3-6-2024

Nigerian Nurses' Perceptions of Caring for Women with Female Genital Mutilation

Jane-Frances Echeozo
Walden University

Walden University

College of Health Sciences and Public Policy

This is to certify that the doctoral dissertation by

Jane-Frances Echeozo

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Jennifer Oliphant, Committee Chairperson, Public Health Faculty
Dr. Michael Schwab, Committee Member, Public Health Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2023

Abstract

Nigerian Nurses' Perceptions of Caring for Women with Female Genital Mutilation

by

Jane-Frances Echeozo

MSN, University of Colorado Denver, 2006

RN-MSN, University of Colorado Denver, 2005

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

August 2023

Abstract

There are numerous health problems associated with female genital mutilation (FGM) practice. In Nigerian healthcare, professionals need to ensure culturally sensitive care for FGM cases. However, there was a literature gap involving culturally sensitive care for Nigerian women with FGM complications, evidenced by some northern Nigerian nurses who were not able to identify FGM categories or cultural given names associated with FGM types. Thus, this qualitative study involved ascertaining the worldview of Nigerian nurses and midwives in Owerri regarding providing culturally competent nursing care for FGM complications, guided by the process of cultural competence in the delivery of healthcare services model. Data were gathered from virtual interviews with 10 nurses/midwives who were 21 and above and recruited through probability purposive sampling. Results were analyzed and coded into five emerging themes and patterns. The main themes were: (a) patient assessment is a standard practice (history taking, physical exam, and documentation), (b) nurses'use of culturally competent skills during care (respect of values and beliefs, awareness of cultural diversity, clarity in local language, nonverbal means), (c) barriers to care of FGM cases (nurses' ignorance of FGM, victims' fear of expression, and cultural acceptance of FGM), (d) cultural dynamics that influence care of FGM, (pain tolerance differences by ethnicity), and (e) motivating factors to care for FGM patients (nurses' empathy, sympathy, desire to stop FGM). Study findings could be used for training of nurses, and help policymakers create appropriate guidelines for culturally sensitive and individualized nursing care for women with FGM and for social change in Nigeria as well as worldwide for better public health outcomes.

Nigerian Nurses' Perceptions of Caring for Women with Female Genital Mutilation

by

Jane-Frances Echeozo

MSN, University of Colorado Denver, 2006

RN-MSN, University of Colorado Denver, 2005

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

August 2023

Dedication

I was successful in this doctor of philosophy dissertation program due to constant reminders from my brother, Valentine-Jude Nnamdi Nkwogu. I dedicate this achievement to him for inspiring me from the great beyond to fulfill this goal. To my mother, Adaukwu Catherine Anagam Nkwogu, I remain grateful to you for all your prayers until your last breath. May your soul and the soul of my brother, Nnamdi, rest in peace.

I also dedicate this research to my dear husband, Chief Sir Don Dozie Echeozo, for your encouragement and support throughout this program. I remain grateful to all who helped me reach this milestone.

Acknowledgments

I thank Dr. Jennifer Oliphant and Dr. Michael Schwab my dissertation chair and committee member respectively. Your guidance throughout this dissertation journey was unparalleled. I will always remain grateful to you, Dr. Oliphant, for encouraging me and reassuring me with your prompt feedback that enabled me to reach this dissertation goal. I really appreciate it.

A special thanks goes to Dr. Michael Schwab and Dr. Reymond Panas for the hope you instilled in me with your comments as you reviewed my study.

I will always remain indebted to my research participants who defied the environmental hardship to participate in this study and verbalize their worldview on this sensitive topic.

To the entire Walden University community including classmates, academic support, technical support group, I accomplished this study because of your constant accessibility.

Table of Contents

List of Tables

Chapter 1: Introduction to the Study

Female genital mutilation (FGM) is a customary practice of excising female external genitalia for no known medical reasons. An estimated 100–140 million girls and women have had FGM worldwide, and three million girls are at risk in Africa annually (World Health Organization [WHO], 2008; Zurynski et al., 2015). This recognized traditional practice emanated from Africa, where 28 countries continue to practice FGM, and some Asian and Islamic countries do as well. Traditional birth attendants or healthcare professionals perform FGM on female infants and girls as culture permits to reduce promiscuity and ensure their sanctity to marriage (Ibekwe et al., 2012). Nigeria is one of the African countries with the highest FGM prevalence; 25% of women and girls between the ages of 15 and 49 and 17% of women and girls between 0 and 14 had undergone FGM in Nigeria (Microdata Library, n.d.; National Population Commission, 2019). The practice of FGM is a human rights issue because of violence against the integrity of the female body, with no known social or medical benefit (Dibua et al., 2010; Onuh et al., 2006).

According to Ojua et al. (2013), many ways of cultural changes will ensure that some negative practices are destroyed through enculturation, and new ones amplified. The culture-based practice of FGM negatively affects the physical, mental, obstetric, and gynecological health of women and girls, resulting in short-and long-term complications, including pelvic inflammatory diseases and complications during childbirth (Anzaku et al., 2018; Elgaali et al., 2005).

The care of women with FGM is a subject of controversy. According to Thierfelder et al. (2005), migrants from countries that practice FGM who reside in

Switzerland lack appropriate obstetrics and gynecological care within the Swiss health system due to a lack of professional guidelines and culturally appropriate FGM information. In Nigeria, a country with high FGM practice, Ashimi et al. (2014) revealed that some northern Nigeria nurses had difficulty recognizing and classifying FGM. Therefore, for better health outcomes, nurses' and midwives' key roles in terms of management and treatment of FGM cases could not be overemphasized. Balfour et al. (2016) posited that FGM is a subject that requires cultural expertise to facilitate communication, prevention, and care, in addition to evidence-based guidelines. Campinha-Bacote (2011) indicated that patient-centeredness and cultural competence improves quality of healthcare. Such an approach to care allows nurses to become sensitized to care of patients from diverse culture. However, there is a lack of literature addressing patient-centered and culturally competent care for FGM cases. There are no known nursing guidelines for culturally sensitive care of women with FGM in developing countries or immigrants with FGM in developed countries. Therefore, in this study, I aimed to identify how nurses and midwives in Owerri the capital of Imo State provided nursing care for women with FGM in ethnically diverse Nigeria.

This chapter includes the study's background, problem statement, purpose of study, research questions, theoretical framework, nature of the study, significance of the research, and a summary. I revealed the gap in literature and need for research. I highlighted needs addressed in this study regarding cultural approaches to care. I provided a concise understanding of aims and objectives as well as research questions.

Background

Nigeria is a country in West Africa where all ethnic groups practice some form of FGM. This multicultural African country is the largest and most populous and accounts for about a quarter of the estimated 115–130 million mutilated women in the entire world (Okeke et al., 2012). FGM is categorized into four types: type 1 (clitoridectomy or Sunna) is the prepuce's excision with or without cutting the clitoris, type 2 is the cutting of the clitoris and labia minora, type 3 is the excision of all the external genitalia also known as infibulation, and type 4 is piercing and pricking the external genitals (WHO, 2008, 2020a). All these FGM forms are performed by some states in Nigeria, with types 1 and 2 prevalent in Imo State, Nigeria (U.S. Department of State, 2001). Invariably, different FGM categories require different individual approaches based on knowledge of culture in dealing with the phenomenon.

The origin of FGM in Nigeria dates back 500 years ago. According to Dibua et al. (2010), FGM predated Christianity and Islam in Africa. Epundu et al. (2018) indicated that the practice of FGM in Nigeria varies by state, geopolitical area, and ethnic groups with the highest prevalence in the southern geopolitical zones, which are Igbo and Yoruba where type 1 and 2 are predominant. The national prevalence rate of FGM among adult women in Nigeria which includes pregnant women is 41.0%. There was progressive decrease of FGM among young girls and a 37.0% of women with FGM opposed continuation of FGM in Nigeria (Okeke et al., 2012). Although the prevalence of FGM had declined among pregnant women and other groups of women, there was a significant increase in 2016 among women between 15 and 49 years in the northeast (1.4%), northwest (19.3%), southwest (41%), and southeast (32.5%), (Epundu et al., 2018). This

indicated that FGM practice was not on the decline in the southern part of Nigeria, which is the geopolitical zone I focused on in this study. Therefore, it was essential to ascertain if nurses and midwives in Owerri, provided culturally sensitive care for women with FGM, since some northern Nigeria nurses could not differentiate FGM types by cultural names.

Lack of appropriate care for women with FGM was evidenced in the "lack of confidence and competence in caring for or talking about FGM by doctors, nurses which suggested the need to develop evidence based services in this area" (Evans et al., 2017, p. 3). Nurses and midwives expressed major concerns regarding their limited knowledge, skills, and technical prowess in terms of managing FGM in high income countries like Sweden, New Zealand, Italy, and the United Kingdom (Zaidi et al., 2007). Therefore, I addressed evidence-based guidelines for nurses and midwives in Owerri to provide culturally sensitive nursing approaches for FGM women.

In Nigeria, there is little information on evidence-based guidelines for FGM care. Some nurses in northern Nigeria could not identify or differentiate various FGM types (Ashimi et al., 2014). Since FGM is a typical cultural process for women in countries like Nigeria, accepting society's practice becomes a healthcare risk. It became imperative to gauge nurses and midwives' experience on FGM care in order to identify perceived cultural challenges and professional strategies that support nurses and midwives to provide culturally sensitive care for FGM cases.

Problem Statement

Odukogbe et al. (2017) stated there are immediate, medium, and long-term morbidities that result from FGM that manifest in excessive bleeding, infection of the

urinary and reproductive tracts, and pelvic inflammatory disease, as well as psychological problems which may result in high maternal mortality. Anzaku et al. (2018) indicated that FGM creates a medium for infectious diseases to thrive in the body and may result in death. WHO (2008) multi country study with more than 28,000 participants revealed that pregnant women with FGM had a significantly substantial risk of childbirth complications like postpartum hemorrhage and cesarean sections than women without FGM. FGM has a substantial economic burden; Ekenze et al. (2007) indicated that treating postpartum complications from FGM among women was extremely expensive and cost more than $120 in terms of managing each child for 3–5 days of hospitalization per Nigerian family.

There are 36 states in Nigeria with more than 250 ethnic groups, where 30 and 625 million girls and women were estimated to have had FGM (U.S. Department of State, 2001). Ashimi et al. (2014) indicated that nurses in tertiary health institutions in northern Nigeria lacked knowledge of FGM types; only 49.0% of these nurses could identify Angurya and Gishiri mutilations as types of FGM. Dike et al. (2012) posited that 51.3% of nursing and midwifery students in the Afikpo Ebonyi state of southeast Nigeria believed that FGM curtailed promiscuity. Therefore, evidence showed a lack of knowledge regarding care of women with FGM among nurses and midwives due to lack of appropriate training and guidelines regarding culturally sensitive care (Abdulcadir et al., 2014; Chidera, 2018; Zurynski et al., 2015). Lack of knowledge of FGM care among caregivers was not only present in developing countries, but evidence showed a lack of culturally sensitive care for women with FGM in the Swiss healthcare system (Thierfelder et al., 2005). Since there was evidence that some nurses and midwives in

Nigeria cannot differentiate types of FGM, it became imperative to ascertain how nurses and midwives provided patient-centered and culturally competent care for women with FGM in healthcare facilities in Nigeria, especially in Owerri with high prevalence of type 2 FGM. Therefore, knowledge of these caregivers' perceptions of nursing care of FGM patients was necessary for identifying gaps and to help policymakers create appropriate guidelines for culturally sensitive and cost-effective nursing care for women with FGM in Owerri.

Purpose of the Study

I explored nurses and midwives' worldviews of their current approaches to care for women with FGM in Owerri. All four types of FGM exist in Nigeria, with types 2 and 1 prevalent in the southwest and southeast, which includes Imo State (Microdata Library, n.d.; Okunade et al., 2016). Nigeria consists of 250 ethnic groups and includes 500 local languages, and each ethnic group differs in terms of their FGM practices (Adedini, 2015). Women from the southeast, which includes Owerri in Imo State, were 16.56% more likely to be at risk of contracting HIV from female cutting (Oyekale, 2014).

Invariably, FGM categories differ in terms of ethnicity and require different individual approaches based on knowledge of cultures when dealing with this phenomenon. Nurses and Midwives need resources and guidelines to treat women and girls with FGM (Zurynski et al., 2015). It became meaningful to identify nurses' perspectives regarding FGM care using the process of cultural competence in the delivery of healthcare services by Campinha-Bacote. This framework is a model that sees cultural competence as an ongoing process for nurses and midwives. A qualitative

research helped to know the worldview of nurses who care for FGM cases for better health outcomes.

According to Akinsanya and Babatunde (2011), tribal culture plays an essential role in the behavior of people towards FGM; hence culture-based interventions involving care of FGM patients is necessary to address not only the health of women with FGM, but also the environmental and social factors that led to perpetuating this practice for better health outcomes.

Research Questions

The research questions for this study are:

RQ1: What are the practices of Nigerian nurses and midwives providing patient-centered culturally competent care for women with FGM in Owerri?

RQ2: What culturally sensitive and patient-centered skills do Nigerian nurses and midwives use to address FGM cases in Owerri?

RQ3: What knowledge barriers do Nigerian nurses and midwives express regarding caring for FGM women in Owerri?

RQ4: What cultural dynamics influence patient-centered care of women with FGM in Owerri?

RQ5: What are the motivating factors for Nigerian nurses and midwives in terms of practicing cultural competence for FGM patients in Owerri?

Theoretical Framework

A qualitative study design with a phenomenological approach was used to understand nurses and midwives' lived experiences when caring for women with FGM in Owerri. Phenomenology focuses on exploring in-depth human experiences of the

phenomenon studied, and it helps researchers understand common shared experiences involving a phenomenon (Creswell, 2013; Rudestam & Newton, 2015). My aim was to seize the underlying form and core aspects of the participants experiences and ensure data collection was focused on the phenomenon in a natural setting where participants verbalized their feelings regarding this phenomenon. The phenomenological approach ensured that the small sample size of 10 participants helped me gain insight into the nurses' experiences in the care of FGM patients for a robust result.

In this study, I used Campinha-Bacote's process of cultural competence in the delivery of healthcare services model as the framework. It consists of five interrelated constructs that involve addressing cultural competence as a process when delivering health services. The five constructs are: cultural awareness which involves being mindful of behavioral patterns expressed by groups of people, cultural skill, requires culturally appropriate nonverbal and verbal interventions that are used when interacting with diverse populations, cultural knowledge calls for learned cultural practices for better health outcomes, cultural encounter implies observing ways culture influences actions and health choices, and cultural desire refers to inclination to partake in cultural processes with care, passion, and commitment. (Campinha-Bacote, 2002, 2011). The level of cultural competence among nurses were measured using the inventory for assessing the process of cultural competence among healthcare professionals-revised (IAPCC-R) tool. Using this theoretical framework helped me understand the competence of nurses and midwives in terms of providing culturally sensitive and patient-centered care to women with FGM by bringing knowledge of their culture based on their beliefs, values, and lifestyles to achieve culturally sensitive care.

Nature of the Study

The qualitative phenomenological approach involved video conference interviews with nurses and midwives who met inclusion criteria. Using the phenomenological approach involves obtaining a holistic and in-depth world view of participants' everyday experiences (Creswell, 2009). I chose this process because it involved developing relationships and patterns from their responses, using inductive reasoning. As a nurse, I used bracketing to understand the participants own experiences while keeping in check my preconceived assumption of the phenomenon. Data collected from participant responses was analyzed and coded for themes and patterns. The 10 participants who met eligibility criteria for the study were invited by me to the National Association of Nigerian Nurses and Midwives (NANNM) headquarters in Owerri. The NANNM headquarters is a natural setting where nurses and midwives from different healthcare facilities in the state meet regularly for conferences, seminars, and meetings regarding concerns and updates on healthcare issues as they impact nursing care.

Before interviewing 10 participants based on demographic data from initial telephone interviews, there was a thorough explanation of the nature of the study and duration of research. Demographic data from initial phone interviews included age of participants, nursing category, number of years as nurses, and whether participants were circumcised or not circumcised.

Due to the present global COVID-19 pandemic and problems involved with traveling to Nigeria for this study, interviewing study participants via video conferencing using phone WhatsApp was the preferred choice. This was to ensure that interviews were conducted and maintained while complying with the Centers for Disease Control

and Prevention guideline to minimize risks associated with contracting the disease. Data was analyzed manually and through thematic coding using NVivo software. Participants' responses were confidential, and I used individual identifiers which ensured anonymity of participants.

Definitions of Key Terms

Angyra cuts: This is a type IV FGM which includes piercing of the clitoris and scraping of the labia and tissues surrounding the vaginal orifice (Ashimi et al., 2014).

Clitoridectomy: This is a type 1 FGM, which involves the least severe cutting of parts of the clitoris (Okeke et al., 2012).

Cultural awareness: Being mindful of behavioral patterns expressed by particular groups of people.

Cultural desire: Inclination to partake in cultural processes with care, passion, and commitment.

Cultural encounter: Observing ways culture influences actions and health choices.

Cultural knowledge: Learned cultural practices for better health outcomes.

Cultural skill: Culturally--appropriate nonverbal and verbal interventions that are used when interacting with diverse populations.

Female genital mutilation (FGM): Cutting of female external genitalia for nonmedical reasons (WHO, 2008).

Gishiri: Backward cutting of the vagina to widen the vaginal outlet (Ashimi et al., 2014).

History taking: A query into patients medical, surgical, obstetrical, gynecological family, social and medication histories that guides the direction of patient care (Nichol et al., 2021)

Infibulations: Type 3 FGM and the most severe form, involving total removal of the clitoris, labia minora, and medial part of labia majora as well as narrowing the vaginal orifice (Okeke et al., 2012).

Sunna: More severe cutting (type 2)which involves removing the clitoris (Okeke et al., 2012).

Assumptions

In this study, I assumed that the target population of nurses and midwives responded with sincerity regarding their cultural awareness, skills, knowledge, encounters, and desires in terms of providing nursing care to women with FGM. Participants also adapted to and managed cultural differences of women with FGM under their care without bias. I assumed findings from this study would lead to culturally competent nursing care expectations among nursing policymakers to ensure patient-centered and culturally competent care for women with FGM based on their specific cultures.

Scope and Delimitations

I used the process of cultural competence in the delivery of healthcare services framework, a model that shows cultural competence as ongoing process for healthcare providers to address the ability and knowledge of 10 female nurses and midwives on cultural competency when providing care for FGM patients in Owerri. Participants who were individually interviewed for the study were active female nurses, 21 years and

above with at least 5years experience or worked in healthcare facilities from 2013-2021 as a nurse and are members of NANNM Owerri, Imo State branch. NANNM is the umbrella organization for all registered nurses and midwives in Nigeria and an appropriate study site because it is the gathering place for registered nurses and midwives to learn issues that impact nursing. I chose Owerri because it is a cosmopolitan city and the capital of Imo state of Nigeria that attracts Nigerian nurses from diverse cultures and ethnicities for various nursing jobs.

I did not include nurses who are not Nigerians, male nurses, and nurses who do not speak one Nigerian language. Male nurses were excluded due to the subject's sensitivity, while the inability to understand a Nigerian language was a massive impediment to communication in terms of providing culturally sensitive care associated with this topic to diverse patients. Data obtained included information on patient-centered and culturally competent care for women with FGM complications in Owerri.

Limitations

The number of study participants was small and recruited from Owerri, thereby limiting generalizing findings to other states. Nigeria consists of more than 250 unique ethnic groups from 36 states of the country (Adedini et al., 2015). Therefore, result findings from one ethnic group are not transferable to other ethnic groups. The study design approach was time consuming and labor intensive in finding themes. In this qualitative research, there is no empirical representation from the result but I used thematic coding which is subjective and relies on my judgement. Interpretation of study results may be influenced by my knowledge of FGM as a nurse, but I used bracketing to prevent any bias during data collection and interpretation of my findings.

Significance

FGM is a public health issue that has negative consequences on the physical, mental, and social wellbeing of women who are victims of the act. Anzaku et al. (2018) described FGM as a break in female body integrity. It constitutes a violation of womanhood and accounts for 55% of all abuses of women's rights. Although numerous studies on FGM in Nigeria exist, it was unclear how the Nigerian health system implements existing laws, guidelines, and policies to prevent and treat FGM. Given the multifaceted nature of FGM as a traditional practice, this study's ability for social change helped me understand how Owerri communities core values, myths, and traditions impacted FGM nursing care. Therefore, this research helped identify patient-centered and culturally competent nursing care for women with FGM in Owerri.

Summary

This chapter included information about the importance of cultural competence and sensitivity in terms of nursing care for women with FGM. It included the problem statement, research questions, theoretical framework, assumptions, scope, delimitations, and limitations. Literature reviewed for this study is discussed in Chapter 2, and Chapter 3 includes an explanation of the study design and methodology, while Chapter 4 includes results. I interpreted findings and provided recommendations for further study in Chapter 5.

Chapter 2: Literature Review

Nurses and midwives who take care of women with complications due to FGM lack professional protocols and guidelines involving care delivery and culturally sensitive approaches (Abdulcadir et al., 2014; Ashimi et al., 2014; Kaplan-Marcusán et al., 2010; Vissandjée et al., 2014; Zurynski et al., 2015). I explored cultural approaches involving care of FGM cases in Owerri. Nigeria comprises many ethnic groups that differ in terms of FGM practice, and some nurses are not aware of or do not understand distinct types of FGM (Ashimi et al., 2014). Lack of proper identification of FGM types by nurses and midwives leads to improper diagnosis of FGM. To avoid misdiagnosis and ensure proper care, Vissandjée et al. (2014) emphasized that proper assessment of women with FGM calls for a cultural mediator to facilitate trust from women with FGM in countries that do not practice FGM. Furthermore, De Beer and Chipps (2014) indicated that values of empathy, truthfulness, respect for choices of patients, and interactions between nurses and patients are key factors that can influence patients' autonomy, establish rapport, and promote better health outcomes. Hence, this study helped bridge literature gaps in terms of improving nurses and midwives' knowledge and understanding regarding consequences, quick diagnosis, and care of diverse types of FGM through cultural approaches.

Overview

According to Adedini et al. (2015), 250 identifiable ethnic groups in Nigeria were affected with under-five deaths due to specific sociocultural practices and values including FGM that affected child health outcome. The U.S. Department of State (2001)

confirmed that the practice of FGM varies among ethnic groups in Nigeria. I investigated cultural approaches involving FGM among Nigerian nurses in Owerri based on the main ethnic groups of Hausa, Igbo and Yoruba. The highest prevalence of FGM in Nigeria is found in the southeast and southwest geopolitical zones, which include states like Ebonyi (74%), Imo (68%), Osun (83%), and Oyo (84%). These states are the traditional homes of Igbo and Yoruba ethnic groups in Nigeria (Microdata Library, n.d.; see Table 1).

Table 1

FGM Prevalence of Four Major Ethnic Groups of Nigeria from 2003 to 2013

Characteristics	2003	2008	2013
Major ethnic groups			
Hausa	.4%	20.3%	19.4%
Fulani	.6%	8.5%	13.2%
Igbo	45.1%	51.4%	45.2%
Yoruba	60.7%	58.4%	54.5%

Note. Adapted from Microdata Library (n.d.).

FGM is a term that covers all harmful practices perpetrated on female genitalia for religious and nonmedical reasons. The four categories of FGM include cauterizing or pricking of the female genital area, partial or total removal of the clitoris, cutting the labia minora or labia majora, and narrowing of the vaginal orifice (WHO, 2008; Zurynski et al., 2015). In Nigeria, most FGM is performed via excision at infancy; 16.0% of girls had FGM before their first birthday, and 82.0% of women between 15 and 49 had FGM before their fifth birthday (Akinsanya & Babatunde, 2011; Microdata Library, n.d.). Regarding all four FGM types, the most common in Nigeria is type 1 (Sunna), which is prevalent in the southeast and southwest areas of the country.

Ashimi et al. (2014) posited that 155 nurses (49.0%) of northern Nigeria nurses who were among 318 respondents for his study who had heard of FGM, could identify Angurya and Gishiri cuts as forms of FGM which are common types of FGM in the north. Lack of knowledge regarding specific forms of FGM among some nurses in northern Nigeria is an indication of inadequate assessment and diagnosis of the phenomenon, which may lead to adverse health outcomes because when women with FGM seek medical attention, primary caregivers are nurses and midwives.

Mojekwu and Ibekwe (2012) showed Nigeria had a high maternal mortality rate at 1,100 maternal deaths per 100,000 deliveries, which is only second to India. The maternal deaths include death from FGM complications, therefore, Nigerian nurses and midwives have a great responsibility in terms of providing culturally sensitive care for women with FGM to help reduce maternal mortality in their country.

This chapter included literature on clinical consequences of FGM, FGM care, clinical practice involving FGM cases, the economic burden of FGM, major Nigerian ethnic groups' perspectives on FGM, and lack of standardized nursing policies and guidelines regarding the phenomenon.

Literature Search Strategy

In this study, I used the following search terms: *female genital mutilation*, *female circumcision or cutting*, *FGM complications*, *practice guidelines*, *knowledge of healthcare professionals on FGM, nurses' perception of FGM in Nigeria*, and *cultural competence in managing FGM*. Rudestam and Newton (2015) posited skillful approaches ensure researchers communicate ideas involving the research topic, procedures, and findings appropriately. I used the following databases: CINAHL, Medline, PubMed,

Cochrane Library, BioMed Central, EBSCOhost, Ovid, Science Direct, Google scholar, ResearchGate. All articles were written in English and published between 1998 and 2020. Creswell (2009) stated that literature reviews for health-related issues should involve peer-reviewed clinical trials, including systemic reviews and practice guidelines, based on evidence reflecting the phenomenon and target population.

Theoretical Framework

Glanz et al. (2015) indicated that to achieve better health outcomes, health officials must identify health concerns and apply a practical theoretical or conceptual framework with strategic interventions that address the health problem using a preventive approach. Therefore, to understand perceptions of nurses regarding FGM care in a culturally diverse country like Nigeria, I used the modified version of the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised IAPCC-R (MV) tool for measuring process of cultural competence in the delivery of healthcare services which includes five constructs . The tool was designed for measuring level of cultural competence among healthcare professionals which includes nurses and midwives. It is a 25-items tool that measure five constructs of awareness, skill, knowledge, encounters and desire quantitatively. Hence it was modified with the permission of the author Dr. Josepha Campinha-Bacote and it involved redesigning the tool originally constructed for quantitative research with close ended questionnaires and scoring keys for qualitative research study. The tool provides a unique approach for understanding a culturally congruent nursing care. According to Campinha-Bacote (2011), cultural competence in delivering healthcare services is an ongoing practice

where nurses strive to acquire culturally competent skills to work effectively within patients' cultural contexts.

The IAPCC-R (MV) tool measured the five constructs of cultural awareness, cultural skill, cultural knowledge, cultural encounter, and cultural desire as they addressed the interview questions during data collection.

Cultural awareness is an important stride in advancing cultural competence in healthcare services. It involves recognition of one's prejudices and biases against people of diverse cultures. In healthcare, nurses identify their respective beliefs and values and become sensitive to other people's lifestyles to avoid cultural imposition on their patients.

In providing nursing care, the nurse should take their patients' tradition and cultural beliefs into account for a better health outcome. Therefore, cultural skill which involves collecting relevant data regarding patients' health issues through culturally based inclusive communications during physical assessments is very essential .

In ensuring nurses understanding of culture, tradition and beliefs, cultural knowledge which involves having the understanding and educational backgrounds regarding diverse cultures with information about patients' views of their cultural values and beliefs related to health issues is an essential step to cultural competency.

Nursing care involves direct interaction with the patients, therefore cultural encounters focused on face-to-face engagement with patients to modify perceptions of different cultures and prevent stereotyping and ethnocentrism.

Cultural desire is when nurses are motivated to become culturally sensitive and competent when providing care. This framework helped in terms of identifying gaps in FGM care among nurses and midwives in Owerri based on patients' cultural context.

Theoretical Foundation

To understand Nigerian nurses' approach to the care of women with FGM within the patients' cultural context, the process of cultural competence among healthcare professionals by Campinha-Bacote developed since 2002 is the study framework (Campinha-Bacote, 2011). In this qualitative study, the modified version of the IAPCC-R tool is an excellent fit to understand the world view of study participants in the care of women with FGM, especially in multicultural countries like Nigeria. Therefore, based on Bacote's process of cultural competence in the delivery of healthcare services framework and permission from the author, the modified version of IAPCC-R tool addressed qualitative questions exclusively for this qualitative research study. Hence for this study, the IAPCC-R tool became the IAPCC-R (MV) tool to address the five constructs of the theoretical framework in other to elucidate Nigerian nurses' lived experience in their care of women with FGM as it addressed the research questions.

To emphasize the essence of utilizing process of cultural competence in the delivery of healthcare services by Campinha-Bacote, Ingram (2011) examined the relationship between health literacy and cultural competence on nurses using the constructs of awareness, skill, encounter, knowledge, and desire. The study findings revealed that cultural competence embodies beliefs, values, customs, and traditions that helped nurses address cultural issues when providing care among diverse groups. This is in keeping with De Beer and Chipps (2014) who emphasized high quality nursing care to culturally diverse groups embody cultural skill, and cultural encounter for a culturally competent nursing care. This current study involved how to care for people of diverse cultures effectively.

Similarly, Aponte (2009) used Campinha-Bacote's cultural competence model to guide nurses on how to provide culturally sensitive holistic care to different Hispanic subgroups. The findings revealed that nurses need a culturally sensitive approach to care for people of diverse cultures. This study ensured the use of a culturally sensitive approach for the care of ethnically diverse Nigerian women with FGM as appropriate. Kardong-Edgren et al. (2010) used the IAPCC-R tool to study cultural competence among Bachelor of Science in nursing (BSN) students; it revealed that achieving cultural competence among nurses demands multiple curricular approaches for a better health outcome. Aponte, (2009) and Kardong-Edgren et al. (2010) revealed that achieving cultural competence among nurses is essential approach for the care of patients from multi-cultural societies. Therefore, in this qualitative study, to understand nurses' worldview in using a culturally competent approach for delivering care, the IAPCC-R tool modified version helped identify appropriate steps and gaps in the care of FGM cases by Nigerian nurses in Owerri for a better health outcomes.

The use of this process of cultural competence in the delivery of healthcare services model by Campinha-Bacote to address research questions ensured that nurses knew their individual biases, understood how to interact with patients, and resisted cultural stereotyping. Nurses accomplished it by having an open mind when providing care, especially in a country like Nigeria, which has diverse ethnic groups (Odemerho & Baier, 2012). This review has disclosed that becoming culturally competent is essential in the provision of nursing care for culturally diverse patients (Aponte, 2009, DeBeers and Chipps, 2014, Kardong-Edgren et al. 2010 and Ingram, 2011) Such culturally sensitive care would help quick recovery, maintain the woman's health, and gain clients'

satisfaction. Therefore, using the process of cultural competence in the delivery of healthcare services for this study created a skillful strategy for communication and care as it addressed the research questions for this study.

Review on Key Variables and Concepts

Cultural Competence

Cultural competence is a set of essential skills for nurses while providing effective patient-centered nursing care (Campinha-Bacote, 2011). De Beer and Chipps (2014) applied the process of cultural competence framework to ascertain the cultural competence of critical care nurses (CCN) in South Africa healthcare system by distinguishing how nurses scored on each specific construct of the framework. The findings revealed that among the 168 CCN, only 74% were culturally aware but not culturally competent, with a mean score result of 14.4. Cultural knowledge scored 14.8 points, cultural desire 14.6 points, cultural encounter 12.6 points, and cultural skills were 13.7 points. This study showed that the respondents scored low in cultural skills and cultural encounters, which are essential cultural competence elements to provide high-quality services to culturally diverse groups. It confirms the findings of Riley, 2010 who examined RN to BSN students on cultural competence using same framework and IAPCC-R tool. The result showed that 50.94% of participants' were culturally competent with the highest score on cultural desire. These research studies were of immense value because they were in South Africa, a country as diverse as Nigeria, and among nurses in Nevada Las Vegas using the same tool as proposed for this study.

Seright (2007) surveyed 205 registered nurses in rural North Dakota on their perspective on cultural competence as educational prepared professionals, using the

IAPCC-R tool. The randomized descriptive study's findings indicated that more than 80% of nurses who participated in the study considered themselves culturally incompetent, but after 38.6% received cultural diversity training, 14.5% of registered nurses became culturally competent. De Beer and Chipps (2014) and Ingram (2011) associated cultural competence of healthcare professionals with health literacy and high-quality care for diverse ethnic groups. Therefore, the framework I chose for this study is a good fit to ascertain how nurses/midwives provide care in Nigeria for FGM cases, a country with more than 250 ethnic groups.

Kardong-Edgren et al. (2010) revealed how BSN students from six nursing programs used Campinha-Bacote's cultural competence framework to ascertain their perception of cultural competence. The quantitative study analyzed each construct of cultural competence using the IAPCC-R tool. The result revealed that 83% of students with prior degrees scored 74.3 points on the IAPCC-R instrument than students without prior degrees who scored 70.6 points. Hence, reiterating the didactic approach using multiple curricular approaches in addressing cultural competence among nursing students. This result was like the findings of Seright (2007), and Croasdell (2012) that showed the need for nurses to understand cultural competency for effective health outcomes.

To the best of my knowledge, an area that lacks adequate intervention in FGM care in Nigeria despite extensive research on the phenomenon is within cultural sensitivity and competency in women's care with FGM by Nigerian nurses. For instance, Onuh et al. (2006) also indicated that culturally sensitive training for healthcare professionals and the community is the key to discouraging FGM practice. Although the

focus of this study will not be the training of healthcare professionals for cultural competence, findings from this research will improve the knowledge base of nurses/midwives to deliver evidence-based clinical care for women with FGM in Nigeria and help decision-makers to create best practices in healthcare for a better health outcome for women with FGM in Nigeria. Vissandjée et al. (2014) suggested that reducing harm in women includes caregivers addressing their socio-cultural lifestyle concerning providing health services and as determinants for female genital cutting. Therefore, the literature by Croasdell (2012), De Beer and Chipps (2014), Kardong-Edgren et al. (2010), Ingram (2011) Riley (2010) and Seright (2007) revealed the nursing need for cultural competence in the care of FGM cases.

Barriers to Effective Nursing Practice in Cases of FGM

Lack of Adequate National Legislation against FGM

Zurynski et al. (2015) revealed that most healthcare workers could not correctly identify categories of FGM. Among the 159 articles reviewed using the guidelines of Preferred Reporting Items for Systematic reviews and Meta-Analysis (PRISMA) on data from articles published from 2000–2014, only 18 articles, including studies from Nigeria, addressed FGM. The findings showed that in determining the knowledge of legislation against FGM by healthcare professionals, only 25% of Sudanese midwives from Eastern Sudan and 45.5% of healthcare professionals from Belgium were aware of legislation against FGM in their countries (Ali, 2012; Leye et al., 2008). In the United States, Hess et al. (2010) revealed that over 56% of certified nurse/midwives were aware of the illegality of FGM practice in the country. These study findings revealed that legislation against FGM practice was more effective in developed countries than countries with

FGM practice, which is a barrier to nursing FGM cases. This was in accordance with study findings from Nigeria which showed healthcare professionals had knowledge of the illegality of FGM in some states but lacked clinical experience on the care of FGM (Dike et al., 2012). This result is similar to Ahanonu and Victor's (2014) findings, which revealed that out of 36 states of Nigeria, only eight states enacted laws against FGM, namely Abia, Bayelsa, Cross River, Delta, Edo, Ogun, and Osun state. Therefore, lack of laws against FGM for all states in Nigeria in the care of FGM is an indicator of lack of proper clinical guidelines, and it is a barrier to delivering effective nursing care by Nigerian nurses on care of FGM. This result confirms the findings of Ashimi et al. (2014) and Onuh et al. (2006), which revealed barriers to effective nursing care like language barriers, ethnicity, customs, and lack of professional guidelines on caring for women with FGM in a diverse culture.

Lack of Customized Cultural Training for Healthcare Professionals Regarding FGM

Croasdell (2012) explored the nursing care provided to women with FGM in the United States. The mixed-method study included 16 respondents, mainly nurses who cared for FGM cases with extreme type 111 (infibulations) in the United States. The research question for the study was: What type of individualized nursing care is the practice with FGM cases? The themes that emanated from the study were: (a) lack of individualized therapeutic conversation and (b) 'cultural incompetence because only 31.25% had moderate knowledge of FGM; also, 87.5% of nurses reported lack of protocol in the care of FGM. In clinical practice, Odermehor and Baier (2012) emphasized that cultural competence necessitates the nurse to comprehend the meaning

of FGM and its adverse impact on the woman. Therefore, the authors suggested the need for streamlined culturally competent care for a better health outcome. This study emphasized the need for customized nursing care based on the cultural context of women with FGM.

Ashimi et al. (2014) on Hausa Fulani lineage was in a tertiary health institution in northern Nigeria. The findings confirmed the inability of nurses to identify and categorize several types of FGM. Among 350 nurses aged 18–60 years who participated in the study, 127 (40%) did not know FGM types, while Angurya and Gishiri cuts the severe forms of FGM identified by 155 (49%) of respondents. Only 77% of the nurses were aware of FGM complications, and 318 (91%) were conversant with FGM. The result is like Zurynski et al.'s (2017) findings on nurses' inability to identify FGM correctly. The authors suggested a different approach to care with an emphasis on cultural competence, which was echoed by Anzaku et al. (2018), Epundu et al. (2018), and Ezenyeaku et al. (2011) for a better health outcome on FGM cases.

In southern Nigeria, Dike et al. (2012) studied the attitude of nursing and midwifery students towards FGM in Afikpo, a suburban town of Ebonyi state, which is of the same ethnic group as Imo indigenes, the state for this study. The study focused on the participants' circumcision status, benefits, and problems associated with FGM. The findings revealed that nursing and midwifery students differ in their view on their knowledge of FGM. Among 269 participants of the study, 49.3% who are circumcised claimed to be happy with their circumcised status, 14.1% believed that FGM prevents promiscuity among women, while 7.1 believed that there is spiritual satisfaction with FGM. Also, student nurses' different views on FGM were due to the participants' level of

education. Therefore, this study revealed a lack of proper education for student nurses on FGM's risks, which raises concern on proper policy and guidelines for nurses who care for women with FGM. This is in consonance with Hess et al (2010) findings on FGM in Nigeria as a rite of passage for the woman into adulthood and essential step to social solidarity, confidence and female submissiveness

Motivated by the findings of previous researchers on barriers to delivering effective patient-centered nursing care, which includes the inability of nurses to classify several types of FGM correctly and lack of cultural training; Balfour et al. (2016) reviewed nursing care of women with FGM in America and Mali Africa, using same PRISMA guidelines. Data from the systematic review of 1,708 literature from January 1995 to August 2015 indicated that 50 articles showed a drop in the number of Malian nurses' inability to identify types of FGM after cultural training from 24% to 5%, while the ability to list FGM complications improved from 61–73%. Similarly, in Central Maine United States, where there is an influx of Somalia immigrants, the confidence level and skill of 11 certified midwives on deinfibulation improved from 2.36–4.18 and their cultural competence level from 2.36–4.09 after training with the presence of a Somalian mediator for the immigrants with FGM and the midwives who care for them. In keeping with the systemic review findings of Zyrunski et al. (2015) on midwives and doctors in London, only 4.0% of respondents could identify FGM types while approximately 45.0% of participants knew procedure to deinfibulate FGM women during labor. These studies strength revealed the importance of training and understanding women's FGM culture for effective nursing care.

Health Consequences of FGM

Maternal Physical Health Effect

The devastating health consequences of FGM on women are overwhelming. From the very moment of the cutting, the individual experienced tremendous pain, bleeding, and risks for infections. Throughout the girl/woman's life, there is agony, trauma, and attendant complication, resulting in morbidities and mortalities (Awolola & Ilupeju, 2019). Adika et al. (2012) addressed the quality of life and reproductive health status after FGM among Ijaw women of Nigeria. This study's findings revealed that the typical Ijaw woman regarded pain from FGM site as usual but affirmed that the quality of life after FGM was low (2%). On the other hand, 2% of nurses who participated in the study endorsed FGM's medicalization and performed FGM on women to prevent increased risk of infection when performed by traditional birth attendants in a home setting. This action supports the study findings by Odukogbe et al. (2017) and Onuh et al. (2006) on the medicalization of FGM in reducing the risk of infection. This study also indicates that Ijaw woman accepts pain as an outcome of FGM and may inhibit reporting of FGM health-related issues that are detrimental to women's health and may influence nurses' approach to care.

Maternal Gynecological and Psychological Health Effect

Ezenyeaku et al. (2011) explored the several types of FGM complications on Igbo women in Enugu and Awka in southeast Nigeria. Among the 342 respondents, 22.4% mentioned prolonged labor and difficulty in delivery, while 23.8% of women felt incomplete after FGM due to sexual dissatisfaction. These findings underscore the gynecological and psychological consequences of FGM later in life from women of the

Igbo ethnic group. This result confirms Adewole and Adayonfo (2017) and Okeke et al. (2012) on later consequences of FGM.

Okeke et al. (2012) highlighted the specific consequences of FGM when the victim struggles during the procedure without any local anesthesia. The authors revealed the damage to the urethra and anal region due to struggle resulting in chronic pelvic infection, gynaetresia and haematocolops, dysmenorrheal, cyst formation, and sexual problems with anorgasmia. These health problems result in psychological consequences, including sexual frigidity, dread for sex, and childbirth as most serious complications. These inward manifestations that occur later for FGM victims prevent them from seeking medical attention. This study supports the findings of Adewole and Adayonfo (2017) and Osifo and Evbuomwan (2009) that highlighted physical and psychological complications from FGM and the difficulty in ensuring a culturally sensitive nursing care approach for FGM cases.

Ndikom et al. (2017) on Yoruba women from Ibadan Oyo state of Southwest Nigeria confirmed that FGM has no proven social or health advantages. Among the 106 respondents for this quantitative descriptive study, 52.8% agreed on FGM as an infection source, 30.2% reported difficulty in child delivery, 5.7% experienced incontinence, while 44.3% affirmed excessive bleeding, and 9.4% agreed that FGM is an infertility source. Also, 17.9% reported FGM awareness from nurses, while 17% did not know if they had FGM. This finding confirmed Anzaku et al.'s (2018) idea on FGM as a source of infection and the leading cause of Vesico and rectovaginal fistula, which results in a continuous discharge of urine and feces into the vagina.

Maternal Psychological and Child Health Effects

There is little empirical research on the psychological effect of FGM on women. According to Mulongo et al. (2014), psychological problems of FGM were posttraumatic stress disorder, anxiety, depression, affective disorder, and socio-cultural differences. O'Neil & Pallitto (2021) indicated that report from numerous studies revealed the women with FGM feeling different, deplorable, subservient, avoid discussing the problem but have the wish for completeness. All these manifest when the physical and gynecological consequences of FGM are ill-managed. The socio-cultural idea of the victim accepting FGM and its consequent complications as the norm is regrettable because most psychological problems of FGM are under reported. This lack of reporting is a challenge for health officials, trained psychologists/counselors in developing culturally adapted interventions for FGM victims' care.

Epundu et al. (2018) explained that due to obstetrics' risks and complications from FGM cases, babies born to FGM women are at risk of neonatal complications like asphyxia from prolonged labor that may result in death. The victims' trauma was due to cutting without anesthesia while holding down and binding legs together, eroding the woman's self-esteem. O'Neil & Pallitto (2021) reinforced the findings that the general morale of women with FGM is low after FGM as they avoid verbalizing their feelings. This is a significant concern for healthcare professionals.

Neonatal Health Consequences

Frega et al. (2013) revealed an elevated risk of childbirth complications. The study was based on 85 women with FGM and 95 women without FGM revealed that women with FGM used more intravenous Oxytocin during delivery due to prolonged

second stage of labor. The result is that weak babies are born with lower Apgar scores of less than 9/10 and sometimes stillbirths. This finding confirms the study by WHO in six African countries, including Nigeria, on 28,393 women. The outcome was a higher incidence of resuscitation and perinatal deaths with severity associated with types of FGM. Findings also revealed that resuscitation of infants from women with type 3 mutilation is higher at 66%, while the death rate for infants from mothers with type 1 FGM at 32% and type 2 FGM is 55%, and a higher death rate in infants from mother with type 3 FGM. This result conforms with the findings of Odukogbe et al. (2017) which explained that babies conceived by FGM women have greater risk of stillbirth, neurological problems due to severe asphyxia, and early neonatal demise.

Major Nigerian Ethnic Groups on the Acceptance of the Practice of FGM

The aforementioned literature review addressed the consequences of the practice of FGM on women. Chidera (2018) and Anzaku et al. (2018) emphasized on the adverse consequences of FGM on women and girls. These consequences can be ameliorated through community specific programs that discourages the act of FGM. Ayenigbara et al. 2013 posited that Yorubas, Muslim and Igbo ethnic groups perform FGM from infancy, two weeks to eight years of life, while women from Ibibio, Akwa Ibom state and Okpe community of Delta state perform FGM from 13–18 years and extends to pregnancy and before delivery. These communities highlights the acceptance of the culture of FGM practice and its health consequences based on ethnic groups and educational level of Nigerian women, which may affect nurses' decision in the delivery of practical nursing care for a better health outcome for women in Nigeria.

Lack of Knowledge of Consequences of FGM by Women from Igbo Ethnic Group

Okhiai et al. (2011) showed that the majority of women of childbearing age from southeastern Nigeria (Igbo ethnic group) like Imo state the area for this study, are not aware that FGM is inimical to their physical, social, and reproductive health, thereby causing irreparable harm. Among 380 women who participated in the quantitative study in Umuzu and Umuleke of Ahiazu local government area, only 162 (42. 6%) were aware of the physical and psychological consequences of FGM, while 218 (57.4%) were unaware that FGM is harmful. It is essential to note that 77% of study participants who were unaware of the consequences of FGM were women with no formal education. This result conforms to the findings of Daniyan et al. (2018), Epundu et al. (2018), and Okonofua et al. (2002) that the cultural practice of FGM on women could change through behavioral improvement, empowerment of women and girls, and education at all levels. This change will ensure that FGM victims become aware of the risks and complications of cultural practice.

Ibekwe et al. (2012) ascertained the knowledge and practice of FGM from a healthcare facility in Abakaliki of the southeastern geopolitical zone of Nigeria who are women of Igbo ethnic group. The study showed that 90% of respondents had an increased level of awareness of FGM, 71.5% were aware that FGM is a banned practice in that state, but 47.7% were concerned that FGM is still a practice in healthcare facilities, and 49.6% had FGM performed during their infancy. Despite all concerted efforts to stop the practice, through advocacy programs from organizations like NANNM enforcement of legislation, social networks against FGM, and global programs to abandon FGM, these findings support the notion that FGM is still a health problem for

women and girls. Dibua et al. (2010) stated that some women's perceived normalcy of FGM as a cultural practice in Nigeria overshadowed their understanding of the risks and consequences of female cutting due to ignorance, misconception towards the practice. Therefore, the right nursing care approach requires cultural competence in the care of FGM cases.

Lack of Knowledge of Consequences of FGM by Yoruba Ethnic Group

Ayenigbara et al. (2013) revealed that performing FGM varies among ethnic groups. The Yoruba communities of Abeokuta, the Igbo communities, and Muslims from northern Nigeria perform FGM from infancy, two weeks to eight years of life, while women from Ibibio, Akwa Ibom state and Okpe community of Delta state perform FGM from 13–18 years and extends to pregnancy and before delivery. The authors stressed the lack of understanding the consequences of FGM leads to inhumane torture of binding of the victims' thighs and legs for 40 days to keep it immobile and introducing adhesive materials like sugar, eggs, acacia, tar to the site, making it a source of infection for tetanus, and cutting dead uncircumcised women. Later in life, FGM victims may suffer from damaged tissues after reinfibulation that causes vesicovaginal fistula and rectovaginal fistula, resulting in urine leakage, marital disharmony, and a considerable healthcare crisis. The Yoruba believe that the clitoris is dangerous to an infant's life if it touches the head during delivery and that a circumcised vagina is esthetically beautiful (Caldwell et al., 2000). Such findings have a negative health impact on the individual, healthcare industry, and society.

Lack of Knowledge of Consequences from FGM by Hausa Ethnic Group

In northern Nigeria, Ashimi and Amole (2015) conducted a study on pregnant women with FGM, Hausa ethnic groups in rural communities. There were 323 participants for the study, only 256 (79.3%) were aware of the practice of FGM and verbalized that Gishiri cut (53.3%) and Angurya (44.1%) were the most typical forms of FGM practiced by women of Hausa ethnic group of northern Nigeria. The women expressed that the cuts ease the child delivery process and enhanced a woman's marriage prospect. Ashimi and Amole (2014) revealed that some nurses from tertiary health institutions of northern Nigeria could not identify Gishiri and Angurya associated with difficulty in childbirth. Hence, there is a clash between culture and nursing practice in Nigeria's geographical zone regarding FGM, in juxtaposition. If Gishiri and Angurya cuts are common in this area, and the nurse/midwife is not familiar with FGM types, this could affect nursing care. The lack of knowledge by northern women on the health consequences of FGM and lack of skill exhibited by nurses in the care of FGM among this ethnic group is counterproductive in the delivery of proper nursing care. Therefore, women with FGM suffer from inefficient healthcare, which negatively impacts the family and society.

Economic Impact from the Practice of FGM

Economic Effect on Some African Countries

Adam et al. (2010) estimated the obstetric cost of 100,000 women with FGM from six African countries namely Ghana, Burkina Faso, Sudan, Senegal, Kenya, and Nigeria, from pregnancy, labor, delivery, and hospitalization until discharge for adverse outcome. The project utilized an international purchasing power exchange rate of the

dollar for cost analysis. The result showed that for all six countries, FGM practice cost about 0–1-1% of total government expenditure and up to 3.7 million dollars in the six countries, which includes the cost of blood transfusion for hemorrhage from FGM and cesarean section at $29–$79 and $36.40, respectively. This findings are in agreement with the result from Epundu et al. (2018) study on the cost of FGM in southern Nigeria. The post FGM cost per girl in this geographical area is not cost effective at $120 per day. Therefore Adam et al. (2010) and Epundu et al. (2018) revealed that FGM is waste of money, resources and economic power.

Economic Effect of FGM on Nigeria

In Nigeria, the negative economic effect of FGM is overwhelming; where a day in a hospital bed due to FGM cost $6.73, and, the cost of type 3 FGM for a 15-year-old costs about $5.82 in medical cost and a reduction of one–fourth a year of life (Adam et al., 2010). The economic challenges of FGM are further elucidated for 13 months follow up of study on respondents on FGM practice in Nigeria. Mpinga et al. (2016) focused on exploring the economic challenges of the social consequences of FGM in some African countries, including Nigeria; it highlighted socioeconomic advantages and disadvantages of the practice of FGM. The economic burdens of FGM were due to the cost of the lack of healthcare professionals' training on the management of FGM and marital consequences due to FGM complications. The investigators listed the only economic advantage of FGM as a marriage incentive, which ensures better bride price, improving the woman's family and the community's economic prosperity. Therefore, it is essential to conclude that FGM is not cost-effective. It is detrimental to a woman's life span and a substantial economic threat to countries like Nigeria. There is a need for a multi-sec toral

strategy to strengthen interventions in the fight against FGM practices in Nigeria and other African countries to save lives and improve its economic status.

Odukogbe et al. (2017) confirmed the findings of the previous researchers but also revealed that the cost of FGM is not only from the price paid to excisors, medical and obstetrical management of FGM, but the loss of 130,000 life years which is equivalent to a loss of half a month from each life span. This economic disadvantage of FGM confirms the findings by Adam et al. (2010) and Epundu et al. (2018) which stated that African countries would lose 130,000 years of life from FGM-related procedures over 12 months. The reasons for the loss of years were maternal mortality, emotional and psychosocial problems that threaten the nation's economy, mainly where women contribute immensely to society's economic process. Their findings concluded a lack of useful scientific data on the economic dimensions of FGM and highlighted a need for further study in this area.

Epundu et al. (2018) addressed the cost of post-FGM in Nigeria. The findings revealed that the cost of the post-FGM procedure in southeast Nigeria, the study's geographical zone is about $120 per girl. Besides life lost per FGM incident among women aged 15–45 years, the practice progressively increases from types 1–111. The study findings revealed that in Nigeria, the national minimum wage is lower than $50 or 18,000 Naira in a month; therefore spending $120 on complications from FGM per girl is a huge economic burden for individuals, communities, and society. To buttress this point, a data tool named the FGM cost calculator, which was launched by WHO for 27 out of 30 countries that practice FGM, revealed that the current and future healthcare cost for women living with conditions of FGM is financial intensive at the cost of 1.4 billion

dollars per year. The new tool also projected health cost savings of 60% by 2050 without FGM (WHO, 2020b). Therefore, it is safe to conclude that FGM is a misuse of money, time, and life, and negatively impacts the individual, healthcare industry, and the nation.

Summary and Conclusion

Diverse cultural populations, traditions, cultures, and customs are essential in terms of molding ways, attitudes, and beliefs involving addressing cultural practices like FGM in Nigeria. I addressed nurses and midwives' approaches to care for women with FGM because it is essential to know how cultural competence influences this type of nursing care.

This literature review was used to elucidate the clinical need for nurses and midwives to improve quality of nursing care for Nigerian women within their cultural context in terms of FGM by identifying the worldviews of nurses in Owerri who care for women with these complications. Therefore, ascertaining nurses' cultural awareness, skills, knowledge, encounter and cultural desire based on their education and nursing training helped me understand their worldviews involving cultural competence on appropriate cultural guidelines within patient's cultural context when providing care of FGM patients for better health outcomes.

This chapter revealed that nurses and midwives need to advocate for women of diverse cultures with FGM because of resultant adverse health and economic consequences. This study's literature review also disclosed the use of IAPCC-R tool in addressing cultural competency among nurses but did not reveal any specific tool prior to this study for measuring cultural competence for Nigerian nurses and midwives in

Owerri pertaining FGM care. Such a gap in research necessitates further study. Chapter 3 includes the study design, my role as the researcher, data collection, and analysis regarding how to bridge the cultural incompetence gap in FGM cases and strengthen nurses and midwives who provide nursing care to FGM in Owerri.

Chapter 3: Methodology

In this study, I aimed to ascertain how nurses and midwives in Owerri provide patient-centered and culturally competent care for women with FGM in healthcare facilities. FGM, which involves partial or total removal of the external female genitalia and other unclassified injuries to female genital organs, has been considered an affront to the health, dignity, and human rights of girls and women from countries in Africa, Asia, and the Middle East (WHO, 2018). FGM poses a massive challenge to nurses in Nigeria. Nigerian nurses and midwives who participated in this study understood several factors that justify caring for FGM complications while maintaining cultural values of their patients.

Chapter 3 includes a discussion of the research design and rationale, my role as the researcher, methodology, trustworthiness, and a summary. I explained overall procedures and addressed research questions for the study. I explained data collection practices and ethical procedures during interviews. This involved strategic steps for collecting, analyzing, and managing data. I addressed issues of trustworthiness credibility, transferability, dependability, and confirmability of data. This was followed by a summary.

Research Questions

The research questions for this study are:

RQ1: What are the practices of Nigerian nurses and midwives providing patient-centered and culturally competent care for women with FGM in Owerri?

RQ2: What culturally sensitive and patient-centered skills do Nigerian nurses and midwives use to address FGM cases in Owerri?

RQ3: What knowledge barriers do Nigerian nurses and midwives express regarding caring for FGM women in Owerri?

RQ4: What cultural dynamics influence patient-centered care of women with FGM in Owerri?

RQ5: What are the motivating factors for Nigerian nurses and midwives in terms of practicing cultural competence for FGM patients in Owerri?

To address these qualitative research questions, the IAPCC-R (MV) tool was used to measure the cultural competence of nurses and midwives in relation to the five constructs of cultural awareness, skill, knowledge, encounter, and desire (see Appendix D). *Cultural awareness* involves personal beliefs regarding nursing care, cultural and religious sensitivity, and aversion and acceptance of care delivery by patients. Nurses who are culturally aware when providing nursing care for FGM patients are sensitive to their own culture and their patients when identifying health risks associated with FGM practice. Glanz et al. (2015) posited effective interventions must be compatible with beliefs, values, and relevant norms, including comprehending and respecting patients. I explored how the nurses and midwives strategized to extract pertinent information and perform individualized cultural assessments. Achieving this *skill culturally* requires a basic understanding of values and customs of patients. Avoiding pitfalls involving stereotyping and intentionally labeling patients based on ethnicity, dialects, and characteristic appearances like tribal marks shows *cultural knowledge*. It includes that nurses and midwives are expected to communicate appropriately with respect and understand international laws regarding FGM as well as Nigerian legislation against FGM (WHO, 2008). Therefore, nurses and midwives should access FGM information

through community meetings, church meetings on FGM, Internet resources, seminars by women organizations, and healthcare workshops involving FGM and maternity homes. *Cultural encounters* include different ethnic groups salutation methods; the Yoruba ethnic group prostrates for elders while the Igbo ethnic group bows. In clinical settings the nurse's salutation includes verbal greetings in the patients' language or using pidgin English which is common language for all ethnic groups, and recognizing traditional titles and women's positions from specific ethnic groups, to avoid disrespecting traditional title holders in Owerri. *Cultural desire* ensures nurses drive for respect for ethnicity and gaining patients' trust when providing care by maintaining good rapport through verbal or nonverbal communications. The theoretical framework of the process of cultural competence in the delivery of healthcare was designed to reveal advantages and challenges involving current nursing care delivery with FGM cases, which could be the basis for further research.

For this study, the research tradition was qualitative with a phenomenological approach based on inductive reasoning because I aimed to investigate lived experiences of participants through interviews during a specified time. Ethnography involves prolonged process of observing the participants and immersion in the research setting (Rudestam & Newton, 2015). Therefore, for these reasons ethnography is not a good fit for this study. The grounded theory design was not selected for this study because this involves generating a theory from participants' data. Additionally, a case study design was not suitable because it involves studying a case across many disciplines. The narrative approach was also not suitable for this study because it involves individual

accounts of events and interpreting the stories thereby incorporating my subjectivity as a nurse who understands FGM as part of the research process.

Role of the Researcher

The investigative process for this study started with selection of participants. My role was to identify personal values and biases during this study and ensure that it did not impact data collection. I was a student midwife in Nigeria and participated in difficult deliveries of women with FGM complications and witnessed the cutting of a two-week-old baby that could have impacted my data collection for this study. To avoid personal biases, I remained objective and wrote reflective memos during data collection in order to address any biases resulting from interviews. I listened with an open mind during interviews, with member checking and bracketing.

Methodology

Participant Selection

In this phenomenological study, the target population was qualified nurses/midwives who are Nigerians, worked in the health facilities including OBGYN department, and cared for women with FGM in Owerri, Imo State, Nigeria from 2013 to 2021. Participants were 21 and above with at least 5 years of experience. I used purposive sampling for my target group to ensure I collected information rich data. Purposive sampling allows for a small sample size and saves time and money (see Creswell, 2013).

Recruitment of Participants

Selection and identification of respondents for this study was on nurses/midwives who responded to the call for study. Flyers were posted in the nurses' lounge of the obstetric and gynecological department of Federal Medical Centre Owerri and NANNM

office after notifying NANNM Imo State headquarters of my intention to conduct this study and to obtain permission to post flyers seeking for potential participants for the study. This process was conducted after receiving approval from Walden University Institutional Review Board (IRB) (See Appendices A & B). The recruitment flyer consisted of the research incentive amount and my contact information for the subjects. An initial screening interview was conducted via phone to establish eligibility for the study from the first 20 nurses who responded to the flyer advertisement. Eligibility for participation in the study was demographic information during the initial phone call, followed by an invitation for approximately 10 participants that met eligibility criteria for interview or until saturation was met (see Appendix C). Nine respondents not recruited for the study could not define FGM appropriately and have not worked with women with FGM. One respondent to the flyer was a Nigerian by naturalization because her husband is from Igbo ethnic group, and she could not speak any Nigerian language.

Criteria for participating in the study

The inclusion criteria for the study (a) female Nigerian registered nurse/midwife; (b) 21 years and above; (c) 5years of work experience; (d) ability to speak a Nigerian language; (e) Knowledge of FGM; (f) NANNM membership; (g) bachelor's degree in nursing, masters's prepared and more; and (h) specialize in psychiatric nursing, pediatric nursing, OBGYN, nursing administration. The reason is to ensure the participating nurses are active in offering nursing care and able to provide rich data for the study.

Instrumentation

According to Creswell (2009), interview would capture the healthcare personnel's livid experience in a study that concerns life events as care givers. Therefore,

the IAPCC-R (MV) tool captured participant's responses based on semi-structured interview protocol (see Appendix D). The study participants were aware that the IAPCC-R tool's modification was by the author's permission specifically for this research to address the five cultural competencies constructs including: (a) cultural awareness, (b) cultural skill, (c) cultural knowledge, (d) cultural encounter, and (e) cultural desire for a qualitative study. This is to strengthen nurses/midwives' cultural competence globally (Albougami et al., 2016, p. 3).

Previous researchers have used the IAPCC-R instrument to obtain accurate and consistent information in various cultural competence studies on healthcare professionals. It includes but not limited to the study of cultural competence of RN-BSN students (Riley, 2010); the measurement of cultural competence education for rural clinic nurses (Fields & Bells, 2020); and evaluating cultural competence in an occupational therapy pediatric course (Davis-Cheshire & Crabtree, 2019) to mention just a few. Therefore, to understand the worldview of nurse/midwives in the care of FGM using a cultural approach, the IAPCC-R (MV) elucidated responses in categories of cultural competence for nurses and midwives which corresponded with the goal and objective of the study with clarity of language (see Appendix D).

The following tools were used to complete the study. It included video conferencing app which was easy to use for interview on remote participants, especially as this study was in Nigeria. It provided the best audio and video as mobile devices like cell phones were used for easy collaboration and participant's control.

Audiotape ensured that data collected were preserved for later analysis and validation of contents. Field notes were used to document data, and responses made

during the interview, research process, and ease during hand-coding. It was an essential tool, especially for Nigeria, where there is a constant power failure, to ensure that no data was lost. Files are a safe tool for collecting participants' information regarding data time of collection, meaningful codes, and data analysis (Polit & Beck, 2004). NVivo software is data management software developed by qualitative research software (QSR) that facilitates researchers to code texts, arrange, and organize data. All these tools facilitated recorded answers from participants during the video conference interview.

Procedure for Expert Panel

To ensure the reliability, internal consistency, and validity of the study modified data collection instrument IAPCC-R (MV), there was expert panel analysis for the instrument with Walden University Institutional Review Board (IRB) approval 01-19-22-0361382. This process guaranteed the accuracy and clarity of the interview protocol. A sample of two expert panelists in public health and nursing profession were interviewed with the questionnaire on the interview protocol to confirm their understanding of the questions and identify their proficiency in using the video conferencing application.

Procedure for Data Collection

Demographic Information Interview: Phase 1

This study comprised of two phases. The first phase was a phone interview to screen for demographics from nurses who responded to call to participate in the study. The phone interview familiarized the subjects with the interviewer, the topic of study, the date, time, and duration of the study. Demographic information to determine eligibility to participate in the study were obtained, screened, and documented on field notes to ensure

that approximately 10 participants who met eligibility criteria were signed up for the second phase of the interview.

Step By Step Recruitment, Screening, and Data Collection Tools

An introductory letter was mailed to NANNM Imo State branch with headquarters in Owerri informing them of the purpose of the study for their cooperation to use NANNM headquarters for the study (See Appendix A). The flyer with details of the topic of study, type of participants for the study, my contact information, and incentives for participants was mailed for posting at the nurses' lounge (See Appendix B). 20 nurses who were interested in the study contacted me after reading the flyer. Their demographic information were obtained to determine eligibility.

Screening phone interview was done initially for the 20 nurses and midwives who contacted me and 10 nurses who met inclusion criteria were invited for the study after the entire process of data collection and ethical consideration was explained to them (Screening interview, See Appendix C). The 10 nurses/midwives who met eligibility for study were invited separately for a second interview at NANNM headquarters for the study (See Appendix D). The NANNM office was notified with scheduled date and time for each nurse.

Consent forms were provided to participants via e-mail to review the study and give their informed decision to participate in the study. Each participant received their copy of the informed consent to keep for their record. Interview of participants using the IAPCC-R tool (MV) was done separately for each participant using a WhatsApp video conferencing that resumed after participants

understood the process, with a detailed explanation of what to expect throughout the process (See Appendix D).

Data Collection:

The NANNM office in Owerri was the study site, a building for nurses' conferences and seminars that ensured participants were not distracted throughout the interview process. I was not physically present at the site due to Covid 19 pandemic, hence the video conferencing. 10 participants who met eligibility criteria were needed after consent was obtained. Each participant individually responded to questions that I asked based on the research questions using the modified IAPCC-R (MV) tool to elucidate Nigerian nurses' lived experience in their care of women with FGM (See Appendix D).

During the intensive interview and saturation point I obtained individually, participants were independently asked to verbalize their feelings and ask questions as they deemed essential regarding the interview. Participant's body language and tone of speech were normal and showed determined readiness for the study during qualitative data collection. Participants for the study were separately notified about the process. Data collected were recorded and later coded for themes and patterns, then stored using field notes and NVivo software to interpret findings during data analysis. Participants were free to leave if uncomfortable with the questions or unable to continue. The interview, lasted for 45minutes to one hour for each participant, and reflected each construct of Campinha-Bacote's process of cultural competence in the delivery of healthcare services and adequately addressed the research questions.

Use of Modified Version of IAPCC-R Tool to Address Research Questions

The IAPCC-R tool (MV) helped identify nurses' biases and approach in the care of women with FGM as it addressed cultural awareness based on RQ1. Using the IAPCC-R tool (MV) for RQ2; it identified the nurse's cultural skills in caring for FGM women with diverse culture. In addressing RQ3, the IAPCC-R tool (MV) revealed nurses' cultural knowledge of the phenomenon studied, and their nursing care of women with FGM. The IAPCC-R tool (MV) elucidated nurses 'cultural encounter with their mode of communication when providing patient-centered culturally competent care regarding RQ4. Lastly when RQ5 was addressed, the IAPCC-R tool (MV) guided me to understand nurses' cultural desire, and inspiration towards improving women's health and ensuring culturally competent care for FGM cases.

According to Glanz et al. (2015), an effective intervention must be compatible with the individual's beliefs, values, and relevant norms for comprehending and respecting the individual. At the end of the interview session, data collected were transcribed and loaded into NVivo then stored for subsequent coding. Rudestam and Newton (2015) stressed that small incentives and minimized time frame for research reduce attrition and increase participation. After completion, some refreshments and $10 incentive was provided to each participant to show appreciation.

If planned strategies failed, the optimal decision was to terminate the study and inform the institution and stakeholders. There was no debriefing or follow-up because of no anticipated deception regarding this study. Participants independently could leave at any time during the study process.

Data Analysis Plan

Data analysis in a qualitative study is a labor-intensive activity because it does not follow a linear fashion; it is less formulaic and complex (Creswell, 2013; Polit & Beck, 2004). In this phenomenological qualitative research, the data involved describing the meaning of the world experience of nurses who care for FGM cases. Therefore, the focus was to search and identify essential themes or patterns from taped responses from each participant during the interview based on commonalities and variations. To ensure confidentiality was maintained, a unique identifier was used for each nurse/midwife as they addressed research questions.

Similarities and differences from participants based on their responses would reveal the nurses/midwives desire towards providing culturally competent nursing care for Nigerian FGM patients.

According to Skjott Linneberg and Korsgaard (2019), skillful use of the human hand in coding was useful with small data and allowed the researcher the flexibility to re-read the data for a quality analysis and findings. Also, identifying themes and patterns by hand for research based in Nigeria was critical due to frequent power outages that may happen. Discrepant data would further need some degree of attention and could be used to modify emerging findings. The nurse/midwife's proficiency in cultural competence in the care for FGM cases was unraveled in this qualitative study through coded themes and patterns. The proficiencies were documented, stored on field notes, laptops, and NVivo software, which is efficient in data storage and organizing research findings in a more scholarly manner that concisely summarized and brought more meaning to the text with a visual display (Creswell, 2013; Janesick, 2016; Patton, 2015).

Issues of Trustworthiness

In this study, establishing credibility involved utilizing reflexivity, which is simply the researcher's awareness and member checking. Reflexivity involved being conscious of my role in the study; behavior, body language, and choice of words, which may significantly impact participants. Ensuring fittingness of the data I collected by playing back information for participant's validation was an option for member checking to confirm the result findings for accuracy and resonance. It was also important I scrutinized data collected to ensure dependability and confirmability of data to maintain this study's trustworthiness and transferability into the cultural surroundings.

Ethical Procedures

FGM is a sensitive subject that is difficult to discuss. The study was guided by principles of respect, beneficence, and justice throughout the process. Ethical standards started when I communicated the purpose for research to all stakeholders in Owerri , after approval from Walden University's IRB. Such communication eased participants' recruitment and selection challenges to capture the universal essence of the phenomenon studied.

Participants' informed consent was necessary after articulating the research's aim and objective verbally and in writing. Rudestam and Newton (2015) encouraged small incentives for participants. For this study, a $10 incentive was given to each participant to minimize travel expenses to the study site and ensure participation. Participants individually expressed their understanding of the process, which includes data collection, confidentiality, management and storage, and participants' ability to stop the interview at any time. All data collected were screened and authenticated before securing it using

NVivo software with a secure password and placed in a secured locked file cabinet accessible to me . All unused data collected were deleted. Hand-coded files and electronically stored information will be scrubbed when no longer needed for the study.

Summary

This chapter includes the research design, target population, sample size, data collection process, and data analysis based on nurses and midwives' lived experiences involving caring for women with FGM in Owerri, Collected data were coded for patterns and stored safely. In this study, my role, the research process, ethical consideration, and trustworthiness issues were explained. Chapter 4 includes results of research findings.

Chapter 4: Results

I conducted this study to explore worldviews of Nigerian nurses and midwives regarding their current approaches to care for women with FGM in Owerri. I sought to understand how knowledge of Igbo, Yoruba, and Hausa culture by Nigerian nurses and midwives in Owerri impacts nursing care of women with FGM in a multicultural country with more than 250 ethnic groups. I used the process of cultural competence in the delivery of healthcare services by Campinha-Bacote which includes the following five constructs: cultural awareness, skill, knowledge, encounter, and desire. My goal was to help nursing decision makers, public health experts, and researchers provide culturally competent policy guidelines as an important health approach for FGM cases to ensure better public health outcomes. The following research questions guided this study:

RQ1: What are the practices of Nigerian nurses and midwives providing patient-centered and culturally competent care for women with FGM in Owerri?

RQ2: What culturally sensitive and patient-centered skills do Nigerian nurses and midwives use to address FGM cases in Owerri?

RQ3: What knowledge barriers do Nigerian nurses and midwives express regarding caring for FGM women in Owerri?

RQ4: What cultural dynamics influence patient-centered care of women with FGM in Owerri?

RQ5: What are the motivating factors for Nigerian nurses and midwives in terms of practicing cultural competence for FGM patients in Owerri?

In this chapter, I present responses from participants from the study site in Owerri, the setting, demographics, data collection, data analysis and management, coding of themes, and results. I also include evidence of trustworthiness and a summary.

Expert Panel Review

The two expert panelists included a member of my dissertation committee and a nurse educator who independently reviewed the IAPCC- R (MV) instrument for the study. The panelists discussed content of the interview questions, the design, and any information to ensure that the instrument measured correct outcomes about the phenomenon. Panelists, who were both female, evaluated the questionnaire and discussed actions, made recommendations based on the IAPCC-R (MV) instrument regarding clarity, correspondence, and acceptability.

The first panelist was a 47-year-old nurse educator who is an Igbo woman with 10 years of experience in the Obstetrics and Gynecology (OBGYN) department. This panelist reviewed the questions and provided a constructive feedback about the interview questions with assurance that the contents addressed the research questions.

The second panelist was a public health expert who expressed that the content of the questionnaire was clear and addressed the research questions. This panelist emphasized that prompting participants should not mean that they must be pressured into responding to question. This public health expert indicated that I should reschedule if no reasonable answers were given for questions.

Conducting this expert panel review reaffirmed my decision to continue using the IAPCC-R (MV) tool for the 10 participants who met inclusion criteria. All panelists had knowledge of FGM and used cultural sensitivity when providing feedback. The expert

panel review was significant because it provided the template for interviews with 10 selected participants without any difficulties.

Setting

This study was originally planned for me to be physically present during data collection. In keeping with Covid 19 protocol I could not travel to Owerri for this study. Therefore, I read out the interview questions through video conferencing to each participant as she arrived at the NANNM office in Owerri as scheduled. I conducted interviews virtually from my office not in person, for each participant in a private room at the NANNM headquarters, using the WhatsApp video conferencing application and recorded responses on laptop and field notes. I began 2 hours late for the first participant due to car problems and waiting to complete the nursing night shift handover to the next shift, which is not unusual in Owerri The total interview time for that day was more than anticipated, and only seven out of 10 participants completed their individual interviews because of the late start. I rescheduled the other three participants for the next day. Each participant arrived to the study site in person at separate times with their phones that has WhatsApp application, and I interviewed them individually using my WhatsApp.

Participants individually exhibited awareness of the phenomenon and showed appreciation that the study focused on nurses and midwives' perceptions of care regarding FGM. During interviews, each participant individually expressed their cultural competence in terms of care for women affected by FGM. N2 stated, "Generally, the women have a laissez-faire attitude towards FGM because of cultural acceptance of the practice of FGM. They do not care." Interviewing these participants individually helped me to understand cultural nursing approaches to care for women with FGM, because of

the strong quality of data I collected. This may help other researchers and public health experts who study FGM cases to ensure equitable, patient-centered, and culturally sensitive approaches to care for women with FGM in Owerri, Nigeria, and globally, with emphasis on social change and not market justice.

Demographic Information

I collected data from nurses and midwives who were 21 and older and active members of the NANNM in Imo State. Demographics included age, years of service, gender, categories of nursing, years of NANNM membership, ethnic group, department, Nigerian language spoken, religion, and knowledge of FGM (see Table 2). Demographic questions were:

1. What is your name and your gender?
2. What is your designation as a nurse/midwife?
3. How old are you and who is your next of kin?
4. How many years have you been a NNANM member?
5. What is the name of your department and how many years of service?
6. What is your ethnic group?
7. What Nigerian languages do you speak?
8. What is the name of your religion?
9. Have you cared for women with FGM in your workplace?

Table 2

Participant Demographic Characteristics

Characteristic	*n*	Percentage
Age		
21–39	3	30

40 and above	7	70
Designation		
Nurse/midwife	7	70
RN	2	20
RM	1	10
NANNM membership		
1–5years	3	30
5years and up	7	70
Department and years of service		
OBGYN	7	70
Clinic	1	10
Labor room	2	20
Labor ward	4	40
Women's ward	1	10
Psychiatric Unit		
Women's psychiatric ward	1	10
Emergency department	1	10
Major ethnic group		
Igbo	10	100
Yoruba	0	0
Hausa	6	60
Kalabari	1	10
Efik	2	20
Other	1	10
Religion		
Christianity	10	100
Muslim	0	0

I screened 20 nurses and midwives who responded to the flyer regarding the study. Participants were 21 years old and above and members of NANNM Imo State. This age bracket was essential because participants within this age range are active nurses. Seven out of the 10 nurses who separately responded to interview questions were double qualified registered nurses/midwives, which was the most noted nursing qualification because they are high in demand, are readily employed, and have the ability to work in both medical/surgical and OBGYN settings. There were four nurses with bachelors and two with master's degree in nursing among the participants. One nurse has

doctor of philosophy degree in emotional counseling, which revealed her interest to further her nursing education.

Every nurse participant for the study was Igbo, only six out of 10 spoke and understood Yoruba and Hausa fluently, which ensured the ability to communicate with patients from the major ethnic group. Two out of the six participants that spoke Yoruba and Hausa languages fluently moved to Owerri due to their husbands' departmental transfer. That also explained the cosmopolitan nature of Owerri, that attracted people of different culture and ethnicity.

All nurses who participated in the study were Christians. Information obtained during screening revealed each nurse worked with women either in OBGYN department, medical and surgical department, and psychiatric hospitals and have knowledge of female circumcision. The nurses individually revealed that types of circumcision are not an intricate part of nursing assessment. No probing questions to determine categories of FGM are an essential procedure during a nursing assessment on a woman but could be determined by doctors during vaginal examination. All 10 participants separately interviewed revealed they can identify complications from FGM immediately after circumcision, like bleeding and shock of the victim during labor and difficult delivery process. This is explained by N1 who indicated that "difficulty in labor, bleeding complications and scar formation that leads to vesicovaginal fistula (VVF)" negatively impacts delivery process. It becomes a huge public health concern in a country like Nigeria with high maternal morbidity and mortality rate.

Data Collection

I collected data after obtaining approval from Walden University's IRB# 01-19-22-0361382 and cooperation of NANNM Imo State and after sending a detailed letter explaining the purpose of study. Recruitment of study participants commenced through purposive sampling of interested participants who responded to the recruitment flyer (see Appendix B) and contacted me. I conducted the initial phone interview based on a demographic questionnaire to identify nurses' eligibility for the study.

I invited each of the 10 participants separately who met criteria set for the study by phone to appear at the Imo State NANNM headquarters Owerri conference room according to individual nurse's scheduled time starting from 8 a.m. on the day of the study. Upon the arrival of each nurse for the phone interview using WhatsApp, the participant became familiar with the topic of study, I assured of her privacy, confidentiality, anonymity, beneficence, and non-maleficence regarding the study (Beauchamp & Childress, 2001). I reemphasized they had the right not to participate and was free to withdraw at any time during the research process. After the explanation of the research procedure, I obtained consent from the participant that signaled permission to conduct the individual video conferencing interview.

Each participant received a stipend of N5, 000 ($10) as a compensation for participating. I conducted the interview via WhatsApp video conferencing, the participant's preferred application at NANNM headquarters Owerri where the nurse received information on the research procedure, which included confidentiality and ability to leave at any time. I documented the participant's responses to interview questions. I completed data collection with seven participants who arrived individually at

NANNM office at different scheduled times on the first day of the interview because the interview started after a 2-hour delay and lasted until 5 p.m. The remaining three participants were rescheduled to arrive at separate times for the next day, making the scheduled interview longer by a day. Findings from each participant were recorded individually on tape recorder. I took field notes with each participant's code labeled on the answer sheet as N1, N2, N3, N4, N5, N6, N7, N8, N9, and N10. After ensuring that responses are catalogued accurately with participant's specific code, I stored them in a locked cabinet. There were not any problems encountered throughout each participant's interview.

The study participants individually were calm, serious, and spoke with low pitched voice, when responding to questions on knowledge of FGM and cultural skills during data collection. Two participants individually agreed that it was their first time participating in a research study. I reminded the respondent could stop participating if unable to continue. All participants who were individually interviewed showed positive body language, were attentive with good eye contact, and maintained good body posture throughout the duration of the interview.

Data Analysis

I analyzed data from the study manually and using NVivo software to transcribe and complete thematic analysis based on range of responses captured during the interview on the lived experiences of Nigerian nurses in Owerri who care for women with FGM. I categorized the themes and patterns from responses based on similarities and differences as they address the research questions.

Using the modified IAPCC-R instrument to reveal the practices of the nurses who care for FGM women, sub questions 1.1, 1.2, and 1.3 of RQ1, addressed cultural awareness**.** Interview responses that addressed cultural skill were 2.1, 2.2, 2.3, and 2.4. of RQ2

The nurses' knowledge on FGM was exposed from their responses of sub questions 3.1, 3.2, 3.3 and 3.4, of RQ3 which were based on cultural knowledge.

Participants responded to questions 4.1, 4.2, and 4.3 of RQ4, based on identifying the participant's cultural encounter with FGM cases.

Responses from sub questions 5.1, 5.2, and 5.3 of RQ5, unraveled the *c*ultural desire of the nurses to culturally care for women with FGM (See Appendix D)

Categories and Themes

Table 3 contains a summary of the results obtained following a thematic qualitative analysis I conducted in NVivo. As shown in the table, there are five levels of categories. The highest level of categories contained broad subjects containing themes, which answer specific research questions. For instance, the category, cultural competence skills, contains themes that directly answer the second research question, by revealing individual nurse's strategy in collecting pertinent health information from the patient using the construct of cultural skill of the framework. The second highest level of categories consists of specific themes that answer research questions directly. For instance, within the cultural competence skills category, there are three themes that answer the second research question. The lowest category level consists of axial codes I combined to form themes for answering the research questions. In order to clarify meaning of the themes and identify patterns in the data, I counted the number of times the frequency occurred with each theme (Table 3). In the long run, the findings illustrated

that the nurses could articulate history taking, assessment and documentation as the standard practice for assessment, demonstrated cultural awareness and competence in the care of ethnically diverse Nigerian women with FGM, identify the barriers to providing services to FGM cases, expressed their understanding in the uniqueness of different culture, and their desire to care for women with FGM as they addressed each research question.

Table 3

Summary of Results

Theme/category	N	Frequency
Practices		
History taking	7	8
Documentation	4	4
Physical examination	3	3
Culturally competent skills		
The nurse understands different cultures	6	6
Types of FGM sometimes differ with ethnicity	1	1
Consider cultural values when offering care	3	5
Convince patients to accept the right values	2	2
Not impose values on patients	4	4
Nurses communicate using local dialect or use interpreter	6	8
Verbal & non-verbal means for communication	4	4
Barriers experienced with FGM cases		
Withdrawn and depressed	3	5

Women sometimes shy and ashamed	2	5
Belief that FGM discourages promiscuity	3	5
Do not care about FGM risks	4	4
Lack awareness on FGM risks and complications	4	4
Cultural dynamics that influence care		
Igbo less tolerant to pain than Hausa & Yoruba	3	4
Pain tolerance different based on tribe	2	2
Motivating factors		
Motivation - has experienced it and found it unpalatable	1	1
Nurses have empathy towards the women	3	4
Passion to care for them and see them happy	3	3
FGM violates women's rights	1	1
Need to stop FGM	4	5

Evidence of Trustworthiness

To ensure credibility of the process, I conducted the study to enhance the believability of the findings by ensuring the trust between each respondent and me the researcher. I encouraged each participant to verbalize her feelings regarding the interview questions to ensure greater understanding of the interview process while revealing her experiences. To ensure fittingness of the data collected through member checking, every participant had the option to view transcripts of responses for validation (see Creswell, 2009). None of the participants accepted the option. I assessed confirmability by ensuring

that all notes, interview transcripts, results, and its interpretation, experts' comments, and my open mindedness to the process to rule out any biases and ensure neutrality were effectively checked.

Results

RQ1

Theme 1: Patient Assessment is a Standard Practice

Subtheme 1a. One of the key objectives of this study was to explore the practices of nurses in Owerri providing patient centered care to women who have been victims of FGM. In line with this objective, patient assessment emerged as an important practice that nurses use to gain a better understanding of FGM patients. Each participant separately described various tools and methods nurses use to assess their FGM patients, which included history taking, physical examination, and documentation. All participants individually contributed to this theme.

N2 and N4 separately mentioned history taking, physical examination, and documentation as the tools and methods used to assess the patients, when interviewed. N2 stated, "We use our history taking tools and also do visualization physical examination. Information is documented on the woman's chart." Participant N4 also had similar contentions. According to this participant, history taking and physical examination is normally done on the patient, and information found from these assessments is documented on the patient's chart. N4 asserted, "Patient's history is taken during physical assessment and documented on patients' chart."

N3, N5, and N7 individually identified history taking and physical examination as the methods and tools of assessing patients who had FGM during one-on-one interview.

For instance, N3 stated, “We take the history taking and do a face-to-face clinical examination.” N5 stated, “History taken is done with physical and vaginal examination for women with FGM.” In a more profound submission, N7 indicated they use history taking and physical assessment tools alongside mentioning their importance in patient assessment. From N7’s experience, history taking, and physical examination tools assist nurses with figuring out complications a woman may be having due to the FGM she underwent. N7 affirmed, “The observation, physical assessment tools help the nurse to see complications like Keloid, cysts during assessment. The picture chart is used to show women what complications they will pass through if they have FGM.”

N6 and N9 individually identified only history taking and documentation as methods and tools used during a patient’s assessment. According to N6, history taking is first conducted to determine the type of FGM a woman underwent, and subsequently, the possible complications arising from that FGM type. Information gathered throughout the history taking session is documented. N6 stated, “In a quiet examination room, data is collected on the woman’s history. A flow chart showing different types of complications of FGM is used during the assessment; all information is documented on a writing material used for assessment.”

N8 disclosed, “As a nurse, history taking is done in the language the woman understands and information collected is documented.” N9 also identified history taking and documentation but offered new insights regarding the need for including a patient’s age before circumcision in the historical information collected and documented. N9 stated, “History taking is done not excluding age before circumcision and first sexual encounter and documented on patient’s chart.”

While responses from the nurses individually interviewed were respectively similar, only N1 specified that they use a set of 14 guidelines on Gordon's work instrument to perform a patient assessment. According to N1, Gordon's work instrument was not only useful for history taking and physical assessment in general but was also important for assessing the functional and dysfunction status of the patient. N1 stated, "We use Gordon's work instrument using the 14 guidelines to show functional and dysfunctional status of the woman including nutritional assessment tool, history taking and physical assessment instrument, all incorporated in the nursing process."

RQ2

Theme 2: Nurses' Use of Culturally Competent Skills During Nursing Care

Subtheme 2a: Respect for Patients' Values and Beliefs When Offering these Skills. As one of the aims of this study, I intended to determine culturally sensitive and patient centered skills that Nigerian nurses/midwives in Owerri use to address FGM cases. One of the skills obtained from the qualitative thematic analysis was ability of the nurses to respect patients' values and beliefs while offering care. Ordinarily, each participant stressed the need for nurses not to force their beliefs and perspectives of FGM on their patients. N1 gave a couple of examples why forcing beliefs and values on people was not appropriate especially for her profession.

N1 stated:

> I cannot impose my belief on the patient. Hausas do not eat snail you cannot impose snail on them, also Jehovah's Witness have problem with receiving blood transfusion, so the Hausa can seek alternative to snail and Jehovah's Witness seek alternative to blood.

N2 also indicated that rather than imposing values and beliefs on patients, she prefers providing care based on the patients' own values and beliefs. N2 stated, "Good communication helps the nurse during history taking, which helps provide health education based on the patients' values and beliefs when rendering nursing care for FGM complications."

Each participant also held similar contentions as N1 and N2. However, unlike N2, N4 convinced her patients to accept values and beliefs that are beneficial in modern healthcare sense. N4 narrated, "I will teach them the right thing to do; Jehovah's Witness people do not receive blood transfusion, I can only educate them on the need to have blood transfusion but will never pressure them because of my belief." N5 also used the example of how she would convince a woman to accept a caesarian section delivery rather than force them against their will.

N5 stated:

> Culturally, some women do not want cesarean section even with poor dilatation of the cervix which occurs in type 3 FGM. As a nurse I will let the woman know why cesarean section is necessary then advise them to do away with FGM.

N6 stated:

> I think of their cultural values when providing care for women with FGM and that will help me know how to change their thinking towards the practice of FGM. I accept the culture of the women but tell them not to obey harmful practice in their culture. I give health education to diverse women not considering their culture. I use my own initiative to provide culturally sensitive care because I did not get specific cultural training.

Separately, N7 and N9 also pointed out the need to respect patients' culture, values, and beliefs. However, each participant insisted that educating patients and convincing them to accept the right beliefs and values is necessary. N7 stated, "Having seen the pain and humiliation women have passed through, patients' belief should override mine, but I will give the patient the right nursing care." N9 expressed, "I will try to convince the patient about my values that will benefit the patient. My values should be first then hers for her benefit. There should be an agreement."

Subtheme 2b. Awareness of Cultural Diversity of Patients. Another cultural competence skill for rendering effective nursing care to victims of FGM is awareness of the cultural diversity of patients. Awareness of cultural diversity was manifested in several submissions. First, N4, N6, and N10 when interviewed separately described the importance of cultural competence, from a generic perspective, in their role as nurses. N10 asserted, "The nurse will have knowledge of the cultural ways of women with FGM and listen attentively to understand why the Igbo women are vocal while the Yoruba are not vocal about issues affecting them." N3 stated, "Passion to understand different cultural perspectives on FGM helps in providing adequate nursing care for complications of FGM."

N4 spoke about her cultural competence and awareness, which she acquired through seminars, social media, and health education. She also added that cultural awareness has helped her provide appropriate care to women with diverse FGM cases. N4 declared, "I am culturally informed through seminars, health education, and information from religious leaders, social media and WhatsApp, and it really help me to

be able to care for diverse women with FGM." N7 also indicated she received cultural awareness training, which she applies in her nursing practice. N7 affirmed:

> As a nurse I am culturally sensitive. I was taught not to condemn other people's culture but to teach them to be better. This is the training I received in nursing school, so I apply it in my nursing care.

Participants independently did not specify how cultural awareness helped them to render care services to women with FGM, N6 offered important insights on the same. In particular, N6 uttered that being aware of a woman's culture would assist the nurse to understand any cultural practices that may directly affect the health of the woman. For instance, N6 indicated that some women use home remedies in accordance with their culture, which may lead to adverse health outcomes. N6 stated, "A nurse caring for women with complications of FGM will be aware of the woman's culture because some use home remedies to care for the wound which may lead to infection." N6 also highlighted some cultural rules that may affect care provision. For instance, N6 indicated that some cultures in Enugu require FGM to be done on 8-day old infants, even though she did not specify how FGM done at such an early age affects provision of adequate nursing care to the FGM women and their babies.

N6 said:

> Rules and regulations that guide the women with FGM in their various community influence nursing care. For example, in Enugu State, FGM is done during naming ceremony for 8-day old child, so it is a cultural norm, and it impacts rendering nursing care.

Sub-theme 2c. Nurses are not only competent in Local Languages but Also use nonverbal means to communicate with Patients. Another critical cultural competence skill that nurses should possess when caring for FGM patients is the ability to communicate effectively. Based on the findings obtained in this study, nurses can achieve clarity in communication with their patients in two ways. The first approach is the use of local languages that the FGM victims, especially the uneducated ones, can understand.

N1 identified use of a patient's native language as an important communication skill during history taking. N1 stated, "Through good communication, history taking is done with patience and understanding using the women's native language or an interpreter." N10 also identified the use of local languages as an important strategy for ensuring important care information is delivered and grasped by patients as intended. N10 stated, "I can speak some Hausa and Yoruba so I can communicate freely with an Igbo, Yoruba or Hausa woman."

From N7's perspective, speaking to the patients in their native languages and identifying them with their titles is one way she uses to establish rapport with the patients. N7 disclosed, "During assessment I make sure I have good rapport with the woman by greeting her in her native language and calling her with her titled name it will allow her to open up and feel free to talk." As an Igbo woman, N8 also uses the Igbo language to communicate with Igbo women who are victims of FGM. N8 stated, "I do not have the misconception that FGM is good for the morals of the girl child, so I use Igbo language to educate the Igbo women."

However, N10 maintained that in situations where local languages were not applicable, she would use broken English that is common in Nigeria. N10 stated, “But if any other ethnic group, I will speak broken English which is very common everywhere.” N5 also indicated that she communicates with the patients using their local languages or broken English, which, as she stated, is very common in Nigeria.

N5 affirmed, “I communicate verbally, greet them in their language or speak broken English which is very common in Nigeria and reassure them while providing care to women with FGM.” Being an Igbo woman, N8 acknowledged she can only communicate in local language with Igbo women because she is herself Igbo. However, when faced with a situation in which she has to care for a Hausa or Yoruba patient, she normally uses broken English. N8 stated, “I speak broken English to educate Yoruba or Hausa women about the disadvantages of FGM.”

N1 identified the use of visual charts as part of the nonverbal means of communication she uses when explaining important or technical information to the client. N1 stated, “I use good communication skill in other to gain their trust. I can use visual charts to explain.” Apart from the visual charts, N5 recommended nurses to watch the patient’s facial expression rather than make assumptions. N5 stated, “It is important for the nurse to watch facial expression of the woman with FGM and not make assumptions.”

Being an Igbo woman, N7 stated that verbal exchange with the patients alone is just not enough. Instead, she carefully observes the nonverbal attitude of the patient to reveal her emotional state. N7 voiced, “As an Igbo woman, I know about the practice of FGM, but it has reduced but when I render nursing services to women with FGM, I see

nonverbal attitude that reveal emotional state of the woman." Lastly, N9 also indicated she uses facial expressions to communicate with her patients: "I communicate to women with FGM using verbal, facial communication (squeezing their faces reveal they are in pain), then I can provide what the woman needs to calm her down."

RQ3

Theme 3: Barriers Experienced with Care of FGM Cases

Subtheme 3a: Ignorance and Lack of Awareness on FGM and its Adverse Health Effects. According to each participant's accounts, many women from the Igbo, Hausa, and Yoruba ethnic communities in Imo State are either ignorant of the adverse health effects of FGM or lack proper knowledge and awareness on the same. Eight out of 10 participants contributed to this theme. N2 and N9 individually pointed out the ignorance and 'don't care' attitude among women who have been victims of FGM. Based on N2's experience, a majority of the women she has handled have a laissez-faire attitude toward FGM simply because their culture endorses it. N2 stated, "Generally, the women have 'laissez-faire' attitude towards FGM because of cultural acceptance of the practice of FGM. They do not care." N9 also described the care-free attitude of women who have been victims of FGM. According to N9, the care-free attitude makes them less receptive to advice against FGM. N9 stated, "Carefree attitude. They think it is a normal practice and some of them find it difficult to take advice on the complications of FGM."

N6 indicated the women attended to have been ignorant. In her experience dealing with FGM victims, this was similar to N8 experience. N8 stated the women she has provided care for are not bothered with FGM at all. N8 affirmed, "The women are not bothered; they accept the practice of FGM though it is not a palatable experience for

them, but as a nurse I sensitize them to the complications of FGM." However, N6 reported the women she has attended to have generally shown ambivalent attitude where some are for while others against FGM. N6 stated, "The women show bivalent attitude because some stick to their cultural norms while others would like to change from the practice."

Still on ignorance as a barrier to culturally sensitive care, each participant separately indicated that some women held on their cultural beliefs that FGM prevents promiscuity in marriage. N9 lamented that women who have been victims of FGM claim that the practice is intended to prevent promiscuity. N9 stated, "They all say that FGM prevents promiscuity." Similar contentions were noted in N4's remarks, who insisted on advocating ending the practice.

N4 disclosed:

> It is the cutting of female external genitals not done under anesthesia; it is performed due to peer pressure to curb promiscuity in the female child. Culturally, FGM is acceptable but as a healthcare professional I am advocating to end the practice.

Apart from ignorance, each participant indicated that most female victims of FGM lack awareness on the negative health effects of FGM. N5 and N9 independently contributed to this theme, highlighting lack of awareness as the main barrier to provision of culturally competent care to female victims of FGM. N5 lamented on the general lack of awareness among women who have been victims of FGM. Due to lack of awareness of the dangers FGM poses on women, no one in the community discourages the practice. N5 stated, "I see lack of awareness of complications of FGM among women of diverse

culture; hence no one discourages the practice." N9 also directly identified lack of awareness as the main barrier towards provision of culturally competent care for FGM victims and eventually bringing an end to the practice.

N8 identified more specific awareness issues that inhibit successful provision of culturally competent care: "Language barrier, lack of knowledge, and the educational level of the woman impact the care I provide as a nurse, but I try to sensitize them on the disadvantages of FGM." Lastly, N7 also claimed that the women do not know that FGM is responsible for some of the complications they encounter. N7 stated, "The women do not complain about the complications they have from FGM based on their ethnic group. For example, the women do not know the reason for the scar on their vulva or they are ashamed to speak up."

Subtheme 3b. Victims of FGM Exhibit Withdrawal and Fear of Expressing Themselves. Barriers that inhibit nurses' capacity to provide effective care to female victims of FGM in the Owerri region are withdrawal and fear of self-expression among the women. Each participant indicated that inability of the patients to share critical information limits provision of appropriate care. Six of the participants independently contributed to this theme. N10 indicated that some women were shy and unable to answer critical questions during assessment. In some cases, women would refer the care provider to their husbands to answer critical questions especially those touching on gynecological issues. N10 stated, "The women lack the ability to answer questions, they are shy, and some younger uneducated wives would tell you to ask their husbands about gynecological issues, it is so difficult to care for such women." N10 clarified that such withdrawal was not common among Igbo women. N10 elaborated, "The Igbo women are

more liberal with their expression while other ethnic groups are not open when responding to questions, and they appear withdrawn."

According to N3, the women were always withdrawn and depressed. Withdrawal made them antisocial thus making it difficult for care providers to acquire certain critical information from them, especially during assessment, N3 stated, "The women are withdrawn; they look depressed because they do not like to associate with others. It really becomes difficult to get some diagnostic information from them." Similarly, N5 stated, "They do not like to associate with others, because they are withdrawn."

From N4's perspective, the women have probably developed psychological trauma due to the harrowing FGM experiences they encountered. N4 emphasized, "The women have psychological trauma due to instruments used for FGM, and they are withdrawn as a result." While answering another different question, N4 reiterated, "They are withdrawn and need psychological care because of the traumatic experience they had with FGM."

Apart from the psychological torture and trauma they experienced as a result of FGM, N7 during her interview, attempted to explain to the interviewer another reason for the withdrawal and anti-social nature. N7 affirmed, "The women do not know the reason for the scar on their vulva or they are ashamed to speak up." Additionally, N7 described the women as lacking expression towards FGM by stating, "As a cultural practice, the women show lack of expression towards FGM, sometimes their tone of voice is trembling when they respond to questions."

RQ4

Theme 4: Cultural Dynamics that Influence Care of FGM

Subtheme 4a: Response to Pain Differs Among FGM Patients Based on Their Tribal Affiliation. The results of the qualitative thematic analysis revealed yet another important theme regarding FGM patients' response to pain. From individual participant's experiences, Igbo women have a greater response to pain than Hausa and Yoruba women. Response to pain affects the quality and mode of care that is given to the patients. If a nurse does not understand the different pain thresholds for different ethnic groups, she may, for instance, mistake Yoruba women of having lesser pain during child delivery when in a real sense; they are experiencing just the same level of pain as their Igbo counterparts. As such, response to pain came out as a dominant theme related to cultural dynamics that affect culturally sensitive care.

Several participants separately contributed to this theme. According to N3, pain threshold assists nurses with determining a woman's tribal affiliation to provide appropriate culturally responsive care. N3 stated, "The Yoruba and Hausa women have low pain threshold for pain while the Igbo woman has high pain threshold. They differ in the way they tie their wrapper, and it helps the nurse to identify their ethnic group." When N4 was interviewed separately, she also reiterated the same thing, indicating that Yoruba and Hausa women are more likely to bear greater pain than Igbo women. N4 described, "Also, during delivery the Igbo women will express when she has pain, but the Yoruba and Hausa women bear their pain."

While response to pain may be regarded as beneficial in helping the nurse to provide appropriate culturally responsive care, N4 had a conflicting perspective on the

same. N4 stated, "The Igbo ethnic group will cry when in pain while the Yoruba and Hausa women do not express their pain, so it is not easy to understand when Yoruba and Hausa woman needs pain medication. Also, the type of food differs among ethnic group." N5 stated:

> The Igbo woman will not hesitate to cry, yell, if experiencing pain, then as a nurse, analgesics are given to the woman to reduce the pain and comfort them, but the reverse is the case with Yoruba and Hausa women, hence there is difficulty in knowing when they are in pain.

N7 clarified, "The difference is that Ijebu Ode woman do not cry during labor and delivery, if they do, they must pay a fine to appease the God because bringing a child into the world is something sacred." Lastly, N8 also acknowledged that tribal affiliation determines whether a woman will express their pain. N8 disclosed, "They show lack of motivation, lack of smile, and based on their ethnic group, some will express they are in pain, therefore as a nurse I show sympathy and empathy."

RQ5

Theme 5: Motivating Factors to Care of FGM Patients

Subtheme 5a: Empathy and Sympathy as Motivation for Nurses Regarding Practicing Cultural Competence on FGM Patients. Every participant individually identified empathy as a key factor that motivates them to practice cultural competence when caring for women who have been victims of FGM. Based on participants' responses, their empathy and sympathy arise from the fact that FGM results in long-term complications that adversely affect the quality of life of the women. It is imperative that nurses understand and have sympathy toward these women when caring for them. N1

stated, “Culturally, the women with complications of FGM express fear later in life due to dyspareunia, difficulty in labor, bleeding complications and scar formation that leads to vesicovaginal fistula (VVF). The nurse should be sympathetic and empathic to these women.” Apart from the physical complications the women face, N7 also identified emotional and psychological torture faced by the FGM victims as complications that motivate her to sympathize and care for them. N7 stated, “I am culturally sensitive; the humiliation these women received from FGM practice, the depression, psychological and emotional torture of these women motivates me to care for them.”

N1, N9, and N10 during their separate interviews empathized with the women because they felt FGM is a violation of women’s rights. N1 stated that her motivation to care for the women came from her empathy towards these victims of FGM. N1 replied, “My motivation is empathy. These women are victims of abuse and violation of their rights. They need compassion; therefore, I will be passionate in providing nursing care to them.” N10 responded, “My cultural belief is based on respect for women with FGM. FGM is actually disrespect towards women, so I empathize with them and show them love, and handle them with care.” In another submission, N9 contended that her passion towards caring for women who have been victims of FGM is her desire to end the practice since it infringes on the rights of women.

N10 stated:

> First: I am a woman and have gone through that pain. Secondly, I want the practice to stop, it is not palatable. When the woman starts producing children, she should know it is infringing in the right of the girl child.

Each participant also indicated their motivation comes from the desire to see women recover from their FGM complications. N10 responded, "I want to see these women happy and recover from their problem. It will make me to be happy as a nurse." Participant N3 during her separate interview also held similar contentions. N3 acknowledged, "I have the passion to care for women from diverse culture because I can help them avoid FGM complications and that is my calling." N6 stated that she could not stand seeing FGM victims undergoing pain from complications. This motivated her to care for them regardless of their tribe.

N6 said:

> What inspires me is to save lives; I cannot see a woman with FGM bleeding without rendering adequate care. It is important to render care without racism or tribalism especially in a society of diverse culture. There is nothing like tribalism in nursing care practice.

Summary

I analyzed data via interviews to respond to the five research questions I developed. Analysis of collected data as discussed in this chapter resulted in five themes that were used to answer the research questions. The five main themes derived from the data from this study were: (a) patients' assessment is a standard practice, (b) nurses use of culturally competent skills during care, (c) barriers experienced during care of FGM cases, (d) cultural dynamics that influence care of FGM, and (e) motivating factors involving care of FGM patients. Several subthemes emerged during analysis and were subsequently discussed (see Table 3). Participants individually said recording patients' history and reviewing patient documents and physical examination were key practices

that were used to assess patients. The second theme was nurses' use of culturally competent skills during care that informed whether they were conversant with diverse cultures and types of FGM performed on women in Nigeria. This involved participants' respect for their patients' beliefs and values in addition to understanding and speaking different ethnic dialects in Nigeria.

The third theme was barriers that were experienced with FGM cases. I sought to report negative impacts of FGM on Nigerian women that affect provision of care. In particular, I established that many women who had FGM suffered from withdrawal, fear, depression, and shame. Participants reported that FGM happened in many communities within Nigeria due to lack of information regarding risks and complications associated with FGM and their belief that FGM discouraged promiscuity. The fourth theme was cultural dynamics that influenced care of FGM. Levels of pain tolerance differed between tribes with Igbo being less tolerant of pain compared to Yoruba and Hausa. The last theme was motivating factors for nurses caring for FGM women. Many participants were motivated because some were victims of FGM and had empathy and passion to help women. The desire to stop FGM and educate women on the dangers of FGM motivated nurses to continue providing nursing care.

This chapter included explanations of gaps involving providing culturally sensitive care, which helped with interpreting findings of the study that are discussed in Chapter 5, which includes recommendations for practical and future implications of the study, implications for social change, and information about further studies on nursing care of women with FGM using culturally sensitive approaches.

Chapter 5: Discussion and Conclusion

The purpose of this study was to explore the worldview of Nigerian nurses and midwives regarding their current approaches to care for women with FGM in Owerri. The public health workforce of Nigeria is made up of nurses who determine appropriate healthcare services to the population in terms of societal, religious, and cultural beliefs as well as perceived value for public health. I sought to understand how knowledge of culture impacted nursing care of women with FGM in Nigeria. I used the qualitative methodology with phone video conferencing using WhatsApp as the main source of obtaining data. Collected data were analyzed manually using NVivo. Five research questions were designed to guide this research. In this chapter, I provide a summary of findings and then interpret results with reference to existing literature. Further, a discussion of limitations, implications, and recommendations both for practice and future research are provided. This is followed by a conclusion.

Interpretations of Findings

The purpose of this qualitative research was to explore worldviews of nurses and midwives regarding their current strategies and barriers they face to provide appropriate care for women with FGM in Owerri and ensure implementation of public health policies to improve knowledge and social change regarding FGM practice. All four types of FGM are prevalent in Nigeria, with types 1 and 2 which is more prevalent types of FGM reported as common in the southwest and southeast Nigeria including Imo state (Okunade et al., 2016). The southwest Nigeria is the geopolitical area for Yoruba ethnic group while southeast Nigeria is the geopolitical area for Igbo ethnic group which includes Owerri. Therefore, it is imperative to know how nurses care for complications from the

most prevalent types of FGM in Owerri. To understand worldviews of nurses and midwives who care for women with FGM in Owerri the following research questions were designed to guide the research process:

RQ1: What are the practices of Nigerian nurses and midwives providing patient-centered and culturally competent care for women with FGM in Owerri?

RQ2: What culturally sensitive and patient-centered skills do Nigerian nurses and midwives use to address FGM cases in Owerri?

RQ3: What knowledge barriers do Nigerian nurses and midwives express regarding caring for FGM women in Owerri?

RQ4: What cultural dynamics influence patient-centered care of women with FGM in Owerri?

RQ5: What are the motivating factors for Nigerian nurses and midwives in terms of practicing cultural competence for FGM patients in Owerri?

RQ1

I sought to understand methods that each nurse in this study used to reveal cultural awareness of FGM in order to better understand their patients' physical and psychosocial wellbeing for better public health outcomes. To be culturally aware in caring for FGM patients begins with obtaining general information about their health, medication, and previous illnesses. Assessing patients allow nurses and other medical practitioners to develop a rapport with their patients and know where to start with care (Butt, 2021; Gardona & Barbosa, 2018). Unlike other types of illnesses, caring for women who have undergone FGM is complicated; It requires patient-centered care,

hence it is essential for nurses to better understand FGM patients and also get patients to establish trust-based association that encourage transparency, respect and evidence based care (Dawson et al., 2022). To gain patients trust starts with assessing patients which helps nurses individually to know their patients and become aware of their culture, which also allows patients to be comfortable before treatment (Kieft et al., 2014; Molina-Mula & Gallo-Estrada, 2020). The nurse who has rapport with her FGM patient shows understanding of the patient's culture and Anzaku et al. (2018) posited that cultural competence is an integral part of providing nursing care for better health outcomes.

Analyzed responses revealed that physical examination, documentation, and history taking were the methods used to assess FGM patients. Conducting a physical examination and examining the health history of female patients helped participants identify complications associated with FGM. During history taking, nurses and midwives gather information about when patients underwent FGM and also complications suffered after this procedure. Physical examinations are conducted to verify the existence of complications or diseases such as cysts and Keloid due to FGM and any tribal marks in order to identify patients' ethnic groups. Nichol et al. (2021) reported taking patients' medical and health history helps healthcare providers create medical profiles for patients. Moreover, documenting patients' medical history in terms of illnesses and complications due to FGM gives healthcare providers a head start in designing and implementing patient-centered care with *cultural awareness* in mind.

Like history taking, physical examination was also found to be an important assessment practice. Concurring with previous scholars such as Nichol et al. (2021), I established that physical examination allows nurses to obtain first-hand data in the effects

of FGM on women. Even though history taking and physical documentation were found to be important in designing patient centered care, Young et al. (2020) argued that some patients were unwilling to disclose personal information on FGM let alone allowing the nurse/midwife to conduct physical examination on them. This difficulty according to Young et al. (2020) interfered with the provision of culturally sensitive and patient centered care for FGM patients. Comparably, the findings by Young et al. (2020) confirms with my study result and elucidates the barriers nurses experienced during care of women with FGM as revealed from participants responses that addressed RQ3.

Overall, both in the current study and previous research, documentation or documenting patient data including the types of complication such as Keloid, VVF allow the nurse/midwife to care for patients who are shy about sharing their health history following FGM which reveals patient's educational status and understanding. This finding is important to the literature in the sense that it highlights the benefits of thorough patient assessment, physical examination, documentation a concept already known in healthcare services, but requires a more in-depth approach based on findings from this study to allow nurses design culturally sensitive patient centered care needed by FGM patients in Owerri, other developing countries, and developed countries worldwide.

RQ2

With this research question, I sought to explore the skills that nurses/midwives were equipped with that allowed them to offer culturally sensitive and patient centered care to FGM patients while addressing the cultural skill construct of the framework for this study. As in theme 2, an analysis of the data collected revealed in sub theme 2a that the participants individually showed elevated levels of respect for values and beliefs of

patients when offering care. Nurses were also aware of the cultural diversity of their patients as in sub theme 2b and were also competent in language and nonverbal communication to easily converse with their patients as in sub theme 2c. Critical to offering culturally sensitive and patient centered care, each participant reported the benefits of knowing and understanding the beliefs and cultural values of their patients. With regards to the current study, existing literature affirm that Owerri is highly diverse, meaning that the patients served have different beliefs and cultural values that must be respected (Okunade et al., 2016; Oyekale, 2014).

Responding to this research question, I established varied responses with the key being nurses/midwives individually respected the beliefs and values of their patients. It was also noted that besides respect, the nurses felt obliged to educate their patients against harmful cultural practices and beliefs that could be detrimental to their health including practices of FGM. However, the decision was solely left to the patients to choose which beliefs and cultural values to continue upholding. This finding corroborates the results of Oyekale (2014) regarding the impacts of cultural values and beliefs on health care practices. For instance, Oyekale established that the ethnic diversity in Nigeria meant that every ethnic group approached care differently. Uniquely, that was the focus for this study to comprehend the provision of nursing care for FGM women from diverse ethnic groups in Nigeria. Data from this current study also conforms with existing literature by Ibekwe et al. (2012) who reported that understanding the tribal perspectives on FGM helped nurses and doctors to design authentic care strategies to FGM patients. Therefore, Nigerian government's policies should emphasize in strategies for health promotion, implementation, regulations, and monitoring for a better public health end

result as posited by Uchendu et al. (2020) and in keeping with the findings from this study.

Like cultural beliefs and values, appreciating diversity of their patients was critical in providing culturally sensitive and patient centered care to FGM patients. It was reported that cultural orientation influenced how FGM patients responded to care. Therefore, being competently aware of the different culture in Owerri allowed providers to design care based on the culture of their patients which is in support of reports by Ibekwe et al. (2012). Data from this study ensured that the treatment modalities being offered do not interfere with the patient's culture but rather uses the culture to offer patient centered care which is in keeping with Zurynski et al. (2015). Competencies in cultural diversity were influenced by the participants' knowledge levels of language and ethnic dialects used in Owerri. According to individual nurse/midwife, speaking similar language of their patients or understanding their patient's language aided the nurse in history taking, documentation, and physical examination.

Croasdell (2012) reported that conversing in a language similar to that of patients, nurses built confidence and trust in their patients allowing them to collect detailed information regarding complications and illness following FGM. Further analysis revealed that being competent in ethnic dialects helped the nurses to learn more about their patients' culture and ask sensitive information that would guide the provision of care (Evans et al., 2017). In accordance with Croasdell (2012) and Evans et al. (2017) data from my study support the findings on how language competency helps the nurse to interact with uneducated patients and offer them quality care including how language barriers negatively influenced offering of patient centered and culturally sensitive care to

FGM patients. Therefore, encouraging nurses/midwives to be bilingual or multilingual as six out of 10 nurses interviewed spoke Hausa and Yoruba languages is an important take away for this finding. Language diversity that is revealed from responses that addressed RQ2, showed that nurse competency in local languages, will not only help in understanding the cultures of their patients but also to obtain critical information about patient's health and educate patients the dangers of FGM in a language they can understand. Such language use may increase health literacy leading to quality healthcare services among women in communities affected by FGM practice locally and worldwide for better public health management.

RQ3

I endeavored to understand the different barriers or challenges that nurses/midwives encountered when offering care to FGM patients based on the nurse's cultural knowledge, in Owerri. A thematic analysis of the collected data revealed as in theme 3 that lack of awareness of the dangers of FGM on the health of women was a significant challenge. As per the independent responses of participants, it was established that many women from the Yoruba, Hausa, and Igbo ethnic communities were blatantly ignorant to the adverse health effects of FGM. Despite a major public health concern based on the study by Mojekwu and Ibekwe (2012) that showed Nigeria as one of the countries with a high maternal mortality rate at 1,100 maternal deaths per 100,000 deliveries, only second to India, many of the participants separately established that it was difficult to offer advice let alone treat women who believed FGM barred them from promiscuous behavior and that it was an important cultural practice.

The second sub theme 3b reported on the individual impacts of FGM on women. Besides the ignorance of women from different ethnic groups on the dangers of FGM and the perception that FGM is an important cultural practice, women who suffered complications due to FGM were withdrawn and feared expressing themselves. As reported, women who went through FGM were unwilling to answer important questions and share their experiences with FGM, hindering the extent to which nurse would provide them with care. Data from this study is in concurrence with similar existing literature by O'Neill and Pallitto (2021) regarding the fear women with FGM experience. Moreover, being ashamed of undergoing FGM, the participating nurse reported that many of their patients were traumatized and antisocial making it difficult for the nurses/midwives to treat them. These findings are in consonance with existing literatures by (Buggio et al., 2019; O'Neill & Pallitto, 2021). These reports advance our understanding from the barriers experienced with FGM by nurses the main theme from RQ 3.

Coupled with trauma and depression was the fear of being exposed as having undergone FGM complicated the nurse's work of offering patient centered care to FGM cases. In previous studies, scholars established that depression, stress, anxiety, and emotional trauma were some of the negative impacts of FGM in females (O'Neill & Pallitto, 2021). A reinforcement of the findings from this research's main theme, barriers experienced with FGM cases. Similarly, Buggio et al. (2019) stated that women who had undergone FGM and had complications during birth were ashamed of their scars and often withdrew from social spaces. In accordance with the data findings from this study, existing literature indicates that majority of the women who had undergone FGM also preferred traditional medication as opposed to modern medication for fear of being

discriminated or having to explain how they got the scar (Andro & Lesclingand, 2016; Shakirat et al., 2020). This reinforces sub-theme 3b that reveals cases of FGM exhibit withdrawal signs and fear of expressing themselves. Based on this finding, the inability of women to speak up and suffering silently calls for more aggressive and expansive training and education on the adverse effects of FGM on female health (Buggio et al., 2019). Like Buggio et al. (2019) the sub theme 3a from RQ3 that revealed ignorance and lack of awareness of FGM, and its adverse effect that calls for expansive training is in keeping with my review of the study by Balfour et al. (2016) which emphasized on training interventions for healthcare professionals which includes nurses and midwives who work with FGM patients or women and girls at risk of FGM for a better provision of health services. It is imperative for Nigerian healthcare system with the help of its public health sector to focus on systemic guidelines in providing mental health and counseling services to women who have had FGM to prevent them from trauma, depression, fear of expression and withdrawal for a better community health.

RQ4

How different ethnic groups respond to pain during child birth influenced the type of care that nurses/midwives offered. Responses to cultural dynamics revealed varied findings many of which participating nurses/midwives culturally encountered separately in their practice and found confusing and ineffective in offering patient centered care to FGM patients. For instance, the results as described in theme 4 revealed that how women responded to pain was indicative of their ethnic group and cultural orientation. Analyzing the qualitative responses, it was established that compared to Igbo women, women from Yoruba and Hausa showed no signs of pain during child birth. Additionally, women from

Ijebu Ode who are ethnically Yoruba did not cry or show pain during birth lest they anger the gods and pay fine. These reports are based on cultural orientation, and they are in compliance with the findings of Adika et al. (2012) that confirm Ijaw women of Nigeria see pain from FGM site as usual. How pain during childbirth helps nurse offer culturally sensitive and patient centered care to FGM women is still an area of further research. In juxtaposition, there is lack of scientific data from this study that supports pain management for culturally diverse women in Owerri based on cultural norms. Therefore, the emphasis should be on evidence-based guidelines to enable public health experts, nursing and midwifery council, and Nigerian government to provide culturally sensitive nursing approaches on pain management for FGM women for a better public health outcome.

RQ5

Like other healthcare professionals, a nurse/midwife needs to be motivated to continue working and offer quality care to patients. For instance, Uchendu et al. (2020) reported that motivated nurses offer quality care and are more concerned with their patient's wellbeing than unmotivated nurses. The data from this study favors this report and it is revealed in the main theme 5 "motivating factors to care of FGM patients" from participant's responses. Correspondingly, it was easier for motivated nurses to offer all-round care to patients without worrying about the physical, emotional, and mental impacts it had on them (Mudallal et al., 2017; Søvold et al., 2021). This report is in keeping with my findings of the study by De Beer and Chipps (2014) that revealed the values of empathy as a key factor that influence and promote better health outcomes. With respect to the current research, I aspire to report each nurse's cultural desire in

providing care and why motivated nurses/midwives continue offering care to FGM patients. Analyzing the data collected, I revealed that the nurses in this study were motivated independently by empathy and sympathy as in sub theme 5a.

In the analyzed data, it was established that nurses/midwives were singularly motivated to offer patient centered care to FGM patients following the negative impacts of FGM that included difficulty during childbirth, excessive bleeding, and the elevated risks of VVF. In line with this observation, Buggio et al. (2019) also reported that nurses were moved with the difficulties that their FGM went through and derived their motivation from such suffering. These reports advance the premise of the emerging theme that addressed this RQ5, highlighting empathy and sympathy as integral part of effective nursing care for women with FGM.

Notwithstanding the risk factors, and adverse health consequences of FGM, the participants associated FGM with violence against women. Marea et al. (2021) asserted that FGM was a violation of women rights, and it was imperative for culturally sensitive care to demystify the cultural value of FGM and discourage such practices by creating more awareness about the health implications of FGM. Data from this study corroborates with this assertion and encourages understanding FGM women through a cultural perspective. The nurses who were individually included in the current study understood the risks of FGM, which many of them separately interviewed interpreted as a violation of women's rights and hence their obligation to educate ethnic women in Owerri on the dangers of FGM. Khosla et al. (2017) agreed that FGM was a violation of human rights, and it is obligatory for governments to discourage women against the practice for better public health outcome. Therefore, the report is in keeping with the findings of this study

that highlights the theme empathy and sympathy as a motivating factor for nurses towards cultural competence practice for FGM patients.

Limitations of the Study

The sample used in this research was drawn from Owerri city the capital of Imo State of Nigeria. While it was expected that the number of ethnic groups in Owerri was evenly distributed, it was found that the Igbo ethnic group comprised the majority of the population in Owerri . Therefore, the first limitation was that the findings obtained could only apply to states with Igbo people as the dominant ethnic group whose nurses are Christians. The second limitation was that the current research was confined to Owerri . While the goal of qualitative researchers is not to generalize the obtained findings (see McCusker & Gunaydin, 2015), it was acknowledged that the transferability of this findings to other states would be a challenge and, in the event, there was clinical need for generalization, the outcome will not be feasible.

The third limitation was associated with the size of the sample used. Compared to quantitative studies, qualitative studies use a small sample size given the amount of information collected on the opinions, views, and perceptions of participants about a given phenomenon (Busetto et al., 2020).Therefore, the limitation was that, while a sample of 10 nurses provided the data needed to answer the research questions, it was not an adequate representative sample of nurses providing care to FGM patients in Nigeria.

The other limitation was bias. Being a nurse and trained in caring for patients presenting with different conditions, there was a possibility that I interpreted the findings not as a researcher but as a trained nurse. Therefore, to maintain objectivity, I used reflexivity, and research etiquette and I conducted member checking to ensure that the

data I collected were as reported by each participant. Finally, I conducted bracketing to mitigate any preconceptions I have about the topic of research, and bracketing allowed me to approach the data with an open mind and objectivity.

Recommendations for Public Health Practice

The results of this study revealed that many nurses/midwives in Owerri region are aware that culturally many women lack knowledge of FGM and its adverse health impacts nurse's provision of culturally sensitive care. It was also established that even though some of the women experienced complications due to FGM, they held the practice in high esteem believing that it was an important cultural practice and discouraged against promiscuous behavior. Therefore, identifying the magnitude of this public health problem based on this research, and for better public health outcome, I recommend the Federal Republic of Nigeria, Owerri local government, public health experts, nurses and midwives and other stakeholders to design public health programs that would educate the communities, FGM caregivers on appropriate steps towards achieving culturally competent care of FGM women. These training programs should seek to demystify the cultural value of FGM on women and increase awareness on the emotional, physical, and mental impact of FGM with evidence-based interventions that address culturally sensitive care of complications of FGM for a better public health outcome.

Another recommendation for practice involves nurses tasked with caring for ethnic women who are victims of FGM. Developing culturally sensitive and patient centered care is physically and emotionally draining. Therefore, nursing institutions, hospital management in Owerri and public health experts should approach culturally

sensitive care of FGM women as a public health concern and therefore organize linguistic training programs and cultural awareness seminars tailored to help nurses/midwives in Owerri to learn about the culture and basic communication of the different dialects in Owerri. With this knowledge, it will be easy for nurses/midwives to understand their patients, explain the dangers of FGM, describe to their patients the kinds of treatment offered to them and help the nurses inform others about the adverse health effects of FGM. The current findings also provide insights into the impacts of empathy and sympathy in providing patient centered care to FGM patients. This research, inform nurses about the importance of being empathetic to FGM patients and sympathizing with FGM patients. It is a springboard to identifying cultural priorities as important public health strategy when providing them with care.

Recommendations for Future Research

With the general increase in the research on the negative impacts of FGM and the kind of health care offered to FGM victims, I made several suggestions for future scholars. The first recommendation for future research involves researchers using more diverse and broader research methods to understand the worldviews of nurses/midwives serving FGM patients. While qualitative research confined me into collecting and interpreting participants' responses, it opened a window to understand the worldview of healthcare givers practicing in a culturally diverse geographical area and dealing with culturally sensitive issue like FGM. In future, other scholars will benefit in conducting a mixed methods research that involved collecting and analyzing qualitative and quantitative data (see McCusker & Gunaydin, 2015). Conducting a mixed methods research study may help researchers explore the perceptions of the participants and also

investigate how these views relate to quality culturally sensitive and patient centered care. The second recommendation for future research involves the geographical area of the study. The current study was geographically confined to Owerri region. Therefore, to ensure generalizability and transferability of the findings, future researchers are encouraged to expand the geographical area of their study sites.

Implications

Practical Implications for Public Health and Healthcare Professionals

The current findings are applicable to professional health nursing practices and the public health outcome. As revealed, FGM has severe health impacts on women including difficulties during childbirth and excessive bleeding hence the need for patient centered care. FGM is a recognized public health issue especially with globalization, more immigrant women and girls migrate from FGM practicing countries to countries where FGM is not a normal practice. Therefore, this study may equip nurses, public health experts and researchers with information needed to design and promote culturally sensitive patient centered care by first developing competencies in language, cultural beliefs, and diversity. Nurses may also use this study's findings to improve their care by comparing their assessment practices and those mentioned in this study for a better specialized assessment tools for FGM cases. Such comparisons will ensure that the nurses/midwives use the necessary culturally competent tools to document the patients' history and the results of physical examination during screening. Having adequate patient information will make it easier for nurses to offer culturally sensitive care and extensive patient centered care for better public health outcome.

Future Implications for Public Health, Research, and Social Justice

The future implications of the current research is that only a few nurses can accurately identify the types of FGM women are subjected to, hence the need for nurse training on FGM (Ashimi et al., 2014). The findings of this study revealed that FGM practice is diverse with every community having their own version and reason for conducting FGM which confirms with the findings of Dike et al. (2012) on various FGM report based on ethnicity. Therefore, as an implication for the future and public health concern, more cultural data are required to fully understand nursing care of FGM practices in other states of Nigeria. The results of the current study revealed that how women display pain during childbirth helps nurses to provide patient centered care. While the results revealed that some ethnic groups showed no pain during labor, there is a clinical nursing need to examine specifically how nurses use pain threshold to design culturally sensitive care for their FGM patients. This study can help public health experts, researchers, nurses and midwives, clinicians, and other stakeholders to create appropriate guidelines for patient centered culturally sensitive care for care of women with FGM in Nigeria and globally.

Implications for Positive Social Change

Social change is a shift from societal norm that transforms family, community, nation, and the world. It is a change that positively brings about social justice beyond the intended population. My study on perception of Nigerian nurses on female genital mutilation through a cultural lens has identified gaps in the care of women with FGM, using a culturally sensitive approach. FGM is an extreme form of violence against

women, gender discrimination and violation of human rights of women and girls. It has put significant economic burden to the tune of 1.4billion dollars annually (WHO, 2020b).

This study has shown that nurses and midwives have a unique position in the health system, especially in multicultural societies. To ensure effective health services to women and girls with FGM and influence societal norms towards the practice and prevention of FGM, the utilization of science-based findings from the lived experiences of nurses and midwives from this study is a starting line to enable decision makers to design effective initiatives that address public health concerns regarding care of FGM. Therefore, this study provides evidence-based findings that program developers, clinicians, healthcare professionals, and nursing policy makers, can use for training programs that address culturally sensitive approach that will strengthen nurses' communication skills and empathy on issues surrounding this phenomenon in Owerri, Nigeria and worldwide for a better public health outcome.

As population grows and more women undergo FGM, if there is no action towards prevention of FGM through improved training of healthcare professionals, and effective dissemination of information against the practice on the target communities, the estimated health cost from FGM will increase by 50% by 2050 (WHO, 2020b). Therefore, public health experts, nurses, and all stakeholders should provide health programs that involve social justice for women with FGM worldwide.

As a change agent my plan is to ensure that I disseminate my findings through conferences, WhatsApp group for nurses, nursing schools especially where FGM is prevalent to ensure I address cultural competence in the care of women with FGM to a wider audience for a better public health outcome.

Conclusion

The problem that prompted this research is that most nurses cannot distinguish between the several types of FGM impacting how they care for FGM patients. This limited knowledge on FGM and the need to understand the nurses and midwives' worldviews regarding care for FGM patients in Owerri prompted this research. Qualitative research allowed me an opportunity to understand in-depth the views, opinions, and the perceptions of nurses regarding care for FGM victims. The findings of this study were grouped into five themes demonstrating the participants' understanding of culturally sensitive and patient centered care for FGM victims.

The findings also revealed that the nurses' assessment practices, culturally competent skills, motivating factors, barriers to offering quality care, and cultural dynamics influenced how nurses and midwives offered culturally sensitive and patient centered care to FGM patients. These result findings explicated the benefits of cultural awareness, cultural skill, cultural knowledge, cultural encounter and cultural desire and linguistics towards the nurses' process of cultural competency in providing patient centered care. It was also established that ignorance on the negative effects of FGM coupled with trauma and depression due to FGM hindered the provision of culturally sensitive care for public health. I concluded that training nurses and midwives on FGM, culture, and counseling services helped them offer culturally sensitive and patient centered care to FGM patients, ensuring cultural checks and balances for women with FGM and for social justice for more effective public health outcomes.

References

Abdulcadir, J., Rodriguez, M. I., & Say, L. (2014). Research gaps in the care of women with female genital mutilation: An analysis. *BJOG: An International Journal of Obstetrics & Gynaecology*, *122*(3), 294–303. https://doi.org/10.1111/1471-0528.13217

Abdulcadir, J. S., Say, L., & Pallitto, C. (2017). What do we know about assessing healthcare students and professionals' knowledge, attitude, and practice regarding FGM? A systemic review. *Reproductive Health*, *14*(1), 1–13. https://doi.org/10.1186/s12978-017-0318-1

Adam, T., Bathija, H., Bishai, D., Bonnenfant, Y. T., Darwish, M., Huntington, D., & Johansen, E. (2010). Estimating the obstetric costs of female genital mutilation in six African countries. *Bulletin of the World Health Organization*, *88*(4), 281–288. https://www.scielosp.org/pdf/bwho/2010.v88n4/281-288/en

Adedini, S. A., Odimegwu, C., Imasiku, E. N., & Ononokpono, D. N. (2015). Ethnic differentials in under-five mortality in Nigeria. *Ethnicity & Health*, *20*(2), 145–162. https://doi.org/10.1080/13557858.2014.890599

Adewole, A. J., & Adayonfo, E. O. (2017). Prevalence and complications of female genital mutilation among patients at University of Benin teaching hospital Benin City. *African Journal for the Psychological Studies of Social Issues*, *20*(1), 1–7. http://www.ajpssi.org/index.php/ajpssi/article/view/202

Adika, V. O., Ezonbodor-Akwagbe, R. E., Bokolo, J. E. T., & Apiyanteide, F. A. (2012). The perspectives and health implications of female genital mutilation among Amassoma women in Bayelsa state, Nigeria. *International Journal of Tropical*

Medicine, 7(2), 80–85. http://docsdrive.com/pdfs/medwelljournals/ijtmed/2012/80-85.pdf

Ahanonu, E. L., & Victor, O. (2014). Mothers' perception of female genital mutilation. *Health Education Research*, *29*(4), 683–689. https://doi.org/10.1093/her/cyt118

Akinsanya, A., & Babatunde, G. (2011). Intergenerational attitude change regarding female genital cutting in Yoruba speaking ethnic group of Southwest Nigeria: A qualitative and quantitative enquiry. *Electronic Journal of Human Sexuality*, *14*. https://www.researchgate.net/publication/289408879_Intergenerational_attitude_change_regarding_female_genital_cutting_in_Yoruba_speaking_ethnic_group_of_southwest_Nigeria_A_qualitative_and_quantitative_enquiry

Albougami, A. S., Pounds, K. G., & Akinsanyataibi, J. S. (2016). Comparison of four cultural competence models in transcultural nursing: A discussion paper. *International Archives of Nursing and Health Care*, *2*(3), 1–5. https://pdfs.semanticscholar.org/f1b7/48b664e1236fc0841a6c33259403e3f4f5e9.pdf

Ali, A. A. A. (2012). Knowledge and attitudes of female genital mutilation among midwives in Eastern Sudan. *Reproductive Health*, *9*(1), 1–4. https://doi.org/10.1186/1742-4755-9-23

Andro, A., & Lesclingand, M. (2016). Les mutilations génitales féminines. État des lieux et des connaissances. *Population*, *71*(2), 224–311. https://doi.org/10.3917/popu.1602.0224

Anzaku, A. A., Angbalaga, A. G., & Achetu, A. C. (2018). Implication of female genital mutilation in Nigeria as portal for infectious diseases. *Journal of Bacterial*

Infectious Diseases, *2*(1), 28–30. https://www.researchgate.net/profile/Abbas-Abel-Anzaku/publication/326113077_Implication_of_female_genital_mutilation_in_Nigeria_as_portal_for_infectious_diseases/links/5b39fe7c4585150d23ee7c3f/Implication-of-female-genital-mutilation-in-Nigeria-as-portal

Aponte, J. (2009). Addressing cultural heterogeneity among Hispanic subgroups using Campinha-Bacote's model of cultural competency. *Holistic Nursing Practice*, *23*(1), 3–12. https://doi.org/10.1097/01.hnp.0000343203.26216.c9

Ashimi, A., Aliyu, L., Shittu, M., & Amole, T. (2014). A multicenter study on knowledge and attitude of nurses in northern Nigeria concerning female genital mutilation. *European Journal of Contraception and Reproductive Health Care*, *19*(2), 134–140. https://doi.org/10.3109/13625187.2014.885940

Ashimi, A. O., & Amole, T. G. (2015). Perception and attitude of pregnant women in a rural community north-west Nigeria to female genital mutilation. *Arch Gynecology and Obstetrics*, *291*(3), 695–700. https://doi.org/10.1007/s00404-014-3478-z

Awolola, O., & Ilupeju, N. (2019). Female genital mutilation: culture, religion, and medicalization, where do we direct our searchlights for the eradication: Nigeria case study. *Tzu Chi Medical Journal*, *31*(1), 1–4. https://doi.org/10.4103/tcmj.tcmj_127_18

Ayenigbara, G. O., Aina, S. I., & Famarakin, T. D. (2013). Female genital mutilation. Types, consequences, and constraints of its eradication. *Journal of Dental and Medical Sciences*, *3*(5), 7–10. https://doi.org/10.9790/0853-0350710

Balfour, J., Abdulcadir, J., Say, L., & Hindin, M. J. (2016). Interventions for healthcare providers to improve treatment and prevention of female genital mutilation: A systematic review. *BMC Health Services Research*, *16*(1), 1–6. https://doi.org/10.1186/s12913-016-1674-1

Beauchamp, T. L., & Childress, J. F. (2001). *Principles of biomedical ethics*. Oxford University Press.

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research*, *26*(13), 1802–1811. https://doi.org/10:1177/1049732316654870

Buggio, L., Facchin, F., Chiappa, L., Barbara, G., Brambilla, M., & Vercellini, P. (2019). Psychosexual consequences of female genital mutilation and the impact of reconstructive surgery: A narrative review. *Health Equity*, *3*(1), 36–46. https://doi.org/10.1089/heq.2018.0036

Busetto, L., Wick, W., & Gumbinger, C. (2020). How to use and assess qualitative research methods. *Neurological Research and Practice*, *2*(1), 1–10. https://doi.org/10.1186/s42466-020-00059-z

Butt, M. F. (2021). Approaches to building rapport with patients. *Clinical Medicine*, *21*(6), Article e662. https://doi.org/10.7861/clinmed.2021-0264

Caldwell, J. C., Orubuloye, I. O., & Caldwell, P. (2000). Female genital mutilation: conditions of decline. *Population Research and Policy Review*, *19*(3), 233–254. https://doi.org/10.1023/A:1026511611930

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model care. *Journal of Transcultural Nursing*, *13*(3), 181–184. https://doi.org/10.1177/10459602013003003

Campinha-Bacote, J. (2011). Delivering patient centered care in the midst of a cultural conflict: The role of cultural competence. *The Online Journal of Issues in Nursing*, *16*(2), Article 5. https://doi.org/10.3912/OJIN.Vol16No02Man05

Chidera, E. (2018). What factors influence the persistence of female genital mutilation in Nigeria ? A systematic review. *Journal of Tropical Diseases*, *6*(01), Article 1000256. https://doi.org/10.4172/2473-3350.1000256

Creswell, J. W. (2009). *Research design, qualitative, quantitative, and mixed methods approaches*. SAGE Publications.

Creswell, J. W. (2013). *Qualitative inquiry and research design: choosing among five approaches*. SAGE Publications.

Croasdell, B. (2012). *Female genital mutilation: A clinical perception of nursing care in the United States*. http://www.academia.edu/2478726

Daniyan, B., Ekwedigwe, K., Sunday-Adeoye, I., Yakubu, E., Uguru, S., & Dantani, D. (2018). Review of the practice of female genital mutilation in Nigeria. *Epidemiology: Open Access, 8*(04), Article 1000356. https://doi.org/10.4172/2161-1165.1000356

Davis-Cheshire, R., & Crabtree, J. L. (2019). Evaluating cultural competence in an occupational therapy pediatric course. *Occupational Therapy In Health Care*, *33*(4), 355–364. https://doi.org/10.1080/07380577.2019.1639097

Dawson, A., Assifi, A., & Turkmani, S. (2022). Woman and girl-centred care for those affected by female genital mutilation: A scoping review of provider tools and Guidelines. *Reproductive Health*, *19*(1), 1–18. https://doi.org/10.1186/s12978-022-01356-3

Dawson, A., Turkmani, S., Fray, S., Nanayakkara, S., Varol, N., & Homer, C. (2015). Evidence to inform education, training and supportive work environments for midwives involved in the care of women with female genital mutilation: A review of global experience. *Midwifery*, *31*(1), 229–238. https://doi.org/10.1016/j.midw.2014.08.012

De Beer, J., & Chipps, J. (2014). A survey of cultural competence of critical care nurses in KwaZulu-Natal. *Southern African Journal of Critical Care*, *30*(2), 50–54. https://doi.org/10.7196/sajcc.188

Dibua, V. A., Agweda, T. O., & Eronmesele, A. O. (2010). The practice of female genital mutilation in Esan land of Edo State, Nigeria. A sociological analysis. *Journal of Sociology, Psychology and Anthropology in Practice: International Perspective*, *2*(1–3), 152–162. http://www.icidr.org/doc/ICIDR%20PDF%20contents/journal%20of%20research%20in%20education%20and%20society/JRESSvol2%20nos3%20december%2011/the%20practice%20of%20female.pdf

Dike, E. I., Ojiyi, E. C., Chukwulebe, A. E., & Egwuatu, V. F. (2012). Female genital mutilation: Awareness and attitude of nursing and midwifery students in Afikpo, Nigeria. *Internet Journal of Gynecology & Obstetrics*, *16*(3), 1–6. https://doi.org/10.5580/2c1b

Ekenze, S. O., Ezegwui, H. U., & Adiri, C. O. (2007). Genital lesions complicating female genital cutting in infancy: A hospital-based study in south-east Nigeria. *Annals of Tropical Pediatrics, 27*(4), 285–290. https://doi.org/10.1179/146532807x245670

Elgaali, M., Strevens, H., & Mårdh, P.-A. (2005). Female genital mutilation – an exported medical hazard. *The European Journal of Contraception & Reproductive Health Care, 10*(2), 93–97. https://doi.org/10.1080/13625180400020945

Epundu, U. U., Ilika, A. L., Ibeh, C. C., Nwabueze, A. S., Emelumadu, O. F., & Nnebue, C. C. (2018). The epidemiology of female genital mutilation in Nigeria–a twelve year review. *Afrimedic Journal, 6*(1), 1–10. https://www.ajol.info/index.php/afrij/article/view/170215

Evans, C., Tweheyo, R., McGarry, J., Eldridge, J., McCormick, C., Nkoyo, V., & Higginbottom, G. M. A. (2017). What are the experiences of seeking, receiving and providing FGM-related healthcare? Perspectives of health professionals and women/girls who have undergone FGM: Protocol for a systematic review of qualitative evidence. *BMJ Open, 7*(12), Article e018170. https://doi.org/10.1136/bmjopen-2017-018170

Ezenyeaku, C. C., Okeke, T. C., Chigbu, C. O., & Ikeako, L. C. (2011). Survey of women's opinions on female genital mutilation (FGM) in Southeast Nigeria: Study of patients attending antenatal clinic. *Annals of Medical and Health Sciences Research, 1*(1), 15–20. https://www.ajol.info/index.php/amhsr/article/view/86912

Fertman, C. L., & Allenworth, D. D. (2010). *Health promotions programs from theory to practice*. Jossey Bass.

Fields, S. C., & Bells, S. E. (2020). Cultural competence education for rural clinic nurses: A comparison method. *Clinical Scholars Review*, 5(2), 91–97. https://doi.org/10.1097/nnd.0000000000000450

Frega, A., Puzio, G., Maniglio, P., Catalano, A., Milazzo, G. N., Lombardi, D., Nitiema, H., & Bianchi, P. (2013). Obstetric and neonatal outcomes of women with FGM I and II in San Camillo Hospital, Burkina Faso. *Archives of Gynecology and Obstetrics*, *288*(3), 513–519. https://doi.org/10.1007/s00404-013-2779-y

Gardona, R. G., & Barbosa, D. A. (2018). The importance of clinical practice supported by health assessment tools. *Revista Brasileira De Enfermagem*, *71*(4), 1815–1816. https://doi.org/10.1590/0034-7167-2018710401

Glanz, K., Rimer, B. K., & Viswanath, K. (2015). *Health behavior: Theory, research and practice*. Jossey-Bass

Hess, R. F., Weinland, J., & Saalinger, N. M. (2010). Knowledge of female genital cutting and experience with women who are circumcised: A survey of nurse-midwives in the United States. *Journal of Midwifery & Women's Health*, *55*(1), 46–54. https://doi.org/10.1016/j.jmwh.2009.01.005

Ibekwe, P. C., Onoh, R. C., Onyebuchi, A. K., Ezeonu, P. O., & Ibekwe, R. O. (2012). Female genital mutilation in southern Nigeria: A survey on current knowledge and practice. *Journal of Public Health and Epidemiology*, *4*(5), 117–122. https://doi.org/10.5897/JPHE11.194

Ingram, R. R. (2011). Using Campinha-Bacote's process of cultural competence model to examine the relationship between health literacy and cultural competence. *Journal of Advanced Nursing*, *68*(3), 695–704. https://doi.org/10.1111/j.1365-2648.2011.05822.x

Janesick, V. J. (2016). *Stretching exercises for qualitative researchers*. SAGE Publications.

Kaplan-Marcusán, A., del Rio, N. F., Moreno-Navarro, J., Castany-Fàbregas, M. J., Nogueras, M. R., Muñoz-Ortiz, L., Mongui-Avilaand, E., & Torán-Monserrat, P. (2010). Female genital mutilation: Perceptions of healthcare professional and the perspective of the migrant families. *BMC Public Health*, *10*(1), 1–9. https://doi.org/10.1186/1471-2458-10-193

Kardong-Edgren, S., Cason, C. L., Brennan, M. W., Reifsnider, E., Hummel, F., Mancini, M., & Griffin, C. (2010). Cultural competency of graduating BSN nursing students. *Nursing Education Perspectives*, *31*(5), 278–285. https://journals.lww.com/neponline/Abstract/2010/09000/Cultural_Competency_of_GRADUATING_BSN_NURSING.4.aspxKhosla, R., Banerjee, J., Chou, D., Say, L., & Fried, S. T. (2017). Gender equality and human rights approaches to female genital mutilation: A review of international human rights norms and standards. *Reproductive Health*, *14*(1), 1–9. https://doi.org/10.1186/s12978-017-0322-5

Kieft, R. A. M. M., de Brouwer, B. B. J. M., Francke, A. L., & Delnoij, D. M. J. (2014). How nurses and their work environment affect patient experiences of the quality of care: A qualitative study. *BMC Health Services Research*, *14*(1), 1–10. https://doi.org/10.1186/1472-6963-14-249

Klitzman, R. L. (2013). How IRBs view and make decisions about social risks. *Journal of Empirical Research and Human Research Ethics*, *8*(3), 58–65. https://doi.org/10.1525/jer.2013.8.3.58

Leye, E., Ysebaert, I., Deblonde, J., Claeys, P., Vermeulen, G., Jacquemyn, Y., & Temmerman, M. (2008). Female genital mutilation: Knowledge, attitudes and practices of Flemish gynaecologists. *The European Journal of Contraception & Reproductive Health Care*, *13*(2), 182–190. https://doi.org/10.1080/13625180701780957

Marea, C. X., Warren, N., Glass, N., Johnson-Agbakwu, C., & Perrin, N. (2021). Factors associated with health care provider attitudes, and confidence for the care of women and girls affected by female genital mutilation/cutting. *Health Equity*, *5*(1), 329–337. https://doi.org/10.1089/heq.2020.0130

McCusker, K., & Gunaydin, S. (2015). Research using qualitative, quantitative or mixed methods and choice based on the research. *Perfusion*, *30*(7), 537–542. https://doi.org/10.1177/0267659114559116

Microdata Library. (n.d.). *Demographic and health survey 2013. Nigeria - Demographic and health survey 2013.* https://microdata.worldbank.org/index.php/catAkinsanyag/2014.

Mojekwu, J. N., & Ibekwe, U. (2012). Maternal mortality in Nigeria. Examination of interventions methods. *International Journal of Humanities and Social Science*. *2*(20), 135–149. http://www.ijhssnet.com/journals/Vol_2_No_20_Special_Issue_October_2012/13.pdf

Molina-Mula, J., & Gallo-Estrada, J. (2020). Impact of nurse-patient relationship on quality of care and patient autonomy in decision-making. *International Journal of Environmental Research and Public Health*, *17*(3), Article 835. https://doi.org/10.3390/ijerph17030835

Mpinga, E. K., Macias, A., Hasselgard-Rowe, J., Kandala, N.-B., Félicien, T. K., Verloo, H., Zacharie Bukonda, N. K., & Chastonay, P. (2016). Female genital mutilation: A systematic review of research on its economic and social impacts across four decades. *Global Health Action*, *9*(1), Article 31489. https://doi.org/10.3402/gha.v9.31489

Mudallal, R. H., Othman, W. M., & Al Hassan, N. F. (2017). Nurses' burnout: The influence of leader empowering behaviors, work conditions, and demographic traits. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, *54*, Article 004695801772494. https://doi.org/10.1177/0046958017724944

Mulongo, P., Martin, C. H., & McAndrew, S. (2014). The psychological impact of female genital mutilation/cutting (FGM/C) on girls/women's mental health: a narrative literature review. *Journal of Reproductive and Infant Psychology*, *32*(5), 469–485. https://doi.org/10.1080/02646838.2014.949641

National Population Commission. (2019, October 1). *Nigeria DHS, 2018 - Final report.* https://dhsprogram.com/pubs/pdf/FR359/FR359.pdf

Ndikom, C. M., Ogungbero, F. A., & Ojeleye, O. A. (2017). Perception and practice of female genital cutting among mothers in Ibadan Nigeria. *International Journal of Nursing and Health Science*, *4*(6), 71–80.

https://www.researchgate.net/profile/Chizoma-Ndikom/publication/320719548_Perception_and_Practice_of_Female_Genital_Cutting_among_Mothers_in_Ibadan_Nigeria/links/5a8200fc0f7e9bda869f4e84/Perception-and-Practice-of-Female-Genital-Cutting-among-Mothers-in-I

Nichol, J. R., Sundjaja, J. H., & Nelson, G. (2021). Medical history. Stat Pearls. Treasure Island (FL). *Stat Pearls Publishing*. https://www.ncbi.nlm.nih.gov/books/NBK534249

Odemerho, B. I., & Baier, M. (2012). Female genital cutting and the need for culturally competent communication. *The Journal for Nurse Practitioners, 8*(6), 452–457. https://doi.org/10.1016/j.nurpra.2011.10.003

Odukogbe, A.-T. A., Afolabi, B. B., Bello, O. O., & Adeyanju, A. S. (2017). Female genital mutilation/cutting in Africa. *Translational Andrology and Urology, 6*(2), 138–148. https://doi.org/10.21037/tau.2016.12.01

Ojua, T., Ishor, D., & Ndom, P. (2013). African cultural practices and health implications for Nigerian rural development. *International Review of Management and Business Research*, *2*(1), 176–183. https://deliverypdf.ssrn.com/delivery.php?ID=109064031101122075026014073071100076099057086000017035067090102103113016091104002100056057025002110121052125024109086082118028022073038044032007100031064076078010066084077054104019071016092069021105103029004127

Okeke, T. C., Anyaehie, U. S. B., & Ezenyeaku, C. C. K. (2012). An overview of female genital mutilation in Nigeria. *Annals of Medical & Health Sciences Research*, *2*(1), 70–73. https://doi.org/10.4103/2141-9248.96942

Okhiai, O., Idonije, O. B., & Asika, E. C. (2011). Awareness of health risks of female genital mutilation among women of childbearing age in two rural communities in Nigeria. *Asian Journal of Medical Sciences*, *3*(6), 223–227. https://maxwellsci.com/print/ajms/v3-223-227.pdf

Okonofua, F. E., Larsen, U., Oronsaye, F., Snow, R. C., & Slanger, T. E. (2002). The association between female genital cutting and correlates of sexual and gynaecological morbidity in Edo State, Nigeria. *BJOG: An International Journal of Obstetrics and Gynaecology*, *109*(10), 1089–1096. https://doi.org/10.1111/j.1471-0528.2002.01550.x

Okunade, K. S., Okunowo, A. A., Omisakin, S. I., & Ajepe, G. (2016). An institutional survey of female genital mutilation in Lagos, southwest Nigeria. *Orient Journal of Medicine*, *28*(1-2), 28–35. https://www.ajol.info/index.php/ojm/cart/view/138748/128423

O'Neill, S., & Pallitto, C. (2021). The consequences of female genital mutilation on psycho-social well-being: A systematic review of qualitative research. *Qualitative Health Research*, *31*(9), 1738–1750. https://doi.org/10.1177/10497323211001862

Onuh, S. O., Igberase, G. O., Umeora, J. O., Okogbenin, S. A., Otoide, V. O., & Gharoro, E. P. (2006). Female genital mutilation: knowledge, attitude and practice among nurses. *Journal of the National Medical Association*, *98*(3), Article 409. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2576104/pdf/jnma00190-0103.pdf

Onwuegbuzie, A. J., Leech, N. L., & Collins, K. M. (2010). Innovative data collection strategies in qualitative research. *Qualitative Report, 15*(3), 696–726. https://files.eric.ed.gov/fulltext/EJ887912.pdf

Osifo, D. O., & Evbuomwan, I. (2009). Female genital mutilation among Edo People: The complications and pattern of presentation at a surgery unit in Benin City. *African Journal of Reproductive Health*, *13*(1), 17–25. https://www.jstor.org/stable/20617091

Oyekale, A. S. (2014). Tribal perspectives on female genital mutilation (FGM) and HIV and AIDS risks among married women in Nigeria. *Studies on Ethno-Medicine*, *8*(2), 187–195. https://doi.org/10.1080/09735070.2014.11917633

Patton, M. Q. (2015). *Qualitative research and evaluation methods*. SAGE Publications.

Polit, D. F., & Beck, C. T. (2004). *Nursing research. principles and methods*. Lippincott Williams & Wilkins.

Riley, D. (2010). *The study of cultural competence of RN to BSN students* (Publication No. 1479092) [Doctoral dissertation, University of Nevada, Las Vegas]. ProQuest Dissertations and Theses Global.

Rudestam, K. J., & Newton, R. R. (2015). *Surviving your dissertation: A comprehensive guide to content and process* (pp 69-97). SAGE.

Seright, T. (2007). Perspectives of Registered nurse cultural competence in a rural state--Part I. *Online Journal of Rural Nursing and Health Care*, *7*(1), 47–56. https://doi.org/10.14574/ojrnhc.v7i1.143

Shakirat, G. O., Alshibshoubi, M. A., Delia, E., Hamayon, A., & Rutkofsky, I. H. (2020). An overview of female genital mutilation in Africa: Are the women beneficiaries or victims? *Cureus*, *12*(9). https://doi.org/10.7759/cureus.10250

Skjott Linneberg, M., & Korsgaard, S. (2019). Coding qualitative data: a synthesis guiding the novice. *Qualitative Research Journal*, *19*(3), 259–270. https://doi.org/10.1108/qrj-12-2018-0012

Søvold, L. E., Naslund, J. A., Kousoulis, A. A., Saxena, S., Qoronfleh, M. W., Grobler, C., & Münter, L. (2021). Prioritizing the mental health and well-being of healthcare workers: An urgent global public health priority. *Frontiers in Public Health*, *9*, Article 679397. https://doi.org/10.3389/fpubh.2021.679397

Thierfelder, C., Tanner, M., & Bodiang, C. M. K. (2005). Female genital mutilation in the context of migration: experience of African women with the Swiss health care system. *The European Journal of Public Health*, *15*(1), 86–90. https://doi.org/10.1093/eurpub/cki120

Uchendu, C., Windle, R., & Blake, H. (2020). Perceived facilitators and barriers to Nigerian nurses' engagement in health promoting behaviors: A socio-ecological model approach. *International Journal of Environmental Research and Public Health*, *17*(4), Article 1314. https://doi.org/10.3390/ijerph17041314

United States Department of State. (2001, June 1). *Nigeria: Report on Female genital mutilation (FGM) or Female genital cutting (FGC).* https://www.refworld.org/docid/46d5787bc.html

Vissandjée, B., Denetto, S., Migliardi, P., & Proctor, J. (2014). Female genital cutting (FGC) and the ethics of care: community engagement and cultural sensitivity at

the interface of migration experiences. *BMC International Health and Human Rights*, *14*(1), 1–10. https://doi.org/10.1186/1472-698X-14-13

World Health Organization. (2008). *Eliminating female genital mutilation: An interagency statement-OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO*. http://apps.who.int/iris/bitstream/handle/10665/43839/9789241596442_eng.pdf?sequence=1

World Health Organization. (2020a, February 3). *Female genital mutilation.* https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation

World Health Organization. (2020b, February 6). *The economic cost of female genital* https://www.who.int/news/item/06-02-2020-economic-cost-of-female-genital-mutilation

Young, J., Nour, N. M., Macauley, R. C., Narang, S. K., Johnson-Agbakwu, C., Suchdev, P., Chan, K. J., Howard, C. R., McGann, P., St Clair, N. E., Yun, K., Arnold, L. D., Fanaroff, J. M., Altman, R. L., Bondi, S. A., Oken, R. L., Rusher, J. W., Santucci, K. A., Scibilia, J. P., . . . Statter, M. B. (2020). Diagnosis, management, and treatment of female genital mutilation or cutting in girls. *Pediatrics*, *146*(2). https://doi.org/10.1542/peds.2020-1012

Zaidi, N., Khalil, A., Robert, C., & Browne, M. (2007). Knowledge of female genital mutilation among healthcare professionals. *Journal of Obstetrics and Gynaecology*, *27*(2), 161–164. https://doi.org/10.1080/01443610601124257

Zurynski, Y., Sureshkumar, P., Phu, A., & Elliott, E. (2015). Female genital mutilation and cutting: A systemic literature review of health professionals' knowledge,

attitudes, and clinical practice. *BMC International Health and Human Rights*, *15*(1), 1–18. https://doi.org/10.1186/s12914-015-0070-y

Appendix A: Letter of Permission to Conduct Study on Nurses and Midwives in Owerri

To Whom It May Concern:

My name is Jane-Frances Echeozo a final year doctoral student at Walden University currently writing my dissertation. To accomplish this, I am conducting research on nurse/midwives currently working in healthcare facilities in Imo state on their perception on the care of women with female genital mutilation (FGM). The reason for this study is because previous researchers including researchers from Nigeria have raised awareness on the lack of cultural approach in the care of FGM cases for a better health outcome. Therefore, I would like to understand the worldview of the nurses to support my quest in the care of women with FGM.

This letter is to formally inform you of this study with target population of registered nurses/midwives to conduct this study timely and effectively. All interested participants will be volunteers and the information obtained from this study remains confidential as all ethical standards are maintained. Participants are free to discontinue at any time of the interview. Thank you for your cooperation!

Sincerely

Doctoral student (IRB # 01-19-22-0361382)

Walden University

Minnesota USA

Appendix B: Flyer

Midwives /Nurses needed for Research on care of women with FGM

This is an invitation for interested midwives and nurses who work in healthcare facilities in Owerri Imo state of Nigeria to participate in a study on the 'Perception of Nigerian nurses/midwives who care for women with FGM'. I am conducting this study for my Walden dissertation. The session will last from 45 minutes to 1 hour through video conferencing. You are free to discontinue at any time.

You will receive N5000 gift per participant as appreciation. For more information, please contact me Jane-Frances @ phone: +1-720-951-1023 directly or through WhatsApp

Appendix C: Screening Tool Questionnaire (Phone Interview)

Name of Researcher: Jane-Frances E

Name of Respondent: XXX

1: What are your name and your gender?

2: What is your designation as a nurse/midwife?

3: How old are you and who is your next of kin?

4: How long have you been a NNANM member?

5: What do you know about FGM complications?

6: What Nigerian ethnic group do you come from?

7: Name Nigerian languages you speak?

8: What is the name of the religion you practice?

9: What types of FGM problems do you encounter in your department?

10: Explain how you identify women with complications of FGM and their culture in your workplace?

11: What are your concerns in using any video conferencing app?

Appendix D: Interview Protocol

Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals (IAPCC-R) MV. Cultural Awareness:

(1) What are your experiences when caring for ethnically diverse women with FGM?

1.1 What types of cultural attitudes impact the care of women with FGM and why?

1.2 How does ethnicity influence your care of women with FGM? (Please explain!)

1.3 What is the link between culture and nursing care of complications from FGM? (Tell me more!)

Cultural Skill:

(2) Describe how to collect information from women who present with FGM complications while providing care?

2.1 Explain your cultural beliefs and how they influence your assessment of women with FGM?

2.2 What are the cultural similarities and differences during assessment of ethnically diverse women with FGM? (What do you think about it?)

2.3 What types of tools are necessary for the assessment of women with FGM?

2.4 How are your assessment tools appropriate for assessing ethnically diverse women with FGM?

Cultural Knowledge:

(3) What do you know about FGM and culture? (Please tell me more about your attitude towards the cultural practice!)

3.1 How is the culture of FGM associated with specific Nigerian ethnic groups? (Please explain!)

3.2 What common FGM types do you observe on Igbo, Hausa, and Yoruba women?

3.3 How do you identify different types of FGM?

3.4 How does cultural training enhance the nursing care of diverse women with complications of FGM*?* (Please tell me more!)

Cultural Encounter:

(4) How do you communicate with women who have FGM while providing nursing care? (Can you give me an example of your approach?)

4.1 How do you identify women of Igbo, Hausa, and Yoruba ethnic groups of Nigeria as a nurse? (Please explain if some women could be of mixed ethnic group!)

4.2 What impact do your nursing education, training, and state legislation have on the care of culturally diverse women with FGM? (Could you tell me more?)

4.3 What happens when your values and beliefs clash with the patient's values and beliefs? (Can you give me an example from your experience?)

Cultural Desire:

(5) What inspires and motivates you to be willing to care for culturally diverse women presenting with problems resulting from FGM practice?

5.1 Why do you care for culturally diverse women with FGM? (Tell me more!)

5.2 What motivates you to become culturally competent in the care of FGM complications? (Please explain!)

5.3 How do rules on culturally competent care impact the care you provide to these women with FGM complications? (Tell me more!)