uncertain extent, while some did not do it at all to their daughters due to fear of prosecution. Commencing an anti-FGM/C health education campaign such as recommended above, while enforcing the ant-FGM/C law simultaneously could result in a significant reduction in the practice of FGM/C in these communities.

Meanwhile, some of the statements of the participants created the impression they were secretly in support of FGM/C but did not want to say directly. It appeared they were trying to disregard the possible consequences of FGM/C they had heard and seen. Although the people were aware of their state government warnings against FGM/C, even though the practice was ongoing in their communities, it may not have been easy to say a direct "yes" to the question about one's stand on the continuation of the practice. Similar reports have been documented in literature, where some women's attitudes contradicted their profession about FGM/C possibly after an FGM/C awareness campaign. Galukande et al., (2015) reported how they had an FGM/C self-reported post-intervention prevalence of 69.2%, but when they later did medical examinations, the post-intervention prevalence was over 95%. This shows the weakness of FGM/C reports from participants as they can profess to have agreed to FGM/C abandonment openly, but still be determined to continue the practice.

A community based anti-FGM/C education programme that clarifies all these factors mentioned above and delivered by their own people, such as influential community members and the circumcisers could help the community to understand the facts about FGM/C and so work towards its abandonment. According to Getachew (2006), it is risky to tackle FGM/C with only laws or non-tailored awareness, because if the communities are not convinced about stopping FGM/C, they would continue the practice secretly.

- **Ignorance and confusion:**

Some of the participants mentioned that parents were confused about FGM/C. This implied that if the battle against FGM/C must be won, the need for community- based, detailed FGM/C education/ training for healthcare practitioners and the entire community cannot be over-emphasised. FGM/C education should be tailored in such a way that the people would understand the dangers of FGM/C and how it violates the rights of their daughters, which cannot be over-emphasised. This can be done by organising a training session on FGM/C annually for the healthcare practitioners, followed by radio and television programmes explaining about FGM/C; use of dramas in the media could be advantageous too (Mohamud, Kaba & Tamire, 2017).

It was also evident that the participants were not properly informed about FGM/C, as some likened the practice to male circumcision and thus questioned why the government was only supporting male circumcision. Some of them knew that FGM/C was also practiced by other cultural groups and thus felt convinced that FGM/C was not bad after all. It would appear that the anti-FGM/C teaching in these communities was not tailored to answer the questions and dissuade the fears of these communities about FGM/C, therefore the people resisted the anti-FGM/C activities as an infringement of their cultural rights and their rights as women. The adoption of the new method by some of the community members may imply the people would not just hold onto any practice that will harm them because it was a culture, rather they were willing to modify, and if need be, abandon any practice which they were convinced caused harm, whether or not rooted in culture. The words of one of the participants supports this statement: "…*the reason why we do male circumcision is the same reason why we do female circumcision …the government and you young people want to turn the world upside down…*"

- **Healthcare practitioners:**

The healthcare practitioners reported that they as residents, with the majority being indigenes of the study communities, were FGM/C practitioners until the current government

of their states began to threaten to prosecute anyone caught doing FGM/C (Eze, 2017). It can therefore be said that medicalisation of FGM/C was routine until the anti-FGM campaigns and warnings by their state governments. This agrees with the findings of the reality of medicalisation of FGM/C in Nigeria (Okeke, Anyaehie & Ezenyeaku, 2012). According to Cahoon,(nd), the state governments of Imo and Ebonyi State, as at the time of this data collection (November 2018 to April 2019) came into power on May 29th, 2011 and May 29th, 2015 respectively. This has resulted in an increase in awareness about ending FGM/C and also reducing medicalisation of the practice, although there is no known report of anyone being arrested for FGM/C in SE, Nigeria (Nigeria28 Too Many, 2019).

These healthcare practitioners reiterated they have joined the government in its campaign against FGM/C by teaching the community women to stop FGM/C. However, some of the participants could not give explanations as to why FGM/C should be stopped, except that the government was threatening to punish anyone reportedly doing the practice. Some of them said they encouraged the community women to imbibe the new method of FGM/C, which does not involve removing flesh, while some boldly declared they still support FGM/C and even do it for various families who request it.

It is important to note the healthcare practitioners who declared their support for the continuation of FGM/C mentioned they do not perform the procedure in the health facilities anymore, but rather go to the houses of the clients on invitation. Also, some participants who declared no support for the continuation of the practice, vehemently defended and explained how FGM/C was not a problem; and that they had successfully performed the procedure for their daughters too. This gives an insight into the possibility that if the statistics about secretly done FGM/C cases in these communities are to be revealed, there may not be much difference in the current prevalence when compared to before the government began warning against it. It provides evidence to the statement by Mr. Ljungqvist in Getachew (2006) that legal processes alone will only result in an increase in FGM/C being done secretly.

The findings about the individual opinion of the healthcare practitioners about FGM/C also revealed these participants did not have proper understanding about FGM/C and were not convinced about the need to end the practice. Thus, they were mostly trying to obey the government who is their employer by not conducting FGM/C in the health facilities, however, they may never be able to convince their own families, never mind the community dwellers, to stop FGM/C. To solve this predicament, there is need for well-tailored education on

FGM/C for the healthcare practitioners in SE Nigeria with the aim of convincing them about the need to end FGM/C in their various communities.

### 6.4.2. Challenges to High quality care of Circumcised Females

It was evident that most of the healthcare practitioners were natives of the study communities, or nearby communities, and residents of the study communities for over one year, hence they were not foreigners to the lifestyle, beliefs and culture of these communities. According to Beach, Saha and Cooper (2006), cultural barriers between health care providers, patients and communities can result in an ineffective delivery of health care services to the patient or community. Therefore, healthcare practitioners need to have a good understanding of the cultural background of their clients to be able to render high quality health services to them. These healthcare practitioners being insiders in the community could be useful agents to bring about positive change and put a stop to harmful practices like FGM/C in these communities.

The practice of FGM/C has been recognised as a culture that has lasted for ages and is highly revered by the practitioners (Getachew, 2006). A similar situation also found in the study communities in South-East Nigeria in so much that almost all the healthcare practitioners were circumcised themselves and many reported that almost all the women who presented at the health centre were circumcised, while some participants reported that throughout their years of practice, they had never assisted an uncircumcised woman in childbirth. It can therefore be said that FGM/C is highly prevalent in these communities of SE Nigeria (NPC [Nigeria] & ICF International, 2014; Nigeria28 Too Many, 2019).

It was also evident that the increase in awareness about stopping FGM/C, although good, led to some modifications in the age of circumcision, and procedure for FGM/C, while also leading to the practice being done in secrecy in so much that the practitioners rarely presented complications resulting from FGM/C for proper management to the healthcare practitioners, nor sought counselling on any issue relating to FGM/C. This situation is not new to SE Nigerian communities, as a similar report has been published by Onyima (2015) about infant FGM/C and the new FGM/C method in SE Nigeria. Galukande et al., (2015) reported an increase in infant FGM/C in Tanzania, while Mr. Ljungqvist in Getachew (2006), opined that if people were not convinced about stopping FGM/C, they would continue with the practice in secrecy. Thus, the need for a community-based initiative to end a culturally rooted practice like FGM/C cannot be over-emphasised.

Fortunately, the press statement by UNICEF and UNFPA (2018) emphasised the need for initiatives that would accelerate the success in eradicating FGM/C. According to them, we do not have to continue with the current pace and watch as FGM/C eradication in persistent communities progresses sluggishly, because many more females will become victims of FGM/C if the current progress rate is maintained (UNICEF & UNFPA, 2018). Hence, a need for an approach to come from within the FGM/C practicing communities to end the practice cannot be over-emphasised. Healthcare practitioners in these communities could be the agents of change that cause the community to reach a consensus by themselves never to practice FGM/C for reasons they understand and believe in. Here in lies another benefit of this study on the FGM/C experiences of the healthcare practitioners and not just medicalisation or knowledge of FGM/C in these communities. To the best of the researcher's knowledge, this study is the first ever done on the FGM/C experiences of healthcare practitioners in FGM/C practicing communities in Africa.

Although some health challenges were reported to be associated with FGM/C by some of the female participants, and discussed under "life after FGM/C above," these reports, in addition to those given by the healthcare practitioners, reiterated the accuracy of many previous FGM/C studies including that of WHO (2018) that there are many health problems associated with FGM/C. Based on the findings of this study, FGM/C places a woman and her baby at a high risk for morbidity and mortality during childbirth as it highly predisposes her to intra-partum haemorrhage, PPH, prolonged labour, high risk for infections, VVF and so much pain during and after childbirth. These findings are in tandem with the reports of UNFPA and UNICEF Nigeria (2016), that FGM/C has a direct impact on maternal and neonatal mortality and places women at a 70% higher chances of PPH and double the chances of death from childbirth complications.

According to the study participants, it was almost the norm that they must give episiotomy and prepare for a tedious suturing of the genitalia for most women who came for child birth. Thus, much skill is required to be able to assist genitally mutilated females during and after childbirth. This calls for the need for a contextualised health education pamphlet to ensure efficient and standardised rendering of care to these genitally mutilated women. This health education pamphlet should be made available and explained to the healthcare practitioners, while the prospective healthcare practitioners must be taught how to use it efficiently to ensure effective care is rendered to these genitally mutilated females before they are authorised to render independent care to the communities.

Having reported that many of the healthcare practitioners in these communities were unskilled; with many not being able to explain why FGM/C should be stopped, these healthcare practitioners reported that some women in the communities had so much flesh removed from their genitals that they found it hard identifying the different parts while rendering health care services to the women. They therefore requested for update training and an increase in the number of skilled healthcare practitioners so that they could render efficient and high-quality health services to the communities. These services included health education, counselling, advocacy, effective referral services and management of minor ailments and complications related to FGM/C. These services are necessary in the bid to end FGM/C in these communities, since from our study and in agreement with previous studies (Obi & Igbinadolor, 2018; Onyima, 2015), girls are very likely to undergo FGM/C if their mothers are genitally mutilated.

There were several reports of child mortality due to uncontrollable haemorrhage following FGM/C, and of mortality due to childhood HIV/AIDS infection from FGM/C in these communities. These findings again gave an insight into the possible increase in neonatal and childhood death in these communities, if this move for infant FGM/C, together with FGM/C going into hiding is allowed to continue. Therefore, the call by UNICEF and UNFPA (2018) on the need for approaches that would bring about a faster eradication of FGM/C cannot be over-emphasised.

Furthermore, the advice by some of the study participants about providing alternative sources of income for the traditional circumcisers, combined with creating increased understanding on the need to stop FGM/C, while enforcing the anti-FGM/C, appears to be a great initiative in the fight to hasten the eradication of FGM/C in these communities and the world.

### 6.5. SUMMARY OF CHAPTER SIX

This chapter presented discussions of findings on the FGM/C experiences of females and their healthcare practitioners in SE Nigeria. It discussed the evidences that FGM/C was culturally embedded, and rationalisation was used to excuse the practice and the associated complications. Projection was also used as the participants told the stories of “other” females who had complications from their genital mutilation to reflect on how bad it was for them, but not for the self. Also, the participants who opposed the practice did so because of the government’s warnings against FGM/C, and not because of personal conviction. Furthermore, the participants lacked knowledge about the anatomy of the female genitalia, and strived for what they perceived as beauty by removing “excess flesh,” while the majority

of them equated male circumcision to FGM/C. The perceived benefits of FGM/C included genital beauty, chastity, marriageability and easy childbirth, while the complications included haemorrhage, infection, keloids and scar formation, vesico-vaginal fistula and childbirth related problems leading to life long suffering.

The next chapter discusses the development of the information leaflet for genitally mutilated females based on the conclusions drawn from Phases 1 and 2 of this study.

# CHAPTER SEVEN

# DEVELOPMENT OF A HEALTH EDUCATION PAMPHLET FOR GENITALLY MUTILATED FEMALES

## 7.1. INTRODUCTION

The previous chapter presented the discussion and interpretation of the findings on the FGM/C experiences of females and healthcare practitioners in SE Nigeria. This chapter refers to the fourth objective and the third phase of the study. It involved the development of the health education pamphlet (HEP) for genitally mutilated females based on the conclusions drawn from Phases 1 and 2 of this study. To achieve this, a methodological triangulation of the findings of the scoping review (Phase 1) and qualitative descriptive study (Phase 2) was done. An outline of the conclusions drawn from Phases 1 and 2 of the study were presented, categorised and then clustered into synthesised findings. Finally, in response to the synthesised findings, a contextualised health education pamphlet (HEP) was developed for use by the genitally mutilated females to make the future better for all. Refer to **Figure 7.1** for a quick view of the process of conducting this chapter.

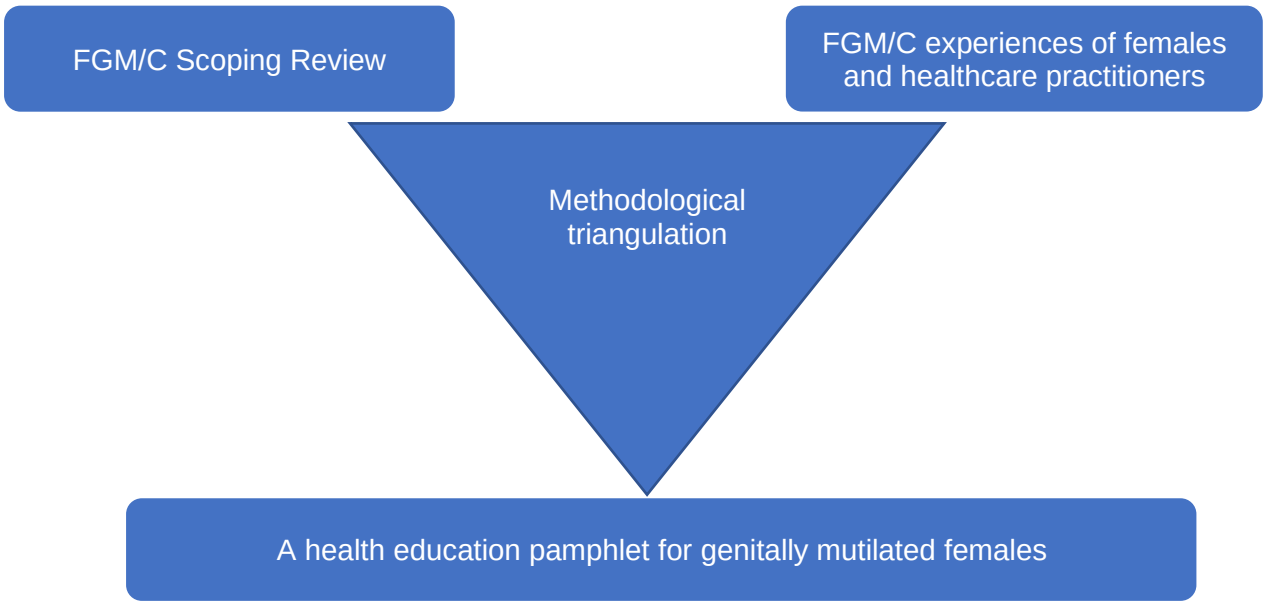



**Figure 7.1. A quick presentation of the third phase of the study**

## 7.2. OUTLINE OF CONCLUSIONS FROM PHASES ONE AND TWO OF THIS STUDY

To achieve the overall objectives of this study as outlined in the first chapter, the whole study was divided into three phases. The first phase referred to the scoping review on FGM/C in Africa, the second phase referred to describing the FGM/C experiences of genitally mutilated females and the healthcare practitioners while the third phase referred to the development of

a health education pamphlet (HEP) for use by the genitally mutilated females. To achieve this third phase, conclusions drawn from the first two phases of this study were presented.

### 7.2.1. Conclusions from Phase 1: A Scoping Review of FGM/C in Africa

Phase 1 of this study was a scoping review on FGM/C in Africa from 1 January 2007 to 31 December 2016. Conclusions drawn from the scoping review were:

- There was a limited number of studies conducted in countries reported to have high FGM/C prevalence.
- Studies investigating the experiences of all the role-players in this practice of FGM/C and how to prevent it were absent.
- FGM/C was associated with several complications.
- Evidence was found that illustrated FGM/C was widely practiced in Africa, despite interventions such as anti-FGM/C laws and campaigns.
- There might have been a recent increase in early age FGM/C.
- Interventions, such as anti-FGM/C laws and awareness campaigns against FGM/C, had both positive and negative effects.
- Cultural influences were the highest determinants of FGM/C, followed by a lack of knowledge.
- Other socio-cultural reasons/myths that motivated the continuation of the practice were, the rite of passage from girlhood to womanhood, religion, safeguarding virginity and fear of the clitoris being similar to the male penis.
- FGM/C was perceived by the practitioners as giving a good and acceptable body image
- Families, in a bid to meet their societal demands or traditions, while still protecting the health of their girls and women resort to medicalisation.

### 7.2.2. Conclusions from Phase 2: FGM/C Experiences of Females and their Healthcare Practitioners

Phase 2 of this study referred to the FGM/C Experiences of Females and Healthcare Practitioners in South Eastern, Nigeria. There were four non-sequential stages in this phase: in-depth interviews of genitally mutilated women, in-depth interviews of genitally mutilated girls, in-depth interviews of mothers of genitally mutilated girls and in-depth interviews of healthcare practitioners. Conclusions drawn from each stage of Phase 2 are outlined:

**Conclusions from the in-depth interviews of genitally mutilated women**

- Most of the participants were not sure of what was removed from them during FGM/C, and therefore might not know about the anatomy of the external female genitalia.
- The practice of FGM/C has its roots in their culture.
- Some myths surround the practice.
- In order to ensure adherence to the culture, some of the participants were forcefully circumcised.
- Some of the participants were circumcised when they were too young to recall their experiences.
- Fathers were in support of their circumcision.
- The cutting was painful.
- Some of them said their wounds healed without any treatment while some had some herbal treatment applied to their wounds to facilitate healing.
- Both those who had FGM/C at a very young age and those who had it at a later age in life attributed sexual problems and negative childbirth experiences to FGM/C.
- Despite being aware of the anti-FGM/C warnings by their state governments, some of the participants had already subjected their daughters to the practice, while some said they planned to have their daughters cut.
- Various categories of circumcisers conducted the FGM/C.
- More participants supported the continuation of FGM/C than those who said they want FGM/C to stop.
- Ignorance was one of the factors that influenced the practice of FGM/C in these communities.

**Conclusions from the in-depth interviews of genitally mutilated girls**

- Most of the participants did not know what was removed from them during FGM/C
- FGM/C was their culture
- The practice was surrounded with beliefs of which some appeared to be threats for those who refused the practice and benefits for undergoing the procedure.
- Participants were not allowed to decide if they wanted to undergo the procedure neither were they given a briefing on the procedure before it was done.
- They underwent the procedure in obedience to their parents' choices for them.

- They were circumcised by various categories of people which included traditional circumcisers, relatives and healthcare practitioners.
- Some of the participants were forcefully circumcised.
- Feelings of fear, uncertainty and helplessness were experienced.
- FGM/C was painful.
- Fever, recurrent infections on the circumcision site and ill health after FGM/C were reported by some participants, while some used projections as they told stories of how FGM/C other girls negatively, but not for themselves.
- FGM/C is ongoing in these communities
- Peer pressure, circumcised mothers, circumcised relatives, fathers and some healthcare practitioners were the perpetuators of FGM/C in these communities.

**Conclusions from the in-depth interviews of mothers of genitally mutilated girls**

- FGM/C is ongoing as many daughters were circumcised in recent years.
- Many of the mothers did not know what was removed from their daughters during FGM/C.
- FGM/C is deeply rooted in culture and traditional beliefs.
- There was evidence of modifications in the age at which FGM/C is done, method of doing FGM/C and the care of the girls after FGM/C procedure.
- All the participants were aware of the anti-FGM/C warnings by their state governments and the teaching from some of the healthcare practitioners.
- Some of the participants expressed unhappiness about the anti-FGM/C activities.
- The participants equated FGM/C to male circumcision.
- Some of the participants advocated for and practiced the new method to avoid being prosecuted under the anti-FGM/C law, while some advocated for the new method because they believed it might not cause some of the FGM/C related complications, but still makes the clitoris to have a “good” shape.
- Majority of the participants supported the continuation of FGM/C for reasons such as culture and other perceived benefits/myths about FGM/C.

**Conclusions from the in-depth interview of the healthcare practitioners**

- FGM/C is part of cultural practices and have been in existence for many years.
- Almost all the women in the study communities were circumcised.
- Most of the healthcare practitioners were circumcised.
- FGM/C was previously conducted when the girls reached the age of marriage but is now done during infancy

- They equated FGM/C to male circumcision.
- Some of the participants indicated they used to do FGM/C before but have stopped since the government began to campaign against it.
- Factors like culture, circumcised mothers, quest for genital beauty, myths and ignorance promoted the practice of FGM/C.
- FGM/C was ongoing secretly despite government warnings against it.
- Some of the participants were in support of various forms of FGM/C, while some said that they want FGM/C to be stopped because the government is warning against it, and not because of their personal conviction.
- Most of the women who presented at the health facilities were circumcised.
- Advanced skills are needed to be able to render efficient health care to genitally mutilated females due to their high risk for morbidity and mortality, especially during childbirth.
- Childhood morbidity and mortality due to FGM/C were reported.

### 7.3. METHODOLOGICAL TRIANGULATION OF CONCLUSIONS

According to Fusch, Fusch & Ness (2018), methodological triangulation is the most frequently used triangulation method, and is often confused with data source triangulation. Methodological triangulation refers to the employment of multiple data collection techniques to study a single problem (Konecki, 2008) and has been found to be beneficial in providing confirmation of findings, more comprehensive data, increased validity and enhanced understanding of the studied phenomenon (Bekhet & Zauszniewski, 2012). Therefore, to be able to triangulate the conclusions drawn from the Phases 1 and 2 of this study, deductive reasoning was utilised to cluster conclusions and so generate statements that adequately represented each cluster. According to Bradford (2017) inductive reasoning refers to making broad generalisations from specific observations, while deductive reasoning refers to starting out with a general statement to reach a very logical conclusion.

Three synthesised findings were generated from the methodological triangulation of the conclusions from Phases 1 and 2 of the study:

- FGM/C: Past and present situations.
- Factors that sustained FGM/C.
- Health information needs.

A table illustrating the conclusions that were clustered under the first two synthesised findings is presented in **addendum 19**

### 7.4. HEALTH INFORMATION NEEDS

The deductive analysis of these aggregated conclusions revealed there was a gap in some basic health knowledge among the study participants. Some conclusions from the phases were that:

- The participants lacked knowledge about the anatomy of the female external genitalia and so strived for what they perceived as beauty by removing the “excess flesh.”
- The participants lacked knowledge of the difference between male and female circumcision.
- Some sexual and health problems were attributed to FGM/C for which the genitally mutilated females suffering those complications would need knowledge on how to improve their self-care.

According to Abdulcadir, Rodriguez and Say (2015), as important as identifying effective policies and interventions to eliminate FGM/C is, there is a need for evidence on how to minimise negative health outcomes for women living with FGM/C. Therefore, in response to these evidences, the researcher decided to develop a “culturally safe” and contextually appropriate health education pamphlet (HEP) that would inform the FGM/C practicing communities on what FGM/C was about, self-care following FGM/C and what to do when they are under pressure to circumcise their daughters. The HEP would be displayed where members of the communities could easily pick it for themselves or to give others. The researcher believes that cultural change takes time and requires an approach that includes building trust with women from FGM/C practicing communities, and also requires contextualised education in-addition to legal measures (Singbeil, 2015).

Furthermore, a health education pamphlet for circumcised females in Africa, Nigeria or SE Nigeria was found neither on the internet nor by manual searches. These were therefore the reasons for the development of the HEP for circumcised females.

### 7.5. DEVELOPING A HEALTH EDUCATION PAMPHLET (HEP) FOR CIRCUMCISED FEMALES

There is an undisputed need to provide the clients in the health care industry with high quality, contextualised and accurate information (Duman, 2003). This has the potential to not only be beneficial for the people, but also for health care practitioners (Duman, 2003), as it encourages good self-care practices and empowers them to make informed decisions about themselves and their loved ones. Health literacy helps people to protect and improve their

health, as well as navigate services and environments, and thereby participate actively in managing their health (Health Service Executive (HSE) Health Promotion Unit and National Adult Literacy Agency (NALA), 2010).

A good HEP addresses risk factors and other underlying determinants of health, thereby reducing the burden of preventable health challenges on society. It must be up-to-date (with the next date for review stated), contextualised, acceptable, culturally safe and easy – to – read and comprehend by the target readership. According to Ley (1992), if communication is to be effective, it must be noticed, read, understood, believed and remembered. According to (National Health Scheme (NHS) Forth Valley, 2003), benefits of HEP include:

- it can give more details than you can give verbally
- it can be kept for future reference
- people can share the information with their family, significant others and friends
- it helps ensure that each patient gets the same information

However, despite these benefits of a HEP, it is necessary to emphasise that HEP does not replace verbal discussion, counselling, health education and clarifications that healthcare practitioners give to the clients.

It has been documented that culture affects how people understand and respond to health information. According to Betsch et al. (2016), congruency between the recipient's cultural characteristics and the respective message will increase the communication's effectiveness especially for very sensitive and complex issues like FGM/C. Therefore, in the development of the HEP for the circumcised females in SE Nigeria, FGM/C was referred to as "female circumcision." This was because the study participants did not only practice the cutting method but were gradually adopting the non-cutting methods. Also, their native word for FGM/C is "ibi ugwu" which when translated verbatim means "circumcision."

Furthermore, even though the researcher observed that the communities where the study was done were conservative, as they rarely discuss issues about the female external genitalia, she still included the diagram of the external female genitalia (vulva) in the HEP. This was because of the evidence that most of the females in FGM/C practicing communities do not know what was removed during their own or their daughters' cutting. The HEP will be validated before implementation. It is hoped that during the validation, it will be subjected to face and content validity by experts and the study participants, and then modified in line with the outcome of the validation exercise.

Besides cultural issues, the general information of the genitally mutilated females in the second phase of this study, as well as published evidence on the literacy of communities in SE Nigeria revealed that most of the people in SE Nigeria have at least completed primary school education (six years) (NPC [Nigeria] & ICF International, 2014). The HEP was therefore written in plain every-day English language, with the words carefully chosen to communicate respect, encouragement and clarity to the recipients. Also, the font “Arial” size “14” was used in typing the HEP to ensure easy reading (National Health Scheme (NHS) Forth Valley, 2003). The HEP would be translated into Igbo language, which is the language of the cultural group of people in SE Nigeria, to ensure effective communication of the message.

### 7.5.1. A Health Education Pamphlet (HEP) For Circumcised Females

The title of the HEP was “The Circumcised Female” and had six main headings. The main headings of the HEP are presented below and a sample is attached in **Addendum 20**.

- Key message.
- The beautiful female body.
- What is female circumcision?
- Difference between male and female circumcision.
- Dangers of female circumcision.
- Now that you are circumcised.

The HEP will be tested for readability, peer reviewed, pilot-tested and adapted for possible dissemination in future studies.

## 7.6. SUMMARY OF CHAPTER SEVEN

Chapter Seven discussed the development of the HEP for genitally mutilated females and presented the contents of the HEP. The next chapter will present the limitation, recommendation and conclusion of the study, including the researcher’s reflection on her experience of conducting this study.

# CHAPTER EIGHT

# LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

## 8.1. INTRODUCTION

The previous chapter presented the development of the HEP for circumcised females. This chapter presents an evaluation of the overall study by discussing the justification of the study, outlining the limitations; and offers recommendations for management and policy makers, nursing education and practice, and for further research. Finally, the researcher's reflection and the conclusion were provided.

## 8.2. LIMITATIONS OF THE STUDY

Despite several steps taken to ensure high validity for the study, like using multiple methods and multiple data sources, various limitations were identified in addition to the limitations of the scoping review already stated in Chapter Four of the study. These limitations were:

- The qualitative enquiry was conducted in communities of two local government areas (one rural and one urban) in two states of SE Nigeria which were reported to have the highest prevalence of FGM/C in SE Nigeria. Therefore, the results of this study cannot be generalised to all the communities in Nigeria.
- The Health Education Pamphlet (HEP) for the genitally mutilated females is still informal. It still needs to be tested for readability, peer - reviewed and pilot tested before it can be disseminated to the intended recipients as a formal information leaflet.
- In addition, since this study was intended for degree purposes, the researcher, who is a student, developed the HEP individually. Therefore, input from a specialist team, the genitally mutilated females and healthcare practitioners should be obtained before the final draft of the HEP is developed.
- Furthermore, the discussions and interpretations in this study might not reflect the only truth about the FGM/C experiences of females and healthcare practitioners in SE Nigeria, as there could be multiple interpretations of the raw data.
- Although the researcher believes that a rigorous process was followed in terms of the translation of the interviews, back translation which is the translation method used by many researchers (Maneesriwongul and Dixon, 2004; Chen and Boore, 2010) was not followed.

## 8.4. RECOMMENDATIONS

In line with the findings and limitations of this study, the following recommendations were formulated for management and policy makers, nursing education and practice, and further research.

### Recommendations for management and policy makers

The following suggestions were made for the management and policy makers:

- Since many of the participants reported they were forcefully circumcised, creating a safe place where girls at risk of FGM/C could report their suspicions might save some girls from experiencing rejection, which might happen if they refuse FGM/C.
- Since it was reported that fathers were in support of the FGM/C for their daughters, including males in the health education campaigns on FGM/C might have a positive impact in the fight against FGM/C.
- The anti-FGM/C crusaders should not only talk about the long and short-term consequences of FGM/C but emphasise to the FGM/C practitioners that FGM/C violates the rights of the female child. Our study revealed that the quest to avoid the possible health challenges from FGM/C contributed to the modification of the method of FGM/C and encouraged medicalisation of the practice. Some of the participants reported they do not have problems due to their FGM/c status and some can allude the cause of their complications to other things.
- Having identified the factors that perpetuate FGM/C, girls at risk (especially daughters of circumcised women) should be identified and followed-up with, to ensure they are not forced to undergo FGM/C.
- Organising a detailed training session on FGM/C (which also clarifies the beliefs about consequences for an uncircumcised girl) annually for the healthcare practitioners followed by a routine radio and television programmes explaining about FGM/C might be helpful in the fight against FGM/C; use of dramas in the media could be advantageous too especially when these are combined with effective implementation of the anti-FGM/C laws.
- It might be helpful if children are taught about FGM/C in school and the teachers equipped with the knowledge on how to identify uncircumcised girls that are at risk of FGM/C, as well as the steps the teachers would take in order to help such girls. A similar approach was reported by (Female genital mutilation: Children to be taught dangers - BBC News, 2019), which described a plan to include FGM/C in school curriculum in England. A similar plan could be considered in Nigeria.

- There might be a need to investigate the possible rise in early-age FGM/C in the communities.
- It might be necessary to evaluate the implementation of the anti-FGM/C law and campaigns
- As suggested by the healthcare practitioners, providing an alternative source of income for the traditional circumcisers could contribute to ending the practice of FGM/C.

**Recommendations for nursing education and practice**

The following suggestions were made for nursing education and practice:

- This study provided evidence that FGM/C puts women and children at high morbidity and mortality risks. Therefore, the need for trained midwives in communities where FGM/C is prevalent cannot be over-emphasised.
- Inclusion of FGM/C courses in the curriculum for nurses and midwives-in-training is recommended.
- Genitally mutilated women who give birth to baby girls should be counselled on the need and how to ensure their daughters are not put through FGM/C, and followed-up to ensure compliance.
- In addition, there is a need for well-tailored training and re-training sessions on FGM/C for the healthcare practitioners in SE Nigeria with the aim that they will get convinced of the need to end FGM/C in their various communities. They can become effective arsenals to champion the stopping of FGM/C in their various communities.

**Recommendations for further research**

The following suggestions were made for further research:

- Before the dissemination of the HEP, it needs to be peer - reviewed and the pilot tested to ensure it is acceptable, readable, and comprehensible, and as well passes on the intended information to the recipients.

- Since the study was contextual, further investigation is required to determine if the HEP can be transferred to FGM/C practitioners in other communities.
- There is need for more studies on the prevalence of FGM/C based on clinical observations, as this will throw more light on the outcome of the many efforts into ending FGM/C and guide effective channelling of the available resources to end FGM/C.

## 8.5. CONCLUSIONS

This study investigated the FGM/C experiences of females in SE Nigeria and the experiences of the healthcare practitioners who care for these females and developed a comprehensive HEP for the genitally mutilated females. To achieve this aim, the study was divided into three phases, which included a scoping review on FGM/C in Africa, in-depth interview of the genitally mutilated females and their healthcare practitioners in SE Nigeria, and finally the development of the health education pamphlet (HEP) using the evidence from the first scoping review and interviews. Evidence found revealed that FGM/C was ongoing in some communities in Africa of which communities in SE Nigeria are part of. The FGM/C practitioners equated FGM/C to male circumcision and reported that the culture was the major reason why the practice has continued over the years. Despite the severe pain associated with the practice, some of the study participants were forcefully circumcised to ensure adherence to this culture. Feelings of uncertainty, fear and helplessness were commonly reported among the girl participants. The healthcare practitioners reported lack of skilled staff and adequate training on FGM/C as advanced skills are required in the care of genitally mutilated females, especially during childbirth. Cases of child mortality and other healthcare challenges due to FGM/C were also experienced. In response to this evidence, a HEP was therefore developed to inform the genitally mutilated females on what FGM/C was about, self-care after FGM/C and what to do when they are under pressure to circumcise their daughters.

## 8.6. RESEARCHER'S REFLECTION ON HER EXPERIENCE

According to Helyer (2015) reflection is associated with "looking back" and examining the past in order to learn from what happened and not repeat mistakes. It is also a learning process which involves revisiting one's thoughts, feeling or actions after an encounter with an event, with the purpose of making sense of the experience (Boud, Keogh & Walker, 2013). Therefore, I would like to look back at my experiences in order to learn from what happened and make sense of my experience.

When I was drafting the proposal for this study, having read articles about FGM/C, I had the impression the FGM/C practitioners would be mostly illiterate and consist of the very poor part of the society who had no access to the internet, and so continued with such practice as FGM/C. I also thought the females would be emotional about discussing a painful practice, and so may not even agree to participate in the study; so I indicated the need for a counsellor in case any participant became emotional.

When I went for data collection, I realised many of these FGM/C practitioners had basic education, and so could read and write. Some of the younger women and girls had phones with internet access and some even had tertiary education; they were bold and some even laughed during the interviews. Some defended the practice vehemently and even spoke as if they were preaching to me about FGM/C and its benefits. However, having been educated on good interviewing skills, I played along with them, laughed when they did and let them feel as experts of their experiences. These females do not see themselves as victims or people to be pitied even when they shared some painful experiences about their FGM/C. They lived their lives happily and expressed much hope for the future. This experience built in me a greater sense of respect and admiration for these females and re-emphasised the need of being non-judgemental in action or words when conducting a research.

The healthcare practitioners were the ones who helped me to recruit the initial study participants. However, I felt disappointed when they later refused to be interviewed and some of them who agreed after explanations on the anonymity of the interviews, refused to respond to some probes. I later realised the healthcare practitioners were exercising their autonomy and I was not prepared emotionally for the refusal from them since I was their colleague. Given a similar situation in future, I now believe that emotional preparation before data gathering is the tool to handle such situations, irrespective of the group of people who will be the participants.

**REFERENCES**

Abathun, A.D., Sundby, J. & Gele, A.A. 2016. Attitude toward female genital mutilation among Somali and Harari people, Eastern Ethiopia. Int J Womens Health 8, 557–569. doi:10.2147/IJWH.S112226.

Abduladir, J., Margairaz, C., Boulvain, M. & Irion, O. 2011. Care of women with female genital mutilation/cutting. Swiss Medical Weekly. 140:13137. Doi:10.4414/smw.2011.13137. ISSN 1424-3997. OMID 21214149.

Abdulcadir, J. & Rodriguez, M.I. Say, L., 2015. Research gaps in the care of women with female genital mutilation: an analysis. *BJOG:* An International Journal of Obstetrics & Gynaecology, 122(3), pp.294–303.

Achia, T.N., 2014. Spatial modelling and mapping of female genital mutilation in Kenya. BMC Public Health 14, 276. doi:10.1186/1471-2458-14-276.

Akinsanya, A. & Babatunde, G., 2011. Intergenerational attitude change regarding Female Genital Cutting in Yoruba speaking ethnic group of Southwest Nigeria: A qualitative and quantitative enquiry. Electronic Journal of Human Sexuality 14.

Ako, M.A. & Akweongo, P., 2009. The limited effectiveness of legislation against female genital mutilation and the role of community beliefs in Upper East Region, Ghana. Reproductive Health Matters 17, 47–54. doi:10.2307/40647445.

Ali A. A. 2012. Knowledge and attitudes of female genital mutilation among midwives in Eastern Sudan. Reproductive Health. 2012;9:23.

Althaus, F.A., 1997. *Female Circumcision: Rite of Passage Or Violation of Rights?* [online] Guttmacher Institute. Available: https://www.guttmacher.org/journals/ipsrh/1997/09/female-circumcision-rite-passage-or-violation-rights [accessed 25.1.19].

Aluko, J.O., Anthea, R. & Marie Modeste, R.R., 2019. Manpower capacity and reasons for staff shortage in primary health care maternity centres in Nigeria: a mixed-methods study. *BMC Health Services Research*, 19(1), pp.10.

Arksey, H. & O'Malley, L., 2005. Scoping studies: towards a methodological framework. International Journal of Social Research Methodology, 8(1), pp.19–32.

Aromataris, E. & Munn, Z., 2017. *Joanna Briggs Institue Reviewer's Manual*. Available: https://wiki.joannabriggs.org/display/MANUAL/2.4+The+JBI+Approach+to+qualitative+synthesis [accessed 22.5.19].

Askew, et al. 2016. A repeat call for complete abandonment of Female Genital Mutilation. Journal of Medical Ethics. 42(9):619-620. doi:10.1136/medethics-2016-103553. ISSN 0306-6800. PMC 5013096. PMID 27059789.

Bailey, R.C., Moses, S., Parker C., Agot, K., Maclean, I., Krieger, J. et al. 2007. Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomized controlled trial. Lancet 369 (9562):643-656. http;//doi.org/10.1016/so140-6736(07)60312-2. [accessed 6.16.18].

Banerjee, A. & Chaudhury, S., 2010. Statistics without tears: Populations and samples. Industrial Psychiatry Journal, 19(1), pp.60–65.

Beach, M.C., Saha, S. & Cooper, L.A., 2006. *The role and relationship of cultural competence and patient-centeredness in health care quality*. Commonwealth Fund New York, NY.

Bekhet, A.K. & Zauszniewski, J.A., 2012. Methodological triangulation: An approach to understanding data. *Nurse researcher*. 20(2), pp. 40-43. https://epublications.marquette.edu/cgi/viewcontent.cgi?article=1395&context=nursing_fac

Bengtsson, M., 2016. How to plan and perform a qualitative study using content analysis. NursingPlus Open, 2, pp.8–14.

Berg, R.C. & Underland, V. 2014. Immediate health consequences of female genital mutilation/cutting (FGM/C). Oslo: Norwegian Knowledge Centre for the Health Services (Kunnskapssenteret), 8 (2014):837-859. ISBN 978-82-8121-856-7. ISSN 18901298. PMID 29320014.

Berggren, V., Abdel Salam, G., Bergstrom, S., Johansson, E. & Edberg, A.K. 2004. An explorative study of Sudanese midwives' motives, perceptions and experiences of re-

infibulation after birth. Midwifery, 20:299-311.

Betsch, C., Böhm, R., Airhihenbuwa, C.O., Butler, R., Chapman, G.B., Haase, N., Herrmann, B., Igarashi, T., Kitayama, S., Korn, L., Nurm, Ü.-K., Rohrmann, B., Rothman, A.J., Shavitt, S., Updegraff, J.A. and Uskul, A.K., 2016. Improving Medical Decision Making and Health Promotion through Culture-Sensitive Health Communication: An Agenda for Science and Practice. Medical Decision Making, 36(7), pp.811–833.

Biglu, M.-H., Farnam, A., Abotalebi, P., Biglu, S. & Ghavami, M., 2016. Effect of female genital mutilation/cutting on sexual functions. Sexual & Reproductive Healthcare, 10, pp.3–8.

Birbili, M. 2000. Translating from one language to another. Social Research Update, 31 (Winter). Retrieved from http://sru.soc.surrey.ac.uk/SRU31.html.

*Blench, R. 2014. An Atlas of Nigerian Languages. Oxford: Kay Williamson Educational Foundation.*

Bogale, D., Markos, D. & Kaso, M., 2014. Prevalence of female genital mutilation and its effect on women's health in Bale zone, Ethiopia: a cross-sectional study. BMC Public Health 14, 1076. doi:10.1186/1471-2458-14-1076.

Bogale, D., Markos, D. & Kaso, M., 2015. Intention toward the continuation of female genital mutilation in Bale Zone, Ethiopia. Int J Womens Health 7, 85–93. doi:10.2147/IJWH.S74832.

Bonino, E. 2012. Banning Female genital mutilation. UN resolution, 20 December 2012.

Boud, D., Keogh, R. & Walker, D., 2013. *Reflection: Turning experience into learning*. Routledge.

Bradford, A., 2017. *Deductive Reasoning vs. Inductive Reasoning*. Available: https://www.livescience.com/21569-deduction-vs-induction.html [accessed 24.5.19].

Brink, H. 2007. Fundamentals of research methodology for health care professionals. 2nd edition, Cape Town; Juta.

Budiharsana, M. 2004. Female circumcision in Indonesia: extent, implications and possible interventions to uphold womens' health rights. Population Council. Jarkata. ISBN 979982351X, 9789799823519.

Byrne, J. & Humble, Á.M. 2007. *An Introduction to Mixed Method Research*. Nova Scotia. Available: http://www.msvu.ca/site/media/msvu/MixedMethodologyHandout.pdf [accessed 10.4.17].

Cahoon, B., nd. *Nigerian States*. [online] Available: http://www.worldstatesmen.org/Nigeria_federal_states.htm#Imo [accessed 2.5.19].

Cambridge University Press, 2019. *EXPERIENCE | meaning in the Cambridge English Dictionary*. [online] Available: https://dictionary.cambridge.org/dictionary/english/experience [accessed 26.8.19].

Cameron, R. 2010. Mixed Methods Research: The Five Ps Framework. The Electronic Journal of Business Research Methods. 9(2):96–108. Available: www.ejbrm.com [accessed 10.4.17].

Cappa, C. et al. 2013. Female genital mutilation/cutting: A statistical overview and exploration of the dynamics of change. UNICEF, New York. http://www.data.unicef.org/wp-content/uploads/2015/12/FGMC-Lo-res-Final-26.pdf.

Carnevale, F.A., 2016. Authentic qualitative research and the quest for methodological rigour. Canadian Journal of Nursing Research Archive, 34(2), pp. 121-128 ISSN1705-7051. Available: https://cjnr.archive.mcgill.ca/article/view/1768/1765

Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J. & Neville, A.J., 2014. The Use of Triangulation in Qualitative Research. *Oncology Nursing Forum*, 41(5), pp.545–547.

Centre for Disease Control and Prevention. 2016. Female genital mutilation/cutting in the United States: Updated estimates of women and girls at risk, 2012. Public Health Reports 131. March-April 2016.

Centre for Reproductive Rights, 2006. Female, Genital Mutilation: A matter of human rights. An Advocate's Guide to Action. [online] Available: https://www.reproductiverights.org/sites/default/files/documents/FGM_final.pdf [accessed 10.1.19].

Chege, J., Askew, I., Igras, S. &, Mutesh, K. 2004. Testing the effectiveness of community-based approaches for encouraging the abandonment of Female Genital Cutting into CARE's reproductive programs in Ethiopa and Kenya. USAID, 2004.http://www.popline.org/node/240450 [accessed 6.14.17].

Chen, H.-Y. & Boore, J.R., 2010. Translation and back-translation in qualitative nursing research: methodological review. Journal of Clinical Nursing, 19(1-2), pp.234–239.

Christofferson-Debi, A. 2005.Taming tradition: medicalized female genital practices in Western Kenya. Medical Anthropology Quarterly, 19:402-418.

Copi, I., Cohen, C. & Flage, D., 2016. *Essentials of logic*. Routledge.

Creswell, J.W., 2012. Qualitative Inquiry and Research Design: Choosing Among Five Approaches, 3rd ed. SAGE Publications, Inc, Los Angeles.

Creswell, J. W. & Creswell, J. D. 2018. Research design: qualitative, quantitative and mixed method approaches 5th ed. SAGE Publications, Inc, Los Angeles.

Creswell, J.W. & Poth, C.N., 2017. *Qualitative inquiry and research design: Choosing among five approaches*. Sage publications.

Cutner 1985. Cited in Nour 2008. Female genital cutting: a persisting practice. Reviews in Obstertrics and Gynaecology. 1(3):135-139. PMC 2582648. PMID19015765

Daly, C. & Carson, M., 2016. Nigeria: 20 million women and girls have undergone FGM. *The Guardian*. [online] 11 Oct. Available: https://www.theguardian.com/society/2016/oct/11/fgm-nigeria-20-million-women-and-girls-undergone-female-genital-mutilation [accessed 29.3.19].

Davis, G., & Jellins, J., 2019. Female genital mutilation: Obstetric outcomes in metropolitan Sydney. Australian and New Zealand Journal of Obstetrics and Gynaecology.

De Vos, A., Strydom, H. & Fouche, C., et al., 2011. Research at grass roots for the social sciences and human services professions. 4th ed. Pretoria: Van Schaik.

Diop, N.J. & Askew, I., 2009. The effectiveness of a community-based education program on abandoning female genital mutilation/cutting in Senegal. Studies in Family Planning 40, 307–318.

Dovlo, D., 2007. Migration of Nurses from Sub-Saharan Africa: A Review of Issues and Challenges. Health Services Research 42, 1373–1388. doi:10.1111/j.1475-6773.2007.00712.

Duman, M., 2003. *Producing patient information: how to research, develop and produce effective information resources*. London: King's Fund.

Dye, C., Reeder, J.C. and Terry, R.F., 2013. Research for Universal Health Coverage. *Science Translational Medicine*, 5(199), pp.199ed13-199ed13.

Edeh, O., 2017. *It's tradition: Female genital mutilation in Nigeria | ICWA*. [online] Available: https://www.icwa.org/its-tradition-female-genital-mutilation-in-nigeria/> [accessed 12.1.19].

Egbokhare, F.O. & Oyetade, S.O., 2002. Harmonization and standardization of Nigerian languages. CASAS.

Ekeanyanwu, O., 2017. *Two years after ban, FGM still rampant in Nigeria*. [online] The Cable. Available: https://www.thecable.ng/two-years-ban-fgm-still-rampant-nigeria [accessed 12.1.19].

Ekenze, S.O., Ezegwui, H.U. & Adiri, C.O., 2007. Genital lesions complicating female genital cutting in infancy: a hospital-based study in south-east Nigeria. Annals of tropical paediatrics 27, 285–290.

Elise, K., Manangi, R. K. & Knut-Inge. 2005. Self-reported and observed female genital cutting in rural Tanzania: associated demographic factors, HIV and sexually transmitted infections. Tropical Medcine & International Health. 10 (1).105-115.doi:1111/j.1365-3156.2004.01350x. ISSN 1360-2276. PMID 15655020.

Elmusharaf, S., Elhadi, N. & Almoroth, L. 2006. Reliability of self-reported form of female genital mutilation and WHO classification: cross-sectional study. BMJ (Clinical Research ed.). 333 (7559): 124. doi:10.1136/bmj.38873.649074.55. ISSN 1756-1833. PMID 16803943.

Enews Channel Africa (eNCA), 2015. Free State police search for victims of genital mutilation, 2015.http://www.enca.com/south-africa/free-state-police-search-victims-genital-mutilation [accessed 6.30.17].

Esho, T., Enzlin, P., Van Wolputte, S. & Temmerman, M., 2010. Female genital cutting and sexual function: in search of an alternate theoretical model. African Identities 8, 221–235.

Etikan, I., Musa, S. A. & Alkassim, R. S. 2016. Comparison of convenience sampling and purposive sampling. American Journal of Theoretical and Applied Statistics 5 (1), 1-4.

Eze, M., 2017. Groups tackle female genital mutilation in Imo, Ebonyi. *The Sun Nigeria*. Available: https://www.sunnewsonline.com/groups-tackle-female-genital-mutilation-in-imo-ebonyi/ [accessed 1.3.19].

Ezeokana, J.O., 1999. Divorce: Its Psychological Effects on the Divorced Women and their Children: A study on the Igbos of Southern Nigeria. Peter Lang Pub Inc, Frankfurt am Main ; New York.

Fahmy, A., El-Mouelhy, M.T. & Ragab, A.R., 2010. Female genital mutilation/cutting and issues of sexuality in Egypt. Reproductive Health Matters 18, 181–190. doi:10.2307/25767373

*Female genital mutilation: Children to be taught dangers - BBC News*. [online] 2019. Available: https://www.bbc.com/news/uk-47348878 [accessed 2.4.19].

Friedman-Jacobs, C. 2009. Commemorating International day of zero tolerance to female genital mutilation. Archived 13 February 2010 at the Wayback Machine Population Reference Bureau.

Fund, U.N.C. & Gupta, G.R., 2013. Female Genital Mutilation/Cutting: a statistical overview and exploration of the dynamics of change. Reproductive Health Matters 21, pp. 184–190.

Fusch, P. I. & Ness, L. R. 2015. Are we there yet? Data saturation in qualitative research. The Qualitative Report 20 (9), 1408.

Fusch, P., Fusch, G.E. & Ness, L.R., 2018. Denzin's Paradigm Shift: Revisiting Triangulation in Qualitative Research. *Journal of Social Change*, 10(1), pp.19–32.

Galukande, M., Kamara, J., Ndabwire, V., Leistey, E., Valla, C. & Luboga, S., 2015. Eradicating female genital mutilation and cutting in Tanzania: an observational study. BMC Public Health 15, 1147. doi:10.1186/s12889-015-2439-1

Gele, A.A., Bø, B.P. & Sundby, J., 2013. Have we made progress in Somalia after 30 years of interventions? Attitudes toward female circumcision among people in the Hargeisa district. *BMC research notes*, 6(1), pp.122.

Gele, A.A., Kumar, B., Hjelde, K.H. and Sundby, J., 2012. Attitudes toward female circumcision among Somali immigrants in Oslo: a qualitative study. International Journal of Women's Health, 4, pp.7–17.

Getachew, I., 2006. *Battling an ancient tradition: Female genital mutilation in Ethiopia*. [online] UNICEF. Available: https://www.unicef.org/protection/ethiopia_34881.html [accessed 23.4.19].

Grant, M.J. & Booth, A., 2009. A typology of reviews: an analysis of 14 review types and associated methodologies. Health Information & Libraries Journal, 26(2), pp.91–108.

Gray, R.H. et al. 2007. Male circumcision for HIV prevention in men in Rakai, Uganda: A randomized trial. Lancet 2007;369 (9562); 657-666. https;//doi.org/10.1016/50140=6736(07)60313-4. [accessed 6.25.18].

Greeff, M. 2005. Information collection: interviewing. In De Vos A.S., Strydom, H., Fouché C.B. & Delport C.S.L. Research at the grass roots for the social sciences and human service professions. 3rd ed. Pretoria: JL Van Schaik Publishers.

Gruenbaum. E. 2006. Sexuality issues in the movement to abolish female genital cutting in sudan. Medical Anthropology Quaterly, 20:121.

Gunasekare, U.L.T. 2013. Mixed Research Method as the Third Research Paradigm: A Literature Review. International Journal of Science and Research *(IJSR) ISSN (Online Index Copernicus Value Impact Factor*. 14(8):2319–7064. Available: www.ijsr.net [accessed 27.10.17].

Harrison, K. A. 2010. Dangers of Female Genital Mutilation. J.com Psychol,122(1):1-8.

Hayes, R.O. 1975. Female genital mutilation, fertility control, women's roles and the patrillineage in modern Sudan: A functional analysis. American Ethnologist.2(4)617-633. JSTOR 643328. http;//www.jstor.org/stable/643328. [accessed 6.16.18].

Health Service Executive (HSE) Health Promotion Unit and National Adult Literacy Agency (NALA), 2010. Plain language style guide for documents. [online] Available: http://hdl.handle.net/10147/98048.

Heather, T., 2013. African myths and legends/norse myths and legends/Romans myths and legends/Egyptian myths and legends. School Library Journal 59, 88.

Helyer, R., 2015. Learning through reflection: the critical role of reflection in work-based learning (WBL). Journal of Work-Applied Management, 7(1), pp.15–27.

Hoberman, J.M.2005.TestosteroneDreams: Rejuvenation, Aphrodisia, Doping, Berkeley. University of California Press 2005. pp. 63

Hong, Q., Pluye, P., Fabregues, S., Bartlett, G., Boardman, F., Cargo, M., Dagenais, P., Gagnon, M., Griffiths, F., Nicolau, B., O'Cathain, A., Rousseau, M. & Vedel, I., 2018. *MMAT_2018_criteria-manual_2018-08-01_ENG.pdf*. Available: http://mixedmethodsappraisaltoolpublic.pbworks.com/w/file/fetch/127916259/MMAT_2018_criteria-manual_2018-08-01_ENG.pdf [accessed 24.7.19].

Howard, J.A. & Gibson, M.A., 2017. Frequency-dependent female genital cutting behaviour confers evolutionary fitness benefits. *Nature ecology & evolution*, 1(3), p.0049.

Hunter, A. & Brewer, J.D. 2015. *Designing Multimethod Research: The Oxford Handbook of Multimethod and Mixed Methods Research Inquiry*. S.N. Hesse-Biber & B.R. Johnson, Eds. Oxford: Oxford University Press, 2015. DOI: 10.1093/oxfordhb/9780199933624.013.13.

Ibebuike, J.E., Nwokike, G.I., Alagwu, S.C. & Kalu, N.P. 2018. Mother's perception of female genital mutilation among mothers in Owerre - Ebiri community in Orlu L.G.A. Int. J. Adv. Res. Biol. Sci. 5(12): 87-94. DOI: http://dx.doi.org/10.22192/ijarbs.2018.05.12.012

Isilo, H., 2011.FGM secretly happening in South Africa, 2011. Africa witness.

Jacobson, D., Glazer, E., Mason, R., Duplessis, D., Blom, K., Mont, J.D., Jassal, N. and Einstein, G., 2018. The lived experience of female genital cutting (FGC) in Somali-Canadian women's daily lives. *PLOS ONE*, 13(11), pp.e0206886.

Jirovsky, E., 2010. Views of women and men in Bobo-Dioulasso, Burkina Faso, on three forms of female genital modification. Reproductive Health Matters 18, pp. 84–93.

Johnson, R. 2007. Experiencing sex in exile-can genitals change their gender? In: Hernlund, Y. & Shell-Duncan, B., eds. Transcultural bodies: female genital cutting in global context: New Brunswick, Rutgers University Press: 248-277.

Johnson, R. 2007. Making madinga or making Muslims? Debating female circumcision, ethnicity and Islam in Guinea-Bissau and Portugal. In: Hernlund, Y. & Shell-Duncan, B., eds. Transcultural bodies: female genital cutting in global context: New Brunswick, Rutgers University Press: 202-223.

Jones, W.K., Smith, J., Kieke, B. & Wilcox, L. 1997. Female genital mutilation/ female circumcision. Who is at risk in the U.S.? Public Health Reports (Washington, D.C: 1974). 112(5):368-377. ISSN 0033-3549. PMID 9323387. PMC 1381943.

Jordan, Z., Konno, R. & Mu, P.F., 2011. *Synthesizing evidence from narrative, text and opinion*. [online] Philadelphia, Pa.: Lippincott Williams & Wilkins. Available at: http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=booktext&D=books3&AN=01607888/1st_Edition/2 [accessed 22.5.19].

Kandala, N.-B. & Komba, P.N., 2015. Geographic Variation of Female Genital Mutilation and Legal Enforcement in Sub-Saharan Africa: A Case Study of Senegal. The American Journal of Tropical Medicine and Hygiene 92, 838–847. doi:10.4269/ajtmh.14-0074

Kaplan, A., Hechavarría, S., Martín, M.& Bonhoure, I., 2011. Health consequences of female genital mutilation/cutting in the Gambia, evidence into action. Reproductive Health, 8, 26.

Kaplan, A., Forbes, M., Bonhoure, I., Utzet, M., Martín, M., Manneh, M., & Ceesay, H., 2013a. Female genital mutilation/cutting in The Gambia: long-term health consequences and complications during delivery and for the newborn. Int J Womens Health 5, 323–331. doi:10.2147/IJWH.S42064

Kaplan, A., Hechavarría, S., Bernal, M. & Bonhoure, I., 2013b. Knowledge, attitudes and practices of female genital mutilation/cutting among health care professionals in The Gambia: a multi-ethnic study. BMC Public Health 13, 851. doi:10.1186/1471-2458-13-851

Karanja, J. 2009. The missionary movement in colonial Kenya: the foundation of African Inland Church. Gottingen: Cuvillier Ver lag. Pp. 93.

Kelly, E. & Hillard, P. 2005. Female genital mutilation. Current Opinion in Obstertrics and Gynaecology, 17(5):450-494. ISSN 1040-872x. PMID:16141763.

Kendra, C., 2018. *Characteristics of Concrete Operational Stage in Cognitive Development*. [online] Verywell Mind. Available: https://www.verywellmind.com/concrete-operational-stage-of-cognitive-development-2795458 [accessed 10.1.19].

Khazan, O., 2015. *What Many People Don't Understand About Female Circumcision*. [online] The Atlantic. Available: https://www.theatlantic.com/international/archive/2015/04/female-genital-mutilation-cutting-anthropologist/389640/ [accessed 20.2.19].

Kirby, V. 2005.Out of Africa: Our bodies ourselves? In Obioma Nnaemeka (ed), female circumcision and the politics of knowledge. African Women in Imperialist Discourses, Westport: Prager, 2005. P 83.

Klein, E., Helzner, E., Shayowitz, M., Kohlhoff, S. & Smith-Norowitz, T.A., 2018. Female Genital Mutilation: Health Consequences and Complications—A Short Literature Review. Obstetrics and Gynecology International, [online] 2018. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6079349/ [accessed 23.4.19].

Knight, M. 2001. Curing cut or ritual mutilation? Some remarks on the practice of female and male circumcision in Graeco-Roman Egypt. Isis. 92(2): 317-338. http://www.jstor.org/stable/3080631 [accessed 6.15.18].

Konecki, K.T., 2008. Triangulation and Dealing with The Realness of Qualitative Research. *Qualitative Sociology Review*, 4(3), pp. 7-28. Available: http://qsr.webd.pl/ENG/Volume11/QSR_4_3_Konecki.pdf

Kool, R. & Wahedi, S. 2014. Criminal enforcement in the area of female genital mutilation in France, England and the Netherlands: a comparative law perspective. International Law Research. 3(1):1. doi:10:5539/ilr. ISSN 1927-5242

Koster, M. & Price, L., 2008. Rwandan female genital modification: Elongation of the Labia minora and the use of local botanical species. Culture, Health & Sexuality, 10:2, 191-204, DOI: 10.1080/13691050701775076. Available: https://dx.doi.org/1080/113691050701775076 [accessed 8.28.17]

Leech, B.L., 2002. Asking Questions: Techniques for Semi-structured Interviews. Political Science & Politics, 35(04), pp.665–668.

Ley, P. 1992. Communication with Patients: Improving Communication, Satisfaction and Compliance. London: Chapman and Hall.

LoBiondo-Wood, G. & Haber, J., 2010. Nursing research: Methods and critical appraisal for evidence-based practice. 7 ed., Mosby Elsevier, St. Louis.

Lopez, G.I., Figueroa, M., Connor, S.E. & Maliski, S.L., 2008. Translation barriers in conducting qualitative research with Spanish speakers. *Qualitative Health Research*, 18(12), pp.1729–1737.

Mackie, G.1996. Ending foot binding and Infibulation. A convention Account. American Sociological Review. 61(6):999-1017 http://www.jstor.org/stable/2096305 [accessed 6.15.18].

Mahmoud, M.I.H., 2016. Effect of female genital mutilation on female sexual function, Alexandria, Egypt. *Alexandria Journal of Medicine*, 52(1), pp.55–59.

Maneesriwongul, W. & Dixon, J.K., 2004. *Instrument translation process: a methods review*. [online] Journal of Advanced Nursing. Available: https://0-onlinelibrary-wiley-com.innopac.wits.ac.za/doi/abs/10.1111/j.1365-2648.2004.03185.x [accessed 2.9.19].

Martins Library, 2014. Ohaukwu local government area - the background information. http://martinslibrary.blogspot.co.za/2014/11/ohaukwu-local-government-area.html [accessed 6.29.17].

Mohamud, M., Kaba, M. & Tamire, M.M., 2017. Assessment of barriers of behavioral change to stop FGM practice among women of Kebri Beyah district, Somali regional state, eastern Ethiopia. Global Journal of Medical Research, 16 (6), pp. 47-49. ISSN 2249-4618.

Morison, L., Scherf, C., Ekpo, G., Paine, K., West, B., Coleman, R., Walraven, G., 2001. The long-term reproductive health consequences of female genital cutting in rural Gambia: a community-based survey. Tropical Medicine & International Health 6, 643–653. doi:10.1046/j.1365-3156.2001.00749.

Moses, S., Bailey, R.C. & Ronald, A.R. Male circumcision: assessment of health benefits and risks. 1998. STI. 74 (5):368-373. http://sti.bmj.com/content/74/5/368. [accessed 6.6.18].

Motaung, T. 2015. Zero tolerance for Female Genital Mutilation in Eritrea? Afric Law. http;//africlaw.com/2015/02/06/zero-tolerance-for-FGM-in-Eritrea/ [accessed 10.6.17]

Muraya, M.W., 2015. Mau Mau War, female circumcision and social-cultural identity among the Agikuyu of Kiambu, Kenya. International Journal of Culture and History, 2(2), pp.26.

National Health Scheme (NHS) Forth Valley, 2003. *Developing Written Information for Patients Good Practice Guidelines*. [online] NHS Forth Valley. Available: http://biostat.mc.vanderbilt.edu/TPT/SOURCE/Extras/TrialRecruitment/InfoGuide.pdf [accessed 24. 5.19].

National Population Commission (NPC), 2006. Report of Nigeria's National Population Commission on the 2006 Census, 2007. . Population and Development Review 33, 206–210.

National Population Commission (NPC), 2016. Data for National Growth.

http://www.population.gov.ng/index.php/80-publications/216-nigeria-s-population-now-182-million-dg-npopc [accessed 7.10.17].

Nigeria Demographic Health Survey Program (NDHS), 2013 - Final Report (English) URL http://dhsprogram.com/publications/publication-fr293-dhs-final-reports.cfm [accessed 6.29.17].

Njogu, G.N., 2018. Female Genital Mutilation and its Effect in Public Primary Schools Participation by the Girl Child : A Study of Samburu County , Kenya. International Journal of Science and Research, 7(5), pp. 1267-1277. Doi: 10.21275/ART20181584

Norwood, S.L., 2009. Research Essentials: Foundations for Evidence-Based Practice, 1 edition. ed. Pearson, Boston

Nour, N.M., 2008. Female Genital Cutting: A Persisting Practice. *Reviews in Obstetrics and Gynecology*, 1(3), pp.135–139.

NPC [Nigeria] & ICF International, 2014. *Nigeria Demographic and Health Survey 2013.* [online] Available: https://dhsprogram.com/pubs/pdf/FR293/FR293.pdf [accessed 24.2.19].

Obi, A. & Igbinadolor, O., 2018. Prevalence of female genital mutilation and its determinants among pregnant women in Benin City, Nigeria. Journal of Community Medicine and Primary Health Care, 30(2), pp.12–21.

Odu, B.K., 2008. The attitude of undergraduate females toward genital mutilation in a Nigerian University. Research Journal of Medical Sciences 2, 295–9.

Odumegwu, C., Okemgbo, C. & Bisiriya, L. 1999. Female Genital Mutilation in Nigeria: what do adult males know? Journal of the Nigerian Anthropological and Sociological Association 1, 2, pp. 97-108.

Ogbugbuaja, C., 2018. Imo communities to end female genital mutilation. *The Guardian Nigeria News - Nigeria and World News*. Available at: https://guardian.ng/news/imo-communities-to-end-female-genital-mutilation/ [accessed 24.2.19].

Okeke, T., Anyaehie, U. & Ezenyeaku, C., 2012. An overview of female genital mutilation in Nigeria. Annals of medical and health sciences research, 2(1), pp.70–73.

Okemgbo, C.N., Omideyi, A.K. & Odimegwu, C.O., 2002. Prevalence, patterns and correlates of domestic violence in selected Igbo communities of Imo State, Nigeria. African journal of reproductive health, pp.101–114.

Oliver-Hoyo, M. & Allen, D., 2005. *The use of Triangulation Methods in Qualitative Educational Research*. [online] NSTA News. Available: https://www.nsta.org/publications/news/story.aspx?id=51319 [accessed 11.7.19].

Onuoha, C., 2018. Female Genital Mutilation persists despite outlaw. *Vanguard News Nigeria*. Available: https://www.vanguardngr.com/2018/04/female-genital-mutilation-persists-despite-outlaw/ [accessed 12.1.19].

Onyima, B.N., 2015. Infant-female genital mutilation (IFGM) in cities and the role of women in perpetuating FGM: a probe on why FGM persists in urban centers in Nigeria. *Mgbakoigba:* Journal of African Studies, 4(0), pp.1-12.

Onyishi, I.E., Prokop, P., Okafor, C.O. & Pham, M.N., 2016. Female Genital Cutting Restricts Socio-sexuality Among the Igbo People of Southeast Nigeria. Evolutionary Psychology, 14(2), p.1474704916648784.

Oxley, J., Günhan, E., Kaniamattam, M. & Damico, J., 2017. Multilingual issues in qualitative research. Clinical Linguistics & Phonetics, 31(7–9), pp.612–630.

Peters, M.D.J., Godfrey, C.M., Khalil, H., McInerney, P., Parker, D. & Soares, C.B., 2015. Guidance for conducting systematic scoping reviews. International Journal of Evidence-Based Healthcare,13 (3), pp. 141-146. Doi: 10.1097/XEB.0000000000000050

Plo, K., Asse, K., Seef, & Dohagneron Yenan, J., 2014. Female Genital Mutilation in Infants and Young Girls: Report of Sixty Cases Observed at the General Hospital of Abobo (Gbidjan, Cote D' Ivoire, West Africa). International Journal of Pediatrics 2014, e837471. doi:10.1155/2014/837471.

Polit, D., & Beck, C. 2014. Essentials of Nursing Research: Appraising Evidence for Nursing Practice, 8th edition. ed. LWW, Philadelphia.

Polkinghorne, D.E., 2005. Language and meaning: Data collection in qualitative research. Journal of Counselling Psychology, 52(2), pp.137–145.

Purkey, W.W. 1988. An overview of self-concept theory for counsellors. Highlights: An ERIC/CAPS Digest. ED 304630. ERIC/CAPS, 2108 School of Education University of Michigan, Ann Arbor, M1 48109-1259. Available: https://files.eric.ed.gov/fulltext/ED304630.pdf [accessed 13.4.19].

Purkey, W. W., & Schmidt, J. (1987). The inviting relationship: An expanded perspective for professional counseling. Englewood Cliffs, NJ: Prentice-Hall, Inc.

Rafferty, Y. 2013. International dimensions of discrimination and violence against girls: A human rights perspective. Journal of International Women's Studies*, 14*, pp.1–23.

Rasheed, S.M., Abd-Ellah, A.H. & Yousef, F.M., 2011. Female genital mutilation in Upper Egypt in the new millennium. International Journal of Gynecology & Obstetrics 114, 47–50.

Refaat, A., 2009. Medicalization of female genital cutting in Egypt. Eastern Mediterranean Journal, 2009,15(6), pp.1379-1388. Available: https://apps.who.int/iris/handle/10665/117774

Reisel, D. & Creighton, S.M. 2015. Long term health consequences of female genital mutilation (FGM). Maturitas. 80(1): pp. 48-51.doi.10.1016/j.maturitas.2014.10.009. ISSN 1873-4111. PMID 25466303.

Rodriguez, S. 2008. Rethinking the history of female circumcision and clitoridectomy: American medicine and female sexuality in the late nineteenth century. Journal of the History of Medcine and Allied sciences. 63(3):323-3447. doi: 1093/jhmas/jrm044. ISSN 1468-4373 BMID 18065832.

Rodriguez, S.B. 2014. Female circumcision and clitoridectomy in the United States: a history of medical treatment. Rochester, N.Y: University of Rochester Press.

Rodriguez, M.I., Seuc, A., Say, L. & Hindin, M.J., 2016. Episiotomy and obstetric outcomes among women living with type 3 female genital mutilation: a secondary analysis. Reproductive Health 13, 131. doi:10.1186/s12978-016-0242-9.

Rogers, C.R. 1947. Some observations on the organization of personality. American Psychologist, 2: 358-368.

Salihu, H., August, E., Salemi, J., Weldeselasse, H., Sarro, Y. & Alio, A., 2012. The association between female genital mutilation and intimate partner violence. BJOG: An International Journal of Obstetrics & Gynaecology 119, 1597–1605. doi:10.1111/j.1471-0528.2012.03481.

Sandelowski, M. 2000. Focus on Research methods-whatever happened to qualitative description. Research in Nursing and Health, 23(4), pp. 334-340.

Serour, G.I., 2010. The issue of reinfibulation. International Journal of Gynecology & Obstetrics, 109(2), pp. 93–96.

Setegn, T., Lakew, Y. & Deribe, K., 2016. Geographic variation and factors associated with female genital mutilation among reproductive age women in Ethiopia: a national population based survey. PloS one, 11(1), pp.e0145329.

Shell-Duncan, B. 2008. From health to human rights: female genital cutting and the politics of intervention. American Anthropologist. 10(2), pp. 225-236.

Shenton, A.K., 2004. Strategies for Ensuring Trustworthiness in Qualitative Research Projects. Education for Information 22, pp. 63–75.

Siddhanta, A. & Sinha, A., 2016. Attitude and perception towards female circumcision: a study of vulnerability among women in kenya and Nigeria. The Journal of Family Welfare, 62, pp.15.

Singbeil, A., 2015. Working with Women and Girls who have experienced Female genital Cutting (FGC). *Sexuality Education Resource Centre (SERC)*, pp.25.

Sipsma, H.L., Chen, P.G., Ofori-Atta, A., Ilozumba, U.O., Karfo, K. & Bradley, E.H., 2012. Female genital cutting: current practices and beliefs in western Africa. Bulletin of the World Health Organization 90, pp. 120–127.

Strabo, G. 64BCE-23CE. Cited in Knight, M. 2001. Curing cut or ritual mutilation? Some

remarks on the practice of female and male circumcision in Graeco-Roman Egypt. Isis. 92(2): 317-338. http://www.jstor.org/stable/3080631 [accessed 6.15.18].

Tag-Eldin, M.A., Gadallah, M.A., Al-Tayeb, M.N., Abdel-Aty, M., Mansour, E. & Sallem, M., 2008. Prevalence of female genital cutting among Egyptian girls. Bulletin of the World Health Organization 86, 269–274. doi:10.1590/S0042-96862008000400011.

Turkewitz, J. 2015. Effects of ancient custom present new challenge to U.S. doctors: genital cutting cases seen more as immigration rises. The New York Times.

UNICEF. 2006. The State of the World's Children 2007: Women and Children: the Double Dividend of Gender Equality. UNICEF.

UNICEF. 2013. Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change, UNICEF, New York. http://www.who.int/reproductivehealth/topics/fgm/prevalence/en/.

UNICEF. 2014. Female genital mutilation/cutting: what might the future hold? New York: http://www.unicef.org/medicalfiles/FGM-C_Report_7_15_Final_LR.pdf [accessed 6.20.18].

UNICEF. 2015. Levels & Trends in Child Mortality–Report 2015: Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation. Report, 2015. UNICEF, New York. https://www.childmortality.org.

UNICEF. 2016. Indonesia: statistical profile on female genital mutilation/cutting. Division of Data, Research and Policy. UNICEF, New York,10017. http://data.unicef.org/wp-content/uploads/country_profiles/indonesia/FGMC_IDN.pdf [accessed 6.20.18].

UNICEF_Nigeria & UNFPANigeria, 2016. Join Me to End Female Genital Mutilation. http://www.nigeria.unfpa.org.

UNICEF_Nigeria & UNFPANigeria, 2016. Preliminary Findings of FGM/C in Nigeria http://www.nigeria.unfpa.org.

UNFPA and UNICEF Nigeria, 2016. *Real people, real stories. Join us to end FGM in Nigeria!* [online] Available: https://nigeria.unfpa.org/sites/default/files/pub-

pdf/FGM%20for%20web%20human%20stories.pdf [accessed 1.5.19].

UNFPA, 2017. *For many girls, school holidays means FGM "cutting season"*. [online] Available: https://www.unfpa.org/cuttingseason [accessed 3.4.19].

UNICEF & UNFPA, 2018. *A race against trends*. [online] UNICEF. Available: https://www.unicef.org/media/media_102559.html [accessed 12.2.19].

Van Bavel, H., Coene, G. and Leye, E., 2017. Changing practices and shifting meanings of female genital cutting among the Maasai of Arusha and Manyara regions of Tanzania. Culture, Health & Sexuality, 19(12), pp.1344–1359.

Velasquez, M., Andre, C., Shanks, T. & Meyer, M., 1992. *Ethical Relativism*. [online] Available: https://www.scu.edu/ethics/ethics-resources/ethical-decision-making/ethical-relativism/ [accessed 2.5.19].

Whittemore, R., Chase, S.K. & Mandle, C.L., 2001. Validity in Qualitative Research. *Qualitative Health Research*, 11(4), pp.522–537.

World Health Organization (WHO) & UNICEF. 2006. Towards the elimination of female genital mutilation: a training manual for the affected countries in the East Mediterranean Region. Cairo, WHO Regional office for the Eastern Meditarranean.

WHO. 2008. Eliminating female genital mutilation: An Interagency statement. http://apps.who.int/iris/bitstream/10665/43839/1/9789241596442_eng.pdf [accessed 8.15.17].

WHO, 2010. Global strategies to stop health-care providers from performing female genital mutilation. http://apps.who.int/iris/bitstream/10665/70264/1/WHO_RHR_10.9_eng.pdf [accessed 6.29.17].

WHO. 2015. Global Health Observatory (GHO) data. Maternal mortality country profiles. http://www.who.int/gho/maternal_health/countries/nga.pdf. [accessed 7.10.17]

WHO. 2016. Female genital mutilation (FGM) URL http://www.who.int/reproductivehealth/topics/fgm/prevalence/en/ [accessed 5.19.17].

WHO. 2016. WHO Guidelines on the management of complications of female genital mutilation. URL https://extranet.who.int/rhl/guidelines/who-guidelines-management-health-complications-female-genital-mutilation. [accessed 8.15.17].

WHO, 2017. Adolescent Health. www.who.int/topics/adolescent_health/en/. [accessed 6.29.17].

WHO, 2017. Female Genital Mutilation: Fact sheet. http://www.who.int/mediacentre/factsheets/fs241/en/. [accessed 6.29.17].

WHO. 2018. Manual for male circumcision under local anaesthesia and HIV prevention services for adolescent boys and men. ISBN:978-92-4-151359-3.Geneva; Switzerland. Licence: CCBY-NC-SA 3.0 IGO.

WHO, 2018a. *Female genital mutilation*. [online] Available: https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation [accessed 13.2.19].

WHO, 2018b. *High-quality health care for girls and women living with FGM: WHO launches new clinical handbook*. [online] WHO. Available: http://www.who.int/reproductivehealth/health-care-girls-women-living-with-FGM/en/ [accessed 2.5.9].

Wu, S.F., 2006. [A two-stage translation and test the validity and reliability of a foreign instrument]. Hu li za zhi The journal of nursing, 53(1), pp. 65–71.

Yaya, S. & Ghose, B., 2018. Female Genital Mutilation in Nigeria: A Persisting Challenge for Women's Rights. Social Sciences, 7(12), pp. 244.

Yirga, W.S., Kassa, N.A., Gebremichael, M.W. & Aro, A.R., 2012. Female genital mutilation: prevalence, perceptions and effect on women's health in Kersa district of Ethiopia. Int J Womens Health 4, 45–54. doi:10.2147/IJWH.S28805

Yoder, P.S, Abderrahim, N. & Zhuzhuni, A. 2004. Female genital cutting in the demographic and health surveys: a critical and comparative analysis. DHS comparative reports 7, 2004. www.measuredhs.com/pubs/pdf/CR7/CR7.pdf.

Yoder, P.S., Wang, S., & Johansen, E., 2013. Estimates of Female Genital Mutilation/Cutting in 27 African Countries and Yemen. Studies in Family Planning 44, pp. 189–204. doi:10.1111/j.1728-4465.2013.00352. ISSN 0039-3665. PMID 23720002

Zayed, A.A., & Ali, A.A. 2012. Abusing female children by circumcision is continued in Egypt. Journal of Forensic and Legal Medicine 19, 196–200. doi:10.1016/j.jflm.2011.12.013

28 Too Many, 2018. *The law and FGM: An overview of 28 African Countries*. 28 Too Many. Available: https://www.28toomany.org/static/media/uploads/Law%20Reports/the_law_and_fgm_v1_(september_2018).pdf [accessed 24.7.19].

**ADDENDUM 1**

**PERCENTAGE OF WOMEN 15-49 YEARS OLD IN NIGERIA WHO ARE CIRCUMCISED AND THE TYPE OF CIRCUMCISION ACCORDING TO THEIR STATES AND THE SIX GEOPOLITICAL ZONES.**

| STATE | % CIRCUMCISED | CUT, NO FLESH REMOVED | CUT, FLESH REMOVED | SEWN CLOSED | DON'T KNOW/ MISSING |
|---|---|---|---|---|---|
| **SOUTH- WEST ZONE** | | | | | |
| Ekiti | 72.3 | 4.9 | 44.1 | 2.0 | 49.0 |
| Lagos | 34.8 | 2.3 | 70.8 | 4.4 | 22.4 |
| Ogun | 11.2 | 19.6 | 68.8 | 1.2 | 10.3 |
| Ondo | 45.0 | 4.1 | 50.2 | 1.1 | 46.6 |
| Osun | 76.6 | 3.4 | 85.2 | 2.9 | 8.5 |
| Oyo | 65.6 | 1.2 | 73.7 | 2.8 | 22.3 |
| **SOUTH- EAST ZONE** | | | | | |
| Abia | 31.9 | 0.3 | 68.2 | 13.7 | 17.8 |
| Anambra | 23.4 | 6.6 | 47.6 | 5.4 | 40.5 |
| Ebonyi | 74.2 | 1.9 | 89.9 | 3.3 | 4.9 |
| Enugu | 40.3 | 1.1 | 89.9 | 5.7 | 3.3 |
| Imo | 68.0 | 16.4 | 70.2 | 5.1 | 8.3 |
| **SOUTH-SOUTH ZONE** | | | | | |
| Akwaibom | 11.0 | 2.8 | 72.0 | 9.4 | 15.7 |
| Bayelsa | 16.2 | 12.7 | 63.6 | 20.1 | 3.7 |
| Cross River | 32.2 | 1.6 | 73.6 | 2.7 | 22.1 |
| Delta | 40.3 | 4.3 | 70.0 | 7.4 | 18.4 |
| Edo | 41.6 | 1.1 | 69.6 | 3.6 | 25.8 |
| Rivers | 14.6 | 5.5 | 45.4 | 8.2 | 41.0 |
| **NORTH-CENTRAL ZONE** | | | | | |
| FCT Abuja | 6.1 | 2.2 | 69.4 | 3.4 | 25.0 |
| Benue | 8.4 | 0.0 | 84.7 | 12.5 | 2.7 |
| Kogi | 1.7 | * | * | * | * |
| Kwara | 53.3 | 3.2 | 50.5 | 2.5 | 43.9 |
| Nasarawa | 9.0 | 3.5 | 61.2 | 22.3 | 13.0 |
| Niger | 2.5 | 0.0 | 60.5 | 16.1 | 23.4 |
| Plateau | 1.7 | * | * | * | * |
| **NORTH-EAST ZONE** | | | | | |
| Adamawa | 1.0 | * | * | * | * |
| Bauchi | 5.2 | 10.6 | 59.1 | 0.0 | 30.3 |
| Borno | 2.3 | * | * | * | * |
| Gombe | 2.9 | 65.4 | 12.5 | 0.0 | 22.1 |
| Taraba | 2.9 | 13.2 | 42.9 | 6.5 | 37.4 |
| Yobe | 2.6 | 9.9 | 45.9 | 1.2 | 43.0 |
| **NORTH-WEST ZONE** | | | | | |
| Jigawa | 39.4 | 5.7 | 74.8 | 3.3 | 16.2 |
| Kaduna | 25.1 | 36.2 | 37.1 | 21.1 | 5.5 |
| Kano | 40.9 | 1.9 | 27.0 | 3.1 | 67.9 |
| Kastina | 0.1 | * | * | * | * |
| Kebbi | 2.6 | 10.7 | 14.8 | 19.3 | 55.2 |
| Sokoto | 3.0 | 3.5 | 2.7 | 0.0 | 93.8 |
| Zamfara | 1.7 | * | * | * | * |

**Source: NDHS (2013)**

**ADDENDUM 2**

## HUMAN RESEARCH ETHICS CLEARANCE CERTIFICATE

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

R14/49 Ms OL Obiora

### HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
### CLEARANCE CERTIFICATE NO. M170834

| | |
|---|---|
| **NAME: (Principal Investigator)** | Ms OL Obiora |
| **DEPARTMENT:** | School of Therapeutic Sciences<br>Department of Nursing Education<br>Medical School<br>University |
| **PROJECT TITLE:** | The experiences and perceptions of genitally-mutilated females and healthcare practitioners in south eastern Nigeria |
| **DATE CONSIDERED:** | 25/08/2017 |
| **DECISION:** | Approved unconditionally |
| **CONDITIONS:** | Change of study title noted on 16/10/2019 |
| **SUPERVISOR:** | Professor JE Maree and Dr N Mafutha |
| **APPROVED BY:** | Dr CB Penny, Chairperson, HREC (Medical) |
| **DATE OF APPROVAL:** | 04/10/2017 |

**This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.**

**DECLARATION OF INVESTIGATORS**

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary on the 3rd Floor, Phillip Tobias Building, Parktown, University of the Witwatersrand, Johannesburg.
I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to submit details to the Committee. **I agree to submit a yearly progress report**. When a funder requires annual re-certification, the application date will be one year after the date when the study was initially reviewed. In this case, the study was initially reviewed in **August** and will therefore reports and re-certification will be due early in the month of **August** each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature _____ Date _____

**PLEASE QUOTE THE CLEARANCE CERTIFICATE NUMBER IN ALL ENQUIRIES**

**ADDENDUM 3**

**INFORMATION LEAFLET FOR WOMEN AND GIRLS ABOVE 18 YEARS**

**PROJECT TITLE:**

**EXPERIENCES AND PERCEPTIONS OF GENITALLY MUTILATED FEMALES AND HEALTHCARE PRACTITIONERS IN SOUTH EASTERN NIGERIA**

**Dear Madam,**
Good day. My name is Mrs. Oluchukwu Obiora and I would like to invite you to participate in a study that will lead to obtaining a doctoral degree in Nursing. This information leaflet will help you to decide whether you would accept this invitation or would prefer not to take part in the study. Before you agree to take part, you should fully understand what is involved. You should not agree to take part unless you are completely satisfied with all aspects of the study.

**WHAT IS THE STUDY ALL ABOUT?**
The study focuses on obtaining insight into your circumcision experiences before and after the procedure, as well as your perception and motivators of the procedure in your community, and the information obtained will be used to develop a health education leaflet for improving self-care of the circumcised females.

**WHAT WILL YOU BE REQUIRED TO DO IN THE STUDY?**
If you decide to partake in this study, the following will be required:

- You will have to sign an informed consent form.
- You will tell me the experience of your circumcision, and this will take approximately 45 - 60 minutes.
- Follow-up interview will also be required to allow for the opportunity to verify that findings and transcriptions were done correctly and also to give you the opportunity to add to anything that was discussed during the initial in-depth interview. The researcher also uses this opportunity to clarify any misconceptions that might arise when reflecting on the initial story telling-interview.
- The interview will be done at your home or any place where you feel comfortable.
- It will be conducted individually
- It will be conducted in your native language (Igbo), however, a community member who is bilingual will assist with language issues should it be necessary.
- You will be required to answer questions about your circumcision experience, your perception and the motivators of circumcision in your community.
- Though no harm is intended, you might experience some emotional discomfort. Should the researcher identify the need for professional support to assist with the management of your discomfort, you will be referred to a professional counsellor.
- During the interview sessions, the researcher might take notes; this is to assist the researcher during the data analysis period.
- The interview sessions will also be audio taped in order to transcribe the stories verbatim. Your real name(s) will not be used to ensure confidentiality.

**WHAT ARE THE INCLUSION CRITERIA FOR THE STUDY?**
You may participate only if:

- You are 20 years and older and have been circumcised.

**CAN ANY OF THE STUDY PROCEDURES RESULT IN PERSONAL RISK, DISCOMFORT OR INCONVENIENCE?**
Due to the sensitive nature of the topic, some discomfort may be experienced during the interview which will be dealt with in a respectable manner by referring you to a counsellor who have consented to assist with any emotional discomfort that arises during the study.

**FINANCIAL COMPENSATION AND THE POTENTIAL BENEFITS THAT MAY COME FROM THE STUDY?**
You will not be financially compensated for participating in this study. However, your participation in the study will assist the researchers and healthcare practitioners to have a better understanding of your circumcision experiences and then develop evidence-based health education pamphlet for improving self-care of the circumcised females. Also, the findings from the study will help strengthen evidences to eradicate female genital mutilation both nationally and internationally.

**WHAT ARE YOUR RIGHTS AS A PARTICIPANT IN THIS STUDY?**
Your participation in this study is entirely voluntary. You are under no obligation to participate you have the right to withdraw at any stage. You don't even have to provide the reason/s for your decision.

**HOW WILL CONFIDENTIALITY AND ANONYMITY BE ENSURED IN THE STUDY?**
All information obtained during the course of this study is strictly confidential. The study data will be coded so that it will not be linked to your name. Your identity will not be revealed while the study is being conducted or when the study is reported in scientific journals. All the data sheets that will be collected will be stored in a secure place. Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. The information received during the interview will only be used for research purposes.

**IS THE RESEARCHER QUALIFIED TO CARRY OUT THE STUDY?**
The researcher is a Nurse-Midwife and Public Health Nursing Officer registered with the Nursing and Midwifery council of Nigeria, as well as the West African Health Education Board. She has six years clinical experience. Furthermore, the researcher is in possession of a Master's degree in Maternal and Child Health nursing. This study forms part of the researcher's doctoral degree and therefore will be supervised by a world renowned expert in the nursing research.

**HAS THE STUDY RECEIVED ETHICAL APPROVAL?**
The research proposal has recieved approval from the Primary Health Care Board, your traditional ruler, and the University of the Witwatersrand Research ethics committee before the commencement of the study. All parts of the study will be conducted according to internationally accepted ethical principles.

**WHO CAN YOU CONTACT FOR ADDITIONAL INFORMATION REGARDING THE STUDY?**
The primary investigator, Mrs. Oluchukwu Obiora, can be contacted on her cellular phone at +2348135178591 or via e-mail: 1670233@students.wits.ac.za. The study supervisor, Prof JE Maree, can be contacted during office hours at Tel (011) 488 4272/4196.

**DECLARATION: CONFLICT OF INTEREST**
This study will be funded by the researcher. No publication prohibitions, conditions or limitations were placed on the researcher.

**A FINAL WORD**

Your co-operation and participation in the study will be greatly appreciated. Please sign the informed consent below if you agree to participate in the study. In such a case, you will receive a copy of the signed informed consent from the researcher.

**ADDENDUM 4**

**INFORMATION LEAFLET FOR CIRCUMCISED GIRLS BELOW 18 YEARS OF AGE**

**PROJECT TITLE:**

**EXPERIENCES AND PERCEPTIONS OF GENITALLY MUTILATED FEMALES AND HEALTHCARE PRACTITIONERS IN SOUTH EASTERN NIGERIA**

Hello, my name is Loveth and I would like to invite you to tell me a story as part of a research study. This information leaflet will help you to decide whether you would accept this invitation or would prefer not to take part in the study. Before you agree to take part, you should fully understand what is involved. You should not agree to take part unless you are completely satisfied with all aspects of the study.

**WHAT IS THE STUDY ALL ABOUT?**
The study focuses on obtaining insight into your circumcision experiences before and after the procedure, as well as your perception and motivators of the procedure in your community, and the information obtained will be used to develop a health education pamphlet (HEP) for circumcised females.

**WHAT WILL YOU BE REQUIRED TO DO IN THE STUDY?**
If you decide to partake in this study, the following will be required:

- You will have to sign an informed assent form, while your parent or guardian will sign an informed consent form on your behalf.
- I will ask you to tell me about your circumcision. This will take approximately 45 - 60 minutes.
- Follow-up interviews will also be required to allow for the opportunity to verify that findings and transcriptions were done correctly and also to give you the opportunity to add to anything that was discussed during the initial story telling. I will also use this opportunity to clarify any misconceptions that might arise when reflecting on the initial interview.
- This interaction will be done at your home or any place where you feel comfortable.
- It will be conducted individually and your parent (s) or guardian (s) will not be there.
- We will communicate in your native language (Igbo), however, a bilingual community member will assist with language issues should it be necessary.
- Though no harm is intended, you might experience some emotional discomfort. Should the researcher identify the need for professional support to assist with the management of your discomfort, a professional counsellor will be available to help you.
- During the interaction section, the researcher might take notes; this is to assist the researcher during the data analysis period.
- The interaction sections will also be audio taped in order to transcribe the interviews verbatim and confidentiality will be ensured.

**WHAT ARE YOUR RIGHTS AS A PARTICIPANT IN THIS STUDY?**
Your participation in this study is entirely voluntary. You are under no obligation to participate you have the right to withdraw at any stage. You don't even have to provide the reason/s for your decision.

**A FINAL WORD**
Your co-operation and participation in the study will be greatly appreciated. Please sign the informed assent form below if you agree to participate in the study. In such a case, you will receive a copy of the signed informed assent form from the researcher.

**ADDENDUM 5**

**INFORMATION LEAFLET FOR PARENTS/LEGAL GUARDIAN OF GIRLS BELOW 18 YEARS**

**PROJECT TITLE:**

**EXPERIENCES AND PERCEPTIONS OF GENITALLY MUTILATED FEMALES AND HEALTHCARE PRACTITIONERS IN SOUTH EASTERN NIGERIA**

**Dear Sir/Madam,**
Good day. My name is Mrs. Oluchukwu Obiora and I would like to invite your daughter to participate in a study that will lead to obtaining a doctoral degree in Nursing. This information leaflet will help you to decide whether you would accept this invitation or would prefer not to take part in the study. Before you agree to take part, you should fully understand what is involved. You should not give consent for your daughter to take part unless you are completely satisfied with all aspects of the study.

**WHAT IS THE STUDY ALL ABOUT?**
The study focuses on obtaining insight into your circumcision experiences before and after the procedure, as well as your perception and motivators of the procedure in your community, and the information obtained will be used to develop a health education pamphlet (HEP) for circumcised females.

**WHAT WILL YOUR DAUGHTER BE REQUIRED TO DO IN THE STUDY?**
If you decide to allow your daughter to partake in this study, the following will be required:

- You will have to sign an informed consent form declaring your agreement for her to partake in the study, while your daughter will sign an informed assent form if she likes to participate in the study.
- Your daughter will tell me her experience and perception of her circumcision, and this will take approximately 45 - 60 minutes.
- Follow-up interactions will also be required to allow for the opportunity to verify that findings and transcriptions were done correctly and also to give you the opportunity to add to anything that was discussed during the initial interaction. The researcher also uses this opportunity to clarify any misconceptions that might arise when reflecting on the initial interaction.
- The in-depth interview will be done at your home or any place where your daughter feels comfortable.
- It will be conducted individually, and you will not be present during the interaction sessions.
- It will be conducted in your native language (Igbo), however, a bilingual community member will assist with language issues should it be necessary.
- Your daughter will be required to answer questions about her circumcision experience, her perception and the motivators of circumcision in her community.
- Though no harm is intended, she might experience some emotional discomfort. Should the researcher identify the need for professional support to assist with the management of her discomfort, she will be referred to a professional counsellor.
- During the interaction sections, the researcher might take notes; this is to assist the researcher during the data analysis period.
- The interaction sections will also be audio taped in order to transcribe the experiences verbatim. Her real name(s) will not be used to ensure confidentiality.

**CAN ANY OF THE STUDY PROCEDURES RESULT IN PERSONAL RISK, DISCOMFORT OR INCONVENIENCE?**
Due to the sensitive nature of the topic, some discomfort may be experienced during the interview which will be dealt with in a respectable manner by the researcher. Should the researcher identify emotional discomfort, she will obtain your permission to allow her be attended to by a counsellor who has consented to assist with any emotional discomfort that arises during the study.

**FINANCIAL COMPENSATION AND THE POTENTIAL BENEFITS THAT MAY COME FROM THE STUDY?**
She will not be financially compensated for participating in this study. However, her participation in the study will assist the researchers and healthcare practitioners to have a better understanding of her circumcision experiences and then develop evidence - based health education pamphlet for improving self-care of the circumcised women and girls.

**WHAT ARE YOUR RIGHTS IN THIS STUDY?**
Your daughter's participation in this study is entirely voluntary. She is under no obligation to participate. You have the right to withdraw her at any stage. You don't even have to provide the reason/s for your decision.

**HOW WILL CONFIDENTIALITY AND ANONYMITY BE ENSURED IN THE STUDY?**
All information obtained during the course of this study is strictly confidential. The study data will be coded so that it will not be linked to your name. Your daughter's identity will not be revealed while the study is being conducted or when the study is reported in scientific journals. All the data sheets that have been collected will be stored in a secure place. The information received during the interview will only be used for research purposes.

**IS THE RESEARCHER QUALIFIED TO CARRY OUT THE STUDY?**
The researcher is a Nurse-Midwife and Public Health Nursing Officer registered with the Nursing and Midwifery council of Nigeria, as well as the West African Health Education Board. She has six years clinical experience. Furthermore, the researcher is in possession of a Master's degree in Maternal and Child Health nursing. This study forms part of the researcher's doctoral degree and therefore will be supervised by a world renowned expert in the nursing research.

**HAS THE STUDY RECEIVED ETHICAL APPROVAL?**
The research proposal has received approval from the Primary Health Care Board, your traditional ruler, and the University of the Witwatersrand Research ethics committee before the commencement of the study. All parts of the study will be conducted according to internationally accepted ethical principles.

**WHO CAN YOU CONTACT FOR ADDITIONAL INFORMATION OR COMPLAINT REGARDING THE STUDY?**
The primary investigator, Mrs. Oluchukwu Obiora, can be contacted on her cellular phone at +2348135178591 or via e-mail: 1670233@students.wits.ac.za. The study supervisor, Prof JE Maree, can be contacted during office hours at Tel (011) 488 4272/4196.

**DECLARATION: CONFLICT OF INTEREST**
This study will be funded by the researcher. No publication prohibitions, conditions or limitations were placed on the researcher.

**A FINAL WORD**

Your co-operation and participation in the study will be greatly appreciated. Please sign the informed consent below if you agree to participate in the study. In such a case, you will receive a copy of the signed informed consent from the researcher.

**ADDENDUM 6**

**INFORMATION LEAFLET FOR MOTHERS OF CIRCUMCISED GIRLS**

**PROJECT TITLE:**

**EXPERIENCES AND PERCEPTIONS OF GENITALLY MUTILATED FEMALES AND HEALTHCARE PRACTITIONERS IN SOUTH EASTERN NIGERIA**

**Dear Madam,**
Good day. My name is Mrs. Oluchukwu Obiora and I would like to invite you to participate in a study that will lead to obtaining a doctoral degree in Nursing. This information leaflet will help you to decide whether you would accept this invitation or would prefer not to take part in the study. Before you agree to take part, you should fully understand what is involved. You should not agree to take part unless you are completely satisfied with all aspects of the study.

**WHAT IS THE STUDY ALL ABOUT?**
The study focuses on obtaining insight into your experience of your daughter's circumcision, before during and after the procedure, as well as your perception and motivators of the procedure in your community. The information obtained will be used to develop a health education leaflet for improving self-care of the circumcised females.

**WHAT WILL YOU BE REQUIRED TO DO IN THE STUDY?**
If you decide to partake in this study, the following will be required:

- You will have to sign an informed consent form.
- You will tell me the experience of your daughter's circumcision, and this will take approximately 45 - 60 minutes.
- Follow-up interview will also be required to allow for the opportunity to verify that findings and transcriptions were done correctly and also to give you the opportunity to add to anything that was discussed during the initial in-depth interview. The researcher also uses this opportunity to clarify any misconceptions that might arise when reflecting on the initial story telling-interview.
- The interview will be done at your home or any place where you feel comfortable.
- It will be conducted individually
- It will be conducted in your native language (Igbo), however, a community member who is bilingual will assist with language issues should it be necessary.
- You will be required to answer questions about your experience of your daughter's circumcision, your perception and the motivators of circumcision in your community.
- Though no harm is intended, you might experience some emotional discomfort. Should the researcher identify the need for professional support to assist with the management of your discomfort, you will be referred to a professional counsellor.
- During the interview sessions, the researcher might take notes; this is to assist the researcher during the data analysis period.
- The interview sessions will also be audio taped in order to transcribe the stories verbatim. Your real name(s) will not be used to ensure confidentiality.

**WHAT ARE THE INCLUSION CRITERIA FOR THE STUDY?**
You may participate only if:

- Your daughter must have been circumcised.

**CAN ANY OF THE STUDY PROCEDURES RESULT IN PERSONAL RISK, DISCOMFORT OR INCONVENIENCE?**
Due to the sensitive nature of the topic, some discomfort may be experienced during the interview which will be dealt with in a respectable manner by referring you to a counsellor who have consented to assist with any emotional discomfort that arises during the study.

**FINANCIAL COMPENSATION AND THE POTENTIAL BENEFITS THAT MAY COME FROM THE STUDY?**
You will not be financially compensated for participating in this study. However, your participation in the study will assist the researchers and healthcare practitioners to have a better understanding of your circumcision experiences and then develop evidence-based health education pamphlet for improving self-care of the circumcised females. Also, the findings from the study will help strengthen evidences to eradicate female genital mutilation both nationally and internationally.

**WHAT ARE YOUR RIGHTS AS A PARTICIPANT IN THIS STUDY?**
Your participation in this study is entirely voluntary. You are under no obligation to participate you have the right to withdraw at any stage. You don't even have to provide the reason/s for your decision.

**HOW WILL CONFIDENTIALITY AND ANONYMITY BE ENSURED IN THE STUDY?**
All information obtained during the course of this study is strictly confidential. The study data will be coded so that it will not be linked to your name. Your identity will not be revealed while the study is being conducted or when the study is reported in scientific journals. All the data sheets that will be collected will be stored in a secure place. Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. The information received during the interview will only be used for research purposes.

**IS THE RESEARCHER QUALIFIED TO CARRY OUT THE STUDY?**
The researcher is a Nurse-Midwife and Public Health Nursing Officer registered with the Nursing and Midwifery council of Nigeria, as well as the West African Health Education Board. She has six years clinical experience. Furthermore, the researcher is in possession of a Master's degree in Maternal and Child Health nursing. This study forms part of the researcher's doctoral degree and therefore will be supervised by a world renowned expert in the nursing research.

**HAS THE STUDY RECEIVED ETHICAL APPROVAL?**
The research proposal has recieved approval from the Primary Health Care Board, your traditional ruler, and the University of the Witwatersrand Research ethics committee before the commencement of the study. All parts of the study will be conducted according to internationally accepted ethical principles.

**WHO CAN YOU CONTACT FOR ADDITIONAL INFORMATION REGARDING THE STUDY?**
The primary investigator, Mrs. Oluchukwu Obiora, can be contacted on her cellular phone at +2348135178591 or via e-mail: 1670233@students.wits.ac.za. The study supervisor, Prof JE Maree, can be contacted during office hours at Tel (011) 488 4272/4196.

**DECLARATION: CONFLICT OF INTEREST**
This study will be funded by the researcher. No publication prohibitions, conditions or limitations were placed on the researcher.

**A FINAL WORD**

Your co-operation and participation in the study will be greatly appreciated. Please sign the informed consent below if you agree to participate in the study. In such a case, you will receive a copy of the signed informed consent from the researcher.

**ADDENDUM 7**

**INFORMATION LEAFLET FOR HEALTHCARE PRACTITIONERS**

**PROJECT TITLE:**

**EXPERIENCES AND PERCEPTIONS OF GENITALLY MUTILATED FEMALES AND HEALTHCARE PRACTITIONERS IN SOUTH EASTERN NIGERIA**

**Dear Sir/Madam,**
Good day! My name is Mrs. Oluchukwu Loveth Obiora and I would like to invite you to participate in a study that will lead to obtaining a PhD in Nursing. This information leaflet will help you to decide whether you would accept this invitation or would prefer not to take part in the study. Before you agree to take part, you should fully understand what is involved. You should not agree to take part unless you are completely satisfied with all aspects of the study.

**WHAT IS THE STUDY ALL ABOUT?**
The study focuses on exploring the FGM/C experiences of genitally mutilated girls, genitally mutilated women, mothers of the genitally mutilated girls and the healthcare practitioners in South Eastern Nigeria. The study is conducted in three phases and this information leaflet gives information pertaining to the second phase of the study.

The objective of the second phase of the study is to explore the FGM/C experiences by asking you as a healthcare practitioner to reflect on your experience on taking care of genitally mutilated females in this community, your perception and the FGM/C motivating factors. Data collected during this phase of the study will be analysed and brought back to you to confirm the credibility of the findings and interpretations. The findings will then be published so as to inspire action to end FGM/C and also develop a health education pamphlet for the circumcised females, thereby improving their quality of life.

**WHAT WILL YOU BE REQUIRED TO DO IN THE STUDY?**
If you decide to partake in this study, the following will be required:

- You will have to sign an informed consent form.
- The researcher will conduct an initial interview with you which will take approximately 45 - 60 minutes each.
- Follow-up interviews will also be required to allow for the opportunity to verify that findings and transcriptions were done correctly and also to give you the opportunity to add to anything that was discussed during the initial interview. The researcher also uses this opportunity to clarify any misconceptions that might arise when reflecting on the initial interview.
- The interview will be done at any place where you feel comfortable.
- Interviews will be conducted individually
- Interviews will be conducted in your native language (Igbo), however, a research assistant will assist with language issues should it be necessary.
- You will be required to answer questions about your FGM/C experience, your perception and the motivators of FGM/C in this community. Though no harm is intended, you might experience some emotional discomfort. Should the researcher identify the need for professional support to assist with the management of your discomfort, you will be referred to a professional counsellor.
- During the interview, the researcher might take notes; this is to assist the researcher during the data analysis period.

- The interviews will also be audio taped in order to transcribe the interviews verbatim and your name(s) will not be used during the interview in order to ensure confidentiality.

**CAN ANY OF THE STUDY PROCEDURES RESULT IN PERSONAL RISK, DISCOMFORT OR INCONVENIENCE?**
Due to the sensitive nature of the topic, some discomfort may be experienced during the interview which will be dealt with in a respectable manner by the researcher. Should the researcher identify the need to refer you to a counsellor who have consented to assist with any emotional discomfort that arises during the study.

**FINANCIAL COMPENSATION AND THE POTENTIAL BENEFITS THAT MAY COME FROM THE STUDY?**
You will not be financially compensated for participating in this study. However, Your participation in the study will assist the researchers to have a better understanding of your FGM/C experiences and then develop evidence based health education leaflet for improving self-care of the circumcised females.

**WHAT ARE YOUR RIGHTS AS A PARTICIPANT IN THIS STUDY?**
Your participation in this study is entirely voluntary. You are under no obligation to participate you have the right to withdraw at any stage. You don't even have to provide the reason/s for your decision.

**HOW WILL CONFIDENTIALITY AND ANONYMITY BE ENSURED IN THE STUDY?**
All information obtained during the course of this study is strictly confidential. The study data will be coded so that it will not be linked to your name. Your identity will not be revealed while the study is being conducted or when the study is reported in scientific journals. All the data sheets that have been collected will be stored in a secure place. Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. The information received during the interview will only be used for research purposes.

**IS THE RESEARCHER QUALIFIED TO CARRY OUT THE STUDY?**

The researcher is a Nurse-Midwife and Public Health Nursing Officer registered with the Nursing and Midwifery council of Nigeria, as well as the West African Health Education Board. She has six years clinical experience. Furthermore, the researcher is in possession of a Master's degree in Maternal and Child Health nursing. This study forms part of the researcher's doctoral degree and therefore will be supervised by a world-renowned expert in the nursing research.

**HAS THE STUDY RECEIVED ETHICAL APPROVAL?**
The research proposal has received approval from the Primary Health Care Board, the traditional ruler, and the University of the Witwatersrand Research ethics committee before the commencement of the study. All parts of the study will be conducted according to internationally accepted ethical principles.

**WHO CAN YOU CONTACT FOR ADDITIONAL INFORMATION REGARDING THE STUDY?**
The primary investigator, Mrs. Oluchukwu Loveth Obiora, can be contacted on her cellular phone at +2348135178591 or via e-mail: 1670233@students.wits.ac.za. The study supervisor, Prof JE Maree, can be contacted during office hours at Tel (011) 488 4272/4196.

**DECLARATION: CONFLICT OF INTEREST**
This study will be funded by the researcher. No publication prohibitions, conditions or limitations were placed on the researcher.

**A FINAL WORD**

Your co-operation and participation in the study will be greatly appreciated. Please sign the informed consent below if you agree to participate in the study. In such a case, you will receive a copy of the signed informed consent from the researcher.

**ADDENDUM 8**

**RESEARCH ASSISTANT CONFIDENTIALITY AGREEMENT**

I, _____, ID number _____, hereby declare that I am willing to assist Mrs. Oluchukwu Obiora during interviews for her PhD study on '**experiences and perceptions of genitally mutilated females and healthcare practitioners in South Eastern Nigeria"**. I will assist with any language issues should it arise. I understand that all information obtained during the interviews would be kept confidential.

Signature: _____ Date: _____

Witness: _____ Date: _____

Witness: _____ Date: _____

**ADDENDUM 9**

**INTERVIEW GUIDE FOR GIRLS**

Section A: General Information

| Nos | Categories | Findings |
|---|---|---|
| 1. | Age | |
| 2. | Caretakers | Parents ☐<br>Grandparents ☐<br>Guardians ☐ |
| 3 | Cultural group | |
| 4 | Religion | |
| 5 | Marital Status | |
| 6 | Highest Educational level | |
| 7. | Age at circumcision | |
| 8. | Assent given? | |
| 9. | Circumciser | |
| 10 | Do you know what was removed from you during circumcision? | Yes ☐<br>NO ☐ |
| 11 | If yes, please tell me | |

Section B: Main Question

*Please tell me about your experience of FGM/C from the day you were circumcised up to now*

Themes to explore:

1. Motivators of FGM/C in your Community
2. Support for FGM/C

**ADDENDUM 10**

**INTERVIEW GUIDE. FOR WOMEN**

Section A: General Information

| Nos | Categories | Findings |
|---|---|---|
| 1. | Age | |
| 2 | Cultural group | |
| 3 | Religion | |
| 4 | Marital Status | |
| 5 | Highest Educational level | |
| 6. | Age at circumcision | |
| 7. | Assent given? | |
| 8. | Circumciser | |
| 10 | Do you know what was removed from you during circumcision? | Yes ☐<br>NO ☐ |
| 11 | If yes, please tell me | |

Section B: Main Question

*Please tell me about your experience of FGM/C from the day you were circumcised up to now*

Themes to explore:

1. Motivators of FGM/C in your Community
2. Support for FGM/C

**ADDENDUM 11**

**INTERVIEW GUIDE FOR MOTHERS OF CIRCUMCISED GIRLS**

Section A: General Information

| Nos | Categories | Findings |
|---|---|---|
| 1 | Age | |
| 2 | Cultural group | |
| 3 | Religion | |
| 4 | Marital Status | |
| 5 | Highest Educational level | |
| 6. | How many daughters do you have? | |
| 7. | How old is/are your daughter (s)? | |
| 8. | What is her/ their marital status? | |
| 9. | What is her/ their highest educational status | |
| 10. | Age at which daughter (s) was circumcised | |
| 11. | Daughter (s) assent obtained | |
| 12 | Mother's consent obtained | |
| 13. | Daughter (s) circumciser | |
| 14 | Do you know what was removed from your daughter during circumcision? | Yes ☐ NO ☐ |
| 15 | If yes, please tell me | |

Section B: Main Question

*Please tell me how you experienced your daughter (s) genital circumcision, from the day she was circumcised up to now*

Themes to be explored

1. Motivators of FGM/C in your Community
2. Support for FGM/C

**ADDENDUM 12**

## INTERVIEW GUIDE FOR HEALTHCARE PRACTITIONERS

Section A: General Information

| Nos | Categories | Findings |
|---|---|---|
| 1. | Age | |
| 2. | Cultural group | |
| 3. | Religion | |
| 4. | Marital Status | |
| 5. | Highest Educational level | |
| 6 | Years of practice in this community | |
| 7. | Years of residency in the community | |
| 8. | Have you witnessed female circumcision? | |
| 9. | If yes to question 9 above, how many times? | |
| 10 | Age at which females are circumcised | |
| 11 | Consent obtained | |
| 12 | What type (s) of female circumcision is done in this community? | |

Section B: Main Question

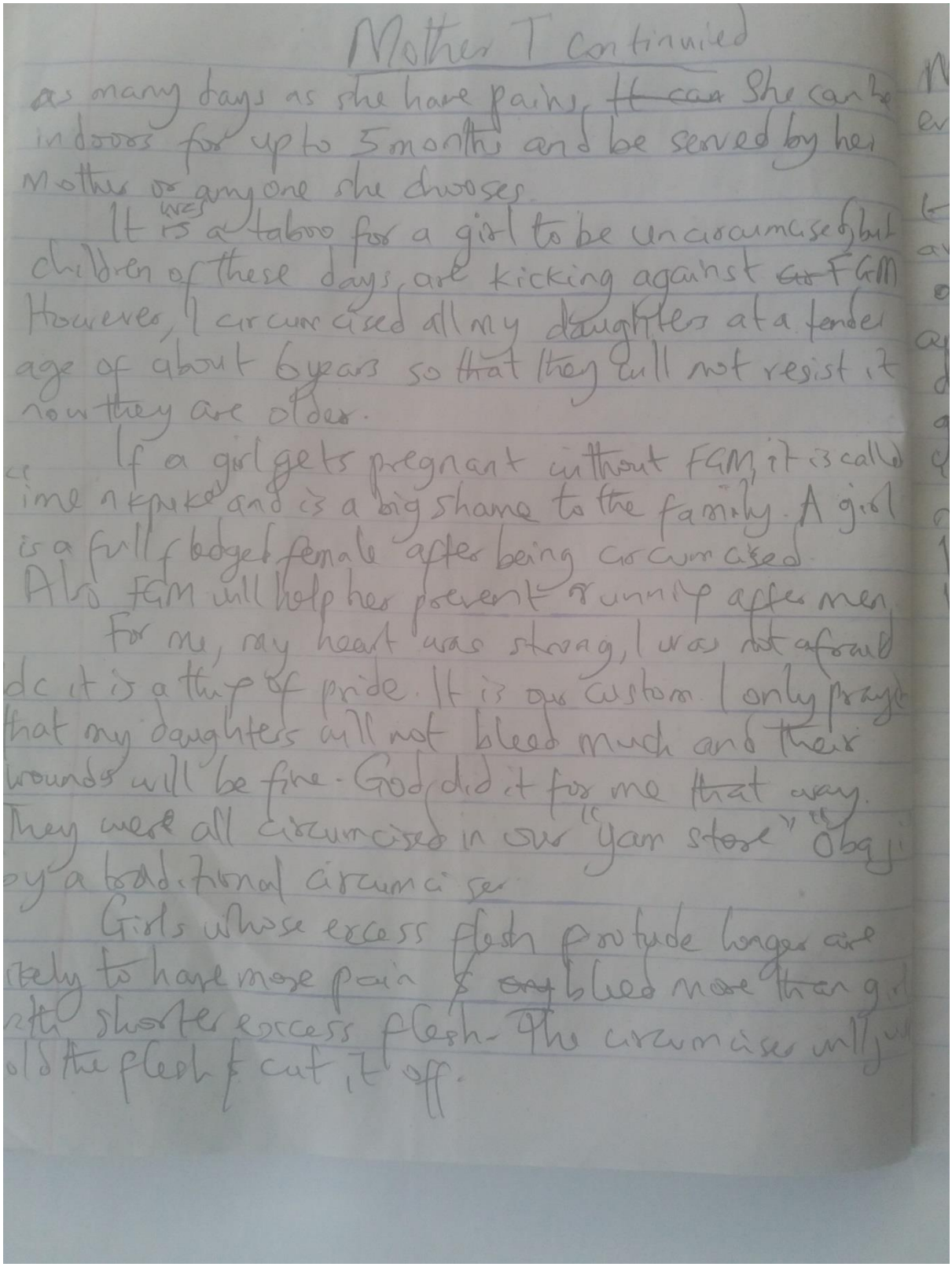
*Please tell me your experiences about FGM/C in this community and reasons why healthcare practitioners assist them with the procedure.*

Themes to explore

1. Reasons that can make a healthcare practitioner assist with doing FGM/C
2. Motivators for FGM/C in this community
3. Support for FGM/C

**ADDENDUM 13**

**SAMPLE OF A FIELD NOTE**



Mother T continued

as many days as she have pains, ~~It can~~ She can be indoors for up to 5 months and be served by her Mother or anyone she chooses.

It is a taboo for a girl to be uncircumcised, but children of these days are kicking against ~~it~~ FGM However, I circumcised all my daughters at a tender age of about 6 years so that they will not resist it now they are older.

If a girl gets pregnant without FGM, it is called ime nkpuke and is a big shame to the family. A girl is a full fledged female after being circumcised. Also FGM will help her prevent running after men.

For me, my heart was strong, I was not afraid do it is a thing of pride. It is our custom. I only prayed that my daughters will not bleed much and their wounds will be fine. God did it for me that way. They were all circumcised in our "yam store" "Obgi" by a traditional circumciser.

Girls whose excess flesh protrude longer are likely to have more pain & ~~are~~ bleed more than girl with shorter excess flesh. The circumciser will hold the flesh & cut it off.

**ADDENDUM 14**

## SAMPLE OF ANALYSED TRANSCRIPT FOR THE HEALTHCARE PRACTITIONERS

P: No.

*N: As a health worker with many years of experience, what do circumcised women used to tell you about their sexual life with their partners?*

Circumcised women have less sexual urge

P: They complain they have less sexual urge or feelings. Hence, it is difficult to arouse them sexually. This lack of sexual feelings is one of the major causes of problems in their homes.

*N: Does it then means that FGM/C prevents promiscuity in women since they have less sexual urge?*

P: The women tell us FGM/C prevents promiscuity but we teach them that the opposite is the case. We educate them that circumcised women have no sexual satisfaction and this makes them more promiscuous in their quest to be satisfied.

*N: As a midwife, what is your experience with FGM mothers who come here to deliver their babies?*

*P*: Some of them have difficult or forceful delivery. So, to help them, we assist with episiotomy on time to avoid tears and bruises which are usually very difficult to suture.

*N: Are there other negative effects of FGM/C which you have experienced here?*

P: Some of them have tight perineum which causes difficult delivery as the vagina is narrowed.

*N: Which period in a girl's life do they normally circumcise her in this community?*

Circ is done few days after birth

P: circumcision is done usually within one week of delivery. The girl child grows up thinking her genital is normal, only to be told during birth that she was circumcised.

*N: What is the relationship between VVF and FGM?*

VVF Stones

P: VVF can be a consequence of FGM. One of the clients told me this morning that her daughter urinates abnormally as urine doesn't flow well (urinary leakage). During history taking, she said she just circumcised the baby.

*N: I learnt that some people in this community are still circumcising their girls? How true is this story?*

Govt has banned FGM/C FGM/C is done secretly in homes

P: Although government has banned circumcision, yet it still is being done secretly in homes.

*N: There is a new method of circumcision trending in this community. Do you have anything to say about it?*

Supposed new method

P: The new method also called type I is not approved but I have no problem with it. They say it destroys the small capillaries in the clitoris and so it's similar to FGM.

*N: since you said you don't have problem with it, why didn't you do it for your daughters?*

P: I did the new method for my daughters. Did new method for daughters

**ADDENDUM 15**

**SAMPLE OF ANALYSED TRANSCRIPT FOR THE GIRLS PARTICIPANTS**

N: Good. Please tell me what your mother told you

P: She said circumcision is done to make a girl's body good and to remove what is called "ikpa" or "api" from the person.

Circ is done to make a girl's body good
" " " " remove "api"

N: Ehee

P: She said that if a girl is not circumcised, she will have difficulty with childbirth. She said it is a type of "crucifixion"; that a girl is supposed to be crucified so she can be like other girls.

- Mother said Circ is like Crucifixion
A girl is crucified so she can be like other girls
Uncirc girl have difficulty with childbirth

N: How many girls did your mother give birth to?

P: We are 8 female children born by my mother.

N: Were all the girls circumcised?

All sisters were Circ.

P: Yes, all of us were circumcised including my younger sister. I didn't witness her circumcision, but my mother told us all that we are all circumcised so we can look like other girls. I suspect that she was circumcised in the hospital.

I suspect I was circ in hospital

N: What makes you have that suspicion?

P: It's just because since my mother came back from hospital after giving birth to my younger sister, we all have stayed together in the same house and yet I never saw nor knew when she was circumcised, but my mother told us that she is also circumcised. My mother believes strongly that circumcision is good for every girl. Even herself was circumcised by he own parents before she married my father.

Mother believes strongly that Circ is good
Mother was circ before marry father

N: So how has been your life since child hood. Have you suffered from any genital infection or pain in your genitals?

P: I have had neither pain nor sign of infection in my genitals. Neither had any of my siblings ever complained of pains or any abnormal feeling in their genitals. I think we all have been living our lives and growing up like other girls in this village. In fact, we rarely remember that we were circumcised, neither do we discuss it often at home.

Never had any pain no problem in my genital
We rarely remember that we were circ at home

N: Have you ever heard that the government is against FGM?

P: Yes, I have heard a male teacher say something like that to us in school

N: So what did he say?

P: I think he said that FGM is not good and that the government said that people should stop it

A Male teacher preached against Circ in sch

2

**ADDENDUM 16**

**SAMPLE OF ANALYSED TRANSCRIPT FOR THE MOTHERS PARTICIPANTS**

that day. My father was very wealthy in our village. So when I was circumcised, my parents did even a bigger ceremony for me. Seven different animals were slaughtered that day. I was told to request for anything I want to eat and it will be provided for me. Look at my hand, My mother brought very skilled women that did this tattoo on my hand using various fine colours of the local powder. It was done to beautify me permanently. So it is not a secret affair. The king was there for the ceremony of my daughters' circumcision.

N: How old were your daughters when they were circumcised?

P: Ehmm, for me, I circumcised my daughters when they were still small girls. They were about six years of age. I am not sure of the age at which I circumcised them but they were very small girls then that were yet to start going to school. But in our community, girls are circumcised when they start developing into womanhood. When they start forming breasts and can now menstruate. Then they can get pregnant and bear children, so they are marriageable. There is no specific age for that. Their body changes give you a sign that they are old enough to be circumcised, then you plan for a convenient day and prepare for them to be circumcised.

N: Why did you choose to circumcise them so early?

P: As we all know, the world is changing and some children today when you allow them to get to that age of developing into womanhood, they will become so bold and refuse circumcision which is our tradition. There are cases of girls in this community who grew up and kicked against FGM. They vehemently disobeyed their parents' desire for them to be circumcised. So I decided to circumcise my girls early in their lives so that they will not grow up and rebel against circumcision.

N: What made you think that they will rebel against circumcision which is the culture?

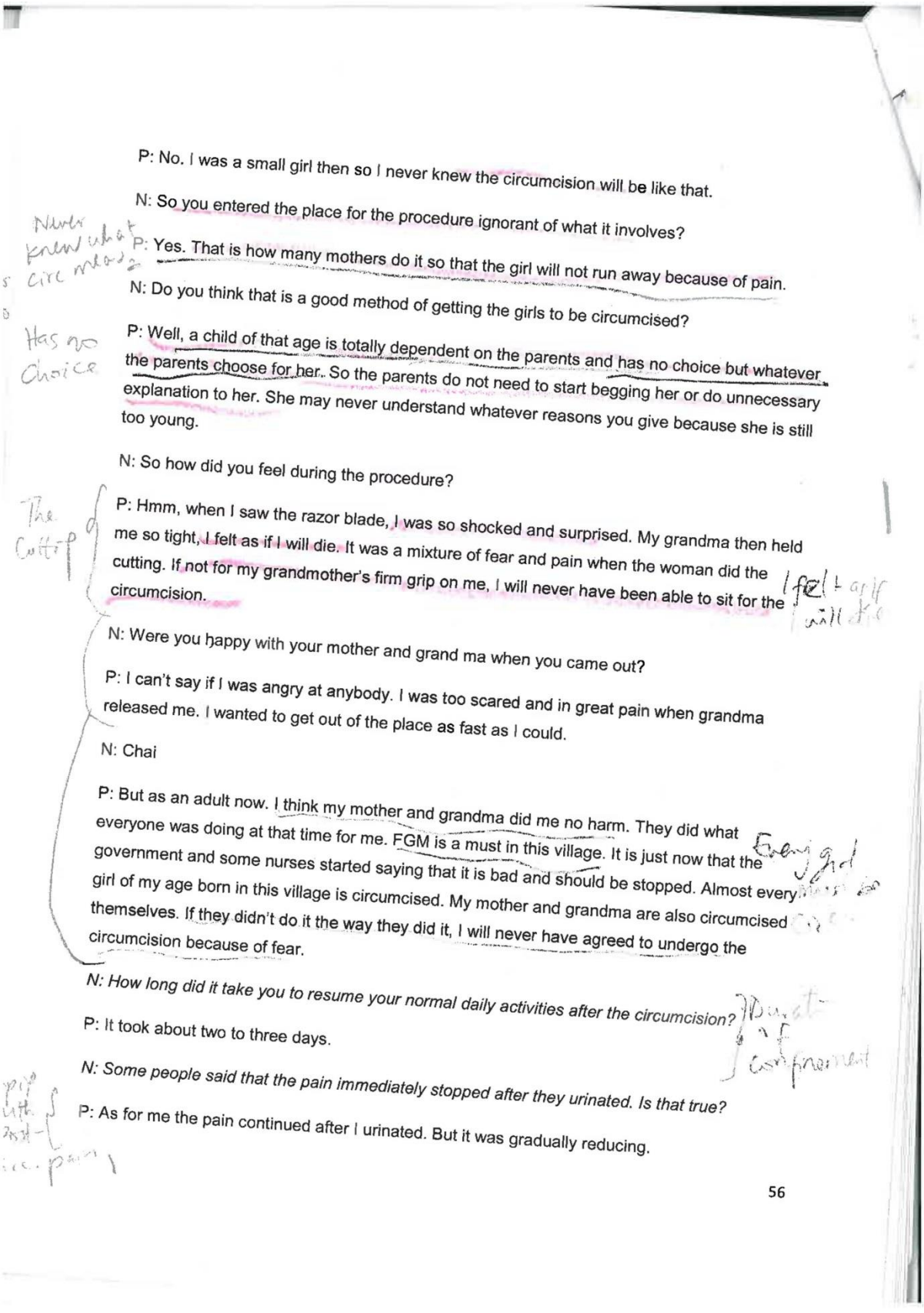
P: Well, I didn't say that they must rebel; but no one knows tomorrow. The world is changing fast. If you go round the village more, you will discover that some mothers also circumcised their daughters at tender ages for this same reason I told you.

N: Well, is it a good idea to change the tradition of circumcising the girls when they are about to enter womanhood?

P: Well, I told you that children of these days are not obedient like us when we were their age, so instead of the girl bringing shame to the family, we circumcise her early in life.

N: Okay, what preparations did you make for their circumcision?

## SAMPLE OF ANALYSED TRANSCRIPT FOR THE WOMEN PARTICIPANTS



P: No. I was a small girl then so I never knew the circumcision will be like that.

N: So you entered the place for the procedure ignorant of what it involves?

P: Yes. That is how many mothers do it so that the girl will not run away because of pain.

N: Do you think that is a good method of getting the girls to be circumcised?

P: Well, a child of that age is totally dependent on the parents and has no choice but whatever the parents choose for her. So the parents do not need to start begging her or do unnecessary explanation to her. She may never understand whatever reasons you give because she is still too young.

N: So how did you feel during the procedure?

P: Hmm, when I saw the razor blade, I was so shocked and surprised. My grandma then held me so tight, I felt as if I will die. It was a mixture of fear and pain when the woman did the cutting. If not for my grandmother's firm grip on me, I will never have been able to sit for the circumcision.

N: Were you happy with your mother and grand ma when you came out?

P: I can't say if I was angry at anybody. I was too scared and in great pain when grandma released me. I wanted to get out of the place as fast as I could.

N: Chai

P: But as an adult now. I think my mother and grandma did me no harm. They did what everyone was doing at that time for me. FGM is a must in this village. It is just now that the government and some nurses started saying that it is bad and should be stopped. Almost every girl of my age born in this village is circumcised. My mother and grandma are also circumcised themselves. If they didn't do it the way they did it, I will never have agreed to undergo the circumcision because of fear.

*N: How long did it take you to resume your normal daily activities after the circumcision?*

P: It took about two to three days.

*N: Some people said that the pain immediately stopped after they urinated. Is that true?*

P: As for me the pain continued after I urinated. But it was gradually reducing.

56

**ADDENDUM 18**

**Table 1: PROFILE OF STUDIES FOR THE SCOPING REVIEW** **n=28**

| No. | AUTHOR (DATE) *COUNTRY* | PURPOSE | STUDY DESIGN | POPULATION *SAMPLING* | INSTRUMENT *DATA COLLECTION* | MAJOR FINDINGS |
|---|---|---|---|---|---|---|
| 1. | Abathun,Sundby & Gele. (2016) ***Ethiopia*** | To explore the attitude toward female genital mutilation (FGM) | Explorative Qualitative. | People of Somali and Harari regions, Eastern Ethiopia *Purposive sampling (n=64).* | Open ended, semi structured questionnaire *Focus group discussions* | Strong support for the continuation of FGM among female discussants. Most of the participants from Harari region and males discussants had a positive attitude toward the discontinuation of the practice. |
| 2. | Rodrigue Seuc, Say & Hindin, (2016) ***Burkina Faso, Ghana, Kenya, Nigeria, Senegal and Sudan*** | To investigate the association between type of episiotomy and obstetric outcomes among women with type 3 Female Genital Mutilation (FGM). | A secondary analysis | Women who presented for singleton delivery at 28 obstetric centres in Burkina Faso, Ghana, Kenya, Nigeria, Senegal and Sudan between November 2001 and March 2003 *Convenience sampling method.* | Direct clinical examination. *Participants had an antenatal examination of the external genitalia, by a trained study midwife, to identify if they had undergone FGM, the type was categorized according to the WHO classification system.* | The type of episiotomy performed varied significantly by FGM status. The most common type of episiotomy performed was posterior lateral (25.4 %). Prevalence of the most anterior and posterior lateral episiotomy increased with type of FGM. Among women without FGM, 0.4 % had this type of episiotomy. This increased to 0.6 % for women with FGM Types 1, 2 or 4 and to 54.6 % of all women delivering vaginally with FGM Type 3. Women with anterior episiotomy, posterior lateral episiotomy and the combination of the two were significantly less likely to have postpartum haemorrhage unlike women with no episiotomy. |
| 3. | Bogale, Markos & Kaso. (2015) ***Ethiopia*** | To find out the intention of women toward the continuation of FGM | Cross-sectional design supplemented by qualitative methods | Bale Zone women of childbearing–age. *Stratified random and purposive sampling methods* | Pretested and structured questionnaire. *FGD and in-depth interview was undertaken* | About 26.7% of the respondents had intention for the continuation of FGM. Religion, safeguarding virginity, tradition, and social values were the main reasons for the perpetuation of FGM. Circumcised respondents and illiterates were three times more likely to support the continuation of FGM |
| 4. | Kandala & Komba. (2015) ***Senegal*** | To examine the prevalence of FGM and the effectiveness of the anti-FGM law in in Senegal | Case study. Quantitative design | Women of reproductive age (15 - 49 years old) and men between 15 and 59 years old *Multistage stratified random sampling* | The 2010/2011 Senegal Demographic Health Survey (DHS) and Multiple Indicator Cluster Survey (MICS). *Nationally representative samples were interviewed.* | Prevalence among women and daughters was 28.1% and 6.2%, respectively. Significant factors were socio-demographics, ethnicity, and region. The law falls short of offering adequate protection to potential victims. |

| | | | | | | |
|---|---|---|---|---|---|---|
| 5. | Galukande, Kamara, Ndabwire, Leistey, Valla & Luboga (2015) ***Tanzania*** | To analyse the impact of an 18 month long campaign to eradicate or reduce FGM/C in a rural predominantly Masai community. | An observational study involving mixed methods. | Villages in Mukulat district of Arusha region.<br><br>*Systematic household (HH) sampling without replacement for non-responses or vacant HH* | Interview guides and FGD schedules were developed.<br><br>*A household survey, key informant interviews, FGDs, school children's group discussions and project document reviews were done.* | The self-reported prevalence of self-reported FGM/C was 69.2%. However, examination of women in labour revealed a prevalence of over 95 %. Those in favour of FGM/C eradication were 88 %. Nearly a third of the 100 FGM practitioners denounced the practice. They also formed a peer group that met regularly. Knowledge about FGM/C health risks increased from 16 to 30 % ($p < 0.001$). The practice is currently done secretly to an uncertain extent. |
| 6. | Achia, (2014)<br><br>***Kenya*** | To map the geographical variations in the practice of FGM/C in Kenya, and the existing support for the continuation of the practice in the country. | Descriptive (cross sectional) survey | Women of reproductive age (15 - 49 years old) in Kenya<br><br>*Two stage stratified random sampling design and a sampling frame maintained by the Central Bureau of Statistics* | A questionnaire based on a model developed by the MEASURE DHS programme, with slight adjustments to reflect relevant issues in Kenya,<br><br>*Secondary data were used. Fieldwork was conducted in 2008* | Prevalence of FGM/C stood at 28.2% and about 10.3% of the women interviewed indicated that they supported the continuation of FGM. Age, region, education, marital status, religion, socioeconomic status and media exposure were found to be significantly associated with FGM/C. The FGM/C status of a woman was also a significant predictor of support for the continuation of FGM/C. |
| 7. | Plo, Asse, Seï & Yenan. (2014)<br><br>***Cote d' Ivoire*** | To describe the epidemiological aspects and clinical findings related to FGM in young patients. | Prospective study | Young females and their mothers in Abidjan<br><br>*Convenience sampling* | Self-structured Questionnaire<br><br>*409 infants and young girls aged from 1 to 14 years. The FGM status of girls was recorded during in or outpatient visits.* | About 15% of the patients were cut. Most of the young females came from Muslim families (97%); age at FGM procedure in patients was less than 5 years (87%). Motivations for FGM were virginity, chastity, body cleanliness, and fear of clitoris similar to penis. Only WHO types I and II were met. |
| 8 | Bogale, Markos & Kaso. (2014)<br><br>***Ethiopia*** | To find out the prevalence of FGM, its health consequences and factors underpinning its perpetuation. | Cross-sectional study design supplemented by qualitative methods | Bale Zone child bearing age women<br><br>*Stratified random and purposive sampling method* | Pretested and structured questionnaire.<br><br>*FGD and in-depth interview was undertaken* | Most (78.5%) of the women had undergone FGM. The reported immediate complications were excessive bleeding at the time of the procedure, infection, urine retention and swelling of genital organ. Muslim women and women from rural areas were significantly more likely to have undergone the procedure. |
| 9. | Kaplan, Forbes, Bonhour, Utzet, Martin, Manneh & Ceesay (2013)<br><br>***Gambia*** | To obtain information on the long term health consequences of FGM/C in Gambia as well as on its impact on delivery and on the health of the newborns. | Descriptive, quantitative study | Women in the Western Health Region of Gambia<br><br>*Women who came for antenatal care or delivery in the Western Health Region.* | Questionnaire and direct medical examination.<br><br>*Participants were examined by a midwifery student, regardless of whether or not they had undergone FGM/C.* | The prevalence of FGM/C was 75.6% (type I: 75.6%; type II: 24.4%). Women with type I and II FGM/C had a significantly higher prevalence of long term health problems and sexual dysfunction. Women with FGM/C were also more likely to suffer complications during delivery and complications associated with anomalous healing after FGM/C. Also, newborns were found to be more likely to suffer complications such as fetal distress and caput of the fetal head. |

| | | | | | | |
|---|---|---|---|---|---|---|
| 10 | Kaplan, Hechavarría, Bernal & Bonhoure *(2013)* ***Gambia*** | To examine the knowledge, attitudes, and practices regarding FGM/C among Health Care Professionals (HCPs) working in rural settings in the Gambia. | A descriptive, quantitative methodology, following a multiethnic approach | Health Care Professionals (HCPs) working in rural settings in the Gambia.<br><br>*All public health system facilities located in the rural regions.* | A pretested questionnaire with open and closed ended questions was developed.<br><br>*The questionnaires were administered face to face.* | About 42.5% of the respondents supported the continuation of FGM/C. About 42.7% intended to subject their own daughters to it while 7.6% indicated that they have performed it during their medical practice. Their knowledge, attitudes, and practices were shaped by sex and ethnic identity. |
| 11 | Salihu, August, Salemi, Weldeselasse , Sarro & Alio, (2012)<br><br>***Mali*** | To determine whether female genital mutilation (FGM) is a risk factor for intimate partner violence (IPV) and its subtypes (physical, sexual and emotional). | Population-based cross-sectional study. | Women of child bearing age (15 - 49) years in urban and rural regions of Mali<br><br>*Two-stage clustered sampling design based on national census data were done.* | The study used the 2006 Demographic and Health Survey (DHS) conducted in Mali.<br><br>*The survey assessed FGM by asking the respondents questions based using the DHS survey questionnaire as a guide.* | Findings revealed that women with FGM had an increased risk for IPV. IPV subtypes were physical, sexual and emotional. The odds of IPV increased with ascending FGM severity (P for trend <0.0001). The most elevated odds were observed among women with severe FGM, who were nearly nine times as likely to experience more than one IPV subtype. |
| 12 | Yirga, Kassa, Gebremichael & Aro, *(2012)*<br><br>***Ethiopia*** | To identify the prevalence, perceptions, perpetuators, reasons, and factors associated with FGM with regard to women's health. | A community based cross-sectional survey | Females of reproductive age (15–49 years), in Kersa district, East Hararge, Oromia region, Ethiopia.<br><br>*Systematic random sampling* | Self-structured Questionnaire<br><br>*House to house interviews were conducted among 858 respondents* | Most respondents (76.1%) reported that local healers were the main performers of FGM, and 78.9% respondents stated that the clitoris was the part removed during circumcision. The main reason for the practice of FGM was reduction of female sexual hyperactivity. Circumcision of daughters was reported by 88.1% of the respondents. |
| 13 | Mahmoud, (2016)<br><br>***Egypt*** | To investigate the effects of FGC on the female sexual function of Egyptian women | A case control study. | Egyptian women<br><br>*A non-probability (accidental sampling) method.* | A socio-demographic profile form and the Arabic Female Sexual Function Index (ArFSFI).<br><br>*Participants were interviewed and also clinically examined* | 73.9% of the respondents experienced dysmenorrhea, 43.4% had obstructed labor and 27.6% got postpartum hemorrhage . 48.9% of FGM was performed by dayas or midwives, 91.2% of the procedures were performed at home, 49.6% of type I, and 87.9% experienced complications. Those who underwent FGM/C had lower mean sexual function. 52.6% supported FGM. |
| 14 | Zayed, & Ali, (2012)<br><br>***Egypt*** | To record the prevalence of FGM in 2010, in the region of Cairo and Giza, after the change in the law and banning of the procedure. | Cross-sectional survey | Females in the region of Cairo and Giza, Egypt<br><br>*Sample was randomly chosen between ages of 5 and 30 years.* | Formatted questionnaire for 244 females.<br><br>*Questionnaires were administered to the respondents individually.* | About 63.9% of the sample had been victimised by FGM. The mean age of circumcision was 10.846 ± 1.98 years. FGM took place at victim's home, private clinics or at hospitals. The procedure was mostly performed by medical personnel. The motivation behind the practice was primarily traditional beliefs and religious considerations. |

| | | | | | | |
|---|---|---|---|---|---|---|
| 15 | Sipsma, Chen, Ofori-Atta, Ilozumba & Karfo. (2011)<br><br>**10 countries in Western Africa.** | To conduct a cross-national comparative study of the prevalence and correlates of female genital cutting (FGC) practices and beliefs in western Africa. | cross-national comparative study | Women, men and children from Burkina Faso, Côte d'Ivoire, Gambia, Ghana, Guinea-Bissau, Mauritania, Niger, Nigeria, Sierra Leone and Togo<br><br>*Two-stage stratified sample design.* | MIC questionnaire was used<br><br>*The MICS used three sets of questionnaires, including a women's self-reporting questionnaire administered face to face to all women in each household between the ages of 15 and 49 years* | The prevalence of FGC was high overall but varied substantially across countries. In Sierra Leone, Gambia, Burkina Faso and Mauritania, the prevalence of FGC was 94%, 79%, 74% and 72%, respectively, while in Ghana, Niger and Togo prevalence was less than 6%. Older age and being Muslim were generally associated with increased odds of FGC, and higher education was associated with lower odds of FGC. Burkina Faso experienced a reduction in FGC prevalence from women (74%) to their daughters (25%). |
| 16 | Rasheed, Abd-Ellah & Yousef (2011)<br><br>**Egypt** | To estimate the influence of the 2007 criminalization law on the prevalence and yearly incidence of FGM in Upper Egypt. | Quantitative, cross-sectional study | Girls and their parents presenting at the departments of Gynecology or Pediatrics of Sohag and Qena University Hospitals. All nurses and physicians in either hospital.<br><br>*Convenience sampling* | Self-structured questionnaire<br><br>*The respondents were presented with the study questionnaire and were asked to respond to the items in it.* | The prevalence of FGM was 89.2%. The procedures were largely performed by general practitioners. In total, 88.2%, 34.3% and 14.9% of nurses, young physicians, and senior physicians, respectively, approved the practice. Thus, the incidence of FGM is still very high in Upper Egypt in spite of the criminalization law. While general practitioners perform most procedures, most nurses are in favor of preserving the practice. |
| 17 | Kaplan, Hechavarria, Martin & Bonhoure (2011)<br>**Gambia** | To ascertain the magnitude of the health consequences of FGM/C in Gambia. | Quantitative study. | Female patients who presented with problem requiring a medical gynaecologic examination and who had undergone FGM/C.<br><br>*Convenience sampling* | Direct medical examination.<br><br>*Data were collected in hospitals and major health centres throughout the country.* | The prevalence of patients with different types of FGM/C were: type I, 66.2%; type II, 26.3%; and type III, 7.5%. Complications due to FGM/C were found in 34.3% of the patients. Even type I, presented complications in 1 of 5 girls and women examined. |
| 18 | Alo & Gbadebo (2011)<br><br>**Nigeria** | To determine the intergenerational attitude changes regarding female genital cutting (FGC) | A Qualitative and quantitative enquiry | Women aged 15-49 years who had at least one surviving daughter in the six states of southwest Nigeria<br><br>*Stratified random sampling* | FGDs and an in-depth interview using modified DHS survey questionnaire.<br><br>*FGDs and an in-depth interview with fourteen women considered to be specialist in FGC were also done.* | The FGC prevalence rate was 75% and 71% for mothers and daughters, respectively. About 52% of the respondents are aware of the health hazards of FGC. Educated mothers were found to be less likely to support the cutting of their daughters. |

| | | | | | | |
|---|---|---|---|---|---|---|
| 19 | Fahmey, El-Mouelhy & Ragab (2010)<br><br>**Egypt** | To examine the role of female sexuality in the continued support for FGM/C, and their perceptions of its sexual consequences. | Qualitative descriptive study | Men and women in two rural communities in upper Egypt.<br><br>*Purposive sampling* | Focused group discussion and in-depth interviews.<br><br>*Data were collected from 102 women and 99 men through FGDs and interviews.* | Findings revealed that FGM/C was intended to reduce women's sexual appetite and increase women's chastity, but was generally not believed to reduce women's sexual pleasure. Men considered sexual satisfaction as a cornerstone of marital happiness while women considered themselves sexually satisfied if they have marital harmony and satisfactory socio-economic status. |
| 20 | Esho, Enzlin, Wolputte & Temmerman<br><br>(2010)<br><br>**Kenya** | To explore circumcised women's own characterisations of sexual experiences | Exploratory, qualitative study | Men and women from Narok district (massai community) in Kenya, East Africa.<br><br>*Convienient sampling* | FGDs, questionnaire for interview and a passive observation procedure.<br><br>*Questionnaires were administered to the sample. Also, majority of them took part in FGDs. Thereafter, the researcher passively participated in a live initiation ceremony* | The findings show that social–cultural factors, namely ritual and symbol, have greater prominence in mediating sexual relations. |
| 21 | Jirovsky<br><br>(2010)<br><br>Burkina Faso | To find out how FGM was viewed by women and men in Bobo-Dioulasso, Burkina Faso 15 years after FGM was banned.. | Ethnographic, qualitative study | Women and men aged 18-89 in Bobo-Dioulasso, Burkina Faso.<br><br>*Snowball sampling.* | An interview guide was used.<br><br>*Informal interviews on FGM were done. Also, 44 semi-structured interviews with 24 women and 20 men aged 18 to 89 years was carried out.* | The prevalence of FGM seems to be decreasing among the respondents. The most important argument for continuing this procedure was the need to control female sexuality so as to ensure morally acceptable behaviour. Bobolaise women used various substances to enhance sexual pleasure for men, both to keep the relationship and to protect the gifts and money many women needed to survive and for their children.. |
| 22 | Ako & Akweongo<br><br>(2009)<br><br>**Ghana** | To determine the role of the state in stopping the practice of FGM through legal means, and why FGM continues to be practised in the communities. | Qualitative study | Communities in upper east region, Ghana<br><br>*Purposive sampling* | Semi-structured interview guides and secondary qualitative data on FGM from journals 1994 to 2009.<br><br>*In-depth interviews were conducted* | Although FGM has been criminalised, but lack political support to ensure that the law is effectively implemented has been lacking. |

| | | | | | | |
|---|---|---|---|---|---|---|
| 23 | Diop & Askew (2009)<br><br>**Senegal** | To determine the effect of a basic education program on women's and men's knowledge, beliefs, and attitudes regarding FGM/C as well as their willingness to abandon this practice. | A quasi-experimental, longitudinal design | Men, women and girls from communities in rural areas in Southern Senegal (Kolda region).<br><br>*A two-stage random sampling plan and also purposive sampling were used* | Community-based educational intervention program and interviews.<br><br>*In the intervention villages, a baseline survey, an immediate post intervention survey, and an end-line survey were carried out.* | Information from the program was diffused widely within the intervention villages, without corresponding improvement in the comparison villages. The prevalence of FGM/C among daughters aged ten years and younger decreased significantly over time but not among daughters in the comparison villages. The results suggested that the program had a positive influence on family behaviors and attitudes. |
| 24 | Refaat<br><br>(2009)<br><br>**Egypt** | To find out the determinants of the practice of FGC among Egyptian physicians. | A cross-sectional descriptive study | Egyptian physicians<br><br>*Stratified random sampling.* | A self-developed questionnaire.<br><br>*Lists of physicians by specialty were obtained. The questionnaires were enveloped and delivered to them through the mail.* | The findings revealed 88% of the physicians knew at least one physical or sexual consequence. About 18% approved of FGC, mostly as a religious observation (82%). One-fifth of physicians practised FGC, mostly due to conviction (51%) or for profit (30%). Cultural influences were the highest determinant (81%). |
| 25 | Tag-Eldin, Gadallah, Al-Tayeb, Abdel-Aty, Mansour & Sallem (2008)<br>**Egypt** | To find out the prevalence and perpetuators of FGC among schoolgirls in Egypt and todocument the rate of reported complications. | A cross-sectional study quantitative study | School girls in Egypt<br><br>*Multistage random.* | An interview questionnaire was used.<br><br>*Interviews were conducted by female physicians working in the school sector of the National Health Insurance Organization.* | The prevalence of FGC among schoolgirls in Egypt was 50.3%. The prevalence of FGC was 46.2% in government urban schools, 9.2% in private urban schools and 61.7% in rural schools. Educational levels of mother and father were negatively associated with FGC ($P < 0.001$). The mean age at the time of FGC was 10.1 +/- 2.3 years. |
| 26 | Koster & Price (2008)<br><br>**Rwanda** | To assess whether Rwandan vaginal practices should indeed be considered a form of FGM. | Qualitative study | Men and women in Rwanda<br><br>*Purposive sampling.* | Semi-structured interviews guides<br><br>*Semi-structured interviews were conducted with a sample of 13 key informants. A review of the scientific literature and consultations with various experts in the field of botany.* | The respondents considered labial elongation as a positive force in their lives, enhancing their sexual pleasure. Also, apart from the risk of lesions and infections that arise from the elongation of the labia minora, the use of plants by Rwandan women enlarging their labia minora was consideredvpotentially beneficial to their health. |

| | | | | | | |
|---|---|---|---|---|---|---|
| 27 | Odu (2008)<br><br>Nigeria | To investigate the attitude of undergraduate females in a Nigerian University towards FGM and the harmful effects of FGM | Descriptive quantitative survey | All undergraduate females in University of Ado-Ekiti, Nigeria.<br><br>*Simple random sampling* | A self-developed and validated questionnaire.<br><br>*The copies of the questionnaire were administered to the females.* | A large percentage of the females have negative attitude towards FGM. Also, there was a significant relationship between female circumcision and health of females as a result of the physical and psychological effects involved. |
| 28 | Ekenze, Ezegwui & Adiri (2007)<br><br>**Nigeria** | To determine the genital lesions complicating childhood FGC and the underlying factors that sustain this practice in south-east Nigeria. | Prospective quantitative study | Girls that presented with genital complications of FGC at Federal Medical Centre, Owerri, south-east Nigeria and their mothers.<br><br>*Purposive sampling* | Clinical evaluation of the girls and interviews for their mothers.<br><br>*Respondents were interviewed at presentation and subsequent visits* | The average age at presentation for FGM/C was 3.5 years and FGC were performed 8–90 days after birth. The procedure was done by traditional practitioners in 14 (66.7%) girls and by nurses in 7 (33.3%) girls. Twelve girls (57.1%) had type I FGC and nine (42.9%) type II. Clitoral dermoid cyst and labial fusion were the complications in 13 (61.9%) and eight (38.1%) respectively. |

**Addendum 19**

**TRIANGULATION OF CONCLUSIONS FROM PHASES 1 AND 2**

| Nos | FGM/C past and present |
|---|---|
| 1 | FGM/C is ongoing |
| 2 | The practice of FGM/C has its roots in their culture, thus Feelings of fears, uncertainties and helplessness were reported. |
| 3 | Majority of the practitioners were not sure of what was removed from them during FGM/C |
| 4 | In order to ensure adherence to the culture, some of the participants were forcefully circumcised. |
| 5 | The cutting was painful. |
| 6 | Interventions, such as anti-FGM/C laws and awareness campaigns against FGM/C, were a double-edged sword because they had both positive and negative effects in the fight against. |
| 7 | Families in a bid to meet their societal demands or traditions, while still protecting the health of their girls and women resort to medicalization. |
| 8 | Some of the participants were circumcised when they were too young to recall their experiences |
| 9 | There might have been a recent increase in early age FGM/C |
| 10 | Some of them said that their wounds healed without any treatment while some had some herbal treatment applied to their wounds to facilitate healing. |
| 11 | Despite being aware of the anti-FGM/C warnings by their state governments, some of the participants (mean age 28.6) have already done some form of FGM/C for their daughters while some said that they plan to do it for their daughters. |
| 12 | Almost all the women in the village were circumcised |
| 13 | The participants who indicated support for various forms of FGM/C to be continued were more in numbers than those who said that they want FGM/C to be stopped. |
| 14 | Majority of the healthcare practitioners indicated that they were circumcised. |
| 15 | Participants were not allowed to decide if they wanted to undergo the procedure or not, neither were they giving a briefing on the procedure before they went in for it. They underwent in obedience to their parents. |
| 16 | They were circumcised by various categories of people which included: traditional circumcisers, relatives and healthcare practitioners. |
| 17 | Some health (fever and recurrent genital infections) and sexual challenges were reported to be due to FGM/C |
| 18 | There were evidences of some modifications in the age at which FGM/C is done (early age FGM/C was being practiced), method of doing FGM/C (non-cutting method referred to as new method is in vogue) and the care of the girls after FGM/C (ceremonies are rarely done again and some use orthodox medicines). |
| 19 | Some of them expressed unhappiness about the anti-FGM/C activities. |
| 20 | Some of the healthcare practitioners indicated that they used to do FGM/C, but have stopped since the government began to campaign against it. |
| 21 | Participants reported challenges like skilled staff like RN and RM as well inadequate supply of some basic medical equipment. |
| 22 | Most of the women who present at the health facilities were circumcised |
| 23 | They lack training so as to be updated on current health care practices |
| 24 | Much skill is needed to be able to render efficient health care to genitally females due to their high risk for morbidity and mortality especially during childbirth. |
| 25 | Cases of childhood morbidity and mortality due to FGM/C were reported. |

| | |
|---|---|
| 26 | FGM/C was previously done when the girls reach the age of marriage but is now done during infancy**.** |
| **Nos** | **Factors that influence FGM/C** |
| 1 | Myths |
| 2 | Ignorance |
| 3 | Anti-FGM/C law. |
| 4 | Fathers were in support of their circumcision |
| 5 | Peer pressure, circumcised mothers, circumcised relatives, fathers and some healthcare practitioners were reported to be the perpetuators of FGM/C in these communities. |
| 6 | Factors like culture genital and beauty promotes the practice of FGM/C. |
| 7 | Health care practitioners. |

**ADDENDUM 20**

# HEALTH EDUCATION PAMPHLET FOR THE CIRCUMCISED FEMALE

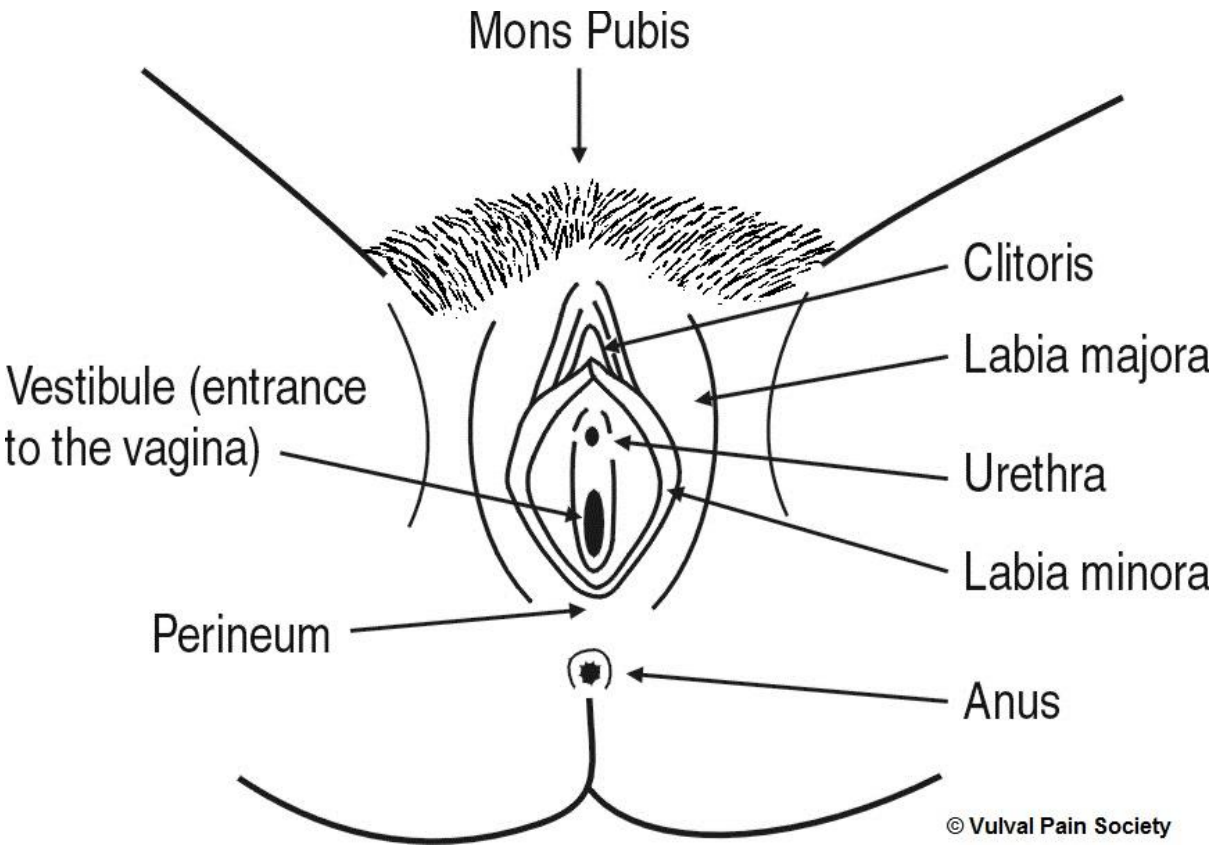
This information is for you if you or any female you know has undergone circumcision or is at risk of having it. It may also be helpful if you are a partner, relative or friend of a female who has been circumcised.

**Key points**

- The female body is perfect, do not change or remove any flesh in it
- Female circumcision is removing, stretching or causing changes in the appearance of the vulva.
- Female circumcision shows that one does not respect the right of girls and women
- Report to the nurse, your schoolteacher or the police if anybody wants to circumcise you, your daughter or another female

**The beautiful female body**

The female body is fine and complete. The female body is for her happiness, for pregnancy and childbirth. Any changes done to any part of her vulva can cause harm to her for the rest of her life.




**What is female circumcision?**

Female circumcision is removing, stretching or causing changes in the appearance of the vulva.

**Difference between male and female circumcision**

| Nos | Male circumcision | Female circumcision |
|---|---|---|
| 1 | Males do not give birth to children. Their bodies are naturally different from the female body. | Female body is naturally fine for her happiness and child birth. Therefore, she does not need to be circumcised. |
| **2** | Male circumcision might help reduce transmission of HIV/AIDS. | Female circumcision might expose her to the risk for HIV/AIDS and cause problem for her during child birth. |

**Dangers of Female circumcision**

Female circumcision can cause many problems for the female. Some of them are:

- Bleeding after the circumcision,
- infection,
- difficulty passing urine
- genital swelling
- Painful periods
- Pain during sexual intercourse
- Emotional problems
- The opening of the vagina will reduce
- High chances for birth through surgical operation
- Feeling ashamed during examination in hospitals outside your community.

**Now that you are circumcised**

- Decide that you want female circumcision to stop.
- Protect your daughter (s) from circumcision.
- Make sure you register at the health facility when you are pregnant.
- Tell the healthcare practitioner that you are circumcised and your past child birth experiences if any.
- Tell the healthcare practitioner about any recurrent infection or any other health challenges you have.
- Seek counsel from healthcare practitioners on any sexual problems.
- Go for family planning counselling or classes in the health facility.
- Share and explain the information on this leaflet with your family, friends and neighbours.
- If you see any female at risk of female circumcision, please report to any healthcare practitioner or police station.

**FOR MORE INFORMATION ON FEMALE CIRCUMCISION, ASK THE HEALTHCARE PRACTITIONERS. THEY WILL BE HAPPY TO HELP YOU.**

*Next possible review in 2024*.

**ADDENDUM 21**

## LETTER FOR PERMISSION AND ASSISSTANCE TO CONDUCT RESEARCH

The Director,
Primary Health Care,
Ohaukwu LGA,
Ebonyi State,
Nigeria.

**PERMISSION AND ASSISTANCE TO CONDUCT RESEARCH**

My name is Oluchukwu Loveth Obiora. I am a registered nurse-midwife, doing a doctoral degree at the Department of Nursing Education, University of the Witwatersrand, Johannesburg, South Africa. I am conducting a study titled **"experiences and perceptions of genitally mutilated females and healthcare practitioners in South Eastern Nigeria"**. The aim of the study is to obtain insight into the experiences of genitally mutilated girls, genitally mutilated women, mothers of genitally mutilated girls and the healthcare practitioners in South Eastern Nigeria, and finally develop a health education pamphlet for improving self-care of the circumcised females. Data gathered will be analyzed using high qualitycontent analysis and qualitative content analysis methods. The research proposal will also receive the approval of the traditional ruler of Ohaukwu Community, as well as an ethical clearance from the Research Ethics committee of the University of the Witwatersrand.

I wish to approach females and healthcare practitioners in Ohaukwu community to participate in this study and to be interviewed at a time and place convenient for them. I would however appreciate your help in identifying females and healthcare practitioners who would be eligible to participate in the study. The inclusion criteria are as follows:

- For the girls: adolescent between the ages 10 and 19, who consented or/ and assented, have obtained consent from her parent or guardian and have been circumcised.
- For the mothers: their daughter(s) must have been circumcised
- For the women: 20 years and older and have been circumcised.
- For the healthcare practitioners: currently working in the community of study, and must have worked there for at least one year.

In view of the above, I hereby ask for permission and assistance to recruit participants from your community to enable me to conduct this study. Please feel free to contact me for any further information required.

Thank you in advance for your consideration.

Yours truly,

_____

Mrs. Oluchukwu Loveth Obiora
Cell phone: +2761 285 2315, +2348135178591
E-mail: 1670233@students.wits.ac.za

**ADDENDUM 22**

**LETTER FOR PERMISSION AND ASSISTANCETO CONDUCT RESEARCH**

The Director,
Primary Health Care,
Orlu LGA,
Imo State,
Nigeria.

**PERMISSION AND ASSISTANCE TO CONDUCT RESEARCH**

My name is Oluchukwu Loveth Obiora. I am a registered nurse-midwife, doing a doctoral degree at the Department of Nursing Education, University of the Witwatersrand, Johannesburg, South Africa. I am conducting a study titled **"experiences and perceptions of genitally mutilated females and healthcare practitioners in South Eastern Nigeria"**. The aim of the study is to obtain insight into the experiences of genitally mutilated girls, genitally mutilated women, mothers of genitally mutilated girls and the healthcare practitioners in South Eastern Nigeria, and finally develop a health practice guide that the healthcare practitioners can use in order to enhance high quality care for circumcised females. Data will be collected using in-depth interview techniques for the females and healthcare practitioners. Data gathered will be analyzed using qualitative content analysis method. The research proposal will also receive the approval of the traditional ruler of Orlu Community, as well as an ethical clearance from the Research Ethics committee of the University of the Witwatersrand.

I wish to approach females and healthcare practitioners in Orlu to participate in this study and to be interviewed at a time and place convenient for them. I would however appreciate your help in identifying females and healthcare practitioners who would be eligible to participate in the study. The inclusion criteria are as follows:

- For the girls: adolescent between the ages 10 and 19, who consented or/ and assented, have obtained consent from her parent or guardian and have been circumcised.
- For the mothers: their daughter(s) must have been circumcised
- For the women: 20 years and older and have been circumcised.
- For the healthcare practitioners: currently working in the community of study and must have worked there for at least one year.

In view of the above, I hereby ask for permission and assistance to recruit participants from your community to enable me to conduct this study. Please feel free to contact me for any further information required.

Thank you in advance for your consideration.

Yours truly,

_____

Mrs. Oluchukwu Loveth Obiora
Cell phone: +2761 285 2315, +2348135178591
E-mail: 1670233@students.wits.ac.za

**ADDENDUM 23**

## LETTER FOR PERMISSION TO CONDUCT RESEARCH

The Traditional Ruler,
Ohaukwu Community,
Ebonyi State,
Nigeria.

His Royal Highness,

**PERMISSION TO CONDUCT RESEARCH**

My name is Oluchukwu Loveth Obiora. I am a registered nurse-midwife, doing a doctoral degree at the Department of Nursing Education at the University of the Witwatersrand, Johannesburg, South Africa. I am conducting a study. The aim of the study is to obtain insight into the experiences of circumcision among the females and Healthcare practitioners in your community and finally develop a health education pamphlet for improving self-care of the circumcised females. Approval for the study will be gotten from the Director, Primary Health Care of your Local Government. The research proposal will also receive ethical clearance from the Research Ethics committee of the University of the Witwatersrand.

I wish to approach females and healthcare practitioners in your community to participate in this study and to be interviewed at a time and place convenient for them. The inclusion and criteria are as follows:

- For the girls: adolescent between the ages 10 and 19, who consented or/ and assented, have obtained consent of her parent or guardian and have been circumcised.
- For the mothers: their daughter(s) must have been circumcised.
- For the women: 20 years and older and have been circumcised.
- For the healthcare practitioners: currently working in the community of study and must have worked in the community for at least one year.

In view of the above, I hereby ask permission to recruit participants from your community to enable me to conduct this study. Please feel free to contact me for any further information required.

Thank you in advance for your consideration.

Yours truly,

_____

Mrs. Oluchukwu Loveth Obiora
Cell phone: 061 285 2315
E-mail: 1670233@students.wits.ac.za

**ADDENDUM 24**

## LETTER FOR PERMISSION TO CONDUCT RESEARCH

The Traditional Ruler,
Orlu LGA,
Imo State,
Nigeria.

His Royal Highness,

**PERMISSION TO CONDUCT RESEARCH**

My name is Oluchukwu Loveth Obiora. I am a registered nurse-midwife, doing a doctoral degree at the Department of Nursing Education at the University of the Witwatersrand, Johannesburg, South Africa. I am conducting a study. The aim of the study is to obtain insight into the experiences of circumcision among the females and Healthcare practitioners in your community and finally develop a health education pamphlet for improving self-care of the circumcised females. Approval for the study will be gotten from the Director, Primary Health Care of your Local Government. The research proposal will also receive ethical clearance from the Research Ethics committee of the University of the Witwatersrand.
I wish to approach females and healthcare practitioners in your community to participate in this study and to be interviewed at a time and place convenient for them. The inclusion and criteria are as follows:

- For the girls: adolescent between the ages 10 and 19, who consented or/ and assented, have obtained consent from her parent or guardian and have been circumcised.
- For the mothers: their daughter(s) must have been circumcised.
- For the women: 20 years and older and have been circumcised.
- For the healthcare practitioners: currently working in the community of study and must have worked there for at least one year.

In view of the above, I hereby ask permission to recruit participants from your community to enable me to conduct this study. Please feel free to contact me for any further information required.

Thank you in advance for your consideration.

Yours truly,

_____
Mrs. Oluchukwu Loveth Obiora
Cell phone: 061 285 2315
E-mail: 1670233@students.wits.ac.za

**ADDENDUM 25**

**INFORMED CONSENT FORM FOR WOMEN, MOTHERS OF GENITALLY MUTILATED GIRLS, GIRLS ABOVE 18 YEARS AND HEALTH CARE PRACTITIONERS**

I hereby confirm that I have been adequately informed by the researcher about the nature, conduct, benefits and risks of the study. I have also received, read and understood the above written information. I am aware that the results of the study will be anonymously processed into a research report. I understand that my participation is voluntary and that I may, at any stage, without prejudice, withdraw my consent and participation in the study. I had sufficient opportunity to ask questions and of my own free will declare myself prepared to participate in the study.

Research participant's name: _____ (Please print)

Research participant's signature: _____

Date: _____

Researcher's name: _____ (Please print)

Researcher's signature: _____

Date: _____

**ADDENDUM 26**

**CONSENT FOR AUDIO-TAPING OF THE INTERVIEW**

I, _____, have consented to be a participant in the study being conducted by Oluchukwu Loveth Obiora and have been asked to give my consent to the interview being audio-taped to aid accurate collection and analysis of the information.

I give my consent for the interview being audio-taped ☐

I do not consent to the interview being audio-taped ☐

Research participant's signature: _____

Date: _____

Researcher's name: _____ (Please print)

Researcher's signature: _____

Date: _____

**ADDENDUM 27**

**INFORMED CONSENT FOR PARENTS/LEGAL GUARDIANS:**

***(On behalf of girls under 18 years old)***

- Mrs Oluchukwu Loveth Obiora has provided me with a copy of the Participant Information Leaflet and Consent regarding this study on **"experiences and perception of genitally mutilated females and healthcare practitioners in South Eastern Nigeria"** and has fully explained to me the nature, possible discomforts, benefits and purpose of the study.

- She has given me the opportunity to ask any questions concerning both the study.

- It has been explained to me that I will be free to withdraw my child from the study at any time, without any disadvantage both now and in the future.

- I have understood everything that has been explained to me and I consent for my child to participate in this study.

**PARENT/LEGAL GUARDIAN:**

---

**Printed Name** **Signature / Mark or Thumbprint** **Date and Time**

**ADDENDUM 28**

**INFORMED PARTICIPANT ASSENT: *** (Seven 10 to 17 years old).

I know what I will be asked in the study. Yes ☐ No ☐

I know that I can withdraw at any time without incurring any disadvantage. Yes ☐ No ☐

I want to participate in the study. Yes ☐ No ☐

| **Printed Name** | **Signature / Mark or Thumbprint** | **Date and Time** |
|---|---|---|

(* Girls competent to understand must participate as fully as possible in the entire procedure)

**PERSON EXPLAINING INFORMED CONSENT (DESIGNATION):**

| **Printed Name** | **Signature** | **Date and Time** |
|---|---|---|

**WITNESS** (If applicable)**:**

| **Printed Name** | **Signature** | **Date and Time** |
|---|---|---|

## Part I: Mixed Methods Appraisal Tool (MMAT), version 2018

| **Category of study designs** | **Methodological quality criteria** | **Responses** | | | |
|---|---|---|---|---|---|
| | | Yes | No | Can't tell | Comments |
| Screening questions (for all types) | S1. Are there clear research questions? | | | | |
| | S2. Do the collected data allow to address the research questions? | | | | |
| | *Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.* | | | | |
| 1. Qualitative | 1.1. Is the qualitative approach appropriate to answer the research question? | | | | |
| | 1.2. Are the qualitative data collection methods adequate to address the research question? | | | | |
| | 1.3. Are the findings adequately derived from the data? | | | | |
| | 1.4. Is the interpretation of results sufficiently substantiated by data? | | | | |
| | 1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation? | | | | |
| 2. Quantitative randomized controlled trials | 2.1. Is randomization appropriately performed? | | | | |
| | 2.2. Are the groups comparable at baseline? | | | | |
| | 2.3. Are there complete outcome data? | | | | |
| | 2.4. Are outcome assessors blinded to the intervention provided? | | | | |
| | 2.5 Did the participants adhere to the assigned intervention? | | | | |
| 3. Quantitative non-randomized | 3.1. Are the participants representative of the target population? | | | | |
| | 3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)? | | | | |
| | 3.3. Are there complete outcome data? | | | | |
| | 3.4. Are the confounders accounted for in the design and analysis? | | | | |
| | 3.5. During the study period, is the intervention administered (or exposure occurred) as intended? | | | | |
| 4. Quantitative Descriptive | 4.1. Is the sampling strategy relevant to address the research question? | | | | |
| | 4.2. Is the sample representative of the target population? | | | | |
| | 4.3. Are the measurements appropriate? | | | | |
| | 4.4. Is the risk of nonresponse bias low? | | | | |
| | 4.5. Is the statistical analysis appropriate to answer the research question? | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 5. Mixed methods | 5.1. Is there an adequate rationale for using a mixed methods design to address the research question? | | | | |
| | 5.2. Are the different components of the study effectively integrated to answer the research question? | | | | |
| | 5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted? | | | | |
| | 5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed? | | | | |
| | 5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved? | | | | |

**ADDENDUM 30**


## PLAGIARISM DECLARATION TO BE SIGNED BY ALL HIGHER DEGREE STUDENTS

I, Oluchukwu Loveth Obiora (Student number: 1670233) am a student registered for the degree of PhD in the academic year 2019.

I hereby declare the following:

- I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.
- I confirm that the work submitted for assessment for the above degree is my own unaided work except where I have explicitly indicated otherwise.
- I have followed the required conventions in referencing the thoughts and ideas of others.
- I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this is not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.
- I have included as an appendix a report from "Turnitin" (or other approved plagiarism detection) software indicating the level of plagiarism in my research document.

Signature: _____ Date: _____

**ADDENDUM 31**

## APPROVAL OF TITLE

UNIVERSITY OF THE
WITWATERSRAND,
JOHANNESBURG

Private Bag 3 Wits, 2050
Fax: 027117172119
Tel: 02711 7172076

Reference: Mrs Sandra Benn
E-mail: sandra.benn@wits.ac.za

04 January 2019
Person No: 1670233
PAG

Mrs OL Obiora
Chibuzor Obiora Compound
Okuzu-mbana
Oba, Idemili South Lga
435101
Nigeria

Dear Mrs Oluchukwu Obiora

**Doctor of Philosophy: Approval of Title**

We have pleasure in advising that your proposal entitled *Female genital mutilation: The untold stories of females and health workers in South Eastern Nigeria* has been approved. Please note that any amendments to this title have to be endorsed by the Faculty's higher degrees committee and formally approved.

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences

**ADDENDUM 32**

## APPROVAL FOR CHANGE OF TITLE

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Private Bag 3 Wits, 2050
Fax: 027117172119
Tel: 02711 7172076

Reference: Mrs Sandra Benn
E-mail: sandra.benn@wits.ac.za

07 October 2019
Person No: 1670233
TAA

Mrs OL Obiora
Chibuzor Obiora Compound
Okuzu-mbana
Oba, Idemili South Lga
435101
Nigeria

Dear Mrs Oluchukwu Obiora

**Doctor of Philosophy: Change of title of research**

I am pleased to inform you that the following change in the title of your Thesis for the degree of **Doctor of Philosophy** has been approved:

| | |
|---|---|
| From: | **Female genital mutilation: The untold stories of females and health workers in South Eastern Nigeria** |
| To: | **The experiences and perceptions of genitally mutilated females and healthcare practitioners in South Eastern Nigeria** |

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences