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Assessment of Opportunities and Expert Counselling Intervention for Persons With Female Genital Cutting in Oyo State, Nigeria

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Abstract— **Study Objective: Female genital cutting (FGC) has been identified as one of the most common harmful traditional practices that affect females' psychological well-being in Nigeria. The aim of this study was to establish the existence of psychological complications due to FGC; and the provision of opportunities and expert counselling especially for those at the adolescent stage.**

Design: The Input-Process-Outcome evaluation model and the survey research design were adopted. Purposive and simple random sampling techniques were used to select participants for the study. Two qualitative (FGC In-depth Interview and FGC Focus Group Discussion Guides) and one quantitative instrument (Female Genital Cutting Update Training Rating Scale [FGC-UDTRS]) were developed by the researchers; while a second quantitative instrument (FGC Opportunities and Expert Counselling Rating Scale [FGC-OECRS]) was adapted for collection of data from relevant respondents.

Setting: Healthcare providers were engaged in one-on-one discussions on the existence of psychological complications due to FGC, especially among females with FGC in their adolescence years; while females with FGC participated in focus group discussion sessions to express their views on FGC and psychological experiences associated with the practice. Relevant quantitative instruments were administered to both groups of participants to establish the outcome of update training on opportunities and expert counselling assessed by HCPs for the provision of psychosocial support services.

Participants: Healthcare providers and females with FGC from five (5) primary healthcare centres/maternal health centres participated in the study. These were selected from the two Local Governments Areas (LGAs) of intervention in Oyo State i.e. Ibadan North East and Lagelu LGAs.

Interventions: Intervention activities included update training on opportunities and expert counselling for HCPs; and the establishment of Maternal Health Counselling Centres (MHCCs) to facilitate psychosocial support services for females with FGC.

Main Outcome Measure(s): Narrative analysis was used to analyse qualitative instruments while quantitative instruments were analysed using Simple Linear Regression.

Results and Conclusions: Evidence from the study shows a high level of psychological complications due to FGC; these were very much associated with the practice by affected females. Effectiveness of update training for healthcare providers is evident in the high rate of psychosocial support assessed at the various maternal health centres. Hence, constant and relevant update training should be embarked on for healthcare providers, in order for appropriate psychosocial support services to be rendered to females with FGC.

Index Terms— **Intervention Programme; Female genital cutting; Psychological experience; Opportunities and expert counselling; Female adolescents; Oyo State.**

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I. INTRODUCTION

Female genital cutting (FGC) is a common traditional practice executed within and outside the shores of Nigeria [1]. The practice involves cuts ranging from slight to extensive cuttings; hence the World Health Organisation describes FGC as 'a practice which involves the partial or total removal of the female external genitaila or other injury to the female genital organs for cultural or other non-therapeutic reasons [2]. Adverse effects of the practice range from physical, physiological to psychological problems; it is therefore considered a serious public health problem in many countries in Sub-Saharan Africa as well as among immigrant communities in Europe and other industrialised countries of the world [3, 4]. FGC is associated with several post-FGC complications such as infections, impaired wound healing, menstrual problems; obstetric, sexual and reproductive health, psychological complications amongst others. These complications affect girls and women, especially those in their pre-pubertal or adolescent stages. Psychological consequence is one of the complications of FGC. Similar to other complications which ensue due to FGC, psychological complications also affects females of pre-pubertal and adolescence stages more than those who were cut as adults [5, 6]. This may be as a result of the long term nature of psychological complications, which may result in behavioural disturbances due to facilitating factors connected to the traumatising procedure of FGC [7].

Psychological complications due to FGC have been said to affect the physical health, social and sexual functions of cut females. Intrusive re-experiences, emotional stress and mental illness manifested as feelings of incompleteness, fear and helplessness, inferiority or low self-esteem, suppression of feelings and severe pain have been reported of females who experienced cutting at an older age/stage, [8, 9]; while several other studies have also inferred higher vulnerability of younger females and adolescents to such psychological complications and consequences [8, 10, 11]. As a result,

psychological experiences of cut females are sometimes characterised by anticipated pain, fear, violence, mockery, ostracizing and uncertainty of outcomes for refusal to conform to the practice. These often result in post-traumatic stress [PSTD] and affective disorders [12]; as well as low sexual quality of life [SQOL-F] [13]. While several studies on FGC have identified significant relationship between fear and sexual intercourse [14, 15, 16] and negative impact of FGC on psycho sexual processes [17, 18, 19], these have been reported to result in fear of penetration, experience of serious pain during intercourse (especially first sexual intercourse), facilitated lack of sexual satisfaction. Some others have also asserted that pain and traumatisation are connected [20] and have concluded that, to a large extent fear dictates the functionality of females with FGC [21, 22]. Hence, according to Nowak, '*The pain inflicted by FGC does not stop with the initial procedure, but often continues as an on-going torture throughout a woman's life*' [23].

In spite of reports on the harmfulness of FGC, several social and cultural benefits are associated with the practice because of its' institutionalised cultural nature. In Nigeria, especially in the South East and South West regions where FGC is predominantly practiced, FGC is considered more of a coming of age, social status (for parents and cut female) and marriageable status indicator among others [24, 25]. Hence, psychosocial experiences exist for parents, significant relatives and affected females of cut or uncut status. According to Vloeberghs et. al. [21, 22], feelings of anger, shame due FGC conditions on examination, guilt, isolation and loneliness as well as relational consequences with partners, children and home countries are expressions by cut females. This signifies cognitive dissonance [26] which manifests as conflicting belief/feeling in relation to their cut status. On the other hand, females who refuse to be cut exhibit feelings of fear because of uncertainty their decision(s) which could include ostracising, stigmatization and rejection by their communities [27, 28] among other things. Hence, ostracism as well as stigmatisation has been reported as having negative impact on the psychosocial function of uncut females thus causing psychological trauma.

Globally, increasingly high prevalence rates of FGC as well as the practice of all FGC types has been adduced to its firm roots in culture and tradition [29, 30, 31]. In Nigeria, a combination of all FGC types is practiced in the six geo-political zones of the country, with the North - East, Central, and West zones having 2.7%, 13.1%, and 12.3% prevalence respectively; and the South - West, East and South zones recording prevalence rates of 46.4%, 49.2% and 35.2% respectively [32]; prevalence rates among girls and women ages 15 – 49 years vary based on religion, education, socio-economic status and geo-political zones among other factors [32, 33, 34]. As a result of fluctuating prevalence rates as well as reports of post-FGC complications, various FGC initiatives and intervention programmes have been executed via training, formal classroom education, media communication, outreach and advocacy programmes, and informal adult education [35]; hence, most intervention activities focus on media communication, outreach and advocacy.

With psychological complications being a salient outcome of FGC [36], the need for provision of psychosocial support for females with FGC has been reiterated in several reports [12, 37, 38]. It has been inferred from several study reports that the onus of such support services inevitably falls on healthcare providers. Hence, assertions have been made on the need for updated training in the provision of psycho-social care for females with FGC, in spite of prior formal training of healthcare providers, as well as provision of routine health services [12, 36, 37, 38, 39]. Therefore, based on the implementation of the opportunities and expert counselling intervention programme in two intervention LGAs in Oyo State; and constant reiterations on the obvious need for training and update training of healthcare providers in relation to the needs of females with FGC, this study investigated (i) the categories and characteristics of healthcare providers who had access to update training and their views on the existence of psychological experiences (ii) views of female with FGC on FGC and psychological experiences associated with the practice (iii) the extent to which opportunities and access to expert counselling (psychosocial support) was provided, including follow-up and (iv) the effect of opportunities and access to expert counselling (psychosocial support) by healthcare providers for females with FGC.

II. METHODOLOGY

Setting for the Study

The study which is a survey **RESEARCH** was conducted between November and December, 2015. The intervention LGAs i.e. Ibadan North East and Lagelu LGAs are located in urban and semi-urban areas respectively, and predominantly occupied by the Yoruba ethnic group. The target population for the study comprised healthcare providers [HCPs], comprising of traditional/community birth attendants [T/CBAs], public health workers [PHEWs], community health workers [CHEWs] and nurse/midwives; and females with FGC [FW-FGC] respectively. At the first phase of selection, purposive sampling was used to select HCPs based on their status as beneficiaries of the update training activity on the intervention programme. Recruitment of FW-FGC was facilitated by HCPs and head nurses/midwives of the various maternal health centres [MHCCs] that hosted the FGD sessions. The various clinic sessions within the healthcare centres (e.g. anti-natal, post-natal, immunization etc.) was an avenue to inform females about the study; the purpose of the study was adequately expatiated on by the recruiters, using the informed consent as a guide. Hence, purposive sampling was used at the second phase of selection involving FW-FGC for the FGD sessions and responding to

the quantitative instrument. Selection of participants for this group was therefore based on proposed participants' cut status, their willingness to participate in the study; and they accessing opportunities and expert counselling services provided by the HCPs. Before the commencement of the various FGD sessions, informed consent sheets were handed to each group head (with Yoruba interpreted versions being read and provided where needed); informed consents were secured with heads of the FGD sessions signing on behalf of members of the group; while recruiters of the various FGD groups signed as witnesses.

III. Instrumentation

Two (2) categories of instruments were developed and used to collect both qualitative and quantitative data from respondents. The Qualitative instruments comprised of two guides; namely FGC In-depth Interview (FGC-IDI) and FGC Focus Group Discussion (FGC-FGD) guides; these were used for the healthcare providers (HCPs) and focus group discussants comprising females with FGC, respectively. The quantitative instruments also comprised of two (2) rating scales, namely Female Genital Cutting Update Training Rating Scale (FGC-UDTRS) and FGC Opportunities and Expert Counselling Rating Scale (FGC-OECRS); these were rated by HCPs and females with FGC respectively. Both interview guides and the FGC-OECRS instrument were developed by the researchers; while the FGC-UDTRS was adapted from the provider knowledge, attitude and practices survey questionnaire on gender-based violence [GBV] [40]. The FGC-IDI made use of a structured interview guide with open ended survey and probe questions; while FGC-FGD comprised of semi structured questions, aimed at ensuring active participation of all participants in the group discussion sessions.

Validity of the qualitative instruments were established using face validity; while Content validity, Construct validity and reliability of the quantitative instruments were established using Lawshe Content Validity Ratio (CVR) and Cronbach alpha on pilot tested instruments. Based on the judgement of experienced persons in the field of qualitative research especially in disciplines of evaluation, sociology, psychology, humanities and health, the interview guides were valid and useable. The content and reliability values for the FGC-UDTRS (0.94; 0.87) and (FGC-OECRS) (0.86; 0.80) instruments respectively indicates high validity and strong reliability of the instruments. Sections A of the quantitative instruments dealt with bio-data of respondents; while section B of both instruments required respondents rating their responses on a 4-point Likert type scale. The FGC-UDTRS consisted of 25 (twenty five) statements covering adequateness of training in five (5) areas, namely: psychological experiences; physical, social and sexual consequences; and other health related issues. Responses were rate as follows: 4 - Very well trained (VWT), 3 – Well trained (WT), 2 – Averagely trained (AT) and 1 – Not adequately trained (NAT). Section B of the FGC-OECRS comprised 22 (twenty two) items rating effectiveness of opportunities and expert counselling in four (4) areas, namely: psychological experiences, physical and psychosocial consequence; and reproductive and maternal health issues. Responses were rated as 4 - Very Effective (VE), 3 – Effective (E), 2 – In Effective (IE), and 1 – Very Ineffective (VIE).

IV. Data Collection and Analysis Procedures

The first author with 5 (five) trained interviewers conducted FGC-IDIs for 29 (twenty nine) HCPs trainees and facilitated five (5) focus group sessions comprising of fifty-two (52) FW-FGC. For the FGD sessions, participants were recruited with the help of matrons in charge of the selected primary health centres (PHCs); discussions covered views on FGC as a harmful traditional practice; at what age is its harmfulness more prominent (i.e. if the practice is considered harmful); if and what psychological detriments occur; attitude toward 'cutting' the girl-child; as well as opinion on effectiveness of opportunities and expert counselling provided by HCPs. FGD sessions lasted between two to three hours; and sessions were held within the premises of the selected PHCs. Responses for the qualitative instruments were recorded, transcribed and subjected to narrative analysis based on the contents of the interview and discussion guides. The same group administered the FGC-UDTRS and FGC-VCRS instruments to the respective respondents, and quantitative data was analysed using simple linear regression.

V. Results

Beneficiaries of Update training

A total of 29 healthcare providers comprising 7 Traditional/Community Birth Attendants; 10 Public/Community Health Workers; and 12 Nurse/midwives accessed update training for the acquisition of opportunities and expert counselling (psychosocial support) skills. Majority of the training beneficiaries were females (25) and the others male (4); and only one trainee had experience of less than 10 years working as a healthcare personnel.

Psychological Experiences and Access to Opportunities and Expert Counselling

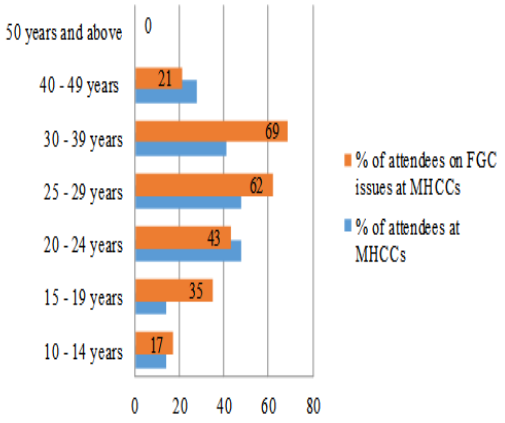

Figure 1: Rating of females attending Maternal Health Counselling Centres (MHCCs) for FGC related Issues

In confirmation of the existence of FGC as well as one-on-one consultations with female patients, majority of the training beneficiaries (18, 62%) confirmed that to a large extent, psychological complications are experienced by females with FGC. According to trainees, psychological experiences in order of importance include: fear of sex due to pain during the process of intercourse; fear of spouse having alternative sex partner or re-marrying; low sexual urge and emotional pain for not enjoying sex. Though females aged 15 to 49 years attended the maternal health centres for other various health reasons, attendance on FGC related issues by female adolescents, ages 10 to 19 years (17% to 35%), as well as females aged 40 to 49 years (23%), was low. This is in contrast to females of reproductive age i.e. 15 to 40 years (see figure 1).

Views on FGC and Psychological Experiences

Table 1: Characteristics of Focus group Discussants in relation to age, developmental stage at cut and type of cut

Age of discussants	*Frequency*	*Developmental stage when cut*	*Frequency*	*Type of cut*	*Frequency*
15 – 19	8	Infancy	32	I	22
20 – 24	5	Toddler	6	II	13
25 – 29	24	Adolescent	14	III	4
30 – 40	15	Adult	-	Don't know	13

Although a lesser concentration of adolescents (see table 1) made up the total number of discussants, from the 5 FGD sessions, they like their older counterparts were of the opinion that FGC is the most prominent and harmful traditional practice within their communities; and it affects their general well-being especially the psychological aspects of their lives, which invariably also affects their future. This view is reflected in the following excerpts as captured during the FGD sessions:

"Even though in the Yoruba culture we have several traditional practices like body and facial/tribal markings (ara finfin/san ju/ewa ara/Ila oju), these are considered as beautification and are considered as beneficial. These markings are also not relegated to only females but are carried out on both sexes; also it is not limited to the Yoruba tribe alone. But female genital cutting (Ki kola oju ara) among other traditional practices in Yoruba land is the most harmful, with no benefits whatsoever…"

In relation to maternal mortality a summary of views on FGC and its effect is as follows:

*"…rather it has caused a lot of havoc both in the personal and family life of circumcised women like us, especially during child bearing and sexual intercourse. Sexual intercourse is inevitable because just as we were born, we to must bear children; and so we have to bear the pain and sometimes also almost loose our lives and that of our unborn babies during child labour" (*Secretary of one of the FGD sessions*).*

Corroborating reports by trainees on psychological experiences, fear, pain, depression, recall of unpleasant memories and shame (embarrassment for cut status) were mentioned as psychological experiences associated with FGC. A member of one FGD session recalled as follows with tears in her eyes:

"With fear written all over me, I was bundled by two elderly women into a hut with my mother looking at me but unable to do anything. In the process of being cut, I sustained a deep cut in my genital region because of my insistent struggles and when the pain was unbearable, I fainted. I remember coming round when I wanted to urinate, and my first attempt at urinating, I ran out of our make shift convenience and kept screaming that my mother had killed me with pain. Since that day, I have lived with physical and emotional pain because sexual intercourse which is necessary in marriage is not an enjoyable experience for me; neither is child bearing because of the extensive cut I sustained."

Another FGD participant expressing her disapproval of FGC, after her personal experience says she had her first daughter and child undergo FGC and she almost lost her due to excessive blood loss.

"My daughter was just 3 years old when I took her to the Olola (local circumciser). Because of the tenderness of her genital region, she was badly cut, lost a lot of blood and went into shock. She had to be stitched and transfused with blood; I was almost imprisoned because of what I had done to my daughter. It was out of ignorance of the consequences of the practice that I took my daughter for FGC, despite the fact that I had always had problems with intercourse and birthing due to the FGC type I experienced. Anytime I remember what my daughter went through and what I must have gone through as a child when I was cut. I feel depressed, sad and sometimes angry at my mother and our culture for encouraging the practice."

Effect of opportunities and access to expert counselling (psychosocial support)

Out of the 18 trainees who attested to the presence of psychological complications, 17 (61%) reported providing relevant psychosocial support in line with expressed psychological experience(s). Hence, psychosocial support was carried out to a large extent. Also, follow-up activities

were carried out using a mixed medium approach; 12 trainees used phone calls; 13 conducted physical visits; while 15 used review(s) of previous visit(s). In other of priority, reasons for other trainees (12, 43%) not conducting follow-up services was due mainly to none reportage or expression of psychological experiences, follow-up not considered as necessary, as well as none availability of monitoring and evaluation (M & E) officer(s).

Table 2: Model summary for opportunities and expert counselling services and beneficiaries

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.561	.315	.301	4.46070

Table 3: ANOVA of Opportunities and Expert Counselling for Females with FGC

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	457.108	1	457.108		
Residual	994.892	50	19.898	22.973	.000[a]
Total	1452.000	51			

See tables 2 and 3 for Model Summary and Regression ANOVA. Analysis of results indicate that the model (update training for programme trainees) significantly predicts opportunities and expert counselling services, assessed by females with FGC ($R = .561$; R^2 adj = .301, $F(1, 50) = 22.97$, $p < .05$). The model accounts for 30.1% of variance in females with FGC rating of opportunities and access to expert counselling.

Table 4: Regression Coefficients of Opportunities and Expert Counselling for Females with FGC

Model	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	Sig.
(Constant)	71.285	.923		77.206	.000
training	-.064	.013	-.561	-4.793	.000

Regression coefficients for opportunities and expert counselling services and beneficiaries is presented as $\beta = -.561$, $t(50) = -4.793$, $p < 0.05$ (see table 4). The result reveals that update training of programme trainees/HCPs is a strong predictor of females' with FGC opportunities and access to expert counselling. The observed significance level is an indication that, update training was instrumental in providing effective opportunities and expert counselling services in relation to FGC, reproductive health as well as other health related conditions due to FGC.

VI. Discussions

Data presented on the characteristics of the trainees specifically healthcare provider designation/categories, years of experience as well as update training facilitated and enhanced trainees skills in identifying psychological issues expressed by females with FGC, especially those at the adolescent stage. This thus confirmed the existence of psychological experiences, irrespective of age and/or developmental stages. This is in line with studies that have suggested and affirmed significant relationship(s) between psychological experience(s) and FGC; and that females of younger age are more vulnerable to the consequences of the practice [5, 6, 10, 11, 18]. The vernacular expression (Yoruba Language) of the process/procedure of FGC connotes force, pain and harm; hence the practice is viewed as harmful with several unpleasant psychological experiences associated with it. Based on the confirmation of trainees on the existence of psychological experiences due to FGC, opportunities and expert counselling (psychosocial support) services with emphasis on follow up activities were executed to a large extent. This is an indication that update training accessed by trainees was effective in achieving the desired outcome, and is in line with studies that have advocated and confirmed the need and significant effect of such services [36, 38, 41, 42]. Based on results presented, it is evident that incorporation of awareness creation on FGC issues during routine women and children focused clinic sessions (e.g. ante-natal and post-natal clinics, immunisation sessions, hypertension clinics etc.) is very effective.

VII. Conclusion

Psychological problem due to FGC is an important issue which needs to be given attention. This is because more of negative psychological experiences are recorded by females who have experienced the practice. As a result psycho social support is very much necessary to help such females cope with the consequences associated with their FGC status. Furthermore, although follow-up as a sub-component of psychosocial support is not often executed for various reasons; or highlighted for reportage, this study has provided information which is believed to have contributed to the effectiveness of the intervention programme. It is thus imperative that psychosocial support is an essential activity

which should be included as part of FGC intervention programmes as well as in primary health centres.

CONFLICT OF INTEREST STATEMENT

There were no conflicts and as such there is nothing to disclose.

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