



Understanding the consequences of Female Genital Mutilation: a phenomenological study in sub-Saharan women living in Spain

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ABSTRACT

Background: Female Genital Mutilation (FGM), which is culturally accepted in some African communities, has serious consequences on the physical, psychological, urogynecological, obstetrical and sexual health of girls and women. It is therefore important to understand women's experiences of the consequences of FGM.

Objective: to understand the experiences of the consequences of female genital mutilation in sub-Saharan female survivors living in Spain.

Design: a qualitative study based on Merleau-Ponty's hermeneutic phenomenology.

Participants and setting: 13 sub-Saharan female survivors of female genital mutilation participated. The study was carried out in two south-eastern Spanish provinces where many jobs in the agricultural and service industry are done by African immigrants originating from ethnic groups in which FGM is still prevalent.

Findings: In-depth interviews were carried out for data collection. ATLAS.ti was used for inductive analysis, from which two main themes were developed that represent the experiences of the consequences of FGM: (a) The impact of FGM: Hijacked sexual health and (b) The difficult process of genital reconstruction: overcoming the aftereffects and regaining integrity.

Conclusion and implications for practice: The mutilated women experienced serious consequences in their sexual, psychological and obstetrical health. Genital reconstruction was a difficult decision but contributed to regaining their sexual health and identity. The professionals involved play an important role in the care provided for the associated consequences of FGM, in identifying risk groups and in providing advice that allows the women to regain their sexual and reproductive health.

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Introduction

Every eleven seconds a girl is subjected to female genital mutilation around the world (Hussein, 2021). Female genital mutilation (FGM) is a global health problem, recognised internationally as a violation of human rights and as violence towards women and girls (WHO, 2016). Around 200 million women and girls have undergone FGM in 30 sub-Saharan and Middle Eastern countries, as well as in some areas of Asia and South America (UNICEF, 2016), and another three million women and girls are at risk annu-

ally (WHO, 2016). It is estimated that between 9–15% of girls between 0–18 years of age were at risk of FGM in Spain in 2018 (European Institute for Gender Equality, 2021 (a)). These girls primarily come from Guinea, Mali, Gambia and to a lesser extent from Egypt, Mauritius and Nigeria (European Institute for Gender Equality (EIGE), 2021 (b)).

FGM involves the partial or total removal of external female genitalia or other injury to the female genital organs for non-medical reasons (WHO, 2023). The WHO classifies FGM into four types (I, II, III y IV) (Dilbaz et al., 2019), depending on the partial or total removal of the clitoris or the labia minora, infibulation or perforation, with different degrees of severity (Evans et al., 2019). Type I and II are the most common and tend to comprise between 80% and 95% of all cases, and the others are less frequent (between 15% and 20% of all cases) and mostly carried out in the countries of the 'Horn of Africa' (Obiora, Maree, & Nkosi-Mafutha, 2020). The practice of FGM, culturally accepted in some African communities (Berthe-Kone et al., 2021), FGM is associated with other forms of oppression and domination of women such as forced marriages (Ahinkorah et al., 2023). Survivors recall FGM as a procedure of physical and psychological torture (Martinez-Linares et al., 2022), which has serious consequences on the physical, psychological, urogynecological, obstetrical and sexual health of girls and women (Pastor-Bravo et al., 2018; Binkiva et al., 2021). FGM leads to sexual complications, problems during childbirth and physical and psychological difficulties (Abdoli et al., 2021), as well as a clitoral neuroma (Zoorob et al., 2019), epidermal cysts (Kibar et al., 2018), fistulas (Matanda et al., 2019), bladder dysfunction (Millet et al., 2019), urinary or stress incontinence (Geynismann-Tan et al., 2019), infection, sexual dysfunction, (Martinez-Linares et al., 2022). Furthermore, FGM can lead to chronic pelvic pain, obstetrical trauma (Payne et al., 2019), maternal and neonatal death during childbirth among women who have been mutilated (Elnakib & Metzler, 2022). Added to this are mental health problems (Abdalla & Galea, 2019), issues relating to female sexual identity (Akinbiyi et al., 2018), posttraumatic stress, anxiety, somatization, phobia and low self-esteem (Buggio et al., 2019), unrelated to antenatal depression (Boghossian et al., 2019).

FGM is a complex cultural phenomenon that requires clear guidelines and specialised centres (Evans et al., 2019). Healthcare professionals must provide women and girls who have undergone FGM with culturally sensitive, quality care, while avoiding negative attitudes (Scamell & Ghumman, 2019) and attempting to prevent this practice in girls at risk (Atkinson & Geisler, 2019). Research has focused on the practice of FGM (Varol et al., 2015; Njue et al., 2019; Graamans et al., 2019), the experiences recalled by survivors (Martínez-Linares, 2022), and the clinical repercussions of the practice (Berg et al., 2017). However, it is necessary to gain a more in-depth understanding of its consequences from the perspective of the women who have undergone FGM (Gayawan & Lateef, 2018; Sabahelzain et al., 2019), as well as the importance of genital reconstruction. While some studies have been carried out on the matter (El-Gibaly et al., 2019; Ormond, 2019; Ahmed et al., 2019), there is a lack of specific research on women's experiences of the consequences of FGM. The objective of this study was to understand the experiences of the consequences of FGM in sub-Saharan female survivors living in Spain.

Methods

Design

This is a qualitative study that used Merleau-Ponty's hermeneutic phenomenology as its framework. Through his incarnation philosophy, Merleau-Ponty considered that we perceive the world through our body (Merleau-Ponty, 2013) and that human aware-

ness cannot be understood without corporality. In this study, the participants' experiences of the consequences and meanings of FGM will be interpreted from the perspective of the inability to separate a woman from the world, society and culture in which she lives, as they are all interconnected. Merleau-Ponty believed that the meaning of a phenomenon is always ambiguous, regardless of when it is studied, and that there is never an absolute truth (Xolocotzi & Gibu, 2014). Therefore, we do not seek to discover the 'truth' about FGM and its meanings but rather shed light on the complexity of the phenomenon in the different ways in which women embody it. Consolidated Criteria for Reporting Qualitative Research (COREQ) criteria were applied when writing the manuscript (Tong y Sainsbury, 2007).

Participants and setting

The group of participants comprised thirteen sub-Saharan African women currently living in Spain. The study was carried out in two provinces in southeastern Spain with a high number of African immigrants. The study was conducted as part of an action research project between a university (University of Almería) and an NGO (Doctors of the World) that actively challenges FGM. This project aims to provide useful information to help prevent FGM and to provide care for its survivors. The participants were recruited through purposive and convenience sampling, fulfilling the following selection criteria: *Inclusion criteria included:* to be a woman who has undergone FGM, to have emigrated to Europe and to be an adult. *Exclusion criteria included:* to refuse to participate, to not speak Spanish, French, English or one of the dialects understood by the interviewer (djoula, bambara, malenké) or to have cognitive impairment that prevents them from recalling or maintaining a conversation.

For the recruitment of the sample, the lead researcher contacted the female FGM survivors through healthcare professionals. Of the eighteen women who were asked to participate in the study, five women declined, two stated that they did not want to recall their experiences and three feared family reprisals.

Data Collection

Data collection included in-depth semi-structured interviews carried out between January and June 2021. The interviews took place in an office in the University of Almería's Department of Nursing, Physiotherapy and Medicine, in healthcare centres and private homes). The interviews were carried out by two researchers with training and experience in leading in-depth interviews, and fluent in various African languages and dialects. One of the researchers was of sub-Saharan origin and fluent in several languages, so he interviewed the participants who did not speak Spanish (Djoula, Malenké, Bambara, French or English). The rest of the interviews were conducted in Spanish by a Spanish female researcher, who is a midwife and part of a health team that had provided care to some of the participants in relation to their sexual and reproductive health. This facilitated communication and provided rich and in-depth data collection. An interview protocol with open-ended questions was used (Table 1). Before starting, the participants received an explanation of the objective and the ethical questions regarding the research (confidentiality, willingness to participate, permission to record, consent). The interviews, with an average length of 86 minutes, were recorded for later transcription. The interviewers took notes of non-verbal elements (e.g. expressions...) and paraverbal features (e.g. tone of voice...) of communication. Data collection ceased when the researchers deemed that there was no more new information to provide, thus considering that data saturation had been reached (Saunders et al., 2018). Researchers used a reflective journal during interviews, created

Table 1
Interview guide.

Stage of the interview	Theme	Content/example question
Presentation	Motives Intentions	Belief that their experience should be well-known to all. Carry out research to raise awareness of the experience.
Start	Starting questions	Tell me a bit about yourself (Who are you? What do you do for a living? Tell me about your country of origin)
Development	Guide for the conversation	When did they carry out female genital mutilation on you? What do you remember? How has your life been since the mutilation? Talk to me about the consequences or discomfort you have had since then. What have you done to overcome those consequences?
Close	Final question Thanks Reaching out	Is there anything else you want to add? Thank you for your attention. Your account will be incredibly useful to us. We want to remind you that if you have any queries, you can call us and that we will share the results of our research with you.

memos, and researchers' interpretations and reflections were continuously edited during the data analysis process.

Data analysis

All of the annotations and recordings of the in-depth interviews were transcribed and incorporated into a hermeneutic unit, for later analysis with ATLAS.ti 9.0 software. The analysis followed various steps organised into three moments based on Merleau Ponty's phenomenology (Fernández-Sola, 2019). First, the interviews were transcribed verbatim and the transcripts were read and re-read (description). Secondly, the transcripts were coded in order to organise the data into units of meaning without any intervening personal or prior concepts (phenomenological reduction). During data analysis, the researchers made memos in ATLAS.ti, where they wrote down their thoughts, analyses, processes, pre-analytical insights and data interpretations. Finally, in the phenomenological interpretation stage, the researchers used the participants' accounts to construct the explanation of the themes and sub-themes (scientific discourse) to understand the phenomenon. These were discussed by the research team for verification. A detailed description of data analysis can be found in Table 2.

Table 2
Data analysis based on Merleau Ponty's phenomenology.

Moment	Process
1. Description	The transcripts were read in full to understand the statements of the participants as a whole (Willig & Rogers, 2017).
2. Phenomenological reduction	We tried to achieve the <i>epoché</i> at three different points (Dantas Guedes & Moreira, 2009): 1. The researchers placed their experiences in brackets (<i>epoché</i>) through analysing the experiences of the participants as they lived them. We avoided the researchers' personal or theoretical concepts from interfering. 2. The researchers organised the data into units of meaning according to the statements of the participants. 3. The researchers focused on the experiences of the participants without including the researchers' previous experiences of FGM. The literature review was done after data analysis.
3. Phenomenological interpretation	The researchers came out of their brackets to interpret the phenomenon. They transformed the statements of the participants into statements that were appropriate for scientific research. The researchers transformed the statements of the participants into appropriate scientific discourse, which was supported by the research. The researchers' perspective allowed them to find the visible and hidden elements within the participants' discourse.

Rigor

To ensure scientific rigor when carrying out the study, the following quality criteria (Lincoln & Guba 1985) were used. (1) Credibility: the data collection process was detailed; data interpretation was supported by member checking amongst the researchers and the analytical process was revised by two independent reviewers. (2) Transferability: the study's setting, participants, context and method were described in detail. (3) Dependability: an expert who did not participate in the data collection and analysis examined the interpretation. (4) Confirmability: all of the researchers read the transcripts independently to ensure that they would reach an agreement regarding the emerging units of meaning, themes and subthemes. Furthermore, some of the participants had the opportunity to see the transcripts. (Morse, 2015). The research team triangulated the data analysis.

Ethical considerations

The study was carried out in accordance with the ethical standards established by the Declaration of Helsinki. It was approved by the Ethics Committee of the University of Almería's Nursing, Physiotherapy and Medicine Department (Protocol number: EFM-03/20). The participants were informed of the objective/aim of the study and the voluntary nature of their participation. They were asked permission to record conversations and they signed informed consent. Confidentiality and anonymity were guaranteed by encoding the names of the participants.

Results

Thirteen women who had undergone FGM participated in the study ranging from 26 to 35 years of age (mean: 29.62, SD: 3.01). The study was carried out in two south-eastern Spanish provinces where many jobs in the agricultural industry are done by African immigrants given its border proximity to Africa. There was a high proportion of migrants from ethnic groups where FGM is an accepted practice, such as Gambia, Senegal, Guinea, Nigeria, Mali and Burkina Faso. The socio-demographic data of the participants are described in Table 3.

Two main themes developed from data analysis: (1) The impact of FGM: Hijacked sexual health and (b) Overcoming the aftereffects and regaining integrity. The difficult process of genital reconstruction. These themes contribute to the understanding of the experiences related to the consequences of FGM in sub-Saharan female survivors living in Spain (Table 4).

The impact of FGM: Hijacked sexual health.

The participants stated that the effects of FGM on their lives were permanent. This practice does not just deprive girls of the right to a healthy childhood but also controls a woman's sexuality and chastity for life. The most commonly studied psychological

Table 3
Sociodemographic data of the participants.

Participant	Age	Religion	Country of origin	Age FGM
P1	35	Christian	Gambia	7
P2	32	Muslim	Senegal	months
P3	26	Christian	Equatorial Guinea	4
P4	30	Muslim	Guinea	6
P5	28	Muslim	Gambia	3
P6	29	Christian	Nigeria	5
P7	32	Muslim	Burkina Faso	1
P8	34	Muslim	Mali	3
P9	26	Muslim	Senegal	6
P10	30	Muslim	Mali	2
P11	27	Muslim	Burkina Faso	4
P12	26	Muslim	Senegal	4
P13	30	Muslim	Mali	months

effects of the practice on women are depression, chronic anxiety, psychotic disorders, lack of confidence, fear and social rejection. Two subthemes emerged from this theme:

Mutilation that transcends the physical body and reaches a psycho-sexual level

Our participants affirmed that, as women, they have been deprived of exploring their sexuality in a broad sense. Furthermore, in order to preserve their morality and chastity, they have denied themselves eroticism, pleasure and sexual desire. They stated that FGM is carried out so that a woman is pure and a virgin at the time of marriage. According to the participants, controlling a

women’s sexuality through mutilating her is justified by the fact that women who have not undergone FGM have sexual relations with many men to fulfil their sexual desire. It is therefore deemed necessary to put an end to it.

By mutilating their body, more specifically, their genitals, the corporal dimension of their sexuality becomes evident. The women feel that their sexuality has been attacked and mutilated through the process of genital mutilation. FGM mutilates them physically but also hinders their desire and removes any possibility of pleasure.

“(…) on a sexual level it affects you because you don’t feel like having sexual relations, you can go without it for years. You don’t feel pleasure and there are lots of complications. My husband wants to have intercourse and I want to sleep. I’m useless, women who have been cut don’t know what good or bad sex is, you have no clue”. (P7)

FGM not only impacts sexuality in terms of genitality; it transcends the physical body and the women are aware that they have had any chance of sexual fulfilment surgically removed. Feelings of shame and inferiority impede sexual development in the mutilated women, far beyond merely the physical aspect of the genitalia. The participants stated they had difficulty in maintaining relationships due to their insecurity, fear and embarrassment to show their genitals. They said that they felt different to other women because they did not feel anything in their sexual relations. They expressed feelings of inferiority that distanced them from men. The effects of FGM on sexual health are irreparable both physically and psychologically.

Table 4
Code-participants analysis.

Theme	Subtheme	Code	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12	P13	Total		
The impact of FGM: Hijacked sexual health	Mutilation that transcends the physical body and reaches a psycho-sexual level	Painful intercourse	5	7	3	3	2	2	5	2	3	2	3	4	43			
		control of one’s sexuality	4	4	1	2	2	5	3	1	5	2	2	1	2	34		
		dysmenorrhoea, dyspareunia	3	6	3	1	2	1	3	1	0	1	1	2	1	25		
		depression	8	4	2	4	3	1	0	1	1	2	1	1	3	31		
		Faking pleasure, frustration	1	1	1	0	1	0	0	1	0	3	0	0	2	10		
		Infections	3	2	4	2	2	1	5	3	4	1	3	1	7	38		
		faking illness to avoiding sexual relations	2	0	2	0	2	1	2	1	0	0	1	0	0	11		
		Lack of desire	3	4	3	2	2	1	1	2	1	3	3	2	2	29		
		lack of natural lubrication	4	3	1	4	3	1	1	1	1	1	1	2	2	25		
		shame	2	2	2	0	1	0	1	0	1	3	0	2	0	14		
		fear of sex	4	3	1	1	2	1	2	1	1	5	1	1	3	26		
		lack of confidence	2	0	0	1	1	0	3	0	3	0	0	3	1	14		
		male rejection	3	1	2	2	1	1	3	4	2	5	1	0	3	28		
		Major haemorrhage	1	3	1	1	1	1	1	1	2	1	3	0	2	18		
		Overcoming the aftereffects and regaining integrity. The difficult process of genital reconstruction	Beyond the sexual: Obstetrical complications during birth	Death	0	0	1	0	1	0	0	0	0	1	0	2	3	8
				obstetrical complications	1	2	3	3	3	1	2	1	2	3	1	3	3	28
Intense pain	8			9	1	1	4	1	2	1	1	1	2	2	0	33		
Genitourinary fistulas	0			2	0	1	0	3	0	2	0	2	0	0	1	11		
Major haemorrhage	1			4	0	1	2	0	1	1	1	0	3	0	0	14		
The tortuous decision to undergo genital reconstruction	3			2	1	1	1	1	1	2	2	1	2	0	0	17		
lack of information about reconstruction	7			3	2	2	0	1	1	3	1	2	3	2	2	29		
doubts about reconstruction	8			4	3	2	1	1	2	2	1	2	2	4	2	34		
Negative feelings: guilt and indecisiveness	3			3	1	0	0	2	0	3	0	0	3	1	1	18		
asking for help to reconstruct	1			2	1	0	2	2	1	1	2	0	3	0	0	15		
The joy of returning to one’s prior self	The joy of returning to one’s prior self	Remembering the trauma	3	2	1	2	3	1	2	1	1	1	1	2	3	23		
		Joy and happiness	4	6	2	1	3	5	0	2	1	1	3	0	0	28		
		Perceived changes in the quality of their sexuality	3	5	1	1	2	1	0	2	5	0	1	0	0	21		
		Recommending it to other women	2	3	1	2	1	2	2	2	0	0	2	0	0	17		
		celebrating reconstruction	4	0	2	0	3	1	0	2	0	0	1	0	0	13		
Recovering what they took away from me	3	1	1	0	1	2	0	1	1	0	3	0	0	13				
self-confidence	5	2	1	0	0	1	1	1	1	0	2	3	0	0	16			

"I've had to go through incredibly difficult situations, how can I explain it?... they told me that mutilation was carried out so that we wouldn't feel pleasure and unfortunately, it affects physical relationships on a sexual level, you can spend years not being interested in having sexual relations. On top of that, one way or another, it's made me reject men". (P1)

The participants spoke of the taboo nature of the topic and how feelings of shame, inferiority and embarrassment prevent them from speaking openly about their sexuality. Indeed, the participants recognised that they do not speak about the topic with almost anyone. The women longed for the possibility to ask their family members about the topic, but it is frowned upon to speak about sexuality within their families, therefore making FGM a private topic. Opening up would surely put them at ease because during the interviews, it was clear that as the women expressed their feelings, they felt grateful to be heard. As a result, it was as if part of their burden were lifted.

"Grandmothers don't talk about this topic as it is taboo. I have been able to talk to my Mum and friends about it but with grandmothers...how embarrassing! If you ask why the practice is carried out they will just say: how can you ask me that? We don't talk about those things (...). (P6)

The participants stated that the psychological consequences were common and long-lasting. These included faking pleasure, frustration, relationship problems, rejecting men and depression. Some of the participants were aware of the suffering caused by FGM; not being able to have sexual relations and feeling incomplete lowered their expectations of achieving happiness. Some of these women had recurring dreams that affected their sleep.

"The psychological consequences, they cause depression, like it or not, you suffer. It depends on the person; you might even have to medicate and go to the psychologist all the time. You can have lots of nightmares or even wet the bed. I don't feel embarrassed but as an adult I've had nightmares and woken up having completely wet the bed. (P1)

Beyond the sexual: Obstetrical complications during birth

The participants described the obstetrical complications as problematic. They include extended duration of labour, increased probability of a caesarean, and a higher risk of maternal and prenatal mortality. The participants know of cases of women who have suffered, lost their children, or died during childbirth, as a result of this practice, which in most cases is carried out under poor hygienic and sanitary conditions. Some of them reported that they felt worried when they saw the astonished faces of the professionals who attended them during childbirth.

"I'm told that you have problems during labour due to the pain and the swelling during pregnancy. That is also why you are more likely to tear and then your recovery is a lot slower. When I am at the gynaecologist, I see their faces and I feel bad. I see them talk amongst themselves and then they look at you with a strange face. They ask if it hurts because they've seen the huge scar". (P3)

The participants also mentioned the possibility of haemorrhaging and tearing in the post-partum period, a prolonged period in hospital, the need for reanimation or stillbirth. A consequence of FGM for these participants was reduced elasticity in the perineal tissue, which does not withstand the stretching of the surrounding tissue during labour. They also referred to scarring that led to chronic pain and tightness in the genitals. Women who have undergone FGM are denied the opportunity to have a low-risk birth. The participants described their experiences and those of other mutilated women from their country with fear, which was evident

by their trembling voice and tearful eyes, that created a silent sadness in the atmosphere.

"When a woman gives birth she's going to die, a lot of blood, I saw that she died from it and I'm scared. I met a woman who gave birth and then died. Baby lives with her father. I'm scared of that, I'm scared." (P13)

Overcoming the aftereffects and regaining integrity. The difficult process of genital reconstruction.

The participants affirmed that asking for help to undergo reconstruction was a difficult and uncertain decision; the lack of information made them feel unsure and confused. Some participants stated that their knowledge of the reconstruction process had come from friends and family members who had found it easier to start the process because they lived in different countries such as France.

The reconstruction process is clear evidence that women live life through their bodies. If their body is mutilated, they are mutilated psychologically and sexually; the reconstruction process transcends the corporal as it allows them to regain their dignity, integrity and female identities.

The tortuous decision to undergo genital reconstruction

The physical discomfort and the psychological stress or suffering made the participants seriously consider the possibility of genital reconstruction, a procedure they had heard about from acquaintances or healthcare professionals. This initial information about the possibility of reconstruction that women receive from the healthcare system makes them consider the decision and discuss it with acquaintances.

"A midwife told me that I could undergo genital reconstruction. Not completely but that I would get it back. I then asked acquaintances about it and they said it was true". (P9)

"I decided to go to a doctor in Barcelona because I want to go ahead with genital reconstruction. I went and they explained the procedure and I decided to go through with it." (P2)

On other occasions the participants shared that they had thought about reconstruction since they were little, although they admitted that at that age, they were not ready for the intervention yet. As it was a taboo subject, they could not talk about it openly with their family, which made it even more difficult.

"It was a decision that I had genuinely been considering since I was very young, 15 or 16. I couldn't do it at the time because I didn't feel ready neither physically nor psychologically because it's more psychological than physical". (P2)

However, making the decision to undergo genital reconstruction was not easy for the participants. Firstly, some of them stated that it was a complex decision that evoked negative past experiences as well as stress, suffering, insomnia and other related negative consequences. Recalling their experience of FGM in the context of wanting to undergo reconstruction reopened the painful process and it was as if they were reliving all of its psychological consequences.

"It was a few years ago that I decided to get operated on...It was really hard to make the decision, I was terrified...I wasn't able to sleep, I had recurring dreams about the moment they cut me. I started to lose weight from all the nerves and stress". (P11)

Furthermore, the participants shared that the decision to reconstruct their genitals brought about guilty feelings for going against their family's decision and the traditions of "their people" (their social group of reference, ethnicity, family...). Their origin culture

is so marked by the weight of the family that the idea of contradicting one's parents brings about feelings of guilt that make it difficult to decide to undergo reconstruction after FGM.

"I sometimes felt guilty because I thought that it must be OK if my parents did it. It must have been for a reason. Am I making the right choice? What will people think?" (P11)

Some of the participants who thought about or decided to go ahead with the reconstruction, stated that they did not have enough information about the procedure. They do not know whether or not they are going to have a transplant and are also unaware of the risks and effectiveness of the procedure. This lack of knowledge translates into uncertainty, nervousness and anxiety about post-FGM reconstruction.

"I was very nervous and the first thing I thought was: What are they going to put on me? Are they going to give me someone else's clitoris? I didn't have any information". (P6)

The participants also recounted the experience of the professional assessment, after having decided to undergo reconstruction. They highlighted that during the professional assessment and tests, they obtained the information they had been lacking at the start of the process, which had led to confusion.

"They did tests on me ...I had to see the psychologist for an assessment to see whether I was ready. I discovered, thank God, that a woman's clitoris is 10cm long and that the operation involved taking it out and reconstructing it. They explained it to me and I said "give me the first possible appointment" (P2)

The joy of returning to one's prior self

The reconstructed participants explained that they were happy with the results, and that it was a joy to return to their prior selves. The participants considered themselves lucky to have undergone reconstruction and highlighted the importance of regaining a part of their body that had been taken from them, thanks to a surgical intervention. The labia majora cannot be restored if the FGM practice included their excision. Even so, participants felt that they regained what was most important and felt 'normal' again.

"The good thing is that I can get operated, I'm like a normal person, well, unfortunately I cannot recover my labia majora but I'm not that worried about that because their function is just to cover our private parts." (P9)

In terms of regaining their sexuality and the possibility of sexual pleasure, the participants felt that they finally had the opportunity to make decisions about their sexuality and that reconstruction was like the light at the end of the tunnel. They clearly noticed the difference in their sex lives after reconstruction and were satisfied by recovering sexual desire and feeling pleasure. They were reclaiming a part of their lives that had been taken away from them.

"I had some feelings, but it wasn't very often and I'm not going to lie, now that I have a clitoris there is a difference, a huge difference". (P 6)

"I want to add that it really does have an impact, there is a big difference, you can feel that you have a clitoris, you feel like having sex more. When you do, you feel twice as much, no, three times as much, you're on cloud nine". (P 9)

Reconstructing their body to recover their identity is the natural way of being in the world. We experience the world through our body and for the participants, regaining the integrity of their bodies was the moment they recovered their identity as a woman

and felt themselves again. They were back in the world in the way that they entered it or as "God created them".

"Why did I decide to do this? Because I truly needed it, after everything I have gone through, I needed to sort it out and feel good about myself and to feel like a woman, to feel like myself, as God brought me to the world." (P8)

The reconstructed participants ended by recommending other mutilated women to undergo the reconstruction process, highlighting the positive results both on a physical and psychological level. Reconstruction is understood as part of the struggle to recover and the end of years of suffering. Reconstruction has a physical (surgical) component but also a psychological component, that requires many years of psychological support so that the women can recover their identity and have the full ability to find happiness.

"I recommend it to all girls not just because of how it will make you feel. I did this because of all the years of struggle. I've had so many problems, I've really had a bad time, I've had depression. It wasn't overnight, I've been working on it with a psychologist for many years, gone through a lot of therapy, lots of information, meeting other people who have gone through the same, a bit of everything". (P6)

Some reconstructed participants spoke of support networks that help answer questions prior to the reconstruction process. Furthermore, they themselves are part of those support networks and tell FGM survivors not to be afraid of genital reconstruction. Being part of the support networks helps them find themselves and feel useful, and it is another way to fight against FGM and its aftermath.

"There are so many websites, associations that support you, don't be afraid". (P 11)

"Helping other women now who decide to reconstruct themselves and encouraging them to do so is another way for me to feel good and to fight for the end of women's suffering." (P8)

On an interpretative/pragmatic level of analysis (coming out of brackets) a conceptual map was produced that relates the different categories to one another (Fig. 1). FGM is not only a negative experience in the moment that it occurs but also has long-lasting effects throughout the survivor's life. These have both a physical and psychological impact that deprive the survivors of their right to a fully exercise their sexuality in the broadest of terms, including the right to enjoy it. FGM is therefore a way of controlling women's sexuality. However, the consequences not only affect their sexual health but also their reproductive health, as they pose a high risk during birth. The survivors are therefore deprived of the chance to have a normal or low-risk birth. All of this justifies the survivors' consideration of surgical genital reconstruction. However, the road to making that decision is torturous and full of fear, uncertainty and insecurity. These feelings arise due to a lack of information and because the survivors recall the traumatic FGM experience. Those who underwent the genital reconstruction process perceive that on a physical level they have recuperated what they lost, allowing them to regain their self-esteem, self-confidence and quality of sexual life. They feel happy to have been reconstructed and they do not hesitate to recommend the surgery and fully support other women who might be doubtful.

Discussion

The objective of this study was to understand the experiences of the consequences of female genital mutilation in sub-Saharan female survivors living in Spain. By adopting an approach based on Merleau Ponty's phenomenology, it has allowed us to have an un-

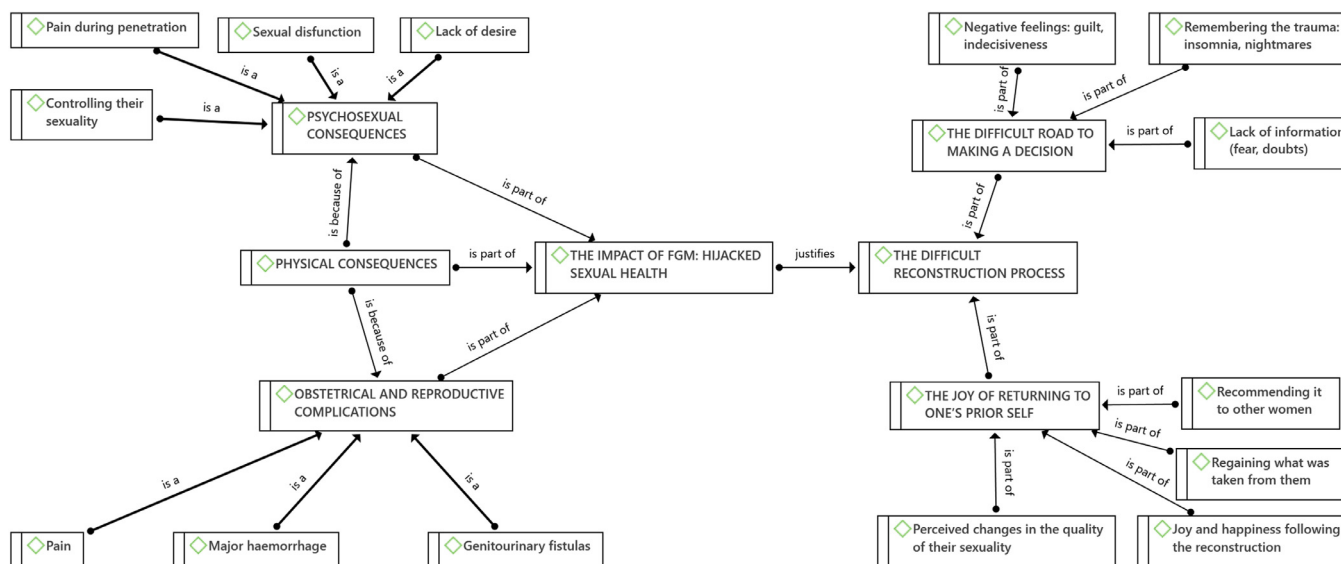


Fig. 1. Conceptual map.

Understanding of a complex phenomenon from the perspective of the women who experience it. This is relevant in a phenomenon that demonstrates how it is impossible to separate the body from conscience (Merleau-Ponty, 2013). We access the world through our bodies (Merleau-Ponty, 2013), and the experiences of the consequences of FGM that the participants described, were interpreted from the perspective of the inseparability of *body* and *being* in the world of the women interviewed.

FGM violates, assaults and abuses the human rights of sub-Saharan women (Varol et al., 2015). FGM had negative sequelae on the sexual function of our participants, who reported decreased sexual desire, difficulty reaching orgasm, pain during penetration, difficulty with lubrication, embarrassment about external genitalia, problems maintaining a relationship or faking orgasm. Similar results were found in several recent studies (Pastor-Bravo et al., 2018; Payne et al., 2019; Zoorob et al., 2019). There are studies that corroborate our results about the impact of FGM on a woman's mental health such as nightmares, depression, lack of confidence in themselves or traumatic memories (Pastor-Bravo et al., 2018; Willig & Rogers, 2017). The participants reported that psychological disturbances were frequent and lifelong, as well as the need for psychological care and sometimes medication for depression. Byrne (2014) highlights that the women never forget their pain, and some refer to flashbacks that cause extreme anxiety. As our informants said, FGM has no positive impact whatsoever on a woman's physical and sexual health. Therefore, FGM is purely culturally accepted torture (Abdalla & Galea, 2019; Zoorob et al., 2019). The participants of our study expressed that FGM was a taboo topic, explaining that they felt embarrassed and unable to discuss it. Our informants and some authors (Graamans et al., 2019; Geynisman-Tan et al., 2019) consider that the topic is interpreted as taboo given that it is not spoken about openly in some African communities. However, our study along with others (Grose et al., 2019; Ilo et al., 2018), indicate that the silence surrounding the topic could be due to FGM being considered a resolved issue. This interpretation is backed by the fact that very few informants could imagine any of their compatriots considering circumcising their daughters (Jordal et al., 2019; Kandala et al., 2018). According to our results, FGM has long-lasting effects on the sexual and reproductive health of women. Our participants told us about the obstetric complications they experienced as a result of FGM, including increased length of labour, increased caesarean sections, increased hospital stays and increased risk of

maternal and perinatal morbidity and mortality. The participants spoke of other gynaecological complications such as reduced elasticity in perineal tissue and scarring following FGM/C, resulting in chronic pain and stiffness in the genital area. Previous studies coincide with our results and also highlight that women who have undergone FGM have a higher risk of suffering complications during labour, especially the increased risk of prolonged labour, perineal tearing, pelvic floor problems, instrumentalised births, obstetric haemorrhaging and having a caesarean (Binkova et al., 2021; Lurie et al., 2020; Zoorob et al., 2019). Furthermore, type III FGM (infibulation) poses a higher risk of maternal and infant mortality (Pastor-Bravo et al., 2018; Payne et al., 2019). Another study identifies problems related to the pregnancies and labour of women who have undergone FGM (Ballesteros et al., 2014). In our study, the participants referred to the possibility of haemorrhaging and tearing during labour and postpartum. However, in the study carried out by Andro et al., (2014) there is no difference in terms of haemorrhaging, but tearing during labour was more frequent amongst women who have undergone FGM.

According to our participants, the reconstruction process was difficult and complex. This situation reminded them of past experiences as well as the stress, suffering, insomnia and other negative consequences associated with FGM. The participants felt unsure and that they lacked information about reconstructive surgery from healthcare professionals, which is demonstrated in other studies (Abdulcadir et al., 2015a; Pastor-Bravo et al., 2018). Our results indicated that the reconstructed participants felt content about recovering their former selves. Furthermore, they felt that they could make decisions regarding their sexuality, which made them happy. The participants in our study perceived positive changes in their sex lives after reconstruction, indicating satisfaction in regaining sexual desire and pleasure. In addition, they did not hesitate to recommend reconstruction to women who were considering undergoing the procedure. There is scientific evidence that there are various benefits of reconstruction such as an improvement in sexual function, a decrease in pain, a more visible and accessible clitoris, and an improvement in gender identity and body image (Abdulcadir et al., 2015b; Sharif Mohamed et al., 2020). In a study carried out by Abdulcadir et al. (2017), of the six women who underwent clitoral reconstruction, three wanted to have the surgery to improve pain and sexual function. However, little is known about whether the women are satisfied with the surgery (Berg et al., 2017). Our study concurs with Vital et al. (2016) in

how it would be useful to carry out prospective studies that use validated questionnaires to evaluate self-esteem, quality of life, depression and body image after clitoral reconstruction surgery on women who had experienced FGM. Furthermore, we believe that, in line with the research of Sigurjonsson & Jordal (2018), long-term monitoring of the results of post-operative morbidities and the potential benefits would allow for reconstructive treatment on women with FGM to evolve, given that it is currently growing at a very slow rate.

Strengths and Limitations

Our results corroborate and extend previous studies on FGM. The characteristics of the participants are diverse in terms of age, religion, country of origin, age when FGM was undergone, and lived experiences, which ensured the variability of the participants' responses. One of the strengths of this study is that it brings together the perceptions about the aftermath of FGM and how women try to cope with the consequences through reconstruction. Some limitations of the study are related to the sample selection. Some of the participants were selected within the framework of a participatory action research project between a university and an NGO (Doctors of the World) that actively challenges FGM. This could have contributed to the participants being particularly against this practice, thus deterring the participation of women who completely accept FGM. All of the participants are survivors living in Spain, where this practice is condemned. If participants who had not left their original context had been included in the study, the results could have differed. Future research should be carried out in different geographical areas to gain a deeper understanding of the issue. Other limitations are related to data collection. The researcher (of African origin) who carried out the interviews in languages or dialects that the women spoke facilitated the communicative process. However, some women may not have shared their most intimate and painful experiences because he was a man. The other interviewer was a woman, which facilitated communication of these experiences, but the interviews were carried out in Spanish, which could have created a linguistic barrier in some cases.

Conclusions

FGM had a significant negative impact on the survivors on a sexual, psychological and obstetric level. Genital reconstruction was a difficult decision for the women who had undergone FGM, but the participants affirmed that they were able to recover their former selves, highlighting the positive changes they experienced. There are support networks that help women with FGM to answer any initial queries prior to the reconstruction process. The results allow for an understanding of these women's experiences and the possibility to create protocols to help them. In turn, they would have an influence in their communities by providing information about the risks of FGM. Women at risk of FGM must have all of the necessary information in order to make their own decision as to whether or not to undergo this practice.

Ethical approval

Ethical approval was obtained from the ethics and research committee of Nursing Physiotherapy and Medicine Department, University of Almeria (EFM-03/20).

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Authorship

V.R.-S.: Data collection and formal analysis, writing; M.I.V.-M.: Writing, data analysis. O.B.-K.: data collection and analysis, supervision; J.M.H.-P.: Conceptualization, editing, supervision. C.F.-S. editing, data analysis, supervision. J.G.M.: Conceptualization, editing, supervision. W.M.-G.: editing, supervision. J.G.-G.: Data analysis, writing. All authors have read and agreed to the published version of the manuscript.

Declaration of Competing Interest

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

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Supplementary materials

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