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Integrating Female Genital Mutilation Abandonment into Routine Healthcare Facility Processes - Experiences of Stopcut trained Healthcare Workers in Southwestern Nigeria

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Abstract

Background

Medicalization of female genital mutilation (FGM) poses a substantial barrier to eradication efforts by legitimizing the practice and undermining the achievement of Sustainable Development Goals (SDGs) 3 and 5. This study investigates the impact of FGM-specific training on healthcare workers (HCW) knowledge, skills, and practices. Specifically, it explores how training enables healthcare workers develop and use innovative strategies to deliver accurate FGM related information and care to clients in healthcare facilities and within the communities as well as support its prevention.

Methods

We conducted focus group discussions (FGDs) with healthcare workers (HCW) trained during the 5-year United Nations Population Fund sponsored female genital mutilation (FGM) “Stopcut” project in Oyo State, southwest Nigeria. The participants included doctors, nurses, community health officers and community health extension workers drawn from healthcare facilities in 5 local government areas. Semi-structured interview questions explored the benefits of training and how it impacted their ability to deliver FGM-related prevention and care activities. We carried out thematic analysis using NVivo 11 Pro software for qualitative data analysis.

Results

Among the Stopcut-trained HCW interviewed, there were 3 doctors, 2 nurses, 6 community health officers and 11 community health extension workers. Three themes emerged from the analysis. The first theme showed how HCW act as catalysts for change in FGM abandonment. The second theme relates to HCW perceptions of challenges, including threats and weaknesses faced by the 'Stopcut' project. The third theme presents recommendations for enhancing HCW and health facilities involvement in efforts to abandon FGM.

Conclusion

Training of HCW proved highly effective in not only enhancing their knowledge but also motivating them to implement innovative strategies, such as developing community outreach programmes. As a result, HCWs demonstrated increased confidence in managing FGM cases, provided more empathetic counselling, and adopted evidence-based practices, which contributed to higher patient satisfaction. Nonetheless, HCW identified threats and weaknesses that hindered effective programming while providing recommendations to strengthen FGM prevention efforts and ensure the delivery of quality, inclusive services.

INTRODUCTION

Globally, Nigeria ranks 127th out of 139 countries, according to the World Economic Forum's Gender Equality Index, which measures disparities in health, education, and economic participation[1]. In 2022, Nigeria's index score was 47.4, showing a slight improvement from its 2015 score of 45.9[1]. This stagnation highlights persistent barriers to progress despite ongoing interventions. Furthermore, significant gender inequality persists across Nigeria’s six geopolitical regions, particularly in education, health, and income-earning opportunities[2].

The United Nations Development Programme’s Gender Inequality Index (GII) gave Nigeria a score of 0.560, placing the country 164th out of 193 nations globally in 2023[3]. The ranking underscores the scale and urgency of gender-based disparities nationwide. When it comes to female genital mutilation (FGM), Nigeria has the third highest prevalence worldwide[4].

According to the Nigeria Demographic and Health Survey (NDHS) 2018[4], 31% of women and girls aged 15–49 had experienced physical abuse, while 9% had suffered sexual violence. These figures highlight the widespread nature of gender-based violence (GBV) in the country. Harmful traditional practices remain prevalent as well: the NDHS 2018 found that 20% of women had undergone FGM, and 43% married before the age of 18. FGM and child marriage are major forms of GBV, undermining efforts by both the national government and international partners to empower women and girls and achieve the Sustainable Development Goals (SDGs) 3 (good health and well-being) and 5 (gender equality)[5–7].

The 2016 Multiple Indicator Cluster Survey (MICS)[8], conducted by UNICEF, reported a national FGM prevalence of 25%, with certain regions showing even higher rates—for example, Oyo State recorded a prevalence of 65.6%[8]. The continued perpetuation of gender-based violence and harmful practices like FGM demonstrates the ongoing challenges facing efforts to promote gender equality and protect the rights of women and girls in Nigeria.

Gender-based violence (GBV) and harmful traditional practices (HTPs) cut across all socioeconomic groups in Nigeria, exhibiting variations influenced by the country's diverse geopolitical zones, as well as cultural and religious affiliations. The entrenched nature of GBV and HTPs in Nigeria

is further exacerbated by high rates of illiteracy and poverty among women and girls, both of which are closely linked to deeply rooted socio-cultural beliefs and practices[9–11].

Approval and prevalence of female genital mutilation (FGM) remain notably high among the Yoruba-speaking ethnic group, predominantly located in the southwestern region of Nigeria. According to the 2013 Nigeria Demographic and Health Survey (NDHS)—a nationally representative household survey that collects data on health and demographic indicators—the estimated FGM prevalence among Yoruba women was 54%, with the broader southwestern region reporting a prevalence of 47% (NDHS 2013)[12]. These figures reflect both regional and ethnic patterns, as the NDHS defines prevalence based on the proportion of women aged 15–49 years who have undergone FGM. At the national level, trends show a slight improvement over time. The 2018 NDHS reported a decrease in national FGM prevalence among women aged 15–49 years, dropping from 25% in 2013 to 20% in 2018. These figures are based on direct interviews and self-reported experiences, allowing for comparison across timeframes and regions (NDHS 2013, NDHS 2018)[5].

Persistently, intergenerational transmission of FGM continues to sustain the practice across generations[13]. An analysis of the differences in FGM prevalence between mothers and their daughters in six southwestern states revealed that Oyo State exhibited the highest rates: 88% among daughters and 91% among mothers. These percentages were derived from survey data targeting women and girls within households, indicating the extent to which FGM is passed from one generation to the next. When compared to a similar study conducted in Oyo State a decade earlier, there was a modest decline in prevalence among sampled women—from 96.8% in 2000 to 89.5% in more recent assessments[14,15]. This gradual reduction suggests some progress, although prevalence remains alarmingly high.

Turning to the issue of medicalization, recent evidence points to the increasing involvement of trained healthcare workers, particularly community health extension workers, in the practice of FGM within communities[16,17]. This medicalization is concerning because it may lend a false sense of legitimacy or safety to the procedure, despite its well-documented harms. The participation of healthcare professionals not only raises serious ethical questions regarding the violation of medical codes of conduct but also poses significant public health risks by perpetuating a practice that undermines women's rights and well-being. Addressing medicalization is therefore critical to advancing both ethical standards in healthcare and broader FGM prevention efforts[18.19].

Building on this foundation, UNFPA partnered with UNICEF to accelerate the abandonment of female genital mutilation/cutting (FGM/C)—a practice involving the partial or total removal of female genitalia for non-medical reasons—in Oyo, Ekiti, Imo, Osun, and Ebonyi States beginning in 2014[20]. In 2018, UNFPA further secured funding from Global Affairs Canada, the Canadian government's department responsible for foreign affairs, to build upon progress made by addressing gaps in tackling GBV and harmful traditional practices in Nigeria.

In alignment with these commitments, the project in Oyo State specifically aimed to reduce the prevalence of GBV and FGM/C while providing treatment and care for affected women and girls. The objectives of this project closely reflect the vision of the National Policy and Action Plan for Accelerating the Abandonment of FGM/C in Nigeria (2021–2025)[21] and are consistent with the Sustainable Development Goals (SDGs) commitment to "leaving no one behind".

Female genital mutilation (FGM) remains a significant public health concern in many regions, necessitating targeted interventions like the UNFPA-funded 'Stopcut' project. This paper explores the contribution of training conducted by this project to the knowledge and skills of healthcare workers (HCWs) in providing age and culturally appropriate FGM services and information. It also examines challenges to service provision and offers recommendations for greater effectiveness.

METHODS

Oyo state is one of the 36 states in Nigeria located in the South-West geopolitical zone of the country and predominantly inhabited by the Yoruba ethnic group. It shares boundaries with the following states: Kwara state (north); Ogun states (south and west); Osun state (east). It also has an international boundary with republic of Benin. The population of the state reputably enjoys a close bond with its ancestry and cultural tradition through the process of cultural transfer. With a land mass of 28,454 square kilometres and according to the UN, an estimated population of 5.5 million in 2023.[22] Oyo State has 33 Local Governments Areas (LGA) and 29 Local Council Development Areas (LCDA).[23]

The philosophical assumption for this qualitative research is based on the ontology and epistemology of a case study methodology. Case study of UNFPA "Stopcut" project LGA's in Oyo state. The study population was trained healthcare workers working in public health facilities in the following LGAs: Kajola, Oyo West; Ibadan North; Ogbomoso South; and Ibarapa North in Oyo state. The Healthcare workers were recruited from the five project LGAs, three FGDs were carried out with the following trained personnels (3 Doctors: 2 Nurses; 6 CHOs and 11 Community Health Workers). The data collection tool is a focus group discussion guide (FGD guide) specifically developed for the study consisting of open-ended questions to capture information to answer the objectives of the study (Supplementary file 1). Ethical approval was obtained from the Lagos University Teaching Hospital Health Research and Ethics (HREC). Interviews were audio taped with consent from the participants. Approval was also obtained from the implementing organizations and PHC coordinators in Oyo state. Participation was voluntary and written informed consent was obtained from all the participants. They were assured of the highest level of confidentiality regarding information given through appropriate data storage and protection.

The audio recordings were transcribed verbatim. An inductive approach was deployed in data analysis. The transcripts were coded and analyzed thematically using Braun and Clarke's procedure for thematic analysis: becoming familiar with the data; generating initial codes, condensing codes into categories; identifying emerging sub-themes; reviewing themes; defining and naming themes; and adding the corresponding verbatim prose.[24] Nvivo 10 (QRS International, Memphis, TN, USA) software was used for data management.

Results

Sociodemographic description of participants

Table 1
Sociodemographic characteristics of the healthcare workers

Code	Gender	Age	Category
P1	M	54	Doctor
P2	M	56	Doctor
P3	M	58	Doctor
P4	F	59	Nurse
P5	F	42	CHO
P6	F	40	CHO
P7	F	47	CHO
P8	F	50	Nurse
P9	F	56	CHO
P10	F	51	CHEW
P11	F	48	CHEW
P12	F	40	CHO
P13	F	43	SCHEW
P14	M	44	CHO
P15	F	43	CHEW
P16	M	47	CHEW
P17	F	49	CHEW
P18	F	45	CHEW
P19	F	38	CHEW
P20	F	45	CHEW
P21	F	40	CHEW
P22	F	43	CHEW

Theme 1: The healthcare worker as the catalyst for achieving desired outcomes

HCW reported that the training strengthened their capacity for effective service provision, they also acquired scientific and medical information regarding the extent of the problem (FGM) in the country. They obtained information regarding the types of FGM, physical complications that are directly or indirectly related to the procedure (immediate & long term) and how to handle them, including the social consequences survivors may develop (mental/emotional/psychological). Other topics at the training included: The law and the legal implications of FGM for supporters, cutters and everybody involved; the process of reporting offenders; socio-cultural factors promoting FGM (myths, misconceptions, belief that FGM prevents promiscuity); financial gains as a motive for FGM (cutting as a vocation, medicalization of cutting provides extra source of income for HCW); how to seek for help and sources of help for women affected.

One very important topic we were taught is the medicalization of female genital mutilation, they believe that health workers can do it better, neater and there won't be any complications which makes health workers to get themselves involved in doing female genital mutilation. But with the new training we found out that there is no reason for touching any female genitals except for therapeutic reason and health workers were discouraged from getting

themselves engaged in female genital mutilation. The other one is the financial gain in doing it, if you get to the health centers there is a different price if you circumcise a boy or a girl. (Dr, Male)

Number one, this training helps me so much because before I don't know the advantage and disadvantage that is in this that this FGM cause but since the day I learn about this FGM I know that this female genital mutilation is not we should not continue to be doing it and we are...we disseminate it to within our communities that they should stop doing this female mutilation activities. (Nurse, Female)

….. while we have been trained on female genital mutilation the area of interest to me is the medicalization of FGM which is telling us and make me know that as a health worker at any point in time we should not be involved in female genital mutilation and during our training as a professional healthcare worker none were trained on female genital mutilation so that gives me an impetus that we should disengage from the female genital mutilation/cutting……. (CHO, Female)

HCW reported that the training improved their history taking technique, allowed them to develop a high index of suspicion for possible symptoms of complications when clerking and inculcating routine examination for female genital cutting in pelvic examinations. This they considered important because the topic was not really addressed in the medical and nursing curriculum most of the healthcare workers were taught. Trained HCW reported feeling confident about their ability to convince women to do the needful with respect to FGM because of the communication skills they acquired. On a personal level, the improved knowledge and understanding of the subject matter allowed HCW the opportunity of self-discovery with regards to their/spouse FGM status.

During the training, we were able to acquire skill of effective counselling, you know, which is applied to parent, new parents who just had their children and they are contemplating on going for FGM. You know, it also afforded us the skill to counsel a survivor who is feeling really very terrible about having been mutilated and how she thinks she can cope with the rest of her life. it also helped our clinical history taking, you know that training exposed us to detailed questions that we need to ask the patient on how to report and how to record everything that we got unlike before where we just do it hazy but this one is now more detailed when you are handling such cases (Dr, Male)

The training really added to my knowledge so much because ehmm through the training I was able to know the implications of Female Genital Mutilation and all those complications that are associated with it. The short term hmmm complications of bleeding, pain, hmmm, infections. The long-term complications are problems of ehh dyspareunia, loss of libido, and erectile dysfunction. Problems like infertility and some of them. So all this you know really added to my knowledge in my day-to-day practice such that whenever I am taking the history of infertility or a woman handling any woman in practice. At least my mind will always be on it, particularly when I come across cases of erectile dysfunction or problems of loss of libido in women. (Dr, Male)

The skill I acquired during the training of FGM that when we are doing our immunization session so we will be able to examine the children to be able to know that private part that they are not mutilated so that be able to tell the nursing mother the importance of FGM and they must put an end to it then during our antenatal care also there I was be able to train the nursing and pregnant woman the importance of the FGM the disadvantages their children will derive from it so they are able to put something in there mind so they have in their mind that if the baby they want to deliver is a female or a girl they will not mutilate that baby and they will be able to put an end to FGM. (Female, CHO)

At the FGM training one of our senior female colleagues suddenly exclaimed "aahhh no wonder so this is what happened to me" every time her husband says let's have sex, she will start crying because of the pain associated with the act. See how long it has taken for her to discover that her pain is a consequence of what they did to her when she was small. (Female, CHEW)

At the training, a male participant also expressed regret about the way he had been treating his wife. He also asked God to forgive him. He didn't know that his wife was circumcised and that is why she is averse to having sex which usually annoys him and causes conflict. (Female, CHEW)

HCW left the training with a renewed commitment to achieve an end to FGM (positive attitude to end the practice). Participants who attended the training expressed the opinion that HCW were sometimes described as complacent in the inability to stop FGM however, the fact is that they have spoken about it on so many occasions, but the populace have refused to listen to them hence they became discouraged. The training therefore afforded them an opportunity to self-reflect and re-examine their attitude towards ending FGM, allowing them to align with the recommitment to action declared by the state. HCW reported leaving the training highly determined and motivated to embrace good practice with regards to desisting from medicalization/deceiving the mothers that they perform it since it has not worked; and developed a work plan of action that embraces health facility and community level activities.

According to HCW, the training made them realize that they have multiple roles to play depending on the circumstances ranging from preventive, routine care, emergency care, rehabilitation, social work, investigative/fact finding. Based on this, they disclosed that on getting back to their facilities, various healthcare professionals were assigned specific roles as well as cross cutting tasks depending on their competency on the end FGM project. They disclosed that they transformed the FGM related services delivered at the health facilities by carrying out the following: Anyone accessing the health facility including patients coming to the out-patient-department for malaria treatment receives routine information about FGM. During the health talk, delivered at Immunization clinics, FP clinics, ANC and delivery/postnatal services the healthcare workers provides relevant information on the consequences, side effects and complications that may arise following circumcision for the child; and the woman during future

childbirth (excessive bleeding that occur during delivery, extensive tear due to scarring of the perineum), inability to have a healthy sexual relationship (loss of libido which causes problems in marriages and can lead to divorce). HCW divulged that the women attending the clinics mentioned above were furnished with this information every week during several sessions. As a result of this "just in time' sessions some children were saved from the cutters because their mothers heard the information when they were trying to make the decision of taking the children to the cutters and changed their minds.

I learnt a lot and it gives me boldness to stand on my feet to inform mothers during antenatal or during immunization the do's and don'ts about FGM, it widened my own knowledge, and it gave me opportunity to inform them even in church I used to.... Whenever we have health talks in church it motivates me to inform my church members. (CHEW, Female)

we are able to inform anyone that have contact with us at our facility …… it's a continuous process ……. it's like an eye-opener as we talk to them ……. as a result there is a positive change in the lives of people but some people are still adamant some people say I will not allow anybody to know I'll just go and do it but we try to let them know that it is wrong we tell them the dangers the implications of the people that have done it in the past. (CHEW, Female)

HCW claimed that the repetitive nature of giving the information ensures that the women assimilate the information resulting in retention and improved knowledge. For greater impact, the healthcare workers stated that they used practical examples to buttress the point to the clients eg in a particular instance, the case of two females who came for delivery (one a survivor and the second one uncircumcised) and the subsequent events that played out. HCW revealed that irrespective of the status of every woman that visits the facility (client/patient/carerer/guardian/visitor), they benefitted equally from the FGM health-related information/counseling. Apart from the health education sessions for all clients, the healthcare workers claimed that they also conducted training workshops specifically for survivors. The information given to the women at the health facilities was delivered in a non-judgmental and open manner which encouraged survivors who had already circumcised their own daughters to desist from harming subsequent offspring. The survivors opined that it gave them hope that it is not too late they could still make a difference, Subsequently the lives of the women were transformed leading to change in behavior while some of women subsequently became champions for change.

HCW reported that they interact with people with diverse opinions (supporters, indifferent to opposers) about FGM ranging from mothers who come on their own, mothers accompanied by their husbands/mother in laws (influencers). The dynamics of such interactions extend from one-to-one at individual level sometimes to interpersonal and group activities. Beyond health education, interaction with mothers provided an opportunity to also increase awareness about the law and penalty attached to it which otherwise a lot of people would have remained in ignorant of. For one of the clients accessing services at the FP clinic, it was the legal implication and the severity of the law mentioned rather than the health-related consequences that really brought it home to her that it is not good practice. Inviting spouses & husbands for counselling provides additional arsenal for resilience to the women and ability for power to change hands from older women (mother in laws) to the young mothers with regards to making decisions regarding FGM. Inspection of the vulva during ANC ensures that survivors are identified (complication readiness) informed and prepared for possible complications as well as future rehabilitative efforts (socio-medical).

As reported by the HCW, their scope of activities within the facilities following the training expanded to include the following: Health education - Routine access to information for clients and patients; Routine inspection of female genitalia during weighing at IWC and ANC; Preventive counselling; Targeted therapeutic counselling; Treatment of complications; Referral services to 2nd or 3rd tier of health facilities; Conflict resolution; mHealth – Telephone numbers to call for information/rescue; Data collation; Witness for prosecution team in the court of law; Building community resilience; Community sensitization and policing; and Experience sharing of actual complications seen in health facilities.

Theme 2 - Challenges (Threat and Weakness) to the "No Cutting" project

HCW identified the following as threat to the successful implementation of the program aimed at ending FGM in the state: They disclosed that FGM related legal information was not routinely disseminated to clients/patients in all health facilities in the state and secondly, most health services were not directly linked to laws/law enforcement hence networking and referrals was untidy. They believed social acceptability of discussing issues relating to sex/FGM is poor making majority of women shy and uncomfortable to discuss the topic and open. This opinion was expressed within the context of FGM being considered a private issue and individuals having rights they exercise in making decisions especially on issues considered personal and private. HCW noted that within the community, some people have very strong convictions regarding the effectiveness of FGM in curbing female promiscuity including lesbianism. They claimed that myths and misconceptions drive the demand side for FGM and prevents the supply side from drying up.

HCW identified the following as weaknesses in the design and implementation of the end FGM project in Oyo state. Facility-based project activities were reliant on RI clinics, they explained that once a child is 5years old, she stops coming to RI clinics and is lost to follow up and currently there are no plans to roll them over into another program that keeps a close check on them and serves as a constant reminder to the mothers and guardians that HCW are still keeping tabs on the FGM status of the child (reinforcing the message). Secondly, they noticed that practitioners in private medical/nursing practice are not involved in activities targeted at discouraging medicalization of FGM. They opined that Criminalizing a social problem like FGM can be problematic such laws can make the practice more hidden. They gave the example of the law criminalizing HIV transmission which is gradually being repelled by most of the countries that instituted it. They observed that their colleagues who had not been trained lacked the capacity and willingness (skills, training, knowledge, readiness) to approach women on FGM issues most especially vulva

examination of adult women. HCW observed that integrating FGM into ANC/RI programs makes it an all-or-none affair. They belief that women who circumcise their babies will run away from the other services to avoid exposure especially because of the criminalizing law. In addition, they revealed that clinics are usually very busy and to ensure that they are attended on time, most mothers come very early without breakfast. These mothers spend a long time waiting to be attended to and by the time the child is attended to, they are usually in a hurry to leave limiting their participation in FGM activities. Lastly HCW disclosed that they suffer from inadequate staffing resulting in heavy workload leading to lost opportunities to engage mothers. Instead of having full discussion followed by question & answer sessions, HCW do mention the subject of FGM within the context of other issues without laying specific emphasis on it or allowing for private conversations with the women to enable them to feel free to open up.

All of us were to talk against FGM and after all the seminar, the woman tapped me and said oga you know what! This one that I have come to do here is just official. Thank God I don't have a female child and if I have, you know my mother did it for me and I will do it for my girl. So I had to counsel her again because that means she will do it for the grandchildren too. She was like I should say whatever I want to say, since they did it to me, I must do it to my children or grandchildren. (Male, Doctor)

Then ehmm under that legal implication, we were told during the training like I said that the law is there in place, but it is so unfortunate we have not actually seen that law been effective in the country. We have not really seen any individual that is actually been pinned down and shamed you understand and that is hampering ehmm the effectiveness of that law. So, until we see a culprit that is you know nailed and shamed, then people will start to take a queue. (Male, Doctor)

I also had contact with the chairman of the circumcisionist in Oyo state, he was also invited to come and talk about female genital mutilation and since it has financial gain. The man said they are ready to stop it and in fact they have stopped but then that is a business that they have stopped. In what way is the government ready to build their capacity for other sources of income but they will stop and they are no more arguing about that again. (Male, doctor)

Theme 3 – Recommendations for optimizing HCW involvement in FGM abandonment

HCW believed the program/subsequent programs could achieve a lot more if some of the following recommendations were taken into consideration in the design and implementation:

- Adequate staffing of health facilities to ensure that adequate attention is devoted to addressing the issue of FGM with mothers. They believed quality preventive care can only be achieved via having access to HCW who spends quality time interacting with clients because FGM is a private matter that requires client centered approach.
- For effective information dissemination they believe that it is important to explain the consequences of FGM; discuss using survivor experiences; use real life scenarios that the women can relate to (e.g. a tribe that circumcises vs those that do not; a man with 2 wives circumcised and uncircumcised)
- They noted that peer to peer policing by HCW is required to end medicalization of FGM and that HCW needs to conduct supportive supervision to community structures for collecting quality data for decision making and at the same time provide feedback to the community
- Training of private and untrained public HCW as well as retraining/on the job training was considered vital. They noted that private health facilities employ and train auxiliary healthcare workers. The public cannot differentiate between an auxiliary nurse and government trained/certified HCW because they wear similar uniforms. Moreover, anecdotal evidence exists that the auxiliary nurses are still conducting FGM within the community, mothers therefore get offended when HCW in government health facilities advise them against FGM claiming it's their colleagues that do it for them.
- They claimed that initiating well woman clinics in PHCs will give women access to routine vaginal examination which will open up access to a combination of preventive care and social rehabilitation, an informal low-cost solution, beneficial to the society and program managers. It will at the same time improve identification of survivors and generate quality data for decision making and monitoring of progress. HCW belief that this will be the ideal setting to provide services not generally provided/readily available in a curative setting e.g., Group therapy – peer to peer solution, Specific counselling for sex.
- HCW opined that FGM is first and foremost a social problem requiring a multisectoral approach and that expanding the scope of stakeholders will ensure that as many people as possible are caught in the net of FGM prevention/management/rehabilitation. They belief that repetitive continuous action is required while talking alone is not enough to end FGM. They suggested that the health sector should work hand in hand with the education sector to upgrade school curriculum (JSS & SSS) and train the teachers on FGM. This belief is the missing link for sustainability. Other relevant sectors/groups considered for inclusion by the HCW are the traditional leaders; artisan groups & other professional groups – they also noted that these groups have a high proportion of young adults who are young parents & future parents.

I think what we have done we may just have to repeat them and that is continual sensitization, continual supportive supervision to make sure that people don't revert to what they said they are no longer doing. So, I think that is what we may have to continue doing for a very long time. So that is what I think we are yet to do, we must continue doing what we are doing that brought it low and if we sustain it then we will believe that it can be finally eradicated. (Male, Doctor)

The posters are necessary, apart from those posters they can do the training because we still have some health workers that've not been trained to do the training for those people then to the private facilities, they can do the training for the private hospitals too so they'll be able to have the knowledge. (Female, Nurse)

Inculcate this FGM into school curriculum so that we will inform those children in school curriculum ok, because I want the...this people to understand to know the implications when I know something will implicate me I will not do when my children even know that this is something that can give them problem in future I believe they will not do it so I just want them to do more this program supposed to go for teachers too, do you understand not teacher that are doing that particular subject but every teacher so that when I'm doing it wherever I am, you are doing it wherever you are doing it. (Female, Nurse)

Discussion

The HCW in this study were not medical specialists such as obstetricians, gynecologists, or pediatricians. Instead, they included doctors working at general hospitals, nurses, and community health workers based at primary healthcarecare facilities. As a result, their exposure to detailed training on FGM was limited, making it unsurprising that they found the training beneficial, impactful and reported a desire for more knowledge and training to improve their competence and skills.

HCW faces challenges regarding FGM, which includes gaps in knowledge, inadequate training, and prevailing cultural norms which support FGM. A systematic review conducted in several FGM-prevalent countries, including Nigeria, identified poor knowledge of FGM-related issues—such as the four types and relevant legislation—as a limitation to HCW ability to provide appropriate clinical care to survivors.[25] Also several local studies have demonstrated low awareness and knowledge of the long term health related complications and side effects of FGM among HCW this includes keloids formation; prolonged childbirth; perinatal risks; excessive perineal laceration during delivery and need for surgeries.[26–28] Most importantly having HCW with unknown FGM status as revealed by our study identifies a gap in the training curriculum of the heath workforce and the ignorance around this issue within healthcare facilities a deterrence to ending the practice.

HCW often receive little or no formal training on female genital mutilation (FGM). This lack of training leaves many providers feeling unprepared to deliver high-quality, culturally competent care to survivors. As a result, they may turn to alternative sources of information, including social media. A 2020 study analyzing social media metatext data identified Twitter as a key platform where individuals both seek and share health information—and misinformation—about FGM[29]. Studies have demonstrated that targeted training programs improve knowledge, communication skills, and reduce support for FGM among healthcare providers [30]. For example, a cluster randomised trial of a health system strengthening approach that applied person-centered communication for the prevention of FGM in three African countries, published in 2024, found that participants initially had low knowledge of FGM typology and were mostly familiar only with common local types. However, following the intervention, HCPs in the intervention arm reported significantly greater confidence in their FGM-related knowledge and communication skills, and expressed less support for practice [28].

The FGM-specific training evaluated in this study significantly improved healthcare workers' knowledge and skills. It enabled them to provide accurate information and develop strategies for sharing this knowledge in various formats and locations with their target audiences. For example, some healthcare workers developed community workshops, created informational pamphlets in local languages, and organised support groups for affected women. Following the training, participants reported increased confidence in discussing FGM with clients, and educational sessions held at health facilities. The Stopcut-trained healthcare workers were motivated to revisit existing approaches and devise innovative, culturally appropriate methods of providing FGM-related information and services, seamlessly integrating both prevention and rehabilitation into all available opportunities at health facilities including general outpatient.

Medicalization has been described as a threat to abandonment of FGM hence professional organizations advocate for comprehensive training of HCW (preservice and on-the-job) to improve their knowledge, clinical competence, confidence, and skills in communication and counselling[31–34]. Involvement of HCW was seen as a way of making the procedure safe (prevent infection and bleeding), modern and acceptable[35,18]. The events of the past few years have shown that it has outlived its usefulness because it fails to address the long-term consequences and the human rights violation of the procedure. However even after it was declared a violation of human rights HCW have continued to act as perpetuators in high prevalence countries like Nigeria either for financial gains, inadequate knowledge and training or because they share the same cultural norms as the community members[36,37]. These findings were corroborated by the HCW in Oyo state trained during the Stopcut project educating the masses through enlightenment campaigns has always been an effective tool to provide factual information for behaviour change however in instances where FGM is carried out by HCW, it entrench the belief that the practice is beneficial.[3] Hence medicalization is a weapon in the hands of individuals positively disposed towards FGM and can be used as a weapon for counter argument by community members and a source of conflict as reported by our study. Prevention of medicalization requires a knowledgeable health workforce. Training is paramount for enhancing prevention, detection and care for women with FGM, as high-lighted in the recent review[38] and supported by the HCW in our study who reported that untrained HCW were the ones performing FGM within the community. Training targeted at various professional categories using blended hands-on techniques, group discussions, and theoretical training with established coordination among the various cadre of HCW resulted in enhanced knowledge and skills of professionals involved in identifying and managing FGM-related complications in a 2025 study[39].

Research indicates that women who have survived FGM are more likely to have daughters who undergo circumcision and less likely to seek skilled care during childbirth[40,41]. This underscores the importance of integrating FGM prevention into a range of health services, such as family planning, general outpatient care, and immunization clinics, to reach a broader population and ensure no woman or girl is overlooked. Healthcare workers who completed targeted training emphasized that embedding FGM-related education and counseling into routine clinical activities—like prenatal visits and immunization appointments—can create valuable opportunities to discuss FGM, address misconceptions, and support informed decision-making. For example, trained providers reported success in initiating conversations with mothers who had experienced FGM, encouraging them to protect their daughters from the practice. These findings support the recommendation that comprehensive service integration is essential for accelerating the abandonment of FGM and improving health outcomes for women and girls.

Healthcare workers (HCWs) play a crucial role in efforts to abandon female genital mutilation (FGM). Engagement of HCWs in prevention activities has been poorly documented. However, without their involvement, the elimination of FGM (SDG 5.3) remains elusive[16]. Available evidence suggests that HCWs are typically less involved in FGM prevention activities in high prevalence settings[42]. Furthermore, previous studies have deduced that inadequate involvement can be attributed to poor FGM-related knowledge among HCWs[25]. This lack of knowledge was reflected in our findings, where participants reported the need to re-educate HCWs on FGM. Additionally, structural barriers within healthcare facilities further compound this issue[17]. HCWs have access to pregnant women and children, which provides valuable opportunities for counseling on FGM-related issues and concerns. This is especially important for women who have experienced FGM and have recently given birth, as counseling can help protect their daughters from undergoing the practice. Notably, the strongest predictor of a child undergoing FGM is the mother who has experienced FGM herself [5]. Consequently, knowledge gaps among HCWs working in primary healthcare centers and community health workers, lack of referral pathways, and inability to identify resources and engage in client-centered activities hinder the ability to maximize opportunities during routine service delivery. Addressing these gaps through targeted education and structural improvements can significantly enhance FGM prevention efforts.

Conclusion

This paper specifically evaluates an FGM related training for various cadres of healthcare workers conducted under the United Nations supported Stop Cut project in high burden communities in southwest Nigeria (Oyo state). The training was effective with regards to capacity building, skills acquisition, attitudinal change and change in practice. Based on the recommendations of HCW, we conclude that a multidisciplinary and multisectoral approach to tackling FGM will be most beneficial while HCW has largely been involved in a response capacity, the scope of activities should be expanded to incorporate all healthcare facility level activities designed by HCW and carried out within that space. Adapting the way HCW render services to be FGM inclusive and improving quality of FGM related services requires fixing the existing shortcomings of the health sector including adequate staffing, allocation of resources and renumeration of HCW.

Declarations

Ethics approval and consent to participate: Informed consent was obtained from all the participants. The study was conducted according to the guidelines of the Declaration of Helsinki and approved by the Health Research Ethics Committee of the Lagos University Teaching Hospital, on 24th February 2022 (ADM/DSCST/HREC/APP/4978)

Consent for publication: Not applicable.

Availability of data and materials: All data generated or analyzed during this study are included in this published article. The primary data was the original data collected by the researchers and are well presented in the results section or submitted as supplementary information. All referenced secondary data are cited in the manuscript, with links listed in the references.

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Authors' contributions: SEO and SAO conceived the study; assisted with methodology, project administration, and drafting of the manuscript. OO, BT, OMB and OBO assisted with implementation. EM, BZ and GE assisted with manuscript and project administration.

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