CIÊNCIAS DA VIDA E DA SAÚDE
LIFE AND HEALTH SCIENCES
CIENCIAS DE LA VIDA Y LA SALUD

millenium

Millenium, 2(Edição Especial Nº23)

en

MUTILAÇÃO GENITAL FEMININA: EXPERIÊNCIAS DE MULHERES MIGRANTES E IMPLICAÇÕES PARA A ENFERMAGEM

FEMALE GENITAL MUTILATION: EXPERIENCES OF MIGRANT WOMEN AND IMPLICATIONS FOR NURSING

MUTILACIÓN GENITAL FEMENINA: EXPERIENCIAS DE MUJERES MIGRANTES E IMPLICACIONES PARA LA ENFERMERÍA

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RECEIVED: 18th September, 2025
REVIEWED: 07th April, 2026
ACCEPTED: 18th May, 2026
PUBLISHED: 12th June, 2026

DOI: https://doi.org/10.29352/mill0223e.43284

RESUMO

Introdução: A Mutilação Genital Feminina (MGF) é uma prática tradicional nefasta reconhecida como grave violação dos direitos humanos, com implicações físicas, psicológicas, sexuais e sociais. Estima-se que mais de 200 milhões de mulheres tenham sido submetidas a MGF, sendo esta perpetuada em nome da tradição, da preservação da honra e do controlo da sexualidade feminina.
Objetivo: Compreender as vivências de mulheres migrantes submetidas a MGF, identificando os impactos multidimensionais e refletindo sobre as implicações para a prática de enfermagem.
Métodos: Estudo qualitativo de natureza fenomenológica, desenvolvido segundo a perspetiva de Max van Manen, no âmbito do projeto *Intercultural Approach to Prevent Harmful Practices (IAPHP)*. Foram realizadas entrevistas fenomenológicas a sete mulheres migrantes oriundas de países com elevada prevalência de MGF. A análise seguiu um processo de identificação de temas e categorias emergentes.
Resultados: Emergiram três eixos principais: (i) motivações socioculturais e religiosas para a prática, associadas à aceitação comunitária e preservação da honra; (ii) consequências físicas (complicações genito-urinárias e obstétricas), psicológicas (ansiedade, depressão, stress pós-traumático) e sexuais (dispareunia, diminuição da libido, dificuldades relacionais); (iii) perceção negativa da prática e estratégias de resistência das mulheres, que expressam desejo de mudança e maior proteção para as gerações futuras.
Conclusão: A MGF reflete desigualdades de género estruturais e compromete a saúde integral das mulheres. Os enfermeiros têm um papel central na prevenção, identificação e acompanhamento, promovendo cuidados culturalmente competentes, sensibilização comunitária e defesa dos direitos humanos. O empoderamento feminino e a educação para a saúde surgem como estratégias essenciais para a erradicação desta prática.

Palavras-chave: mutilação genital feminina; práticas tradicionais nefastas; saúde da mulher; direitos humanos; enfermagem transcultural

ABSTRACT

Introduction: Female Genital Mutilation (FGM) is a harmful traditional practice recognized as a serious violation of human rights, with physical, psychological, sexual, and social implications. It is estimated that more than 200 million women have undergone FGM, which continues to be perpetuated in the name of tradition, the preservation of honor, and the control of female sexuality.
Objective: To explore the lived experiences of migrant women subjected to FGM, understanding the meanings attributed to this experience and reflecting on its implications for nursing practice.
Methods: A qualitative study grounded in Max van Manen's hermeneutic phenomenology was conducted within the scope of the *Intercultural Approach to Prevent Harmful Practices* (IAPHP) project. Phenomenological interviews were carried out with seven migrant women originating from countries with high prevalence of FGM. Data analysis followed an interpretive phenomenological approach focused on identifying experiential meanings emerging from the women's narratives.
Results Women described FGM as a practice deeply embedded in cultural traditions, social belonging, and gender expectations, often associated with silence, coercion, and lack of consent. The experience emerged as profoundly embodied, marked by pain, fear, obstetric and genitourinary complications, psychological suffering, and sexual difficulties. Migration and contact with different sociocultural realities contributed to greater awareness regarding women's rights, bodily autonomy, and the harmful nature of the practice. Participants also expressed resistance strategies and a strong desire to protect future generations from similar experiences.
Conclusion: FGM reflects structural gender inequalities and compromises women's dignity, health, and bodily integrity. Nurses play a central role in prevention, early identification, culturally competent care, psychosocial support, and human rights advocacy. Educational, community-based, and empowerment-focused interventions are essential for the prevention and elimination of FGM.

Keywords: female genital mutilation; harmful traditional practices; women's health; human rights; transcultural nursing

DOI: https://doi.org/10.29352/mill0223e.43284

RESUMEN

Introducción: La Mutilación Genital Femenina (MGF) es una práctica tradicional nociva reconocida como una grave violación de los derechos humanos, con implicaciones físicas, psicológicas, sexuales y sociales. Se estima que más de 200 millones de mujeres han sido sometidas a MGF, perpetuada en nombre de la tradición, la preservación del honor y el control de la sexualidad femenina.
Objetivo: Comprender las vivencias de mujeres migrantes sometidas a MGF, identificando los impactos multidimensionales y reflexionando sobre las implicaciones para la práctica de enfermería.
Métodos: Estudio cualitativo de naturaleza fenomenológica, desarrollado según la perspectiva de Max van Manen, en el marco del proyecto *Intercultural Approach to Prevent Harmful Practices* (IAPHP). Se realizaron entrevistas fenomenológicas a siete mujeres migrantes procedentes de países con alta prevalencia de MGF. El análisis siguió un proceso de identificación de temas y categorías emergentes.
Resultados: Emergieron tres ejes principales: (i) motivaciones socioculturales y religiosas para la práctica, asociadas a la aceptación comunitaria y la preservación del honor; (ii) consecuencias físicas (complicaciones genitourinarias y obstétricas), psicológicas (ansiedad, depresión, estrés postraumático) y sexuales (dispareunia, disminución de la libido, dificultades relacionales); (iii) percepción negativa de la práctica y estrategias de resistencia de las mujeres, que expresan deseo de cambio y mayor protección para las generaciones futuras.
Conclusión: La MGF refleja desigualdades de género estructurales y compromete la salud integral de las mujeres. Los enfermeros desempeñan un papel central en la prevención, identificación y acompañamiento, promoviendo cuidados culturalmente competentes, sensibilización comunitaria y defensa de los derechos humanos. El empoderamiento femenino y la educación para la salud surgen como estrategias esenciales para la erradicación de esta práctica.

Palabras clave: mutilación genital femenina; prácticas tradicionales nocivas; salud de la mujer; derechos humanos; enfermería transcultural

INTRODUCTION

Female Genital Mutilation (FGM) is internationally recognized as a harmful traditional practice and a severe violation of human rights. According to the World Health Organization (WHO, 2022, 2025) and UNICEF (2024, 2025), more than 200 million women and girls worldwide have undergone FGM, and approximately three million girls are at risk every year. The practice consists of the partial or total removal of external female genitalia, or other forms of injury to the genital organs, for non-medical reasons. It is deeply rooted in sociocultural beliefs, community traditions, and gender norms, often justified by arguments of social acceptance, preservation of virginity, preparation for marriage, or the guarantee of fidelity (UNFPA, 2020; UNFPA–UNICEF, 2024).

FGM is highly prevalent in about 30 countries across Africa, the Middle East, and parts of Asia, but has also been documented among migrant and refugee communities in Europe, North America, and Oceania (Cardoso, 2019; CIG, 2020; Coutinho, Magalhães et al., 2024). In countries such as Somalia, Guinea, and Djibouti, prevalence rates exceed 90%, whereas in other regions such as Cameroon or Uganda, it affects less than 1% of the female population (UNICEF, 2024). The persistence of FGM across generations demonstrates the complexity of its cultural legitimacy and the resistance to change, even in contexts where legislation prohibits the practice. Migration flows have contributed to the persistence of this practice in the diaspora, including in Portugal. Despite a global decline in prevalence over the past three decades, progress is uneven, and eradication remains a challenge (UNFPA,2020, 2025).

The health consequences of FGM are severe and multidimensional. Short-term complications include hemorrhage, infections, and urinary retention, which may in some cases result in death. In the long term, women may suffer from obstetric complications such as prolonged labor, perineal lacerations, and neonatal morbidity, as well as chronic pelvic pain, infertility, and recurrent urinary tract infections (Bendiksen et al., 2021; Dura et al., 2023). In addition to these physical effects, women frequently experience sexual dysfunction, reduced sexual satisfaction, and psychological consequences such as anxiety, depression, and post-traumatic stress disorder (Reman et al., 2023). These multidimensional impacts illustrate that FGM is not only a health issue but also a determinant of gender inequality, perpetuating stigma, discrimination, and social subjugation across generations (Burayu & Degefa, 2024).

International conventions, such as the *Convention on the Elimination of All Forms of Discrimination against Women* (United Nations, 2011) and the Council of Europe Convention on preventing and combating violence against women and domestic violence (Council of Europe, 2011), strongly condemn FGM as a violation of women's and children's rights. Global initiatives such as the UN International Day of Zero Tolerance for FGM (United Nations, 2025) reinforce the urgency of accelerating progress toward the elimination of this practice by 2030, as outlined in the Sustainable Development Goals. Yet eradication requires more than legal

DOI: https://doi.org/10.29352/mill0223e.43284

prohibition: it requires community engagement, culturally sensitive education, and empowerment strategies for women and girls, ensuring that interventions are grounded in human rights and adapted to local contexts (UNFPA–UNICEF, 2022, 2024; WHO, n.d.). HHealthcare professionals, particularly nurses, are in a privileged position to prevent, identify, and intervene in cases of FGM (Coutinho, Costa et al, 2024). Nurses not only provide clinical care but also act as advocates for women's rights, engaging in health education, awareness-raising, and culturally competent interventions. Understanding the lived experiences of women who have undergone FGM is therefore essential to strengthen professional training and to promote humanized and equitable healthcare (Coutinho, Magalhães et al., 2024).

Beyond its clinical consequences, FGM must also be understood as a gendered practice sustained by unequal power relations, community control over women's bodies, and intersecting axes of vulnerability, including migration status, culture, and social subordination. An intersectional perspective allows for a deeper understanding of how women's experiences are shaped not only by gender, but also by the interplay of sociocultural context, displacement, legal frameworks, and access to healthcare. From a nursing perspective, this requires culturally responsive and ethically grounded care that neither relativizes violence nor reproduces stigma, aligning with transcultural nursing approaches centered on dignity, safety, and relational care.

Understanding how women live, interpret, and give meaning to this experience is essential to inform ethically grounded and culturally responsive nursing care.

Within this context, the present study, developed under the Intercultural Approach to Prevent Harmful Practices (IAPHP) project, aims to explore the lived experiences of migrant women subjected to FGM, seeking to understand the meanings they attribute to this experience and to reflect on its implications for nursing practice.

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1.1 Ethical and Human Rights Perspective

FGM is internationally condemned as a violation of the rights of women and children, particularly their rights to health, bodily integrity, and freedom from torture or cruel, inhuman treatment (Council of Europe, 2011; UN Women, 2024). However, the persistence of the practice highlights the limitations of legal frameworks alone. Eradication requires community engagement, intercultural dialogue, and empowerment strategies that challenge gender norms and patriarchal traditions (UNFPA, 2020).

1.2 Implications for Nursing

Nurses are in a key position to contribute to prevention and intervention (Reis & Spinola, 2016). Their proximity to communities, especially in primary healthcare and maternal-child services, places them in a strategic position to:

- Identifying and supporting women and girls at risk of FGM or already subjected to it.
- Providing culturally competent care, balancing respect for cultural diversity with advocacy for human rights.
- Promoting health education and awareness campaigns to challenge myths sustaining FGM.
- Engaging in advocacy, working with policymakers, NGOs, and community leaders to strengthen protective environments (Coutinho, Magalhães et al., 2024).

In this context, nursing care extends beyond clinical management, encompassing dimensions of social justice, advocacy, and empowerment, and aligning with global efforts to eliminate FGM.

2. METHODS

2.1 Study Design

A qualitative phenomenological study was conducted, guided by Max van Manen's hermeneutic phenomenology approach. This methodology was chosen as it allows for an in-depth exploration of the lived experiences of women subjected to Female Genital Mutilation (FGM), emphasizing meaning, lived experience, and contextual interpretation.

2.2 Setting and Participants

The study involved seven migrant women living in Portugal, originally from countries where FGM is prevalent. The inclusion criteria included: (i) being of legal age, (ii) having direct experience of FGM or originating from a cultural context where the practice is common, and (iii) providing informed consent.

The study was carried out within the framework of the *Intercultural Approach to Prevent Harmful Practices (IAPHP)* project, approved by the European Commission and ethically endorsed by the project's Ethical Board. Participants were engaged through a purposive and experiential approach, guided by their relevance to the lived experience of the phenomenon. Recruitment was conducted with voluntariness and cultural sensitivity throughout the process.

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2.3 Data Collection

Data were collected in August 2023 through in-depth phenomenological interviews. A semi-structured interview guide was developed and included questions to explore participants' experiences, perceptions, and the meanings they attribute to FGM in their lives. Interviews were conducted in a private setting by the study supervisor, recorded with prior consent, and anonymized to ensure confidentiality. Additionally, sociodemographic data were collected to provide contextual information. Interviews were conducted in a flexible and participant-centered manner, allowing space for the emergence of meanings grounded in the women's lived experiences.

2.4 Data Analysis

All interviews were audio-recorded with prior consent and subsequently transcribed verbatim to ensure fidelity to the participants' narratives. Transcriptions were carefully reviewed against the original audio files to guarantee accuracy. Data was managed and organized using NVivo 14 software (QSR International, 2018), which supported the organization of the data and facilitated the interpretive process. The analysis followed Max van Manen's hermeneutic phenomenological approach, which combines descriptive and interpretive processes to uncover the lived meaning of experiences. The analysis involved a hermeneutic movement between parts and the whole, with repeated immersion in the narratives to identify meaningful experiential structures while preserving the integrity of participants' lived experiences.

Trustworthiness was ensured through strategies of credibility, dependability, confirmability, and transferability. Direct quotations from participants were preserved to illustrate the meanings emerging from the narratives and to maintain the authenticity of women's voices.

2.5 Ethical Considerations

This study adhered to the ethical principles of the Declaration of Helsinki (2013 revision) and complied with international standards for research involving human participants.

Prior to data collection, the research protocol was reviewed and approved by the Ethical Board of the Intercultural Approach to Prevent Harmful Practices (IAPHP) project and by the Ethics Committee of the Escola Superior de Saúde de Viseu (ESSV). Authorization was granted following submission of the study protocol, the interview guide, and the informed consent form.

Informed consent was obtained from all participants prior to their involvement in the study. Each participant received oral and written information regarding the objectives, methods, potential risks, and benefits of the study, and had the opportunity to clarify any doubts at this time or later (by contacting the systematic coding, retrieval of meaning units, and construction of thematic categories researchers). Participants were assured that their participation was voluntary and could withdraw from the study without consequences. All participants provided and signed an individual informed consent form, including their agreement to be recorded (audio) to participate.

To ensure confidentiality and data protection, interviews were anonymized with alphanumeric codes, and no identifying information was included in the transcripts. Audio recordings and transcripts were stored on a password-protected institutional computer, accessible only to the research team. In accordance with the General Data Protection Regulation (GDPR 2016/679), all data will be securely stored for five years. After this period, audio recordings will be permanently deleted, and printed materials (e.g., signed consent forms) will be destroyed by certified shredding.

Given the sensitive nature of FGM, specific measures were taken to minimize harm. Interviews were conducted in a private, safe environment, with attention to participants' cultural context and emotional vulnerability to ensure participants' safety, privacy, and comfort. When signs of distress were observed, the interviewer paused the conversation and/or redirected the discussion to ensure the participant's well-being.

A referral protocol for psychological support was ensured for participants whenever necessary.

By adopting these procedures, the study guaranteed respect for human dignity, autonomy, and confidentiality, safeguarding the rights and well-being of all participants.

Attention was given to the sensitive and potentially traumatic nature of the topic, ensuring a respectful, non-judgmental, and participant-centred approach throughout the research process.

3. RESULTS

The phenomenological analysis of the interviews revealed that Female Genital Mutilation (FGM) is experienced by women not only as a physical act, but as a deeply embodied and socially constructed experience shaped by culture, gender norms, silence, fear, and resistance. Three major experiential themes emerged from the women's narratives: (i) FGM as tradition, identity, and social control; (ii) living the body through pain, fear, and rupture; and (iii) awareness, resistance, and hope for change.

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3.1 FGM as Tradition, Identity, and Social Control

Participants described FGM as a ritualized practice strongly connected to cultural identity, community belonging, and expectations surrounding femininity and marriageability. In many narratives, the procedure emerged as a normalized and socially valued tradition transmitted across generations.

"The 'fanado' ceremony is a traditional practice, so they feel proud to do it."

"All ethnic groups have this practice, the tradition of 'fanado'."

Women explained that the practice was frequently associated with becoming a "proper woman," worthy of respect, marriage, and social inclusion. Religious and cultural justifications were deeply intertwined in the narratives, particularly within Muslim contexts, where FGM was perceived as part of a broader moral and social framework.

"It is a way of preparing girls for life."

"It is the reality of a certain population, a certain group of people. They believe and think that it must be so."

The women's accounts revealed that girls were often subjected to the procedure without consent and, in some cases, even without parental authorization. Participants described situations involving coercion, secrecy, and social pressure, reflecting mechanisms of control over the female body and sexuality.

"They do it… family members there perform it when the children are one year old, so that she cannot report it."

"I was about 7 or 8 years old when they performed the mutilation on me."

FGM was reported as being performed at different stages of childhood and adolescence, including infancy, school age, and early adolescence. Some women explained that the procedure was intentionally carried out at very young ages to minimize resistance and prevent disclosure.

"If you have a baby, a child less than one year old, she undergoes [the mutilation]."

"From the age of 11, girls are cut."

The narratives also revealed the precarious and unsafe conditions in which the procedure frequently occurred. Women described FGM being performed outside healthcare facilities, including in huts, family homes, fields, or directly on the ground. In some cases, the practice involved blades or knives and occurred in hidden or clandestine settings.

"Now they do [FGM] in secret, hidden from the authorities."

Participants additionally described practices of isolation and bodily control following the procedure, including restrictions related to hygiene and the expectation that girls remain separated until healing occurred. In some narratives, punishment and discipline were associated with the ritual, reinforcing the submissive position imposed on girls.

Some women also reported that families paid individuals to perform the procedure, illustrating the normalization and institutionalization of the practice within certain communities.

At the same time, the narratives suggest that migration and contact with different sociocultural contexts contributed to questioning practices previously perceived as culturally unquestionable.

3.2 Living the Body Through Pain, Fear, and Long-Term Consequences

Participants described FGM as a profoundly embodied experience marked by pain, fear, vulnerability, and suffering. Fear emerged across multiple dimensions of women's experiences, including fear before the procedure, fear of speaking about it, fear of criticism, fear of hospitals, and fear of reporting the practice.

"Some leave with fever, going straight to the hospital."

"A child who is a victim of mutilation can die."

The women's narratives revealed severe physical consequences associated with FGM, including bleeding, infections, inflammation, urinary difficulties, and chronic suffering. Obstetric complications were also strongly present in the accounts, particularly difficulties during pregnancy and childbirth, infertility, and maternal death.

"Some women die after mutilation."

Participants additionally described sexual difficulties and emotional suffering associated with the procedure. Pain during sexual intercourse, reduced sexual well-being, psychological suffering, and persistent emotional distress emerged throughout the interviews.

The body appeared in the narratives not as a place of safety or autonomy, but as a site marked by pain, silence, fear, and social control. Several women described experiences that continued to affect their intimate relationships, emotional well-being, and sense of self long after the physical procedure itself.

"At the time of genital mutilation, diseases can be transmitted."

Some participants also associated FGM with broader risks to women's lives and health, including HIV transmission and repeated excision procedures associated with marriage rituals.

Although most women emphasized the harmful consequences of FGM, a few participants initially described the practice as having no negative impacts. However, these accounts frequently coexisted with descriptions of suffering, fear, or physical complications, illustrating the complexity of normalization processes within certain cultural contexts.

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The narratives suggest that women often live between two realities: one shaped by collective normalization of the practice and another marked by personal suffering and awareness of harm.

3.3 Awareness, Criminalization, Resistance, and Hope for Change

Despite the strong cultural normalization surrounding FGM, participants expressed predominantly negative perceptions of the practice, describing it as harmful, painful, and unnecessary. Many women recognized FGM as a violation of women's dignity and rights.

Participants demonstrated awareness regarding the criminalization of FGM and the existence of legal sanctions against those performing the procedure.

"Female genital mutilation is now a crime."

"The women who perform female genital mutilation have to serve several years in prison."

Some women perceived that the frequency of the practice had decreased over time, particularly after legal measures and greater public awareness.

"It was from 2011 onwards that this practice [female genital mutilation] decreased a little."

The narratives additionally revealed forms of resistance and protection developed by women and families. Some participants described girls escaping from home to avoid being subjected to the procedure, while others referred to financial payments made by parents in attempts to prevent the mutilation.

"Even other girls ran away from home so as not to be mutilated."

"If I don't want this to be done to her, beforehand, like, I have to pay."

A particularly significant aspect emerging from the interviews was the women's desire to protect future generations. Participants frequently expressed hope that their daughters would not experience the same suffering, emphasizing the importance of education, awareness, and social change.

Migration and exposure to different healthcare, educational, and legal systems appeared to contribute to greater awareness regarding women's rights, bodily integrity, and autonomy. Through these experiences, women increasingly questioned practices previously accepted as inevitable within their communities.

Overall, the narratives reveal a movement from silence and normalization toward reflection, resistance, and hope for transformation. Although FGM remains sustained by powerful sociocultural structures, the women's voices demonstrate emerging processes of awareness, agency, and intergenerational change.

4. DISCUSSION

This study explored the lived experiences of migrant women subjected to Female Genital Mutilation (FGM), revealing how the practice is sustained through sociocultural expectations, gender norms, and intergenerational traditions, while simultaneously being experienced as a source of pain, fear, suffering, and violation. The findings reinforce that FGM cannot be understood solely as a cultural ritual or medical issue, but rather as a complex phenomenon situated at the intersection of gender inequality, bodily control, migration, and human rights.

4.1 Sociocultural Motivations and Social Control

Participants' narratives revealed that FGM is strongly associated with expectations surrounding purity, femininity, marriageability, and family honor. Similar findings have been described in studies conducted in Ethiopia and the Gambia, where social acceptance and community belonging remain central to the perpetuation of the practice (Bendiksen et al., 2021; Burayu & Degefa, 2024). The women's accounts suggest that the female body becomes socially regulated through rituals of obedience, silence, and conformity, reflecting broader patriarchal structures that control women's sexuality and autonomy.

Although participants frequently associated FGM with religious beliefs, international evidence demonstrates that the practice is not prescribed by sacred texts, but rather sustained through sociocultural interpretations and intergenerational pressures (WHO, 2022). The persistence of FGM despite legal prohibition highlights the limitations of punitive approaches when deeply rooted social norms remain unchanged (UNFPA–UNICEF, 2022, 2024). Consequently, prevention strategies require culturally sensitive educational interventions, community dialogue, and empowerment approaches capable of challenging misconceptions while respecting cultural complexity.

The clandestine nature of the practice described by participants, particularly after criminalization, further illustrates the tension between legal frameworks and cultural continuity. These findings reinforce the importance of interventions that engage not only women and girls, but also families, religious leaders, and communities.

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4.2 Living the Body Through Pain, Fear, and Suffering

The women described FGM as a profoundly embodied experience marked by pain, fear, vulnerability, and long-term suffering. Physical complications such as bleeding, infection, urinary difficulties, infertility, and obstetric complications emerged prominently in the narratives and are consistent with previous literature describing the severe health impacts associated with FGM (Bendiksen et al., 2021; Dura et al., 2023).

However, the findings also demonstrate that the consequences of FGM extend beyond physical injury. Fear emerged as a persistent dimension throughout the women's experiences, including fear of the procedure itself, fear of social criticism, fear of disclosure, and fear of seeking healthcare support. These experiences suggest that violence may continue long after the physical act, shaping women's emotional well-being and relationship with their own bodies.

Psychological suffering and sexual difficulties were also present in the narratives, corroborating studies describing associations between FGM, anxiety, depression, post-traumatic stress disorder, dyspareunia, and reduced sexual satisfaction (Reman et al., 2023; Dura et al., 2023). Some participants initially minimized the impacts of FGM, reflecting possible processes of normalization and internalization of violence within certain sociocultural contexts. This apparent contradiction highlights the complexity of women's lived experiences and reinforces the importance of sensitive and non-judgmental healthcare approaches.

From a phenomenological perspective, the findings suggest that FGM affects not only the physical body, but also women's sense of dignity, safety, intimacy, and autonomy. The body emerges simultaneously as a site of suffering and social inscription, marked by memories of pain, silence, coercion, and vulnerability.

4.3 Awareness, Migration, and Resistance

Despite the strong normalization of FGM within their countries and communities of origin, participants expressed predominantly negative perceptions of the practice, describing it as harmful, unnecessary, and a violation of women's dignity and rights. These findings are aligned with international reports showing that many women living in high-prevalence contexts increasingly oppose the continuation of FGM and advocate for its eradication (UNICEF, 2021; UNFPA, 2020).

Migration and exposure to different sociocultural realities appeared to play an important role in promoting critical reflection about the practice. Contact with different healthcare systems, legal frameworks, and educational opportunities contributed to greater awareness regarding bodily integrity, women's rights, and autonomy. These findings are consistent with previous studies suggesting that migration may facilitate changes in attitudes toward FGM by creating opportunities for dialogue, education, and empowerment.

The narratives additionally revealed forms of resistance and protection, including escape attempts, concealment strategies, and parental efforts to prevent daughters from undergoing the procedure. These findings are particularly relevant because they reposition women not merely as passive victims, but also as individuals capable of agency, reflection, and transformation. As highlighted by the United Nations Economic and Social Council (2008), engaging women's voices and lived experiences is essential for dismantling harmful practices and promoting sustainable change.

4.4 Implications for Nursing Practice

The findings reinforce the central role of nurses in the prevention, identification, and care of women affected by FGM. Due to their close contact with women, families, and communities, nurses are strategically positioned to provide culturally competent and trauma-informed care across primary healthcare, maternal health, pediatric, and community settings.

Participants' narratives demonstrate the importance of healthcare environments that promote safety, confidentiality, respectful listening, and emotional support. Nurses must therefore be prepared not only to recognize physical complications associated with FGM, but also to address psychological suffering, fear, sexual health concerns, and social vulnerability.

The incorporation of transcultural nursing frameworks, such as Leininger's Culture Care Theory, may strengthen the sensitivity and effectiveness of interventions by balancing respect for cultural diversity with advocacy for human rights and women's dignity. In this context, nursing extends beyond clinical management and assumes ethical, educational, and advocacy dimensions.

Educational interventions, community awareness programs, and collaboration with cultural mediators, educators, NGOs, and community leaders are also fundamental to prevention efforts. WHO (2023, n.d.) recommends survivor-informed and culturally responsive approaches, positioning nurses as key actors in prevention, education, support, and advocacy.

4.5 Strengths and Limitations

This study contributes to the limited body of qualitative research exploring the lived experiences of migrant women subjected to FGM within the Portuguese context. The phenomenological approach allowed an in-depth exploration of meanings, emotions, and embodied experiences that are often difficult to capture through quantitative methodologies.

Nevertheless, some limitations should be acknowledged. The small sample size limits transferability, and the sensitive nature of the topic may have influenced participants' willingness to disclose more intimate experiences. Additionally, the diversity of migration trajectories and sociocultural backgrounds may have shaped women's experiences in different ways.

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Despite these limitations, the study offers important insights into the multidimensional impacts of FGM and highlights the importance of culturally sensitive and ethically grounded healthcare approaches. Future research should further explore nursing-led interventions, survivor-informed care models, and community-based prevention strategies capable of promoting empowerment and reducing vulnerability among women and girls at risk of FGM.

Overall, the findings demonstrate that although FGM remains sustained by powerful sociocultural structures, women increasingly recognize its harmful consequences and express hope for change through education, empowerment, legal protection, and professional support. Nurses have a central role in promoting culturally competent care, advocating for human rights, and contributing to global efforts toward the elimination of FGM (United Nations, 2011, 2025).

CONCLUSION

This study revealed that Female Genital Mutilation (FGM) remains a harmful practice sustained by sociocultural norms related to honor, purity, femininity, and marriageability, while simultaneously being experienced by women as a profound violation of their dignity, bodily integrity, health, and autonomy. The women's narratives highlighted severe physical, psychological, sexual, and obstetric consequences, alongside feelings of fear, suffering, and vulnerability. At the same time, participants expressed critical awareness of the harmful nature of the practice and a strong desire to protect future generations from similar experiences.

The findings reinforce that the elimination of FGM requires more than legal prohibition alone. Sustainable change depends on culturally sensitive education, community engagement, empowerment of women and girls, and intersectoral collaboration capable of addressing the sociocultural norms that sustain the practice. In this context, projects such as the *Intercultural Approach to Prevent Harmful Practices* (IAPHP) play an important role by fostering intercultural dialogue, promoting awareness in both host and origin communities, and creating safe spaces where women's voices and lived experiences can be heard and valued.

For nursing, the implications are particularly significant. Nurses are often among the first healthcare professionals to establish contact with women affected by FGM in primary care, maternal health, pediatric, and hospital settings. Their role extends beyond the management of physical complications and includes culturally competent care, psychosocial support, health education, early identification of women and girls at risk, and advocacy for human rights and gender equity.

The findings also highlight the importance of integrating FGM-related content into nursing education and continuous professional development programs, ensuring that healthcare professionals are equipped with the knowledge, ethical sensitivity, and cultural competence required to provide safe, respectful, and survivor-informed care.

Future efforts should prioritize community-based interventions involving women, families, religious leaders, educators, and healthcare professionals, as well as the development of nursing-led and culturally responsive prevention strategies. Further qualitative research grounded in women's lived experiences may also contribute to a deeper understanding of the long-term impacts of FGM and support the design of more effective interventions.

Ultimately, eliminating FGM is not only a matter of public health, but also of human rights, social justice, gender equality, and human dignity. In this process, nurses have an essential role as caregivers, educators, advocates, and agents of social change.

ACKNOWLEDGEMENTS

The authors would like to thank the women who generously shared their personal experiences, despite the sensitivity and emotional weight of the topic. We also acknowledge the support of the Intercultural Approach to Prevent Harmful Practices (IAPHP) project, which provided the framework for this research, and the Escola Superior de Saúde de Viseu (Polytechnic Institute of Viseu) for institutional backing. Special thanks are extended to the research team and colleagues who contributed to the ethical review, data collection, and analysis process.

AUTHORS' CONTRIBUTION

Conceptualization, E.C., C.C., A.P.N., A.B.A. and C.M.; data curation, C.M. and E.C.; formal analysis, C.M. and E.C.; funding acquisition, E.C., C.C., A.B.A. and C.M.; investigation, E.C., C.C., A.B.A. and C.M.; methodology, E.C. and C.M.; project administration, E.C.; resources, E.C., F.J., C.Q. and C.M.; software, E.C., F.J., C.Q., J.C., M.G. and M.A.; supervision, E.C. and C.M.; validation, E.C. and C.M.; visualization, E.C., F.J., C.Q. and C.M.; writing – original draft, E.C., C.C., A.P.N. and A.B.A.; writing – review & editing, E.C., S.B., C.C., F.J., C.Q. and C.M.

CONFLICT OF INTEREST

The authors declare no conflict of interests.

DOI: https://doi.org/10.29352/mill0223e.43284

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