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ORIGINAL ARTICLE

Lived experiences and opinions of women of sub-Saharan origin on female genital mutilation: A phenomenological study

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Abstract

Aims and objectives: This study aimed to describe and understand the lived experiences and opinions of sub-Saharan women living in Spain in relation to female genital mutilation.

Background: Female genital mutilation is a bloody procedure with serious consequences for the health of women and girls. Understanding mutilated women's lived experiences plays a crucial role in the management of health consequences and could help healthcare professionals to provide assistance to these women.

Design: A descriptive phenomenological study was carried out. The COREQ checklist was followed as guidance to write the manuscript.

Methods: A total of 12 in-depth interviews were conducted. Interviews were recorded, transcribed and analysed using ATLAS.ti 9.0.

Results: Two themes with four subthemes were identified from the data analysis: 1) 'The traumatic experience of female circumcision' with the subthemes 'Female mutilation is a physical and psychological torture procedure' and 'recognising and coping with negative emotions'; 2) 'The fight for the eradication of female genital mutilation' which contains the subthemes 'the need for a real sociocultural change at the origin' and '"I want to be the last": Personal development leads to sociocultural change'.

Conclusions: Female genital mutilation was experienced by women as a very aggressive and traumatic event. It causes considerable negative emotions that last over time. Although there is a tendency to reject the practice, in women's countries of origin, there is social pressure for girls to be mutilated.

Relevance to clinical practice: Caring for women who have suffered from female genital mutilation requires awareness of the traumatic experience they underwent when they were girls. Healthcare professionals play a crucial role in eradicating female

genital mutilation. Apart from education, preventive measures may include specific recommendations when girls are travelling to the country of origin and participatory action research.

KEYWORDS
female circumcision, female genital cutting, female genital mutilation, lived experiences, qualitative study

1 | INTRODUCTION

Female genital mutilation (FGM) is defined as the removal of some or all parts of the external female genitalia or another injury to the female genital organs for non-therapeutic reasons (WHO, 2020). It is a traditional practice with strong ancestral and sociocultural roots (Duivenbode & Padela, 2019). It is estimated that each year approximately four million girls worldwide are at risk of being mutilated, usually before the age of 15 years (UNICEF, 2020). This procedure is practised in around 30 countries, most of which are in sub-Saharan Africa (Koski & Heymann, 2017). However, the increase in migratory movements of people from these countries to European countries and the continuity of this practice in European territory make FGM a public health problem worldwide (WHO, 2018).

What does this paper contribute to the wider global clinical community?

- Female genital mutilation/cutting constitutes a traumatic experience that conditions the quality of life of women who suffer it. Stress, pain, sexual dissatisfaction and identity issues are regularly reported.
- Education of men and women is the foundation of activism against female genital mutilation.

2 | BACKGROUND

Female genital mutilation involves non-medical excisions or incisions on and of the female external genitalia (WHO, 2020), usually without the consent of the person (Odukogbe et al., 2017). This procedure is generally motivated by a desire to maintain virginity, promote prospects of marriage and control female sexual desire (Mathews & Dallaston, 2020). It is classified into four types: 1. clitoridectomy (partial or total removal of the clitoris); 2. excision (partial or total removal of the clitoris and labia minora with or without excision of labia majora); 3. infibulation (narrowing of the vaginal opening by means of a covering formed by cutting and repositioning the labia minora or majora, with or without resection of the clitoris) and 4. other (all other harmful procedures: pricking, incising, piercing, scraping and cauterising the genital area) (Dilbaz et al., 2019; WHO, 2018). FGM is internationally recognised as a violation of the human rights of women and girls (UNICEF, 2020) and a form of child abuse and gender violence against women (Dean, 2017). The process of FGM is a very painful and traumatic experience for girls and women (Obiora et al., 2020).

Female genital mutilation causes serious physical, psychological and social complications in women and girls who undergo it. Physical complications include chronic pelvic pain, urogenital fistulas, urinary infections or voiding dysfunctions (Zambon et al., 2018). These complications can become chronic and affect their quality of life (Binkova et al., 2021). Mutilated women also suffer from sexual dysfunctions such as lack of sexual desire, arousal and difficulties reaching orgasm (Jacobson et al., 2018). Additionally, childbirth in mutilated women causes intense pain in the genital area, anxiety and memories of the moment of mutilation, which entails a re-traumatisation (Hamid et al., 2018). Regarding the psychological consequences, mutilated women are four times more likely to suffer psychological trauma and depression (Fox & Johnson-Agbakwu, 2020). The more extensive forms of FGM are associated with more severe psychopathological symptoms, in particular with increased vulnerability to post-traumatic stress disorder, low self-esteem, phobias, loss of identity and socialisation problems (Köbach et al., 2018).

In Spain, there is no epidemiological data regarding the number of women of sub-Saharan origin living in Spain who have been mutilated. In addition, there is no evidence that FGM is performed in Spain (Ministry of Equality, 2020). The National Strategy for the Eradication of Violence Against Women (Ministry of Health, Social Services, & Equality, 2013) introduced this practice into the criminal agenda. However, FGM has been considered a Crime of Injuries in the Spanish Criminal Code since 2003 (BOE, 2003).

Healthcare professionals play a decisive role, not only in treating complications directly and indirectly related to the practice but also as direct and active agents in promoting its discontinuation (UNICEF, 2020). In Spain, three care protocols were launched in 2010, 2015 and 2017 (Ministry of Equality, 2020) and were published by Wassu-UAB Foundation (WF) and Union of Family Associations (UAF), in order to guide preventive care. WF is an international academic organisation whose main purpose is the management and prevention of FGM through medical and anthropological research (Ministry of Equality, 2020). However, although women affected by FGM have a favourable perception of the health care received (Pastor-Bravo et al., 2018), several studies have revealed the lack of knowledge of healthcare professionals on the subject (Dawson et al., 2015). Most

of the published studies on FGM have focused on the symptoms and health consequences of the procedure (Jacobson et al., 2018; Zambon et al., 2018), but few studies have reported on the experiences of women (Johansen, 2017; Jordal et al., 2019; Kawous et al., 2020), the intention to continue FGM and the motivations to eradicate this practice (Obiodora et al., 2020). Understanding the lived experiences of these women could help healthcare professionals to improve the health care provided to them. Additionally, it could be useful for developing international or national strategies to eradicate FGM. This study is therefore an attempt to expand the identified knowledge, by answering the research question: What are the lived experiences and opinions of women of sub-Saharan origin living in Spain who have undergone FGM? The philosophy of existence of Merleau-Ponty (2002) is our theoretical framework. According to his philosophy, we experience the world through our bodies, which are the vehicles that allow us to be in the world and immersed in the socio-cultural, political and historical context. Our body is a key element for self-identification, and it further constitutes part of our behaviour. The aim of this study was to describe and understand the lived experiences and opinions of women of sub-Saharan origin living in Spain, who have undergone FGM.

3 | METHODS

3.1 | Design

A descriptive phenomenological study was designed following the methods described by Dantas Guedes and Moreira (2009) and Martins (1992), both of which are underpinned by Merleau-Ponty's philosophy. Although Merleau-Ponty rejected aspects of Husserl's philosophy, he retained parts of his approach to describing phenomena (Earle, 2010). Through his philosophy of incarnation, Merleau-Ponty considered the body as 'point of view on the world', and the embodied person exists in a knot of relationships that opens them to the world (Merleau-Ponty, 2013). This approach allows us to understand the lived experiences and the meanings that participants give to FGM from the perspective of the inseparability of women from the world, society, culture and the significant others with whom they interconnect. The Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong et al., 2007) (Appendix S1) were followed when producing the manuscript.

3.2 | Participants and setting

Participants were women of sub-Saharan origin living in Spain who have undergone FGM. The inclusion criteria were to be a sub-Saharan woman ≥18 years old at the time of the interview and to have experienced genital mutilation in their country of origin. Women who did not speak any of the dialects understood by the interviewers (Spanish, French, English, Djoula, Malenké or Bambara) were excluded.

Recruitment was carried out through purposive and convenience sampling (Moser & Korstjens, 2018). These techniques are used and are useful to gain a deep understanding or internal validity rather than a generalisation of the results, as is the case in qualitative research (Andrade, 2021). The study was carried out in two provinces in southeastern Spain with a high presence of people migrating from Africa, due to its geographical proximity. This population, which generally enters with an irregular migratory status (Jiménez-Lasserrotte et al., 2020), is engaged in agricultural work and/or domestic help. This means that women who live in this area are from ethnic groups where FGM is an accepted practice, such as in Gambia, Senegal, Guinea, Nigeria, Mali and Burkina Faso. The study was carried out as part of a knowledge transfer contract between an NGO (Doctors of the World) and a university (University of Almería). The objective of the contract was to generate useful knowledge to help prevent FGM. However, recruiting women solely through the NGO could be biased as these women tend to be particularly in favour of eliminating the practice of FGM. Women were therefore also recruited from other groups unrelated to the NGO. To recruit the participants, the main researcher contacted healthcare professionals who worked at gynaecology services at hospitals in southern Spain. These professionals were previously known by the researcher and they disseminated the information of the study to women who met the inclusion criteria and visited these gynaecology services. Those women willing to participate gave their consent to be phoned by the researchers to arrange a personal meeting. Twenty women showed interest in the study, but later eight of them refused to speak on the subject for fear of being identified through their testimonies. The final sample consisted of twelve women with an age range between 26 and 35 years. 75% of them identified with Islamic religious beliefs. The sociodemographic characteristics of the participants were collected and are shown in Table 1.

3.3 | Data collection

Data collection was completed between May and August 2021 through semi-structured interviews, conducted by two researchers who had previous training and experience in qualitative research. One of the researchers was of sub-Saharan origin and had command of other languages, and therefore, he interviewed those women who were not fluent in Spanish. Thus, some of the interviews were conducted in Djoula, Malenké, Bambara, French or English by a male researcher. This researcher is a nurse who collaborates with the NGO (Doctors of the World) and provides social and health care to groups of women that include those he interviewed, which is how they knew each other. The rest of the interviews were conducted in Spanish, by a Spanish female researcher, a midwife who is part of a health group that had attended to some of the female participants in relation to their sexual and reproductive health, thus explaining how they previously knew each other. This facilitated communication and allowed for detailed and rich data collection. An interview guideline with open-ended questions based on the literature review

was used to conduct the interviews (See Table 2). The interviews began with the formulation of a general question such as 'Could you tell me about your experience of FGM?' The interviews, with an average duration of 80 min, were conducted in the facilities of the local university. Each woman was interviewed only once. Before the interviews, informed consent and sociodemographic data were obtained from the participants. All interviews were audio-recorded and transcribed verbatim for further analysis. The fourth author translated the interviews verbatim from Djoula, Malenké, Bambara or French into Spanish, for the analysis. Data collection ceased after reaching data saturation, that is when no new information arose from the interviews. Saturation was reached with the tenth participant, although two more participants were interviewed to verify this. Field notes of participants' non-verbal cues and researchers' thoughts were written down in a reflective journal during the interviews. Afterwards, the researchers created memos in ATLAS.ti 9.0 in which they wrote down their reflections, pre-analytical insights and data interpretations to support the analytical work. The researcher's interpretations and reflections were continuously edited throughout the data analysis. Bibliographic research on the topic was conducted once data collection was completed, in order to assure phenomenological reduction.

TABLE 1 Sociodemographic data of the participants

	Interviews (*n* = 12)
Age	
20–30	50 (6)
31–40	50 (6)
Religion	
Muslim	75 (9)
Christian	25 (3)
Country of origin	
Gambia	16.7 (2)
Senegal	25 (3)
Nigeria	8.3 (1)
Mali	16.7 (2)
Burkina Faso	16.7 (2)
Equatorial Guinea	8.3 (1)
Guinea	8.3 (1)

3.4 | Data analysis

The data were transcribed along with the interviewer's annotations and were incorporated into the qualitative analysis computer program ATLAS.ti 9.0. The data were analysed according to the three steps proposed by Martins (1992). First, the descriptions provided by the participants were read and reread (description). Second, true and literal transcriptions of speech were made to organise the data into units of meaning without allowing personal concepts to get in the way (phenomenological reduction). During data analysis, the researchers made memos in ATLAS.ti, where they wrote down their thoughts, analysis, processes, pre-analytical insights and data interpretations. Finally, in the phenomenological interpretation step, the researchers elaborated the explanation of the quotations (scientific discourse) based on participants' words, to fully understand the phenomenon. In this step, a table with units of meaning, subthemes and themes was developed (Table 3). The quotations selected to be included in the paper were translated into English (except those from women interviewed in English) by a native English speaker who is bilingual in Spanish. The translations were revised by a native Spanish speaker bilingual in English to guarantee that the lexical and semantic richness of expression was maintained.

3.5 | Rigour

The rigour of the study was ensured by the criteria of Lincoln and Guba (1985). All participants received a copy of their transcript

TABLE 2 Sample of the questions used during the semi-structured interviews

Introductory question	What has been your experience with female genital mutilation?
Questions to explore mutilated women's narratives about the procedure	How was the procedure? Could you tell me how you lived the procedure? What type of interventions has been carried out during the procedure?
Questions to explore mutilated women's narratives about feelings and emotions	How have you felt after procedure? Can you describe what kinds of emotional problems have you suffered from mutilation?
Questions to explore mutilated women's narratives about the impact of mutilation on their lives	Can you describe your opinion about the use of female genital mutilation? What is the opinion of other members of your family about the mutilation? What are the main difficulties have you encountered to eradicate the tradition?
Final question	Would you like to add something else that you consider important?

TABLE 3 Examples of quotes, units of meaning, subthemes and themes

Examples of quotes	Example of units of meaning	Subtheme	Theme
'The first cut was terrible, horrible. After the whole process, they tied us from the big toes to the waist and we had to spend a month with constant discomfort and pain. I was lying on the ground, and I remember seeing a lot of blood, many women came, and I was screaming'.	Pain, screams, life risk, being tied, torture, knives, deep bleeding, be forced, discomfort, dyspareunia, panic, insecurity	Feminine mutilation is a physical and psychological torture procedure	The traumatic experience of female genital mutilation.
'I think about what happened to me every day, but I don't understand anything, that's why I totally deny doing it to my children. I think FGM/C is silly. What is happening in our country is unforgivable. To mutilate a girl is to make her suffer for the rest of her life'.	Anger, rage, hatred, fear, insecurity, sadness, psychological therapy, lost identity	Recognising and coping with negative emotions.	
'In my country yes, not here, in my country if she is a girl, she is going to cut her off'.	Crime, receive information, prohibited in Europe, social rejection, recent prohibition, legislative changes, not related to religion, comparison with non-mutilated girls, FGM/C performed in origin countries, the practice exists in a hidden way, FGM/C is an unjustified practice	The need for a real sociocultural change at the origin.	From survivor to activist: The fight for the eradication of female genital mutilation.
'I have done all this (participate in the study) because my intention is to explain my story and together help and support each other among the young women who are now mothers, to try that our daughters do not have to go through this'.	Refusal to follow the tradition, protection of the daughters, help victims, female union, knowledge on FGM/C, denouncer, study to understand, legislate to deter, eradicate FGM/C, deny tradition, promote support networks	'I want to be the last': Personal development leads to sociocultural change	

to confirm the answers and ensure credibility. To demonstrate confirmability, the interviews were conducted by researchers who had clinical relationship with the participants. Data interpretation was performed independently by two researchers, and similarities and disparities were discussed to ensure reliability. A detailed description of the research steps, context and data collection has also been provided. Finally, transferability was meticulously verified, through the saturation of data throughout the participants' narratives.

3.6 | Ethical considerations

The study received approval from the Research Ethics Committee of the Department of Nursing, Physiotherapy and Medicine of the University of Almería (EFM-03/20). The research was carried out respecting the ethical principles of the Declaration of Helsinki. Participants were informed of the objective of the study and reminded of their right to withdraw from the study at any time without explanation. All participants signed an informed consent prior to the interview and participated voluntarily. Participating women's anonymity, privacy and confidentiality were ensured. Participants' names were replaced by alphanumeric codes and personal identifiers were removed from study documents.

4 | RESULTS

Two themes with four subthemes emerged from the analysis of data. All of them help us to understand the lived experiences and opinions of sub-Saharan women living in Spain of FGM (Figure 1). In the following section, the themes and subthemes are presented together with a selection of the most representative quotes.

4.1 | The traumatic experience of female genital mutilation

This theme reflects women's devastating experience of FGM, a practice marked by pain and intense suffering at a very young age, which triggers intense negative feelings that last over time.

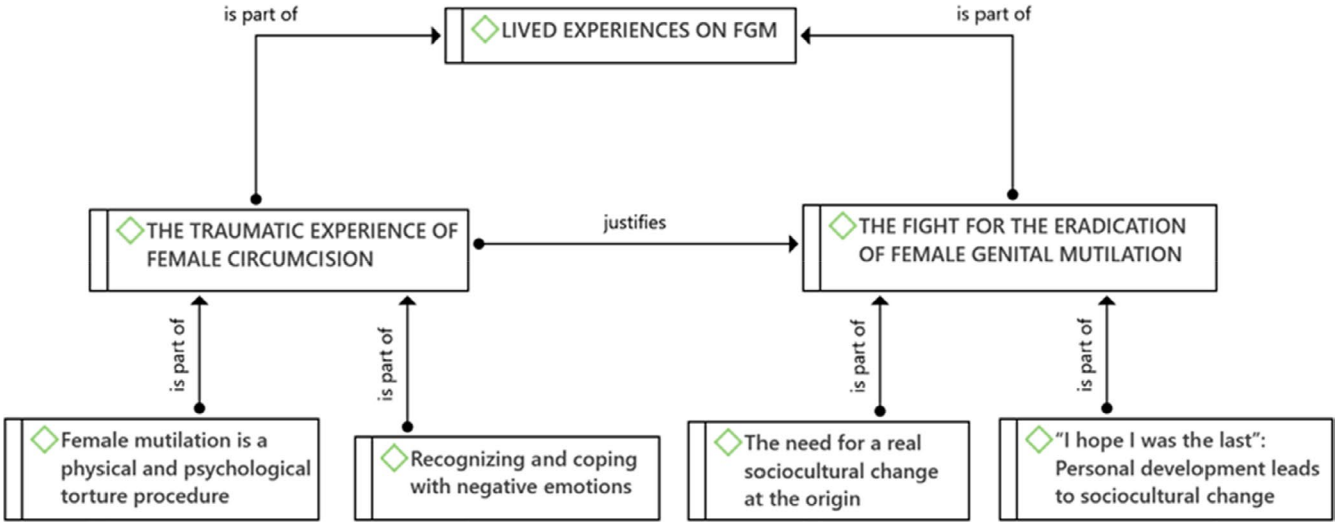

FIGURE 1 Conceptual map of themes and subthemes

4.1.1 | Female mutilation is a physical and psychological torture procedure

The perception of violence and lack of consent were present in the FGM process in all the women in our study. The participants highlighted the tremendously aggressive nature of the practice, which was an attack on their bodily integrity. FGM is a forced practice on girls that causes irreparable physical and psychological trauma to women. For the women in our study, FGM was a horrible experience with an immediate effect, whereby the women felt abused, and this caused long-term sequels.

> The first cut was terrible, horrible. After the whole process, they tied us from the big toes to the waist, and we had to spend a month in constant discomfort and pain. I was lying on the ground, and I remember seeing a lot of blood, many women came, and I was screaming.
>
> (Participant 10)

Mutilation was defined by our participants as a clear manifestation of inequality, subordination and even a power relationship. The women felt that they had no other option since it is the parents who decide without wondering whether there is any benefit in this process. Because of this, women perceived FGM as mistreatment for having consented to the practice and depriving them of the right to feel pleasure in being women.

> The psychological damage is the worst because neither our parents nor the person who practices this has any right to take away the desire to feel. There are women who have suffered, have lost their children, or have died at the time of childbirth, all this due to this miserable mutilation.
>
> (Participant 8)

The women in our study highlighted the poor hygienic-sanitary conditions in which the procedure is performed. The mutilation was carried out either in the home of a relative or in the home of the woman who practices the mutilation, without analgesia and with kitchen utensils or razors, each used to mutilate several girls. Furthermore, the mutilators lacked formal training in any health field. All of these elements make mutilation an unsafe practice that puts women's health at risk.

> This practice is done without any kind of precaution; they don't give you a pain pill, nor do they anesthetize the area to be cut. The pain is quite strong. I can compare it to the pain of childbirth, and the knife used is the one used in the kitchen to cut onions or fruit. Unfortunately, my wound opened, and they had to sew it again, and I had another terrible pain.
>
> (Participant 3)

4.1.2 | Recognising and coping with negative emotions

The memories retained in the memory of the mutilated women contain considerable negative emotions. Impotence, generated by the feeling of helplessness or the refusal of help, was the central axis of the memories of our participants. However, although some of the women reported having blocked their memories, others still recall the pain and suffering caused by the wounds, causing them intense anguish. All the participants in our study agreed that mutilation is an indelible experience that has stolen their childhood and sexuality and with which they must live the rest of their lives.

> I think about what happened to me every day but I don't understand anything, that's why I totally refuse to let my daughters have it done. I think FGM is ridiculous. What is happening in our country is

> unforgivable. To mutilate a girl is to make her suffer for the rest of her life.
>
> (Participant 5)

Mutilation at a very young age meant that some of the women in our study were unaware that they had been circumcised. Some of them found out that they had been mutilated by other members of the community, but others even grew up believing that their genitalia was normal until they went to a gynaecological consultation. Anger, rage and hatred towards their family and the people who had carried out the mutilation were the dominant feelings of our participants when they understood the humiliation to which they had been subjected. These emotions are still present in most of the participants in our study.

> I hate those who cut me, I no longer understand my mother. There are the grandmothers who, when a girl is born, right away, they say bring her so we can do it to her, I was one of those who was mutilated at a later age… .
>
> (Participant 9)

Other emotions most referred to by women were fear and sadness. In this traumatic situation and without any prior information, terror seized our participants. Fear obeys a basic survival instinct; however, the perceived brutal attack caused that fear, and instead of helping women to protect themselves or defend their physical integrity, it left them more helpless. Furthermore, the participants in our study reported that sadness is not only an inherent feeling they have, but they also feel it for their parents as they are culturally obliged to carry out these practices.

> I was very afraid because before entering I heard other girls crying and screaming, I grabbed my grandmother so hard, but she forced me to enter. My mother feels sadness and regrets what they did to me, but she says it was not her decision, that it was her family's… .
>
> (Participant 1)

4.2 | The fight for the eradication of female genital mutilation

Women are fully convinced that the practice of FGM should be eradicated, and this theme reflects the women's desire to eradicate FGM, the current social perception and the ways to try to carry out a sociocultural change.

4.2.1 | The need for a real sociocultural change at the origin

The participants reported that the social perception of FGM has undergone a modification in recent years. Previously, it was a widely accepted practice, but today more and more people are rejecting it. The number of girls who benefit from not being mutilated is increasing because both the mother and the father refuse to have it done to their daughters. It has been shown that even some male sectors have also modified their attitude in favour of not perpetuating this practice.

> His wife did want her to have it done (FGM to her daughter), but he forbade it, he told her that if it was done, he would get a divorce.
>
> (Participant 7)

However, according to one participant, some men reject the practice not because of a question of protection of women's rights but rather because of the search for greater sexual pleasure.

> Men no longer want cut women, they just want to know if sex is going to be good or bad with that woman.
>
> (Participant 4)

The participants were aware that FGM is internationally understood as a violation of human rights. They know that in many sub-Saharan countries there are laws prohibiting it but they maintain that, despite the legislation, it is not so easy to eradicate the practice of FGM. According to some accounts, there are still people who are in favour of FGM, especially in their countries of origin. One can also glimpse the lack of decision or authority that a mother can have over the health of her daughter when both are in a geographical location where the practice is carried out. This is how one participant put it:

> When we were in Senegal to visit, I was very careful with my daughters so that they didn't do it to her.
>
> (Participant 7)

Along the same lines as the previous example, they themselves may not want to have their daughters mutilated because they live in Spain, but if they once again lived in their countries of origin, it is very possible that they would have it done due to the social pressure of the surroundings.

> In my country yes, not here, in my country if she is a girl, she is going to be cut.
>
> (Participant 6)

On the other hand, the global interpretation of the interviews revealed that FGM is not linked to any specific religion. This, together with the fact that it involves health risks and great suffering, led the women in our study to question whether it is an unjustified practice. There are no health benefits to FGM, regardless of which form of FGM is carried out and, from an ethical point of view, it is considered a crime or a form of exclusion.

> There is nowhere that says that to be a good person or a good Muslim or a good wife, to be clean, to be pure for whatever it is, you have to be mutilated.
>
> (Participant 2)

> and support each other among the young women who are now mothers, to try to prevent our daughters from having to go through this.
>
> (Participant 9)

4.2.2 | 'I hope I was the last': Personal development leads to sociocultural change

Leaving their country of origin and studying are important steps for women themselves to critically reflect on what the experience of genital mutilation meant for them.

> I study, I now understand that cutting is not good.
>
> (Participant 6)

It is from this understanding which they have gained that they decide not to continue perpetuating this tradition that is so traumatic and harmful to women. Preventing the suffering of their daughters becomes an act of refusal and cessation of this form of violence against women, which has strong cultural roots, as one woman commented:

> I hope I was the last in my family, I want to have it finished, I'm not going to have it done it to my daughters, my partner doesn't want to either. Now it's no longer done, in my country it is forbidden, but when I was little and before it was done to all of them, they were all cut. I want to end this tradition.
>
> (Participant 12)

On the other hand, the participants welcomed the Spanish legislation against FGM as an example of prohibition. Knowledge of the legal consequences that may arise from carrying out the practice, and the possibility of refraining from having it done it, and also seem to favour its eradication.

> Here in Spain it is forbidden to do it. Since 2005, parents can go to jail if the doctors find out that a girl who lived here in Spain has been to their country and has been mutilated. Both I and the sub-Saharan women I know are against this practice because it is a horrible experience in terms of the immediate and long-term effects.
>
> (Participant 11)

One participant emphasised the idea of making their stories known to the world. She considered the unity of mutilated women very important so that they all speak, express themselves and are not afraid to speak out against FGM.

> I have done all this (participated in the study) because my intention is to explain my story and together help

5 | DISCUSSION

The aim of this study has been to describe and understand the lived experiences and opinions of women of sub-Saharan origin living in Spain in relation to FGM. FGM is considered one of the worst forms of violence against women, not only because it is practiced on girls, but also because of the serious negative effects it causes to the physical and emotional health of the women who undergo it (Cappa et al., 2019). Coinciding with other studies, FGM is a forced ordeal that is experienced as violence by women and that in addition to putting their physical integrity at risk, also involves a loss of their identity as a woman (Mwanri & Gatwiri, 2017). FGM is a family-based and culturally accepted torture procedure (Abdalla & Galea, 2019; Jacobson, 2018). The psychological trauma caused by FGM can lead to post-traumatic stress disorder (Buggio, 2019). Most of the women who have been mutilated, coinciding with our results, reported experiencing intense fear and impotence (Köbach, 2018). Mutilated women are more likely to suffer from conditions such as depressive anxiety, somatisation and low self-esteem (Buggio, 2019). In addition, a large proportion of circumcised women have emotional problems such as flashbacks or the vivid memory of the cutting event (Ahmed et al., 2017). Some authors adopt the concept of polyvictimisation to reveal sequelae of trauma (Andrews, 2015).

Even though, as our results indicate, there is currently a significant proportion of women who oppose the continuation of FGM, it is often a practice that is accepted with resignation (Cappa et al., 2019). The study carried out by Melese (2020) pointed out that, although some women had a favourable attitude towards FGM and the perpetuation of the practice among their daughters, married women with a high level of knowledge about the procedure are often opposed to its performance. According to the study conducted by Pashaei (2016), subjective attitude is one of the strongest predictors of mothers' intentions to have FGM performed on their daughters. Therefore, community education and awareness could be an effective way to reduce the practice of FGM. The role and attitudes of men towards FGM seem to depend mainly on education. Varol et al. (2015) reported several studies in which the reasons why men were in favour of abandoning FGM were due to the physical, psychological and sexual consequences that affected both women and themselves. In the study carried out by Shahawy et al., (2019), men, who had received training on the consequences of FGM, wished to abandon the practice due to its adverse effects. On the other hand, the male position reported by the women interviewed by Jacobson et al. (2018), was to be in favour of having their daughters cut, or, otherwise, they would not get married (we do not know whether the participants in this study lacked training in FGM or not). However, our participants referred to male sexual dissatisfaction and challenges to

their masculinity as reasons why there are currently men who reject the practice. These results add to the limited studies on men's perspectives on FGM in Western countries.

The decision whether or not to carry out FGM on a girl is not that of the mothers. All the participants in our study were against continuing the tradition of their daughters (Karlsen et al., 2020), and, according to their statements, they can now decide because they reside in Spain. In their countries of origin, those who make the decision to carry the practice out are paternal grandmothers (Ballesteros-Meseguer et al., 2014). In fact, mothers take special care with their daughters when they travel to their countries of origin since grandmothers or other relatives may take advantage to have the girls mutilated without their mother's consent (Doucet et al., 2020; O'neill & Pallito, 2021).

Social pressure is an important element in the maintenance of FGM (Mpinga, 2016). Women who live in these cultural contexts and have not suffered FGM may feel shame, isolation or bullying (Jacobson et al., 2018). In the present study, some of the women interviewed showed between the lines that, if they had continued to live in their countries of origin, their daughters would have been circumcised to avoid conflict with their community and not to be stigmatised and ostracised (Doucet et al., 2020). This highlights the enormous pressure exerted by the environment, overriding the wishes of many women to avoid the physical and psychological suffering of their daughters in the short and long term.

Another issue that emerged in the interviews was the origin of FGM. None of the women suggested that it was linked to religion but rather to tradition and to culture. These results are consistent with those of other studies (Doucet et al., 2020; Karlsen et al., 2020) and with the opinions of most of the participants interviewed by Pastor-Bravo et al. (2021) and Shahawy et al. (2019). The mutilated women have realised that FGM is a practice that has no justification of a religious nature, neither in the field of health nor in the field of ethics. Its origin can be found in ethnocultural discourses (UNICEF, 2013).

In the data analysis, three factors were found that contribute to the change in viewpoint over time and the abandonment of the practice: education, immigration and legal prohibition. Educating people about the health risks and harm of FGM is strongly attributed to changing opinions (Fox & Johnson-Agbakwu, 2020; Karlsen et al., 2020; Mwanri & Gatwiri, 2017; Shahawy et al., 2019). The fact of emigrating from their countries of origin to Western countries has contributed to increasing knowledge of FGM (Karlsen et al., 2020; Shahawy et al., 2019) and becoming aware of the damage and violation of rights that it entails. In addition, the criminalisation of FGM is also seen by the participants as a factor that helps the eradication of the practice although it is not considered in itself as sufficient (Shahawy et al., 2019). Proof of this is that, in various African countries, despite the existence of legislation against the practice, it continues to be carried out (Nabaneh & Muula, 2019). Connelly et al. (2018) revealed that the leadership of women who have survived the practice is an essential aspect in the fight against 'point of view on the world' (Merleau-Ponty, 2013). Merleau-Ponty wonders: What is our body? How do we relate to it, and how does it relate to the world? That which each subject carries within themselves is a force for communication and reflection on that which is in the world and provides meaning and action. In our participants, it is genuinely clear how corporeality is linked to life experience and awareness. The importance of FGM victims speaking up and telling their own lived experiences to the world is highlighted. The lived experiences of the participants have provided them, despite their suffering, with enough strength to become activists against FGM. This study is the only one carried out in Spain that shows the activism of mutilated women against this practice and hence this could be of great value in designing preventive activities.

This study is not without limitations. It only represents the lived experiences of sub-Saharan mutilated women who emigrated to Spain. Mutilated women's lived experiences in other countries or geographical locations could differ. Future research from different geographical locations should be carried out to gain a deeper understanding of the topic. Furthermore, the results that emerged from this study need to be complemented with the lived experiences and opinions of women who practice mutilation and with men. In addition, although the researcher of African origin facilitated the communication process, for some women it might have been difficult to talk to a man about their most intimate and painful lived experiences. The other interviewer was a woman, who facilitated the communication of these lived experiences, but her interviews were conducted in Spanish, which might have represented a linguistic barrier in some cases. No differences were observed between the interviews conducted by the man and those conducted by the woman in regard to duration and depth.

6 | CONCLUSIONS

The women experienced FGM as a very aggressive and traumatic event. Women still remember the helplessness, pain and suffering they experienced during the mutilation. Other predominant feelings were rage, anger and hatred towards the people who took part in the act of mutilation. FGM is considered by women to be an example of female submission that makes them not feel like a woman. Although there is a tendency to reject the practice, even amongst men, in their countries of origin women lose their authority due to the social pressure that exists for girls to be mutilated. Living in another country and studying caused women to be more critical of FGM. The unity among these women and the account of their lived experiences are the first steps towards the eradication of FGM and preventing their daughters from suffering.

6.1 | Relevance to clinical practice

This study contains the lived experiences of women who have undergone FGM. Their testimonies explain the serious physical and psychological consequences of the procedure, such as pain, low self-esteem, depressive anxiety or female identity issues. Knowing about

their traumatic experiences, their hope that they *were the last*, and realising the support that men are willing to give to eradicate FGM constitutes an opportunity to keep on fighting against this practice. Girls at risk of and women who suffer from FGM need culturally sensitive care from healthcare professionals. It is necessary to strengthen health and legal systems and professional training to eradicate FGM. Healthcare professionals must proactively address the issue of FGM and may also give recommendations to sub-Saharan families who travel to their countries of origin with their daughters. It is crucial to avoid leaving them alone with their grandmothers. Conducting future studies from the sociocritical paradigm, such as participatory action research, may provide an opportunity to tackle this type of violence against women in their countries of origin.

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CONFLICT OF INTEREST

The authors declare no conflicts of interest.

AUTHOR CONTRIBUTION

José Manuel Martínez-Linares participated in the conception and design of the study, in the analysis and interpretation of data, in drafting the paper and in critically reviewing the paper. Olga María López-Entrambasaguas participated in the conception and design of the study, in the analysis and interpretation of data, in drafting the paper and in critically reviewing the paper. Isabel María Fernández-Medina participated in the conception and design of the study, in the analysis and interpretation of data, in drafting the paper and in critically reviewing the paper. Ousmane Berthe-Kone participated in the conception and design of the study and in the acquisition, analysis and interpretation of data. María del Mar Jiménez-Lasserrotte participated in the conception and design of the study, in the analysis and interpretation of data and in the English translation of the final version of the manuscript. Cayetano Fernández-Sola participated in the conception and design of the study, in the analysis and interpretation of data, in drafting the paper and in critically reviewing the paper. José Manuel Hernández-Padilla participated in the study design. He co-supervised Ousmane Berthe-Kone Masters' thesis in which the study was designed and carried out. Furthermore, after the last round of reviews, Prof. Hernández-Padilla has contributed not only to addressing comments about the study's reflexivity and design, but he has also performed a throughout critical review of the entire manuscript. Olga Canet-Vélez participated in the conception and design of the study, in the analysis and interpretation of data, in drafting the paper and in critically reviewing the paper. All the authors believe that the manuscript represents valid work, have carefully read it and fully approved it.

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