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A qualitative study of Primary healthcare professionals' knowledge, beliefs, and practices of Female Genital Mutilation (FGM) in Delta State, Nigeria.

Agatha Ejiroghene Ogigbah Adogho
MScN, BScN, RN.

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Abstract

Background: Female genital mutilation (FGM) remains a global issue because of its high prevalence among infants, young girls and women, and the associated detrimental health implications. Nigeria has a high prevalence of FGM and rate of medicalisation, however there is a dearth of evidence regarding healthcare professionals' (HCPs) understanding of FGM and the quality of care that is available for women living with FGM in Delta state Nigeria.

Purpose: To explore primary HCPs' current knowledge, beliefs, and practices of FGM in Delta state, Nigeria.

Methodology and methods: This study followed the tenets of social constructivism and qualitative design. Purposive and snowball techniques was used to recruit 2 doctors, 15 nurse/midwives and 9 community health extension workers (CHEWs) that were practising in 11 primary healthcare (PHC) facilities in two local government areas (LGAs) in Delta state, Nigeria. A semi structured interview was conducted with the 26 HCPs and the recorded interviews were transcribed verbatim and exported onto NVivo12Pro data management software, where data construction was undertaken following Braun and Clark's (2006) inductive thematic analytical approach.

Findings: Two main themes and five sub-themes were generated from the interview data. The main themes were "*Knowledge of FGM: The influence of sociocultural system and professional practices"* and *"Encounters with FGM in the clinical setting: Experiences and challenges of providing care for women with FGM".* The five sub-themes include (i) sociocultural influence (ii) professional influence (iii) encountering FGM in clinical practice (iv) clinical service development for the care of FGM (v) beliefs and attitudes towards FGM practices.

Irrespective of the professional group, the HCPs had a good cultural understanding of FGM, but the professional knowledge about the concept of FGM and its typology was poor. Some of the HCPs had themselves undergone FGM procedures, some had been requested to perform FGM, while some had performed FGM in the past. Notwithstanding, almost all the HCPs had negative attitudes towards FGM and declared that they had a role to play in ending FGM practices. The majority of the HCPs had encountered and cared for women with FGM during parturition, and they described the experience as a *'tug of war'.* These HCPs identified lack of guidelines on FGM, lack of professional trainings, lack of specialist services and resources such as clinical instruments and staff as some of the challenges that they experienced when supporting women affected by FGM.

Conclusion: There is need for collaborative efforts by key stakeholders including the PHC system, the Nigerian healthcare system, and professional bodies to provide guidelines and procedures for the delivery of women with FGM and management of FGM complications. There is also a need to organise specialised training for HCPs, ensure a working referral pathway by establishing a specialist clinic for FGM cases, and provide adequate staffing and basic gynaecological and obstetric instruments.

Scholarly outputs from the study

Presentations

Adogho, A.E.O. *Healthcare professionals' knowledge, beliefs, and attitudes towards the practice of FGM*. Nurses' week: Department of nursing science, Delta state university, Abraka Delta state Nigeria. May 2022 (Oral presentation).

Adogho, A.E.O. *Encounters with FGM in clinical settings*. Nurses' week: School of midwifery, Delta state Nigeria. May 2022 (Oral presentation).

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Adogho, A.E.O. *The role of nurses and midwives in ending FGM in Delta state, Nigeria.* Umuagu PHC facility, Asaba Delta state, Nigeria. September 2019. (Oral presentation).

Adogho, A.E.O. *Creating awareness about FGM among pregnant women in ante natal sessions in Delta state, Nigeria.* Ante natal Clinic, Umuagu PHC facility, Asaba Delta state, Nigeria. September 2019. (Oral presentation).

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List of abbreviations

ACNO	Assistant Chief Nursing Officer
CCHEW	Chief Community Health Extension Worker
CHEW	Community Health Extension Worker
CHO	Community Health Officer
CNO	Chief Nursing Officer
DHS	Demographic and Health Survey
Dr	Doctor
DSPHCDA	Delta State Primary Health Care Development Agency
FCT	Federal Capital Territory
FGM	Female Genital Mutilation
Hb	Haemoglobin
HCA	Healthcare Assistant
HCPs	Health Care Professionals
HOD	Head of Department
JCHEW	Junior Community Extension Worker
LGA	Local Government Area
MOH	Medical Officer of Health
MOHREC	Ministry of Health Research Ethics Committee
MP	Malaria Parasite
NBHSS	National Basic Health Services Scheme
NIHR	National Institute for Health Research
NM	Nurse/Midwife
NMCN	Nursing and Midwifery Council of Nigeria
NPHCDA	National Primary Healthcare Development Agency
PHC	Primary Health Care
PHCUOR	Primary Health Care Under One Roof

PCV	Packed Cell Volume
SEM	Socioecological Model
SMO	Senior Midwife Officer
SNM	Senior Nurse Midwife
SNO	Senior Nursing Officer
TBA	Traditional Birth Attendant
UN	United Nations
UNFPA	United Nations Population Funds
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VAPP	Violence Against Persons Prohibition
WHO	World Health Organisation

CHAPTER ONE: BACKGROUND OF STUDY

1.0 Introduction

Female circumcision or female genital mutilation (FGM) is a global issue as over two hundred million girls and women have been subjected to FGM procedures and another three million are at risk of being cut annually (World Health Organisation (WHO), 2022b). The term female genital mutilation is used to describe all procedures that involve the partial or complete removal of external female genitalia for non-therapeutic purposes (WHO, 2022b). The procedure is often performed without anaesthetics and with the use of unsterile instruments such as knives, razor blades, scissors, pieces of glass and sharp stone (United Nations Population Funds (UNFPA), 2022;UNFPA, 2018b). However, in some settings in Ethiopia and the Gambia, FGM is performed by cauterisation or the use of fingernails to pluck out the clitoris of new-borns (WHO, 2001). Culturally, FGM is mostly carried out by traditional cutters, elderly women and traditional birth attendants (TBA) whose role also included attending to pregnant women and parturition (WHO, 2022b;Adogho et al., 2021). Aside traditional cutters, some trained healthcare providers practised and performed FGM procedures for varied reasons (WHO, 2010c).

FGM is a life threatening practice and an extreme form of discrimination against women, hence it is recognised worldwide as a violation of the human rights of children, young girls and women, including their rights to health, security and physical integrity (WHO, 2022b;WHO, 2008). FGM also violates the right of girls and women to be free from torture and cruel, inhuman or degrading treatment, and the right to life in situations where the procedure led to death (WHO, 2022b;Fisaha, 2016).

1.1 The practice of FGM

FGM is an entrenched cultural practice that is concentrated in some parts of Africa, the Middle East and Asia, but due to migration of people from practising countries, the practice is now documented in other parts of the world (UNFPA, 2018b). Overall, the prevalence of FGM has declined in the past three decades, but the practice is still prevalent among girls and women aged 15 to 49years in some countries in Africa (United Nations Children's Fund (UNICEF), 2021b). For instances, the practice is widespread in Somalia(99%), Guinea(95%), Djibouti(93%), Egypt(87%) and Sierra Leone(86%) (UNICEF, 2021b). While the highest number of girls and women who had undergone FGM remain high in Egypt (27.2mllion), Ethiopia (23.8million) and Nigeria (19.9million) (WHO, 2022b;UNICEF, 2016). Indeed, a recent projection of FGM global prevalence revealed that around 68 million girls would be subjected to FGM by 2030, and about five million girls will be cut yearly if more work is not directed towards eliminating FGM practices (UNFPA, 2018b). The estimated increase in FGM practices was based on available data on FGM and the growth in population in the countries where FGM was concentrated (UNFPA, 2018b). For example, it is expected that between 5,000 and 20,000 girls in Nigeria, Egypt, Sudan and Ethiopia would have FGM by 2030 (UNFPA, 2018b). The persistence of FGM practices in some settings in Africa and the projected prevalence is quite alarming, and requires the evaluation of abandonment programmes, and the intensification of research and interventions to prevent the estimated 70 million girls from being subjected to FGM by 2030.

1.1.1 Types of FGM

FGM is classified into the following broad types by WHO (1995 and 2007),

> *Type I - Involves the partial or total removal of the clitoris. This type of FGM is known as clitoridectomy.*

Type II – This type of FGM is also referred to as excision. It involves the partial or total excision of the clitoris and labia minora, with or without the removal of the labia majora.

Type III - This type of FGM is also referred to as infibulation and it is the most severe form of FGM. It involves the narrowing of the vaginal orifice by cutting and stitching together the labia minora and/or the labia majora to form a covering seal, with or without the excision of the clitoris.

Type IV – This entails all other harmful procedures to the female genital organs for non-therapeutic purposes including scraping, piercing, burning, and pricking (WHO, 2022b;WHO, 1996).

Other terms related to FGM are deinfibulation and reinfibulation (WHO, 2022b;UNFPA, 2022). Deinfibulation is a practice that involves the cutting open of a woman who had been infibulated to allow coitus or parturition, while reinfibulation is the practice of suturing back the external labia after deinfibulation (UNFPA, 2022).

All the types of FGM and other associated practices have been reported across practising countries, and can cause severe health consequences regardless of the type practised (WHO, 2022b;UNICEF, 2021a).

1.1.2 Health consequences of FGM

FGM could cause severe immediate and long-term health complications. The immediate health complications of FGM include pain, severe bleeding, swelling around the external female genitalia, fever, shock, and death (WHO, 2022b). While long term complications may include psychological problems, risk of infections such as tetanus and HIV transmission, formation of scar tissues, urinary problems, obstetric and gynaecological problems, stillbirth and neonatal death (WHO, 2022b;WHO, 2018a).
In addition, evidence from a study of the effect of FGM on obstetric outcome showed a high risk of obstetric complications during childbirth in women

with FGM compared with women without FGM (Banks et al., 2006). This study observed that infant resuscitation, stillbirth or early neonatal death and low birthweight were significantly higher in women with FGM as compared with women without FGM (Banks et al., 2006). However, the most reported obstetric complications of FGM were caesarean section, episiotomy, prolonged labour, dystocia (difficult labour) and postpartum haemorrhage (Adogho et al., 2021;Banks et al., 2006).

These health complications have resulted in a huge financial burden for countries where FGM is practised. In 2018 alone, over 1.4billion USD was expended by 27 countries to treat complications that resulted from FGM procedures (WHO, 2022b). The economic cost of treating FGM related complications will rise to over 2.3billion USD by 2047 if the prevalence of FGM persists, and this would be equivalent to a 68% rise in the cost of inaction (WHO, 2022b). However, this cost will reduce by 60% over the next three decades if practising communities abandon FGM (WHO, 2022b).

1.1.3 Reasons for practising FGM

FGM is practised for different reasons depending on the sociocultural beliefs within practising families and communities. The most common motivations for FGM practices are as a ritual passage into womanhood, preservation of virginity before marriage, to increase marriageability, curb women's sexual urges and to prevent promiscuity (UNFPA, 2022;WHO, 2018a). In some settings, it is believed that FGM ensures fertility and prevents the clitoris from growing to the size of the male sexual organ (UNFPA, 2018b), while some families practised FGM due to social pressure to comply with what other members of the community do, in addition to the fear of being socially excluded (WHO, 2022b;UNFPA, 2018b).

FGM is believed to be a religious requirement though there are no known religious instructions for FGM (UNFPA and UNICEF, 2011). There is also a misconception that FGM is connected to Islam as it had been documented among some Muslim groups, however not all Muslim groups practice FGM

(UNFPA and UNICEF, 2011). In addition, FGM has been documented amongst other religious groups including Christians, Jews, and traditional African religion (UNFPA, 2018b). Nevertheless, FGM is widespread in some communities in Africa, irrespective of the religion and socioeconomic background (UNFPA and UNICEF, 2011).

1.2 Strategies to end FGM

Over the past four decades, collaborative efforts have been made by international agencies, government, non-governmental organisations and other stakeholders to eliminate the practice of FGM by conducting researches (Adogho et al., 2021;Evans et al., 2019;Waigwa et al., 2018), and developing strategies and interventions to reduce FGM (WHO, 2022b;Muteshi and Sass, 2005). Some of the community led interventions were conducted in Burkina Faso, Egypt, Ethiopia, Somalia, Kenya, Mali, Nigeria, Senegal, and other parts of Africa, and included the health risk information approach and the legal approach (Berg and Denison, 2012;Diop and Askew, 2009;Njue and Askew, 2004).

1.2.1 The legal approach

This strategy focused on criminalising FGM with the expectation that it will deter people from continuing the practice for fear of being prosecuted (UNFPA, 2018a;UNICEF, 2010). The aim of this approach was to enact laws that will legally recognise FGM as a violation of the human rights of children, girls and women, and protect future generations of girls from the practice (WHO, 2011). This approach raised debates among stakeholders, as critics believed that legislations may drive the practice underground or lead to poor reporting of FGM in national surveys (WHO, 2001). In addition, healthcare professionals (HCPs) may be reluctant to treat complications that occurred from FGM procedures due to fear of prosecution (WHO, 2001). While proponents of this strategy argued that FGM laws would protects girls and women from FGM, and give stakeholders such as the

police, community committees and HCPs the legal right to intervene in FGM cases (Johansen et al., 2013). Nonetheless, relentless efforts and pressure from international agencies and stakeholders prompted national governments to enact laws prohibiting FGM. At present, 25 countries in Africa and the Middle East now have laws prohibiting FGM practices, whereas in countries such as Mali, Sierra Leone, Somaliland and Somalia the practice of FGM remain effectively legal (UNFPA, 2022;28 TOO MANY, 2018). Despite the existence of FGM laws in many countries, these legislations have failed to protect children, girls and women from FGM as the laws were rarely enforced and there are no reports of prosecutions (28 TOO MANY, 2018). Indeed, legislations alone cannot eliminate the practice of FGM, as they need to be combined with other strategies such as providing information on the detriments of FGM, and highlighting the rights of children, girls, and women.

1.2.2 Health risk information approach

This approach began more than 40years ago, the goal was to engage HCPs to create awareness on the health consequences of FGM, with the hope that practising communities will pay attention and abandon the practice (Johansen et al., 2013;Berg and Denison, 2012). This strategy was somewhat effective as it motivated many Christian and Muslim leaders in different parts of Africa to support the elimination of FGM by disassociating the practice from religion (UNFPA and UNICEF, 2011). Indeed, it created awareness for policy makers and motivated support for the abandonment of FGM through education and enactment of legislations (Kaplan et al., 2011). However, this strategy was not without challenges as a recently conducted systematic review by a team of experts identified some factors that may affect the success of health education interventions on FGM (Waigwa et al., 2018). This review was undertaken to assess the effectiveness of health education as an intervention to prevent FGM in practicing communities (Waigwa et al., 2018). The systematic review (Waigwa et al., 2018) included twelve empirical studies that was conducted

between 1995 and 2015 among men and women from FGM practising communities in Africa and the Middle East. The review included seven quantitative studies, three qualitative studies and two studies employed mixed methods, but the total number of participants included in the systematic review was not stated (Waigwa et al., 2018). The quality of the twelve included studies was assessed using the Mixed Methods Appraisal Tool (MMAT), and the quality mean score was over 83% with each included study scoring over 50% in their individual categories (Waigwa et al., 2018). The systematic review by Waigwa et al (2018), provided findings that indicated that the success of health education interventions was dependent on factors such as sociodemographic, socioeconomic, traditions and beliefs, and intervention strategy, structure, and delivery (Waigwa et al., 2018). It is evident that community-based interventions that focused on health education and provided information about the detriments of FGM could be vital for preventing and reducing FGM if the afore mentioned factors are addressed at every phase of the intervention. Another issue with the health risk information approach was that practising communities and families shifted to practising less severe forms of FGM, to reduce the health complications of FGM as seen in Somali and Sudan (Njue and Askew, 2004). In addition, there was high demand for HCPs to perform FGM as practising communities believed that the risk for infections would be minimised if the procedure was undertaken by trained healthcare personnel (WHO, 2010c). This led to the medicalisation of FGM as most HCPs capitalised on the demand and began to perform FGM procedures as most shared the beliefs that there would be little or no complications if the procedure was performed by skilled HCPs. However, some HCPs performed FGM for other reasons that included, financial gain and fear of being ostracised by the community (WHO, 2010c).

1.2.2.1 Medicalisation of FGM

The medicalisation of FGM describes any situation in which FGM is performed by any category of healthcare provider in any setting, including

public or private clinics, and at home (WHO, 2010c). Analysis of data from 25 countries in Africa where FGM was documented indicated that 26% of girls and women with FGM were cut by HCPs totalling about 16million women (Shell-Duncan et al., 2017). The involvements of HCPs in FGM practices was highest in countries such as Sudan (67%), Egypt (38%), and Nigeria (13%) (Shell-Duncan et al., 2017). Consequently, about 99% of the affected women and girls reside in these countries – Egypt, Nigeria, and Sudan with more than half of the women and girls living in Egypt (28 TOO MANY, 2018).

Indeed, the medicalisation of FGM is a recognised problem by the global health community and national authorities as it violates medical ethics, promotes FGM practices and impede efforts to eliminate the practice (WHO, 2018a;WHO, 2010c). Hence, in 2010 a global strategy to stop the medicalisation of FGM was developed to interdict HCPs from performing FGM in any setting (WHO, 2010c). This approach required national governments and stakeholders to mobilise funding, and strengthen the understanding of HCPs by providing education, designing regulatory frameworks and developing professional guidelines on FGM (WHO, 2010c). Similarly, in 2008 and 2012 the World Health Assembly (WHA), and the United Nations General Assembly respectively resolved to end FGM and its medicalisation (Johansen et al., 2018;WHO, 2010c). In these said assemblies, all member states were urged to develop, support and implement national policies and action plans on FGM, as well as allocate funds for its implementation and monitoring (Johansen et al., 2018). As a result, few countries in Africa including Burkina Faso, Egypt, Kenya, Ethiopia, Mali and Sudan now have fully implemented national health policies and budgetary allocations on FGM (Johansen et al., 2018). The aforenamed countries and The Gambia, Ghana, Somaliland and Sierra Leone also trained and empowered HCPs to educate the populace about the detriments of FGM (Johansen et al., 2018). Equally, some countries in Africa have criminalised the medicalisation of FGM and set penalties for

offenders, while many countries including Nigeria are yet to implement national health policies, provide training programmes for HCPs or prohibit their involvements in FGM practices (Johansen et al., 2018;UNFPA, 2018a).

Furthermore, despite collective efforts to end the medicalisation of FGM through the formation of health policies, legislations and professional trainings in some parts of Africa, most HCPs in these settings continued to have limited understanding of FGM and remained supportive of the practice (WHO, 2018a). For instance, a review of empirical papers on HCPs knowledge, attitudes and experiences of FGM in sub-Saharan Africa, revealed that some of the examined HCPs had received training on FGM in order for them to provide direct care and counselling for women with FGM (Adogho et al., 2021). Notwithstanding, the studied HCPs in this review (Adogho et al., 2021) had limited understanding of FGM and some had subjected their daughters to FGM and are still offering and performing FGM procedures. The continued support for the medicalisation of FGM amongst HCPs may be a result of multiple factors that are not limited to cultural affiliations as some of these HCPs are from FGM practising communities (Ali, 2012;Berggren et al., 2004), limited knowledge of FGM due to lack and poor design of professional courses on FGM (Adogho et al., 2021;WHO, 2018a), and lack of health sector involvements in FGM issues in some settings in Africa (Johansen et al., 2018;WHO, 2018a). Hence, it is important to explore HCPs current understanding of FGM, and their beliefs and practices of FGM within PHC facilities in Delta state, Nigeria.

1.3 Study country: Nigeria

Nigeria is located in West Africa, bordering the Gulf of Guinea between Benin, Cameroon, Chad, and Niger (National Population Commission, 2018). It is the most populous country in Africa with an estimated population of 214,000,000 million and an annual growth of 2.67% (Worldmeter, 2022). Nigeria covers an area of about 924 thousand square kilometres and it is comprised of a federal capital territory, thirty-six states

that are grouped into six geopolitical zones (Northwest, Northeast, North central, Southwest, Southeast and South-south), and 774 Local Government Areas (28 TOO MANY, 2016;Onwughalu, 2011). The country is made up of over 250 ethnic groups with more than 500 languages, but the major languages are Igbo, Yoruba and Hausa while English is the official language (Falola et al., 2020;28 TOO MANY, 2016).

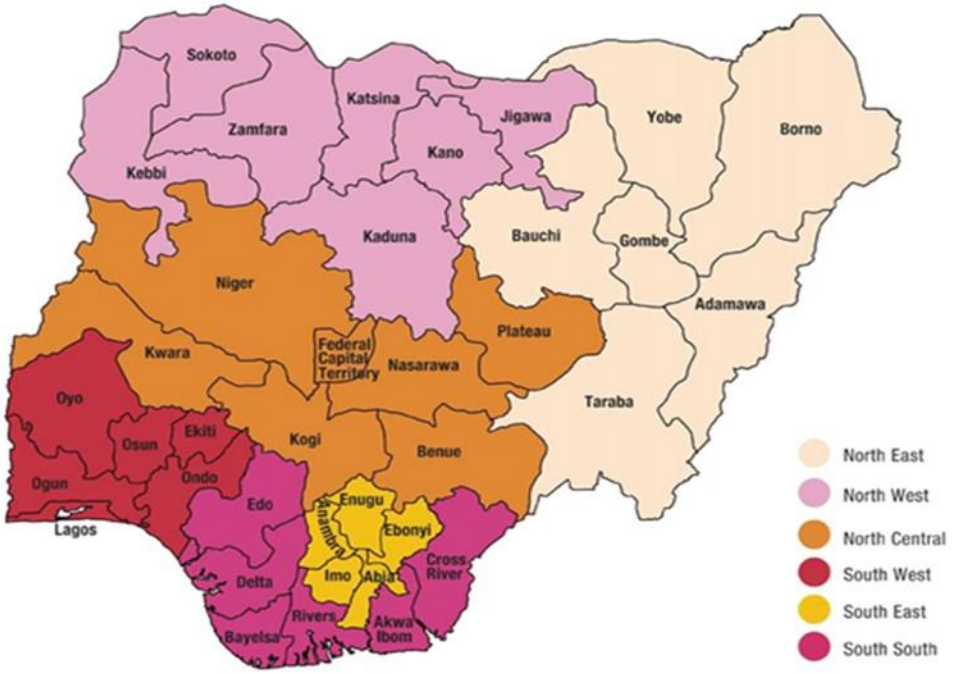


Figure 1.1 Map of Nigeria showing the states and geopolitical zones (28 Too Many, 2016).

1.3.1 Cultural and economic overview

Nigeria has several cultural practices and beliefs that are derived from the mixture of its diverse ethnic groups (Falola et al., 2020). For example, it was a common cultural practice among some Hausa-Fulani ethic groups to subject their young male suitors to a whipping ordeal to eliminate the weak ones, so that the strongest one becomes the only acceptable suitor (Falola

et al., 2020). Other practices included the confinement of girls of marriageable age to a room where they are fed fat to make them appear more attractive to their suitors (Falola et al., 2020), and the engrained cultural practice of circumcising female children and women in some settings in Nigeria (28 TOO MANY, 2021). The said practices and other harmful beliefs amongst ethnic groups in Nigeria were discouraged by the missionaries and colonial administrators, and eventually became obsolete (Falola et al., 2020). However, the circumcision of young girls and women continued predominantly amongst the Igbos, Yorubas, and some minority ethnic groups across Nigeria (National Population Commission, 2018).

In terms of economic status, Nigeria remains the largest economy in Africa with a gross domestic product of $440 billion as at 2021, and a projection to around $445 billion at the end of 2022 and $450 billion in 2023 (Trading Economics, 2021). Nigeria benefits from a wealth of natural resources including petroleum and natural gas and these resources have continued to be the main source of export earnings and government revenues (Organization of the Petroleum Exporting Countries (OPEC), 2022;Falola et al., 2020). Nigeria's economy was disrupted and suffered a great loss due to the COVID-19 pandemic and decline in the prices of oil (The World Bank, 2021). Consequently, in 2020 Nigeria experienced its worst recession in two decades which made more than 60% of Nigerians to live in abject poverty as they could not afford food products or healthcare services (U.S. Department of state, 2021;Falola et al., 2020). Presently, Nigerians are experiencing poverty and insecurity as the economy remain weak. However, there is hope that with the easing of the pandemic restrictions, the prices of petroleum and other products may reduce, and the government would implement policies that will ameliorate the economic and social crisis in Nigeria.

1.3.2 Structure of the Nigerian Government

Nigeria is a federal republic with a presidential system. The system comprise of three tiers of government and three arms of government, and the three tiers of government are subdivided into federal, state, and local governments (Federal Republic of Nigeria, 2011). The federal government is the highest tier of government, and it is headed by a president with the appointed ministers as members of the cabinet (Federal Republic of Nigeria, 2011). The governor oversees the affairs at the state level and heads the state cabinet which is made up of commissioners and advisers (Federal Republic of Nigeria, 2011). While the third tier is headed by the local government chairperson and other elected members (Federal Republic of Nigeria, 2011).

The Executive, the Legislature, and the Judiciary are the arms of government in Nigeria. The executive arm of government is headed by the president, and it is made-up of members representing each of the states, and their duty is to implement and maintain laws (Federal Republic of Nigeria, 2011). The legislative branch of government is in charge of making laws and it is made up of two chambers, the upper chamber is known as the Senate and the lower chamber is called the House of Representatives; these lawmakers were responsible for approving the legislation criminalising FGM in Nigeria (The Embassy of Nigeria, 2021;Mberu, 2017). At the state level, the legislative branch is called the house of Assembly, it comprises of members representing each of the local government areas in the state. The role of the house members is to institute laws at the state level, and they were responsible for enacting the laws prohibiting FGM in some states in Nigeria (Federal Republic of Nigeria, 2011;Mberu, 2017). The duty of the Judiciary is to interpret and ensure compliance with laws, and this includes the Supreme Court of Nigeria, state courts and election tribunals (LawPavilion, 2016). The Judiciary is legally responsible for prosecuting perpetuators of crimes such as FGM.

1.3.3 The Nigerian health care system

The Nigerian health service operates a pluralistic system that includes orthodox, alternative, and traditional healthcare delivery system. The three tiers of government (federal, state and local) are responsible for the administration and organisation of health care through the ministry of health, while the provision of health services is administered through the three tiers; tertiary, secondary and primary levels (WHO, 2014). (See figure 1.2).

The federal government manages the tertiary level of healthcare, and its duties are to provide policy guide, plan, and coordinate national health policies (Federal Republic of Nigeria, 2011). Health facilities at the tertiary level of care include specialist and teaching hospitals, and these facilities are established to serve as referral centres for both secondary and primary healthcare (PHC) facilities (Kombe et al., 2009).

Secondary healthcare facilities are overseen by the state government, while the provision of health services is shared by the ministry of health and the state hospital management board (WHO, 2014). The secondary facilities render general and specialised medical care, and they serve as a referral centre for PHC facilities (Kombe et al., 2009).

The Local Government Area (LGA) and the National Primary Healthcare Development Agency (NPHCDA) are responsible for the smooth operation of PHC facilities; these include health centres, dispensaries, and community health post (WHO, 2014). PHC facilities provide preventive and curative care including immunisation against deadly diseases, monitoring, and reporting of disease outbreaks (National Primary Health Care Development Agency (NPHCDA), 2020;WHO, 2014).

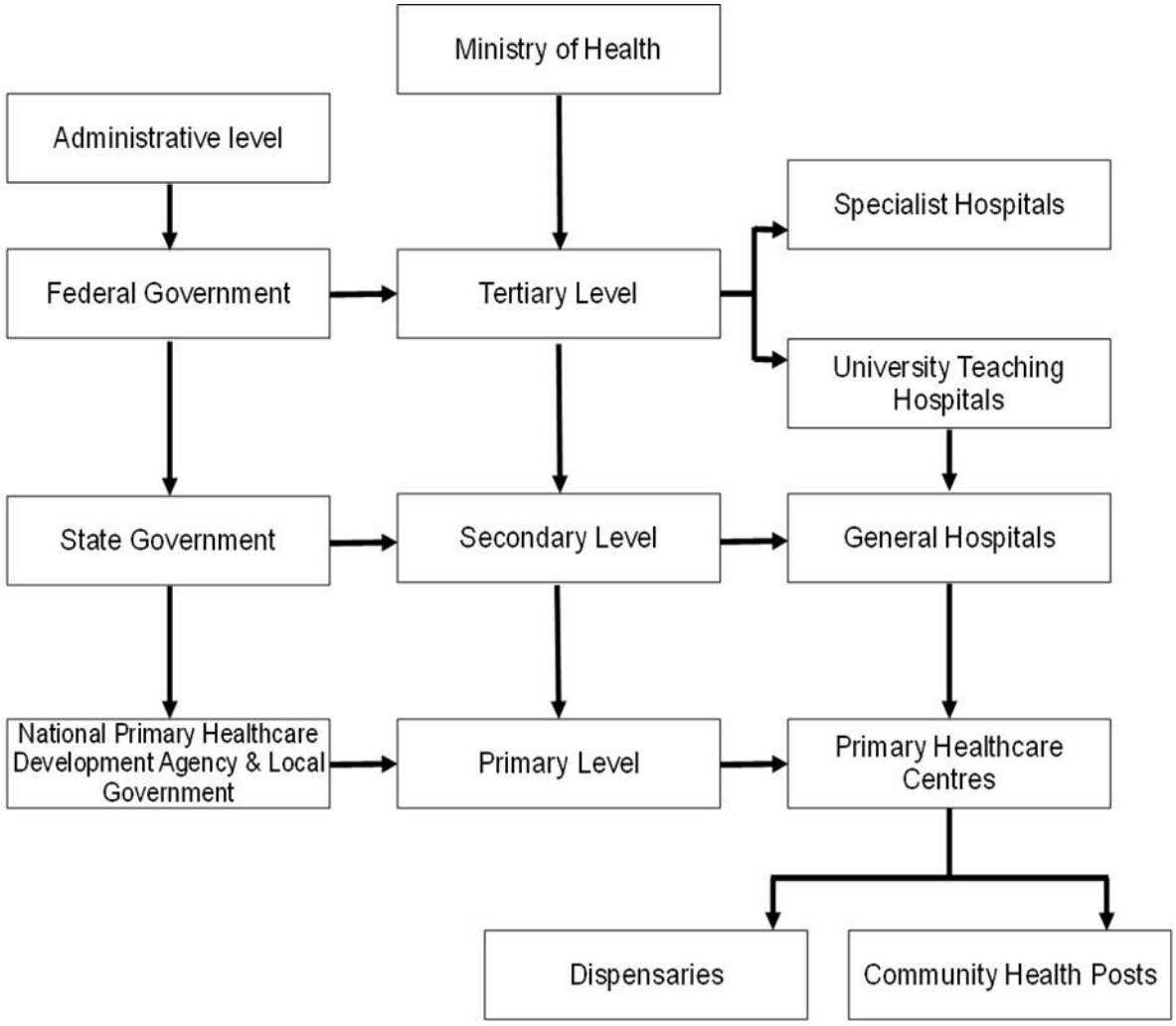


Figure 1.2 Illustration of the structure of the Nigerian Healthcare System

1.3.4 FGM in Nigeria

Overall, the prevalence of FGM has declined compared with previously reported figures (National Population Commission, 2013), though the practice is still continuing across some communities in the six geopolitical zones in Nigeria (28 TOO MANY, 2021). A 2016-2017 multiple indicator cluster survey in Nigeria reported a prevalence of 18.4% among girls and women aged 15 to 49 (National Bureau of Statistics and UNICEF, 2017). This percentage (18.4%) appears to be the most reported figure representing the prevalence of FGM in Nigeria (28 TOO MANY, 2021;Kandala et al., 2020). However, the latest 2018 Nigerian

Demographic and Health Survey (NDHS) reported a prevalence of 20% among the said age group (15-49years), indicating a 5% decrease from the 25% reported in the 2013 NDHS (National Population Commission, 2018;National Population Commission, 2013). The current prevalence (20%) shows that more than twenty million girls and women had been cut in Nigeria, representing about 10% of the global prevalence of FGM (28 TOO MANY, 2021). In addition, current statistics indicates an alarming rise in the prevalence of girls aged 0-14years from 16.9% in 2013 to 19.2% in 2018 (National Population Commission, 2018;National Population Commission, 2013). This led to UNICEF highlighting that the increasing prevalence among this vulnerable group is a disconcerting trend of FGM in Nigeria (UNICEF, 2022). This could be an indication that contrary to existing assumptions that the practice is obsolete, FGM appears to be a continuing practice in Nigeria. The reported decrease in prevalence could be due to the practice being conducted underground or there could be under reporting because of the existing law on FGM in Nigeria.

The prevalence of FGM varies across states, geopolitical zones, and ethnic groups in Nigeria. For instance, data showed that the prevalence of FGM is 35% among Yoruba women while only 1% of Tiv and Igala women had been cut (National Population Commission, 2018). In terms of prevalence by geopolitical zones and state, the southeast and southwest zones had the highest prevalence of 35% and 30% respectively, while Imo state in the southeast and Ekiti state in the southwest had the highest prevalence of nearly 62% and 58% respectively (National Population Commission, 2018). Whereas in the Northeast zone, the prevalence was 6%, while Adamawa and Gombe states had the lowest prevalence of less than 1% (National Population Commission, 2018). (See Figure 1.3).

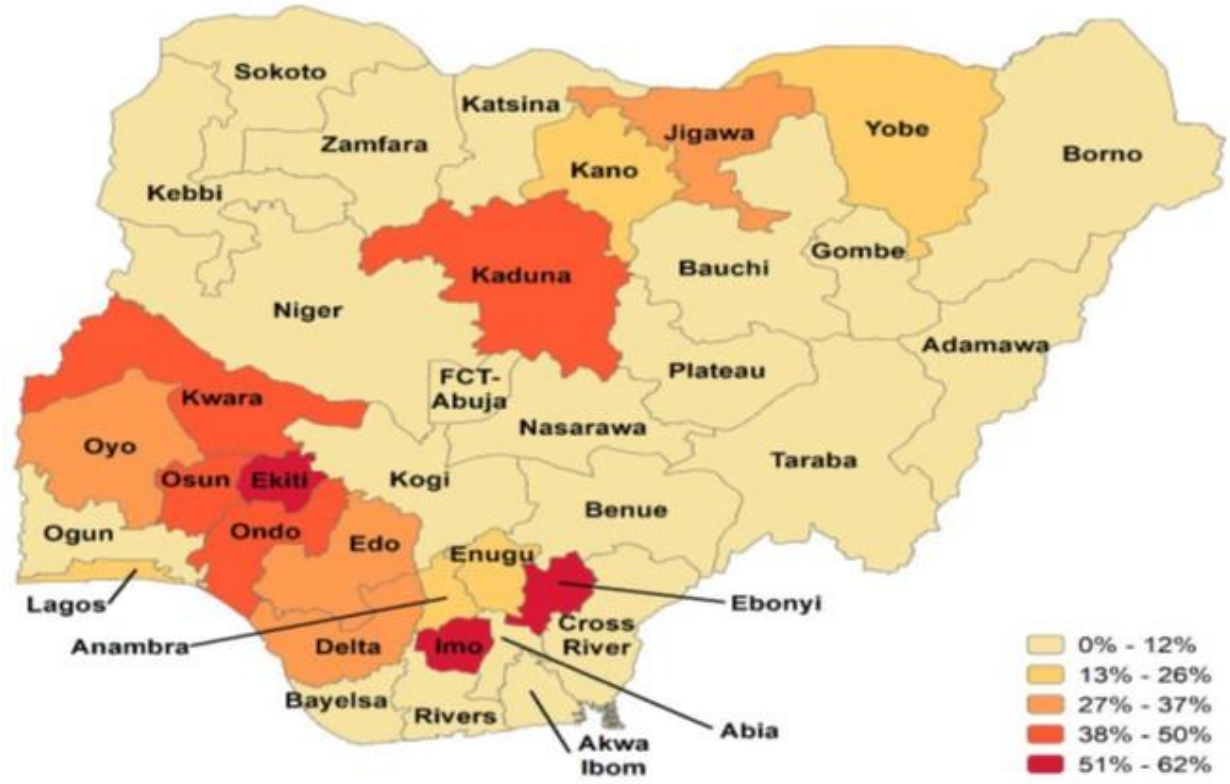


Figure 1.3 Map showing FGM prevalence in Nigeria by state (National Population Commission, 2018).

FGM is often practised in the rural areas, but available data indicated that 16% of women aged 15-49 years living in rural areas had undergone FGM compared with 24% of women living in urban areas (National Population Commission, 2018). Though the prevalence of FGM appeared to be higher in urban areas and among the rich and educated, this group of women were less likely to subject their daughters to FGM and may support the elimination of FGM (National Population Commission, 2018;28 TOO MANY, 2016). Whereas, women in the rural areas who are underprivileged were most likely to encourage FGM, and subject their daughters to FGM even though the prevalence is lower in rural areas (National Population Commission, 2018). The high prevalence of FGM in urban areas could be explained as migration of women who practised FGM from rural areas to urban settings in search of better education, jobs, and opportunities. While intentions by mothers to subject daughters to FGM in rural settings could

be due to pressure to conform to cultural obligations. Nevertheless, about 42% of the over 20million women who had undergone FGM in Nigeria believed that FGM practices should continue (National Population Commission, 2018).

The practice of FGM in Nigeria is associated with sociocultural factors that includes preservation of virginity, prevention of promiscuity, prerequisite for the preparation of young girls and women for marriage, a rite of passage for young girls into womanhood and as a sexual pleasure for men (National Population Commission, 2018). According to the 2018 demographic and health survey (DHS) about 25% of the surveyed women who had FGM declared that the practice was a religious requirement (National Population Commission, 2018). However, most of the women who had this view were traditional worshippers, who more than other religious groups believed that the practice of FGM should continue.

The four types of FGM are practised in Nigeria, however the 2018 DHS showed that the most reported type of FGM among women aged 15 to 49 was Type II (41%), while Type I and Type III was reported respectively in about 10% and 6% of the examined women (National Population Commission, 2018). In addition, an undetermined type of FGM was documented in nearly 44% of the surveyed women, some (7%) of which were mutilated using corrosive methods (National Population Commission, 2018). Aside from the use of corrosive substances, it was unclear if the undetermined types found in some of these women had any of the characteristics of the fourth classification of FGM.

Evidence from the 2018 DHS revealed that FGM procedures were mostly performed on babies and women aged 15 to 49 by traditional circumcisers and traditional birth attendants (TBA), while healthcare professionals, including doctors, nurses and midwives carried out FGM procedures on 15.6% of the surveyed girls and women (National Population Commission, 2018). Indeed, this evidence could indicate that HCPs continue to support and engage in FGM practices.

Over the years, the Nigerian government has made efforts to eliminate the practice of FGM by ratifying all international and regional conventions on the right of women and children condemning the practice of FGM (UNFPA, 2018a). The conventions and declarations included the African Charter on Human and Peoples' Rights in 1983, the Convention on the Elimination of All Forms of Discrimination Against Women in 1985, the Convention on the Rights of the Child in 1991, the International Covenant on Civil and Political Rights in 1993, the International Covenant on Economic, Social and Cultural Rights in 1993, the African Charter on the Rights and Welfare of the Child in 2001, the Maputo Protocol in 2004 and the African Youth Charter in 2009 (UNFPA, 2018a).

Similarly, non-governmental organisations in and outside Nigeria have also contributed to the elimination of FGM by organising anti-FGM programmes and carrying out interventions that included community mobilisation and dialogue, capacity building and awareness campaigns in communities and schools (28 TOO MANY, 2016). The national association of Nigerian Nurses and Midwives, the Nigerian Medical Association and the Nigerian Medical Women's Association have carried out campaigns to create awareness about the detriments of FGM (The Girl Generation, 2016). Nurses and paediatricians in Nigeria have organised national workshops, talk shows on TV and radio, articles in newspapers and short dramas to highlight the dangers of performing FGM (The Girl Generation, 2016). Furthermore, a module on FGM was added to the training curriculum for nurses and doctors in Nigeria (28 TOO MANY, 2016;Mberu, 2017). However, the implementation of this module is questionable as there are no known evidence suggesting that the module is operational in Nigeria. If the module does exist, it is unclear the extent and depth to which it is taught and its impact on student nurses/midwives' and doctors' capabilities in managing FGM related cases.

In addition, a national policy and plan of action for the elimination of FGM in Nigeria was developed in 2013, and the Violence Against Persons

Prohibition (VAPP) Act 2015 was signed into law in 2015 (Federal Ministry of Health, 2013;LawPavilion, 2016). Prior to the enactment of the VAPP Act in 2015, some states in Nigeria including Bayelsa, Cross River, Delta, Ebonyi, Edo, Ekiti, Ogun, Ondo, and Rivers had state laws prohibiting FGM practices (Mberu, 2017).

1.3.5 National policy and plan for the elimination of FGM in Nigeria

This policy was developed in 2013 to improve the health and quality of life of girls and women living with FGM (Federal Ministry of Health, 2013). The policy aimed to reduce the prevalence of FGM in Nigeria, promote community behavioural change initiatives to eradicate FGM, establish a legal framework for the elimination of FGM at national and state levels, and to strengthen system for research, monitoring and evaluation of FGM programmes in Nigeria (Federal Ministry of Health, 2013). The Nigerian government planned to achieve some of these objectives by 2017 through the establishment of more healthcare facilities to provide care for women with FGM (Federal Ministry of Health, 2013). The government projected that by 2015, it would have stopped HCPs from performing FGM, created educational and empowerment programmes for HCPs and enacted a federal law on FGM (Federal Ministry of Health, 2013). Hence, the Federal Ministry of Health and the NPHCDA were assigned to implement the policy, with the hope that they would draw on all available resources to ensure that the purpose for the national policy and plan of action for the elimination of FGM was fully achieved.

Arguably, the policy and plan of action was comprehensive and appeared to have covered a wide range of the issues identified as hindering the elimination of FGM in Nigeria. However, it did not include a clinical guideline for the management of women with FGM, neither did it provide a mechanism for reporting, referring, and protecting women and girls at risk of FGM. Currently, there is no evidence suggesting that this national policy

has been implemented across Nigeria, as the only notable achievement by the government regarding the eradication of FGM was the enactment of the VAPP Act in 2015. Indeed, there are no indications that HCPs in Nigeria have undergone professional trainings on FGM, and it is uncertain if they possess the professional skills to deal with FGM related issues, especially those working in PHC facilities in rural communities.

1.3.6 The Violence Against Persons Prohibition (VAPP) Act 2015

During the drafting of the law, the federal government of Nigeria consulted with practising communities, religious leaders, and other collaborators to ensure that there was input from all stakeholders in the establishment of the law (UNFPA, 2018a).

The law criminalised FGM and declared that anyone who performed female circumcision or genital mutilation or engaged another to carry out such circumcision, or mutilation has committed an offence and would be liable on conviction to a prison term not exceeding 4years or to a fine not exceeding N200,000.00 ($480) or both (LawPavilion, 2016;Federal Government of Nigeria, 2015). Likewise, anyone who attempts to carry out the practice of FGM has committed an offence and will be liable on conviction to a prison term not exceeding 2years or a fine not exceeding N100, 000 ($240) or both (LawPavilion, 2016).

All stakeholders including the ministry of health, ministry of women affairs, ministry of justice and the police commission were responsible for executing the law, however there was no budgetary allocation for its implementation and enforcement (UNFPA, 2018a). Also, there was no provision for reporting, referring, and protecting children, girls, and women at risk of FGM in Nigeria (UNFPA, 2018a)

A major drawback of the VAPP Act is that it was enacted at the federal level, which implied that it was not directly applicable in all 36 states in Nigeria,

because it was limited to the Federal Capital Territory (FCT). About 13 states in Nigeria have adopted this legislation however, only the high court of the federal territory has the jurisdiction to hear FGM cases brought under the Act (28 TOO MANY, 2018;LawPavilion, 2016). Also, the law did not specify the penalty for HCPs who performed and perpetuated FGM practices (UNFPA, 2018a). Additionally, the enforcement of the law is questionable as many states in Nigeria had laws criminalising FGM as far back as 1999, however these states do not have any implementation strategy in place and thus no documented convictions (Mberu, 2017). For instance, in 2001 a bill was passed in Delta state to prohibit the practice of FGM with a penalty of three months' imprisonment and a fine for offenders, but to date no arrest has been recorded in the state (United Nations High Commissioner for Refugees (UNHCR), 2015). Similarly, there are no indications that convictions have been made since the enactment of the VAPP Act in 2015 (UNFPA, 2018a). It is expected that after seven years of prohibiting FGM in Nigeria the effect of the legislation would be somewhat visible, yet evidence suggesting that the law is being implemented is lacking and consequently the awareness and effect of the legislation on the practice of FGM is questionable.

1.4 Study state: Delta

Delta State is one of the 36 states in Nigeria, and it is situated in the South South geo-political zone. The state has a total land area of 16,842 square kilometres (6,503 sq. mi), and it is inhabited by 4,112,445 persons (males 2,069,309 and females 2,043,136) according to the last census conducted in 2006 (National Population Commission, 2006). Currently, Delta state is ranked the 9th most populous state in Nigeria with an estimated population of 5, 663,362 as at 2016 (Nigeria Data Portal, 2022). The state is headed by the governor and other appointed and elected officials, including officials from the state Executive, Legislature and Judiciary (Delta State

Government, 2021). See figure 1.4 for the illustration of the structure of Delta state government.

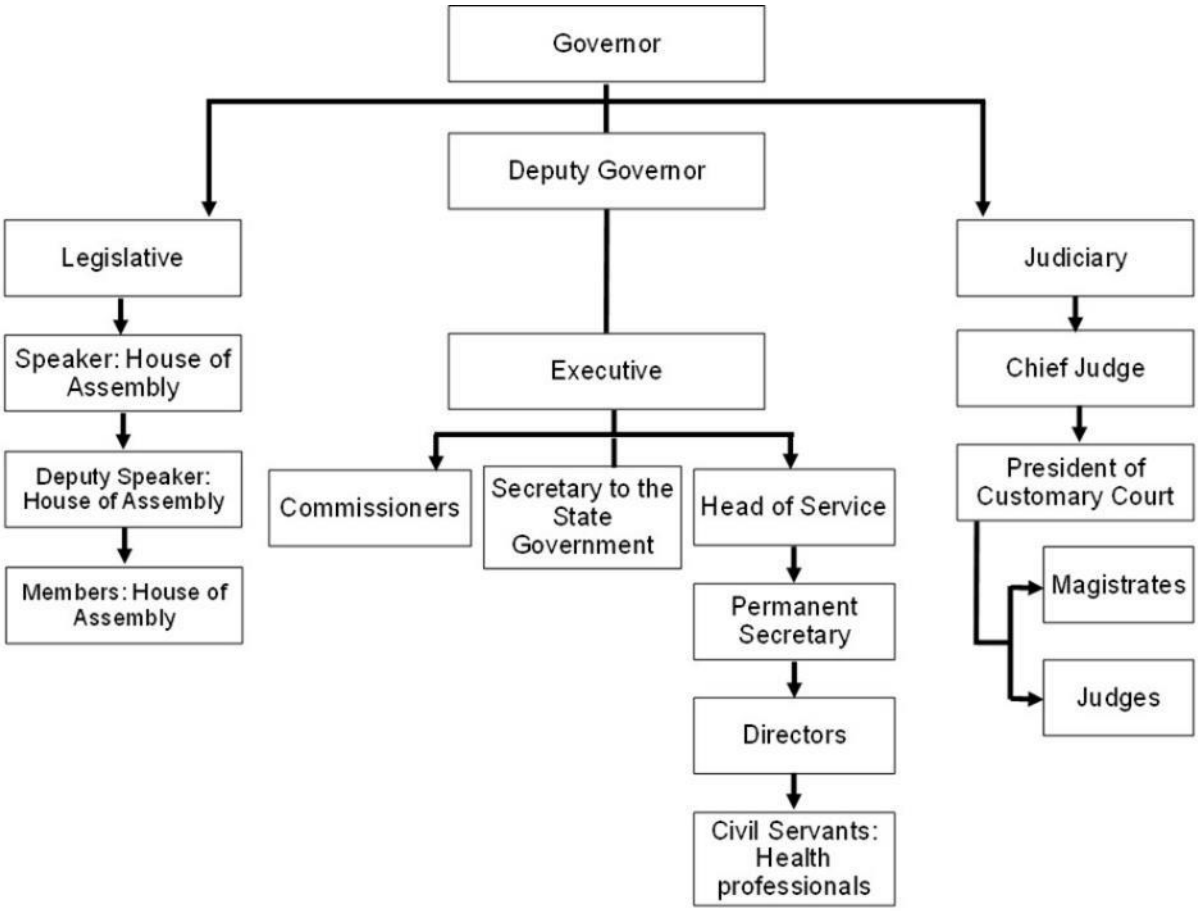


Figure 1.4 Illustration of the structure of Delta State Government

1.4.1 Economic status

Delta state is an agricultural and oil producing state with large deposits of crude oil and solid minerals, such as industrial clay, silica, lignite, kaolin, tar sand, decorative rocks, and limestone (Delta State Government, 2021). These minerals are a great source of revenue generation for the state as they are used by manufacturing companies to produce bricks, ceramics, bottles, glasses, decorative stones, sanitary products, and chemicals/insulators for both industrial and domestic use (Delta State Government, 2021). Within the state, there are many public and private

educational institutions at state and local government levels where formal education is provided, and a total of 2 tertiary and 64 secondary healthcare facilities and, 392 primary healthcare facilities responsible for providing healthcare services to the populace (Delta State Government, 2021). Delta state is considered one of the richest states in Nigeria as it is ranked the second state with the lowest poverty headcount rate of 6% in 2019 (National Bureau of Statistics, 2019).

1.4.2 Beliefs and practices

There are five main ethnic groups in Delta State (Urhobo, Anioma, Ijaw, Itsekiri and Isoko) and 25 Local Government Areas (LGAs), which are grouped into three senatorial districts - Delta North, Delta South and Delta Central (Delta State Government, 2021). Delta North is inhabited by the people of Anioma and it is made up of 9 LGAs, while Delta South senatorial district consists of 8 LGAs and it is a home for the Itsekiri, Ijaw and Isoko ethnic groups. The Urhobos occupy the central part of the state which includes 8 LGAs (Delta State Government, 2021).

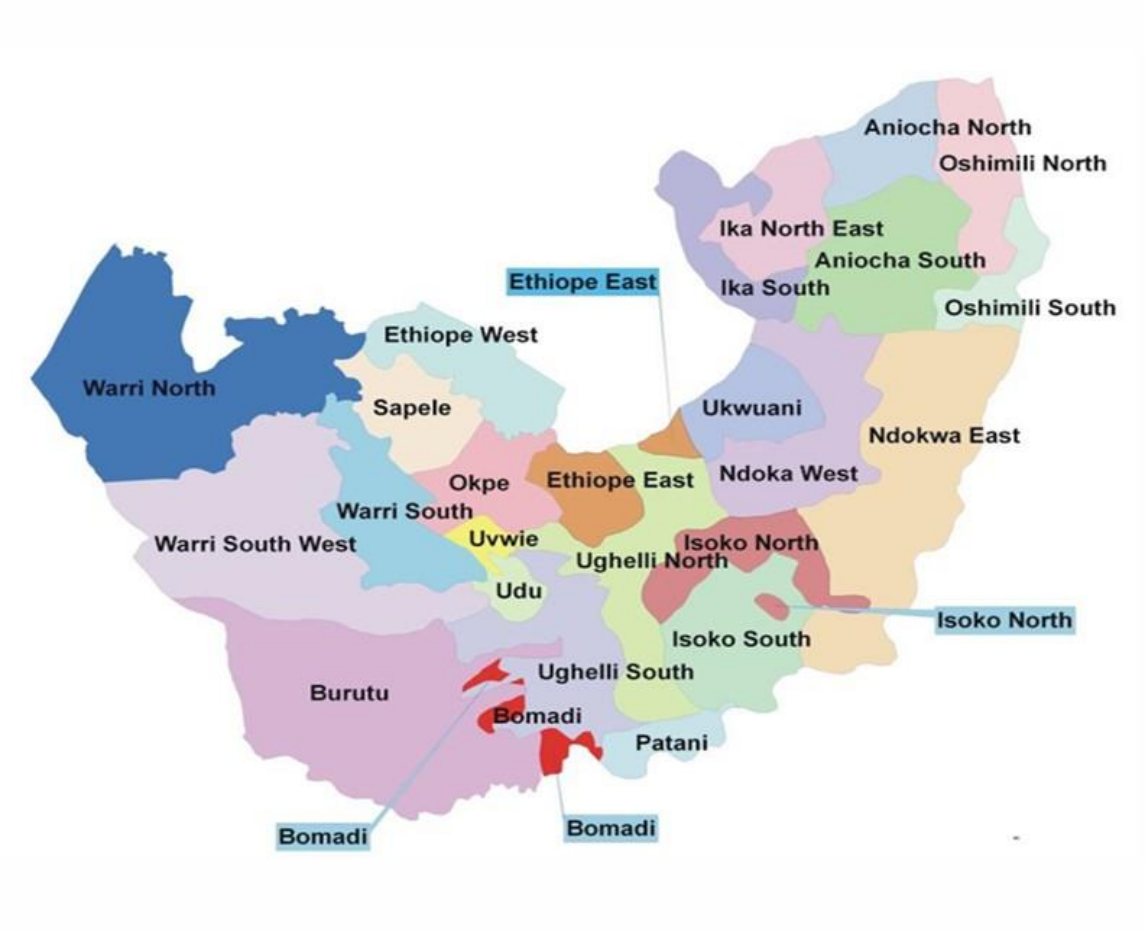


Figure 1.5 Map of Delta state showing the 25 LGA (Delta State Government, 2021)

The indigenes of Delta state are mostly Christians, but some believe in the traditional religion which involves ancestral worship, divination, rites, and annual traditional festivals such as masquerade displays, dancing and offering of sacrifices to their deities (Delta State Government, 2021;Nabofa and Elugbe, 1981). The people from these ethnic groups are largely nurtured in cultural settings that support traditional norms, beliefs, myths, and practices which are meaningful to them (UNHCR, 2003;Nabofa and Elugbe, 1981). They maintain a belief that the physical world is highly influenced by the supernatural, which embraces evil and good forces and thus fear the consequences of disobeying these cultural norms and practices (Awusi, 2009;Nabofa and Elugbe, 1981). For instance, it is a popular belief among the Urhobos, the Isokos, the Ijaws and some parts of

Anioma that when a married women is intimate with another man, the ancestors *(Erivwin*) or gods will cause her husband and or children to die mysteriously except she confesses her deeds and make divinations to appease the ancestors and the gods (Nabofa and Elugbe, 1981). It is also believed among ethnic groups in Delta state that children born with some form of congenital malformations such as Down, Pfeiffer and Sirenomelia syndromes were possessed with evil spirit, and such children are usually abandoned and left to die.

Besides cultural beliefs, there are some common sociocultural practices that exist in Delta state including, early marriage and childbearing, polygamy, initiation of the eldest son into traditional cults and idol worship, breast flattening and female circumcision, also known as female genital mutilation (FGM) (Awusi, 2009).

From the researcher's viewpoint, these beliefs and practices are motivated by cultural and traditional stipulations that are obligatory and respected due to the fear of the perceived repercussions. Given that the researcher and the HCPs examined in this study are from these settings, there is great respect for ancestral rules and regulations. There are inherent positive behaviours, attitudes, and perceptions towards these cultural recommendations. It is based on the fear of the grievous consequences of refusing these cultural prescriptions, that some parents' consent to have their daughters cut, and young girls and women succumb to FGM procedures. As it has already been instilled from a young age that refusing FGM would cause infertility, promiscuity, and death of babies when the head touches the uncut clitoris during delivery and other dangerous repercussions. Though with education, campaigns, and enlightenment more people are beginning to question the validity of these cultural stipulations and repercussions, these beliefs are still common especially in rural communities due to cultural, family and peer influences.

1.4.3 FGM in Delta State

Like some states in Nigeria, FGM is illegal in Delta state. In 2001 a bill was passed prohibiting the practice of FGM in Delta state, and a penalty of 3 months imprisonment and a fine was set (UNHCR, 2015). However, to date no arrest or conviction has been recorded in the state, and the practice remains widespread among practising communities in Delta State (UNHCR, 2015).

Granted that FGM is a customary practice among all five ethnic groups in Delta state (UNHCR, 2015), its prevalence is unclear. A recent demographic health survey conducted among 592 women aged 14-49years in Nigeria, reported a prevalence of 33.7% in Delta state with 13.5% of the women declaring that FGM should continue (National Population Commission, 2018). This survey reported a decline in FGM practices in Delta State compared with the 2013 demographic health survey which reported a prevalence of 40.3%, representing 400 of the 993 women studied (National Population Commission, 2013). The number of women (592) included in the recent survey (National Population Commission, 2018) was by far smaller than the previous study (National Population Commission, 2013) and this may have affected the outcome of the survey, and the decrease in prevalence of FGM reported in Delta State and Nigeria in general.

1.5 Primary health care (PHC) system

Over the past fifty years, the PHC system in Nigeria has undergone serial transformation amidst the many challenges encountered by the wider healthcare system. Before gaining independence, the Nigerian government had no clear plan for developing the healthcare system. However, in the early 1960's the government established health policies which focused on building infrastructures that enabled the provision of interventional treatments, but little attention was paid to preventive measures (Fatusi, 2015). Then, between the mid-1970s and early 1980s the National Basic

Health Services Scheme (NBHSS) was created to provide healthcare facilities and professionals trainings with the PHC as a foundation for its activities (Fatusi, 2015). Unfortunately, this program was unsuccessful as it was unable to achieve its objectives due to poor implementation strategies and weak community participation (Aregbeshola and Khan, 2017). Consequently, PHC services were not provided across Nigeria until the appointment of Professor Olikoye Ransome-Kuti as the Minister of Health in 1985 (Fatusi, 2015;Ransome-Kuti, 1998).

The appointment of Olikoye Ransome-Kuti brought development and reform to the PHC system in Nigeria and in line with the Alma Ata Declaration of 1978, the goal of providing 'health for all' was realised as PHC services became available in 52 LGAs in Nigeria (Aregbeshola and Khan, 2017). Thereafter, a comprehensive national health policy was introduced in 1988 to provide PHC services to rural dwellers with a focus on preventive measures, immunisation, maternal and childcare, nutrition, health education, community mobilisation and nationwide campaigns on HIV/AIDS (Fatusi, 2015). This initiative was a huge success as rural dwellers had access to PHC services, and within seven years, the Minister of Health improved the healthcare delivery system in Nigeria especially at the PHC level and transferred the responsibility of the PHC system to LGAs (Fatusi, 2015). During this time, the National Primary Health Care Development Agency (NPHCDA) was launched to facilitate the sustainability of the PHC programme. However, in 1993 the military took over the governance of the country and this resulted in poor implementation of policies and the deterioration of the Nigerian healthcare system, especially the PHC (Aregbeshola and Khan, 2017;Fatusi, 2015).

Since 1993 several efforts have been made to improve and strengthen the PHC system, including the introduction of the Primary Health Care Under One Roof (PHCUOR) programme in 2011, but this did little to enhance the situation of the PHC due to limited resources and poor implementation of policies (Aregbeshola and Khan, 2017). Currently, the PHC system

fundamentally fails to meet the needs of the populace as only about 20% of the 30,000 PHC facilities in the country are functional (Aregbeshola and Khan, 2017;Adewole, 2016). Consequently, the PHC which is the bedrock of the healthcare system in Nigeria, is barely able to meet 20% of clients' needs, while the referral system is practically non-existent (Agofure and Sarki, 2017;Abdulraheem, 2012).

The narrative is the same in Delta state as PHC facilities lack the capability of providing basic healthcare services to the populace due to governmental factors (Aregbeshola and Khan, 2017). These issues are not limited to the lack of political commitment, inadequate funding/misappropriation of funds, poor physical infrastructure and basic amenities, lack of medical supplies and equipment and poor staffing, and distribution of healthcare workers (WHO, 2017;Kress et al., 2016;Omuta, 2016;Abdulraheem, 2012). These challenges also continued to have negative effects on the monitoring and evaluation of PHC programmes. For instance due to poor staffing and distribution of HCPs, the daily activities of PHC facilities are being managed by nurse/midwives which could result in poor adherence to guidelines, malpractices and delivery of substandard services (WHO, 2017;Omuta et al., 2014). Also, poor monitoring, supervision, and accountability of PHC activities may result in HCPs especially those working in rural settings to carry out procedures that are against PHC policies like performing FGM, selling essential drugs to clients and asking clients to pay for health services that are supposed to be free. The perceived misconduct within the PHC system has impacted negatively on the utilisation of PHC services by the populace (Agofure and Sarki, 2017).

1.5.1 Access and utilisation of PHC services

Access to good healthcare services to a large extent determines the utilisation and impact of the outcome for service users (Makita-Ikouaya et al., 2010). In Delta State, healthcare services are provided by the joint efforts of the public and private health sectors at the tertiary and secondary

levels of care (WHO, 2017). While at the PHC level, the goal was to provide access to immediate healthcare services for urban and rural dwellers (Omuta et al., 2014). With the availability of PHC facilities in most towns and villages in Delta state, the gap between the people and health services is somewhat reduced in these settings (Omuta and Onokerhoraye, 2015). However, for individuals living in riverine areas and other remote villages and communities, access to basic health care remains a considerable challenge (Agaja, 2012).

An investigative study of the distribution pattern of PHC in Nigeria by Odubanjo et al., (2009) reported that there is extremely inequitable access to PHC services between rural and urban settings and private and public health facilities. This report was supported by a recent study on the spatial distribution of PHC facilities in Ughelli North and Warri South LGAs of Delta state (Agaja, 2012). The study showed that PHC facilities were clustered in the urban areas of the LGAs whereas in rural areas with difficult and poor terrain, PHC facilities were few and far apart and in deplorable state (Agaja, 2012). Indicatively, access to healthcare services in Delta State and Nigeria in general is dependent on financial status and geographical location. For example, in urban areas, there are many well-equipped healthcare facilities with skilled health professionals, which makes access to healthcare services easier, quicker, and affordable for people living in these settings.

The disparity in accessing healthcare services has had a huge toll on the utilisation of PHC services in rural settings. For instance, a qualitative study of perspectives on PHC in Nigeria, showed that participants from communities in Delta State mentioned the challenges of accessing PHC services to include-, poor condition of roads and having to walk long distance on foot to PHC facilities to utilise maternal and childcare services (Omuta et al., 2014). In this regard, pregnant women found it difficult to visit PHC facilities for antenatal check-ups and delivery services, as there were no options for using the popular means of transportation (bicycles and motorcycles) because of the difficulties in navigating bad roads. Hence,

women living in these remote communities are unable to access PHC services even with the awareness of the services rendered by the PHC (Agofure and Sarki, 2017;Omuta et al., 2014).

Whilst the utilisation of healthcare services in rural communities is often dependent on access to PHC facilities, there are other barriers to utilising PHC services in these settings (Agofure and Sarki, 2017;WHO, 2017). A cross-sectional study of 383 participants regarding the utilisation of PHC services in Nigeria found that availability of skilled health workers, poor attitudes of staff, long waiting time and the lack of diagnostic services were some of the factors which prevented the use of PHC services (Agofure and Sarki, 2017). Similarly, WHO (2017) attributed the poor utilisation of PHC services to- community perceptions of poor quality of care provided, lack of basic care services in PHC and poor community participation in PHC activities (WHO, 2017).

The poor access and utilisation of PHC services by rural dwellers is further compounded by the fact that in the public health sector, there is a huge shortage of doctors, nurses, and midwives especially within the PHC system (Obembe et al., 2014). According to NPHCDA (2020), the minimum staffing standard for PHC facility is doctor (1) if available, nurse/midwives (4), CHEW (3) and JCHEW (6) but realistically, most PHC facilities across Delta State only have one nurse/midwife minding a PHC facility (NPHCDA, 2020). This is mainly because most HCPs work simultaneously for both public and private health facilities in urban areas for higher salaries and better working environment (WHO, 2014). Consequently, only a few HCPs are found bearing the responsibility of providing care for rural dwellers while struggle tirelessly to deal with the pressure from the increasing healthcare demands in PHC (1.95 per 1,000 population) (WHO, 2020;Alonge, 2020). For these HCPs, the lack of basic amenities which characterises rural communities, poor staffing, inadequate drug supply and lack of equipment lead to difficult working conditions, and this ultimately impacts negatively on job

performance and the quality of healthcare services delivered to clients (WHO, 2017).

Furthermore, due to the challenges that exist within the PHC system, rural dwellers have opted to utilising the services of traditional birth attendants (TBAs) to meet their health needs (Amutah-Onukagha et al., 2017). TBAs are women situated in the community who assist mothers during childbirth and had previously trained to deliver babies through apprenticeship or other TBAs (WHO. et al., 1992). They mainly provide delivery and other maternal and child related services, including circumcision. Available data show that 59% of women in Nigeria delivered at home, of which 20% were undertaken by TBAs while only 39% delivered their babies in public facilities and 13% in private healthcare facilities (National Population Commission, 2018). Similarly, in Delta state, more than 40% of live deliveries were taken at home by TBAs (National Population Commission, 2018). The importance of TBAs cannot be undermined as they contribute significantly to the healthcare system in Nigeria by providing maternal and childcare services to rural communities; however, it is unclear if these TBAs are adequately trained to provide safe healthcare services. Some of the reasons for patronising TBAs services include- cultural affiliation, convenience, affordability and non-availability of functional healthcare facilities, and TBAs were perceived as having compassionate attitude compared with trained nurses and midwives (Amutah-Onukagha et al., 2017;Ebuehi and Akintujoye, 2012).

Conceptually, the establishment of 30,000 PHC facilities and the NPHCDA should provide the opportunity for the effective implementation of PHC services across Nigeria. However, the Nigerian government has not utilised the availability of these mechanisms to achieve a sustainable PHC system that will strengthen the healthcare system in Nigeria and improve the health status of the populace. Arguably, PHC policies need to be improved through the increment of domestic resources and budgetary allocation for healthcare services, to develop PHC infrastructures, roads, and

transportation system, and encourage the relocation of healthcare professionals from urban to rural settings. This could facilitate the provision of quality healthcare services to the general population thereby significantly reducing the gross inequality in the accessibility and utilisation of PHC facilities. Figure 1.6 shows an illustration of factors and barriers affecting the access and utilisation of PHC services among rural dwellers in Delta state.

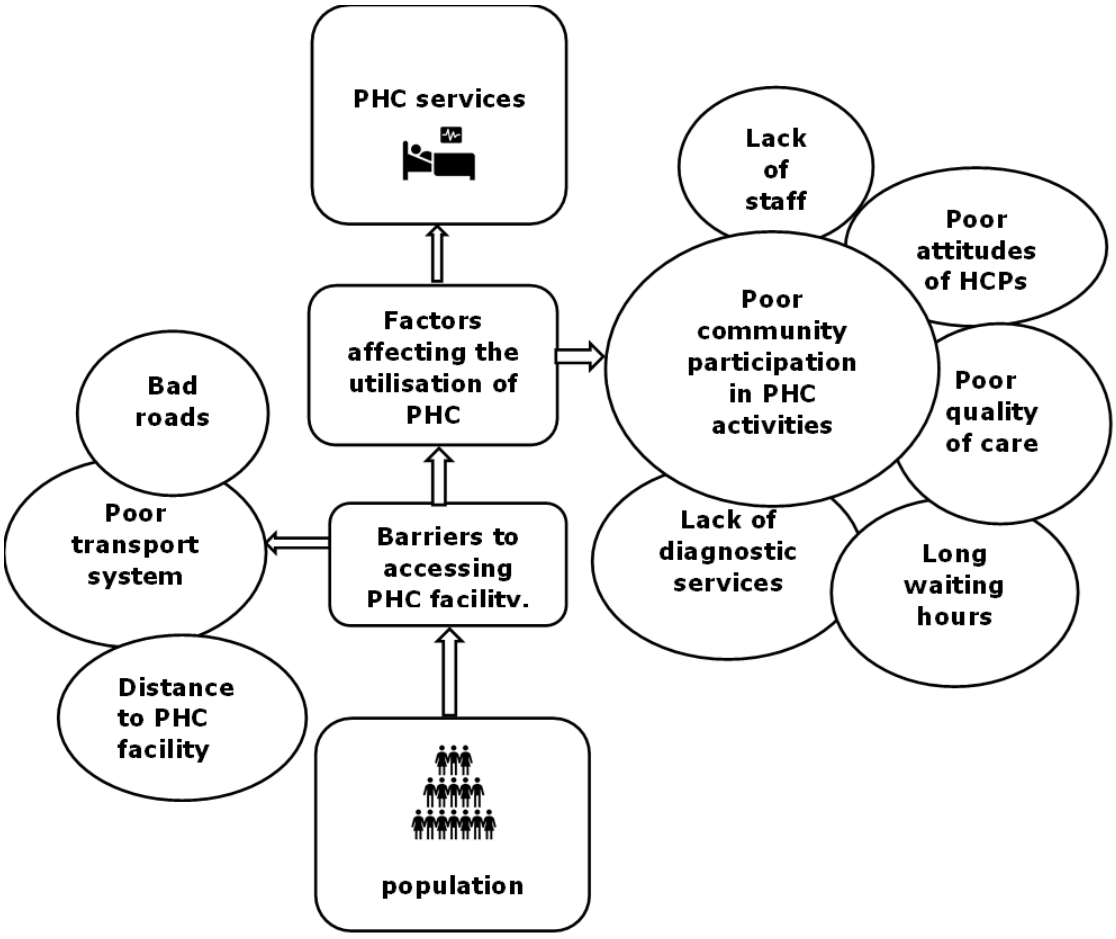


Figure 1.6 Illustration of factors and barriers affecting the access and utilisation of PHC services.

1.5.2 Organisation of the PHC

PHC facilities are made up of clinical and non-clinical staff which are employed by the state government through the Ministry of Health, the Civil Service Board, Health Management Board, Local government authorities and the NPHCDA. The clinical HCPs include doctors, nurses/midwives, community health officers (CHO), and community health extension workers (CHEWs). While other HCPs include non-clinical staff such as, health educators, healthcare assistants, pharmacy technicians, medical laboratory scientist, and medical records officers (NPHCDA, 2020;Omuta et al., 2014). Figure 1.7 shows the managerial structure of PHC facilities and how information flows from the supervisory head of the PHC to the most senior nurse/midwife in charge of the PHC facility and, down to nurses and other HCPs working within the facility.

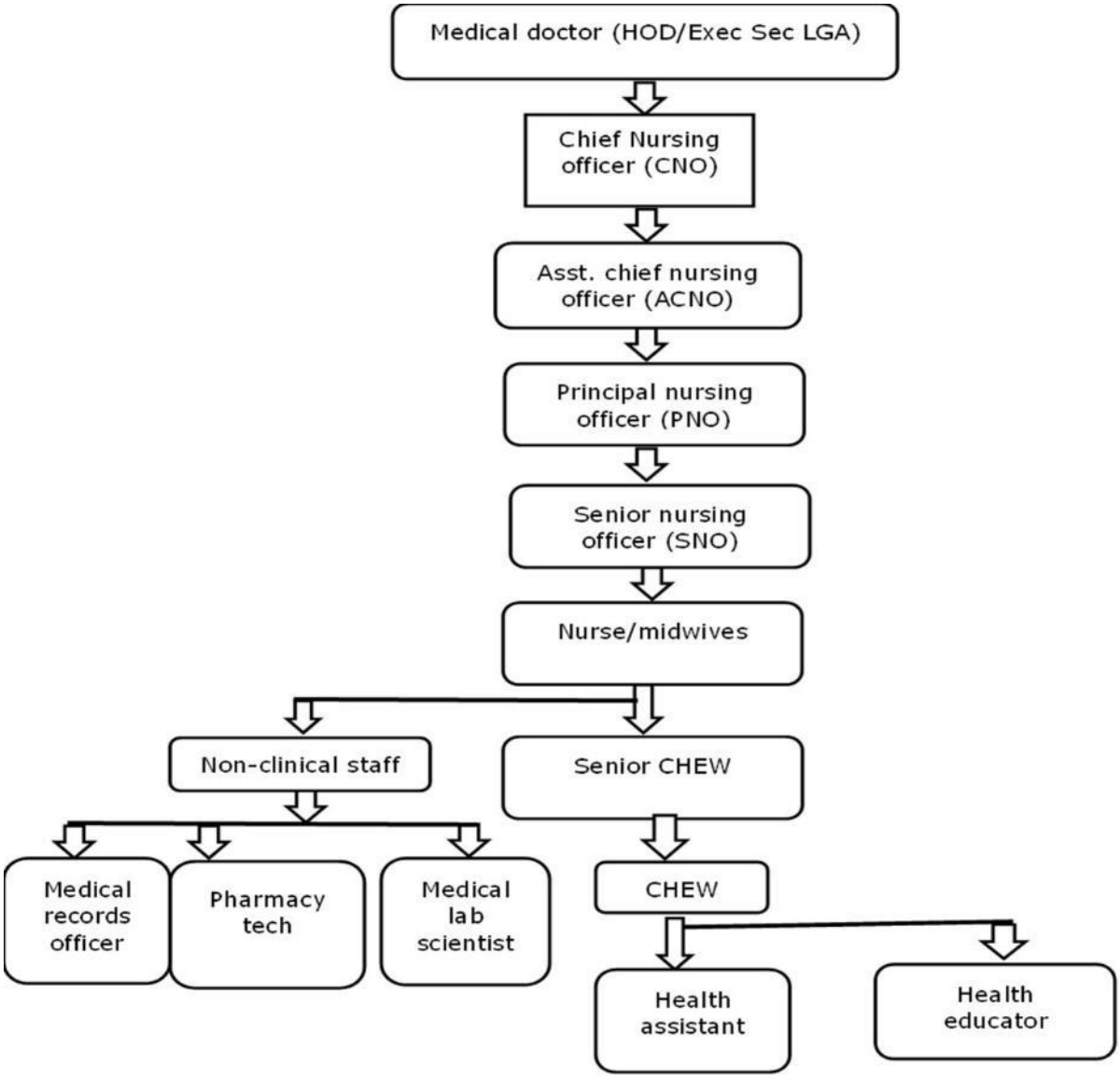


Figure 1.7 Illustration of the organisational structure of PHC facilities

1.6 Summary

FGM is a global challenge as it violates the human rights of girls and women and causes detrimental health consequences. The Nigerian government has made efforts over the years to eliminate the practice of FGM by ratifying all international and regional conventions on the right of women and children condemning the practice of FGM. The efforts made by the government and non-governmental organisation had a positive effect on the practice, as there is a notable decline in the prevalence of FGM in Nigeria from almost 30% in 2008 to 24.8% in 2013 and a further decline

to 20% in 2018 (National Population Commission, 2018). Notwithstanding, the practice has remained persistent, and despite existing laws, campaigns against FGM and the development of the national policy and plan for the eradication of FGM in Nigeria, some HCPs in Nigeria still perpetrated FGM practices. In addition, HCPs understanding of the practices of FGM, and the quality of care provided for women living with the health consequences of FGM are unclear. Therefore, it is important to explore HCPs current understanding of FGM, and their beliefs and practices of FGM in Delta state Nigeria.

The following chapter will provide a systematic narrative review of literature on HCPs knowledge, beliefs, attitudes, and practices of FGM in Africa to identify gaps in existing literature and the justification for a new study.

1.7 Thesis structure

This thesis is made up of six chapters. Chapter one presents contextual information about the studied phenomenon and an overview of the study settings in Nigeria.

Chapter two provides a systematic narrative review of existing literature on FGM in relation to healthcare professionals knowledge, beliefs, and practices of FGM in Africa. This entailed a logical presentation of the search for relevant empirical studies through the identification of a review aim, question, a clear set of inclusion and exclusion criteria and the search strategy. This was followed by the discussion of findings from the included empirical studies and the justification for undertaking this study.

Chapter three describes the methodology and methods applied in this study. It discusses the philosophical assumptions underpinning this study and the rationale for the adopted methodological design. The techniques used for sampling and recruitment, data collection and construction were subsequently presented. Then, strategies used to enhance the study's rigour and ethics were discussed. Followed by a reflexivity account of the

researcher's cultural and professional background and how this affected the research process, as well as the challenges encountered during the field work.

Chapters four and five present in-depth description of findings generated from the semi structured interviews. Chapter four describe findings from HCPs knowledge of FGM, the influence of sociocultural system and professional practices. Chapter five described findings in relation to HCPs encounters with FGM in the clinical setting and their experiences and challenges in providing care for women with FGM.

Chapter six discusses the key findings from this study in relation to existing empirical literature and proposed a theoretical framework for FGM prevention. It highlights the strengths and limitations of the study, and subsequently provides the study's implications for education, practice, polices and further research. This chapter also presents a conclusion based on the overall aim and objectives of this study.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

This chapter provides a review of existing literature on healthcare professionals' knowledge, beliefs, attitudes, and practices of FGM in Africa. The review is focused on exploring peer reviewed papers on the studied area to identify gaps in existing literature and highlight the significance of a new research (Cronin et al., 2008). This review process entails the identification of a review aim, question, and setting clear inclusion criteria. It also includes a detailed search of databases to identify relevant studies which were synthesised, and subsequently presents a comprehensive analysis of current evidence on healthcare professionals' knowledge, beliefs, attitudes, and practices of FGM in Africa.

2.1 Systematic Narrative review

Fink (2005) defines literature review as a 'systematic', explicit, and reproducible method for identifying, evaluating, and synthesising the existing body of completed and recorded work produced by researchers, scholars, and practitioners (Fink, 2005). Similarly, Baker (2016) describes literature review as the summary of a piece of selected studies in a specific topic with a critical analysis of the synthesised findings to identify new knowledge and gaps in existing literature to inform new studies (Baker, 2016). Systematic in the context used by Fink (2005) means that literature review is conducted in a logical manner, and not systematic in terms of the standard systematic review which follows a methodological guideline (Coughlan and Cronin, 2021;Fink, 2005). The term literature review is used to describe different approaches used to search, identify, collate, and present outcomes of literature and they include but not limited to-; systematic review which could be qualitative, quantitative, or mixed methods, scoping review, rapid review, systematised review, overview

review and narrative review which is like literature or traditional review, among others (Coughlan and Cronin, 2021;Cronin et al., 2015). Regardless of the type of literature review, they all contain elements of systematicity and share some similarities in the approach to searching, identifying, selecting, and reporting research outcomes (Coughlan and Cronin, 2021;Booth et al., 2016)..

Systematic review is the summary of a literature review that is focused on a particular question (Bettany-Saltikov and McSherry, 2016). The National Institute for Health Research (NIHR) (2010) defines systematic review as a process of identifying, evaluating, combining, and summarising the findings of all relevant primary studies to provide decision-makers with evidence-based data about the effectives of tests, treatments and other interventions used in health and social care (NIHR, 2010). Systematic review follows a standard and rigorous methodology and depending on the type, there are recommended protocols to follow, including the Joanna Briggs Institute (JBI), The Cochrane Library and the Centre for Reviews and Dissemination (Bettany-Saltikov and McSherry, 2016). The steps to conducting systematic reviews include an introduction or background, a rationale for the systematic review, specified objectives, a well-defined selection criteria for choosing empirical research papers or reports, a critical appraisal of the quality of the included papers, a synthesis of each of the included papers, and the findings are interpreted and presented objectively without any bias (Booth et al., 2016;Bettany-Saltikov and McSherry, 2016). Systematic reviews are useful for studies that intend to synthesise evidence from large Randomised Controlled Trials (RCTs), studies comparing efficacy of treatments, studies on how outcomes have changed or improved over time to ascertain benefits to patients' outcome, studies that aim to determine how certain factors such as age, sex, ethnicity influence treatment or clinical outcomes using RCTs, studies that aim to identify and report the range of specific outcomes among others (Powell and Koelemay, 2022;Booth et al., 2016).

In addition, systematic reviews are increasingly becoming more popular in published literature and are considered important sources of clinical and evidence-based practices (Powell and Koelemay, 2022). Arguably, systematic reviews are undertaken to add current data to existing evidence however, more than 90% of systematic reviews are not clinically useful as they are redundant, misleading, and conflicting (Powell and Koelemay, 2022;Ioannidis, 2016). While some are regarded as research waste (Powell and Koelemay, 2022;Roberts and Ker, 2015). Perhaps, conducting a different type of review such as narrative review would be more useful for summarising findings, identifying knowledge gaps in existing literature, providing justification for further research, and important for informing policies and clinical guidelines.

Conversely, narrative review involves the examination and description of published literature that cover a wide range of subjects in health and social sciences at different levels of completeness and comprehensiveness (Greenhalgh et al., 2018;Booth et al., 2016;Grant and Booth, 2009). It is useful for defining and refining research questions, as well as identifying areas of the field of interest that had previously been studied to avoid duplications. Narrative review involves identifying a topic area, developing a literature review aim and question, search databases for literature, select empirical papers to be included in the review, analyse the findings of the included empirical papers, provide a summary of the included papers, and write a review of findings using themes, whilst considering gaps in literature and justification for new study (Coughlan and Cronin, 2021).

Furthermore, systematic, and narrative reviews are often referred to as the two main approaches for searching, identifying, and extracting and analysing literature (Turnbull et al., 2023;Greenhalgh et al., 2018). They both have their strengths and weaknesses, narrative review provide comprehensiveness, in depth interpretation, critique and understanding of the reviewed topic, but are still referred to as unsystematic and biased (Greenhalgh et al., 2018). Critics of narrative review argue that its methods

are not always clearly defined (Ferrari, 2015;Collins and Fauser, 2005) and the selection criteria for the reviewed papers and their validity are not usually explicit (Ferrari, 2015). However, proponents suggest that narrative reviews can be strengthened by drawing on the principles of systematic reviews (Turnbull et al., 2023;Collins and Fauser, 2005).

Therefore, this review draws on the characteristics and principles of both narrative review and systematic review, making this review a hybrid systematic narrative review. This is because both types of review complement each other - narrative review is useful for providing a broad overview of relevant literature by exploring peer reviewed papers on the studied area to identify gaps in existing literature and highlight the significance of a new research. While systematic review addresses the biases associated with narrative review by adding rigour, transparency and explicit methodological approach to literature search, inclusion/exclusion criteria and search strategy which can be replicated or reproduced (Turnbull et al., 2023;Bettany-Saltikov and McSherry, 2016). Although, systematic review is not without its biases - for instance, systematic review is mostly conducted to determine whether a particular intervention worked or not (Booth et al., 2016). Hence, studies under review are appraised and scrutinised to ensure that only good quality studies are included in a systematic review to confirm or disprove the effectiveness of an intervention (Booth et al., 2016;Grant and Booth, 2009). By so doing studies that are considered poor quality are excluded from the review, and these excluded studies could contain useful evidence that may contribute to the overall findings of the review. This is a rationale for employing both narrative review and the systematic approach, as narrative review allows the researcher to include studies that are rich in data, thereby addressing the biases of systematic review and the omission of valuable data. Thus, this study did not assess the quality of the included empirical papers as it is irrelevant to this research if the papers under review are of poor quality by the systematic review standard. This is because the focus of this review

is to provide rich evidence that will contribute to the understanding of the researched topic, and the so-called poor-quality studies may contain evidence of valuable insight. Furthermore, employing systematic review techniques alone is unsuitable for answering the research question as the present study is not focused or concerned with clinical interventions or effectiveness of any sort (Powell and Koelemay, 2022), but on providing in-depth understanding of FGM practices among HCPs in rural communities in Delta state, Nigeria.

This systematic narrative hybrid approach to literature review is increasingly becoming popular as several empirical reviews have also adopted similar approach in different subject areas including health and social care (Alfandari and Taylor, 2023;Powell et al., 2009), Psychiatry (Robinson et al., 2016), Education (Fleischer, 2012), social media (Sarmiento-Lawrence et al., 2020) and (Best et al., 2014), computer sciences (Boyle et al., 2012) and social sciences (Turnbull et al., 2023). These studies employed a systematic review approach to identify the literature and applied narrative review methods to synthesising findings in the discussion section, like this review. The utilisation of the systematic narrative hybrid review method by these references provided an explicit and detailed methodological presentation of the technique used for the selection of the included papers and synthesis of outcomes, and removed biases associated with each of the methods.

2.1.1 Aim of the literature review

I. To explore existing evidence on HCPs knowledge, beliefs, attitudes, and practices of FGM in Africa
II. To identify gaps in existing literature about HCPs knowledge, beliefs, attitudes, and practices of FGM and highlight the importance of a new study.

2.1.2 Literature review question

What is the existing evidence on HCPs knowledge, beliefs, attitudes, and practices of FGM in Africa?

2.1.3 Inclusion and exclusion criteria

Inclusion criteria: will be studies that-

- ✓ Focused on the practice of FGM
- ✓ Examined HCPs of any group
- ✓ Primary and secondary source of data
- ✓ Used qualitative or quantitative designs
- ✓ Studies conducted in Africa
- ✓ Studies published in English and peer reviewed
- ✓ Conducted across all years

Exclusion criteria

- ✓ Studies that did not include HCPs knowledge, beliefs, attitudes, and practices
- ✓ Studies that were not published in English
- ✓ Studies that were not conducted in Africa

2.1.4 Search strategy

The exploratory search for relevant studies involved the identification of key concepts and keywords that are related to the review aim as a guide for literature search. These key concepts and keywords are shown in Table 2.1.

Table 2.1 Key concepts and key words

Key concepts	Keywords
Female genital mutilation	Female genital mutilation/cutting, female genital cutting, female genital circumcision, female circumcision, FGM, FGM/C, FGC
Knowledge	Awareness, understanding
Attitude	Belief, perspective, opinion, view, perception
Practice	Experience, exposure, training
Health professionals	Health care professionals, Health workers, Primary health care workers, Health care providers, Doctors, Nurses, Midwives, Community nurses, community midwives, Community Health Extension Workers (CHEW)

The search for relevant literature began with an initial search of PubMed and CINHAL using key concepts such as 'female genital mutilation', 'knowledge', 'belief', 'attitude', 'practice' and 'health professionals. The titles, abstract and citations were reviewed. Then key concepts and their synonyms (key words) were entered individually into the included databases (CINHAL, PubMed, Embase, MEDLINE, PsycINFO and ASSIA) and linked together by Boolean operators "OR" and then with "AND". In addition, a hand search and snowball search were undertaken on reference list and grey papers in relevant organisations (WHO, UNICEF, UNFPA).

At the end of the search, a total of 609 studies were exported onto EndNote X9 reference management software where duplicates were removed, leaving a total of 392 studies. Then the title of all 392 studies were read and 287 studies were excluded because they were unrelated to study scope. The abstracts of all remaining 105 studies were scanned through and 67 were excluded because the studies did not examine health professionals. Using the inclusion criteria, 23 studies were excluded because 13 were FGM intervention studies and 10 were unrelated secondary studies. At the end of the search, a total of 15 empirical studies were included for review.

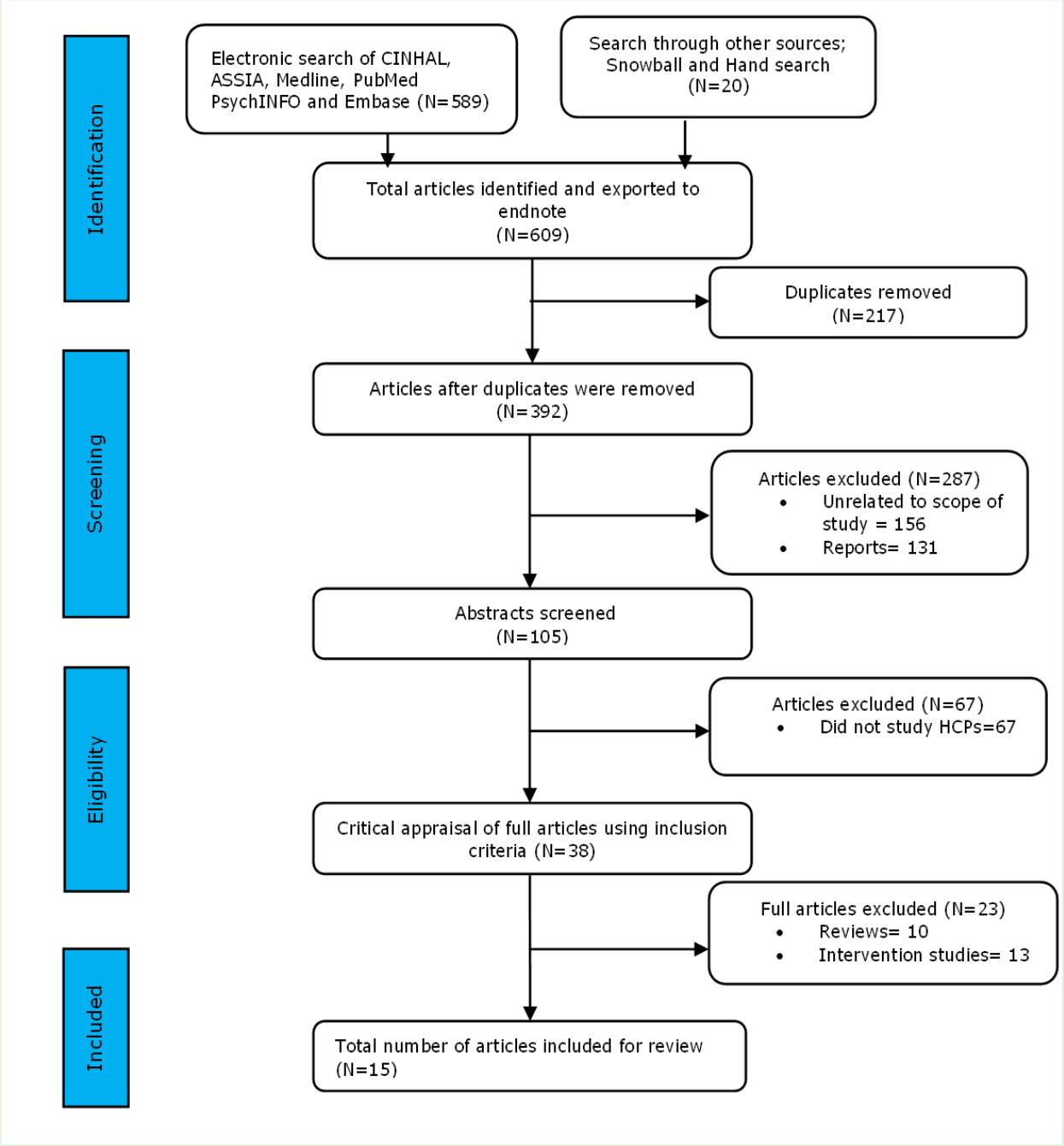


Figure 2.1 PRISMA Chart of included studies

2.1.5 Summary of included studies

Fifteen empirical studies were included in this review. The studies were conducted between 2006 and 2021 in six countries in Africa. Eight were from Nigeria (Obiora et al., 2021;Obianwu et al., 2018;Ashimi et al., 2014;Umar and Oche, 2014;Ibrahim et al., 2013;Dike et al.,

2012;Adekanle et al., 2011;Onuh et al., 2006). Two studies were included from Egypt (Refaat., 2009;Mostafa et al., 2006) and another two studies were identified from Gambia (Kaplan et al., 2016;Kaplan et al., 2013). One study was selected from Somaliland (Isman et al., 2013), one from Liberia (Tarr-Attia et al., 2019) and one was included from Sudan (Ali, 2012).

The fifteen studies were carried out within tertiary, secondary and primary healthcare settings in urban and rural communities. Four (Obiora et al., 2021;Tarr-Attia et al., 2019;Obianwu et al., 2018;Isman et al., 2013) of the studies employed qualitative design and in-depth interviews as the method of data collection, while the remaining eleven studies (Kaplan et al., 2016;Ashimi et al., 2014;Umar and Oche, 2014;Ibrahim et al., 2013;Kaplan et al., 2013;Ali, 2012;Dike et al., 2012;Adekanle et al., 2011;Refaat., 2009;Onuh et al., 2006;Mostafa et al., 2006) utilised quantitative approach and collected data using questionnaires.

The included empirical studies examined a total of 3,721 HCPs of different professions including doctors (363), nurses (633), midwives (26), nurse/midwives (668), student nurses and midwives and medical students (1380), community health extension workers (CHEW) (8) and voluntary village health workers (VVHW) (5). Also, one of the study examined six auxiliary nurses who were identified as healthcare providers by members of the community (Obianwu et al., 2018), and another studied 157 traditional birth attendants (TBA) who were recognised as midwives within the community because they performed delivery services (Ali, 2012). (See appendix 1)

All the included studies explored different concepts relating to the scope of this study and after an in-depth analysis, three overarching themes and six subthemes were generated from a thematic table of the included studies (See appendix 1). The identified themes and subthemes are stated in table 2.2.

Table 2.2 Generated themes and subthemes

Review themes	Subthemes
Knowledge of FGM	Knowledge about the types of FGM Knowledge about health complications of FGM
Beliefs and attitude towards FGM	Beliefs about the reasons for practicing FGM Attitude towards the continuation of FGM
Practice and experience of FGM	Practice of FGM Clinical experience of FGM

2.2 Literature review findings

Findings from the synthesis of the fifteen empirical studies will be presented following the three review themes and the six subthemes shown in table 2.2.

2.2.1 Knowledge of FGM

This section presents findings from studies that examined the knowledge of FGM. The domains examined under this section include knowledge about the types of FGM and knowledge about the health complications of FGM. In this context, knowledge means HCPs understanding and correct description or identification of the four types of FGM and the health complications of FGM.

2.2.1.1 Knowledge about the types of FGM

The understanding of the four types of FGM was explored by ten studies; six of these studies were conducted in Nigeria (Obianwu et al., 2018;Ashimi et al., 2014;Umar and Oche, 2014;Ibrahim et al., 2013;Adekanle et al., 2011;Onuh et al., 2006), two were carried out in Egypt (Refaat., 2009;Mostafa et al., 2006), one was undertaken in Sudan (Ali, 2012) and one was conducted in Liberia (Tarr-Attia et al., 2019).

The findings indicated that the HCPs examined in this review had limited knowledge about the four types of FGM. A survey of 154 midwives in Sudan reported that only about 7% of the HCPs could identify the four types of

FGM (Ali, 2012). Similar result was reported in a study of 182 nurses in Nigeria where only a small percentage (6.6%) of the nurses could correctly describe the four types of FGM (Onuh et al., 2006). While, a recent study of 100 nurses in Nigeria declared that only 34 of the nurses knew all the types of FGM (Umar and Oche, 2014). The nurses who had knowledge about the four types of FGM in the Umar and Oche (2014) study may have their expertise from years of clinical practice and encounters with women with FGM, as some of them had more than 25years of nursing experience.

The recent qualitative study of 17 midwives in Liberia claimed that the midwives had an extensive understanding of type I *(clitoridectomy)* of FGM (Tarr-Attia et al., 2019), whereas an in-depth interview of 6 auxiliary nurses in a study in Nigeria revealed that the HCPs had limited knowledge about the types of FGM (Obianwu et al., 2018), though these auxiliary nurses discussed type I with precision that could be indicative of having an understanding of the type I. Other studies corroborated the findings reported by Tarr-Attia et al (2019) and Obianwu et al. (2018). For instance, a survey of 250 nurse/midwives and doctors in Nigeria declared that nearly 70% of the HCPs were able to identify type I of FGM (Adekanle et al., 2011). Corresponding reports from a study of 298 medical students in Egypt revealed that more than half of the HCPs knew of FGM type I (Mostafa et al., 2006). It is evident that most of the studied HCPs had good understanding of the type 1 of FGM as it appeared to be the commonly practised type in some of the settings where these studies were conducted (Tarr-Attia et al., 2019;Obianwu et al., 2018;Refaat., 2009;Mostafa et al., 2006).

In regard to findings about the commonly practised types of FGM, the two studies included from Egypt reported contrasting findings. The study of 193 physicians in Egypt revealed that almost all the physicians were able to identify type II of FGM (Refaat., 2009). The physicians in the said study declared that type II of FGM was the most practised form of FGM in the study setting, hence they had a good knowledge of it. However, paradoxical

findings were reported in a similar study from Egypt (Mostafa et al., 2006) where more than half of the HCPs stated that they were familiar with type I of FGM because it was commonly practised in Egypt. The controversy about the most prevalent type of FGM in Egypt raised the question of whether the 27 governorates in Egypt practised different types of FGM, or the HCPs in both studies (Refaat., 2009;Mostafa et al., 2006) did not know the difference between clitoridectomy (Type I) and excision (Type II). Therefore, the studied HCPs seemed to be unaware of the existence of other forms of FGM.

Despite reports of some understanding of types I and II among most of the surveyed HCPs in this review, the study of 118 HCPs in Nigeria revealed that only a few of the HCPs could identify types I (20.3%) and II (24.6%) of FGM (Ibrahim et al., 2013). Likewise, the study by Adekanle et al. (2011) showed that only 7.3% and 0.8% of the 250 surveyed HCPs knew types III and IV respectively. While a recent study in Nigeria asserted that nearly half of the 350 nurses that was examined knew no type of FGM (Ashimi et al., 2014).

Overall findings from the review of HCPs understanding of the different types of FGM revealed a knowledge gap among the studied HCPs, as only a few of the HCPs could accurately identify and describe the four types of FGM. In studies where HCPs claimed they knew type I of FGM due to years of experience and contact with women with FGM, other HCPs with similar experiences were found to have limited knowledge about the types of FGM (Umar and Oche, 2014). In addition, some HCPs in Egypt had declared that they knew FGM type I because it was the most practised type (Refaat., 2009), however other HCPs in same setting (Mostafa et al., 2006) had expressed conflicting views as to the most prevalent type of FGM in Egypt. While in other instances, some of the surveyed HCPs did not know any type of FGM, hence HCPs understanding of the types of FGM seems limited.

2.2.1.2 Knowledge about health complications of FGM

HCPs' knowledge of the harmful effects of FGM was examined by fourteen of the included studies. This was to ascertain if the surveyed HCPs were aware of the health consequences of FGM or had observed any FGM related complications. All the studies except one (Isman et al., 2013) of the included studies explored HCPs understanding of the health implications of FGM.

Some of the studies (Ashimi et al., 2014;Umar and Oche, 2014;Adekanle et al., 2011;Refaat., 2009) that explored HCPs knowledge of FGM complications reported that the HCPs had adequate knowledge about the dangers of FGM as most were able to mention at least one health complication. Majority of the surveyed HCPs cited bleeding, risk of infections and lacerations as complications of FGM, and this was reflected in over 80% of the HCPs in the study by Ibrahim et al. (2013), Dike et al. (2012) and Onuh et al. (2006). In addition, most of the HCPs in the qualitative studies (Obiora et al., 2021;Tarr-Attia et al., 2019;Obianwu et al., 2018) mentioned severe pain and haemorrhage as some of the detrimental effects of FGM. The midwives in the study by Tarr-Attia et al. (2019) based their knowledge of the complications of FGM on their personal experiences of FGM. They drew from these experiences to describe how profusely they bled when they were cut, and added that the severity of the pain could lead to shock:

> *"I can tell you. When I went there [to the 'bush', to be 'cut'], I almost died. I bled almost to death'' Midwife (Tarr-Attia et al., 2019 p.5)*

Other complications mentioned by the surveyed HCPs included shock, vesicovaginal fistula, genital keloids, infertility, painful coitus, sexual dysfunction, and scarification (Obiora et al., 2021;Tarr-Attia et al., 2019;Umar and Oche, 2014;Ibrahim et al., 2013;Dike et al., 2012). Aside the mentioned health implications, few HCPs declared that FGM procedures

led to prolonged labour and difficult delivery (Kaplan et al., 2016;Ashimi et al., 2014;Kaplan et al., 2013;Onuh et al., 2006). It is quite concerning that most of the examined HCPs did not seem to know of the severe obstetric complications (prolonged labour, fetal asphyxia and pelvic organ prolapse) that could arise during delivery, even though some of these HCPs were midwives and doctors who claimed to have provided care for women with FGM.

A limited understanding of the health implications of FGM was reported in the study by Mostafa et al. (2006) where HCPs claimed to be aware that FGM constituted health problems, but when the complications were categorised into long- and short-termed complications, nearly half of the 298 HCPs were oblivious to the long- and short-termed health dangers of FGM. Similar findings were observed among the midwives in the study by Ali (2012) where nearly all (76.4%) of the midwives maintained that only some types of FGM were harmful, while others stated that no type of FGM was detrimental to health. Likewise, some HCPs declared that the practice of FGM had health benefits not dangers (Ashimi et al., 2014;Mostafa et al., 2006).

The findings from the exploration of HCPs awareness of the health complications of FGM indicated that some of the HCPs had a good understanding about the dangers of FGM as they were able to mention some adverse effects of FGM. Nevertheless, a proportion of the HCPs had limited knowledge about the negative effects of FGM on young girls and women.

In summary, findings from the review of the included studies on HCPs knowledge of FGM suggested that the surveyed HCPs had limited understanding about the four types of FGM and the health implications of FGM. HCPs are required to provide counselling and direct care for women affected by FGM (WHO, 2018a). Therefore, a limited understanding of the types and health complications of FGM could hinder accurate diagnosis, and clinical support for women suffering from FGM especially during parturition.

The subsequent section will discuss findings relating to HCPs' beliefs and attitudes towards FGM practices.

2.3 Beliefs and attitude towards FGM practice

This theme presents findings from studies that examined HCPs' beliefs and attitudes towards FGM. It included the exploration of HCPs' opinion, stance, and suppositions about the practice of FGM. The domains examined under this section are beliefs about the reasons for practising FGM and attitudes towards the continuation of FGM.

2.3.1 Beliefs about the reasons for practising FGM

HCPs beliefs about the rationale for practising FGM was examined by eleven of the included studies. Six of the studies were conducted in Nigeria (Obiora et al., 2021;Obianwu et al., 2018;Ashimi et al., 2014;Ibrahim et al., 2013;Dike et al., 2012;Onuh et al., 2006), two were carried out in Gambia (Kaplan et al., 2016;Kaplan et al., 2013), and two were undertaken in Egypt (Refaat., 2009;Mostafa et al., 2006) and one was included from Liberia (Tarr-Attia et al., 2019).

The qualitative study of seventeen HCPs in Nigeria found that almost all the HCPs believed that FGM was a culturally embedded practice (Obiora et al., 2021). The report from the study by Obiora et al. (2021) corresponded with findings from other qualitative studies (Tarr-Attia et al., 2019;Obianwu et al., 2018) where the HCPs declared that FGM was culturally motivated. Especially, Tarr-Attia et al. (2019) observed that it was obligatory for the head of the family to have their daughters cut as part of an initiation ceremony to a secret society called *Sande*. The HCPs in the said study added that FGM was commonly practised in that setting for social acceptance, control of women and their sexuality, and to indoctrinate girls about accepted behaviours and cultural values (Tarr-Attia et al., 2019). Hence, FGM was not discussed publicly in that part of Liberia where the study was conducted because it was perceived as questioning the legacy of

the secret cult (Tarr-Attia et al., 2019). The findings by Tarr-Attia et al. (2019) were corroborated by studies conducted in Gambia where HCPs declared that FGM was practiced as a rite of passage of young girls into womanhood (Kaplan et al., 2016;Kaplan et al., 2013). Besides, the survey of 118 HCPs in Nigeria (Ibrahim et al., 2013) and 1288 HCPs in Gambia (Kaplan et al., 2016) observed that more than 96% of the HCPs in both studies acknowledged that FGM was a cultural requirement.

Some of the included studies reported contrasting views about the motivations for FGM practices as the examined HCPs declared that FGM was socially motivated. For instance, the study of 350 nurses in Nigeria found that about 30% of the nurses believed that FGM preserved virginity (Ashimi et al., 2014). Some studies (Obiora et al., 2021;Tarr-Attia et al., 2019;Dike et al., 2012;Mostafa et al., 2006) reported that some HCPs declared that FGM prevented promiscuity. While some HCPs observed that FGM prevented the clitoris from growing large and ugly, thus beautified the female external genitalia (Ibrahim et al., 2013;Dike et al., 2012;Mostafa et al., 2006;Onuh et al., 2006). However, a proportion of the nurses in the Ashimi et al. (2015) study argued that FGM was practised due to ignorance.

In addition, some of the HCPs believed that FGM was a religious obligation. For example, the study of 468 nurse/midwives in Gambia declared that more than half of the HCPs stated that FGM was a religious prescription (Kaplan et al., 2013). This belief was shared by nearly one third of the HCPs examined in some of the included studies (Kaplan et al., 2016;Ibrahim et al., 2013;Refaat., 2009;Mostafa et al., 2006).

To summarise, the findings from the examination of HCPs beliefs about the practice of FGM indicated that most HCPs recognised that FGM was practised based on cultural reasons as they declared that FGM was performed as a rite of passage into womanhood and a criterion to be initiated into a secret society. However, some of the HCPs believed that FGM was practised for social reasons as some HCPs mentioned social acceptance, control of women, chastity, and beautification as reasons for

FGM, while some HCPs asserted that FGM was a religious recommendation. This evidence shows that there are existing beliefs that FGM was a cultural requirement for social acceptance in practising communities. It also suggests that some HCPs continue to hold engrained beliefs about the motivations for FGM, and these beliefs are still embedded within the health system. These entrenched cultural beliefs could impede a good care provider-client relationship as most of the HCPs surveyed in these studies belonged to communities where FGM was obligatory (Obiora et al., 2021;Tarr-Attia et al., 2019;Obianwu et al., 2018;Kaplan et al., 2016). Therefore, they may trivialise the physical and emotional health problems experienced by girls and women who had undergone FGM.

2.3.2 Attitude towards the continuation of FGM

HCPs' attitudes towards the continuation of FGM practices was explored by twelve studies. The studies were conducted in Liberia (Tarr-Attia et al., 2019), Nigeria (Obiora et al., 2021;Ashimi et al., 2014;Umar and Oche, 2014;Ibrahim et al., 2013;Dike et al., 2012;Onuh et al., 2006), Gambia (Kaplan et al., 2016;Kaplan et al., 2013), Egypt (Refaat., 2009;Mostafa et al., 2006), and Sudan (Ali, 2012).

All the HCPs in the study by Tarr-iAttia at al. (2019) claimed that they did not support FGM, but they advocated for the continuation of the secret society (*sande*) and the traditional instructions that young girls received when joining the secret society (Tarr-Attia et al., 2019) . This is considering that FGM was the main basis for the secret society. Similarly, most of the HCPs interviewed by Obiora et al. (2021) claimed that they did not support the continuation of FGM practices, but they approved of the new method of performing FGM as it was believed to be harmless:

> *"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." P6 (Obiora et al., 2021).

Regardless of the dangers associated with FGM, most of the HCPs declared their support for FGM practices for reasons that included cultural affiliations, religious beliefs, and financial gain (Obiora et al., 2021;Umar and Oche, 2014;Kaplan et al., 2013;Ali, 2012;Refaat., 2009;Mostafa et al., 2006). Though the midwives in the qualitative study by Isman et al. (2013) described FGM procedures as evil, awful and painful, most declared that they will perform mild forms of FGM on their daughters (Isman et al., 2013). Likewise, the study by Ali (2012) reported that nearly all the surveyed midwives (104 of the 157) stated that they would continue to practice FGM, while 37% (58) of them will consent to have FGM done on their daughters. This report concurs with other included studies, for instance Kaplan Marcusan et al. (2013) and Mostafa et al. (2006) which revealed that about half (47.2% and 32% respectively) of the HCPs declared that they would subject their daughters to FGM procedures. While some HCPs stated that girls who had not undergone FGM procedures should be discriminated against but did not specify how (Kaplan et al., 2016;Kaplan et al., 2013).

Conversely, some HCPs expressed negative attitudes towards FGM. This was evident in the study by Kaplan Marcusan et al. (2016), and the survey of 269 student nurse/midwives by Dike et a. (2012) where almost all the HCPs supported the eradication of FGM and declared that FGM practices should stop. Likewise, some HCPs observed that the practice of FGM was a crime against humanity and a violation of the human rights of young girls and women, and should be discouraged (Umar and Oche, 2014).

It is evident that the surveyed HCPs appeared to have mixed feelings about the continuation of FGM practices. Though some declared that FGM should be stopped at all levels (Kaplan et al., 2016;Dike et al., 2012), most HCPs openly supported the practice as it was believed that women with FGM were

decent and proper while uncut women were promiscuous (Tarr-Attia et al., 2019). The positive attitudes toward FGM observed in some HCPs in this review could be due to cultural and social orientations, as some of them acknowledged that they would perpetuate the practice of FGM by consenting to have their daughters cut. Consequently, interventions aimed at eradicating FGM could be hindered because these HCPs who are required to take a leading role in the elimination of FGM by educating the populace they meet about the dangers of FGM, are advocating for its continuance.

HCPs practices of FGM and their experiences of providing clinical care and support will be unpacked in the following section.

2.4 Practice and experience of FGM

The practice and experience of FGM was explored by all fifteen studies. This theme presents findings relating to HCPs practises and clinical experiences of FGM. Therefore, findings will be presented following these two subthemes: practice of FGM and clinical experience of FGM.

2.4.1 Practice of FGM

The three included qualitative studies (Obiora et al., 2021;Tarr-Attia et al., 2019;Obianwu et al., 2018) reported that almost all the interviewed HCPs were indigenes of communities where FGM was practised. Likewise, the Gambian studies (Kaplan et al., 2016;Kaplan et al., 2013) observed that about 70% of the surveyed HCPs belonged to families that practised FGM. While some of the examined HCPs revealed that they themselves had undergone FGM procedures (Tarr-Attia et al., 2019;Ashimi et al., 2014;Ibrahim et al., 2013;Onuh et al., 2006). For instance, the recent study of eight midwives in Somaliland observed that all the HCPs had been cut (Isman et al., 2013). Similarly, more than half (54.3%) of the HCPs in the Dike et al. (2012) study had personally experienced FGM and 49.3% of them claimed that they were pleased with their FGM status, while 41.7% expressed sadness over their FGM situations (Dike et al., 2012).

Despite existing laws and FGM abandonment messages, some of these HCPs articulated that they had performed FGM in the past (Tarr-Attia et al., 2019;Obianwu et al., 2018) and some still practised FGM for varied reasons (Isman et al., 2013;Refaat., 2009). In the Ali (2012) study, about 80.9% of the examined midwives had performed FGM procedures while 7% of the nurses in the Umar and Oche (2014) study revealed that they had participated in the decision making process of FGM (Umar and Oche, 2014). Findings from the study by Tarr-Attia (2019) suggested that some of the interviewed HCPs still performed FGM on babies and young girls (Tarr-Attia et al., 2019). Equally, almost all the midwives in the Isman et al. (2013) study continued practising FGM (Isman et al., 2013). Regardless of claims to be against FGM practises, the midwives in the said study (Isman et al., 2013) perpetuated FGM to satisfy family demands and pressure from young female relatives who wanted to be cut, while some midwives expressed difficulty in having to abruptly stop FGM practices (Isman et al., 2013).

In addition, Refaat (2009) revealed that 19% of the 193 surveyed physicians practised FGM, and 51% of this population performed FGM due to conviction while 43.3% declared that physicians were the most suitable people to perform the procedure. This claim could be interpreted as promoting the medicalisation of FGM within the care sector in Egypt. In other instances, 14.3% of the nurses examined in the Onuh et al. (2006) study articulated that they had performed FGM in the past and they did so to discourage clients from patronising traditional cutters, while some HCPs provided FGM services for financial gain and to uphold their deep-rooted cultural beliefs, however 57.7% of the nurses declared that they would continue to practise FGM (Onuh et al., 2006). Though some of the HCPs who were examined in the reviewed studies acknowledged that they had indulged in FGM practises, only two HCPs in the Nigerian studies (Obianwu et al., 2018;Ibrahim et al., 2013) revealed that they still participated in FGM practices. It is curious that only two HCPs in the said studies acknowledged their involvements in FGM practices, considering that FGM

was universal in Nigeria with an overall prevalence of more than 25% at the time that the studies were conducted.

2.4.2 Clinical experience of FGM

The quantitative study of 468 nurses/midwives in Gambia found that a proportion (40.9%) of the nurses/midwives had attended to women and girls who presented with complications of FGM, hence 73% of the examined nurse/midwives declared that HCPs had a crucial role in the eradication of FGM in Gambia (Kaplan et al., 2013). Notwithstanding, nearly half (42.9%) of the nurses/midwives in the said study declared that the medicalisation of FGM was the safest way to prevent FGM complications as 7.6% of them acknowledged that they had caried out FGM procedures on girls during their healthcare praxis (Kaplan et al., 2013). These assertions corresponded with findings from the recent study by Kaplan Marcusan et al. (2016) whereby an increased proportion (10.5%) of HCPs declared that they had rendered FGM services within their professional practice. However, nearly all the HCPs surveyed articulated that they had a duty to prevent FGM practices and compared with the later Gambian study (Kaplan et al., 2013), only 28.7% favoured the medicalisation of FGM as a way of containing FGM and making it safer (Kaplan et al., 2016). The findings from the Gambian studies suggest that some HCPs were harkening to FGM abandonment messages and moving away from the idea of medicalising FGM, but some HCPs continue to advocate for the medicalisation of FGM.

The studies included from Nigeria reported findings that were parallel to those found in the Gambian studies. For instance, Ibrahim et al. (2013) reported that about 29% of nurse/midwives and 25% of doctors had provided direct care for women affected with FGM and cited haemorrhage and infections as some of the complications of FGM that they had treated (Ibrahim et al., 2013). Likewise, the study of 250 HCPs in Nigeria revealed that majority of the examined HCPs had provided medical support for women who presented with labial agglutination and clitoral cyst following

FGM procedures (Adekanle et al., 2011). In addition, nearly half (48.4%) of the HCPs in the Adekanle et al. (2011) study had been requested to perform FGM, but nurse/midwives were mostly approached to render FGM services compared with doctors (Adekanle et al., 2011). The reason nurse/midwives were mainly requested to perform FGM could be because nurse/midwives worked closely with families within the communities in Nigeria, and therefore easily accessible.

The included qualitative studies from Nigeria reported findings that were somewhat like those reported by the quantitative studies from Nigeria. The study of six auxiliary nurses by Obianwu et al. (2018) revealed that FGM was not concealed among HCPs in the setting where the study was undertaken because FGM procedures were openly performed within healthcare facilities (Obianwu et al., 2018). HCPs may be performing FGM publicly in this setting because the practice was generally accepted in the states (Delta, Ekiti, Imo and Kaduna) where the study was conducted. At the time of the study, the medicalisation rate in these states was 61% in Imo, 28.9% in Delta, 26.2% in Ekiti and 22.4% in Kaduna, while the prevalence of FGM was 72.3% in Ekiti, 68% in Imo, 40.3%in Delta and 25.1% in Kaduna (Obianwu et al., 2018).The HCPs in this study (Obianwu et al., 2018) disclosed that they were taught how to perform FGM procedures by senior colleagues who practised FGM, as there was great admiration for HCPs who were skilled at FGM procedures. Some of the HCPs in the same study asserted that FGM could sometimes be performed for free if the baby was delivered by the HCPs, otherwise at the time the study was conducted, some HCPs charged a fee of 3,000 NGN (equivalent to £5.94p) for FGM services. In addition, the HCPs mentioned that after performing FGM they often prescribed analgesics and antibiotics to relieve pain and prevent infections. The HCPs further revealed that they performed FGM for reasons that included, perfecting their cutting skills, meeting clients request for FGM, financial benefits and to prevent clients from spreading rumours that they were professionally incompetent (Obianwu et

al., 2018). The HCPs declared that though many HCPs publicly discouraged FGM practices, most of them still performed FGM procedures in secret (Obianwu et al., 2018). Though FGM is illegal in Nigeria, it is an accepted cultural practice, therefore HCPs who openly condemned it may be doing so to disassociate themselves from the practice because of professional reasons, and the negative conceptualisation of the practice but, they support FGM. Furthermore, the study (Obianwu et al., 2018) did not clearly state or verify the educational qualification of the interviewed HCPs, hence it is unclear if they had a practicing licence from a professional organisation (Obianwu et al., 2018).

Another recent study (Obiora et al., 2021) from Nigeria described HCPs' experiences of FGM in the clinical setting. The HCPs in the Obiora et al. (2021) study revealed that FGM procedures were often conducted in secret because of laws banning the practice. As a result, many babies have died due to parents' failure to seek prompt healthcare services for life threatening complications such as severe bleeding (Obiora et al., 2021). The HCPs claimed that they were unable to provide quality care for women with complications of FGM because they lacked the skills and human resources to do so, but they were skilful in performing FGM procedures as they described FGM as a minor procedure that required only few days to heal completely (Obiora et al., 2021). The HCPs had explained that during the delivery of women with FGM, they often performed episiotomy to prevent lacerations, but it was observed that some of the HCPs who performed episiotomy procedures were CHEWs and VVHW who were not trained or certified to conduct episiotomy (Obiora et al., 2021). This revelation raises concerns for practice as it may be implied that there were medical malpractices occurring within some healthcare facilities in Nigeria. Moreso, the idea of encouraging CHEWs and VVHV to step outside their stipulated roles (Aluko et al., 2019), to perform a surgical procedure like episiotomy was exposing the women who seek delivery services to serious health risks. Within the Obiora et al. (2021) study, some HCPs declared

their support for the 'new method' of performing FGM which they adopted after the prohibition of FGM because they considered it safer, unbeknown to them the new method could be classified as type IV of FGM. In addition, despite existing laws in Nigeria, some of the HCPs still preferred to cut as they believed that the 'new method' which involved the flattening of the clitoris took a longer time to heal:

> *"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 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." P7 (Obiora et al., 2021).*

The findings from the Gambian and Nigerian studies were similar to those reported by the study conducted in Liberia (Tarr-Attia et al., 2019) and Somaliland (Isman et al., 2013). The midwives in the Liberian study (Tarr-Attia et al., 2019), observed that women with FGM often experienced severe tears from FGM scars and bleeding during delivery and the extent of tear and bleeding is dependent on the baby's size (Tarr-Attia et al., 2019). Within this study, the midwives expressed that they were unable to plan delivery care for the women with FGM because in most instances they were unaware of the woman's FGM status until the labour when vaginal examination was performed (Tarr-Attia et al., 2019). These midwives' obliviousness to the women's FGM status could be because of the secrecy of FGM practices and the secret society *(sande)* that existed within that setting, whereby women who had been cut were reluctant to discuss the practice or the complications that they experienced with midwives who had not undergone FGM. This secrecy could impede delivery and care plans and put the women at risk of severe intra and postpartum haemorrhage that

could cause death. However, the midwives explained that when they encountered such situations, they would take control of the delivery by administering episiotomy to prevent multiple lacerations and bleeding (Tarr-Attia et al., 2019). The Tarr-Attia (2019) study also revealed that though some of the midwives were confident in providing FGM related care, majority of the midwives lacked the knowledge, skills, and experience to do so and advocated for trainings and guidelines on FGM, and the addition of FGM to the midwifery curriculum. In addition, the midwives stated that they did not provide counselling about the detriments of FGM because they thought that the women found it offensive for the midwives to discuss FGM due to the secrecy of the *sande* rituals and FGM practices in general (Tarr-Attia et al., 2019). These assertions could imply that the midwives in the study (Tarr-Attia et al., 2019) believed that FGM practices would be difficult to stop because of the existing *sande* (secret society) and the sacredness of FGM practices in that locality.

Unlike the midwives in the study by (Tarr-Attia et al., 2019), the midwives in the Somaliland study (Isman et al., 2013) had be trained to provide care and counselling for women with FGM and were confident to render FGM related care and support. The midwives in this study (Isman et al., 2013) observed that they experienced cultural and religious challenges when providing care for women with FGM, because they were perceived by the community as meddling with family matters and undermining the Somali cultural beliefs (Isman et al., 2013). Consequently, the women with FGM did not seek timely medical help as they usually endured and hid whatever health difficulties they experienced from FGM procedures, as such they suffered prolonged health repercussions (Isman et al., 2013). The reason women affected with FGM did not seek prompt medical care is unclear, perhaps they feared being judged by uncut HCPs, or lacked the knowledge, financial means, or confidence to ask for help. However, the midwives in this study (Isman et al., 2013) revealed that their personal experiences of FGM enabled them to understand the problems that these women

encountered, so they often encouraged the women to express their concerns since they themselves had been cut and experienced similar health issues. Despite these positive reports, it was evident that the midwives still required continuing professional education to improve their skills in tackling the existing challenges (cultural, religious, and superstitious beliefs) that they encountered when providing counselling and clinical care for women with FGM.

2.5 Summary of systematic narrative review

This was a review of existing literature on HCPs knowledge, beliefs, and practices of FGM in Africa. The extensive search for relevant literature yielded fifteen empirical studies that were included for a systematic narrative review. The fifteen studies were conducted in six African countries (Nigeria, Sudan, Somaliland, Gambia, Liberia, Egypt), and examined HCPs of different professional groups. The reviewed studies explored different aspects of FGM including HCPs knowledge, beliefs, attitudes, practices, and experiences of FGM, and three main themes and six subthemes were generated from the thematic synthesis of all fifteen studies. The main themes were – *Knowledge of FGM*, *beliefs and attitudes towards FGM* and *practice and experience of FGM.*

The findings from this systematic narrative review indicated that HCPs had limited knowledge about the four types of FGM and the obstetric complications of FGM. Most of the examined HCPs were from communities where FGM was practised, and some had themselves undergone FGM procedures. Most of the HCPs believed that FGM was a cultural obligation and therefore had performed FGM and continued to practise FGM to meet family demands, for financial gain, to prevent TBAs from rendering FGM services and to perfect their cutting skills. Majority of the surveyed HCPs had seen and cared for women with complications of FGM, yet some of the HCPs declared that they would consent for their daughters to be cut and would perform FGM procedures if requested. Some of the HCPs supported

the continuation of FGM practices and its medicalisation as they believed that this would make FGM safer.

2.6 Identification of gap

The findings from this review showed that the medicalisation of FGM was a reality in many countries in Africa, including Nigeria. The review identified existing gaps in HCPs' knowledge and clinical competency to provide FGM related care for women with FGM. There are salient concerns regarding the existence of clinical guidelines for the management of the health implications of FGM, and the quality of care that was rendered to women with FGM. This is considering that these HCPs had limited understanding of FGM and shared the same cultural orientation about FGM as practising communities. The highlighted limitations in knowledge and clinical skills to tackle FGM-related issues, and the support for FGM and its medicalisation was reflected more in the studies conducted in Nigeria compared with other reviewed studies.

The review also reflected the need for further study in Nigeria based on the following gaps in existing literature-; firstly, the studies that have examined HCPs in FGM-related problems in Nigeria were scarce and no study existed in the setting that examined primary HCPs. Secondly, there are no known studies that explored how primary HCPs understand the care or support that was provided for women living with FGM in Delta state, Nigeria. Previous studies conducted in Nigeria examined nurses, doctors, and other groups of healthcare professionals in tertiary and secondary healthcare institutions, but none have been undertaken in primary healthcare settings in rural communities in Nigeria where the practice of FGM is concentrated. Thus, there is limited evidence about primary HCPs' understanding of FGM and their experiences of providing care for women with FGM, especially among community health extension workers who have not been explored by previous studies.

Thirdly, there are no known studies that had examined primary HCPs' understanding of FGM typologies, reasons for the practice and health complications of FGM in Delta state, Nigeria. Though, few studies have explored these concepts in Nigeria, none were conducted in Delta state which is comprised of different ethnic groups whose cultural beliefs and values are different from other ethnic groups in Nigeria. Also, the studies that had examined the knowledge of the types, reasons for practicing FGM and the detrimental consequences of FGM in Nigeria were conducted many years ago, and their findings may not be the true representation of HCPs' current position and knowledge about FGM practices.

Fourthly, there was no study identified that examined primary HCPs' beliefs and attitudes towards the practice of FGM in Delta state, Nigeria. The reason for this is unknown, perhaps researchers find it difficult to access HCPs in Delta state, or there are fears of victimisation and intimidation due to the sensitivity of the research topic. This is important considering that FGM is concentrated in some communities in Delta state, and the prevalence of FGM in the state is over 40% (National Population Commission, 2018).

Finally, there is limited work existing in Delta state and Nigeria in general that had explored this phenomenon applying qualitative methodology. The use of qualitative methods to explore FGM is very limited in Nigeria. For instance, at the time of this research only two studies exist in Nigeria that employed qualitative methods in examining FGM practices. One of the studies was conducted in the Eastern part of the country (Obiora et al., 2021), and the other was conducted within four states in Nigeria using unregistered HCPs including auxiliary nurses (Obianwu et al., 2018). It is important to utilise qualitative methods for this research because it would provide meaning and understanding to existing statistical data on FGM. For example, a study conducted by Ashimi et al. (2014) among 350 nurses in Nigeria using quantitative methods reported that nearly half (41%) of the nurses had no knowledge about the different types of FGM. Perhaps, if data

was collected using methods that allowed interactions with the studied nurses to determine the reasons for the limited understanding of FGM typology, it may have provided data that could inform plans to develop and implement interventions to improve HCPs' understanding of FGM in Nigeria. Furthermore, qualitative methods would enable the researcher and the participants to share experiences and delve deep to explore participants' cultural, and professional interpretations of FGM practice. Hence, there is need to conduct a new study using qualitative methods to explore primary HCPs as these group of HCPs are under studied in Nigeria, as a result their understanding of FGM, including their beliefs and attitudes towards the practice, and the support they provide for women with FGM in rural communities is unknown.

2.7 Justification for the study

The federal government of Nigeria has made efforts to eliminate the practice of FGM by ratifying all international and regional conventions on the right of women and children condemning the practice of FGM. However, FGM still continues as over twenty million girls and women had undergone FGM in Nigeria, representing around 10% of the global prevalence (UNICEF, 2016). The practice of FGM is detrimental to health hence HCPs are required to provide direct care for women affected by FGM and take a leading role in educating and counselling the populace they meet about the detriments of FGM. However, there is no clear understanding of the practice of FGM from the perspective of primary HCPs in Delta state, Nigeria, and consequently their knowledge, beliefs, and practices of FGM and the care that is given to women living with FGM is questionable. Granted that FGM is often practised in communities, it is essential for HCPs who work in PHC facilities to have excellent understanding of FGM to enhance their ability to educate and provide direct care for women with FGM. Hence, it is important to explore primary HCPs' knowledge, beliefs, and practices of FGM to

understand the care that is rendered to women with FGM who access PHC facilities.

There are existing studies in Nigeria and other parts of Africa that are somewhat like the present study, however the findings from those studies are not transferrable due to insufficient description of methodological approach, study settings and study population. For instance, a study conducted in Liberia by Tarr-Attia et al., (2019) among 17 midwives to understand the health implications of FGM, and the one conducted in Somaliland by Isman et al., (2013) among 8 midwives to elucidate their experiences of providing care and counselling to women with FGM related problems were both untransferable because they used one group of HCPs, and their study settings were not described in depth (Tarr-Attia et al., 2019; Isman et al., (2013). Similarly, some studies employed quantitative methods that were not clearly defined and produced findings that could not be transferred to this study setting because of difference in methodological tenets and approach (Kaplan Marcusan et al.,2016; Refaat, (2009). Also, some studies that were conducted in other parts of Nigeria failed to provide rich description of their study population and research settings making transferability of such studies impossible (Obiora et al., 2021; Obianwu et al., 2018). Hence, there is need for a new study to ensure a detailed methodological approach and a rich description of study settings and participants which can be easily reproducible; and provide valuable evidence that will contribute to the body of existing knowledge about FGM practices.

In addition to the current gap in literature on HCPs' knowledge, beliefs, and practices of FGM, recent evidence indicates that studies that had explored HCPs' practices of FGM to understand the care that was provided for women living with the health consequences of FGM was lacking (WHO, 2022a). The statistics of current studies on FGM related practices was reflected in an empirical article by WHO (2022), where it was highlighted that published research on FGM were mostly focused on the medical and psychological

implications of FGM (52%), prevalence and ethics of FGM (34%), and socioeconomic consequences of FGM (14%) (WHO, 2022a). Likewise, it was predicted that most studies in the future would be aimed at generating data on strategies to end FGM and enhance eradication programmes (WHO, 2022a). However, there were no indications of studies that focused on exploring the care that was provided for women with FGM who access healthcare services. This shows the importance of this study as despite decades of collaborative work on FGM, there is continued gap in data on the care that is available/provided for survivors of FGM, especially those living in low-income countries where the practice of FGM is concentrated.

Furthermore, this study may be important in addressing current gaps in research and practice. It may provide data that would support in-depth understanding of FGM from the perspective of primary HCPs in Delta state, Nigeria. This new knowledge could improve health outcomes, and prompt professional trainings that would empower HCPs to take a pivotal role in providing care and support for women at risk of or living with FGM. This study and other related studies on FGM may provide evidence that could contribute to the development of FGM-related clinical guidelines or protocols for HCPs in Nigeria.

2.8 Research question

How is the knowledge, beliefs and practices of primary HCPs' in Delta state, Nigeria?

2.9 Research aim

The purpose of this study is to explore primary HCPs' current knowledge, beliefs, and practices of FGM in Delta state, Nigeria.

2.10 Research objectives

1. To explore the knowledge of FGM among primary HCPs working in PHC facilities in Delta State, Nigeria.
2. To understand primary HCPs' beliefs and attitudes towards FGM.
3. To identify the factors that may influence primary HCPs knowledge and practises of FGM.

The aim and objectives of this study will be achieved using qualitative approach which will be detailed in the following chapter.

CHAPTER THREE: METHODOLOGY

3.0 Introduction

This chapter presents the practical aspect of this study within the set aim and objectives. The first section of this chapter addresses the philosophical beliefs and assumptions underpinning this study and the rationale for the applied methodological framework. This is followed by a detailed description of the methods employed, including study settings, sampling and recruitment process, data collection and analytical procedure. The chapter also encompassed discussions about ethical issues, strategies used to maintain study rigour and a reflective account of the researcher's standpoint and how this affected the research process.

3.1 Research paradigm

A paradigm is a philosophical manner of thinking (Guba and Lincoln, 1994). It is a collection of fundamental beliefs and practices that determine research approach and how research problems are examined and resolved (Schwantt, 2000;Guba and Lincoln, 1994). Research paradigms explain researchers' philosophical position or the conceptual lens through which they see, explore, understand, and interpret the world around them (Crotty., 1998;Guba and Lincoln, 1994;Schwandt, 1994). Paradigms are therefore important because they guide research actions and influence the methodology and methods to adopt in a research (Lincoln et al., 2011). There are several paradigms in the field of research however, philosophical authorities such as Guba and Lincoln, (1994) identified four main paradigms (positivism, post-positivism, critical theory, constructivism), and these paradigms are different in their beliefs, approaches to research, and contributions to knowledge constructions (Lincoln et al., 2011;Weaver and Olson, 2006). This is because research paradigms are characterised by their philosophical assumptions about the nature of reality and being *(ontology)*

(Patton, 2002), how knowledge about reality is acquired *(epistemology)* (Rehman and Alharthi, 2016;Guba and Lincoln, 1994), action plan of inquiry *(methodology)* (Scotland, 2012;Creswell, 1998;Crotty., 1998) and specific techniques used to generate and analyse research data *(methods)* (Crotty., 1998). See figure 3.1.

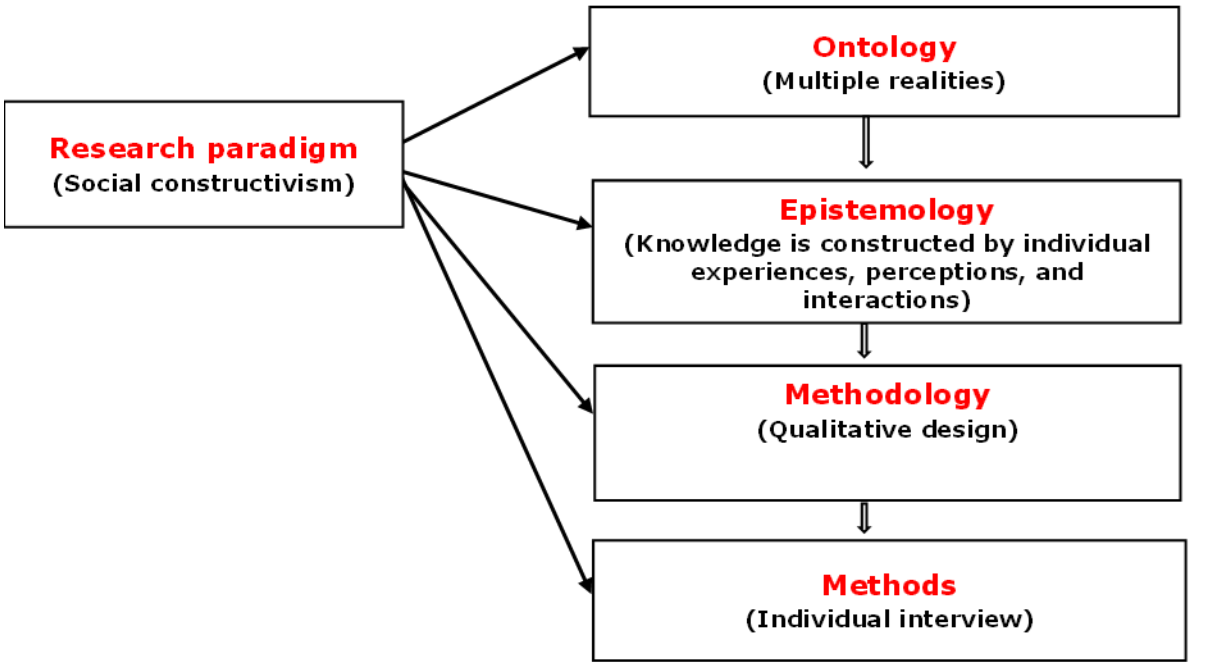


Figure 3.1 Research paradigm

The philosophical standpoint for this study is therefore informed by the nature and aim of this study, which is to explore participants' personal knowledge and views about FGM to understand the care that was provided to women with FGM who access healthcare services. This involves engaging interactively with participants to gain in-depth understanding, and gather multiple meanings about the practice of FGM from participants point of view (Guba and Lincoln, 1994). Conversely, the positivist paradigm believes in the use of measurements and statistical techniques to seek a single verifiable truth that can be generalised (Crotty., 1998;Guba and Lincoln, 1994). Positivist studies are purely factual, which means that the researcher is completely objective and independent of the research and

have minimal interactions with the study participants (Crotty., 1998). Hence, the social constructivism paradigm is considered most suitable for exploring this study as its unique tenets allows interactions with study participants to acquire in-depth understanding of the studied phenomenon (Smith, 1983).

3.1.1 Social constructivism

The constructivism paradigm takes its roots from the thinking of Edmund Husserl's phenomenology and Wilhelm Dilthey's study of interpretive understanding called hermeneutics (Lincoln et al., 2011;Schwantt, 2000). Social constructivism is a type of constructivist thinking which argues that people share and construct knowledge through social interactions rather than on individual experience (Schwantt, 2000;Creswell, 1998).

The social constructivist paradigm assumes a relativist ontological stance that rejects the notion of realism, objective truth, and universalism (Schwantt, 2000;Schwandt, 1994). Proponents of this paradigm believe that individuals construct their own meaning of the world based on their experiences of events and a reflection on their understanding of these experiences (Ponterotto, 2005). Hence, constructivist researchers hold the tenet that there are multiple realities that are co-constructed by individuals who participate or experience the same phenomenon (Smith, 1983).

Epistemologically, social constructivist assumes a stance that is transactional and subjective, this means that knowledge is constructed and dependent on individuals' diverse perceptions, interactions, and social/ cultural experiences (Guba and Lincoln, 1994). Arguably, the practice of FGM has been socially constructed through family values, communities, and cultural beliefs, experiences, and social interactions (See figure 3.2), because the practice of FGM is evidently embedded in cultural beliefs and myths that had been passed down generations. Hence, people born in settings where FGM is practiced hold a set of beliefs and multiple constructions that could shape their understanding, perspectives, and

interpretations of the practice. Accordingly, the researcher focused on the actual environment where participants lived and worked to gain an understanding of their cultural backgrounds and how this may have influenced their understanding, views and practices of FGM (Creswell and Creswell, 2018). Likewise, the researcher recognised how her own experiences, cultural orientation and position as a Nigerian woman and certified nurse impacted on the interpretation of FGM and the research findings (Creswell and Creswell, 2018;Ponterotto, 2005;Crotty., 1998). The social constructivist stance enables the researcher and the researched to interactively construct meanings and findings that are explicit and accurate throughout the research process, making the research to be value- bound and reliable (Guba and Lincoln, 1994).

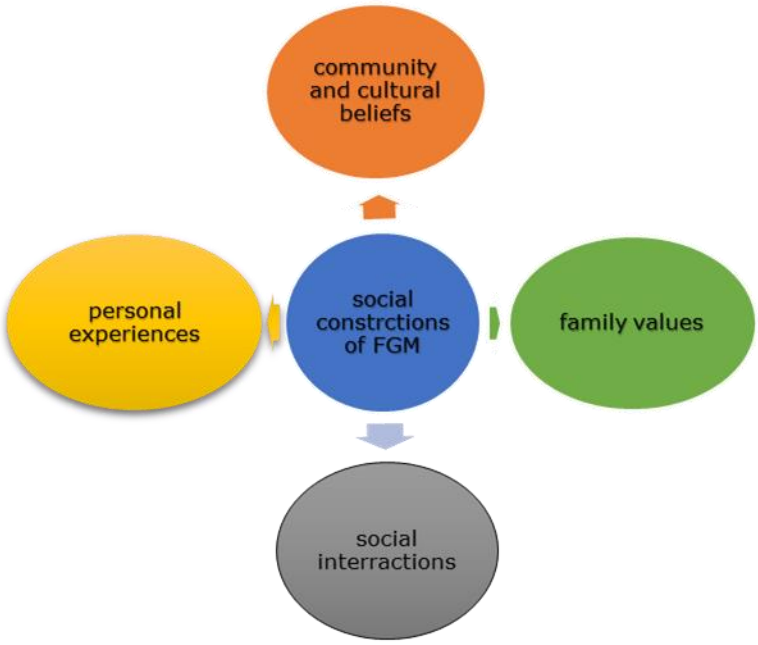


Figure 3.2 Illustration of social construction of FGM

3.1.2 Qualitative research design

Qualitative research is a type of research design that is used for exploring and providing in-depth understanding of real life occurrences and problems (Lincoln et al., 2011). Qualitative research uncovers and explains the meaning people attribute to social phenomena (Creswell and Creswell, 2018). This means that it is focused on investigating participants' subjective opinions, attitudes, beliefs, and reflections about their knowledge or experiences of things happening in the real world (Percy et al., 2015). This type of research is undertaken in its natural setting whist trying to interpret and understand the studied phenomenon from the perspective of study participants (Creswell and Creswell, 2018). It involves developing a research question, then selecting a data collection, and analytical technique that is most suitable for answering the research questions and achieving research objectives whilst adhering to the tents of the chosen philosophical assumption (Bellamy et al., 2016). Qualitative studies produce findings that are derived from interactions with study participants through interviews, focus group discussions and observation rather than statistical techniques or other forms of quantifications and measurement (Strauss and Corbin, 1990).

The key strength of qualitative research is its ability to explore and provide detailed explanation of processes, patterns and trends of human behaviour that can be difficult to quantify or measure statistically (Foley and Timonen, 2015). The practice of FGM is deep-rooted in cultural belief systems, and understanding this phenomenon means engaging interactively with individuals who are healthcare professionals and indigens of communities where FGM is practiced. Hence, this study followed the tenets of qualitative research because;- firstly, the research aim and question falls within the qualitative paradigm, though do not fit neatly into any of the clearly defined traditional methodologies such as grounded theory, phenomenology and ethnography (Teodoro et al., 2018;Bradshaw et al., 2017;Hunt, 2009). Secondly, it allows meaningful engagement with study participants to delve

deep into the practice of FGM. Thirdly, it enables the researcher to interact with participants to uncover their understanding and beliefs about FGM practices, and the support that they provide for women with FGM who access healthcare services in communities in Delta state, Nigeria.

3.2 Methods

3.2.1 Research setting

This study was conducted in eleven PHC facilities in Ughelli South and Oshimili South local government areas (LGAs) in Delta state, Nigeria. Delta state is one of the 36 states in Nigeria and has 25 LGAs and 392 PHC facilities (NPHCDA, 2020). Four of the PHC facilities were in Oshimili South while 7 PHC facilities were situated in Ughelli South. The PHC facilities were supervised by physicians but managed daily by the most senior nurse in charge of each facility.

The social constructivist is concerned with gathering data that is rich and comprehensive (Thorne et al., 1997). Hence, these PHCs facilities were utilised as they are situated within communities where FGM was practised and therefore had a wealth of experience to share. Also, there was relative proximity between the two LGAs making it more accessible to conduct the field work. A detailed description of the research setting is presented in chapter four.

Table 3.1 Characteristics of study setting

Local Government Area (LGAs)	Number of PHC facilities	Number of PHC facilities used	Names of PHC facility
Ughelli South	20	7	Edjophe PHC
			Oginibo PHC
			Okpare PHC
			Otu-Jeremi PHC
			Oviri-Olumu PHC
			Ovwodokpokpo PHC
			Umolo PHC
Oshimili South	16	4	Umuagu PHC
			Model PHC
			Okwe PHC
			Cable-Point PHC
Total	36	11	11

3.2.2 Study population

This study benefits from multiple sources of data from different groups of primary HCPs working in the PHC facilities, including Doctors, Nurses/Midwives and Community Health Extension Workers (CHEW). Their role is to provide people living in the community with direct care that includes diagnosis, treatment of minor ailments, prenatal, ante natal and post-natal care, immunisation, prevention of communicable disease and health education and counselling on health promotion and practices (NPHCDA, 2020). See chapter 4 for a detailed description of participants' demographics.

3.2.3 Sampling and recruitment

This study used purposive and snowball sampling techniques to select and recruit the study participants. Purposive or purposeful sampling is a non-probability sampling techniques that involves the selection of participants based on their unique understanding of the researched topic, and the importance of their contributions to achieving the aim and objectives of the research (Ritchie and Lewis, 2003). Purposive sampling approach was used to select doctors, nurses and CHEWs who provided care for clients within

the PHC facilities and had some understanding of FGM. This was to ensure that a cross section of views and experiences are gathered from study participants that fit the specified criteria (Ritchie and Lewis, 2003).

Different sampling approaches could be used at different stages of a study (Strauss and Corbin, 1998). This study also utilised snowball sampling technique to recruit study participants. Snowballing is a sampling method whereby study participants nominate or refer another individual to partake in the study (Creswell and Creswell, 2018). This technique is suitable for researching private or sensitive issues (Waters, 2015;Browne, 2005), and recruiting individuals with similar characteristics and experiences that fit the study's participant criteria (Atkinson and Flint, 2001). The snowballing process begins with the initial study participants referring other individuals for the study, then continues until the desired sample size is reached or saturation is attained (Creswell and Creswell, 2018). FGM is a sensitive topic to research as such some people were sceptical about participating in the study probably due to the legalities or sociocultural consequences of FGM, or the perceived risk associated with disclosure. Nonetheless, the use of snowballing was beneficial in this study as the referral and networking process created trust among participants, and potential participants were less concerned about ethical issues such as confidentiality, anonymity and privacy.

The sampling and recruitment process started after ethical approval was received from both the Faculty of Medicine and Health Sciences Research Ethics Committee at the University of Nottingham and the Delta state ministry of health ethical committee. The researcher visited the director of the Delta State Primary Health Care Development Agency (DSPHCDA), who had agreed to be a gate keeper (See appendix 4). This was to enable the researcher to gain access to HCPs working within PHC care facilities in the selected LGAs. The director informed the heads of department (HOD) of the PHC facilities in the two LGAs about the research via telephone conversation and requested the HODs to introduce the researcher to the chief nursing

officers (CNOs) in charge of each of the PHC facility in Oshimili South and Ughelli South LGAs.

3.2.3.1 Oshimili South LGA

Firstly, the researcher visited the HOD of Oshimili South LGA who gave the researcher an introductory note to the CNOs in charge of the PHC facilities within Oshimili South LGA. This was to enable the researcher access to HCPs working in these PHC facilities.

The researcher visited eight PHC facilities in Oshimili South LGAs on separate occasions. In one of the PHC facility the person in charge refused to partake in the study and did not permit other HCPs to participate. The individual claimed that they did not have any knowledge about FGM and did not provide care for women. However, this was not the case because in the said PHC facility, HCPs performed similar duties and attended to clients as other PHC facilities within the state. In other instances, the CNOs in charge of three of the PHC facilities visited were unavailable, hence the HCPs working in those PHC facilities refused to take part in the study without the authorisation of the nurse in charge.

The CNOs in charge of four PHC facilities were more receptive. In all facilities, the CNO introduced the researcher to the HCPs who were on duty, which provided the researcher the opportunity to speak to the HCPs individually and as a group. Almost all the HCPs in the four PHC facilities were sceptical about taking part in the study. They argued that the practice of FGM was no longer in existence and did not see the importance of the study. The researcher perceived that the HCPs may be unwilling to participate in the study because they did not trust the researcher.

McDermid et al, (2014) stated that there are possibilities of encountering challenges with trust when potential study participants are researcher's professional colleagues, and the researched topic is considered sensitive (McDermid et al., 2014). Thus, to build trust and create rapport with the HCPs, the researcher requested permission from the CNOs in charge to

speak to HCPs and mothers about FGM on ante natal and immunisation days. Subsequently, the researcher visited these PHC facilities on several occasions within a space of about four weeks to give health talks to mothers. As a result, trust was established, and some HCPs became interested in the research.

Through these regular interactions with HCPs, the researcher was able to identify 15 HCPs that had knowledge about the practice of FGM in four PHC facilities in this LGA. These HCPs were given the participants information sheet which contained all the information they needed to decide about taking part in the study. Thereafter, the 15 potential participants were given a period of one week to confirm their participation and the researcher collected their mobile numbers for follow up.

3.2.3.2 Ughelli South LGA

Similarly, in Ughelli South LGA the researcher was introduced to the CNOs in charge of the PHC facilities by the HOD of Ughelli South LGA. The researcher visited a total of five PHC facilities in Ughelli South LGA. The CNO in charge of one PHC facility was unavailable, and the HCPs would not grant the researcher audience without authorisation from the nurse in charge. The CNOs in charge of the other four PHC facilities introduced the researcher to the HCPs working in these facilities. The researcher had interactions with the HCPs and during the process identified 8 key informants. The researcher gave the key informants the participant information sheet and a period of one week to confirm participation, and their mobile numbers were collected to ensure follow up.

At this stage, the study utilised the snowball technique to recruit participants that could contribute to achieving the objectives of the study. The nurse in charge of one of the PHC facility in Ughelli South LGA, recommended other nurses that were knowledgeable about FGM who may be interested in the study. Hence, the researcher visited three more PHC facilities in Ughelli South where the potential participants worked. After

introducing self and the research topic, 3 HCPs indicated their interest, and the researcher gave them the participants information sheet and phone numbers were also exchanged for the purpose of follow up. A total of 11 HCPs were recruited from 7 PHC facilities in this LGA. This brought the overall number of study participants to 26 HCPs.

3.2.3.3 Justification for sample size

Qualitative research does not have a defined guideline for the appropriate sample size for research (Thorne et al., 2013;Creswell and Creswell, 2018). It is suggested that the sample size should be defined based on the nature of the research and what it aims to achieve (Hennink and Kaiser, 2022). Creswell and Creswell, 2018 and Ritchie and Lewis (2003) recommended that a sample size of between 5 and 30 is enough for a study that is aimed at engaging with participants and data to produce an in-depth understanding of the researched topic. Empirical studies that have utilised qualitative research design had sample sizes of between 5 to 32 participants (Murphy et al., 2016;Archibald et al., 2015;Lasiuk et al., 2013;Olsen et al., 2013;Nkulu Kalengayi et al., 2012;Clark et al., 2011). Since there are no specified principles for sample size in qualitative research, it is pragmatic for qualitative researchers to maintain a sample size that falls within the proposed size (Hennink and Kaiser, 2022). Therefore, the argument is not about justifying the sample size for the present research as the sample size sits neatly within the recommended sample size for qualitative research and was based on the depth of understanding that the study aimed to provide. But it is about providing a transparent report of how and when saturation was attained in this study to further demonstrate rigour (Hennink and Kaiser, 2022).

Saturation is a concept broadly used in qualitative research to determine when data collection and or analysis was discontinued (Hennink and Kaiser, 2022;Saunders et al., 2018). The term saturation originated from grounded theory (Glaser and Strauss, 1967), though it is now accepted and used across a range of qualitative research approaches where it is typically

referred to as data saturation or thematic saturation (Hennink and Kaiser, 2022). The issue of saturation in qualitative research has generated ongoing debates and uncertainties regarding how saturation should be conceptualised or used in qualitative research (Saunders et al., 2018). Some qualitative authorities believe that saturation is a guiding principle for assessing or determining the adequacy of sampling in qualitative design (Sandelowski, 1995;Morse, 1995). However, there are no existing guidelines to determine or test when saturation of any sort is attained in qualitative research (Morse, 1995). Therefore, it is the researchers' responsibility to make a pragmatic proclamation or determination of when saturation is attained by evaluating the adequacy and comprehensiveness of sampling, data and or result (Sandelowski, 1995;Morse, 1995).

Qualitative research seldom goes as planned (Thorne, 2016), the researcher assumed that the recruitment process would be without hitches but that was not the case. The recruitment process occurred over a period of eleven weeks and at the end 26 HCPs were recruitment to take part in the study. Evidence from a recent systematic review of 23 empirical studies to assess sample sizes for saturation in qualitative research showed that the sample size for saturation ranged between 5 to 24 interviews (Hennink and Kaiser, 2022). In the mentioned review, the lowest size for saturation was 5 interviews (Constantinou et al., 2017), while the highest sample size for saturation was between 20 to 40 (Hagaman and Wutich, 2017). This shows that sample size is guided by data sufficiency and not the number of study participants, as the most important factor in qualitative research is the ability of the study to provide data that gives a rich and nuanced account of the studied topic (Hennink and Kaiser, 2022). Therefore, saturation was reached in this study after the 24th interview was conducted, and the data showed repetitions and no new data to further provide understanding or contribute to the researched phenomenon. However, the researcher recruited two more participants to; firstly, ensure that adequate data was collected to provide a rich and in-depth understanding of the

research topic. Secondly, to establish that no data has been lost or omitted due to sampling insufficiency and lastly, to confirm sample, data, and thematic saturation. Figure 3.1 provides a summary of the recruitment process.

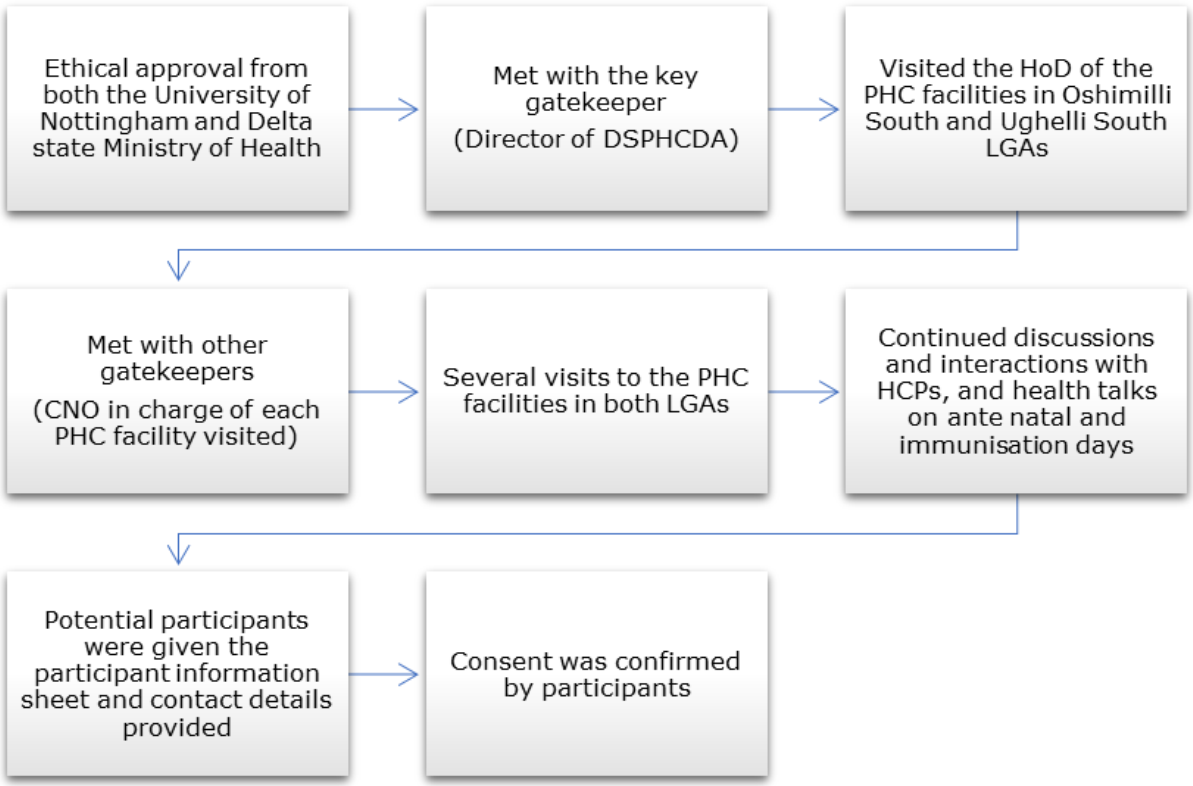


Figure 3.3 Summary of recruitment process

3.2.4 Data construction: collection

Individual interview is a method of data collection that is frequently used in qualitative methodology, however other established methods such as observation and focus group discussions can be used in addition to individual interviews (Creswell and Creswell, 2018;Ritchie et al., 2013).

The social constructivist tenet supports exploring and understanding of real-life experiences of individual participant through interactions between the investigator and participant to bring about merging meanings to a

reconstructed knowledge (Guba and Lincoln, 1994). Interview is a method of interaction that has intrinsic characteristics which allows the collection of detailed and robust information regarding participants' individual perceptions, understanding, and meaning of their experiences of social events (Creswell and Creswell, 2018). In addition to its key features, individual interviews are flexible and provide a basis for exploring multiple realities, whilst employing a variety of probes to unpack responses in terms of explanation and depth (Ritchie and Lewis, 2003;Ritchie et al., 2013).

A semi-structured interview was used to collect data in this study as; firstly, it was the most suitable method for achieving the objectives of the study. Secondly, due to the sensitivity of the research topic, it was important to adopt a data collection method (individual interview) that ensured privacy and allowed participants to freely verbalise and contribute meaningfully to the study without the fear of being judged or victimised. Whereas, with focus group discussions all the participants in the group would be privy to each other's contributions as such anonymity and confidentiality is difficult to maintain, and participants are not protected from the consequences of verbalising their opinions, experiences, or contributions.

Furthermore, the researcher did not conduct digital interviews mainly because the study was conducted in rural areas where internet service was very limited. Therefore, conducting interview using any type of program (Telephone, Skype, Zoom) would have been impossible because of technical difficulties such as loss of internet connection, participants not possessing mobile phones or laptops, lack of financial resources to purchase internet data or no access to internet services.

In addition, individual face to face interaction was very useful for the researcher to build trust and rapport with potential participants before the actual interview began. It helped to reduce distrust and discomfort for the participants and facilitate a better emotional connection through participants' increased sense of ease during the individual face-to-face interviews. All these would not have been achieved through digital

interviews considering the sensitivity of the topic, and the legal and sociocultural consequences surrounding the practice of FGM. There are ongoing debates about the use of technologies and digital interviews in qualitative research (Thunberg and Arnell, 2022); though with hindsight, it would have been extremely difficult to recruit participants for this study let alone conduct interviews, if any aspect of the method used for this study was undertaken remotely (online) due to the mentioned reasons.

3.2.4.1 Data collection process

The procedure for data collection in this study entailed the following steps:

Step 1: interview guide

Prior to commencing fieldwork, an interview guide was prepared to provide structure and guide the interview process (Bryman, 2012). The interview guide included questions that were developed from the research objectives with the purpose of answering the overall research question and achieving the research aim without being overly specific (Bryman, 2012). Hence, the interview guide was formatted in a flexible way that allows it to be refined based on emerging themes and issues.

Following the recommendations of Ritchie and Lewis (2003), the interview guide was reviewed and modified where necessary by the supervisory team to ensure that the questions encompassed the study objectives and contained open ended questions that will allow participants to respond in depth. Thereafter, the interview guide was validated by the supervisory team once they were satisfied that it covered the study objectives, and there was a clear understanding of what each section was seeking to accomplish (Ritchie and Lewis, 2003).

The interview guide for this study consisted of two sections (See appendix 7). The first section provided information about the purpose of the study, and what the interview process entailed. It also included confirming that participants had read and understood the information sheet and were

happy to continue with the interview and consented for the interview to be recorded with an audio recorder.

The second section was made up of seven questions; question one was designed to obtain participants background information such as professional group, job description and years of experience (Bryman, 2012). Question two explored HCPs' understanding of FGM, including the different types of FGM and the health complications associated with FGM. Question three examined participants beliefs and attitudes towards the practice of FGM. Questions four and five explored the care that was provided for women with FGM and the challenges that the HCPs experienced. While questions six and seven were designed to give participants the opportunity to make suggestions, comment or contribute to the interview in areas that the researcher had not explored.

The seven questions had sub questions. The main questions were exploratory, which allowed participants to describe their understanding, perceptions, and experiences of FGM. While the sub questions encouraged participants to explore the initial questions in more details by expanding on those points that were considered important. In applying these questions, participants were able to describe their experiences in depth and this allowed for a level of interpretation of common patterns during data analysis (Teodoro et al., 2018;Thorne et al., 2004).

Step 2: Before the interview

Before the face-to-face interview, the researcher visited and made telephone calls to potential participants to confirm their participation in the study and to schedule interview day, time and venue that was most convenient for participants. For their convenience, all participants who agreed to partake in the study, preferred the interviews to take place during lunch break in a quiet office within the PHC facility where they worked.

Prior to the interview day, the researcher familiarised herself with the interview guide to ensure that the main issues are explored systematically

and at the same time promote flexible and responsive interview process (Ritchie and Lewis, 2003). In accordance with the tenets of qualitative research, the researcher familiarised herself with the different PHC facilities to understand the natural settings where the interviews will take place (Bryman, 2012;Thorne et al., 2004). An office in the quiet section of the PHC facility was booked in advance for the interview. The researcher ensured that other staff members were informed about the interviews, and a notice was placed on the door on the day of each interview to promote privacy and avoid unnecessary noise, interruptions, and distractions.

The researcher ensured that she had a good quality digital voice recorder that was fully charged to last up to 72hours of use, and a password protected mobile phone as a backup voice recorded. The researcher was a novice and had no prior experience or skills for conducting research interviews. To develop the necessary skills and tips needed to conduct a successful interview, the researcher undertook a short course on interview skills. The course helped broaden researchers' knowledge about the importance of establishing rapport with interviewee to gain trust, build confidence and credibility by asking clear, simple short and relevant questions (Bryman, 2012;Ritchie and Lewis, 2003). It highlighted the need to respect participants' individuality and views, and to show interest in interviewees' responses by listening attentively and using prompt, probes, and clarification when necessary whilst incorporating the use of nonverbal communication such as nodding and smiling (Ritchie and Lewis, 2003;Mason, 2002).

Step 3: During the interview

On the interview day, the researcher arrived an hour before the scheduled time and as stated earlier, a sign was posted on the door indicating that interview was taking place in the office. The researcher tested the audio recording device to ensure it was in good working condition, then read through the interview guide and the research aim and objectives to remind self of what the interview was aimed to achieve.

The interview started with introduction and exchange of pleasantries to put the participant at ease. The interviewer explained the purpose of the study, confirmed consent by requesting the consent form to be signed by participants and reassured participants about confidentiality and anonymity. Then researcher asked permission to record the interview and informed participants that they could opt out of the interview process at any time without prejudice and were free to comment and ask questions.

The researcher guided the interview by exploring anticipated and emerging themes from the interview. Each concept relating to the focus of the study was explored in depth with probes, prompts, and follow up questions and silence when required. The researcher encouraged elaboration and clarifications of participants' responses and asked follow-up questions for clearer understanding (Doody and Noonan, 2013). This enabled questions that were genuinely data-driven rather than researcher-driven to be asked, to contribute to the quality and credibility of the findings (Braun and Clarke, 2006). At the end of the interview, the researcher asked participants for additional comments or suggestions on areas related to the focus of the research (Ritchie and Lewis, 2003). Then the audio recorder was switched off at the end of the interview. The participants were thanked warmly by the researcher and provided her contact details for any additional discussions, queries, or feedback.

Step 4: After the interview

At the end of each interview, the participant was given a light refreshment of snacks and a non-alcoholic drink as a show of appreciation for taking part in the study. At the end, a total of 26 interviews were conducted with doctors (N=2), nurse/midwives (N=15), and community health extension workers (CHEW) (N=9). Overall, 518.66 minutes was spent on conducting all 26 interviews with an average of 20 minutes for each interview and all interviews were conducted in English which is the official language used in Nigeria (See chapter 1.4).

Following the principles of qualitative research, a fieldnote was used as a means for capturing observations and reflective thoughts (Teodoro et al., 2018). The researcher kept a reflective field note which helped her to record her feelings and thoughts regarding the dynamics of the research process and ideas that could be relevant during the analytical phase. The researcher made a mental note of interviewees countenance during the interview and the researcher's opinion and assessment of each interview. This was jotted down immediately after the interview as taking notes during the interview will distract the interviewer, and may lead to the loss of vital responses from participants (Bryman, 2012). The fieldnote also served as a reflective diary that captured researcher's biases and change of thoughts or responses during the study (Teodoro et al., 2018). (See appendix 8).

3.2.4.2 Pilot interview

Prior to conducting the main interviews, a pilot interview was conducted to test the efficiency of the interview guide and to determine if it was understandable and served the purpose for which it was formatted (Yujin, 2010). The small-scale pilot interview was conducted with three HCPs because they were the first people to be recruited to take part in this study; they included a nurse, a CHEW, and a doctor. All pilot interviews followed the conditions specified in the interview guide – consent was affirmed, and participants were reassured about confidentiality and anonymity and the interviews were recorded with participants' permission. The interviews and analysis of the data from the pilot study occurred simultaneously to effect changes/modify the interview guide if necessary and inform subsequent interviews. The feedback from the pilot interviews was focused on amending the style used by the researcher to ask the interview questions. The feedback indicated that the participants clearly understood the questions that were asked and suggested that the researcher should be more relaxed and explicit when asking the questions. Overall, the interviewees stated that they fully understood the questions. Thus, no amendment was made to the interview guide and the data from the pilot

study was included in the overall findings of this study. The pilot interview helped the researcher to gain some experience and skills for interviewing before conducting other interviews.

3.2.5 Data construction: Analysis

Congruent with qualitative beliefs, data collection and analysis occurred simultaneously in this study to inform a rich and in-depth analytical finding. Data analysis in qualitative research is characterised by an active and constant relationship between data collection and analysis to make sense of the entire interview data beyond the immediate superficial meaning (Ritchie et al., 2013).The analytical process for this study began with the researcher transcribing the interview data so as to know the data and engage with the nuances, words, phrases and pauses, whilst listening deeply to the language to make meaning of the responses (Thorne et al., 2004;Bryman and Burgess, 1994).

3.2.5.1 Transcribing

An integral aspect of data analysis is listening attentively to audio recording from the recorded interviews to format them correctly into written words and not merely a process of typing participants' responses into words (Kvale, 1996). Presenting a quality transcript of interactions between the researcher and the researched is largely dependent on the quality of the audio recordings and how accurately the interactions were transcribed (Thorne et al., 2004). All 26 interviews were conducted in English and to ensure honesty and accuracy, the researcher transcribed all 26 interviews recordings and participants were allocated pseudonyms. After transcribing all interview recordings, the researcher reviewed the final transcripts by reading through each transcript whilst listening to the recording to ensure that it was accurately transcribed. The final transcripts were reviewed by supervisors to validate the quality and rigour of the transcription process.

Transcripts are the interpretive constructions that are important in providing explanations and understanding of the studied phenomenon and

not simply copies of participants' realities (Kvale, 1996). However, whatever interpretations made during transcribing were soon forgotten as continuous review of the transcripts and analysis yield further interpretations and constructions (Thorne et al., 2004). This meant that through constant reading of the transcripts new meaning and interpretations were conveyed. However, despite this, and the thorough transcription of the audio recordings and review by supervisors, the researcher acknowledges that inaccuracies in interpretations and meaning may still be present.

3.2.5.2 Analytical approach

Data could be a studied phenomenon in terms of how the researcher seeks to understand the way the participants' account of reality are constructed (Ritchie and Lewis, 2003). Thus, the approach used to analyse a set of data will determine the vital bit extracted from the data set and this will in turn influence the interpretation, constructions, and overall outcome of the study (Bryman, 2012). The most popular approach in qualitative analysis is to identify key themes, concepts, and categories, however the approach used to generate these themes and concepts vary depending on the aims and objectives of the research and analytical approach (Thorne et al., 2004;Ritchie and Lewis, 2003).

In contrast to quantitative research, qualitative research does not have a clearly laid out procedure for analysing qualitative data but recommends analytical approaches that enables the researcher to organise and summarise dataset to capture explicitly the descriptive elements of participants' responses (Ritchie et al., 2013;Harper and Thompson, 2012). It supports analytical approaches that are aimed at presenting pattens and relationships to make sense and meaning of the issues that are being unravelled, but cautions against approaches that involve tearing data apart and putting them back together again (Bradshaw et al., 2017;Thorne et al., 2004).

There are different approaches to analysing qualitative data; this includes but not limited to interpretive phenomenology analysis (IPA), which is concerned with how study participants make sense of their individual experiences of the studied topic (Ritchie et al., 2013;Harper and Thompson, 2012;Smith et al., 2009). This type of analysis is aimed at producing an outcome that captures and reflects the claims and lived experiences of the study participants (Smith et al., 2009). That is, giving the study participants a voice whilst trying to make sense of their accounts by providing an interpretation of the data which reflects the study participants' experiences and concerns (Harper and Thompson, 2012;Smith et al., 2009). The aim of this study was to explore HCPs understanding of FGM and the support provided for women with FGM, and not their personal experiences of FGM practice. In addition to interest in people's lived experiences, IPA uses small samples, themes are developed through conversations between the participants and the researcher, and themes are reported to capture lived experiences of participants. Therefore, IPA approach was not adopted in this research because it was unsuitable for answering the research question and providing in-depth understanding of the studied phenomenon.

Also, there is grounded theory which aims to develop new theories that are grounded in the data (Harper and Thompson, 2012;Glaser and Strauss, 1967). Since, this study was not focused on developing a new theory, this approach was rejected. The researcher also considered narrative analysis, this approach to qualitative data analysis focuses on telling and interpreting the fundamental narratives from study participants' personal stories (Ritchie et al., 2013;Harper and Thompson, 2012). It uses a person's narratives, expressions and constructs, and data is obtained and organised to allow the researcher to understand how study participants experienced the researched phenomenon (Harper and Thompson, 2012). The main aim of narrative analysis is to turn participants' individual stories into data that can be coded and organised to understand how the studied phenomenon impacted on the feelings, and or decisions of the participants (Harper and

Thompson, 2012). Basically, the outcome of narrative analysis is to produce a narrative or identify a core story that captures or explains participants' experiences (Ritchie and Lewis, 2003). Again, this approach was rejected as it is concerned with presenting narratives from participants' individual stories and experiences, not shared experiences. This study adopted thematic analysis as it serves as a useful tool for understanding social phenomenon. It is useful for illuminating peoples' attitudes and beliefs, and the meaning that they attribute to these social occurrences (Braun and Clarke, 2021;Silverman, 2913).

Therefore, data analysis was conducted using Braun and Clarke (2006) inductive thematic analytical approach as it provides a logical framework for rigorous identification and presentation of themes and concepts that are laden with meaning, and vital for producing a reliable interpretive description study. A data management software (NVivo12Pro) was used to store, organise, and code interview transcripts. The use of Braun and Clarke (2006) and NVivo12Pro was consistent with other empirical studies situated within qualitative methodology (Murphy et al., 2016;Archibald et al., 2015;Dmytryshyn et al., 2015;Manuel and Crowe, 2014;Maheu and Thorne, 2008).

Thematic analysis is used across a wide range of epistemological approaches, and it is not tied to any theoretical framework (Braun and Clarke, 2021;Braun and Clarke, 2006). This means that it sits within any epistemological beliefs of most qualitative approaches. Congruently, thematic approach holds the tenets of social constructivist, and explores participants' individual account of events and experiences and how the constructions of these experiences affects the meaning read to social occurrences (Braun and Clarke, 2021;Braun and Clarke, 2006;Thorne et al., 1997). Conversely, thematic analysis can be conceptualist, a belief that people make meaning of their experiences and that the larger society affects those meanings, but within material and reality limits (Braun and Clarke, 2006). Consequently, Braun and Clark (2021) stated explicitly that

thematic analysis holds several epistemological assumptions about the nature of data and can be used to reflect realities and to unpack accounts of realities.

Thematic analysis provides a useful and flexible framework for generating detailed, complex, and rich report of data (Finlay, 2021;Braun and Clarke, 2006). This flexibility has been critiqued as lacking a clear boundary and concise guidelines, thus accepts anything (Antaki et al., 2003). However, Braun and Clarke (2006) provide an explicit six phases guide to data analysis with a description of what the researcher should achieve in each phase. The six phases method was recently extended and developed to include reflexivity and a clear constructivist approach to data analysis (Braun and Clarke, 2022;Braun and Clarke, 2021;Braun and Clarke, 2019). The explicitly structured six phases, the flexibility of the method and transparency regarding the acceptance of multiple epistemological beliefs make thematic analysis theoretical and methodologically sound.

In addition, the inductive approach to thematic analysis means that themes that are identified are linked strongly to the data generated from interviews (Patton, 2002). The researcher analysed data inductively because it promoted the process of coding without trying to fit the data into researcher's pre-conceptualised codes and themes. This means that findings were generated specifically from participants' views and interpretations of their reality without a pre-exiting theoretical influence, which made the analytical process to be data driven (Braun and Clarke, 2006;Patton, 2002). However, the researcher acknowledges that her epistemological commitments and personal biases cannot be fully separated from the analytical process, and this was evident in the construction of meaning to data.

Therefore, the researcher immersed herself in the data by reading transcripts and moving back and forth between the dataset and the coded extracts and referred to reflective notes to master the data. This was done

by following the six phases proposed by Braun and Clarke (2006). (See table 3.2).

Table 3.2 Six phases of thematic analysis (Braun and Clarke, 2006)

Phase	Description of the process
1. Familiarising yourself with your data	Transcribed data, read and reread the data and noted down initial ideas.
2. Generating initial code	Coded interesting features of the data across the entire data set in a systematic manner, then collated data relevant to each code.
3. Searching for themes	Collated codes into potential themes, gathered all data relevant to each potential theme
4. Reviewing themes	Checked if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), then generated a "thematic map" of the analysis
5. Defining and naming themes	Continued with the analysis to refine codes and themes, and the overall narrative from the analysis, then generated clear definitions and names for each theme.
6. Producing the report	The final opportunity for analysis. Selected compelling extract examples. Final analysis of selected extracts, relating back to the analysis, the research question, and literature, then produced a scholarly report of the analysis.

Phase 1: *Familiarisation with data*

This phase involved the researcher becoming familiar with the interview data (Braun and Clarke, 2021;Braun and Clarke, 2006). Once the researcher finished transcribing the audio recorded interviews and was confident that participants' responses were correctly captured to the best of her knowledge, the 26 interview transcripts were imported onto NVivo12Pro data management software where data coding and generation of nodes, subthemes and themes occurred. At this point, all personal identifiers were removed, and participants were assigned pseudonyms.

To ensure the generation of meaningful codes to tell participants' story, the researcher repeatedly read the transcripts while listening to audio recording

and referring to field notes to piece the data together and understand the dataset.

At this phase of the analysis, the researcher concentrated on the bigger picture and tried to answer questions like 'what is happening here?' and 'what am I learning about this data?' as suggested by Throne (2004). The researcher began to jot down notes and map ideas for codes that could be useful for subsequent phases. Then, spent time immersing herself in the data to know the data beyond the immediate thought of what the data contained. This was in preparation for the formal coding phase.

Phase 2: *Generating initial codes*

The second phase of data analysis began after the researcher had familiarised self with the data (Braun and Clarke, 2021;Braun and Clarke, 2006). The researcher worked systematically, reading the transcript line by line to ensure that the entire content on the dataset was coded. The decision to perform a line-by-line coding was to ensure that the data was examined critically without missing any segment of the data. Secondly, it enabled the researcher to identify interesting parts of the data that were similar and repeated across the data set, and to produce a pattern that could later be grouped to form themes. Coding in Nvivo involves gathering similar data set into a container called node (Green et al., 2007). This can be achieved by highlighting words, lines or phrases and then dragging it into a new or existing node. However, new nodes are created as new ideas emerged.

During the coding process, the researcher identified captivating segment of the data and ascribed a code that was considered meaningful in terms of the research context. The researcher coded broadly as many potential patterns as possible which could be useful as the analysis progresses. The researcher coded and un-coded and recoded the individual segments of the data several times while grouping them into different nodes if they fitted and depending on the similarity of the context.

The researcher ensured that the codes were data driven so that the themes that would be generated will be dependent on the data. For instance, data that related to 'women running from one man to another' or 'uncircumcised women tend to follow men' were coded as 'FGM prevents promiscuity'. Also, the researcher was careful to retain the accounts that were emerging that did not relate to the dominant story (Bryman, 2012). The entire process entailed revisiting the transcripts and audio recordings several times to completely appreciate what was being said by participants in order to clarify and to understand the meaning around nuances.

The researcher moved to phase three once satisfied that the entire data has been thoroughly organised into codes and nodes that captured the intriguing aspects of the data in terms of the research question. Importantly, the initial codes and nodes are provisional as some were modified or deleted as the analytical process developed.

Phase three: *Searching for themes*

This phase began with a collation of a long list of initial codes that had been identified from the entire data set into nodes (Braun and Clarke, 2021;Braun and Clarke, 2006). In this phase, the identified nodes were reviewed and sorted into groups of similar dimensions of participants' stories and then they were collated into potential themes (Braun and Clarke, 2006).

Thereafter, an initial thematic map was drawn to show the main themes subthemes and nodes, and the relationship between these and the codes (Braun and Clarke, 2006;Thorne et al., 2004). It was noted at this stage that some of the initial codes made up the key themes while some formed the subthemes. However, there were some codes that did not fit into any group of recurring themes, these themes were then grouped under a different theme named 'miscellaneous' as suggested by Braun and Clark (2006).

At this stage, the researcher began to understand the individual themes that were generated from the data – 'knowledge and awareness' 'in or out - mixed feelings' 'encountering FGM in clinical practice' 'clinical service development for FGM' and 'a sense of belonging' (See figure 3.4). However, these themes appeared not to completely capture the true nature of the data in terms of achieving the overall of aim of the study. For this reason, it was necessary to continue to ponder on the themes and refine them until the themes and subthemes are produced, before moving to the next phase. The researcher continued to have series of discussions with the supervisory team about the generated themes, and whether the initial themes answered the overall research question and told a story that reflected both participants' and researcher's constructions of the studied topic.

Phase 4: *Reviewing potential themes.*

This phase entails reviewing and refining themes at two levels (Braun and Clarke, 2006). At the first level, coded data extracts were reviewed by reading all the extracts gathered for every theme to ensure that they formed a consistent and meaningful pattern (Braun and Clarke, 2006). The researcher at this point, determined that the five overarching themes needed more work and continued to read, review, and move back and forth the data set and codes to ensure that data within themes were coherent and meaningful.

The researcher took time away from the data in order to discuss with colleagues and supervisors about the analysis process. This enabled the researcher to reflect on the focus of the study and return to the data set with a fresh perspective. Then, the researcher continued to reshuffle, review, and refine existing themes to fit into nodes and generate new themes where necessary. Then a thematic map was generated once the main themes were satisfactorily captured (See figure 3.4), and the second level of reviewing themes commenced.

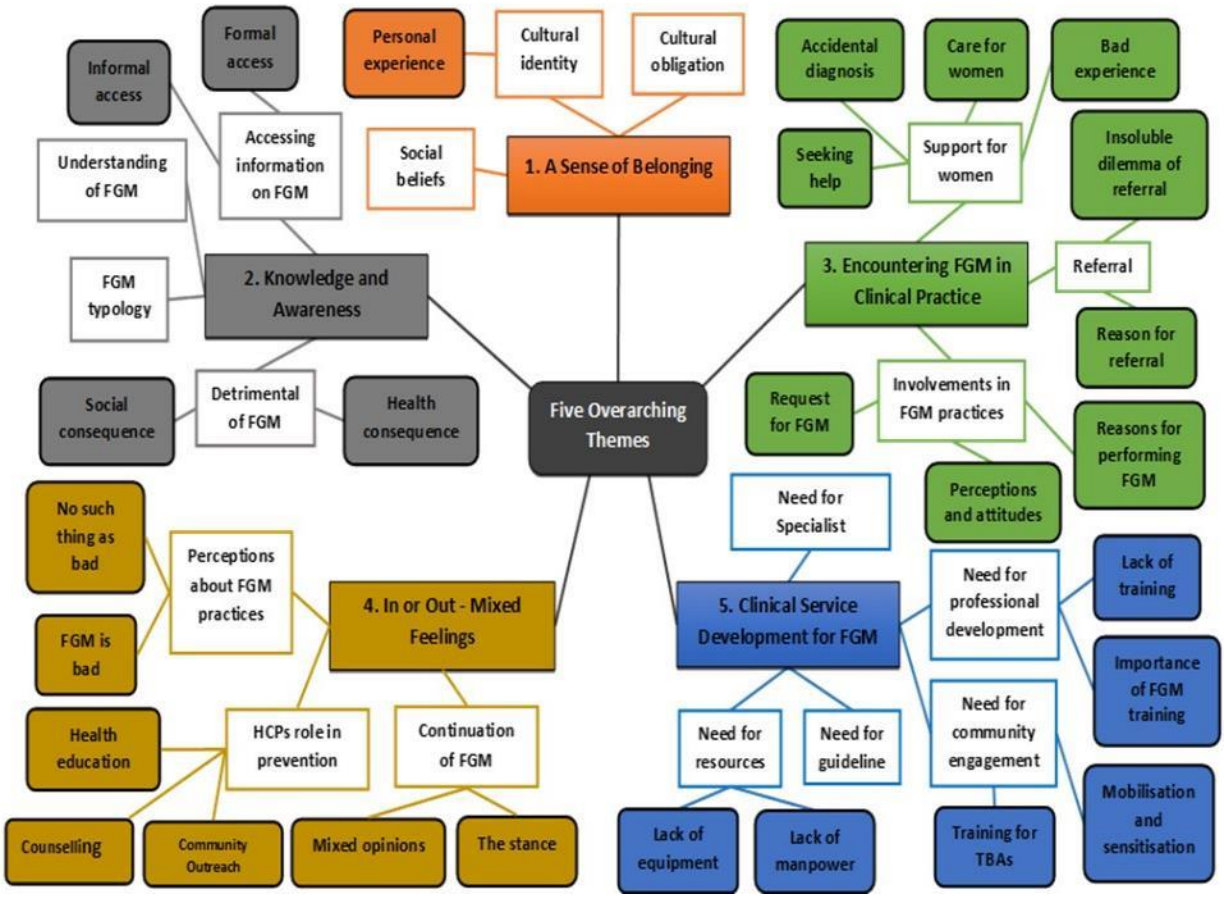


Figure 3.4 Thematic map

The second level involves the validity of individual themes in connection to the data set to determine if the thematic map correctly and evidently represents the meaning of the entire data set, bearing in mind that coding was done inductively (Braun and Clarke, 2021;Braun and Clarke, 2006). A further review was done to ensure that the themes were related to the data. As coding is a continuous process, other data within these themes that had been missed at the second phase of the data analysis were coded. Once all data set were completely coded and merged or collated into themes, and the themes have been reviewed and refined, and there were no missed codes or substantial emerging themes, the analytical process moved to the next phase. At the end of this phase, the researcher

understood the different themes and was confident that the themes fitted together to tell the overall story about the data.

Phase 5: *Defining and naming themes*

This phase is concerned with defining, refining, and naming themes that will be presented for the analysis (Braun and Clarke, 2006). This means that the essence for each theme was identified individually and the part of the data that captured each theme was ascertained. It was necessary to ensure that the themes were not too complicated and different. Hence, the collated data set for each theme was revisited, to review and reorganise them into a consistent and clear account, with an accompanying intriguing story. Consequently, the five mapped out themes were further refined and reorganised into two overarching themes (See Table 3-3).

Table 3.3 Themes, subthemes, and nodes

Main themes	Subthemes	Nodes
1. KNOWLEDGE OF FGM	• Sociocultural influence	• Superstitious beliefs • Superstitious consequences • Personal experiences
	• Professional influence	• Wearing of the skin • Different types of FGM • Dangers of FGM • Source of information about FGM
2. ENCOUNTERS WITH FGM IN THE CLINICAL SETTING	• Encountering FGM in clinical practice	• Medicalisation of FGM • Support for women during parturition
	• Clinical service development for the care of FGM	• Policies and Procedures • Professional trainings on FGM • Specialised services • Limited resources
	• Beliefs and attitudes towards FGM	• Beliefs about FGM practices • Attitudes towards the medicalisation of FGM • Perceived role in preventing FGM

Phase 6: *Producing report*

This phase involved the production of a final report (Braun and Clarke, 2021;Braun and Clarke, 2006). The overall aim of writing a thematic report is to present a narrative of the data in a logical and coherent manner that depicts the comprehensiveness and intriguing aspects of the themes within the data. In this study, the write up showed evidence that the themes were explored in depth to produce a narrative that demonstrates the constructed meaning of the data from participants stories. Chapters five and six presents a narrative of the two overarching themes generated from the 26 semi structured interviews.

3.3 Ethical considerations

Quality ethical research on FGM is important for international, national and local stakeholders to make inform decisions regarding policies and interventions to end FGM practices, whilst safeguarding the rights of study participants (WHO, 2022a). For many decades research on FGM were conducted with no specific ethical guidance, despite potential risk and harm to the study participants (WHO, 2022a). Consequently, WHO provided a guidance document to strengthen the ethical consideration of research on FGM (WHO, 2022a). Given the sensitivity of FGM and potential harm to participants for discussing the practice of FGM, it was important that efforts be made to reduce risk by adhering to the ethical principles recommended by WHO (WHO, 2022a).

3.3.1 Ethical approval

Research that involves human participants sometimes raise complex ethical, legal, social and political issues (WHO, 2022a;CIOMS, 2016). Thus, such research must seek ethical approval from the appropriate organisation to minimise risk of harm for individuals partaking in the study (WHO, 2022a;Fouka and Mantzorou, 2011). Since the research was conducted by a student at the University of Nottingham, ethical approval was sought from

the Faculty of Medicine and Health Sciences Research Ethics Committee (MHSREC). Similarly, an application for ethical approval was submitted to the Ministry of Health Research Ethics Committee (MOHREC) as the study was conducted within PHC facilities in Delta State Nigeria. The study commenced after receiving ethical approval from both ethical committees (See appendix 2 and 3). The researcher adhered to all ethical principles in accordance with the ethical approval.

3.3.2 Informed consent

This means that study participants knowingly, voluntarily, and intelligently gave their consent to participate in the research (Armiger, 1997). It is a continuing process during the research and not just a one-off activity (WHO, 2022a). Obtaining informed consent helps to prevent assaults on the integrity of the participants and protect their liberty and veracity (WHO, 2022a;Fouka and Mantzorou, 2011). It is one of the ways in which study participants' rights to autonomy can be protected (Armiger, 1997). Hence, after the identification of potential participants, an information sheet containing key details about the study and researcher's contact details were given to potential participants (see appendix 6). The researcher ensured that the information on the information sheet was comprehensible and contained sufficient details to enable participants to decide to be part of the study. This research includes HCPs, and it was vital to reassure them that there will be no professional consequences for taking part in the study. As recommended by WHO, potential participants were made aware that participating in the study was voluntary and that they could withdraw or decide not to partake in the study with no repercussions (WHO, 2022a).

Participants who confirmed their interest to participate in the study were made aware that a signed consent form was a requirement for participation in the study. On the interview day, the consent form was given to participants to confirm participation. The researcher reiterated the aim, objectives, and scope of the proposed study, including the benefits and possible risks of the study and encouraged participants to ask questions

and discuss any concerns that they had about the consent form and the research in general. The interviews proceeded after consent has been confirmed, and all issues that were raised were addressed and resolved.

3.3.3 Anonymity and confidentiality

Anonymity is a process in which the researcher conceals participants' identity so that participants cannot be linked to their responses (Nieswiadomy and Bailey, 2016). While confidentiality is concerned with keeping participants information private to protect their identity (Fouka and Mantzorou, 2011). The reason for maintaining confidentiality and anonymity during the research process is to minimise risk of harm due to disclosure of sensitive information that could be linked to a particular participant (WHO, 2022a). In this study, details of participants who disclosed sensitive information such as personal experiences of FGM, beliefs (support for FGM) and behaviours (intentions to continue FGM) were kept confidential. During the process of applying for ethical approval from the University of Nottingham, the researcher stated in the application and informed the committee in a panel discussion that any disclosures made by participants will not be reported; because of the poor implementation of laws in Nigeria, the safety of the researcher and risk of HCPs not partaking in similar studies in future. However, in some instances confidentiality could be broken especially when participants disclose information that may cause harm to themselves or other people (Nieswiadomy and Bailey, 2016). If any disclosure was made in this study that could cause harm to the participants or other individuals, then the researcher would have informed the director of the Delta State Primary Health Care Development Agency (DSPHCDA) without naming names.

In addition, anonymity and confidentiality were maintained in this study by ensuring that all documents, including research questions, audio tapes of interviews and participants personal information were kept in a password protected computer that only the researcher had access to. Pseudonym was used as identifier for all interview transcripts at analytical and publication

phase. Again, participants were informed that they were free to withdraw from the interview at any time.

During interview, the researcher acknowledged that potential risk for psychological and emotional harm could arise because of the sensitivity of FGM practices. To safeguard the psychological and emotional safety of participants, interview guide did not include questions about personal experience of FGM, and participants were informed that they can opt out of the research at any time if the process becomes stressful. Also, participants who become distressed during the interview or research process will be referred to the matron in charge of the PHC facility, or they could schedule a meeting with the researcher. This is because, there is no mechanism in place within the study settings to support participants who experience emotional or psychological distress because of their involvements in research studies. However, the participants were assured that any information that they provided during the interview will be used during analysis.

Furthermore, there were issues with participants unwillingness to participate in the study or speak with the researcher because she was perceived as an insider being a registered nurse from Nigeria. Participants were sometimes vague and uncommitted when responding to the researcher. This could be due to fear of being judged, victimised, or persecuted if they disclosed harmful information. However, the researcher continuously assured participants about confidentiality and anonymity, that all conversations are confidential except when it has the potential to cause harm to themselves or other people, then the researcher is bound by nursing ethics to report such information to the Director of the Delta State Primary Health Care Development Agency (DSPHCDA), who oversees all activities relating to PHC in Delta state.

3.4 Study rigour

Study rigour is the quality of the research process (Lincoln and Guba, 1985). The importance of demonstrating quality in a research process through data collection and analysis cannot be over-emphasised (Bradshaw et al., 2017). The quality of a qualitative research process cannot be judged by using quantitative criteria – validity and reliability (Creswell and Creswell, 2018). Rather, quality in qualitative research is judged by using the four criterions of trustworthiness, which are credibility, transferability, confirmability, and dependability (Lincoln and Guba, 1985). In addition, a quality qualitative research should reflect the philosophical underpinning for the study approach (Bradshaw et al., 2017). Hence, this study is aligned with the tenets of social constructivism. To reiterate that social constructivism assumes an ontological position that is relativist, which means that reality is subjective and individually constructed (Schwantt, 2000). While epistemologically, constructivist hold a subjective and transactional position which believes that people's perceptions, experiences, and reality in the social context are what constitute knowledge (Bradshaw et al., 2017;Guba and Lincoln, 1994). Similarly, the ID methodological framework acknowledges that there are multiple interpretations to the realities that exist, which are based on subjective interpretations that are supported and underpinned by participants' verbatim transcribed interviews (Bradshaw et al., 2017).

3.4.1 Credibility

Credibility is reporting accurately the complexities of the analytical process (Emden and Sandelowski, 1999). This means that researchers must be honest about the outcomes of the research findings and acknowledge their position and subjective constructs throughout the research process. Credibility can also be ensured through participants' perceptions and opinions about the accuracy of the interpretation of the data as represented by the researcher (Cope, 2014). In the study, the researcher ensured

credibility of findings by employing strategies such as reflexivity, triangulation and member checking (Billups, 2014;Thomas and Magilvy, 2011).

3.4.1.1 Reflexivity

Reflexivity is a concept and a process that involves the introspection of the researcher's subjective role in the research process (Palaganas et al., 2017). This means that the researcher continuously reflects, examines, recognises, and understands how their values, social background and assumptions affect the research (Palaganas et al., 2017). This increases transparency and trustworthiness of the study process and outcomes (Lincoln and Guba, 1985). In this study, the researcher reflected on her position as a woman, a trained nurse in Nigeria and her cultural background, including her beliefs and values and how these influenced the research process and outcome. See chapter 3.6 for more details about reflexivity and the researcher's position.

3.4.1.2 Triangulation

Triangulation is the use of several sources of data to produce an in-depth understanding of the study phenomenon (Hadi and José Closs, 2016). This can be accomplished by using method, data, or theoretical triangulation (Billups, 2014).

This study employed data and method triangulation. Data was collected from three groups of HCPs, which was examined across the three professional groups for corroboration (Lewis-Beck et al., 2004). Using purposive and snowball sampling techniques, aided the recruitment of key informants who possessed vast understanding and experiences of FGM practices, and this provided triangulation in terms of study settings. In addition, this study was conducted using several PHC facilities (11) located in different locality, and this provided varied perspectives from HCPs belonging to different ethnic background and cultural orientation. Furthermore, face to face interviews in addition to field note was also used

to ensure triangulation by providing an understanding of the discourses around the practice of FGM and reporting a congruence of results.

The concept of triangulation has been critiqued by positivists who maintained that they supported the tenets of realism which suggested that there was only a single true account of reality (Bryman, 2001). However, constructivist argued that findings from research should be viewed as one in many potential interpretations of social events, and declared that the use of triangulation enhances essence, richness, and complexity of a study and thus an instrument to increase credibility and influence study findings (Bryman, 2012). Another critique was that triangulation assume that data derived from different sources may not be the same for answering research questions as the ambiguousness of one source could complement the other (Mays and Pope, 2000). However, this view failed to consider the different social circumstances and the sensitivity of some researched phenomena in terms of utilising different data sources or methods. For instance, the inability of findings gathered from semi-structured interviews to converge with data derived from focus group discussion could be due to the later, being provided in private and the other in public setting as a general contribution that may not necessarily represent participants' actual realities.

3.4.1.3 Member checking

This is an important strategy for ensuring study credibility. It involves asking selected participants to review preliminary findings to ascertain if the findings reflected what they told the researcher (Billups, 2014;Lincoln and Guba, 1985). The primary focus of most qualitative research is to correctly understand participants' worldview and present same to ensure validity (Lincoln and Guba, 1985). Despite the usefulness of member checking, it has been critiqued and termed problematic because researchers have reported that participants could misinterpret researcher's interpretations of the findings (Bloor, 1997). For example, a study conducted to determine the experiences of validation of interviews,

reported that participants expressed discomfort with the shift from providing information to interpretation (Buchbinder, 2010). The participants in the said study (Buchbinder, 2010) had troubles dealing with the boundaries and power dynamics in the research relationship (Buchbinder, 2010). Conversely, some qualitative researchers support member checking, as it is believed to provide participants with another opportunity to co-construct research findings (Thorne, 2016). Thus, Member checking in this study was done by sending the initial findings by mail to three participants (Doctor, nurse, and CHEW) that the researcher believed could give the best feedback or comment on whether the preliminary findings and conclusions accurately reflected the reality of the interviews. However, in agreement with critiques who observed that member checking was problematic (Bloor, 1997), the participants that were selected to provide feedbacks on the initial findings from this study did not respond to the researcher's emails. All efforts made by the researcher to reach them was unsuccessful, which is similar to reports from other empirical qualitative studies (Stake, 1995). The lack of response from the participants could be due to the sensitivity of the research topic, or participants felt uncomfortable about providing feedback. It could also mean that the participants agree with the transcript and did not have additional contribution since they were present at the interviews.

Member checking is considered a one-time event that is undertaken by selected participants at the end of data collection to confirm the accuracy of the interview transcripts (Billups, 2014;Lincoln and Guba, 1985), it does not validate the entire interview transcripts and research. In addition, the supervisory team validated the transcripts and agreed that the transcripts are a representation of the interview data. Therefore, the lack of member checking in this study did not affect the validity of the research.

3.4.2 Transferability

This applies to the ability to transfer methods or findings from one study to other study groups and settings (Thomas and Magilvy, 2011). Transferability was established in this study by giving a rich and in-depth description of field experiences (See chapter four), including the use of purposive and snowball sampling techniques to recruit key informants (Ritchie and Lewis, 2003;Thorne et al., 1997). A detailed description of the three groups of HCPs and the geographical boundaries of the study setting was presented in depth. In addition, a carefully constructed semi-structured interviews supported by prompts, probe and field notes was employed to gather rich data to enhance study transferability.

3.4.3 Confirmability

This is the ability of the researcher to demonstrate that the findings from data collection are truly a representation of participants' story and experiences as told by them and not the researcher's opinion and prejudices (Cope, 2014). To demonstrate confirmability, the researcher applied audit trails tactic to capture data collection and analysis process, in addition to references to reflective notes and triangulation (Lincoln and Guba, 1985). Audit trial served as the research blueprint as it enabled other researchers to understand the research process and relate with the decision trail. For instance, one key decision made was to keep a field note which served as the researcher's reflective diary where all her thoughts, plans and decisions throughout the research process was documented (See appendix 8). Furthermore, the supervisory team took time to review the data from the interviews and the analytical process, and commented on inconsistencies and perceived biases (Cope, 2014).

In addition, the chosen methodology provided an opportunity for the voices of study participants who were experts in recounting their experiences of the studied phenomenon to be heard (Bradshaw et al., 2017;Thorne, 2016). The interview process, the step-by-step analytical phases that

showed the coding process and how the themes were generated, and the report of findings and conclusions were all data driven and presented to reflect researcher's biases as well as maintain transparency.

3.4.4 Dependability

This is the stability and consistency of data overtime in a similar condition (Billups, 2014). Dependability can be achieved by audit trail and peer participation; audit trail means that other researchers agree with the decision trail of the primary researcher at each phase of the research (Cope, 2014). For this study, the researcher provided a detailed and transparent description of every stage of the research, including the philosophical standpoint, methodological allegiance - and corresponding approaches for data collection and analysis, as well as researcher's biases, beliefs and assumptions and how this influenced the research process (Lincoln and Guba, 1985). The supervisory team, other research colleagues and study participants were included in the data analysis process to provide constructive and critical feedback that enhanced the presentation of findings that depicted accuracy and trustworthiness.

3.5 Reflexivity and researcher's standpoint

After the completion of my Basic nursing studies (Diploma in Nursing) in 2009, I volunteered for six months as a nurse in the Accident and Emergency Department at the Central hospital, Warri Delta state. Thence, I began my career as a certified nurse on the paediatric ward at the General hospital Ughelli, Delta state Nigeria, where I remained until I travelled to the United Kingdom in 2012. That same year, I started a top up undergraduate studies in nursing at Anglia Ruskin University, Chelmsford and achieved a bachelor's degree in international nursing studies, BScN (Hons) in 2013. Thereafter, I enrolled for a master's programme at the University of Sunderland and obtained a master's degree in nursing (MscN) in the year 2014. In 2015, I gained employment with the Delta state

university Abraka, Nigeria, where I became an academic staff in the department of nursing science. My responsibilities as a nurse lecturer included teaching, mentoring and supervision of examination, clinical placement, and research students, and I was a level adviser and the focal person to the nursing and midwifery council of Nigeria (NMCN). I remained on this position until I gained admission into the University of Nottingham in 2017 to undertake a PhD in nursing studies (FGM practices).

As a Nigerian woman and a nurse, I grew up in a community where FGM was practised for sociocultural reasons. In my community FGM was practised as part of marriage ceremony, to prevent promiscuity and infidelity after marriage, during pregnancy and as a rite of passage of young girls into womanhood. As a young child, I witnessed several of my female relatives being circumcised by the elderly women in the family or traditional cutters. Notwithstanding the pain and sufferings of FGM procedures, the circumcised girls in my community were proud, and carried themselves in a manner that suggested that they were better than uncircumcised girls.

For many years I was intrigued by the practice of FGM, and I sometimes wondered why I was not circumcised like my older relatives. Perhaps by the time I came of age, there were enlightenment campaigns on the elimination of FGM practices, or my mother's educational background played a role in her decision not to cut my sister and myself. Nonetheless, during my years as a clinical nurse, I encountered women with FGM who visited the hospital to seek help for FGM related complications. Sadly, we (HCPs) were unable to provide the specialised care that these women needed partly because of limited clinical skills and knowledge in the field of FGM and the fact that FGM was not considered a as detrimental practice in my community. These experiences informed my interest and curiosity about FGM practices, and the need to undertake a PhD study to explore HCPs knowledge, beliefs, and attitudes towards FGM practices to provide evidence-based data that may inform guidelines and strategies to improve

the quality of care that is rendered to women with FGM who utilise healthcare services in Delta state, and Nigeria in general.

Researching a sensitive topic such as FGM could be traumatic for both the participants and the researcher, not to mention the legal issues surrounding the practice of FGM and the risk of prosecution in situations where there is disclosure. This raised ethical issues during the process of seeking ethical approval from the Faculty of Medicine and Health Sciences Research Ethics Committee at the University of Nottingham. The main issue raised by the committee was around disclosure and the safety of the researcher. After a careful consideration and reflection on my role as a nurse and cultural background and based on the value that was attributed to FGM in the communities where the study was taking place, I informed the committee that any disclosure will not be reported. This decision was based on three reasons, first reporting a disclosure could put me at risk of being victimised when I returned to the healthcare setting after the PhD programme. Secondly, reporting a disclosure would bring distrust for the researcher and other researchers which may hinder the recruitment of participants for the present study and future studies. Thirdly, due to the weak enforcement of laws in Nigeria, a disclosure may not be investigated but could lead to animosity between the researcher, participants, law enforcement officers and the NMCN. For these reasons, I acknowledged that I would not report any disclosure except when it has the potential to cause harm to other people. After truthfully stating my position regarding the disclosure of participants' involvements in FGM practices, the ethical committee accepted my request for ethical approval after a careful consideration of the issues that were identified, and the amendment to the participants information sheet and the consent form.

Before the commencement of this study, I acknowledged that my background and cultural beliefs would play a significant role in the research process. While reflexivity is an important element in qualitative studies, especially during data collection and analytical process, the process to it,

the relevance and meaning is far from simple and can sometimes be overwhelming (Dodgson, 2019). However, throughout the process of this study I had critically reflected on my beliefs and prejudices about the practice of FGM and how this influenced my decisions at each stage of this research. I kept a field note which I used as a reflective diary, and recorded my thoughts, perceptions, and assumptions all through data and analytical process. The field note was not to generate data but to help me understand the implication of my role in data collection and construction of findings (Thorne, 2016).

As a nurse I have a shared knowledge and experiences of FGM as the studied HCPs. I considered myself an insider and would have entered the field with that role because it would enable me to understand the studied topic and any issues that were identified. Secondly, it would ensure social interactions and facilitate the extraction of relatable data from the study participants (Bonner and Tolhurst, 2002). However, I made an initial decision to step out of my role as a nurse and an insider and undo my knowledge about FGM, the communication and clinical skills that I would usually have used to engage clients, and take up the role of a learner – someone who has entered participants world in order to learn (Thorne, 2016;Thorne et al., 1997), with the hope that taking the outsider role would enable me to view things from a different lens and remain neutral and objective (Khaliza and Aizan, 2017). Despite all intentions to step out of my role as a nurse and focus on being a learner, it soon became apparent that conducting research amongst professional colleagues and in a familiar setting as an outsider was a difficult task. Consequently, accessing participants was problematic and the recruitment process became extended. As challenging as the recruitment process was, it provided an avenue for me to spend quality time with potential participants thereby prolonging my engagement with them and further demonstrating study credibility (Bradshaw et al., 2017).

My first encounter with HCPs during the early stages of the field work and recruitment was that of distrust. HCPs perceived me as a threat and feared that the government had sent me to monitor and report their activities. This was not surprising to me because as a former bedside nurse, I have had similar distrust for strangers who came to the clinical settings to ask for one favour or the other. So, I completely understood their suspicions or scepticisms and that made me to decide to build trust by stepping out of the outsider role and situating myself as an insider. I started by introducing myself first as a student, which appeared to be less threatening, and then as a nurse and professional colleague. I engaged in conversations that were not pertaining to the study and volunteered to give health talks during ante natal visits and engaged in immunisation exercises to create rapport with HCPs. This facilitated the recruitment process and enabled me to develop a trusting relationship with the HCPs which led to their willingness to participate in the study and provide information.

There were times during the field work that I switched roles from insider to outsider and to learner, depending on the situation. However, taking on the learner role was not without hitches. During the interviews I struggled with my own biases about the practice and how this may influence the study outcome. It was challenging to not bring my expertise about the researched topic into the interview process. For instance, during the first interview the participant stated that they performed re-infibulation but was oblivious of the implications of performing re-infibulation. I immediately informed the participant that *re-infibulation was unacceptable in some settings.* Reflecting on that interview, I acknowledged that I should not have provided the information at the middle of the interview, as that could have prevented the participant from continuing the interview or providing further information due to fear of being criticised. However, since it was a pilot interview, the feedback from that participant and other pilot interviews helped me to address these sorts of challenges. Therefore, in subsequent interviews I enhanced the quality of the interview by ensuring flexibility,

calm and humility so that my knowledge of the practice and passion does not steer the interactions in a predicted direction (Thorne, 2016). Also, I maintained a neutral stance while encouraging the participants to explain in detail their understanding, perceptions, and experiences of FGM by using probes, prompts and silence. As a curious learner, it was important to learn from the interviews by expressing genuine interest in the expertise that the participants offered, which helped me understand participants' constructs of their realities (Throne, 2008).

Situating myself as an insider had some benefits (Dwyer and Buckle, 2009). It facilitated recruitment process, access to PHC facilities and contextual data that would not have been accessed by an outsider (Bonner and Tolhurst, 2002). However, as an insider it was challenging to step out of the role of a nurse, this combined with my cultural background and beliefs about FGM shaped my constructs and interpretations of the data during data analysis. Although prior knowledge about the practice of FGM in a social and professional context helped me engage with the data to understand the practice of FGM from the perception of participants (Thorne et al., 1997). It was vital not to be self- absorbed (hyper-reflexivity) in the data collection and analytical process as this could negatively affect my interpretation of the data (Sandelowski and Barroso, 2002), which could lead to misrepresentation of meaning and the capacity to present credible and meaningful findings. Nevertheless, congruent to the constructivist tenets - the shared (researcher and researched) experiences produced co-construction of findings that would reflect in the writing up of findings and the presentation of the conclusion in this study.

3.6 Summary

The study was underpinned by the tenets of social constructivism, qualitative research design and interpretive description framework. Ethical approval was sought from the appropriate ethical committees and all ethical considerations were maintained. The study was conducted within eleven

PHC facilities in Oshimilli South and Ughelli South LGAs of Delta state Nigeria among 26 primary HCPs, including doctors, nurse/midwives and CHEWs that were recruited using purposeful and snowball sampling techniques. A semi-structured individual interview was conducted with the 26 HCPs, and the interview data were transcribed verbatim and imported onto NVivo12Pro data management software where data was stored. A thematic analysis was employed and at the end of the analysis two overarching themes were generated from the interview data. The study ensured rigour by demonstrating credibility, transferability, confirmability, and dependability. Furthermore, a detailed reflexive account of researcher's position and influence on the research process provided.

The next chapter (chapter four) provides a detailed presentation of the findings from the research.

CHAPTER FOUR: KNOWLEDGE OF FGM: The influence of sociocultural system and professional practices.

4.0 Introduction

This is the first chapter that presents the interpretation of the interview data gathered from the 26 HCPs. The chapter serves as a basis for understanding the studied HCPs and their constructions of FGM from a sociocultural and professional standpoint. This provides important context for subsequent chapters regarding how these interpretations shapes the care that they rendered to women with FGM who seek healthcare services within PHC facilities.

This chapter will first present a description of participants demographics, and subsequently highlight how the HCPs in this study understand the practice of FGM. From participants' narratives, these understandings have been acquired through two distinct interactions within their sociocultural settings and professional practice. In this context, sociocultural influence means the understanding that HCPs obtained from being members of communities where FGM is practised for cultural reasons. Professional influence is the knowledge that they acquired during their training as doctors, nurses/midwives, and community health extension workers (CHEWs) in their respective pre-qualifying educational institutions. Therefore, the ensuing sections will present two subthemes that unpacks HCPs understanding of the practice of FGM as acquired via their sociocultural and professional lenses.

4.1 Participants demographics

This study was conducted among 26 HCPs working in 11 PHC facilities in 2 LGAs in Delta state, Nigeria. The participants included 2 doctors, 9 CHEWs, 13 nurse/midwives, 1 nurse and 1 midwife. The 26 participants included 2

males and 24 females. Their years of experience as HCPs ranged from 3years to 35years. Below is a table of participants demographics.

Table 4.1 Participants demographics

Participant Number	Group of Healthcare Profession			Years of Experience	Sex
	Doctor	Nurse/Midwife	CHEW		
1			✓	15 years	F
2		✓		15 years	F
3			✓	10 years	F
4			✓	3 years	F
5		✓		5 years	F
6		✓ (Midwife)		9 years	F
7		✓		11 years	F
8		✓		21 years	F
9		✓		15 years	F
10			✓	11 years	F
11		✓ (Nurse)		3 years	F
12	✓			15 years	M
13	✓			12 years	M
14		✓		35 years	F
15			✓	7 years	F
16		✓		4 years	F
17			✓	5 years	F
18			✓	5 years	F
19		✓		19 years	F
20			✓	18 years	F
21		✓		5 years	F
22		✓		18 years	F
23		✓		13 years	F
24		✓		15 years	F
25			✓	5 years	F
26		✓		26 years	F
Total	2	15	9		

4.2 Sociocultural influence

This theme presents findings regarding participants' understanding and knowledge about FGM practices from their cultural standpoint. All 26 participants in this study were indigenes of communities where FGM was practised. Their narratives depicted cultural affiliations as well as in-depth understandings of FGM practices. The participants described FGM as a practice that is embedded in cultural and traditional beliefs which have been passed down many generations. They believed that FGM is accepted culturally and fostered by the shared beliefs of practising communities.

> *"Female circumcision is a practice that has been with us for years. It was taught to us by our forefathers, and it is traditionally acceptable... it is the cultural belief of the people in this area''. (P13-Dr).*

It was observed that some of the participants used the term female circumcision interchangeably with FGM to refer to the practice. They also used 'our' to identify with their culture. This could be perceived as participants' way of validating the practice. It could also be interpreted as participants having a sense of belonging and connection to their cultural heritage and existing traditional stipulations, hence they possessed this explicit culturally inclined knowledge about FGM and the associated superstitious beliefs and implications.

> *"FGM is…our people call it female circumcision and it is part of our custom to circumcise female children'' (P1-CHEW).*

"If we are to follow our culture, we just believe that a woman has to be circumcised…it is our traditional belief'' (P2-NM).

4.2.1 Superstitious beliefs

FGM was widely practised within different communities in Delta State. All the 26 participants articulated that the practice was mostly perpetuated among the Urhobos, Isoko, Kwale, Ijaw and Itsekiri ethnic groups in Delta State because of entrenched superstitious beliefs. The participants in this study described the diverse ages and times at which FGM was performed, and how the practice was perceived as a commitment and honour to the gods and girls and women who undergo FGM procedures.

4.2.1.1 Age and time of circumcision

In narrating their stories, some of the participants stated that the age at which girls undergo FGM procedures differed in Delta State depending on the ethnic community. They asserted that the timing of the procedure was usually flexible even within the communities, because of the significance of the ritual and the traditional beliefs in those settings. Some participants stated that in some communities within Delta State, the procedure was carried out at infancy, while some participants believed that it was done at puberty.

"The child is often circumcised before the 8th day of birth in my community" (P21-N/M).

"FGM is performed as a form of introductory rite into womanhood, so the child is circumcised when she reaches puberty'' (P14-N/M).

However, a segment of the participants observed that FGM was performed in adulthood, preferably during the early stages of pregnancy as it was

erroneously believed that it gave the woman enough time to heal before delivery.

> *"Circumcision is not done on young children in this part, it is usually done when the lady is about four to seven months pregnant because it gives the girl time to heal without infection before she delivers" (P18-CHEW).*

> *"Female genital mutilation has been in existence, and it is practised in this community though the time of cutting varies from community to community and from state to state. In some cases, the girl is circumcised when she is about to get married, some communities perform it when the girl becomes pregnant, and some are done on infants and young children. In this community, it is done during the woman's first pregnancy. So, FGM is performed when the woman is in her 7th month of pregnancy but among the Urhobos, which is my ethnic community it is done when the woman is about to get married'' (P22-N/M).*

4.2.1.2 Sense of honour

The participants in this study attributed the practice of FGM to respect for ancestors and deities, and the girls and their mothers. All 26 participants agreed that FGM was practiced because of superstitious beliefs in traditions and deities, and their abilities to protect the girl child from harm. They described the ritualistic divinations and presentations of the foreskin to the gods.

> *"Yes, it has to do with our culture. It is believed that when a female child is born, the clitoris should be cut and presented to the gods. So, now when female children are circumcised, they take the clitoris and present it to the gods as a form of dedication. That is, a way of dedicating that girl to their deity. It has to do with superstitious beliefs that*

the gods will protect the woman as she matures into womanhood." (P12-Dr).

FGM procedures were usually accompanied with traditional ceremonies performed in some communities to honour the girls that were undergoing the circumcision. The participants were from different ethnicities and communities within Delta State, and they told colourful and diverse stories regarding the circumcision rites.

" You know we the Urhobos believe in female genital mutilation which is called female circumcision. It is usually performed as a festive ceremony where young daughters are circumcised. After their circumcision, the girls are dressed beautifully and decorated with red chalk called "isele". The girls then walk round the community with pride and onlookers would greet and praise them for their beauty. So, it is seen as an important festival because it brings pride to mothers that their daughters have been circumcised" (P14-N/M).

"In Kwale community, a feast is prepared to honour the woman that has just been circumcised, the woman must go through the procedure in that community especially those women whose grandmothers and mother in laws believe that female children should be circumcised." (P7-NM).

"It is the traditional belief here in Olomu community that female children must be circumcised whether they agree or not, and the parents usually honour the girl with a feast... it is just the tradition of the people" (P25-CHEW).

The participants narratives suggested that the circumcision rite was an important event, and a significant part of the lives of girls and women in

these settings as they were honoured with gifts and embellished with expensive coral beads and trinkets. They reported that the mothers of cut girls exude pride and satisfaction for having successfully abided by the traditional prescriptions to prevent all superstitious implications that were associated with not cutting their daughters.

4.2.2 Superstitious consequences

The participants revealed that the practice of FGM was considered a cultural obligation and failure to practice it could result in severe consequences for the individual and the families involved. Most participants accentuated promiscuity, misfortunes, and death as the most feared superstitious consequences of not undergoing FGM within communities in Delta State.

4.2.2.1 Promiscuity

All the participants declared that if FGM was not performed on female children, they would grow up to have increased sexual libido, and this would result in them being promiscuous.

> *"Many communities here in Delta state practice FGM because there is a fear that the girl child will be a prostitute when she grows up. This is because they believe that if a woman is not circumcised, she will be promiscuous…that the clitoris is very sensitive, and it must be removed".*
>
> *(P2-N/M).*

> *"Some communities believe that if the clitoris is not removed the female child will seek for sex from different men… uncircumcised women usually have high sexual urges but if the clitoris is scraped off the sexual urges will be reduced" (P15-CHEW).*

These assertions indicated that the participants shared the belief that uncircumcised girls tend to be wayward, because they might solicit sexual pleasures from multiple men in the community with the aim of satisfying their sexual urges.

"To avoid any problems in future, the girl is circumcised as it is believed that it makes the woman less promiscuous and prevents her from moving from one man to another when she is married" (P12-Dr).

In some instances, this belief was inculcated into the children by their parents, though it is unclear if this was a strategy to indoctrinate or coax their daughters into undergoing the procedure. Emphasis has been added to the quote by P10 as supporting evidence for the preceding claim.

*"**According to our parents, female children are circumcised to prevent them from running after men and to stop their sexual desires… It is believed that if FGM is not done, the women will run after men**".*

(P10-CHEW).

4.2.2.2 Misfortunes

The studied HCPs believed that failure to practice FGM as stipulated by culture would bring series of punishments by the gods, and ill luck to the girls or women who refused to be cut, their families and the community.

"Some communities believe that it is taboo not to participate in FGM practices… It is believed to be the custom and anyone that does not participate in these customs will face the consequences of the gods".

(P1-CHEW).

"Young girls who are from communities where FGM is practiced, naturally want to be circumcised because there is this fear that the gods will cause something bad to happen" (P21-N/M).

Some participants declared that children born to uncircumcised mothers were often labelled and discriminated against within the community.

"The community people believe that if a pregnant woman delivers without being circumcised, the baby will be discriminated against and called a slave" (P8-N/M).

Most participants in this study articulated that death was one of the gravest superstitious repercussions of not practising FGM. It is commonly believed within most communities in Delta state that not adhering to the traditional requirements of circumcision could lead to the death of the child.

"I mean here in Olomu, it is believed that if a girl is not circumcised, her first born will die either during delivery or after delivery… that is just the belief" (P18-N/M).

"It is also a belief within communities that new-born babies die if their head touches the clitoris of an uncircumcised woman: Some communities believe that when the head of the baby touches the clitoris during delivery, the baby will die" (P22-N/M).

4.2.3 Personal experience

Three of the 26 participants disclosed that they had undergone FGM procedures. One of the participants narrated how close relatives coaxed her into undergoing the procedure at a young age.

> *"Like myself, how old was I when they circumcised me? I was in class two so I should be around 13years when I was circumcised. In my time, circumcision was performed as a rite of passage into maturity. My elder sister approached me to say, I was old enough to undergo the procedure and to get ready to be circumcised…they just brainwash you and before long you see yourself giving in. It was when I became a nurse that I found out that FGM was totally wrong" (P14-N/M).*

Another participant expressed sadness and anger over her circumcision and threatened legal actions against the people who performed the procedure on her.

> *"I mean personally… I was circumcised and each time I feel that part of my body I am not happy. I often tell my mum that I am unhappy with the person that circumcised me and if I find that person, I might get them arrested. I know that my clitoris was tempered with badly and each time I feel it… I am very sad and unhappy. My sister is the lucky one because she was not circumcised. My mum was scared that something will happen to my younger sister because she was not circumcised until one of my aunties told my mum that nothing will happen to my sister, and nothing did happen to her" (P2- N/M).*

Nevertheless, of the three participants, one declared that she was happy with her FGM status and revealed that she belonged to an FGM practising family and all the women in her family were circumcised.

> *"Our mothers and grandmothers were circumcised, I was circumcised, and my siblings were too, and our mothers carried out the circumcision by themselves. I do not mind that I am circumcised, I am comfortable with the way I am. Some women who were circumcised end up circumcising their own children, while some do not. For me, I did not but my siblings circumcised their daughters… It does not really matter anymore these days unlike before… It was an important practice when I was growing up" (P23-N/M).*

4.3 Professional influence

An excellent knowledge about the practice of FGM is crucial for the accurate identification of the different types of FGM and the associated complications (WHO, 2018a). This is to ensure that HCPs can correctly diagnose and provide a person-centred care for women with FGM who utilise PHC facilities (Federal Ministry of Health, 2013). For this reason, it was deemed important to explore participants' theoretical knowledge of FGM and how this affects the care that is provide for the affected women. Therefore, this theme unpacks participants' understanding of FGM practices under the subsequent subthemes.

4.3.1 Wearing of the skin

This section presents details of participants' knowledge and understanding of the practice of FGM. The participants in this study had an awareness of FGM but did not possess a comprehensive knowledge about FGM practices.

Only two (P25-CHEW and P11-N) of the twenty-six participants stated that FGM involved the cutting of part or all the female genitalia.

"My understanding is that it is a process in which the labia minora and majora and in some cases the clitoris is cut off" (P25-CHEW).

"Well… what I understand by female genital mutilation is that... it is the surgical cutting of the clitoris or other organs in the vulva'' (P11-N).

These two participants were somewhat knowledgeable about FGM, however the other participants had limited understanding and seemed uncertain about the details they were providing about FGM practices.

"I think FGM is the removal of the female part of the body, which is the clitoris… that is the female organ" (P16-N/M).

While most of the participants described the practice of FGM as they understood it in the cultural context, they used terms such as 'wearing away or wearing of' to describe FGM procedures.

"My understanding of female genital mutilation is that it is the wearing of the labia majora of the vulva" (P7-N/M).

"What I know is that female genital mutilation, which we know as female circumcision is the wearing of some part of the female genital organ, especially around the vulva'' (P21-N/M).

"Female genital mutilation is the cutting of part of the female reproductive system'' (P9-N/M).

However, no participant was able to accurately describe FGM as a practice that involved the partial or total removal of the external female genitalia, or other injury to the female genital organs for non-therapeutic reasons (WHO, 2022b).

4.3.2 Different types of FGM

This subtheme describes participants' awareness and understanding of the various forms of FGM. Only one participant (P5-N/M) could partially describe three of the four types of FGM.

"I know that type one involves the removal of only the clitoris or little part of the clitoris, Type two, may involve the removal of the clitoris and part of the labia minora. Then type 3 and 4 are the worse types and it may involve the removal of all the clitoris, labia minora and the labia majora" (P5-N/M).

A few of the participants knew that there were different types of FGM but could not correctly describe the types that they had identified.

"There are three types of FGM. First, is the total removal of the clitoris which is clitoridectomy. Then infibulation is where the labia majora and part of the labia minora is removed and there is the unclassified type which involves the total removal of all the genital organ. In this case, they scrape off everything, the clitoris, the labia minora and majora leaving just a plain vulva which is hazardous and criminal. Also, after the circumcision the circumciser sometimes puts herbs on the cut to help the healing

process. Or they would suture the vagina orifice leaving a small opening where blood can pass through during menses. I doubt that they consider childbirth when carrying out this procedure" (P14-N/M).

Some of the participants mixed up the different types of FGM as they could describe some types but did not know the exact type that they were referring to.

"There is one type that includes the cutting of the clitoris leaving the majora and minora intact… while in some cases, the clitoris and the minora is cut off and some types may involve both the clitoris, the minora and the majora. But to be truthful, I do not know which type is type one or four. I do not know the classification" (P21-N/M).

Nonetheless, almost all the participants in this study had poor knowledge of the four types of FGM as most were unable to describe any type of FGM, while some stated that they have forgotten.

"Well, it is not a subject that I have really looked at properly, but I know we have different types, partial and total and we have type 1, 2, 3 and so on, depending on the degree of removal of the clitoris" (P12-Dr).

"I think FGM is classified into four, but I cannot describe the four types because it has been a long time I was taught" (P3-CHEW).

"Types? I do not know how FGM is classified…to be frank I cannot remember" (P20-CHEW).

4.3.3 Dangers of FGM

This section explored participants' understanding of the complications of FGM procedures. All the participants in this study indicated and acknowledged that FGM can cause serious problems. They were able to reference more than one complication of FGM. The complications were categorised as physical and psychosocial problems, and these will be unpacked in the following sections.

4.3.3.1 Physical problems

Physical problems in this context refers to complications that visibly affects the body of women who had undergone FGM procedures. The majority of the participants indicated infection and bleeding as the most common physical problems experienced by women with FGM. Indeed, one participant in describing these known complications stated that FGM procedures are mostly carried out by untrained persons who do not practice aseptic techniques, and this predisposes women to infections.

> *"Let us start from infection, some of the people involved in female circumcision are not trained personnel hence they use materials that are not sterile such as razor blades and all kinds of things for the procedure and that can lead to infection" (P12-Dr).*

Some participants cited some obstetric complications that could occur as a result of FGM.

> *"It can also cause fetal asphyxia during delivery because of the narrowness and loss of elasticity of the vulva area".*
>
> *(P6-M).*

Other physical complications mentioned by the participants included infertility, anaemia, fistulas, pain, and risk for caesarean section.

"There are a lot of health consequences including pain, imagine the clitoris being cut without anaesthetics, the pain will be excruciating" (P21-N/M).

"For instance, there was a pregnant woman with severe FGM who was unable to deliver normally because the vulva has lost its elasticity, so she had to undergo an emergency caesarean section" (P26-N/M).

In reference to FGM complications that occurred among pregnant women, participants cited bleeding and multiple lacerations as the gravest.

"I know that in most cases the procedure is carried out on pregnant women and that is risky because during pregnancy, the veins are prominent and circumcising at this time will cause bleeding that could lead to blood transfusion and other complications" (P23-N/M).

"Then the long-term complication could be very severe depending on the type. For instance, the type that involves the removal of the clitoris and narrowing of the vagina orifice could hinder vagina delivery because the baby will not be able to pass through and this could result in multiple lacerations" (P9-N/M).

Some participants also declared that uncertified healthcare providers usually performed FGM procedures on infants without much care and these babies end up with complications.

"Traditional birth attendants usually perform the worse types of FGM and at the end the babies will be rushed to the health centres bleeding profusely amid other complications" (P7-N/M).

4.3.3.2 Psychosocial problems

In this context, psychosocial problems relate to issues that affect the individuals' mental, emotional, and social health. Some participants articulated that FGM causes devastating psychosocial issues. They mentioned that women who had undergone FGM feel stigmatised because the normal anatomy of their private part has been altered.

"Any woman that has been circumcised always feel branded for life. This is because each time they feel themselves, it is a reminder that their genital organ has been cut and do not want other people to see that part of their body" (P11-N).

It was also believed that FGM procedures led to marital problems resulting from the women's inability to fulfil their sexual duties.

"FGM leads to broken marriages because the men are unable to deal with the sexual difficulties experienced by these women. So, they divorce their wives and proceed to marry someone else. Some women are not married today because of circumcision while others got married but are now divorced because the men got tired of their sexual excuses" (P4-CHEW).

The participants cited painful coitus, reduced sexual libido and lack of sexual gratification as some psychosocial problems associated with FGM practices.

"Female circumcision can lead to problems in the marriage such as separation and divorce. This is because the man does not receive the sexual response that he desires from the woman. In such instance, he can decide to go elsewhere to seek for that affection. The men would say that the women do not show interest in sexual activities due to loss of sensation around the clitoris… so there is frigidity and lack of sexual desires'' (P2N/M).

"When a lady is circumcised and the prepuce is cut off, during healing there is stricture which causes pain during sexual intercourse, and she does not have any sexual feeling because the clitoris has been removed. So, there is no pleasure from engaging in sexual intercourse. That is why some of these women marry out of necessity and to make babies but not because of any sexual satisfaction''(P14-N/M).

4.3.4 Sources of information

The 26 participants in this study represents three cadres of HCPs in Nigeria, which are doctors, nurses/midwives, and CHEW. These HCPs acquire their professional education from higher institutions such as the university, schools of nursing and midwifery and schools of health technology. The practice of FGM and its impact are now part of the teaching curricula for nurses, doctors, and other healthcare professionals in Nigeria (Mberu, 2017;Umar and Oche, 2014). These participants confirmed that they

received lessons on FGM in their respective training schools but cited other avenues through which information about FGM was acquired. Therefore, this subtheme included the sources from which information about FGM was obtained by the participants, and this has been classified as formal and informal sources. Formal sources in this circumstance means information derived from taught programmes and other formal learning approaches, while informal sources included self-study, community, and clinical practice.

4.3.4.1 Formal sources

Most of the participants articulated that they were taught about FGM practices in school.

> *"Uhm… we were taught a little about FGM in schools but not really in details" (P11-N).*

> *"When I was a student CHEW, we were taught that severe complications could arise from female circumcision but that was a long time ago'' (P15-CHEW).*

Though the participants stated that they had lessons on FGM in school, some revealed that they also obtained information about FGM from health talks.

> *"We were taught about FGM back then in school, but I recently heard about FGM again when the researcher came to give health talk about FGM in the facility where I work" (P5-N/M).*

"I think we were taught in school during my training as a CHEW but occasionally, not very often people come to the health centre to talk about FGM'' (P3-CHEW).

A few of the participants mentioned that they acquired information about FGM from seminars that were organised by the Delta State Ministry of Health as part of the professional development programmes.

"We are sometimes called to attend seminars, and on few occasions…they have given lectures on FGM practices'' (P1-CHEW).

Interestingly, some participants revealed that information about FGM was obtained through professional education and clinical experience as well as being members of an FGM practising community.

"I am a trained medical practitioner, so I have that knowledge first from school. I also have experience from being in the health system and then through experience from growing up in areas where FGM is practised" (P13-Dr).

4.3.4.2 Informal sources

Notably, a small number of the participants, mainly participants P16-N/M, P12-Dr and P14-N/M stated that they had conducted their own self-directed learning to understand and gain knowledge about FGM practices, and this is because some of the participants were involved in campaigns against FGM as they themselves were cut.

"I get all information about FGM on the internet…I use the internet on my phone. I read and print some of the information out so I can share with other people in my community and within the PHC facilities in my locality" (P14-N/M).

"I gathered information about female circumcision from books and the internet" (P12-Dr).

However, some participants did acknowledge that they gained knowledge about FGM from the media.

"In those days we usually hear jingles on the radio and television about the health risks of FGM but that was many years ago" (P3-CHEW).

Some of the participants acquired information about FGM from informal conversations with the indigenes within the community where they practised as HCPs. For example, one participant stated that there was a working relationship between the PHC and the community which made it possible to gather useful information regarding FGM practices in the community.

"There is a synergy between us and the community and because we are community workers, we get our information about FGM from the communities... we have informants in the community. So, when we have issues relating to FGM... generally... we are informed because most of our PHCs are in communities" (P13-Dr).

Other participants corroborated this assertion as they revealed that, speaking the same language as the indigenes served as a basis for trust and acceptance which made it easier to obtain information about FGM and other activities within the community.

"I get information about female circumcision from the community because I understand the language that is spoken in this community, and they have accepted me as one of them. That is why during my discussions with them, they tell me whatever is going on in the community and about their beliefs and practices. So, I learn as I communicate with them" (P25-CHEW).

"Hmmm you know because I work in the village, after a time you are considered as part of the community and the people will tell you anything that is going on in the community" (P24- N/M).

Additionally, clinical experience was another source of knowledge for these participants as some participants asserted that they had gained useful information about FGM during their practice as students and as certified HCPs.

"I mostly get information and knowledge about FGM from experience because the more I meet these women the more I see different types of FGM and know about the practice" (P7-N/M).

"During my years of practice as a Midwife… I gained some experience and knowledge about FGM… just by attending to some of the women and chatting with them'' (P6-M).

"I came across children and women that had undergone FGM during my clinical placement as a student and I learnt from these exposures" (P20-CHEW).

4.4 Summary

This chapter focused on how participants in this study understood the practice of FGM. The participants' narratives indicated that their knowledge of FGM was obtained through interactions within their sociocultural settings and professional practice.

The participants recounted their stories with authority and demonstrated diverse understanding, knowledge, and beliefs about FGM practices, which was evidently influenced by their background as members of communities where FGM is practised. They described FGM in a validatory manner as they perceived the practice as an obligatory entrenched cultural practice that is practiced based on existing superstitious beliefs. The participants believed that not practising FGM could have dire consequences that included death of infants, misfortunes, and promiscuity. A few participants in this study revealed that they had undergone FGM procedures and were unhappy with their FGM status, except one participant who declared that she was comfortable with being circumcised.

Whilst the participants under study displayed a considerable understanding of FGM practices from the sociocultural perspective, their professional knowledge of FGM was limited. All 26 participants declared that they were educated about FGM practices in their professional training schools, and some obtained additional information from private reading and clinical experiences. However almost all the participants were unable to accurately

provide details about FGM and its typology, although they were knowledgeable about the physical and psychosocial problems associated with FGM practices.

The next chapter will further present and describe participants' encounters with FGM in clinical practice, including their experiences and the challenges of providing care for women with FGM in PHC settings. It also presents the themes exposed about the findings relating to participants' feelings and the continuation of FGM practices, and their perceived role in preventing FGM in Delta State and Nigeria in general.

CHAPTER FIVE: ENCOUNTERS WITH FGM IN THE CLINICAL SETTING: Experiences and challenges of providing care for women with FGM.

5.0 Introduction

This chapter is based on HCPs' experiences of FGM in the clinical setting. It provides details about participants' involvements in FGM activities and their perceptions about the medicalisation of FGM. It presents rich and comprehensive descriptions of the care that was provided for women with FGM during parturition, and the several challenges encountered by the participants in this process. The chapter further identifies and explores the factors affecting the care that is delivered to women with FGM who accessed healthcare services in PHC facilities.

5.1 Encountering FGM in clinical practice

This theme describes participants' encounters with women living with FGM who accessed the PCH facilities for healthcare services that includes pre- and post-natal care. Their accounts indicated that most of the participants who took part in this study had cared for women with FGM. The participants observed that most women living with FGM do not seek help for FGM related issues. Some of the participants revealed that they had recently been requested to perform FGM procedures, while some had performed FGM in the past. The majority of the participants expressed negative opinions about HCPs who performed FGM procedures as they discussed their involvements in the practice and the reasons for the medicalisation of FGM. This theme also provides participants' narratives of the support they render to women with FGM during parturition and the difficulties they encountered on such occasions.

5.1.1 Clinical experience

A majority of the participants in this study had met women with FGM during their clinical career. For the majority these encounters occurred when women were in labour. For instance, one participant revealed that they inadvertently discovered that a client had undergone FGM procedure during a routine examination.

> *"I have seen women with FGM during labour and delivery process. It is during vaginal examination that I usually discover that these women's external genitalia look abnormal with visible scarification marks of circumcision" (P6-M).*

> *"In most cases, we see them during labour when we do vaginal examination" (P19-N/M)*

This account was corroborated by other participants who asserted that women with FGM were predominantly seen when accessing parturition services.

> *"I have seen women with severe forms of FGM during delivery" (P15-CHEW)*

The participants that had cared for women with FGM mentioned that some of these occasions occurred in 2019, that is within the same year that the data for this study was collected. The majority of the participants stated that they had encountered several women and young girls with FGM, which further confirmed that FGM was commonly practised within communities in Delta State.

> *"So many circumcised women come to this PHC facility to deliver their babies" (P4-CHEW).*

> *"I have seen about 6 women with FGM. At the beginning of this year, I took delivery of one woman whose clitoris had been cut" (P21-N/M)*

"This year, I have seen at least two women with FGM who came for delivery, and during my clinical experience as a student I also came across children and women that had undergone FGM" (P20-CHEW).

Based on participants' narratives, it was observed that all 26 participants in this study were members of communities where FGM was practised traditionally.

"Female circumcision is part of our communities in this state… most communities practice FGM especially among the Urhobos, Anioma, Ijaw and Isoko ethnic groups… it is part of our culture" (P13-Dr).

Despite this, nearly half of them (11) maintained that they had neither encountered women with FGM in the clinical setting nor witnessed FGM procedures.

"Actually, I have not seen anyone done…I do not have any personal experience as I have not cared for any woman who had undergone the procedure" (P26-N/M)

These assertions could be due to participants' inability to identify the different types of FGM when they came across them, because of the limited knowledge of FGM among HCPs in these settings.

Though, some participants observed that most women who had undergone FGM did not seek help for FGM related challenges. They believed that women with FGM would only visit healthcare facilities when they experienced serious health problems resulting from the procedure.

"The women in this community do not come to the PHC facility for FGM related issues, when they come to seek help then we can treat such cases but so far, we have not had complains of FGM related complicated" (P11-N).

"Nobody has come to officially inform us in this health centre that they were experiencing problems that were related to FGM" (P4-CHEW).

Indeed, some participants revealed that the majority of the women in the community sought the services of TBAs for their healthcare challenges.

"Most of the women who bring their children here for immunisation, did not deliver in the health centre, they delivered at home using the services of the TBAs" (P10-CHEW).

5.1.2 Medicalisation of FGM

As stated earlier in the literature review chapter (See Chapter two), the medicalisation of FGM simply describes situations where HCPs performed or practised FGM in any healthcare settings, at home or elsewhere. In this doctoral study, the participants discussed HCPs involvements in FGM practices including requests for FGM, reasons for medicalisation and their perceptions about the medicalisation of FGM.

5.1.2.1 Request for FGM

Nearly half (n=12) of the participants had recently been asked by parents and sometimes a mother-in-law to perform FGM procedures on new-born babies, and in some instances on young female adults and pregnant women.

"One of my family friends called me early this year saying he wanted to circumcise his child, I thought it was a male child, so I asked him to bring the baby to the clinic, but he called me later to say it was a female child… I told him that I do not perform circumcision on girls only boys" (P2-N/M).

"Imagine few months ago, a woman came to the health centre that she wanted her baby to be circumcised, we took the baby from her thinking it was a boy, but when we

removed the clothing, we discovered that the baby was a girl" (P21-N/M)

The participants mentioned that in some cases, parents travelled from urban areas to the PHC facilities in rural communities to request FGM. This could be as a result of HCPs in urban areas refusing to conduct FGM procedures. It could also be that the parents who travelled from urban areas felt that since FGM was an accepted cultural practice in rural communities, HCPs in these settings may be more inclined to accept their request for FGM.

"Sometime this year, a woman who was a native of this community but lives in Warri, brought two of her daughters to the village for circumcision… I counselled her about the side effects of circumcision, and she left with the children in anger… but I do not know if she went somewhere else to do it" (P22-N/M).

Some of the participants declared that they often discouraged these family members from practising FGM, but in some instances the parents were adamant on having the procedure done.

"When parents come to request FGM, we counsel them against the practice but even when you tell them that the practice is wrong, they insist that you perform it" (P13-Dr)

A majority of the participants revealed that the parents or relatives would sometimes request HCPs to make a small incision on the clitoris indicating that circumcision had been performed.

"Sometimes they say just put a small cut there… to show that my daughter has been circumcised" (P15-CHEW).

The participants revealed that in extreme circumstances, family members who were insistent on pursuing FGM were threatened with the existing FGM law in Delta State. This was described as an effective strategy for deterring parents and other relatives from practising FGM due to fear of the repercussions.

> *"We usually threaten people who come to request for female circumcision with the law, we tell them that they will be arrested and handed over to the government… I think this frightens them away and puts them off asking us to perform circumcision" (P7-N/M).*

Participants who had encountered parents requesting FGM asserted that, in some instances they had followed up on relatives to ensure that they had not proceeded to patronise other HCPs or TBAs for the procedure. However, on some occasions the participants were unable to undertake longer term follow up.

> *"One old lady brought her grandchild for circumcision and after we counselled her against it, we informed her that we will monitor the child because she usually brings her to the health centre for immunisation… but since then we have been examining the baby and she has not been circumcised" (P7-N/M)*

> *"Well, we educated the mother about the dangers of cutting her daughter, but we do not know if she went somewhere else to carry out the procedure because there was no follow up on our part" (P21-N/M)*

5.1.2.2 Involvements in the medicalisation of FGM

All participants were encouraged through the interview technique, to share their experiences and feelings regarding FGM practices within the PHC system. This generated mixed emotions among the participants as some of them declared that HCPs do not perform FGM procedures and had not

witnessed the procedure being performed by any trained healthcare professional or within government healthcare establishments

"For me, I do not think that health professionals are practising female circumcision because I have worked in many healthcare centres, and I have not seen anybody performing it" (P24-N/M).

"Any health professional who is certified will not engage in female circumcision" (P20-CHEW)

"I do not think there is any hospital that you will take a girl to for circumcision, and the procedure will be carried out" (P6-M).

However, other participants demonstrated contrasting opinions as they declared that FGM was still practised among HCPs in clinical settings.

"I saw one of the matrons performing female circumcision in a healthcare facility I used to work, but I cannot remember which one" (P23-N/M).

"FGM is mostly seen and practised in primary healthcare centres" (P7-N/M)

One participant revealed that they had performed FGM procedures in the past when the practice was not concealed or prohibited.

"When I was working in Ndokwa area, then... there were no laws on female circumcision and people practised it openly A child was brought to me for circumcision…I nicked the labia majora a little enough for the cut to bleed so that the parents will think that the child has been circumcised because if I don't do that, they will take the child to other places where the baby's clitoris will be completely damaged" (P22-N/M).

The participant recounted their experience and the challenges they encountered for agreeing to FGM requests. They stated that the parents

were dissatisfied with the outcome of the procedure and described them to other members of the community as incompetent.

> *"When the parents of one of the babies I cut discovered that I did not cut the clitoris, the mother brought another child with a severe form of circumcision and told me to cut her child the same way the other baby was cut… when I refused, she started spreading rumours in the community that I don't know my work as a nurse" (P22-N/M)*

5.1.2.3 Reasons for the medicalisation of FGM

Participants offered a number of reasons for the perceived medicalisation of FGM among HCPs in these settings. They observed that HCPs mostly participated in FGM practices for monetary benefits and to discourage families and communities from patronising TBAs. Some participants added that making FGM a safer practice, and ignorance, were also reasons for the medicalisation of FGM.

5.1.2.3.1 Monetary gain

Some participants asserted that financial benefits could be one of the motivating factors for HCPs involvements in FGM practices.

> *"Sometimes they perform the procedure because of material gain… just to get money… that is why they perform female circumcision" (P12-Dr).*

Some participants mentioned that the monetary value for performing FGM procedures was between N3500 (Naira) to N5000 among HCPs in PHC facilities, which was equivalent to £6.19 to £8.84.

> *"Most health professionals do it because of money, because they pay huge amount of money to the health workers for circumcision. Some of them know the implications, but they see it as an avenue to make money because they usually charge about N5000.00" (P15-CHEW).*

5.1.2.3.2 Discouraging TBAs FGM services

The participants in this study stated that some HCPs performed FGM procedures in these settings to deter practising communities from requesting the procedure from TBAs. This is because they believed that TBAs performed extensive cutting such as types two and three of FGM, which could lead to serious health problems.

> *"Most of the people practising female circumcision now do not go to professionals for it, they go to quacks and TBAs for the circumcision because health workers no longer perform it, so they patronise quacks and TBAs" (P23-N/M).*

> *"Some women have complications especially those performed by TBAs, because they usually do the severe forms of circumcision where all the organs in the female genitalia would be totally scraped off" (P24-N/M).*

Another participant described the encounter they had with a colleague who performed FGM procedures, and the reasons they gave for rendering FGM services.

> *"I had a conversation with a colleague who informed me that, they do perform FGM in their healthcare centre to help the community people. She said that the villagers would ask the TBAs to perform the circumcision if they refused to. So, when the villagers come to request for female circumcision from them, some of the nurses used forceps to cut off a small part of the clitoris so that the parents or family members would think that the babies had been circumcised" (P7-N/M).*

Similar stories were told by other participants regarding TBAs FGM activities and HCPs opting to perform FGM as a strategy for reducing FGM activities among TBAs.

"Yes, I think most HCPs put a cut on the clitoris or labia majora or minora. There was a case that happened at Okpare Olomu PHC of a woman who wanted the nurse to circumcise her daughter, but the nurse informed her that female circumcision was no longer accepted. The woman told the nurse that she would take the daughter to the TBAs for the circumcision. So, to avoid that the nurse took the daughter into the treatment room and put an incision on the labia minora. When the incision site started bleeding, the mother became convinced that the daughter had been circumcised" (P18-CHEW).

In addition, some participants declared that FGM would be safer if performed by healthcare personnel, as it was believed that TBAs often used unsafe and unhygienic techniques.

"It will reduce health complications… at least you will have skilled persons to do it and they would follow sterile procedures so that all the associated complications will be reduced" (P13-Dr).

"I think if health professionals are allowed to carry out circumcision, infection and the severe removal of the clitoris will be avoided because we have more knowledge than the TBAs" (P18-CHEW).

Though most participants cited financial gain and discouraging the utilisation of TBAs for FGM procedures as reasons for the medicalisation of FGM, there were participants who indicated that some HCPs performed FGM procedures out of sheer ignorance. They observed that these group of HCPs were oblivious to the dangers associated with the practice of FGM and lacked appropriate education and information about the practice.

"Some health workers still perform FGM without knowing the dangers of the practice (P4-CHEW).

"Some healthcare professionals carry out circumcision because they are not well informed about the practice" (P12-Dr).

5.1.3 Support for women during parturition

This subtheme describes participants' experiences of taking deliveries of women with FGM, the strategies they employed to ensure that the deliveries were less painful, and some of the challenges they encountered in this process. The participants' stories were similar across all the eleven PHC settings used for this study, the only significant difference was that some participants in these settings, irrespective of their cadre, had more frequent encounters with women who had FGM and thus had more experiences in terms of delivery.

5.1.3.1 Tug of war

Some participants shared their experiences of providing labour and delivery related care for women living with FGM. They described the process as painful for the women and difficult for the health care provider.

"Well, I saw a woman whose clitoris was cut… during delivery she had a tear because the vaginal opening was small due to the circumcision, so the baby forced itself out and this resulted in a tear. The woman started bleeding… we tried to stop the bleeding and sutured the tear afterwards, but it was a painful experience. After the whole process, I discussed the situation with her and reassured her" (P21-N/M).

"Actually, I have not had many experiences but in the case of the woman whose clitoris was completely removed…there was a tear because the normal function of the vaginal wall has been tempered with. So, there was no elasticity or expansion to expel the baby…the circumcision scar broke and burst open as the baby was struggling to come out…this caused multiply tears and bleeding and for each delivery this would occur, and we usually stitched it up on every delivery….it is not a good experience" (P22-N/M).

The participants revealed that delivering women with FGM was challenging. Their shared experiences suggested that taking delivery of women with FGM was difficult, and the participants recognised that these group of women required specialist care that is tailored to meet individual needs, especially during labour and delivery. However, these participants have not received the necessary training to provide such care.

> *"The last delivery I took the woman was circumcised…when I saw her vulva, I knew she has been cut because the clitoris did not look normal…as I am not trained to provide FGM specific care…I just managed the deliver as best as I could though there was a little tear but there was no bleeding…but it was a very difficult delivery and a problem for us" (P20-CHEW)*

Some of the participants described in great details how they struggled to deliver women with FGM, and the approaches they had applied to ensure that the delivery sessions were less exhausting, and with minimal complications and pains for the women.

> *"I had seen a case of a woman with FGM when I was working in another health centre…the lady came for delivery and during labour the head of the baby was in the perineum, but it was a tug of war to push the baby out because the scar from the circumcision was blocking the vaginal opening. We tried to give episiotomy to enable her to push the baby out, but it was not easy… with God on our side we were able to deliver the baby…this is one experience I always remembered" (P8-N/M).*

Another participant who had many experiences of delivering women with FGM described their encounters with FGM in the delivery room.

> *"There was another woman who came in during labour, she was circumcised and had varicose veins around her*

vagina… I was unfortunate to be on duty, but I was ready for the worse… and because she was circumcised, the vagina opening was very tight… I had no option but to cut and use artery forceps to clip the varicose vein. It was after that, that we were able to deliver the baby. So, it is not easy for us to care for these women and this lady came in at night…there was no place to refer her to at that time. Sometimes, before we give the episiotomy cut, we call the husband… if he is present to come and look at how narrow the vaginal opening was before cutting. In some cases, the circumcision is cut round… so there is no beginning and end. The scar is not in one place…how I wish we will be lucky to have one come in for delivery, so you would see what I am talking about. Like I told you, in some cases the circumcision is severe, there is no organ in the vulva just a small hole… like the woman I told you about, I think it was chemical that was used…there was no hair growing around the area. They must have used chemicals to burn off the entire area, so you can see the scar…it was very pronounced… and because we were giving a bilateral cut, the cut must pass through the circumcision scar. Sometimes too, the vaginal gapes open on its own as the baby passes through…in such cases the bleeding is usually mild…If on examination we think that the woman just needs a little cut, we would allow the baby to give the tear" (P7-N/M).

5.1.3.2 Approaches to alleviate delivery

The participants revealed that due to the difficult and enervating process of birthing women with FGM, they sometimes provided episiotomies and used lubricants as strategies to facilitate an uncomplicated delivery process.

"It is usually not easy to deliver women who had been circumcised because it takes longer time as the scar tissues do not stretch like the normal tissue… so it takes more time, but we try our best to guide the perineum to ensure that there is no tear, but if we assess the situation and that approach does not help, then you give episiotomy" (P14-N/M).

In some instances, episiotomy was administered to prevent foetal distress.

"Well, if the baby is finding it difficult to come out…we just give episiotomy to prevent the baby from asphyxiating and after the baby is delivered, we repair the lacerations as best as we can" (P22-N/M).

Some participants declared that the women had normal deliveries in some cases, but this depends on the type of FGM that was performed.

"When we are faced with such cases… we give episiotomy but some of these women push and deliver on their own without episiotomy. In the case where the circumcision is a severe one, we give episiotomy and after the delivery we educate the women on how they can care for the episiotomy cut, but we have not encountered a very severe case" (P19-N/M).

However, in situations where the women were unable to push out the baby due to strictures around the vulva, they had applied lubricants on the perineum as they believed that it would make the baby slip out without having to use the episiotomy method.

"In such cases, we use mentholated balm or oil to swab the inside area… as the woman is pushing…then we guide the perineum. If there is still difficulty, then we give the woman a cut so that the baby can come out… to save the baby. Then we stitch the cut afterwards. Sometimes during these deliveries, the place that was circumcised would tear by itself… it will burst open by itself… this combined with the suturing process often cause the woman so much pain" (P4-CHEW).

"When there is delay and the child is struggling to come out, we manage the situation by using gel or olive oil to

make the vaginal opening to be greasy as it has been tampered with… this aids the delivery" (P3-CHEW).

Overall, the participants believed that there was only so much they could do to support women with FGM during parturition.

"The only thing we can do to help these women during birthing is to guide the perineum to avoid further complications…give episiotomy or use olive oil to lubricate the vulva to enable the baby slide out to ease delivery" (P20-CHEW).

5.1.3.3 Barriers to effective parturition

The participants highlighted some of the challenges that they encountered during the delivery of women with FGM to include-, accidental diagnosis and referral.

5.1.3.3.1 Accidental diagnosis

Some participants expressed their frustrations of not having prior knowledge of the women's FGM status before the time of delivery. They observed that whilst women with FGM do not seek medical help, they did come to register for ante natal clinic. However, there were limitations as to what questions they could ask the pregnant women during clerking. This is because the ante natal card has specific questions such as previous medical history, pregnancy history and operations history. Operation means surgery and in the Nigerian context, it refers to any surgical procedures including appendectomy, caesarean section and so on. Since FGM was generally not considered a surgical procedure amongst Nigerians, there would be no expectation for it to be included or mentioned as a past operation history. Also, the women with FGM may lack the awareness about the consequences for delivery and therefore considered their FGM status not worth mentioning.

"The issue is that we only find out during the delivery that the woman had undergone FGM, because the antenatal form does not include questions about past female circumcision history. There are other questions relating to past medical and surgical history but there are none about circumcision history" (P22-N/M).

"It is during delivery that we discover that the women had been circumcised because if they did not take off their clothes, how would we know that they have been circumcised" (P20-CHEW).

The lack of prior knowledge made it difficult for the participants to ascertain which woman had FGM and could be at risk of complications during delivery, or what additional support could be provided in such instances.

" If we know that a woman had undergone female genital mutilation and the type, it will help us to better prepare for her delivery" (P22-N/M).

5.1.3.3.2 Referral

The participants stated that on some occasions they had referred women with FGM to secondary level care facilities because they were unable to clinically manage complex cases of FGM.

"I had a patient who came for delivery but on examination I discovered that the clitoris was removed, and this prolonged the labour because the baby was finding it difficult to come out due to the narrowing of the vaginal opening… I just had to refer the woman and she was booked for a caesarean section" (P12-Dr).

Sometimes the participants referred these women because they feared the complications that could arise if they carried on with the delivery.

"We had a case of a woman that had multiple tears during delivery because of the narrowness of the vagina orifice because of the circumcision, the tear was so much it got to her anus, and she was bleeding profusely we could not repair it here at the health centre, so we had to refer her" (P7-N/M).

Aside from the fear of possible complications, the participants also referred women with FGM because PHC facilities provided limited health care services.

"Immediately I discover that a woman has been circumcised and there is risk of complications, I just refer instantly to a secondary facility because they have the manpower and equipment to help the woman at that level… because of the terrain that we are in, if I take the delivery and the woman starts bleeding… I cannot transfuse here…and I do not have an ambulance to transport the woman… so, I quickly refer" (P24-N/M).

"We usually referred the women to secondary facilities where experienced gynaecologists will care for them" (P26-N/M).

The participants revealed two main issues that they experienced with referral, the first issue was that the secondary and tertiary facilities usually rejected these women based on limited healthcare resources, and as such there was no appropriate follow up care.

"The general hospitals should accept these cases because that is a major issue that we are having. When you refer these women to the secondary level of care, they are usually not accepted due to logistic reasons… and the Federal Medical Centre (FMC) is the only tertiary healthcare

facility in the locality, when these women get there…there are usually no beds. This cuts off the chain of referral and prevents us from doing proper follow up, because the woman may go to any private hospital, and we will not be able to track or follow up. Sometimes we can't access the address they have written down. So, the secondary healthcare facility should accept these cases when we refer them" (P7-N/M).

The second issue was that the women and their relatives expressed fear and unhappiness about referrals. It was revealed that the women would sometimes not accept the referral because they believed that the reason for the referral was that their health condition was too severe to be managed at the PHC level, and this usually caused fear and anxiety to the service users and their families.

"Even when you refer these women to the secondary level of care, they are usually not happy, they would worry that their situation was very bad that was why they were being referred" (P18-CHEW).

In addition, some of the women preferred to birth their babies in a familiar setting not minding the possible complications.

"Referral is usually not easy because the women and their families do not like the idea of being referred…they would rather deliver in the local PHC facility and with healthcare providers that they were used to" (P25-CHEW).

"We usually explain to them that we do not have the equipment or manpower to help them at the PHC level, and it was for their best interest that we refer them to the secondary health facility" (P20-CHEW).

5.2 Clinical service development for the care of FGM

This theme highlights some of the institutional challenges encountered by the participants within the PHC setting. The participants declared that there was a shortage of resources in the PHC system to adequately support and meet the needs of the women with FGM. It was observed that the participants were eager and interested in supporting the women as they themselves acknowledged the difficulties of caring for the women, and the importance of meeting their parturition needs. The participants believed that if empowered with the required skills and resources, they would be better able to provide these women with the quality care that they needed in terms of the complications arising from FGM, pre and postnatal care and other psychosocial needs. They mentioned some factors that affect the care that was provided to the women with FGM who access PHC services, and these will be unpacked in the following sections.

5.2.1 Policies and procedures

All the participants declared that there were no existing guidelines on the management of FGM. They indicated that there was no written plan of action or set of instructions that described the approved and recommended steps to follow when faced with FGM complications. Some of the participants did not know what to do when they encountered women with FGM and declared that the care for the women will be easier if they had a protocol on FGM in place.

> *"We do not have any guidelines, we use experience… I feel that we need guidelines to follow to make the care process easy" (P25-CHEW).*

Some participants had used their initiative and relied on years of experience to manage some challenging situations, especially as it relates to labour and deliver services.

"No, there is no guideline, we just use experience and common sense to care for the women" (P20-CHEW)

"We rely on our experiences to care for these women, and I think it will be helpful to have a guideline in place to direct what we do including diagnosis, treatment-, and management of the women that had been circumcised" (P5-N/M).

Some participants believed that a guide to practice would empower them to confidently deliver some evidence-based care to these women at the community level.

"There are no guidelines on FGM…I think a guideline should be provided to direct the care we give, so that when we are faced with such cases, we can meet some of their care needs at the PHC level before referring the women to the secondary level if the need arises" (P17-CHEW).

In corroboration of the participants' claims, it was observed that the PHC system in Delta State did not have a policy on FGM; this could indicate that FGM is not considered as a health priority within the PHC system. It could also imply that the decision makers at the state level of the PHC system were unaware of the challenges that were occurring at the grass roots. At the time of this study's data collection, the participants mainly cared for the women based on their personal judgement and years of experience and made referrals when they felt unable to clinically deal with any complex situation.

5.2.2 Professional training on FGM

The participants expressed disappointment over the lack of professional training and development programs within the PHC system. They declared that they had not received any professional trainings on how to care for women with FGM in their years as HCPs.

"I have not attended any trainings on FGM since I started practising as a nurse" (P11-N).

"I have not attended any training on FGM and no training on FGM has been organised. We have not been trained particularly on FGM, so it is difficult to know what to do when these cases present. I think that health professionals should be trained on how to care for women who had undergone FGM. The government should organise trainings and professional courses on FGM" (P2-N/M).

Some participants believed that professional training on FGM was vital as it would broaden their understanding of the practice and provide them with the skills needed to manage FGM cases.

"Well, we need training. So that we can recognise the different types of FGM when they present and be able to provide care for women in such instances. The training will also equip us to do community outreach and advocacy on FGM…So that when we give health talk on FGM, it will be based on knowledge and understanding" (P10-CHEW).

"Refresher training for PHC professionals is very important… so that they will be better equipped to handle issues relating to FGM. Knowledge and skills… We need knowledge for counselling and skills if there are issues that are within the body of PHC activities then we can also manage them" (P13-Dr).

The participants articulated that they were unhappy with how professional training within the PHC system was conducted. They observed that there was favouritism in terms of training.

"I have not had any training on FGM… and another problem is the idea of selecting only one person from each PHC facility for training, this is wrong because care is given by all the healthcare professionals that are working in the PHC, so the idea of selecting one from each PHC, limits the other people... for example, picking nurses for training and leaving CHEWs. So, when the nurses are not around who

does the work? CHEWs… so we all need to be trained not just a selected few" (P20-CHEW).

The dissatisfaction over professional training was expressed by other participants who declared that training programmes within the PHC setting were limited, unevenly distributed, and targeted at the wrong group of HCPs.

"I have not attended any training on female circumcision. Even when I was a health assistant, they usually send us for seminars and teach us a lot of things that will make us do our jobs better but now, the government does not do that anymore. If there are seminars, the government trains people that they are not supposed to train because of the financial benefits, but they do not train the people that really need the training" (P4-CHEW).

"I have not attended any training. If such training exist, they usually pick people to attend, not everybody will have the opportunity to attend…for now I do not have any knowledge on how to care for a woman with FGM issues" (P8-N/M).

5.2.3 Specialised services

The participants declared that there was no referral protocol for FGM. They stated that when they are confronted with complex FGM cases, they usually referred the patients to the secondary facility, and these caused a lot of issues especially in terms of the women not been accepted at the secondary level and the lack of follow up care from HCPs at the PHC levels (P7-N/M). They believed that the availability of an accessible specialist centre would to a large extent resolve some of the uncertainties regarding FGM and the challenges of parturition and referral.

"For now, there is no centre for FGM at the secondary healthcare facilities. So, we do general referral but there is no established guidelines or clinics set up for FGM alone. I think that the government should set up a clinic to attend to women with FGM it will go a long way to solve the situation with FGM cases at the PHC" (P12-Dr).

"Since I started working here, we have not had a referral centre for FGM cases…so where should we refer this people with FGM… especially when the labour becomes difficult, and we cannot handle it… so we will be happy if the government can build one for us to serve as a referral place for treatment and counselling" (P5-N/M).

5.2.4 Limited resources

During the recruitment and data collection phase of this study, it was observed that the PHC facilities visited by the researcher experienced a shortage of staff and clinical equipment (See chapter four). In some instances, a PHC facility servicing a community of an estimated population of six thousand people would have only one nurse and a healthcare assistant or a CHEW. On many occasions the researcher had visited some PHC facilities and found them empty aside from the gateman. This also applied to the availability of essential clinical instruments, as the researcher observed that HCPs were sharing one thermometer in one of the PHC facilities where data was collected. Therefore, it was not a surprise when the participants revealed their frustrations regarding the shortage of staff and clinical instruments. They expressed concerns and frustrations about the limited resources available to them to appropriately perform their duties within the PHC settings. They declared that they would provide better care for the women with FGM who access PHC services if they had the necessary resources.

Some participants revealed that there was a shortage of essential instruments in the PHC facilities. They observed that the lack of clinical

equipment was one of the reasons they referred the women to secondary facilities as they were unable to address some of their health concerns.

> *"In most cases, we just reassured the women and their relatives and tell them that they were being referred because there were no instruments to help them in the health centre… because sometimes we do not even have suturing materials to repair tears and episiotomy… in some cases we send someone to the health centre in the next community to borrow medical supplies" (P21-N/M).*

They disclosed that they usually informed the women that they did not have the capability to meet most of their needs at the PHC level due to insufficient supply of clinical equipment.

> *"FGM is mostly seen in the primary healthcare centres, but we are not equipped to look after them. For example, there are no instruments in this health centre… even needle holder we may not have more than two, most times only one" (P7-N/M).*

The participants stated that the lack of human resources hindered the ability to provide the care that was required by the women. They recognised the need for follow up visits, health talks and community visitation and mobilisation but they were unable to meet all of these demands because of the shortage of clinical staff.

> *"So, because of the lack of manpower we do not have time to be with these women to educate them and follow up their health practices and activities or to even have a one-on-one private discussion with them… so we will need more hands to do all that" (P18-CHEW).*

Some participants stated that they did not have physicians to consult in the PHC facility as such there were limitations to the care they could provide within the setting.

"We are usually short staffed here…for instance in this health centre we do not have a resident doctor…If we have an experienced doctor then we can solve some of these women's problems" (P6-M).

5.3 Beliefs and attitudes towards FGM practices

This theme describes participants' feelings and perceptions about the practice of FGM and its continuation, and their perceived roles in preventing the practice in Delta State and Nigeria in general. They expressed negative opinions about FGM and declared that the practice should be stopped completely. The participants believed that HCPs had a role to play in reducing FGM practices as they cited community engagement, health education-, and the training of TBAs as some of the perceived responsibilities of the HCPs working in PHC facilities in rural communities.

5.3.1 Beliefs about FGM practices

Nearly all the participants in this study did not subscribe to FGM practices. They stated that the practice was obsolete and a global health concern that should be discouraged.

"For me, I do not think it is healthy…In fact, it is a very bad practice…It is archaic, and it is a bad procedure for women to undergo" (P11-N).

"So, female circumcision is not a good practice…it is a public health issue that must be addressed" (P12-Dr).

A majority of the participants articulated that FGM was a harmful practice that has no health advantages and thus should not be practised.

"Well, the practice of female genital mutilation is not advisable because it does not have any positive effect on the woman. There are no benefits of the practice to the women that have been circumcised… so yes, I think it is a dangerous practice" (P17-CHEW).

Despite the existing beliefs that FGM was practiced to curb promiscuity, nearly all the participants acknowledged that FGM does not prevent a woman from having high sexual libido and promiscuity. They believed that other biological factors were responsible for high sexual urges, and cited cases of women who had undergone FGM procedures but still had high sexual drives.

"I don't think that the belief is right, though I know there might be some elements of truth because I know that the sensitive part of a woman is the clitoris, but I don't believe that removing the clitoris can reduce sexual urges totally. I do not believe that, because sexual urges also have to do with hormones and other changes in the body. So, the belief is not totally true about the removal of the clitoris and promiscuity. We have seen cases where women who were circumcised turned out to be more promiscuous than those that were not circumcised" (P12-Dr).

"They claimed that circumcision curtails promiscuity, but we have discovered that it is not true because the women who are into prostitution are not the ones that were uncircumcised but the circumcised ones…Even women who left their marriages to prostitute because of one reason or the other were mostly circumcised" (P14-N/M).

Though nearly all the participants agreed that FGM was bad and should be discouraged, one participant believed differently, they declared that FGM was not a bad practice as it was being misrepresented.

"For me I do not see it as a bad practice because my mother circumcised us when we were young and we do not suffer from any complications, and I am not saying, that is why we are not promiscuous… it is the way they perform it that is why it is bad but the practice itself is not bad…In the olden days it was not a bad practice, because the way they did it then is not how they do it now" (P23-N/M).

Regarding the participants' perceptions and attitudes towards the continuation of FGM, some of the participants stated that FGM was no longer practised as it may have been eradicated.

"Nobody practises FGM around here anymore, for now, I know that FGM is outdated… no more existing" (P19-N/M).

However, most participants rejected this claim, they stated that people do not discuss FGM openly that is why it was thought to be eliminated.

"FGM is not a concept that people talk about" (P12-Dr).

FGM was believed to be a continued practice in some rural communities in Delta State Nigeria.

"FGM is still practised in some villages…it is done by TBAs in the villages not in health centres" (P10-CHEW).

" FGM is practised in this community" (P16-N/M).

All the participants except one declared that the FGM should be stopped because of the health implications and the sufferings and pains associated with the practice.

> *"I think that the practice should be stopped because it has so many complications on the mother and the baby… so I think there is no need to continue the practice" (P6-M).*

It was observed during the recruitment and interviews that one of the participants was quite unfriendly and reluctant to divulge much information about the topic, though she willingly agreed to take part in the study. In response to the question about the continuation of the FGM, the participant made the following statement.

> *"Well, they have stopped it… they have stopped it now…I did not circumcise my children, I just left them like that" (P23-N/M).*

The participant was perceived at that time as expressing mixed emotions, there was anger and sadness in the tone of communication. Following this, the researcher asked if they wanted to end the interview, but the participant was happy to continue. In hindsight, this could be interpreted as the participant being uncomfortable with the topic of discussion because of the sensitivity of the practice and considering that she had disclosed that she was circumcised. It could also imply that she was not in complete support of the abolishment of the practice and the changes that had occurred over the years regarding the practice of FGM.

5.3.2 Attitudes towards the medicalisation of FGM

The participants expressed their feelings regarding the medicalisation of FGM. Majority of the participants declared that they were against HCPs who practised and performed FGM.

"I do not support the medicalisation of FGM because it has no medical value and should not be medicalised" (P12-Dr).

Some participants declared that both HCPs and TBAs should be discouraged from participating in FGM activities as the practice is undesirable.

"I do not think the practice is advisable whether it is carried out by health professionals or traditional birth attendants (TBAs)" (P11-N).

They participants believed that FGM has no medical benefit and should not be performed by healthcare professionals.

"I will not encourage any health professional to be involved in FGM because…there is no benefit to the practice… I am against it because the harm is far more than the benefits… if it has any benefits" (P13-Dr).

"HCPs who perform FGM should be discouraged… they should desist from it because it is harmful to the health of females" (P16-N/M).

5.3.3 Perceived role in preventing FGM

All the participants agreed that HCPs had a role in the eradication of FGM. They asserted that it was the practice of the PHC facilities to engage the community in sensitisation and outreach programmes in the communities, but that had been stopped and thus they did not have access to the entire community for group meetings (P4-CHEW). The participants mentioned that FGM could be prevented by creating awareness through community engagements, health education and the training of TBAs.

5.3.3.1 Community engagement

The participants acknowledged that sensitisation and outreach programmes were a great opportunity for them to educate members of the community about FGM practices. They believed that their role in ending FGM included providing information about FGM and organising town hall meetings with the decision makers and key stakeholders in the community.

> *"I would say that we should all continue to disseminate information about FGM at the grass root. The campaign should involve the education of community leaders and members of the community. I think we could also educate the people living in the community about FGM when we go on outreach" (P11-N).*

Another participant mentioned that FGM programmes should be targeted at changing the behaviour of the people about FGM practices.

> *"I think we need to go into the community, get involved in community dialogue… create awareness for people not to indulge in such practices. For me, creating awareness to effect a change in behaviour is the most effective approach because it is best for the behavioural change to come from within, and this involves giving and spending a lot of time and resources, and creating enlightenment in the rural areas. Creating awareness in these communities will go a long way… we should know that this awareness creation is not just a onetime thing, it should be continuous so that over time the people will start changing their behaviour towards FGM practices" (P13-Dr).*

Other participants asserted that the focus of the community engagements should be on young girls as the procedure was sometimes performed at a young age.

> *"I mean going on outreach, advocacy, meeting with traditional rulers, women groups and even young girls and secondary school children, because that is when they start*

recruiting them for circumcision. So, we should involve young girls and even men groups…so they will know that there are no benefits to the practice" (P14-N/M).

Some participants argued that since women were the decision makers on FGM practices, they should be the targeted population in FGM campaigns.

"Well, because the practice concerns women and in most cases these women leaders are the key decision makers regarding when a girl should be circumcised, it is important to include them in the awareness campaign because they can then convince other women to stop the practice" (P17-CHEW).

"I would like to add that, the elderly women in the community and mothers should be the focus of community mobilisation, because they are the ones who insist on circumcising their daughters. So, they should be educated and informed about the dangers of the practice" (P25-CHEW).

The participants also revealed that TBAs were eminent members of the community and considered as the gatekeepers, hence people paid attention to their views. They believed that the TBAs should be engaged in FGM campaigns as they would be useful advocates for the fight against FGM.

"To reach the villagers one must go through the TBAs otherwise they will not listen. The TBAs play a vital role in the community and the people living in the community listen to them, so they can be of help when it comes to campaigns against FGM" (P10-CHEW).

5.3.3.2 Health literacy

The participants acknowledged that one of the roles they had in reducing FGM was to provide information about the health implications of FGM to the populace.

"It is our duty as health professionals to tell people about the practice, so that they can understand the dangers and stop the practice" (P10-CHEW).

A majority of the participants stated that they often conducted health teachings on FGM during ante natal and immunisation sessions. They revealed that these sessions were the only time they could get the women together in one place, hence they used it as an opportunity to educate the women about the detriments of FGM practices.

"In this facility we usually preach against it, especially during ANC clinic. We tell mothers that as they are pregnant, they should not allow their mother or mother-in-law to talk them into circumcision. This is usually done during immunisation session, family planning and ANC… we health educate them about circumcision because it is good to discuss the practice with mothers whenever we meet them, even if they are in the clinic for unrelated issues" (P15-CHEW).

The participants articulated that aside educating the women about FGM, they also encouraged them to seek advice when they felt pressured by relatives to undergo the procedure.

"Sometimes during ante natal clinic, we provide health educate to mothers about the dangers of the practice and that they should not get involved in it…we also tell them to come and report to us if their mother or mother-in-law were convincing them to be circumcised, so that we can report this to the appropriate authority" (P21-N/M).

5.3.3.3 Training of TBAs

The participants mentioned that it was their role to train the TBAs because the TBAs were the perpetuators of FGM practices.

"The birth attendants should be taught about FGM and the complications because they still perform FGM in the communities. They should be trained, or the nurses can be trained then we in turn can train the TBA. We taught the TBAs about HIV testing and referral so we can also teach them about FGM practices" (P7-N/M).

Some of the participants believed that since TBAs performed FGM and delivery services, they should be trained on how on to carry out procedures and provide care services using the right techniques.

"The TBAs should be trained on clinical hygiene, sterilisation, care of women during delivery, safe procedures and the complications that could arise from female circumcision" (P19-N/M).

The participants observed that the TBAs carried out FGM procedures because they had limited knowledge about the different aspects of FGM. They declared that if these TBAs were trained and educated about FGM, then they may desist from performing FGM procedures.

5.4 Summary

This chapter focused on participants' encounters of FGM in the clinical setting and their experiences of providing delivery services for women with FGM. It presented findings regarding HCPs' involvement in FGM practices and their thoughts and feelings about the medicalisation of FGM. It further identified and explored the difficulties in supporting women with FGM, the factors that affected the care that was being provided and the participants' roles in preventing FGM practices.

The participants' accounts of their clinical experiences of FGM indicated that-, most of the participants had met and cared for women with FGM and

had recently been requested to perform FGM by community members, while some had performed FGM in the past. Majority of the participants believed that FGM was still practised in rural communities by HCPs and TBAs; they declared that they were against the medicalisation of FGM and cited financial gain and a means to discourage practising communities from patronising TBAs as the main reasons for the medicalisation of FGM. The participants described the delivery of women with FGM as painful and complicated, as they cited episiotomy and lubricants as the strategies that they employed to ease the delivery process. They highlighted accidental diagnosis and referral as the immediate challenges they encountered during parturition.

The participants expressed disappointment over the lack of resources and support that existed within the PHC system as they revealed that they had not had any professional training on FGM, as this would empower them with the skills and knowledge to care for these women. They further mentioned that there were no existing policies and procedures on FGM and relied on experience and common sense to meet some of the delivery needs of the women. They declared that the lack of FGM specialist clinics, staffing and clinical equipment had seriously limited and affected the care that was delivered to women with FGM in PHC facilities.

Overall, majority of the participants believed that the practice of FGM was dangerous and should be stopped at all levels. They declared that the role of HCPs in preventing FGM included creating awareness about the detriments of FGM in rural communities through community engagements, health education and training of TBAs to become change agents.

The next chapter will entail a discussion of the key findings and the use of the socio-ecological model to further interpret the findings. The socio-ecological model considers the influence of complex factors such as the individual, interpersonal, institutional, community and public policies on an individual's beliefs and behaviours. This model may help provide a better understanding of how participants' sociocultural background influenced

their practices and experiences of FGM in the clinical setting, and how this may have affected the care that was rendered to the women with FGM who access healthcare services within PHC facilities in rural communities.

CHAPTER SIX: DISCUSSION AND CONCLUSION

6.0 Introduction

This study was conducted to explore primary healthcare professionals' knowledge, beliefs, and practices of FGM in Delta State Nigeria, to understand the support that was rendered to women with FGM who access PHC facilities. This introductory section will include a summary of the study findings and how the social constructivist positioning shaped the findings. This chapter will subsequently discuss the key findings of this research, and a presentation of the socioecological model of FGM prevention which serves as a recommendation. Then, this will be followed with a discussion of the strengths and limitations of this study, implications of this study and the conclusion.

Summary of findings

Following the tenets of social constructivism, a semi-structured individual interview was conducted with 26 HCPs which generated two main themes that are presented and discussed in subsequent sections.

The findings from the first theme (*Knowledge of FGM: The influence of sociocultural system and professional practices*) showed that the twenty-six HCPs were from communities where FGM was practised and some had themselves undergone FGM procedures, so they had a culturally inclined understanding of FGM. However, there was significant gap in their professional knowledge of FGM practices as all twenty-six HCPs were unable to correctly provide details about FGM and its typology. This is despite their claims that they were educated about FGM in their professional training institutions and obtained additional information from private learnings and other sources.

The second theme *(Encounters with FGM in the clinical setting: experiences and challenges of providing care for women with FGM)* provided findings

that indicated that more than half of the participants had met and cared for women with FGM, while some have been requested to perform FGM and have been involved in the medicalisation of FGM. They mentioned financial benefits and a means to discourage TBAs services as the main reasons for medicalising FGM. The HCPs who had supported women with delivery services revealed that birthing a woman with FGM was a painful and complicated process and declared that they sometimes administered episiotomies and lubricants as strategies to ease the delivery process. In addition, instructional barriers to effective delivery included lack of policies and procedures on the management of FGM cases, lack of professional trainings, lack of specialist services and limited resources such as equipment and staffing.

Overall, most of the HCPs showed a negative attitude towards FGM practices and declared that FGM was dangerous and should be stopped at all levels. The HCPs recognised that they had a role in ending FGM practices and stated that community engagements, health literacy and the training of TBAs were some of the approaches that could be employed to reduce the practices of FGM in Delta State and Nigeria in general.

Social constructivist positioning

The social constructivist belief is that reality, knowledge, and learning are all socially and culturally constructed through human activities and social interactions (Lincoln et al., 2011; Creswell, 2013). Hence, social constructivism seeks to understand a phenomenon through interactions with individuals based on their experiences and the meaning they attribute to such experiences (Creswell, 2013). This means that knowledge is co-construction by individuals who experience the same phenomenon (Smith, 1983). The researcher's cultural background and position as a woman, and a certified nurse from Nigeria, helped in the co-construction of the findings of this study. The researcher understood the language used by the participants during the interviews. Though the interviews were conducted in English language, there were expressions that the participants used that

an outsider would not have understood the concept of its use. For instance, most participants used the word 'we' (see chapter 4 and 5). The 'we' did not imply that they were providing collective information about themselves and other participants, but it is a comfortable word used in Nigeria to avoid the consequences of one's response or action. Similarly, when some of the participants described the meaning of FGM, they related it in the way it was understood from the cultural perspective. This was evidence in their use of 'wear off' to describe FGM, which implied that the participants were translating the cultural meaning of FGM to the professional definition of FGM. Therefore, my cultural background helped me to co-construct and understand what the participants meant when they used 'wearing off' to mean 'cut off'.

In social constructivism, knowledge is shared rather than an individual experience (Lincoln et al., 2011; Creswell, 2013). The researcher and the participants' shared cultural background, experiences of FGM, attributes as Nigerian women and professional colleagues influenced the constructions of the research findings; from the data collection process to analysis and the write up of findings. These co-constructions, including the researcher's biases are reflected in this research.

6.1 HCPs' understanding of FGM.

One of the objectives of this study was to explore the knowledge of FGM among HCPs working in PHC facilities. This is because the understanding of FGM is essential for the clinical care and management of women and girls living with the complications of FGM, especially when rendering labour and delivery services (WHO, 2018a;Kaplan et al., 2016). This study produced new findings that showed that HCPs acquired their understanding of FGM from interactions within their sociocultural settings and professional practices, and this will be discussed in subsequent sections.

6.1.1 Sociocultural influence

FGM is widely practised among the five ethnic groups (Urhobos, Isoko, Anioma, Ijaw and Itsekiri) in Delta State Nigeria, and all the HCPs in this study were from these communities and they shared same beliefs about FGM as members of the communities. Given their cultural affiliations, HCPs described with authority their understanding and beliefs about FGM practices as they provided diverse perspectives about FGM.

FGM was reported to be practised at different times depending on the ethnicity and their beliefs-, in some instances it was performed on babies and young girls, while some communities in Delta State performed FGM as part of marriage ceremonies or during pregnancy especially at the second trimester. Findings like those reported in this study were documented in other parts of Africa. For instance, a large-scale qualitative study of 100 health personnel and 48 key informants on the medicalisation of FGM among the Abagusii in Nyanza province of Kenya reported that the cultural age for cutting was from teenage age onto adulthood; however, there has been a shift in the age of cutting to include girls as young as six years (Njue and Askew, 2004). This change was said to enable the girls heal in time for school and marriage. A parallel cutting age was documented among girls of about five to eight years old in a study about the changes in the types of FGM cutting in Somaliland (Powell and Yussuf, 2018). In Nigeria, a qualitative study on the understanding of the medicalisation of FGM among parents and 5 HCPs in four states in Nigeria reported that FGM was performed on new-borns and young women (Obianwu et al., 2018). While the study by Tarr-Attia et al., (2019) found in their qualitative study of 17 midwives that FGM was performed mostly on young girls in Liberia. This shows that irrespective of the country, the age of cutting varied depending on sociocultural beliefs and convenience of the practising communities about the age of cutting, which usually ranges from neonates to adults.

The studied HCPs declared that FGM was culturally motivated and practised by communities and families to show honour and respect for tradition. The ritual presentation of parts of the clitoris to the gods signified that the gods would protect the girls and women from harm, and perceived superstitious consequences such as promiscuity, misfortunes, and death. The traditional rituals that accompanied FGM procedures are performed to honour the cut girls and their mothers, and to demonstrate the importance of FGM to practising communities. These findings corresponded with those reported in a survey of 269 student nurses/midwives in Nigeria (Dike et al., 2012). The student nurses/midwives in the said study declared that ancestral and spiritual satisfaction were some false beliefs for practising FGM (Dike et al., 2012). Likewise, a qualitative study of 8 midwives' experiences of providing care and counselling to women with FGM in Somaliland reported that FGM was practised to prevent the anger of the gods (Isman et al., 2013). In corroboration, a recently conducted qualitative study of 21 HCPs in Iraq asserted that communities and families practised FGM because it was a cultural requirement that needed to be fulfilled to prevent repercussions such as promiscuity and stigmatisation (Shabila et al., 2017). The similarities of this study's findings to other studies (Shabila et al., 2017;Isman et al., 2013;Dike et al., 2012) could be because these studies like the present study were conducted in settings where FGM was practised for cultural reasons; hence the HCPs shared similar beliefs about FGM. Furthermore, the importance attributed to FGM practices may be as a result of the entrenched cultural beliefs and values that existed amongst practising communities, and the fear of the repercussions for disregarding cultural obligations. This may be one reason the practice of FGM continues, and the task of eradicating it is much more complex.

Three of the HCPs in this study had undergone FGM procedures. Their personal experiences of FGM contributed to their knowledge about the various aspects of FGM including the age of circumcision, the reasons for the practice, the preparatory and honour ceremonies and how young girls

were indoctrinated and coaxed by close relatives to undergo FGM. Two of the three HCPs stated that the lasting experience of FGM shaped their perceptions about the practice and aroused an interest that motivated them to become counsellors and advocates for the elimination of FGM. Corresponding findings were reported among HCPs in previous studies (Obiora et al., 2021;Tarr-Attia et al., 2019;Isman et al., 2013). For example, the Obiora et al., (2021) study of 17 HCPs in the Eastern part of Nigeria, declared that all the participants had undergone FGM procedures and their personal experiences of FGM enabled them to have a significant knowledge and understanding of FGM. This accounted for their ability to identify the various forms of FGM, the associated health complications and provide counselling care for women with FGM. Likewise, some of the midwives in the study by Tarr-Attia et al., (2019) observed that having FGM enabled them to relate culturally with the women with FGM and recognise the difficulties that these women experienced.

The HCPs in the present study demonstrated a considerable culturally inclined knowledge of FGM. They provided rich data regarding shared cultural beliefs surrounding FGM practices as a result of their cultural orientations. The influence of culture on the knowledge of FGM has previously been described in literature. For instance, the study by Isman et al., (2013) observed that the 8 midwives examined in their study were from FGM practising settings which ultimately influenced their understanding of FGM, and their ability to subsequently transfer this culturally acquired knowledge to educating others about FGM. Another qualitative study of 17 midwives in Liberia showed that the midwives were indigenes of communities where FGM was practised, and this informed their knowledge of FGM as they described in details the decisions and processes leading to the cutting exercise, including the cultural preparation of girls for FGM procedures (Tarr-Attia et al., 2019). In contrast, some existing studies observed that despite cultural affiliations, some HCPs had limited culturally oriented knowledge about FGM practices. For example, Ashimi et al.,

(2014) cross-sectional study of 350 nurses' knowledge and attitude towards FGM in northern Nigeria, reported that though the nurses were from communities where FGM was practised-, they had limited awareness about the forms of cutting that was practised in their communities and some of the nurses were oblivious of FGM practices. This made the study (Ashimi et al., 2014) to conclude that the nurses' ethnicity did not contribute to their understanding of FGM practices. Equally, a quantitative study by Ali (2012) on the knowledge and attitudes of FGM among 154 midwives in Eastern Sudan, declared that all the midwives in the study were from communities that practised FGM, but their cultural affiliations did not enhance their knowledge of FGM as all the midwives reported a limited culturally motivated knowledge of FGM. It is unclear why these HCPs had limited cultural awareness of FGM as being an indigene of a community that practised FGM, it is expected to have some influence on an individual's understanding of the practice. It is possible that, the studies (Ashimi et al., 2014;Ali, 2012) did not ask questions that explored the participants' cultural awareness of FGM, or the instrument of data collection (structured questionnaires) did not provide the avenue for the participants to express and contribute their cultural expertise of FGM to the findings of the studies.

Despite reports suggesting that cultural background did not influence the understanding of FGM (Ashimi et al., 2014;Ali, 2012;Refaat., 2009), it could be argued based on the findings from this study and other empirical studies (Obiora et al., 2021;Tarr-Attia et al., 2019;Isman et al., 2013) that cultural affiliation plays a significant role in the knowledge and understanding of FGM. This was reflected among the 26 HCPs examined in this study, who demonstrated expertise in their understanding of FGM in terms of the age at which FGM is typically carried out, beliefs about the practice and the consequences for not adhering to cultural prescriptions of FGM, and personal experiences of FGM. The culturally inclined knowledge displayed by these HCPs could be as a result of the following. Firstly, the HCPs have had years of exposure to the concept of FGM from interactions

within their immediate and extended family circle and the community at large. Secondly, the synergy that existed between the HCPs in this study and the community provided the opportunity for them to gather information from the indigenes about FGM activities which further increased their cultural understanding of FGM (See chapter 4). Thirdly, the level of HCPs' acculturation in the community provided opportunity to build trust and acceptance, for example speaking the same local language as members of the community where the HCPs practised as healthcare providers, made the people in the community feel comfortable to share FGM related information with the HCPs (See chapter 4).

Nonetheless, the contrasting views regarding the impact of cultural orientation on the understanding of FGM, could inform further investigation into the role and importance of sociocultural affiliations in the knowledge and understanding of FGM practices.

6.1.2 Professional influence

The World Health Organisation and other international agencies such as UNFPA and UNICEF have provided a wealth of information about FGM practices including, the definition, typology and associated consequences, to create awareness to the general populace and key stakeholders, especially HCPs (See chapter 1) (WHO, 2022b). This is to ensure that HCPs are empowered with the right information to prevent FGM and protect vulnerable groups from FGM and provide direct care and counselling for women affected by FGM. Evidently, the HCPs in this study demonstrated a sociocultural motivated understanding of FGM, but the professional knowledge of the concept of FGM, including the types and health implications were limited.

6.1.2.1 Wearing of the skin

FGM is defined as the partial or total removal of external female genitalia or other injury to the female genital organs for non-medical reasons (WHO, 2022a). It was important to explore HCPs' knowledge of the definition of

FGM because FGM practices were still being referred to as 'female circumcision' as such practising communities likened the practice to male circumcision, thereby creating a confusion between the two practices and concealing the severity of the health repercussions of FGM (UNFPA, 2022). The knowledge of the working definition of FGM meant that the examined HCPs understood that there was a clear distinction between FGM and male circumcision, and that the mutilation of any part of the female external genitalia for non-therapeutic purposes was harmful to girls and women.

The HCPs in this study had limited knowledge about the definition of FGM. Indeed, there was a general awareness of FGM but only two HCPs could somewhat correctly define FGM. The majority of the HCPs defined FGM as the wearing of the skin or of some parts of the female genital organ (See chapter 4). Interestingly, when the HCPs provided information about FGM in the sociocultural context, they described FGM as female circumcision which meant that they may not have fully understood that the practice involved the mutilation of the vulva, and not a simple circumcision exercise. Also, when asked to provide a definition of the term FGM, they transfer their cultural understanding of the concept of female circumcision to their professional knowledge; hence, they used words such as 'wearing of the skin' to describe the meaning of FGM. The inability of the examined HCPs to provide an accurate definition of FGM, may be due to limited access to information and continuous education about FGM.

Corroborating findings were observed in a qualitative study conducted among 21 HCPs in Iraq where the participants provided inaccurate definitions of FGM that included-, cutting of the sensitive part of the female organ or the edge of the genitalia (Shabila et al., 2017). The Shabila et al., (2017) study attributed the limited knowledge about the definition of FGM to lack of media, research, and educational information on FGM in the setting. Similarly, a survey of 298 medical students' knowledge about FGM in Egypt reported a poor conceptualisation of FGM in their study as only few of the students could provide a correct definition of FGM (Mostafa et al.,

2006). Whereas, a study conducted to examine the knowledge of FGM among 45 HCPs in the United Kingdom observed that nearly all (98%) the participants knew the correct definition of FGM (Zaidi et al., 2007). The findings reported by Zaidi et al., (2007) were contrary to those documented in the present study and in existing literature (Shabila et al., 2017;Mostafa et al., 2006). It is remarkable to note that HCPs in the study conducted in the United Kingdom (Zaidi et al., 2007), where the practice of FGM was not concentrated had better understanding of the meaning of FGM compared with HCPs who were studied in settings where FGM was widespread. Perhaps the considerable knowledge of the definition of FGM reported in the Zaidi et al., (2007) study was due to accessible information and educational resources in the study setting.

Despite sociocultural and professional interactions with FGM practices, the HCPs in this study were unable to accurately provide the working definition of FGM; probably due to limited exposure to educational resources about FGM. Notably, this study appeared to be the first in Nigeria to explore HCPs knowledge about the definition of FGM. Previous studies (Ashimi et al., 2014;Ibrahim et al., 2013;Dike et al., 2012) in Nigeria examined healthcare professionals' knowledge of FGM, but none of these studies explored the definition of FGM. Perhaps knowledge about the definition of FGM was considered inconsequential compared with other aspects of FGM. Indeed, HCPs' knowledge of the definition of FGM is critical for understanding the meaning of FGM and its severity, and the dissemination of accurate FGM abandonment information and health literacy.

6.1.2.2 Types of FGM

The HCPs who participated in this study exhibited a fragmented and limited knowledge of the four types of FGM. There was a general paucity about the knowledge of the categories of FGM among the HCPs, except for one HCP who was able to describe three of the four forms of FGM. Corresponding findings were observed in previous studies (Tarr-Attia et al., 2019;Khalesi et al., 2017;Ashimi et al., 2014;Ibrahim et al., 2013;Adekanle et al.,

2011;Ali, 2012) where some participants had knowledge of only types one or two of FGM, while in some instances the participants had no knowledge of any of the four types of FGM (Ashimi et al., 2014). Some studies in Nigeria reported that the participants had knowledge about some of the types of FGM. For example, Onuh et al. (2006) reported that the 182 examined nurses described at least one type of FGM, but only 12 of the nurses could correctly identify all the types of FGM. While in the Umar and Uche (2014) study, only about 30 of the 100 participants had adequate knowledge of the types of FGM and this was due to years of clinical experience (Umar and Oche, 2014). However, in the current study the cadre of HCPs or duration of practice did not appear to influence their knowledge of the types of FGM, considering that fourteen of the HCPs in this study were also certified midwives.

The weak knowledge about FGM typology is not limited to studies conducted in Africa and the Middle east. Some studies in high income countries also reported a limited understanding of the categories of FGM among HCPs. For instance, the Australian study of 11 midwives showed a gap in the knowledge about the types of FGM, which was attributed to the lack of FGM content in the midwifery curriculum (Ogunsiji, 2015). Likewise, a survey conducted in London to assess the knowledge and attitudes of 79 HCPs about FGM, revealed that only a few of the HCPs could correctly identify the different forms of FGM (Relph et al., 2013). This further highlights the limited knowledge of FGM typology across HCPs irrespective of the professional group, years of practice and country of practice. A considerable knowledge of the types of FGM is crucial for the accurate diagnosis and care of women presenting with FGM, especially during parturition (WHO, 2018a;WHO, 2001). Hence, there is need for HCPs to have a good understanding of the different types of FGM.

6.1.2.3 Dangers of FGM

This study showed that the HCPs had a comprehensive knowledge and experiences of the complications that could arise as a result of FGM. The

HCPs mentioned several health implications of FGM, which were categorised into physical and psychosocial problems. The HCPs cited infections, bleeding, anaemia, pain, infertility, lacerations-, and difficult delivery as some of the physical complications of FGM. These findings were similar to those reported by previous studies (Obianwu et al., 2018;Kaplan et al., 2016;Umar and Oche, 2014;Ibrahim et al., 2013;Dike et al., 2012;Onuh et al., 2006). Regarding the psychosocial problems, the HCPs in this current study referred to lack of sexual gratification, marital problems, painful coitus and reduced sexual libido. The same was documented in some earlier studies (Sureshkumar et al., 2016;Kaplan et al., 2016;Hess et al., 2010;Njue and Askew, 2004;Berggren et al., 2004). Some HCPs in this study cited stigmatisation as a psychosocial complication of FGM as some of the women with FGMFGM felt stigmatised by the cutting. A parallel finding was reported by Hess et al. (2010) where the nurses/midwives stated that the women with FGM often felt ashamed and stigmatised by the HCPs, but the study did not elaborate on this finding.

Generally, irrespective of the settings, the HCPs appeared to be well-informed about the health consequences of FGM as comparable findings were also reported in high income countries (Sureshkumar et al., 2016;Relph et al., 2013;Hess et al., 2010;Leye et al., 2008). This study presented corroborative findings about HCPs extensive knowledge and experiences of the health complications of FGM, and further highlights new evidence that indicated that birth asphyxia was a potential complication of FGM. It was observed that asphyxia was a grave complication that puts babies born to mothers with FGM at a greater risk of birth asphyxia due to the narrowness and loss of elasticity around the vulva. This new evidence may be relevant for planning delivery care for women with FGM because of the possible negative outcome. HCPs, especially those who provide parturition services need-, to be well informed about this possible life-threatening complication.

6.1.2.4 Sources of information

HCPs professional knowledge of FGM was acquired from several sources. Most of the HCPs acknowledged that they were given some classes in school on FGM but revealed that they have forgotten the little that was taught to them. Parallel evidence was reported among some participants in previous studies (Cappon et al., 2015;Umar and Oche, 2014;Leye et al., 2008). For instance, the survey of 334 gynaecologists in Belgium revealed that the participants acknowledged that they received lectures on FGM in their basic and specialised medical training (Leye et al., 2008). Despite receiving formal education on FGM some of the HCPs continued to demonstrate limited knowledge about FGM, questioning the adequacy or suitability of training. Unlike the HCPs in the current study and existing studies who stated that they received classroom lectures on FGM, nearly half of the 198 midwives examined in the Australian study by Turkmani et al. (2018) declared that they did not receive any information on FGM during their midwifery education which accounted for their limited knowledge about FGM (Turkmani et al., 2018).

The HCPs in this study mentioned seminars, self-learning, books, media (jingles on radio and television) and the internet as some of their sources of information about FGM. These are like findings from previous studies (Umar and Oche, 2014;Mostafa et al., 2006). Some HCPs in this present study also indicated that they got their knowledge of FGM from years of clinical practices and frequent interactions with women presenting with FGM, and this finding corresponded with those documented in existing literature (Sureshkumar et al., 2016;Umar and Oche, 2014).

In summary, the HCPs in this study exhibited a commendable culturally motivated knowledge of FGM, however the study identified a significant gap in the HCPs professional knowledge of FGM. This is considering that FGM was concentrated in the study setting, and FGM is part of the teaching curriculum being implemented across training institutions in Nigeria. It is imperative for HCPs to have comprehensive information about FGM as this

would inform HCPs about the practice of FGM and how to manage the associated complications. It would contribute to the elimination of FGM by providing HCPs with the expertise needed for educating families and communities about FGM. Additionally, it would encourage HCPs to oppose the medicalisation FGM.

6.2 HCPs encounters with FGM in clinical settings

This section provides a discussion of the findings from HCPs' experiences of FGM in the clinical setting. This theme helps to unravel some questions around the medicalisation of FGM, and the care that was provided for women with FGM who access primary healthcare services and the challenges that they encountered during this process.

6.2.1 Clinical experience

Most of the HCPs in this study had met and provided direct care for several women with FGM, especially during labour and delivery and as recent as 2019 when the data for this study was collected. This finding was supported by other studies (Cappon et al., 2015;Isman et al., 2013), including an American study of 243 nurse/midwives where some of the participants revealed that they had encountered and provided direct care for women with the history of FGM (Hess et al., 2010). Similarly, majority of the 250 HCPs examined in the Adekanle et al., (2011) study admitted having recently witnessed FGM related problems. Comparable findings were reported in another study of 66 doctors and 52 nurse/midwives in Nigeria, where some of the participants had cared for women with FGM and more nurse/midwives than doctors had provided care (Ibrahim et al., 2013). The current study and the study by Ibrahim et al. (2013) observed that more nurse/midwives than doctors had provided some level of care for women with FGM, however Adekanle et al. (2011) reported that specialist doctors (gynaecologist and paediatricians) predominantly saw and cared for women with complications of FGM. This could be due to the availability of specialist

team in the tertiary setting where the study was conducted (Adekanle et al., 2011). Arguably, the Ibrahim et al. (2013) study was also conducted within tertiary and secondary health facilities- still, more nurse/midwives had confronted FGM compared with doctors. Perhaps, due to easy access to nurse/midwives in clinical settings, or the limited clinical staff within the PHC led nurse/midwives to take up additional roles which caused the frequent contact with the women affected by FGM.

Despite shared cultural identity and beliefs with FGM practising communities, eleven of the HCPs in this current study declared that they had neither encountered nor cared for women with FGM. A study conducted among 41 HCPs working with female asylum seekers in Italy reported that a high percentage (70.7%) of the participants in the study had never seen or assisted women with FGM; this is despite working closely with asylum seekers from countries where FGM was concentrated (Caroppo et al., 2014). Perhaps, the HCPs who had not encountered women with FGM were unable to identify FGM when they came across it due to limited understanding of the practice. Also, there could be limited contact with FGM because women with FGM did not always seek help for their difficulties as revealed in this study (Chapter 6.2.1) and corroborated by earlier studies (Isman et al., 2013;Hess et al., 2010). Conceivably, most women with FGM patronise TBAs for their obstetrics and gynaecological issues and this could be another reason for the lack of contact with FGM reported by some HCPs.

6.2.2 Medicalisation of FGM

Twelve of the HCPs in this study had been requested to perform FGM procedures on babies, young girls and pregnant women by family members who resided within the rural communities and urban settings. It appears that people who request FGM from urban communities did so because the HCPs in urban areas declined performing FGM, therefore resolved to asking HCPs who practised within rural settings. In all instances, the request had been rebuffed by the HCPs and used the existing FGM law to scare off persistent relatives. It is not surprising that women living in Urban areas

visited rural health facilities to request FGM as existing evidence in Nigeria indicated that FGM was more prevalent among urban than rural dwellers (National Population Commission, 2018). However, the reason FGM was common among urban dwellers was unclear, it could be due to the migration of people from practising communities to bigger towns and cities in search of better life opportunities. Perhaps, parents who resided in urban settings were concerned that failure to perform FGM on their daughters may lead to promiscuity because of high peer pressure, socialisation and the enlightenment that occurred in urban areas. Nevertheless, previous studies documented similar findings of families and communities requesting HCPs to perform FGM procedures within and outside healthcare facilities and in these instances, some HCPs had succumbed to the requests (Obiora et al., 2021;Obianwu et al., 2018;Ibrahim et al., 2013;Adekanle et al., 2011;Berggren et al., 2004).

Evidently, more than 18% of the women and girls that had undergone FGM procedures in the 25 countries where data was available in Africa, were conducted by HCPs of different cadres (Shell-Duncan et al., 2017). As stated earlier (Chapter 2), the medicalisation of FGM includes any circumstance in which HCPs performed FGM procedures at home, in public or private facilities (Shell-Duncan et al., 2017;WHO, 2010c). In an effort to stop the medicalisation of FGM, several countries have enacted laws banning HCPs from performing or perpetuating the practice (Shell-Duncan et al., 2017;WHO, 2010c;UNICEF, 2010). Though there are state and federal laws against FGM in Nigeria, these laws did not make provision for HCPs who violate the laws (LawPavilion, 2016). The scale of medicalisation goes from 0.0% to 66.8% depending on the country, in Nigeria the rate of medicalisation is 12.7% making it the 5th country with the highest rate of medicalisation in Africa (Shell-Duncan et al., 2017).

Despite violating the human rights of women and girls and the medical ethical principle of 'do no harm', and the related health implications, some HCPs still participated in FGM activities (WHO, 2010). Previous studies in

Nigeria and other countries (Obianwu et al., 2018;Kaplan et al., 2016;Umar and Oche, 2014;Onuh et al., 2006;Njue and Askew, 2004) recognised HCPs' involvement in the preservation of FGM. For instance, a recent qualitative study conducted in the eastern part of Nigeria reported that some HCPs declared that they have stopped performing FGM, but some were still actively involved in FGM activities (Obiora et al., 2021). This is similar to views expressed by some authors (Refaat., 2009;Dike et al., 2012), where HCPs affirmed their continued interest in medicalising FGM. However, only one HCP in this present study acknowledged that they had performed FGM in the past, but none admitted to currently rendering FGM services. This evidence could mean that the HCPs in the southern part of Nigeria where this study was conducted may be moving away from conducting FGM. This claim was corroborated by other authors who reported that the participants in their studies were not interested in medicalising FGM (Shabila et al., 2017;Ogunsiji, 2015;Dike et al., 2012).

Paradoxical views were reported among the other HCPs in this study, as most of the HCPs provided evidence that indicated that the medicalisation of FGM may be a reality in Nigeria. The HCPs declared that FGM was ongoing within PHC facilities and among TBAs, who they stated were the chief perpetuators of FGM practices. It was observed that some HCPs continued to practice FGM within PHC facilities in the study setting for monetary gain, as they requested between N3500 (Naira) to N5000 (*Approximately £6.19p to £8.84p*) for FGM services. Comparable findings were reported in previous studies, where HCPs performed FGM for financial benefits and charged similar amount of money for conducting FGM on new-born babies (Obianwu et al., 2018;Refaat., 2009;Onuh et al., 2006;Berggren et al., 2004). Given that HCPs were not well paid, they may be trying to generate more income to meet their needs as reported by the HCPs in a study conducted among midwives in Sudan (Berggren et al., 2004). The minimum wage for civil servants in Nigeria is N30,000.00 per month, which is about £57.83p and for health professionals, such as nurses

- the average salary is around N70,000 to N90,000 (£135.02p - £173.47) monthly for entry level nurses with less than two years working experience (Nigerian Price, 2022;Yusuf, 2022). The salary structure in Nigeria is poor and barely able to sustain an average family and with the increased inflation rate of 16.82%, it is difficult for families to meet their daily needs (Oyekanmi, 2022). The payment that these HCPs received for performing FGM is about 10% of their monthly salaries which is a substantial amount to solve some of their financial problems. The existing hardship in Nigeria coupled with the meagre salaries could be reasons for rendering FGM services. In contrast, some studies noted that HCPs performed FGM for free especially on new-born babies (Obianwu et al., 2018;Isman et al., 2013). This may have been culturally motivated to preserve FGM practices because they struggled to reconcile their cultural and professional identities, or they themselves may have been cut. It is important to highlight that these HCPs' cultural orientation and identity places them in a juxtaposition between their professional position and their role in their community, which could cause bias in their understanding and attitudes towards FGM practices. In addition, the reported prevalence of FGM among girls 0-14 years has increased significantly in Nigeria from 16.9% in 2013 to 19.2% in 2018 (UNICEF, 2022;Obiora et al., 2021). It is unclear if the free administration of FGM on neonates by some HCPs had a role in the reported increase in the prevalence of FGM in new-born babies in Nigeria.

Notably, some HCPs in this study had witnessed senior nurse/midwives nick babies and young girls to discourage parents from patronising TBAs and make FGM safer. This is because the HCPs believed that TBAs performed severe forms of FGM and used unsterile techniques that often led to infections and other FGM associated complications. These views were similar to those shared by HCPs in some studies conducted in Nigeria and other parts of Africa (Obianwu et al., 2018;Kaplan et al., 2016;Umar and Oche, 2014;Kaplan et al., 2013;Onuh et al., 2006). The findings from the Nigerian demographic and health survey shows that 8% of girls and women

were cut by TBAs (National Population Commission, 2018). TBAs provide care in a compassionate and empathic manner, and they contribute significantly to the decrease in maternal and neonatal mortality rate as they provide delivery services within rural communities in Nigeria (National Population Commission, 2018;Ebuehi and Akintujoye, 2012). In addition, existing evidence indicates that these TBAs offer FGM services at a cheaper rate, though the price was not included in the reference (Obianwu et al., 2018). The perceived compassionate nature in which the TBAs provide care, and the cheap rates charged for performing FGM procedures could be reasons why members of the community utilised TBAs' services. Notwithstanding, the medicalisation of FGM is unacceptable at all levels as it validates FGM practices and hinder efforts to end it (WHO, 2022b;UNFPA, 2022). For instance, the process whereby HCPs make small incisions or nick the clitoris to satisfy sociocultural norms and the people who requested FGM, could be interpreted as perpetuating FGM and impeding the eradication of FGM practices even though their intentions were meant to discourage the services of TBAs and protect the future health and wellbeing of girl child.

6.2.3 Caring for women during parturition

This study provides new evidence to help understand the care that was available to women with FGM, and the difficulties encountered by the HCPs who deliver care to the women. To the best of the researcher's knowledge, this study is the first to explore the care that was provided for women with FGM during childbirth in PHC settings in Nigeria. A recent study conducted in the south eastern part of Nigeria explored HCPs' experiences of providing care for women affected by FGM, but the focus was on the complications that arise from rendering care to the women (Obiora et al., 2021). Although, the HCPs in the said study commented on some of the challenges that they encountered during this process (Obiora et al., 2021). The study did not provide details to help understand the care that was accessible to the women.

The HCPs in this current study described the process as a 'tug of war' and revealed that it was a painful and difficult experience for both the women and the HCPs. The HCPs declared that they did not ask pregnant women about FGM during antenatal registration, and the women themselves did not volunteer this information as they may be oblivious to the possible obstetric complications of FGM. Similar findings were reported in the study of 497 paediatricians by Sureshkumar et al., (2015), where 69.5% of the participants revealed that they had never asked about FGM practices when taking history, while some rarely asked about FGM and only one participant declared that they always asked about FGM when they met women in the clinical settings (Sureshkumar et al., 2016). The findings from the Sureshkumar et al (2015) were not surprising considering that the study was conducted in Australia where FGM is not prevalent and asking about FGM history may be unnecessary. Conversely, the midwives in a qualitative study of 48 midwives in Australia, declared that building trust and rapport with the women with FGM enabled them to obtain complete information that facilitated their care (Dawson et al., 2015).

Nonetheless, the lack of prior awareness of the women's FGM status was a major hindrance to delivery plan and care in this study setting. Consequently, the HCPs provided delivery care using some approaches that may not be considered best practice. For instance, they sometimes poured olive oil or used mentholated balm to lubricate the vulva to prevent perineal tears during delivery. This method appeared to ease the delivery process and save the HCPs from the difficulties of birthing women with FGM. Granted that it is a popular practice among midwives, nurses, and CHEWs, it is unclear whether it is accepted as best practice or considered malpractice within the Nigerian healthcare system. The use of this technique was not corroborated by previous studies and existing policies in Nigeria. However, a recently conducted randomized controlled trial (Bayraktar and Başer, 2021) to determine the effect of perineal massage with olive oil in the second stage of labour on perineal lacerations,

episiotomy, and perineum tears in 700 multiparous women, provided some useful insights into the advantages of using lubricants to facilitate delivery. This study found that it was safe to massage the perineum with olive oil during delivery as it reduced the risk for episiotomy, prevented perineal trauma, shortened hospital stay and improved the mother's health (Bayraktar and Başer, 2021). A corresponding experimental study conducted in Saudi Arabia also provided evidence that suggested that the use of olive oil during delivery was beneficial (Almefarfesh et al., 2019). The said study examined 40 primiparous women to identify the effect of using extra virgin olive oil versus obstetric gel during vaginal examination on the outcome of second stage of labour, and found that the application of olive oil had possible benefits for shortening the duration of the second stage of labour without any harm (Almefarfesh et al., 2019). However, WHO recommended techniques for preventing perineal tear during the second stage of labour included warm compresses, perineal massage, and a hands on guarding of the perineum depending on the woman's preference and the available options (WHO, 2018b). Still the use of lubricant was not mentioned or included in the recommendations for positive delivery experience. The olive oil technique seems to be a global phenomenon with perceived benefits.

Depending on the type of FGM performed, the women sometimes delivered normally without any complications. The women with FGM types three and four often experienced difficult deliveries, and if the use of lubricants did not ease the delivery, the HCPs in this study resolved to administering episiotomy to prevent multiple lacerations and foetal asphyxia. This finding was supported by evidence from 6,187 women presenting with type three o FGM in seven African countries, which reported that episiotomies prevented sphincter lacerations and postpartum haemorrhage in women with type three of FGM (Rodriguez et al., 2016). Similarly, episiotomy was reportedly used in a recent study in Nigeria to facilitate delivery of women with FGM (Obiora et al., 2021). In this study (Obiora et al., 2021) CHEWs

and village volunteer workers were found to be performing episiotomies which was a gross misconduct on the part of these HCPs, because this was not part of their role as only certified midwives are trained to administer episiotomy in Nigeria. Episiotomy is a surgical cut made on the perineum during parturition (Service, 2020). It is a restricted practice and HCPs especially doctors and midwives are required to clinically decide when and if the procedure was necessary (Melo et al., 2014).

The WHO episiotomy recommended rate is 10% for all normal deliveries, however a rate of between 9.35 – 54.9% has been recorded across teaching hospitals in Nigeria (Ononuju et al., 2020), but there is no information on the scale of episiotomy within the PHC system. Similar rates have been reported in other parts of Africa. For instance, an Ethiopian study recorded a high episiotomy rate of 44.1% which was significantly higher than the recommended rate (Woretaw et al., 2021). Whereas in high income countries like Sweden the rate of episiotomy was 9.7%, while in England, episiotomy was performed in only about 1 in 7 deliveries (Woretaw et al., 2021;Service, 2020). In these settings, episiotomy is not a routine practice but in Nigeria, episiotomy is a norm and in most cases these women were unaware of the procedure, and HCPs failed to provide them with the information to make the right decisions (Ononuju et al., 2020).

Again, the WHO episiotomy policy did not recommend episiotomy for women with FGM and discouraged the routine or liberal use of episiotomy for women undergoing spontaneous delivery (WHO, 2018b). Meaning that women with FGM who can delivery per vagina do not need to be administered episiotomy, while those who are unable to deliver spontaneously can consent to caesarean section after thorough assessments have been made by care providers. The HCPs in this study were passionate about providing care for the women with FGM but they acknowledged that these women needed specialist care as they were disempowered, and do not possess the skills to render such specialised care

for women with FGM during childbirth. It is therefore not surprising that they used these techniques as a solution to their delivery care difficulties but remained oblivious to the postpartum complications that may occur, such as infections on episiotomy sites. The study has therefore provided evidence that indicates that there are existing concerns around the care that was available to women with FGM in Delta state and Nigeria in general that needed to be addressed, as well as the accessibility of respectful maternity care within these settings.

6.3 Barriers to effective care of women with FGM

The HCPs highlighted institutional challenges that included absence of policies and procedures on FGM, professional trainings, specialist services and limited resources as the main barriers to the effective delivery care of women with FGM. The impact of these challenges on the care for women with FGM are discussed in the following sections.

6.3.1 Lack of guidelines on FGM

There are no existing guidelines on the management of FGM within the PHC settings in Delta State. Consequently, the care that was given to the women with FGM from antenatal to postnatal was based on the HCPs initiatives and past experiences. This lack of guidelines on FGM could be the reason HCPs followed whatever techniques that worked when faced with delivery difficulties. The lack of policies and procedure may have opened doors to malpractices and misconducts in terms of the nature of care provided for women with FGM. An example is using lubricants or administering episiotomy in a bit to support the women but without proper assessment and consent from the women. Since there are no guidelines, monitoring and evaluation of the care provided to the women with FGM within the PHC settings becomes irrelevant as there are no standards to measure HCPs performance, and no avenue to improve existing care.

The lack of existing policies and procedures on the management of FGM cases is not particular to this study's setting. Comparable findings was evident in a study of HCPs perceptions of the challenges of providing care to Somali refugee women with FGM in Ohio, where it was revealed that none of the specialist centres had protocols on the management of women with FGM (Lazar et al., 2013). While some previous studies reported findings that suggested that the HCPs were unsure about the existence of guidelines on FGM in their clinical settings (Dawson et al., 2015;Leye et al., 2008). Conversely, earlier studies in Australia, Belgium and the UK documented the existence of FGM protocols in these settings, but most HCPs were not aware of the guidelines in Belgium (Turkmani et al., 2018;Cappon et al., 2015;Zaidi et al., 2007).

Given the absence of FGM guidelines in some settings, the WHO published a clinical handbook for the management of FGM complications (WHO, 2018a). This clinical handbook was designed to support HCPs who provide direct care for women with FGM and contained important information about how to provide care to girls and women with immediate and short termed obstetric, gynaecological or urogynaecological complications (WHO, 2018a). The WHO clinical handbook is very detailed and an essential guide that could be adopted by healthcare facilities that are yet to develop a clinical guideline on the management of FGM. Healthcare systems could draw from this clinical handbook to develop an FGM guideline that is tailored to the needs of the women and HCPs in their respective settings. The clinical handbook could be introduced into professional training schools to build HCPs capacity to provide care for women with FGM especially in PHC settings which is the first point of contact with healthcare, and closest to FGM practising communities. However, it is worthy to mention that the awareness of this clinical handbook among HCPs is questionable. Therefore, there is need to explore the awareness and importance of adopting the WHO recommended clinical handbook for a unified management of FGM related complications.

6.3.2 Lack of professional trainings on FGM

The HCPs in this study have not received any professional training on FGM in their professional praxis. Although some HCPs stated that they were taught little about FGM in their pre-service education, they acknowledged that they lacked the professional skills to provide the care that was required by the women. The lack of training may be responsible for the theoretical and practical knowledge deficit reported among the HCPs in this study. Indeed, the HCPs declared that they would like to be trained on the various aspects of FGM, particularly the identification of the different types of FGM and how to competently provide specified parturition care for women with FGM. The HCPs in a recent Nigerian study declared that they lacked continuous professional education and training (Obiora et al., 2021). Some other studies also reported parallel findings (Ogunsiji, 2015;Lazar et al., 2013;Leye et al., 2008). Some studies reported that a few of their participants had received formal training on FGM. For example, 15% of the 497 paediatricians in an Australian study reported that they had received training on FGM (Sureshkumar et al., 2016). This was similar to the findings reported by Turkmani et al. (2018) where less than half of the midwives stated that they were taught about FGM in their midwifery education (Turkmani et al., 2018). Like some of the HCPs in this study who asserted that they gained some knowledge and training from past experience, the midwives in the study by Dawson et al (2015) learnt about FGM on the job but a few occasionally attended in service training on FGM (Dawson et al., 2015). However, some studies reported contrary findings as all the participants declared that they had received professional training on FGM (Isman et al., 2013;Berggren et al., 2004).

The training of HCPs on FGM is important as it could contribute to increasing HCPs knowledge of FGM, and possibly improve their clinical practice, competence, and confidence in providing FGM related care.

6.3.3 Lack of specialist services

Aside the lack of guidelines and professional trainings, the HCPs encountered referral problems due to absence of specialist services. In Nigeria, PHC facilities referred difficult cases to secondary facilities where they are either treated or referred to the tertiary level of care for specialised care (Kombe et al., 2009). Given the importance of a good working referral system for the provision of quality maternal and childcare, the findings from this study showed that the secondary facilities often refused to accommodate women with FGM delivery complications. Reasons include limited healthcare resources, and this breaks the referral chain as the women would sometimes go to private hospitals in urban settings for emergency care. Referral is a huge issue in Nigeria, though there are referral protocols in Nigeria, they are sometimes not duly followed leading to dissatisfaction among service users (Daramola et al., 2019). One of the reasons for referral in Nigeria was comprehensive emergency obstetric complications in pregnant women of child bearing age, and labour emergency constituted 68% of delivery referrals in Nigeria (National Population Commission, 2018). Still there is continued difficulties in getting the women with FGM the specialist care that they needed. The break in the referral chain makes it impossible for HCPs in rural areas to provide follow-up care as they do not have the resources to locate these women.

The existence of FGM specialist centres in Nigeria, will relieve the pressure and uncertainty experienced by the women and the HCPs who are care for these women. This is true for countries like Australia where there are available specialist hospitals that provide continuity of care, de-infibulation and counselling for women affected by FGM (Dawson et al., 2015). The midwives in the Dawson et al. (2015) study also revealed that they often received referrals from FGM specialist midwives with care packages that enabled them to provide person centred care to the women, whereas the HCPs in this study do not have the support they required in terms of specialist centres and good referral channels. This continues to be a

challenge as it interferes with the continuity of care for the women who are referred from primary settings to higher level care facilities.

6.3.4 Lack of resources

It was observed that the clinical staff strength within the study setting was limited, and it affected the recruitment process in this study and importantly the care that was provided to members of the communities who utilise PHC services (See chapter four). This was corroborated by the HCPs in this study who revealed the existing shortage of doctors and nurses/ midwives had negative impact on the care that they provided. The PHC facilities service an average population of about six thousand and more in some cases or less, depending on the population of the community. This coupled with low wages and difficult working environments puts a lot of work-related stress on the HCPs, making it impossible to provide quality care (See chapter four).

The shortage of clinical staff was also highlighted in a recent Nigerian study, where the participants revealed an existing shortage of HCPs especially nurses and midwives (Obiora et al., 2021). In the Obiora et al. (2021) study, only four of the seventeen participants were nurse/midwives the remaining thirteen were CHEWs and village volunteer health workers (VVHW), it is no wonder that these CHEWs and VVHW were found to be performing episiotomies when they are not certified to do so. In this same study (Obiora et al. (2021), CHEWs and TBAs were observed to oversee health care facilities, which could lead to poor delivery of health care and malpractices of all kinds because of limitations in skills and certifications. Another Nigerian study reported limitations in sampling and recruiting of a small number of HCPs, that did not include any certified nurses or midwives but mostly auxiliary HCPs (Obianwu et al., 2018). This limitation may have been a result of shortage of skilled HCPs or the use of inappropriate sampling techniques. Interestingly, the limitation in the Obianwu et al., (2018), is one of the strengths of this current study, as the researcher was

able to single handily sample and recruit 26 HCPs of different cadre within 11 PHC facilities in Delta state, which was pivotal for the rich data generated in this study.

Aside shortage of clinical staff, there was limited essential clinical instruments such as needle holders, thermometers, fetal stethoscope and other obstetrics and gynaecological instruments. The Obiora et al (2021) study also reported similar findings. The participants in the mentioned study revealed that they lacked consumable resources such as electricity, water and poor condition of roads which affects provision of care and referral (Obiora et al., 2021).

The lack of human and consumable resources has plagued the PHC system for decades, which has contributed largely to the sub-standard care that was provided at the grass root level. The HCPs in this study believed that they could provide good support for the women with FGM if they had adequate staffing and resources, as this may also limit the rate of referral.

6.4 Beliefs and attitudes towards FGM practices

This section addresses one of the objectives of this study which was to understand primary HCPs beliefs and attitudes towards FGM and its continuation. Therefore, a discussion of findings about HCPs beliefs and attitudes towards FGM and their perceived role in ending FGM practices will be presented in subsequent sections.

6.4.1 Beliefs and attitudes towards FGM

All the HCPs in this study were against the practice of FGM and its medicalisation and continuation except one who believed that FGM was not an undesirable practice, just misrepresented. Most of the HCPs declared FGM as a detrimental practice that should be discouraged among all HCPs and stopped at all levels. It is surprising that despite existing cultural orientations and beliefs, almost all the HCPs recognised that FGM did not prevent promiscuity as they declared that the practice of FGM was founded

on myths and misconceptions. These findings concurred with other findings from previous studies where most of the participants had negative attitudes towards FGM, except a few that continued to support FGM practices (Khalesi et al., 2017;Kaplan et al., 2016;Cappon et al., 2015;Ashimi et al., 2014;Ibrahim et al., 2013;Onuh et al., 2006).

Some studies reported contradictory findings about participants attitudes towards FGM-, there appeared to be a conflict between some midwives' professional role and their cultural beliefs, because despite being against FGM the midwives still support and perform FGM procedures for cultural reasons (Isman et al., 2013). Likewise, some HCPs in a study conducted in Nigeria displayed positive attitudes towards FGM as they continued to offer FGM services to members of FGM practising communities (Obiora et al., 2021). In contrast, another study in Nigeria revealed that all the participants in their study opposed the practice of FGM (Dike et al., 2012). The negative attitudes shown by the HCPs in the current study, and other studies may be due to abandonment campaigns on FGM, adherence to professional ethics, empathy towards the women who had experienced FGM and living with its consequences, or personal convictions about FGM practices.

6.4.2 HCPs roles in reducing FGM

All the HCPs recognised that they had a role in the eradication of FGM practices in Delta State and Nigeria. Some HCPs declared that engaging women, TBAs and other stakeholders in practising communities through sensitization programmes on FGM was crucial for ending FGM. Similarly, participants in earlier studies believed that partnership with communities to build trust and deliver FGM information was a step towards the eradication of FGM (Dawson et al., 2015). Other studies (Kaplan et al., 2016;Leye et al., 2008;Onuh et al., 2006) reported that community programmes were needed to tackle FGM practices. Indeed, using participatory approach to empower communities has reportedly been

successful in reducing the prevalence of FGM, and establishing positive social change at grassroot levels in many countries in African, including Senegal, Burkina Faso, and Egypt (Johansen et al., 2013;WHO, 2008).

Most of the HCPs believed they could play a pivotal role in providing counselling and information about the health consequences of FGM to the populace and women during antenatal clinics and immunisation sessions. For instance, the HCPs often encouraged women and young girls to seek help when they felt pressured by relatives to undergo FGM procedure to provide support and guidance for the women. These findings corresponded with those reported by more than half of the 820 midwives examined in the study by Cappon et al. (2015). Likewise, Isman et al. (2013) noted the importance of health educating women and young girls about the dangers of FGM to bring about a sustainable eradication of FGM. Other studies echoed the importance of raising awareness about the health detriments of FGM among women and girls to correct misconceptions, myths and taboos associated with FGM (Shabila et al., 2017;Dike et al., 2012). The health risk approach is the most used strategy by HCPs working in rural communities to highlight, and increase the understandings of FGM (Johansen et al., 2013). It is believed that providing information about the health dangers of FGM to service users will encourage reflections and deliberations that will ultimately lead to the abandonment of FGM practices. This approach is vital for informing health policies, trainings of HCPs on FGM and changing attitudes towards FGM (Johansen et al., 2013). In addition to providing information and educating women and the community about FGM practices.

The HCPs observed that they had a duty to train and educate TBAs to provide quality care to clients. They stated that TBAs were the main perpetuators of FGM but had limited knowledge of FGM as observed by other studies (Ali, 2012). Since they undertake deliveries in most communities, they needed to be educated about the health complications of FGM and trained to provide quality care by using aseptic techniques to

prevent infections and complications (Ebuehi and Akintujoye, 2012). Findings corresponding with those reported in this study were also reported by previous studies (Obiora et al., 2021;Ali, 2012). Indeed, TBA services are very popular within communities in Nigeria, and the majority of the women in the community patronised TBAs as their services were culturally accepted and very effective (Amutah-Onukagha et al., 2017). This could be improved by training and developing a working partnership with primary HCPs as opined by some participants in a Nigerian study of perception and utilisation of TBAs by pregnant women attending PHC clinics in a rural community in Ogun state, Nigeria (Ebuehi and Akintujoye, 2012;Amutah-Onukagha et al., 2017).

6.5 Socio-ecological model of FGM prevention

The main aim of this study was to explore primary HCPs' knowledge of FGM in Delta State Nigeria to understand the care that was given to women with FGM who access healthcare services. Generally, the overall purpose of FGM research is to contribute to the body of existing evidence on FGM to inform interventions and guidelines to promote the health of women with FGM and prevent the practice of FGM in future generations. This study employed the socio-ecological model to further explain the findings from this study and rejected the feminist ideology based on the reasons identified in subsequent paragraphs.

Feminist ideology

FGM is a gender-based practice as the procedure is performed on women including infants and young girls (WHO, 2022b;United Nations, 2019). This practice is a discriminatory act against women based on gender, sex, age and other protected characteristics, and a violation of the human rights of women and young girls (United Nations, 2019;Fisaha, 2016). Hence, some argue that FGM should be conceptualised and viewed from a feminist lens rather than a sociocultural or human right perspective (Hellsten, 2004;Accad, 1993;Rafti, 1979). Feminist theory or feminism is a range of

concepts and beliefs about how people view the social world, and illuminate the system that create and support oppression, inequality, and injustice, with the aim of promoting the pursuit for equality and justice (Tong, 2002).

The first wave of feminist interest in FGM practices began in the 1970's with Fran Hosken who was known for her anti FGM activities and, articles on FGM in a newsletter called 'women's International Network News' (Hosken, 1981;Rafti, 1979). Hosken was driven by the belief that women were united globally by patriarchy and FGM was seen as an oppressive practice, which prompted ideas to support the eradication of FGM practices (Hosken, 1981;Rafti, 1979). Hence, Hosken devised the term 'female genital mutilation' in place of 'female circumcision'. In the years that followed, Hosken and her colleagues mobilised a generation of western feminist who conceptualised FGM as a barbaric form of male control (Jaggar, 1983;Rafti, 1979). They believed that FGM was a horrific, brutal, cruel, torturous, and inhuman practice, and people from communities where FGM was practised were sometimes referred to as cruel, ignorant, or helpless (Hosken, 1981;Rafti, 1979).

Similarly, the radical feminism belief that the oppression and discrimination of women is mainly caused by a society that is structured and controlled by men (Tong, 2002;Daly, 1978). Radical feminism frames FGM within a patriarchal society where gender is socially constructed and women are extremely oppressed and controlled by men (Andermahr et al., 2000). As a result, women are vulnerable and coerced into undergoing FGM procedures to control their sexuality and keep them dependent and submissive to men. Studies that adhere to feminism beliefs are focused on highlighting and challenging the impact of the patriarchal system on women, and the society in general (Amaefula, 2021;Jain, 2020;Herouach, 2019). This set of beliefs informed several ideas and debates about FGM and patriarchy including, post-colonial critiques and other feminist theories like liberal feminism and Marxist feminism among others (Herouach, 2019;Wade, 2009;Jaggar, 1983). Basically, every feminist theory attempts

to describe women's experiences of oppression in the society, whilst identifying and explaining the reasons, consequences, and strategies to liberate women from the patriarchal society.

There were indications of gender issues in the findings of this study, especially around the superstitious beliefs surrounding the practice of FGM, fear of the repercussions of not conforming to the cultural prescriptions of FGM, participants traumatic narrative of personal experiences of FGM, and discussions about the pain and sufferings experienced by women with FGM during delivery (See section 6.1 and 6.2). These findings indicate that gender issues cannot be separated from the practice of FGM (Andermahr, Lovell and Wolkowitz, 2000). However, this study rejects the feminist theory because-; firstly, the focus of this study was to explore HCPs' knowledge of FGM to understand the care and support provided for women with FGM. This study did not examine personal experiences of women who had undergone FGM, or debates about FGM and the sufferings and oppressions of women, or the dichotomy between women and men in the social system.

Secondly, the researcher is a member of a community where FGM is practised for cultural reasons and can speak with authority that FGM is not performed on females for malicious reasons. Rather, it is the belief of parents and relatives that cutting their daughters would keep them modest, not recognising the health implications of such decisions or practice. Thirdly, contrary to beliefs that men coerce women into undergoing FGM procedures and perpetuate the practice of FGM, evidence from this study and existing literature show that women are the decision makers for when and how FGM should be performed on their daughters (WHO,2010; WHO, 2008).

The researcher does not share the feminist beliefs or views that FGM is performed to oppress and discriminate against women, and the findings from this study does not support that belief and claim. As a result, the feminist perspective was rejected as it is not suitable for providing further

explanation of the research findings. This study adopts the socio-ecological model (SEM) to explain a multifaceted strategy for the prevention of FGM among HCPs and practising communities in general.

Socio-ecological model

Brofenbrenner Urie's framework suggested that human behaviour is influenced by the relationship of multiple environmental factors that consist of the entire ecological systems (McLeroy et al., 1988;Bronfenbrenner, 1977). This framework was later reconceptualised as a behavioural/health promotion model (McLeroy et al., 1988). The SEM is accepted widely and often used to inform health promotion interventions (Ezenwaka et al., 2020;Salihu et al., 2015;Townsend and Foster, 2013;Golden and Earp, 2012;Ohri-Vachaspati et al., 2015) and prevention strategies (Scarneo-Miller et al., 2019;Bogardus et al., 2019;Henderson et al., 2016;Cramer and Kapusta, 2017). Though SEM has been applied in many health-related context, no study was found to have applied the model to inform FGM prevention measures. SEM posits that changes to individual health activities and outcomes are influenced by multiple interactions of levels of environment and sociocultural factors (Ohri-Vachaspati et al., 2015). SEM acknowledged the influence of five multilevel concepts on individual's health behaviours; intrapersonal, interpersonal, organisational, community and policy (McLeroy et al., 1988).

Arguably, HCPs' experiences of FGM are influenced by interactions within the family, and other societal factors, which subsequently determines their beliefs and attitudes towards FGM practices. The purpose of using SEM is to highlight how the different levels of the SEM interrelatedness influences the perpetuation of FGM, and proffer strategies to preventing FGM among HCPs and practising communities. Therefore, to align with the context of this study, the SEM was found to be most appropriate for identifying the determinants and deterrents of FGM practices among HCPs, as opposed to the behavioural change model which is often referenced in FGM related

studies (Brown et al., 2013;WHO, 2011;WHO, 2010a;Diop and Askew, 2009;WHO, 1999).

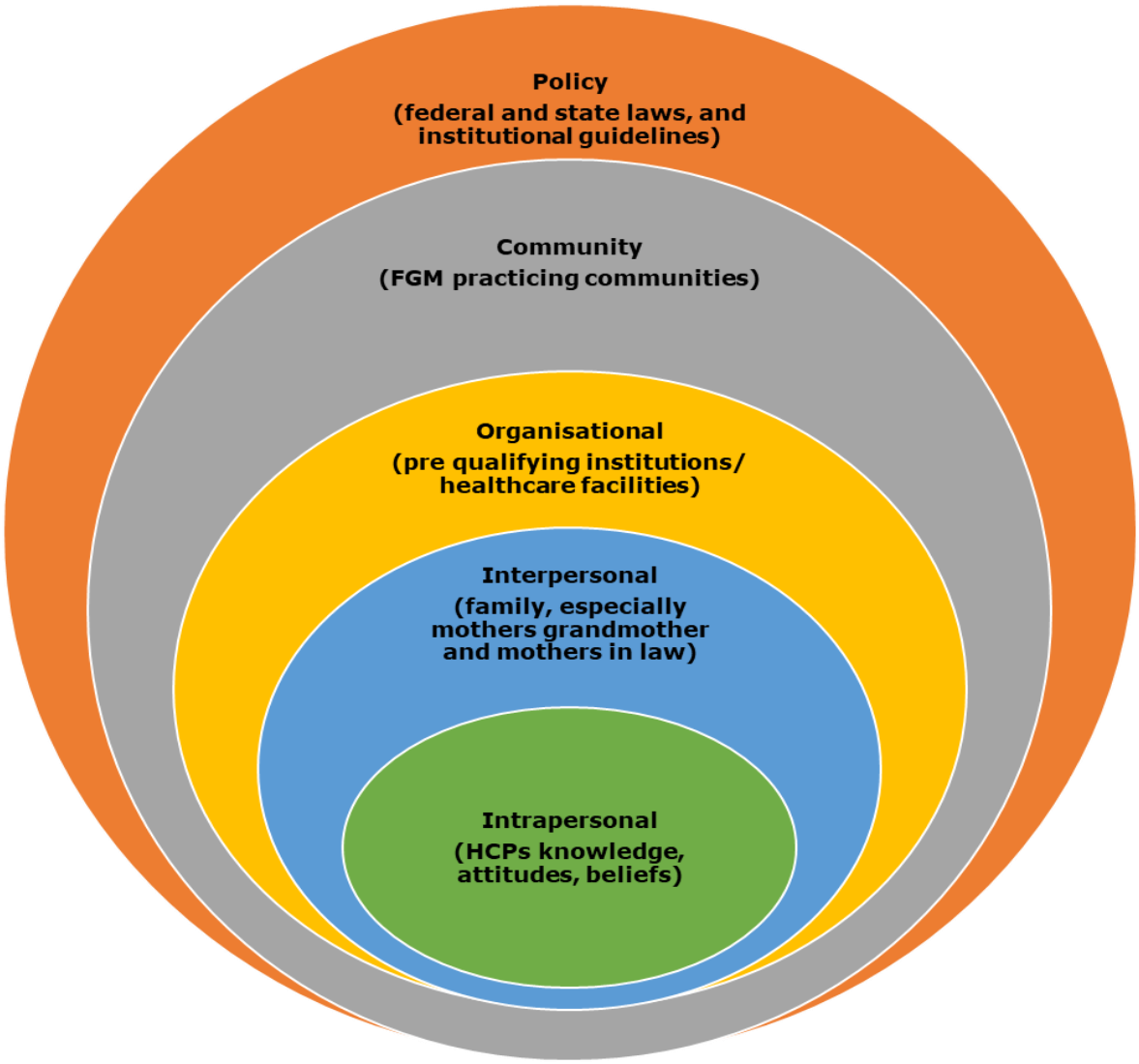


Figure 6.1 SEM of FGM prevention

6.5.1 Intrapersonal level

This is the core of the model, and it describes the HCPs (individuals) whose behaviour and practices are influenced by personal knowledge, beliefs, and attitude. This study and other existing literature indicate that HCPs have limited knowledge of FGM which can inform positive attitudes towards FGM practices (Obianwu et al., 2018;Khalesi et al., 2017;Ashimi et al., 2014;Ali,

2012;Onuh et al., 2006). These studies reported that some HCPs perpetuated FGM because they lacked in depth understanding of FGM and its health detriments. When applying the SEM to FGM prevention, intervention programmes need to focus on creating awareness and education that can help address barriers to negative attitudes to the continuation of FGM. Education and building capabilities should not be based on providing information on FGM and its consequences alone, but on developing effective educational programmes that would include creating opportunities for HCPs to have a shared space to promote interactions and discussions among HCPs and other stakeholders and specialist. This could include the utilisation of realistic female anatomical model of the vulva to identify and describe the anatomical alterations resulting from FGM, that is the various types of FGM. Another FGM preventive strategy would be to adopt a unified curriculum on FGM for pre-registration HCPs to ensure that FGM is properly taught in educational institutions. It is important for more content to be included in the curriculum for HCPs as they would take a leading role in caring for the growing population of women living with FGM globally. The proposed curriculum could be drawn from current work on FGM by international stakeholders such as WHO. For instance, the student manual (WHO, 2001), WHO recommendations for intrapartum care for a positive childbirth experience (WHO, 2018b), the clinical handbook on the care of girls and women living with FGM (WHO, 2018a), and the global strategy to stop HCPs from performing FGM (WHO, 2010c). These mentioned references are all informative documents that could promote the understanding of FGM, behavioural changes towards FGM and prevent continued support for FGM practices.

6.5.2 Interpersonal level

The second level of the SEM is interpersonal which focuses on the influence of family members, especially mothers, grandmothers, mothers in laws and other social groups including extended family members and friends on HCPs decisions to practice FGM. In corroboration, the social convention model

implies that people's behaviours and actions are often dependent on those around them (WHO, 2010a). Since FGM is mainly motivated by cultural beliefs and intergenerational family convention and peer pressure, HCPs who were born into families and communities that practice FGM tend to support the practice due to the influence of family members, especially mothers and grandmothers who are key decision makers of FGM practices (WHO, 2010a). Therefore, as with the intrapersonal level of SEM, creating awareness and education about FGM practices is a strategy for preventing FGM among family members. Prevention approaches could include communication and interactive sessions with families and key decision makers on the health detriments of FGM, so that the knowledge of the dangers of FGM will deter FGM continuation. Family meetings and discussions with FGM specialists to dispel myths and misconceptions about FGM may help prevent continued support to FGM. Families who have made collective choices to stop FGM could be urged to make public statements and open declarations of abandonment to encourage other practising families to do same as this has been effective in recording huge number of FGM abandonment pledges (WHO, 2011;WHO, 2010a;WHO, 1999).

Granted that there are no easy ways to stopping FGM practices, there is need for the development of robust preventive programmes that can support effective and sustainable behavioural change. For instance, the use of interprofessional education strategy whereby students from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes (WHO, 2010b). In this case, student and certified nurses, midwives, doctors-, and other groups of healthcare professionals from FGM practicing communities could meet to learn about the various aspects of FGM, share ideas and experiences of FGM, and hopefully proffer suggestions to end FGM from the community level. The interprofessional education approach to learning may be useful for developing and promoting interprofessional thinking and action about FGM, promote the exchange of beneficial information and knowledge, and

highlight the possible factors and challenges hindering the eradication of FGM practices. In addition to education approaches, mechanisms to address fundamental beliefs and values should be established to promote positive social influences that will bring about the abandonment of FGM practices among HCPs, families, and communities in general.

6.5.3 Organisational level

This level describes influences from institutions such as pre-registration schools and healthcare facilities on FGM practices. Some of the factors that influence the continuance of FGM within organisations include-, lack of training, poor salaries, lack of resources and lack of health sector involvements in FGM programmes (Yusuf, 2022;Obiora et al., 2021;Obianwu et al., 2018;Johansen et al., 2018;WHO, 2010c). In corroboration, all the examined HCPs in this study had not received training on FGM during their professional practice and only a few were taught about FGM in their training schools. Strategies to prevent FGM among HCPs in health institutions should involve training programs on FGM for pre-certified HCPs so they have prior understanding of FGM and their role in ending the practice before they proceed into the work force. Likewise, hospital management should organise mandatory continuous professional courses on FGM for all HCPs who encounter FGM in their practice. There should be a protected time to attend these and an annual update and review of the effectiveness of the courses. The mandatory courses should include modules on different aspects of FGM such as introduction to FGM practices, types and health implications of FGM, community involvements in FGM practices, management of FGM complications, and FGM legalities (WHO, 2010c;WHO, 2001). Such trainings have been effective in building HCPs' capabilities to deal with FGM related complications and change attitudes towards the continuation of FGM practices (WHO, 2010c).

Financial benefits were linked to motivations for FGM as observed in this study and previous studies (Obianwu et al., 2018;Refaat., 2009;Onuh et

al., 2006;Berggren et al., 2004). Therefore, the salaries of HCPs need to be reviewed and upgraded by health sector management to prevent undue hardship among HCPs and discourage FGM activities among HCPs, especially those working in rural and deprived areas. In addition, there is need for extensive health sector involvement in FGM as evidence shows poor interests, especially in countries where FGM was practised, including Nigeria (Johansen et al., 2018). The situation is even worse in Nigeria as there are no known records of health sector or hospital involvements in FGM in the country (Johansen et al., 2018). This is a concern, as lack of involvements means that there could be a gap in knowledge about HCPs FGM activities, systemic documentation of FGM in medical records, and needs such as funding, trainings, adequate staffing and reusable medical instruments and equipment. These inadequacies could be major motivation for FGM practices among HCPs and practicing communities.

6.5.4 Community level

FGM is a cultural practice which means it is embedded within communities. HCPs who are nurtured in these communities are thereby influenced by family beliefs and social interactions to practice FGM. Therefore, the relationship between the community and the HCPs who provide healthcare services to the community is crucial to the abandonment of FGM practices. HCPs are respected role models in the community and could play a vital part in impeding or promoting FGM practices. However, evidence from this study indicates that HCPs had limited contact with members of the community mainly because the women in these communities mostly patronised TBAs for delivery services, and HCPs do not undertake community activities as they used to because of limited human and financial resources. Consequently, FGM practices continue to be perpetuated by FGM practitioners, TBAs and some HCPs with the community. To prevent FGM activities, HCPs need to build a trusting relationship with FGM practising communities, provide information about FGM and dispel beliefs and myths about the practice. Therefore, it is important for the healthcare

system to empower HCPs to advocate for the elimination of FGM through community mobilisations, outreach programmes and home visitations. The community led programmes should be participatory and collaborative in nature to include HCPs, groups of respected community leaders, men, women, youths and TBAs to become change agents. For instance, a UNFPA and UNICEF jointly led community engagement through education, dialogue, and consensus-building, brought about behavioural change and public declarations on the abandonment of FGM in over 42.5 million people in 30,182 communities in 17 countries and more than 361,808 girls were prevented from FGM procedures (UNFPA and UNICEF., 2021). In addition, community engagements may also include health talks on health practices such as oral hygiene, immunisation sessions, counselling, routine physical and eye examination, role play and distributions of medical and food supplies. For successful outcomes, HCPs need to improve their skills so they can gently guide communities to identify their problems and proffer solutions by themselves, and the conventional nature of FGM could motivate some families within the community to collectively decide to abandon the practice. Furthermore, community programmes that include HCPs as change agents should take into consideration HCPs identity as members of FGM practising communities, so share same cultural beliefs and values that sustain FGM practices. Hence, HCPs need to clarify and examine their own beliefs, values and attitudes towards FGM so that they do not take actions that are contrary to FGM elimination, and for them to better understand and recognise the experiences that formed the beliefs and values of practising communities and be able to advocate for the abandonment of FGM (WHO, 2008;WHO, 2001;WHO, 1999).

6.5.5 Policy level

This level includes state and national laws and guidelines on FGM. Regardless of existing state laws in Delta State and national laws on FGM, the practice persists in Nigeria and other countries where there are laws on FGM (UNFPA, 2018a;LawPavilion, 2016;UNHCR, 2015). This shows that the

existence of laws may have made no difference in ending FGM practices as there are no recorded prosecutions in Nigeria since the enactment of the VAPPs Act 2015 (UNFPA, 2018a). Perhaps the practice has gone underground due to existing laws, or people are not aware of the existence of laws against FGM in Nigeria. Nonetheless, there is need to create awareness about the existing state and federal laws against FGM in Nigeria to deter HCPs and the populace from indulging in FGM practices. Indeed, it is important for all stakeholders including the Ministry of Health at federal, state, and local levels, Ministries of Justice, and Women Affairs, educational institutions of all levels, professional bodies, and primary HCPs in particular to create awareness about FGM laws in Nigeria to curb FGM activities among practising communities.

Importantly, evidence from this study and prior studies indicated the lack of guidelines on the management of FGM complications (Obiora et al., 2021;Obianwu et al., 2018;Turkmani et al., 2018;Cappon et al., 2015;Zaidi et al., 2007). The lack of guidelines on FGM is a major hindrance to the care of women with FGM and the elimination of FGM as both HCPs and the women with FGM may perceive the lack of policies on FGM as inconsequential to FGM practices, thereby trivialising the claim that FGM causes severe health complications. Therefore, the development of guidelines and procedures for the management of FGM complications in Nigeria, and other countries without existing guidelines is vital for the avoidance of unnecessary pain and suffering experienced during delivery by women with FGM, as evidenced by this study and previous studies (Obiora et al., 2021;Tarr-Attia et al., 2019;Isman et al., 2013).

6.6 Study implications

This study identified the needs and challenges experienced by the HCPs that could influence education, practice, research, and policies. Some of the implications have been highlighted in the SEM model of FGM prevention.

6.6.1 Implications for education

This study shows the gap in professional training and knowledge of FGM and related health complications. Despite the existence of FGM content in the curriculum for pre-qualified nurses, midwives, doctors and other licenced healthcare professionals in Nigeria, and other countries where FGM is documented, there is still continued lack of knowledge and skills to provide FGM related care (WHO, 2022c). To respond to the gap in FGM knowledge and training content, there is need for the development and implementation of the current curriculum on FGM at all levels of education, including undergraduate and post graduate nursing, midwifery, community health studies and medical sciences across national and sub-national regions. To develop a curriculum that is relevant to context and needs of HCPs' in providing FGM care, the WHO recently provided a practical guide to support the development of a systematic FGM curriculum for the education of pre-qualified and qualified nurses and midwives (WHO, 2022c). This document has six learning outcomes and provides guidance for curriculum planners and educators with a three-step process for planning an FGM curriculum. This include: - providing guidance on the preparatory steps, such as conducting a context assessment regarding FGM and identifying relevant stakeholders to be involved in the curriculum development or update. Providing details on how the responsible educational organisation applies the findings of the context assessment and review of existing FGM training content already in the curriculum to develop FGM content aligned with the six learning outcomes. Then, it describes how to pilot or test the FGM content and scale-up and evaluate the implementation process. (WHO, 2022c). The WHO guidance document is laden with information on how to integrate FGM content into nursing and midwifery education. Educational institutions and professional bodies in Nigeria and other countries where FGM has been recorded could draw upon the information provided by WHO in the practical guide, to design FGM specific curriculum that suits the needs of HCPs in their respective settings.

Though WHO designed the document for the education of nurses and midwives, it could also be used for the training of other HCPs. The overall purpose of the FGM education content is to empower HCPs with the necessary knowledge and training to provide quality care for women and girls who had undergone FGM or at risk of FGM. Indeed, the education and training of HCPs would enhance HCPs capabilities in making informed diagnosis and accurately identify the different types of FGM, manage FGM complications, counsel-, and educate the public about FGM, reporting FGM practices and acting as advocate for the eradication of FGM.

In addition to developing and implementing FGM curriculum, there is need for specialised training of qualified nurses and midwives on how to provide direct care for women and girls living with FGM. Again, WHO clinical handbook is recommended for the care of girls and women living with FGM (WHO, 2018a). This document provides guidance on how to communicate with girls and women with FGM, diagnosis and care of the immediate and long-term complications of FGM, care for women during pregnancy, labour, parturition and post-partum, provide de-infibulation care, and sexual and mental health care (WHO, 2018a;WHO, 2018b). The clinical handbook would be useful in training HCPs, especially in low- and medium-income countries such as Nigeria where economic resources are limited. The clinical handbook could be used by specialist in the field of FGM to educate and provide practical training for HCPs in the classroom and clinical settings. In settings where there is limited access for funding, the WHO handbook could be printed with permission from WHO and distributed to HCPs and student HCPs for self-study as the handbook is easy to use. Individual HCPs could also be encouraged to download the clinical handbook from the WHO website and used as a reference guide when providing FGM related care. National, state, and local government health institutions could also appeal to international stakeholders such as WHO to donate or provide hard copies of the student manual, and the clinical handbook to HCPs in rural

communities to support the provision of quality care for girls and women living with FGM.

Furthermore, there is need for continuous professional development on FGM through short courses, seminars, conferences, and workshops. Health institutions and professional bodies such as the National Primary Health Care Development Agency (NPHCDA) and the Nursing and Midwifery Council of Nigeria (NMCN) could collaboratively provide conferences and courses on FGM. This could include protected learning time in which pre-qualified HCPs are supported to learn with supervision, assessment-, and evaluation of learning programmes. Qualified HCPs such as nurses, midwives and community health extension workers should be funded to attend seminars, conferences-, and workshops, to motivate and encourage them to participant in such programmes. Continuous professional development courses on FGM could be accredited by relevant professional bodies as part of the requirements for revalidation.

6.6.2 Implications for practice

Evidence from this study provided valuable insights into the care that was provided for women with FGM during parturition within the PHC settings, which appeared to be the first in the Nigerian context. This evidence is indicative of the unavailability of specialised clinics and professionals, and lack of basic gynaecological and obstetric instruments to facilitate care. There is urgent need for the PHC system and the secondary and tertiary healthcare levels to work collaboratively to provide clinical supplies for the effective management of women with FGM.

Based on the suggestions of the HCPs, there is need for the establishment of FGM specialised clinics to ensure a working referral pathway and prompt quality care for women who experience delivery emergencies. The federal, state, and local government need to develop a plan, and set budgetary allocation to establish FGM specialist clinics in the 36 states in Nigeria. In addition, the PHC system could include a unit within PHC facilities that

would attend to the needs of women with FGM, similar to family planning and HIV units in PHC facilities.

It was observed during the field work of this study that the ante natal registration form did not include a section for the women to provide history of FGM, as they do past medical history. There is need for the Ministry of Health and NPHCDA to review the ante natal registration card to include questions about FGM. This is to enable nurse/midwives have prior knowledge of the women's FGM status including the type of FGM performed to be able to plan delivery care. Also, to keep accurate records of FGM cases for monitoring, evaluation, and research purposes, and possibly provide evidence that could inform the development of policies and guidelines on FGM.

Furthermore, there is need for the provision of a clinical environment that would enable the delivery of high-quality care to women with FGM. The HCPs in this study stated that there was shortage of resources such as essential instruments. The NPHCDA, Local Government services and the Ministry of Health have a duty to collaboratively evaluate the availability of essential equipment and supply the essential instruments such as thermometers, blood pressure monitors, fetoscope, needle holders, stitch removal, vaginal speculums, uterine forceps, clamps-, and other clinical resources needed to promote the provision of quality care.

6.6.3 Implications for policy

One major hindrance to the care provided to women with FGM was the lack of guidelines and procedures on the management of FGM. Consequently, the HCPs relied on past experiences and common sense to care for the women, which had resulted in several malpractices including untrained persons administering episiotomies and using olive oil as lubricant to aid delivery. There is need for the PHC system, the Federal Ministry of health and professional bodies to jointly develop a unified guideline on the management of FGM. This is to ensure that HCPs, especially those in PHC

facilities in rural areas know what procedures to follow when faced with the challenges of delivering women with FGM. WHO has provided guidance documents to support the development of guidelines and procedures on FGM including the WHO guidelines for the management of the health complications of FGM (WHO, 2016). Care of women with FGM: a clinical handbook (WHO, 2018a). WHO recommended intrapartum care for a positive childbirth experience (WHO, 2018b). Person-centred communication for FGM prevention: a facilitator's guide for training healthcare providers (WHO, 2022d). Professional bodies and Healthcare systems, and organisations could draw from these references to develop guidelines and procedures to meet their specific FGM needs.

In addition, there should be a network of policy makers, officials of the Nigerian healthcare system, and community representatives to build on the existing laws on FGM at both state and federal levels. This is to foster a nationwide enlightenment campaign on laws prohibiting FGM and provide a channel for reporting offenders without victimisation.

Furthermore, there is also a need for health authorities to create a process for reporting FGM cases, whether at community level or within HCP settings. This might enable the creation of a database of cases, types, and clinical outcomes - which could be useful for subsequent studies or research and such collective experience base could support further understanding of FGM practices and management of new cases.

6.6.4 Implications for research

There is an existing dearth of literature about FGM in Nigeria, especially those that utilised qualitative methods. To the best of the researcher's knowledge, this is the first study that had conducted a study on FGM among HCPs using qualitative methods in Delta State, Nigeria. Prior to this study, only one study existed that had applied qualitative methods (Obiora et al., 2021), while another study examined participants that were not certified HCPs (Obianwu et al., 2018). Due to the scarcity of references on FGM in

Nigeria, there is need to for more studies to be conducted among HCPs, especially among those who provide care for women affected by FGM. There are existing gaps in evidence about HCPs' experiences of providing care especially at the community level and how these challenges are managed within the clinical setting. There is also a gap in knowledge about women's perspective of the care that was rendered to them during delivery. In addition, there is a need for training interventions, and studies to determine their effectiveness and impact on the quality of care that was provided to the women with FGM. Furthermore, the socioecological model of FGM prevention could be explored further through research to highlight other factors within the five multifaceted model that could influence FGM practices among HCPs and other social, cultural, and professional groups.

6.7 Strength and limitations

6.7.1 Study strengths

To the best of the researcher's knowledge, this is the first study that has explored the knowledge, beliefs, and practices of FGM using four cadres of HCPs (doctors, nurses, midwives, and CHEWs) in Delta State and Nigeria in general. The HCPs in this study practised in PHC settings and this is the first time that this group of HCPs were included in this type of research. The HCPs also belonged to FGM practising communities and it is based on these unique characteristics that this study generated a rich body of data on FGM practices. In addition, the HCPs worked closing with the community at grassroot level, which was advantageous in acquiring the culturally inclined understand of FGM and the co-constructed knowledge reported in this study. This co-constructed knowledge of FGM is important for counselling, understanding the community, building trust, and obtaining information from the community, due to the existing synergy between HCPs and the communities.

The study was conducted within eleven PHC facilities in rural communities in two LGAs of Delta state Nigeria where FGM was concentrated and practised for sociocultural reasons. The study explored these unique HCPs using interviews to understand their experience of FGM, which was a technique that was not frequently used in FGM research in Nigeria. The study specifically generated new findings that highlighted the type of care that was provided to women with FGM at the grass root level, and some of the challenges experienced by the primary HCPs who rendered delivery care. The combination of the particular characteristics of the study population, settings and methodological approach made the findings from this study very unique, as the data was in-depth, rich and from direct sources-, that is, HCPs who belonged to FGM practising communities and had themselves undergone FGM procedures and provided direct care for women living with FGM.

6.7.2 Study limitations

Research studies often have limitations and there were several limitations in this study. Firstly, the researcher was a novice who went into the field with mixed feelings, uncertainty, and fear of the outcome of the field work. This inexperience affected the recruitment and interview phases of this study. For example, one participant who had agreed to participate in the study but refused to be recorded, was excluded. In hindsight, the participant could have been interviewed and notes taken instead of audio tape-recorded, but that potential data source was lost because the participant had reservations about being recorded. Secondly, the participants were nervous and sceptical about the interview process as they have not participated in any research and were unsure of what to say or not say. This may have affected their responses in some ways, though the researcher continuously reassured them about confidentiality, anonymity and privacy which made them more comfortable. Thirdly, the researcher on her own part was nervous during the initial interviews and this may have affected how the interview questions were delivered and the responses

received from participants. It was observed during the transcription of the interview data that some responses could have been followed up in depth with more probing questions. However, the researcher became more confident and relaxed in subsequent interviews and explored in depth the participants' responses.

In addition, there was limitation to the application of the SEM in this study. The SEM was useful for drawing out the difference levels of socioecological factors influencing the practice of FGM and providing strategies for the prevention of FGM. To the best of the researcher's knowledge this is the first time that the SEM has been adopted for a prevention strategy in the context of FGM. Hence, it was difficult to utilise as there were no prior references, and the researcher struggled to decide how and when to apply the model, and the sense making of the SEM in relation to this study context was challenging. Despite the associated challenges, it is hoped that the utilisation of the SEM has been useful for drawing out the intrapersonal, interpersonal, organisational, community and policy factors enabling FGM practices and the suggested approaches to preventing FGM practices among HCPs and practicing communities in Delta state and Nigeria in general.

6.8 Conclusion

FGM is a global issue as over 200 million girls and women have been subjected to FGM procedures and another 3 million are at risk of being cut annually. The practice is concentrated in Africa, Asia and the Middle East and documented in other parts of the world due to migration of practising families. FGM is an entrenched cultural practice that is associated with severe long-term and short-term health complications that include- pain, bleeding, infections, obstetric and gynaecological problems, and death. Global efforts have been made to eradicate FGM through various approaches, including legal approach and the health risk approach, but the practice persists.

In an effort to end FGM practices in Nigeria, the Federal Government of Nigeria ratified all international and regional conventions on the right of women and children condemning the practice of FGM, a national policy and plan for the elimination of FGM was developed, and the Violence Against Persons (Prohibition) (VAPP) Act 2015 was enacted to deter people from practising FGM. Still, FGM continued as over 20 million girls and women have been cut in Nigeria, representing around 10% of the global prevalence. The national policy and plan to eradicate FGM required HCPs to play a pivotal role in ending FGM practices and provide direct care for women affected by FGM. However, existing literature in Nigeria suggests that HCPs have limited knowledge about FGM, some support FGM and had subjected their daughters to FGM, and some would perform FGM if requested. In addition, there is no clear understanding of the care that was provided for women who had undergone FGM in Nigeria, especially those residing in rural communities. Hence it was important to explore primary HCPs' knowledge, beliefs, and practices of FGM to understand how this may affect the care that was rendered to women with FGM who access PHC facilities.

This study explored primary HCPs knowledge, beliefs, and practices of FGM in Delta State, Nigeria. This is in anticipation that evidence from this study may serve the overall aim of contributing to the improvement of the care that was given to women with FGM who sought healthcare services. The study was based on the tenets of social constructivism and employed a qualitative approach and the interpretive description framework as methodology guide. The study used purposive and snowball sampling techniques to identify and recruit 26 HCPs including 2 doctors, 15 nurse/midwives and 9 CHEWs. A semi-structured individual interview was conducted with the 26 HCPs and this generated rich data that was transcribed by the researcher and imported onto NVivo12Pro data management software where data coding and themes were generated using Braun and Clarke (2006) thematic framework. At the end of the data

construction, two main themes and several subthemes were generated from the interview data, and these were presented in two chapters (chapters 5 and 6).

The findings for this study indicated that HCPs had a cultural understanding of FGM but the professional knowledge about FGM and its types was poor. Some of the participants had themselves undergone FGM procedures, some have been requested to perform FGM and some have performed FGM in the past. Notwithstanding, almost all the HCPs had negative attitudes towards FGM and declared that they had a role to play in ending FGM. The majority of the HCPs have encountered and care for women with FGM during delivery and described the experience as a *'tug of war'.* It is no wonder that these HCPs identified lack of guidelines on FGM, lack of professional trainings, lack of specialist services and resources as some of the challenges that they encountered when supporting women with FGM. To improve the care that was provided for women with FGM, there is need for a collaborative effort of all stakeholders including the Nigerian healthcare system and professional bodies to develop educational curriculum on FGM, provide guidelines and procedures for the management of FGM complications, organise specialised training for HCPs, ensure a working referral pathway by establishing specialist clinics for FGM cases, and provide basic gynaecological and obstetric instruments.

6.9 Dissemination of findings

Findings from this research was disseminated through oral presentation to HCPs working in PHC facilities, and pre-qualified nurses and midwives in Delta State Nigeria. To maximise the benefit of this research and ensure effective dissemination, findings will be shared through publications in academic journals, and oral and poster presentations at relevant conferences, seminars, and workshops. Importantly, oral presentations and face to face meetings will be arranged with key stakeholders of FGM in

Delta State where this study was conducted, including the Delta State Commissioner for Health, the Delta State Commissioner for Women's Affair, Delta State Primary Healthcare Development Agency, and the Delta State House of Assembly. The mentioned stakeholders are the decision makers in issues relating to FGM and practice, and they have prior knowledge of this study. It is hoped that sharing the findings of this study with these important stakeholders could inform outcomes that may lead to the provision of quality care for women with FGM.

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Appendices

Appendix 1: Thematic table of included empirical studies

S/N	Author (Year)	Setting	Aim of study	Methodology/ methods	Domains examined/Findings		
					Knowledge	Beliefs and Attitudes	Practices and experiences
1	Obiora et al. (2021)	Nigeria	To describe the experiences of healthcare workers caring for the genitally mutilated females in South-Eastern Nigeria	Qualitative descriptive design Data collection: In depth interviews Study sample: 17 HCPs 1=RN 1=RM 2=NM (nurse/midwives) 8=CHEW (community health extension workers) 5=VVHW= (voluntary village health workers)	Good knowledge of the complications of FGM. Complications identified included - perineal tears, intrapartum and postpartum haemorrhage, infections, vesicovaginal fistula (VVF), severe pain, prolonged labour, genital keloid No type	Almost all participants declared that FGM was an entrenched cultural requirement FGM prevents promiscuity and reduces sexual urges Most participants did not think FGM was a major procedure Most of the participants did not support the continuation of FGM but they supported the new method of performing FGM 5 of the participants openly supported FGM practices and continuation	All participants had cared for women with FGM All participants were from FGM practicing communities Some participants still performed FGM on babies and young girls FGM was being conducted secretly even in clinical settings Women with FGM do not seek healthcare services Challenges of providing care included – shortage of nurses/midwives, lack of professional training, Some participants have adopted the new method of performing FGM procedures known as 'flattening of the clitoris' Episiotomy was performed to facilitate delivery Some CHEW and VVHW performed episiotomy (not certified to do so malpractice)

							Some participants were not willing to carry out health education and counselling
2	Tarr-Attia et al. (2019)	Liberia	To understand the health implications of FGM/C as perceived by qualified female midwives.	Qualitative study Data collection: In depth interviews Study sample: 17 Midwives	Good knowledge about types and complications of FGM Type 1 of FGM was the most practiced type in the setting Listed complications of FGM to include - pain, bleeding, risk for infections, lacerations, prolonged labour, lack of sexual gratification, painful coitus	FGM ceremony symbolized a girl's entrance into Sande (a secret society) FGM practices were not publicly discussed for fear that they may be seen as questioning the legacy of the secret cult FGM was practiced for social respect and acceptance FGM was practiced to prevent promiscuity and increase marriageability They believed that the practice kept women under control All participants declared that they were against FGM but supported the existence of the secret society for cut girls and women, and FGM	Most participants were from FGM practicing communities Some had undergone FGM procedures Some participants had attended to women with FGM Some participants had treated girls with FGM complications Some had performed FGM procedures Women with FGM who belonged to the secret society only discussed their FGM related complications with midwives who were also members of the secret society Participants found out that women were cut at antenatal clinic during vaginal examination. This helped midwives to prepare for delivery Episiotomy was used to prevent tear during delivery Some participants declared that they were taught about FGM in school Most participants lacked training on how to care for women with FGM
3	Obianwu et al. (2018)	Nigeria	To inform the design and implementation of abandonment interventions through enhanced	Community-based, cross-sectional qualitative study Data collection: In depth interviews	General awareness of FGM Limited knowledge about the types and	FGM was practiced for cultural reasons FGM is a minor procedure with health benefits	Participants had performed FGM because of their cultural beliefs All were taught how to perform FGM procedures by other health workers who practiced FGM

			understanding of the factors of medicalised FGM in Nigeria	Study sample: 6 Health workers (Auxiliary nurses) and community members in Delta, Ekiti, Imo and Kaduna states of Nigeria	complications of FGM Type 1 was the most practiced form of FGM		FGM is not a concealed practice among health workers in these settings FGM is performed within hospital facilities FGM is sometimes performed for free Claimed to have abandoned FGM but still practiced it One participant declared to still practice FGM
4	Kaplan Marcusan et al. (2016)	Gambia	To explore, measure and assess changes in knowledge, attitude and practices regarding FGM among health care professionals (HCPs) in The Gambia	Cross-sectional descriptive study Data collection: Self-administered questionnaire Study sample: 1,288 HCPs in 6 regions of The Gambia	Good knowledge about types and complications of FGM no type 78.5% of HCPs stated that FGM can lead to transmission of infectious diseases 33% FGM cause lack of sexual libido 65% difficult delivery	96.5% believed that FGM was practiced for cultural reasons 24.6% FGM was a religious requirement 41.3% declared FGM was a ritual passage of girls into womanhood 77.9% believed FGM was a violation of the human rights of women 71.6% FGM is harmful 76.4% think FGM should be stopped 25.4% support FGM and its continuation 14.5% think FGM is a good practice	10.5% have performed FGM 71.5% belonged to families that practiced FGM 24.4% subjected their daughters to FGM 28.7% supported medicalisation of FGM (controls the practice and makes it safer) 93.7% think HCPs have a role to play in eliminating FGM

						10.5% claimed that girls who have not undergone FGM should be discriminated against	
5	Ashimi et al. (2014)	Nigeria	To determine the knowledge and attitudes of nurses in northern Nigeria concerning FGM	Cross-sectional study Data collection: Self-administered questionnaire Study sample: 350 nurses working in 3 tertiary institutions in northern Nigeria	General awareness of FGM. Good knowledge about the complications and limited knowledge about the types of FGM 91% of the participants have heard of FGM 41% knew no type of FGM 49% could mention one type of FGM Majority mentioned haemorrhage (77%), risk of HIV and tetanus (73%), painful coitus (63%), and difficult labour (54%) as complications of FGM 8% FGM had medical benefits	10% FGM was a religious requirement 28% preserves virginity 53% FGM prevent promiscuity 3% people practiced FGM out of ignorance 17% do not know if FGM has benefits 4% support FGM	Some have been cut (5%) 4% will perform FGM if requested 4% will cut their daughters
6	Umar and Oche (2014)	Nigeria	To identify the predictors of professional care workers (PHWs) practicing FGM in Sokoto, Nigeria	Descriptive cross-sectional study Data collection: Questionnaire Study sample: 100 female nurses working	Good knowledge about FGM and complications but limited knowledge about the types of FGM	86% believed that FGM was a violence against women 14% support the continuation of FGM	7% had participated in the decision-making process of FGM and have performed FGM FGM was performed outside hospital environment

				in a teaching hospital in Sokoto, Nigeria	75% had general awareness about FGM and the health consequences 34% had knowledge about the types of FGM (associated with years of practice)	Ethnicity and positive attitudes were the main reasons for supporting FGM	
7	Ibrahim et al. (2013)	Nigeria	To determine the knowledge, attitude, and practice of FGM among doctors and nurse/midwives practicing in secondary and tertiary hospitals in Bayelsa state, Nigeria.	Cross-sectional study Data collection: structured questionnaire. Study sample: 118 HCPs Doctors (66) and Nurse/midwives (52) in secondary (2) and tertiary (2) hospitals in Bayelsa state, Nigeria.	Good awareness of FGM and complications All the participants were aware of FGM 20.3% were able to identify type 1, 24.6% type 2 Almost all could mention some health complications of FGM- HIV (69.5%), haemorrhage (82.2%), keloid (67.8%) difficult delivery (52.5%), perineal tear (28%) 9.7% believed that FGM was not harmful	96.6% believed FGM was a cultural practice 12.7% FGM is a religious requirement 3.4% FGM made the external genitalia attractive 9.3% FGM reduced promiscuity 4.2% support FGM 5.1% will encourage the practice 57.6% government was not doing enough to eradicate FGM	Only 1 participant admitted to performing FGM 27.1% have undergone FGM procedures 2.6% will cut their daughters 20.3% had seen type 1 of FGM 24.6% had treated women with FGM complications
8	Isman et al. (2013)	Somaliland	To elucidate midwives' experiences in providing care and counselling to women with FGM related problems	Qualitative inductive study Data collection: Semi-structured interview Study sample: 8 midwives living in Somaliland.			All the participants had been trained to provide direct care and counselling for women with FGM problems All 8 midwives had undergone FGM Midwives faced cultural and superstitious beliefs and religious

							challenges when providing care for women with FGM Most midwives will perform mild FGM on their daughters Most of the midwives still performed FGM despite being against the practice Reasons for performing FGM included, to meet family demands, pressure from young female relatives who wanted to undergo FGM procedures and difficulty in having to abruptly stop performing FGM
9	Kaplan et al. (2013)	Gambia	To examine the knowledge, attitude and practices regarding FGM among health care professionals (HCPs) working in a rural setting in The Gambia	Cross-sectional descriptive study Data collection: Questionnaire Study sample: 468 nurses/midwives in health facilities in rural areas of The Gambia.	General awareness of FGM Complications of FGM -transmission of infectious diseases (59.1%), bleeding (53.4%), difficult delivery (46.3%), reduced libido (25.2%) 2.1% FGM declared that FGM has no health complications No type	53.8% FGM is practiced for religion reasons 48.2% FGM is a cultural practice 34.4% Rite of passage 42.1% control of sexuality 42.5% supported the continuation of FGM 12.8% uncut girls should be discriminated against 54.8% FGM cannot be eradicated in Gambia 57.5% think the practice should stop	47.2% will cut their daughters 40.9% have seen women and girls with FGM complications 68.6% belonged to families who practiced FGM 7.6% have performed FGM 42.9% FGM should be medicalised 40.6% medicalisation should be stopped 73% HCPs have a role to play in the elimination of FGM

10	Ali (2012)	Sudan	To assess knowledge and attitude of midwives towards FGM	Quantitative study Data collection: Opened questionnaire Study sample:157 midwives (Traditional Birth Attendants) in kassala state, Eastern Sudan	General understanding of FGM. Limited knowledge about types Only 7% could identify the four types of FGM 64.3% FGM decreases the sexual pleasure 53.5% FGM does not increase the risk of HIV transmission 76.4% some types of FGM are not harmful 4.5% no type of FGM is harmful	66.2% will continue the practice of FGM, for cultural reasons (51.2%), religious reasons (26%) and financial benefits (22.8%)	80.9% had performed FGM
11	Dike et al. (2012)	Nigeria	To determine the awareness and attitudes of female nursing/midwifery students towards FGM	Quantitative study Data collection: Semi structured questionnaire Study sample: 269 students at school of nursing and midwifery, Afikpo Ebonyi state, Nigeria.	Good knowledge of FGM No type Almost all mentioned bleeding (86.6%), HIV (84.4%), painful coitus (75.6%), and difficult delivery (26.7%) as complications of FGM.	51.3% FGM prevented promiscuity 26.7% FGM was a traditional practice 17.4% made external genitalia neat	More than half had undergone FGM (146/54.3%) 49.3% of those that had undergone FGM are happy with their status All participants will not cut their daughters
12	Adekanle et al. (2011)	Nigeria	To assess the knowledge and experience of health workers in obstetrics and gynaecology, paediatrics, and	Descriptive cross-sectional study Data collection: Questionnaire	Good Knowledge of FGM 80% had good knowledge about FGM		66.6% have seen FGM type 1 64.4% have treated one form of FGM complication

			private facilities in Nigeria	Study sample: 250 HCPs (146 nurse midwives and 104 doctors) practicing in health institutions in Osun, Oyo and Ogun states, Nigeria.	66.6% could identify type 1, 25.2% type 2, 7.3% type 3 and 0.8% type 4 Complications reported labial agglutination (90.4%)' clitoroidal cysts (5.2%) virginal bleeding (4.4%)		More nurses/midwives (69%) than doctors (52.9%) had treated FGM complications. 48.4% (121) have been requested to perform FGM Nurses/midwives (57.3%) were mostly asked to perform FGM procedures compared with doctors (37.7%)
13	Refaat (2009)	Egypt	To identify the prevalence and determinants of the practice of FGC by Egyptian physicians.	Cross- sectional study Data collection: Self-administered questionnaire Study sample: 193 Physicians	Good Knowledge of FGM, types and health consequences Most practiced type was type 2 (76%) 88% at least one complication of FGM= listed bleeding (74.6%), shock (64.2%), genital disfigurement (62.7%) sexual dysfunction 63.7%) 14% FGM has no complication if performed by a physician	18% of the physicians approved of the practice due to religious beliefs 61% cultural affiliation	19% of the physician practiced FGM 43.3% of the physicians believe that physicians are the most suitable people to perform the procedure 51% performed FGM due to conviction 30% for financial gain 19% to reduce harm Performed within clinical/hospital settings 65%/21.6% 34.3% has had complications arising from performing the procedure 34.7% of the physicians do not approve law banning FGM
14	Mostafa et al. (2006)	Egypt	To explore the knowledge, beliefs, and attitudes of 5th year medical students in Alexandria University towards female genital mutilation	Cross-sectional study Data collection: structured questionnaire Study sample: 298 medical students	General awareness of FGM practices. Limited knowledge of the types and complications of FGM Only 51.7% and 29.9% of the students were able	24% prevented the clitoris from growing 34% essential part of culture 49% FGM prevented promiscuity 30% FGM was a religious obligation	32% will subject their daughters to FGM 73.2% supported the medicalisation of FGM 91% favoured the medicalisation because it reduced pain if carried out under anaesthetics Not trained to educate against FGM (61.7%)

					to identify Type 1 and 2 respectively 42.7% could mention some complications of FGM	64.8% FGM was not a health issue 44.6% does not violate human rights 52% supported the continuation of FGM	Limited clinical skills to identify FGM complications
15	Onuh et al. (2006)	Nigeria	To determine the knowledge, attitude, and practice of FGM among nurses in the ancient metropolis of Benin city, Nigeria.	Cross-sectional study Data collection: Structured questionnaire Study sample: 182 Nurses	Awareness of FGM practices Only 6.6% correctly identified the four types of FGM 38% identified type 1 and 2 of FGM All could mention some complications of FGM: haemorrhage (97%), difficult delivery (50.2%), lacerations (83.5%), infections (81.3%) 72% all forms of FGM are harmful	9.9% FGM beautifies the vagina 2.8% FGM is good	44% were cut 57.7% will perform FGM in future 4.4% will have their daughters undergo FGM 6.6% practiced FGM 14.3% had performed FGM in the past Reason for performing FGM- cultural (83.3%), financial gain (50%), discourage clients from patronizing traditional cutters (25%)

Appendix 2: **University of Nottingham ethical approval letter**

University of Nottingham
UK | CHINA | MALAYSIA

Faculty of Medicine & Health Sciences
Research Ethics Committee
Faculty Hub
Room E41, E Floor, Medical School
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham, NG7 2UH
Email: FMHS-ResearchEthics@nottingham.ac.uk

7 May 2019

Agatha EO Adogho
PhD Student
c/o Dr Julie McGarry
Associate Professor/Safeguarding Research Lead – Sexual Safety
School of Health Sciences
B Floor, South Block Link
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham, NG7 2UH

Dear Miss Adogho

Ethics Reference No: 284-1904**– please always quote**	
Study Title: Primary Healthcare Professional's Knowledge, Beliefs and Attitudes towards the Practice of Female Genital Mutilation (FGM) in Delta State, Nigeria: A Qualitative Study.	
Location of Study: Delta State, Nigeria	
Chief Investigator/Supervisor: Dr Julie McGarry, Associate Professor, Safeguarding Research Lead – Sexual Safety.	
Lead Investigators/student: Agatha Adogho, PhD Student, School of Health Sciences	
Other Key Investigators/Collaborators: Dr Kathyrn Hinsliff-Smith, Senior Research Fellow/Associate Editor, School of Allied Health Sciences De Montfort University, Leicester	
Proposed Start Date: 01/05/2019	**Proposed End Date:** 01/11/2019

The Committee considered this application at its meeting on 12 April 2019 and the following documents were received:

- FMHS REC Application form and supporting documents version 1.1: 29/03/2019

These have been reviewed and are satisfactory and the study has been given a favourable opinion.

A favourable opinion has been given on the understanding that:

1. Assurance from the Nigerian IRB that in case of voluntary disclosure by a participant to the researcher of their involvement in the practice of FGM there are processes in place to protect the researcher and also to deal with the disclosure.
2. All appropriate ethical and regulatory permissions are respected and followed in accordance with all local laws of the country in which the study is being conducted and those required by the host organisation/s involved
3. The protocol agreed is followed and the Committee is informed of any changes using a notice of amendment form (please request a form).
4. The Chair is informed of any serious or unexpected event.
5. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

Professor Ravi Mahajan
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

Appendix: 3 Delta state ministry of health ethical approval letter

Telegram PERMHEALTH

Telephone

DELTA STATE
MINISTRY OF HEALTH
P.M.B. 5012
ASABA
DELTA STATE OF NIGERIA

Our Ref : HM/596/T/226

25th June, 2019.

Agatha E.O Adogho
School of Health Sciences
University of Nottingham,
United Kingdom.

Dear Madam,

LETTER OF RESEARCH ETHICS APPROVAL TO CARRY OUT RESEARCH IN DELTA STATE

The Ministry of Health Research Ethics Committee (MOHREC) has reviewed your proposal titled "Primary Healthcare Professionals' Knowledge, Beliefs and Attitudes towards the Practice of Female Genital Mutilation in Delta State, Nigeria: A Qualitative Study".

Having satisfied the requirement for an ethical research, Research Ethics approval is hereby granted to enable you carry out the research in Delta State in accordance with the terms of the proposal. You are required to submit a progress report on the research to the Ministry of Health every 6 months as well as a copy of your findings at the conclusion of the research.

The duration of the approval is one year, after which you are requested to re-apply for renewal if the research is still in progress at the end of one year.

Thank you.

Dr. Efiro Ogheneaga.
Chairman (MOHREC)

Appendix 4: Letter of support from the gatekeeper

DELTA STATE PRIMARY HEALTH CARE DEVELOPMENT AGENCY

No.1 Onyeka Close
Off DBS Road
P.M.B. 95114,
Asaba.

School of Health Sciences,
University of Nottingham.

14th March,2019

Letter of support as Gatekeeper to Agatha Adogho (PhD Student) School of Health Sciences, University of Nottingham

I have accepted to act as your gate keeper in your research topic on primary health care professional's knowledge, beliefs and attitudes towards the practice of Female Genital Mutilation (FGM) in Delta state of Nigeria.

2. It will be my pleasure to assist you to access the required primary health care professionals in your selected LGAs of interest in the pursuit of your research.

3. It's also important you obtain an ethical approval from Delta State Ministry of Health before you start your research work.

4. I look forward to the commencement of your research project in Delta State

5. Best of Regard.

Dr. Akporere Francis Onojeta
Director Community Development,
Advocacy & Social Mobilisation

To develop a sustainable Primary Health care service system which is equitable & qualitative through the participation of all Nigerian people, in partnership with all levels of Govt. and NGOS.

Appendix 5: Participants information sheet

University of Nottingham
UK | CHINA | MALAYSIA

Faculty of Medicine & Health Sciences
School of Health Sciences
B Floor, South Block Link
Queen's Medical Centre
Nottingham
NG7 2HA

Participant Information Sheet
Draft Version 1.2/Final version 1.2: 10/05/2019)

Title of Study: Primary Healthcare Professionals' Knowledge, Beliefs and Attitudes towards the Practice of Female Genital Mutilation in Delta State, Nigeria: A Qualitative Study.

Name of Researcher: Agatha E.O Adogho, PhD Student School of Health Sciences
Names of Supervisors: Dr Julie McGarry, Associate Professor School of Health Sciences
Dr Kathryn Hinsliff-Smith, Senior Research Fellow De Montfort University

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. The researcher will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask me if there is anything that is not clear.

What is the purpose of the study?
This research is a part of a PhD doctoral study. The researcher is undertaking this study as a PhD candidate of the University of Nottingham.

Female Genital Mutilation (FGM) is a global challenge as over two hundred million girls and women worldwide have undergone the procedure and another three million girls are at risk of undergoing FGM yearly. The practice is detrimental to health as it is known to cause severe health repercussions such as severe pain, haemorrhage, infections, urinary and menstrual problems, formation of scar tissues, obstetric complications, neonatal death and psychological problems. Health professionals have a role to play in caring for women living with the effect of FGM and educate/ counsel the populace they meet about the detriments of FGM. Hence, the purpose of this study is to understand primary healthcare professionals' knowledge, beliefs and attitudes towards the practice of FGM in Delta State to improve the care given to women with FGM who access health care system in Nigeria.

Why have I been invited?
You are being invited to take part because you are a primary healthcare professional who currently works as a doctor, nurse, midwife, Community Health Extension Worker (CHEW) in a Primary Healthcare facility in Delta State, Nigeria. We are inviting 25 to 30 participants like you to take part.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?
If you decide to take part in this study, you will be invited for an interview with the investigator. This interview will be conducted in a quiet and safe office within your work place or wherever is convenient for you. The interview is expected to last no longer than 45 to 60 minutes. The researcher will be available to answer any questions you may have. The interview will be recorded using a digital audio recorder with your permission.

Expenses and inconvenience allowance

Participants will not be paid an inconvenience allowance to participate in the study. However drinks and food will be provided for participants at the end of the interview.

What are the possible disadvantages and risks of taking part?

There are no expected risks or adverse effects expected as a result of participation in this study, however you may still withdraw from the study at any point. Please be aware however that if you wish to withdraw the data collected to date cannot be erased and may still be used in the final analysis

What are the possible benefits of taking part?

The information we get from your participation in this study may help to fill the current gap in existing knowledge, illuminate factors that may contribute to the development of professional trainings and clinical guidelines that will enhance health professionals' capabilities in providing care, education and counselling for women at risk of or living with FGM.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the institution will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

Your personal data (address, telephone number) will be kept for 1 year after the end of the study so that we are able to contact you about the findings of the study *and possible follow-up studies* (unless you advise me that you do not wish to be contacted). All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

You can find out more about how we use your information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx.

Although what you say is confidential, should you disclose anything which we feel puts you or anyone else at any risk, the researcher will find it necessary to report this to the appropriate persons without naming names (please indicate you agree to this on the consent form).

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw we will no longer collect any information about you or from you but will keep the information about you that we have already obtained as we are not allowed to tamper with

study records and this information may have already been used in some analyses and may still be used in the final study analyses. To safeguard your rights, we will use the minimum personally-identifiable information possible.

What will happen to the results of the research study?

The results of the study will be written up as a PhD thesis which will be lodged under the University of Nottingham e theses so that it is publicly available. Some direct quotes given during the interview may be used within the results of the study but, as stated above you will remain anonymous, identifiable by a unique ID number only. The data will remain confidential and used for research purposes only.

We hope that we may be able to publish the results in a peer-reviewed journal and possibly present them at any relevant conferences. If you would like to be informed of the results of the study you can request a copy of these to be sent to you.

Who is organising and funding the research?

This research is being organised by the University of Nottingham as part of a PhD doctoral study and it is funded by the Tertiary Education Training Fund (TETFUND), Nigeria.

Who has reviewed the study?

All research in the University of Nottingham is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Faculty of Medicine & Health Sciences (FMHS) Research Ethics Committee.

What if there is a problem?

If you have concerns about any aspect of this study, you should contact the Research and Ethics Committee, Ministry of Health Asaba, Delta state, Nigeria.

Further information and contact details

Researcher: Agatha Adogho
Email: ntxaa41@nottingham.ac.uk.
Mobile 07062112893

Appendix 6: Consent form

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

CONSENT FORM

Title of Study: Primary Healthcare Professionals' Knowledge, Beliefs and Attitudes towards the Practice of FGM in Delta State, Nigeria: A Qualitative Study

Name of Researcher: Agatha Adogho, PhD Student School of Health Sciences, University of Nottingham.

PhD Supervisors: Dr Julie McGarry, Associate Professor School of Health Sciences, University of Nottingham.
Dr Kathryn Hinsliff-Smith, De Montfort University

Name of Participant: **Please initial box**

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐
3. I understand that relevant sections of data collected in the study may be looked at by responsible individuals from the University of Nottingham, the research group where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐
4. I understand that information about me recorded during the study will be kept in a secure database. If data is transferred to others, it will be made anonymous. Data will be kept for 7 years after the results of this study have been published and then destroyed. ☐
5. I understand that the information collected about me will be used to support other research in the future and may be shared anonymously with other researchers. Any data used will be anonymised, and I will not be identified in any way. ☐
6. I understand that the interview is confidential. However, should I disclose anything which the investigator feels will puts me or anyone else at any risk, the investigator may have to report this to the appropriate persons without naming names ☐
7. I voluntarily agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Principal Investigator	Date	Signature

Appendix 7: Research topic guide FOR HCPs



Interview Guide

Research Topic: Primary Healthcare Professional's Knowledge, Beliefs and Attitudes towards the Practice of FGM in Delta State, Nigeria: A Qualitative Study.

Interview Mode: Face to face with Primary Healthcare Professionals

Introduction:

- General introduction: Greet participant and exchange pleasantries
- Personal introduction: Introduce self
- Explain the nature of the research and the purpose and process of the interview
- Explain that the interview will be recorded, transcribed and used as data for research
- Explain that the participant is free to ask questions and can stop the interview at any time
- Explain that the interview will last for approximately 45-60 minutes
- Ask if participant has read the information sheet and consent form?
- Ask if participant is happy to continue with the interview?
- Seek consent

Start recording
**** Obtain verbal consent to participate on tape**

1. Thank you for agreeing to speak with me today… could you please tell me about your background and role in this PHC facility?

2. Could you please tell me your understanding of FGM?
    - *Classification of FGM*
    - *Why FGM is practiced (Myths)*
    - *Health consequences of FGM*
    - *Awareness of FGM laws*

3. What do you think about FGM as a practice?
    - *Opinion about the practice of FGM*
    - *View about health professional performing FGM*
    - *Views about the continuation of FGM*
    - *Role of health professionals in reducing the practice of FGM*

4. Could you please share with me any experiences that you would have had in providing care for women with FGM?
    - *Guidelines and protocol for management of women with FGM*
    - *Counselling and health education*
    - *Reporting and referral protocol*
    - *Access to information*
    - *Professional trainings*

5. Facilitators and barriers associated with dealing with FGM related issues
    - Needs
    - Care rendered to women with FGM related issues

6. Suggestions on:

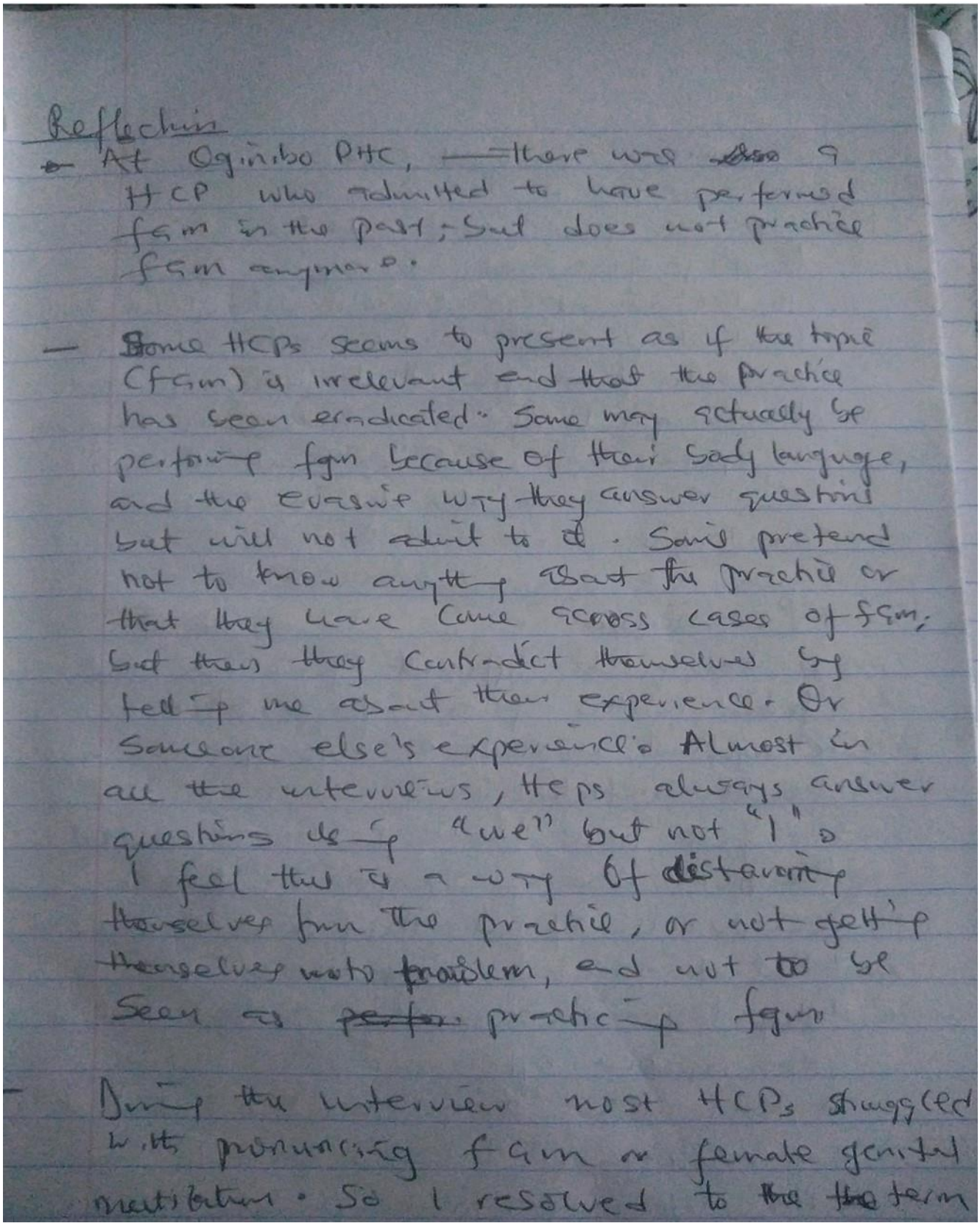
- *How to improve the care given to women with FGM*
- *Suggestions on how to reduce the practice of FGM*

7. Are there any comments that you would like to add?

End of interview

Thank you

Appendix 8: example of field notes



Reflection

- At Ogwibo PHC, ——There was 9 HCP who admitted to have performed fgm in the past; but does not practice fgm anymore.

— Some HCPs seems to present as if the topic (fgm) is irrelevant and that the practice has been eradicated. Some may actually be performing fgm because of their body language, and the evasive way they answer questions but will not admit to it. Some pretend not to know anything about the practice or that they have come across cases of fgm; but then they contradict themselves by telling me about their experience. Or someone else's experience. Almost in all the interviews, HCPs always answer questions as "we" but not "I". I feel this is a way of distancing themselves from the practice, or not getting themselves into trouble, and not to be seen as ~~perpetu~~ practicing fgm

— During the interview most HCPs struggled with pronouncing fgm or female genital mutilation. So I resolved to the the term

"Circumcision" in most cases.

- It was quite difficult for some health professionals to express themselves in English (proper english). Though I understood what they were trying to say because I am from that locality and I am quite familiar with how English is spoken and what it means when certain words are use in certain context.

- Recruitment

It was quite difficult getting into the field in the first instance. I am confused, unsure of myself and not quite confident.

The first few health centres I visited, the HCPs where skeptical, almost suspicious of me. They were unsure
- what I wanted from them,
- why I was researching a topic that is not spoken off
- A topic that they considered taboo or non existent as I heard comments such as "Ha nobody performs female circumcision

anymore" "That practice has been extinct"
"I don't have anything to really say about that practice" "We don't do it here so I don't know about it" "Go to the rural areas, it is actually practiced there".

Hearing this type of remark, was initially discouraging. I felt that my research may be considered as unimportant or irrelevant. ~~Then~~

Then I read my proposal again and I reminded myself of the reason why I decided to do the Study in the first place. And that is " I realised from experience as a nurse and evidence from existing literature that " We as health professionals have a role to practice in the management of women with fgm and in reducing the practice of fgm by changing perceptions", but how can we do this if we are not well informed or there are no policies and guidelines directing our practice?

So, I decided to ~~go into~~ continue the recruitment process by dressing less flashy

* I was more friendly
* I visited the health Centres
* Started Conversations with Health professionals to gain their trust
* I helped around Each time I visited my health ~~professionals~~ centres
* And I gave health talk on few to mothers as well.
* After awhile, they were Comfortable with me so I me regularly and I was able to get people to show interest in the topic and participate in the Study. Even of that, some where still Skeptical Even though they agreed to participate, as one refused to be recorded and on one health Centre, the matron said She and other staff members will not participate in the Study because they don't attend to women in the Centre; but that was not true because, I saw women coming there for family planning and other services.

Monday 19th August — Nairobi

Visited the head of Primary Healthcare Development Agency (PHCDA).

He gave me a note to the doctor (Dr Ebuka) in charge of the PHC in Oshakati South.

— Then I went to see Dr Ebuka, who gave me a note to the ~~matrons~~ heads of the selected PHC.

— I went to Mwangu PHC, to ~~give~~ see the head of that PHC facility but she was not available.

20/8/2019 ——

Visited Mwangu PHC on tuesday 20th August 2019. I had a discussion with the Chief matron in charge about my study. She showed interest in the study —— She wanted me to give a talk on fgm to Pregnant women tomorrow —— wednesday 21/8/2019.

Reflection

21/8/2019 —— Visited Mwangu PHC — Gave a talk on fgm to Pregnant women who came for antenatal clinic — It was an eye opener for me — At the end of the talk — I asked