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Female Circumcision: A Phenomenological Study of Somalian Immigrant to the United States

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Abstract

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by

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MS, Rochester Institute of Technology, 2011

BS, Nazareth College Rochester, 2009

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Female circumcision (FC) is the partial or total removal of the female genitalia for nonmedical reasons. This study was designed to examine the lived experiences of Somali women who underwent FC before coming to the United States. FC is widely carried out in Somalia with a prevalence of 98%, making Somalia the country with the highest percentage of circumcised women. There are short- and long-term consequences associated with FC such as bleeding, infection, and death. Therefore, it is important to understand how Somali women who underwent FC think and feel about circumcision, why they would continue the practice, and whether they would recommend the practice for others. Using a qualitative research method with a phenomenological approach aligned with the use of social convention theory as a conceptual framework, data were collected from 12 Somali women who underwent FC, who were living in the United States at the time of the study, who were 18 years old and above and who were recruited online through SurveyMonkey without disclosing their identities. Thirty-five open-ended questions were posted online for participants to complete. Interpretative Phenomenological Analysis method was used for data analysis. The respondents reported experiencing negative consequences from FC practice including pain, miscarriages, and heavy bleeding. The majority of the women in the study supported the eradication of FC in all forms. Based on the findings of this study, possible implications for positive social change include enabling health professionals to create culturally-diverse education and care and altering the social convention of FC so that the morbidity and mortality caused by FC is reduced and the lives of girls and women in Somalia are improved.

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Dedication

This study is dedicated to my mother, Anna Wirsungnin (deceased), who as a single mother made sure she provided me with what I needed to build up an academic foundation; to my lovely brother, friend, and only sibling, John Nsah (deseased), who was my academic mentor; and especially to my wife, Leoncillian Tatah, and my children, Charlie Tatah, Sorin Tatah, Callin Tatah, and Borin Tatah, whose encouragements and commitments towards the completion of this program paid the price. And for my aunt, Immaculate Kewir and uncle, Shey Kishi, who never doubted I could accomplish this research.

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Chapter 1: Introduction to the Study

Introduction

Female genital mutilation (FGM), also known as female circumcision (FC) or female genital cutting (FGC), is the partial or total removal of the female genitalia for no medical reason (World Health Organization [WHO], 2013). With rapid growth in immigrant populations, some countries in Asia, Europe, and North America are seeing an increase in the number of circumcised women (WHO, 2008a). In 2006, there were about 75,000 Somali refugees in Minnesota alone (DeShaw, 2006). As more immigrants continue to come to the United States, they bring along their cultural practices (Burstyn, 1995). Between 100 and 130 million women worldwide have undergone some form of FC (Gele, Bø, & Sundby, 2013) with approximately 2 million subject to the practice each year. About 98% of women in Somalia have been circumcised with one or more forms or types of FGM, with the most common being the complete removal of the clitoris and labia minora, together with the inner surface of the labia majora (Jones, Ehiri, & Anyanwu, 2004; Rasaq, 2012; Weir, 2000).

There is no single justification for the practice of FC, as different communities have different reasons. Some national and international organizations consider FC to be a human rights violation, while many practicing communities consider it a part of their unchanged culture that has been with them for centuries (Horowitz & Jackson, 1997). In Somalia, FC is often justified under cultural, religious, and social factors and uncircumcised girls or women often find it difficult to get married (WHO, 2013).

No matter the reasons for the practice of FC, there are short and long term gynecological and obstetric complications such as hemorrhage, shock as a result of pain and hemorrhage, difficulties passing urine, HIV/AIDS, psychological consequences, infection, keloids, increased risk of sexually transmitted diseases, reproductive tract infections, reduced quality of sexual life, birth complications, danger to the newborns, and death (Hamoudi & Shier, 2010, WHO, 2013).

Instead of advocating banning the FC as a harmful practice, Amnesty International and some other international organizations have recommended measures that will remove physical and psychological harms while maintaining and promoting the cultural traditions of countries that practice FC (Feminist Majority Foundation, 2014). There is sufficient clinical information that clinicians can use to effectively treat circumcised women who need medical care (Horowitz and Jackson, 1997). Circumcised women need those clinicians who are knowledgeable about such surgeries. However, because many people have different justifications for FC, and circumcised women do not speak openly about their situations for cultural reasons, banning FC outright could disrupt their cultures and traditions. Therefore, it is necessary to find out from circumcised women their lived experiences with circumcision. The objective of this study is to explore the lived experiences of Somali women who underwent female circumcision to obtain a deeper understanding of this phenomenon.

There are some potential positive changes that may arise from this research study. Findings from this study could enable more research within the field of FC. To better understand FC, researchers have to hear from women who have experienced circumcision

themselves. Also, the findings from this study could help policymakers to formulate policies banning or promoting a modified form of FC among practicing communities. Health care practitioners and people working in social services and refugee services need to understand the importance of circumcision in the lives of women who underwent this procedure so they can provide culturally sensitive care to circumcised women, their families, and the community they live in without interfering with their cultural beliefs.

The terms FGM, FGC, and FC are all used to describe the removal of the external female genitalia. Some people do not want to use the word circumcision, as it might be seen as linking FGC to male circumcision, a procedure that, while somewhat controversial (WHO, 2008), is generally viewed as far less harmful to boys and men with few to no serious side effects. For the purpose of this research study, I will use the term female circumcision (FC) throughout the study for female genital mutilation (FGM) or female genital cutting (FGC).

The major sections of Chapter 1 include an introduction to the study, background, problem statement, purpose, research questions, conceptual framework, nature of the study, definitions, assumptions, scope and delimitations, limitations, significance, and summary of the study. I also provide a summary of the research literature in this chapter.

Background

About 140 million girls and women worldwide have undergone FC with a majority of them coming from 28 countries in the continent of Africa (Gele, Kumar, Hjelde, & Sundby, 2012). More Somali women are circumcised than any other women: about 98% of the population between 15 to 49 years old (Gele et al., 2013). Among

countries that practice FC, Somali people make up one of the largest immigrant groups in Europe, America, and Asia, and are considered a cultural group that supports the practice of FC (Gele et al., 2012). In 2000, it was estimated that between 150,000 to 200,000 girls and women in the United States were at risk of undergoing circumcision, and experts estimate that this number has increased since the study was conducted (Sanctuary for Families, 2013). Sanctuary for Families indicates that Somali and other African families import traditional practitioners from overseas into the United States to circumcise their daughters, and in some cases, they send their daughters abroad for circumcision. The practice of sending their daughters abroad has become known as "vacation cutting" (Sanctuary for Families, 2013). Due to the increase in this immigrant population in the United States and their continued practice of circumcising their daughters, whether the procedure takes place in the United States or abroad, health care practitioners in the United States need more information about specific ethnic groups to better provide them with culturally appropriate care (Sanctuary for Families, 2013).

Social and religious factors also constitute reasons why FC is practiced in Somalia. In Somaliland, the term FC is known as *gudniinka dunarka* or removal of female external genitalia for no medical reason (WHO, 2013). Traditional practitioners and in some cases health care practitioners usually carry out circumcision without anesthesia, which often results in pain as well as major medical and psychological issues such as infections, excessive bleeding, shock, difficulties in menstruation, impaired sexual pleasure, HIV, complications in childbirth, keloid, and death (Hamoudi & Shier,

2010, WHO, 2013). The level or degree of complication usually depends on the type or category of circumcision performed (WHO, 2013).

Many consider FC to be abuse and a violation women's basic rights, which has caused many women to migrate to other countries in fear of being thrown out of their societies for refusing to be circumcised. Some circumcised women find it difficult to attend prenatal and postnatal care, as western health care professionals have less experience providing culturally sensitive care to circumcised women (Chalmers & Hashi, 2000). Additionally, many Somali refugees in Minnesota do not have health insurance and lack health care practitioners who can properly communicate with them concerning their health problems (Minnesota Department of Health [MDH], 2005). If they happen to develop chronic health problems such as high blood pressure and diabetes in addition to being circumcised, they will suffer a higher rate of health complication (MDH, 2005).

Morison, Dirir, Elmi, Warsame and Dirir (2004) concluded that women who arrived and lived in London at a younger age were more likely to abandon circumcision than older women. Males, older generations, and new arrivals were resistant to abandoning the practice and attributed it to religion, marriageability beliefs, and sexuality. Despite national and international efforts to eradicate FC in communities, social norms and conventions have continued to play a part in keeping the practice alive (Mackie, 2000). Mackie (2000) argued that FC could successfully be abandoned only through the context of social movements, such as a combination of education, political will, and media involvement. Education involves teaching basic human biology, sexuality, and the practice of hygiene for women, and media involves creating an

awareness to target rural dwellers about the health consequences of FC and availability of help from social agencies.International organizations fighting to eliminate FC should have a role to play in such efforts (Ayenigbara, Aina, & Famakin, 2013; Rojer, 2011).

The gap in the literature is that few studies have sought to understand FC through the point of view of women who have undergone the practice. It is important to know how Somali women think and how they feel about FC in order to create any real or lasting change. My intention is to fill this gap with this study. In order to find out their views about FC as they have experienced it, participants in this study were Somali women who underwent circumcision before coming to the United States. Hence, this phenomenological study sought to investigate the lived experiences of Somali women who underwent circumcision. Their recommendations regarding the practices of FC could be used to establish and promote policies that will be sensitive to their needs. This study could raise questions for future research in the area of FC, enable healthcare professionals to create better ways of providing care to circumcised women, and also improve the health and lives of women in the communities.

Problem Statement

Different communities and families have different reasons for practicing FC, according to Hernlund and Shell-Duncan (2007). It has been difficult for families to abandon this practice despite the many complications that follow FC, as those who do so risk being seen as outsiders to their society. There is a perception in communities where FC is practiced that a woman's clitoris resembles a man's penis and must be cut off for her to be considered a female (WHO, 2011). In Somalia, for example, female

circumcision is widely practiced and even determines a girl's prospect of getting married within the community (UNICEF, 2005). Some families in Somalia depend on a substantial bride price for their daily living, while others consider FC part of raising their daughter properly (Hernlund & Shell-Duncan 2007; Yoder, Abderrahim, & Zhuzhuni, 2004). Because of the impact on the future of the girls in the family and the fact that it is collectively practiced in Somalia, it is difficult for individual families to abandon the practice of FC (Gele et al., 2012). Somali women might continue the practice of FC not because they wish to do so but based on the expectation that others in the same society are practicing FC as a social rule or convention (Mackie & LeJeune, 2009). As such, some countries such as the United States have labeled FC as a harmful practice that needs to be abandoned (Sanctuary for Families, 2013).

Even though FC in all forms has been illegal in the United States since 1996, there has been a rise in the number of girls and women circumcised in the United States (Sanctuary for Families, 2013). Sanctuary for Families found that the federal government did not penalize circumcision performed outside of the United States until 2013, when President Barack Obama signed the Transport for Female Genital Mutilation Act, which will penalize anyone who transports a minor abroad for circumcision purposes.

However, because there are many different justifications for the practice of FC, it is difficult for health care practitioners, social workers, and immigration officers to provide women who have experienced FC with culturally appropriate care. Knowing what Somali women think and how they feel about FC will make it easier for international organizations such as those dedicated to human rights to ban or modify the

practice of FC and at the same time take into account various cultural significances and values of practicing communities. Hence, there is a need to explore the lived experiences of women who underwent female circumcision Therefore, in order to better understand the attitudes and beliefs about FC among Somali women, I investigated the lived experiences of a group of Somali women who underwent FC and now live in the United States. This can help clinicians and policy makers to better understand what the women experienced and their feelings about the practice of FC.

Purpose of the Study

The purpose of this phenomenological study was to explore the lived experiences of Somali women living in the United States who had undergone circumcision . This research took into account the age and educational experiences of the participants. Participants were 18 years and above and had to be able to read and write English because those who could not read or write in English would not have been able to answer the online questions independently. Questions were open-ended and were posted online. This study allowed Somali women to describe their experiences along with religious, cultural, and social factors that relate to FC practices. They were also able to describe how they think and feel about having been circumcised. The literature review section provides more understanding and justifications for the practice of FC among Somali women. The method of investigation was through a phenomenological approach, which will be explained in Chapter 3.

Research Question

RQ: What are the lived experiences of Somali women currently living in the United States who experienced circumcision in Somalia?

Conceptual Framework

The conceptual framework for this study is the idea of social convention. Social convention is a pattern of behavior that results from the interdependency of actions of different agents that have possible alternatives; in other words, things that are part of a society's expected behaviors and beliefs (Jamieson, 1975; Marmor, 2009). According to Jamieson (1975), David Lewis was a pioneer in the field of social convention. Lewis used game theory to analyze convention and went on to argue that social conventions are rules established by people to solve recurring conditional problems (Jamieson, 1975). Jamieson used an example to illustrate Lewis's social convention. Suppose everybody drives on the left side of the road. It matters little because everyone is driving in the same direction. However, if some drivers decide to drive on the left side of the road while others drive on the right side of the road, everyone will be in danger of a collision. Everyone has to collectively choose whether to drive on the left side of the road or on the right side of the road.

The reason why FC is still practiced is partly because of social convention, which is linked together with sociocultural factors such as social acceptance, pressure from peers, and the fear of not being able to get married within the community (Mackie, 1996). In essence, the social convention theory illustrates the difficulties experienced by individual families when they decide to abandon FC because the decision impacts the

potential for their daughters to get married (Gele et al., 2012). For example, foot binding continued in China for several centuries, even by those who said they opposed the practice, because trying to abandon it individually was not possible (Mackie, 1996). The only way to abandon FC within a practicing community is to do so collectively (Hansen, 2006; Mackie, 2009; Shell-Duncan, Wander, Hemlund, & Moreau, 2011; UNICEF 2010). Social convention can be used successfully to stop or modify practices that are considered harmful in communities while allowing communities to maintain their cultures. If it is determined that FC is a harmful practice by Somali women living in the United States who underwent circumcision , social convention may be used by researchers for future research, educators for health education, policymakers to design or improve policies, and health practitioners to better care for circumcised women. More detailed analysis about social convention theory is contained in Chapter 2.

Nature of the Study

The study was qualitative, using an inductive approach with a goal to gain a deeper understanding of the experiences of a person or group studied. The phenomenological research study was consistent with exploring lived experiences of Somali women in the United States who underwent FC. In Somalia, there are different reasons why women have been circumcised. These include religious, cultural, and social factors (WHO, 2013). The goal of this research study was to find out what circumcised women thought and felt about circumcision and whether there were any existing patterns that emerged from their stories. Common existing patterns could be used for future positive changes in the field of FC research. A phenomenological approach describes a

phenomenon that is common to all participants in the study, such as FC to the Somali women living in the United States who I surveyed in this study (Creswell, 2009). Furthermore, a phenomenological approach described how participants experienced circumcision (Moustakas, 1994).

According to Patton (2002), qualitative research can be used to study selective issues in more detail then quantitative research studies. Using the phenomenological approach, the lived experiences of Somali women who underwent FC were studied individually rather than as a group. Initially, the study was supposed to be conducted face to face in upstate New York, but because of the sensitive nature of the study, I was advised to carry on the research electronically. Participants were contacted through Somali community groups in the Northeastern region of the United States through snowball sampling. The questions used were open-ended, and were sent to participants through a link so that the survey could be completed online.

Many techniques can be used for analyzing qualitative data. These include ethnographic analysis, narrative analysis, the constant comparative method, and phenomenological analysis (Kawulich, 2004). In this study, interpretative phenomenological analysis (IPA) was used to analyze data. IPA is used to explore in detail the lived experiences of participants and how they themselves make sense of their experiences (Smith & Osborn, 2003). This process involves an in-depth analysis of how participants are trying to describe their actions and reactions to a phenomenon, in this instance, FC (Smith & Osborn, 2003). It is important for researchers to give meaning to data collected from participants rather than finding out what the data says about

participants (LeCompte & Schensul, 1999); this can be done better by attaching meaning and significance to the data in order to expose themes. When using IPA, more attention is focused on reducing bias by trying to bracket the researcher out and enter into participants' perceptions. Collected data was extracted, classified, and coded into common themes, and the common themes were then interpreted.

Definitions

Anesthesia: The condition of not feeling pain, especially by use of special drugs (Duncan, 2001;Nour, 2008; WHO, 2008a).

Attitude: Learned tendency to evaluate things in a certain way, which includes evaluations of people, issues, objects, or events. (Gele et al., 2012).

Female genital mutilation: Female circumcision, also called female genital mutilation, or female cutting is any intentional alteration or injury to the female genitals for nonmedical reasons (WHO, 2013).

Gudniinka dunarka: In Somalia, *Gudniinka dunarka* refers to the removal of female genitalia for nonmedical reasons (WHO, 2013).

Health care practitioner: A trained and licensed professional who delivers medical care in a systematic way, following prescribed protocols and procedures.

Hemorrhage: A medical condition in which there is an uncontrolled flow of blood (Hamoudi & Shier, 2010; WHO, 2013).

Assumptions

Assumptions are ideas in a study that are expected to be true even though they may not be true and are sometimes out of the researchers' control, but if they disappear,

the study will not be relevant (Simon, 2011). There are several assumptions included in this study. First, I assumed that the participants in this study were actually Somali women who underwent FC and are living in the United States. Second, I assumed that participants understood the interview questions and answered them honestly and accurately and that the responses were interpreted without any bias. To assume that participants answered honestly, anonymity and confidentiality were preserved and all participants were volunteers who could withdraw from the study at any time with no consequences. Third, I assumed participants who underwent FC would be able and willing to share their lived experiences. These assumptions were necessary for this study because I wanted to understand how Somali women who underwent FC and are now living in the United States thought and felt about circumcision in order to present their actual stories.

The use of a phenomenological method provided a rich understanding of the lived experiences of Somali women who underwent FC and were living in the United States. In order to assure participants that the online survey questions would answer the research question, I conducted a pilot study with participants similar to Somali women who underwent FC and were living in the United States at the time of the study.

Scope and Delimitations

The scope of this research study was limited to 18 Somali women. This study focused on lived experiences of Somali women who underwent FC in Somalia and were living in the United States at the time of the study. Participants 18 years and older and able to read and write in English completed an online open-ended survey. The

questionnaire included basic demographic questions and questions that asked participants to explain their experiences, beliefs, and attitudes towards female circumcision. The snowball sampling technique was used to recruit participants for the study.

Delimitations for this research study were that a face-to-face interview, which I thought to use from the beginning of this research study, was not possible because of the sensitive nature of the study topic. Somali women culturally are not allowed to speak to men to whom they are not related. Second, the lack of access to computers by some participants may have influenced their ability to participate in this research study. Third, the study did not cover any Somali woman who was circumcised somewhere other than Somalia or Somali women living outside of the United States. Demographics such as gender, age, marital status, profession, educational level, and number of children might also have influenced the way participants responded to the survey. Also, quantitative research methods were not used in this study because the study did not seek to find out the number of participants circumcised or other demographic information, but rather their lived experiences. Although participants were Somali women living in the United States, I focused only on Somali women in Northeast New York State in order to limit the study. No men were included in the study.

Potential transferability for this research study involved comparing participants' characteristics to their available demography and/or whether their behavior and the content of the interview were typical to their lives (Krefting, 1991). It is important to understand that the purpose of this phenomenological study was to find the meaning of FC from those who personally experienced the phenomenon. As with any other

phenomenological studies, the results of this research study could not be generalized to the larger population of Somali women who underwent FC and are living in the United States. The goal is to interpret what these participants thought and felt about FC and not to generalize the results, as is the case with quantitative research study (Creswell, 2007).

Limitations

Limitations in this study are potential weaknesses that are possibly related to the design, analysis, or sample such as age, gender, ethnicity, and/or geographical location and that cannot be controlled. The population of this study was limited to Somali women 18 years old and above who underwent FC and were living in the Northeastern region of the United States at the time of the study. As such, the results were limited to participants of the study and not all Somali women or all circumcised women living in the United States. Therefore, what might have been true for participants of this of study might not be true for other circumcised women in the United States. Findings from this study were specific to only one group of Somali women of age 18 years and above who underwent FC and were living in the United States.

Significance

The study is significant because it raised several questions for future research in the area of FC. There is limited literature on FC, especially on Somali women who underwent circumcision; therefore, this study adds to the existing studies that describe FC. The research could also enable communities to develop programs aimed at reducing or eliminating some of the negative consequences of FC such as pain, childbirth complications, and death. The results could enable policy makers to establish and

promote policies that will be sensitive to the views and concerns of affected women and better understand the causes and repercussions of FC. This study also could enable health care professionals to provide culture-appropriate care to women who have experienced circumcision from various cultural backgrounds, which could improve the lives of the women and the communities in which they live. Moreover, the findings could provide governments with information needed to draft laws that may impact the practice. The study could generate positive social change by assuring circumcised women that their views about FC matter and could potentially impact the health care system. The study could also empower circumcised women to attend western health care facilities without any hesitations. Overall, the study could improve, promote, and maintain a healthier outcome for circumcised women leading to improved lives for them, their families, and their communities.

Summary

Chapter 1 presented an introduction to the practice of FC throughout the world. The problem statement focused on circumcised Somali women living in the United States. The theory of social convention, which was used as the framework of this study, was discussed. Chapter 1 also reviewed the current literature; a full review will be provided in detail in Chapter 2. The literature focuses on issues that concern FC with regard to women from Africa. The literature review also analyzes scholarly articles focusing on other circumcised women's experiences, beliefs, and expectations. Chapter 2 will also review the conceptual framework of the study and some of the challenges that circumcised women, especially Somali women, face, as well as ways to impact FC.

Chapter 2: Literature Review

Introduction

The practice of FC is a worldwide issue, with over 30 African countries and parts of the Middle East practicing some form of FC (Daley, 2004; Lee, 2007;WHO, 2008). It has been estimated between 100 and 140 million girls and women worldwide and about 92 million in Africa have been circumcised with about 3 million girls at risk of undergoing FC every year (Momoh, 2006; Rasaq, 2012; Serour, 2006; UNICEF, 2007;WHO 2008a; WHO 2008b). Somalia has the highest prevalence of FC (UNICEF, 2008) with more than 98% of women circumcised in one or more forms or types of female circumcision. The most common is the complete removal of the clitoris and labia minora, together with the inner surface of the labia majora (Jones et al., 2004; Rasaq, 2012; Weir, 2000). Other countries with a high prevalence of FC are Egypt, Ethiopia, Kenya, Nigeria, and Sudan (Warner & Nieto-Salinas, 2010). The practice is emerging among refugee populations in North America and Europe because of an increase in population movement and immigration from practicing countries (Dustin, 2010). Some of these communities, especially those from Somalia, do not receive appropriate health services because of cultural reasons (Pavlish, Noor, & Brandt, 2010). Hence, there is a need for further research about FC.

Preview of Chapter

The literature review begins with the search strategies, discussion of articles related to the history of FC, definitions, types of FC, reasons why FC is practiced, medical and health consequences, how to manage FC complications during pregnancy,

and debates ranging around the practice. This review is centered on articles that relate to the theoretical foundation of the dissertation and legislation that is in place to combat the practice of FC, as well as those who oppose the legislation to end the practice. While data and articles for this research study are scarce, I have decided to concentrate more on articles from Europe and the United States, which harbor more immigrants from communities that practice FC.

Purpose

The purpose of this phenomenological study was to explore the lived experiences of Somali women in the United States who underwent FC. This section focuses on the literature that supported and guided the study. The review will identify several reasons why FC is practiced in 30 African countries and several Middle Eastern countries, which include, among others, cultural, religious, and social factors. The review will also provide some ethical, moral, and legal issues that surround FC practices. As the review continues, a conceptual framework will be discussed for current and future scholarly considerations of FC, not only with Somali women, but also for all women in countries where FC is practiced.

Literature Search Strategy

To explore the lived experiences of Somali women in the United States who underwent FC, I had to search sources from various databases. I searched for articles using CINAHL, ProQuest, MEDLINE, SocINDEX, SAGE premier, Cochrane Database, PsycINFO, and an electronic search from Walden University online Library. Commercial search engines such as Yahoo and Google were used as well. Key terms used for each

search included *female genital mutilation, female circumcision, female circumcision in Somalia, history of female genital mutilation, consequences of female genital mutilation, social convention, child protection, human right, Somali, transcultural health, education, laws, policies, history, attitudes, types,* and *female genital cutting*. I used these key terms either alone or in combination while researching the topic. I reviewed more than 200 articles for this research study, and a majority of them were published less than five years ago. A few articles used were more than five years old, but they were found to be important for this study because of the rich information they carried. I reviewed books from experts in the field of female FC; papers from scholars and educators and videos about FC were also explored. Databases listing conference abstracts and scanned reference lists of articles were searched. Articles were then organized into headings and subheadings that reflect FC practices.

Conceptual Framework

Social Convention

The theoretical framework for this study is social convention theory. David Lewis (1969), who is considered the pioneer of social convention theory using game theory, considered "conventions" to be solutions repeated to solve coordinated problems. According to Lewis, a convention is any regularity in action that solves society's coordinated problems, even if every individual in that society does not agree upon the convention. Such regularity can continue to persist because it is accepted as being in everyone's interest (Verbeek, 2002). In other words, social convention occurs when some group of agents widely observe a regularity, such as driving on the right side of the road

rather on the left in the United States. If in the United States it is agreed that people should drive on the right, there will be no reason for anyone to drive on the left since otherwise this will cause a collision Verbeek, 2002), Many communities abide by conventions of dress, language, and food so that one person or family alone would find it difficult to abandon practicing them (UNICEF, 2008).

In the case of FC, social convention theory illustrates that since the decision made by a single family on whether or not to circumcise a daughter depends on the practice in the community at large, the change of attitude towards FC to phase out this practice is only possible if it is a collective decision (Hansen, 2006; Shell-Duncan et al.2011; UNICEF 2010). Social convention was successfully used in reducing the prevalence of FC in Egypt, Kenya, and Sierra Leone (USAID, 2013). In Egypt, 91% of women underwent FC in 2008 as compared to 96% in 2005; in Kenya 27% underwent FC in 2008 as compared to 32% in 2003 and 38% in 1998; and in Sierra Leone, 88% underwent FC in 2010 as opposed to 94% in 2006 (USAID, 2013).

In Somalia, FC is widely practiced and even determines a girl's prospect for getting married. As such, parents in Somalia carry out the practice to ensure that their daughters are able to marry within that society (UNICEF, 2005). In essence, the social convention theory illustrates the difficulties experienced by a single family on its own to abandon the practice of FC because of the impact on the future of the girls in the family (Gele et al., 2012). Somali women might continue the practice of FC not because they truly wish to do so but based on the expectation that others in the same society are practicing FC as a social rule or convention.

Phenomenological Approach

This qualitative research study endeavored to examine the lived experience of Somali women who underwent FC and were living in the United States, based on the theoretical framework of phenomenology. A phenomenologist investigates different ways in which people experience or think about something (Patton, 2002; Van Manen, 1997). By listening to different stories from participants, the researcher's emphasis is on the world as lived by the individual, not the world as something separate from the individual (Vale, King, & Halling, 1989). Phenomenology as a method describes accurately an individual's lived experiences in relation to what is being studied, and/or interprets the characteristic of the phenomena rather than describing a grand theory or developing a model (Munhall, 2007).

According to Lester (1999), there is an overlapping of phenomenological research with ethnography, hermeneutics, and symbolic interactionism. In a pure phenomenological approach, the phenomenologist seeks to describe rather than explain the phenomena and usually starts from a perspective that does not have a hypothesis or preconception (Husserl, 1970). According to Munhall (2007), interpretive phenomenology is used to search for situated meanings in order to interact in time because people are constantly making meaning of ongoing experience. I used phenomenology as a conceptual framework to study circumcised Somalian women's personal experiences and interpretation of their bodily experiences, perceptions, and sensations (Munhall, 2007) as individuals or an embedded group.

History of FGM

The history of FC is not known, but many theorists believe that it began some two thousand years ago in Egypt and then spread to other parts of the world (Little, 2003). Female mummies in Egypt were found circumcised as a sign of distinction. Although female circumcision has been practiced in Somalia since the beginning of recorded history, it is still unknown when it started in Somalia (Gele, Johansen, & Sundby, 2012). Somalian FC practitioners perform Pharaonic (Type III) circumcision, which is known to be the most radical form of female circumcision (WHO, 2004). Traditional practitioners in Somalia usually perform FC, but recently, the number of modern health practitioners performing the practice has increased (World Bank, 2004; UNICEF, 2008).

Justification for FC Practice

Different communities have different reasons for practicing female circumcision (Hernlund & Shell-Duncan, 2007). The practice of FC in Somalia is justified under cultural, religious, and social factors (WHO, 2013). In a mixed method research study of single Somali men and women living in Britain, Morison et al. (2004) found that religion was claimed to be one of the primary reasons for FC in Somalia. The majority of female participants said that infibulation, which is known as *haram,* was central to Islam but continued that *Sunnah*, also known as Type I circumcision was acceptable under Islamic practice. Reasons why participants in Morison et al.'s study either did not want to be circumcised, were willing to marry uncircumcised women, or allowed their daughters to be circumcised or remain uncircumcised were found to be not because of religion but as a result of how long they had been in Britain, despite the participants' claims that religion

was the motivating factor (Morison et al. 2004). In a study to find out why FC was performed, Utz-Billing (2008) found out that 95 % of participants said that FC was performed for cultural and traditional reasons, 49 % said to prevent promiscuity, while 18 % said it was to reconstruct the perceived ugliness of the of the vagina. The rest of the participants had various reasons for FC practices. Although some participants recognized tradition as one of the reasons for FC, they favored the discontinuity of the practice and said that they did not know the origin of this tradition. Morison et al. (2004) used snowball sampling to identify study participants. The sampling may therefore have overrepresented those willing to discuss the sensitive topic of FC and participants who looked favorably upon the clan of the research assistant, who was a member of the community involved. In this study, I asked Somali women in the United States who underwent FC whether religion was a reason or one of their reasons for accepting circumcision in order to identify and clarify the misconceptions that may exist about the practice of FC in regard to religion.

Marriageability

Aside from religious and traditional reasons, Somali women have been found to choose FC for their daughters so that they are more eligible for marriage. A desire for proper marriage is perhaps one common justifiable reason offered across practicing communities, including Somalia, as girls without circumcision find it difficult to marry within that society (Braddy & Files, 2007). Men wanting a circumcised woman for marriage was one of the reasons that many Somali families said they want their daughters to be circumcised (Morison el al., 2004). Poverty has made some families depend largely

on bride price for their daily living, while other families consider FC to be part of raising their daughter properly (Hernlund & Shell-Duncan 2007; Yoder et al., 2004). In considering the idea that marriage is a good reason for FC as noted above, Morison et al, (2004) argued that males of the older generation and those who recently arrived in Britain from Somalia were those who favored FC. In this study, I looked into more detailed social factors associated with FC

Passage to Womanhood

In addition, FC is considered a rite of passage to womanhood that is necessary for girls to have in order to be respected and accepted as adult women. Many parents go so far as taking their girls back to their countries of origin to have such procedures performed for fear of being prosecuted in locations where FC is illegal (Krása, 2010; USAID, 2007). Moreover, if a girl refuses to undergo FC, she is seen as an outcast and is therefore rejected by her peers (Ahmadu, 2000). Those who undergo FC can participate in adult social groups.

Hygienic purposes

Rashid and Rashid (2007) cited that FC is practiced because of hygiene and cleaning and a belief that it guarantees female virginity until she gets married. Female genitalia that are not cut are believed to be unclean or polluted and poisonous to the baby during birth (Royal College of Nursing, 2006). It is believed that during childbirth, the baby or the mother will die if the baby touches the clitoris (Abusharaf, 2001)

Fidelity Purposes

Some communities believe that FC reduces the possibility of premarital and extra-marital sex (Royal College of Nursing, 2006). For example, the Ejagham people of Cameroon believed that circumcision cools down a woman's anxiety for sex (Ngambouk, 2010). Ngambouk determined that higher numbers of prostitutes in Cameroon are women who did not undergo female circumcision. In a cross-sectional study of 1,836 women who underwent FC and those who did not undergo FC in three hospitals in Nigeria to analyze the sexual pleasure of circumcised women, In addition, narrow vaginal openings heighten male sexual pleasure during sex (Braddy & Files, 2007; Lee, 2007; Serour, 2006). It is believed in Somali communities that the lack of sexual pleasure experienced by a man with an uncircumcised wife might result in marriage breakdown. Okonofu et al. (2002) found no significant different between FC women and non-FC women. One problem with the study is that it was done in hospitals with participants that did not necessarily represent the population at large. Hospital-based sampling, according to Obermeyer (2005), may introduce sampling bias that might skew the study.

Lack of Education

Dalal, Lawoko, and Jansson (2010) and Hayford and Trinitapoli (2011) pointed out that education, which is highly correlated with social class, was in part and still remains the key point in FC practices. Women and girls with higher education and from wealthy households were more likely to oppose FC practices and less likely to have their daughter circumcised than less educated women and girls in less wealthy households (Hayford & Trinitapoli, 2011; Kemsley, 2013). In a quantitative study to gain insight into

what beliefs or knowledge were conducive to supporting FC, Allam et al. (2001) randomly selected and interviewed 1070 medical and non-medical students in Cairo, Egypt and found out that a higher percentage of medical and non-medical students favored the abolishment of FC when compared to their non-student peers. However, Allam et al.'s, (2001) sources of information were from medical literature, radio, television, and relatives and friends of those who actually underwent FC, which might not be realistic. Participants, being medical students, were highly educated and were likely going to support the abolition of FC practice. Education has been shown to affect individual perceptions of FC practices (Almroth, et al., 2001), which can result in changes rate of the practice of FC.

Ethical and Moral Justification

Elsayed, Elamin and Sulaiman (2011) defined moral principles as the principles of right or wrong and ethics as a set of codes of conduct that has been determined by people in specific profession that is governed by sets of principles that professionals should abide by. The authors continued that individuals who oppose FC should not be considered immoral, and if they refused to circumcise their daughters, they should not be punished for morals that are not the same as ethics. In terms of medical ethics, FC the ideal is that it should only be performed by medical doctors or trained professional with medical justifications in order not to violate principle of nonmaleficence. In Sudan, medical professionals continue to perform FC that has no medical benefit or value, due to public pressure. When they refuse to perform FC for one reason or another, the society tends to consider them to be disrespectful to their societal norms (Elsayed et al., 2011).

FC Controversy

The practice of FC has elicited some controversy all over the world. Although many countries and international organizations consider FC a human rights violation, practicing communities view it an integral part of their culture that has not been changed for centuries (Gruenbaum, 2001). According to Gruenbaum (2001), there is no practicing community that has identified sexuality as the only reason for practicing female circumcision, even though FC is commonly seen in the West as a result of gender inequality. FC, as noted by the author, is a consequence of religion, marriage, and sexuality; Gruenbaum suggested that the entire community has to come together as a single group if they want to abolish FC.

Another FC controversy is portrayed in the film *Moolaade,* which was directed by Ousmane Sembene. In the movie, the character Colle tries a string of yarn to evoke *Moolaade* (Magic protection), across the door of her house to prevent her daughter Amsatou from circumcision. So long as the girl stayed in doors, no person could enter the house to circumcise her. The magic caused a division among traditional elders and the younger generation. The girl finally got married to Ibrahima, a rich man returning from France, despite being denounced by the community (Sembene, 2004). The director presented cultural change from within, in relation to FC.

Complications

Both long and short-term medical complications can arise from FC; these differ according to the type of circumcision performed (Safari (2013). Severity of complication depends on the type of FC, the individual's physical condition, the skill of the cutter, and

the cleanliness of the procedure (WHO, 2013). Short-term or immediate complications are those that occur immediately following the operation, and long-term complications are those that occur after the primary healing of the practice (Braddy & Files, 2007: WHO, 2013). Long and short-term complications are dangerous to the circumcised girl or woman and to the newborn child of a circumcised mother.

Short-Term Complications

Short-term complications may occur because of unsanitary conditions during the procedure or lack of proper medical care during and after the cutting. Short-term complications of FC include pain from lack of anesthesia; however even when used, anesthesia is not always effective, as the duration of the procedure may be longer than expected; hence, the intensity and duration of pain are more extensive. Other short-term complications include hemorrhage, shock as a result of pain and hemorrhage, difficulties passing urine or urine retention, infections, HIV due to unsterilized surgical tools, psychological consequences, and death (WHO, 2013). Short-term complication might progress to long-term complication depending on the age, of the girl, where the circumcision was done, and how it was done.

Long-Term Complications

Keloids (hardening of the vaginal scars), sexually transmitted disease, reproductive tract infections, reduced quality of sexual life, birth complications, and danger to the newborn are some long-term complications (Hamoudi & Shier, 2010, WHO, 2013). Other complications include depression, psychosis, anxiety, and post traumatic stress disorder (Braddy &Files, 2007). In addition, in a study to assess the risk

factors of cervical cancer in Khartoum, Sudan, Ibrahim, Rasch, Pukkala, and Aro (2011) concluded that women who underwent FC were at higher risk of cervical cancer. Type III circumcision can cause prolonged or obstructive labor due to tightness and can result in fetal distress and death. It was reported in 2006 that one in every 100 women in Somalia died during childbirth due to the high rate of FC been performed (Royal College of Nursing) with a nationwide estimate of 1 to 2 babies out of 100 deliveries dying from FC complications (UNFPA, n.d.). Sclerotic scars and loss of vaginal tissues can occur due to constant cutting and stitching, which usually takes place at home (Krása, 2010).

HIV as a long term complication. Brewer, Potterat, Roberts and Brody (2007) did a study to examine the relationship between circumcision and HIV infections in Kenyan, Lesothoan, and Tanzanian virgins and found that HIV prevalence ranged between 1% and 3% in virgins of all age groups. In addition, circumcised virgins were more likely to be HIV positive than uncircumcised virgins. This is because traditional practitioners who performed FC used unsterilized instruments on multiple individuals who might have been infected with HIV. According to the authors, there was no association between FC and other sexually transmitted diseases. Ibrahim et al. (2013) also conducted a study in Nigeria and found female circumcision to be a public health issue. Out of those interviewed for the study, 14 nurses/midwives and 15 doctors mentioned HIV as one complication associated with female circumcision. According to Ali (2012), the majority of participants believed that FC does not increase the risk of HIV but argued that FC practice should be discouraged regardless.

Some obstetrical problems as long-term complications. In the long-term, women may suffer from accumulation of menstrual blood in the abdomen (haematocolpos), which can cause serious abdominal distention (Momoh, 2011). Haematocolpos can prevent menstrual flow, causing severe lower abdominal pain or dysmenorrhea during menstruation (Momoh, 2011). Scarring from Type II and III FC can prolong or obstruct labor, which can lead to perineal tearing and/or fetal death in labor. However, in a hospital-based study in Nigeria, Slanger, Snow, and Okonofua (2002) found no significant differences among women who underwent FC and those who did not during their first deliveries. In another study of 492 Ethiopian women with obstetric fistulae, who had undergone FC, Browning, Allsworth, and Wall (2010) cited that those women were not more likely to develop obstetric fistulae from obstructed labor and concluded that obstetric fistulae resulted from childbirth injury. Rouzi (2010) reported on a Muslim population after FC and cited that clitoral cysts are a common complication of female circumcision. Fifteen women in the Rouzi study did not undergo FC, 14 did not know if they were genitally mutilated or not, and 3 reported that they did not undergo FC. However, 28 of the 32 women underwent surgical excision regardless of whether they had history of FC while one of the women had incision and drainage of a clitoral abscess performed. There is no evidence from this study that epidural clitoral cysts were a more common complication of FC, as the author concluded.

Painful sexual intercourse as a long-term complication. It is believed that narrow vaginal openings heighten male sexual pleasure during sex (Braddy & Files, 2007; Lee, 2007; Serour, 2006), but that is not the case for women who underwent FC.

The opposite is that the small opening of the vaginal entrance causes more pain to women rather than pleasure. In a study in Egypt, Baron and Denmark (2006) found that women who underwent circumcision had less sexual activity, less frequency of orgasms, and less sexual satisfaction than women who were not circumcised; these women also experienced pain during sexual intercourse as a result of penetration and small passage of vaginal orifice. Baron and Denmark continued that lack of sexual desire and pain during sex can lead to a high level of divorce. A woman is considered strong, powerful and highly respected in the society according to Abusharaf (2001) if she is able to resist her husband's sexual advances during sexual intercourse. This contradicts Okonofu et al.'s (2002) findings that sexual activity of circumcised women starts earlier as well frequency of orgasm during sexual intercourse. This qualitative study sought more information from circumcised Somali women in the United States about their sexual activities and whether they achieve orgasm during sexual intercourse.

Management of FC Complications During Pregnancy

According to the Royal College of Nursing (2006), a care plan should be in place as soon as the woman becomes pregnant, and women should be discouraged from resuturing or re-infibulation when they deliver. The Royal College of Nursing (2006) also suggested that deinfibulation should be offered to circumcised women where appropriate, with the involvement of their partners. Deinfibulation is recommended during the second trimester to allow healing before delivery and to avoid spontaneous abortion (Afewerki, 2010). Additionally, women who choose not to be deinfibulated during pregnancy are advised to deliver in hospital in case of any complications. Deinfibulation in Somalia is

performed by midwives, traditional birth attendants, and sometimes by circumcisers (Nour, 2008).

Changing Attitudes

Choice to Stop FC Practices

Gele, Kumar et al.(2012) carried out a qualitative research study to explore the attitudes of Somalis living in Oslo, Norway in regard to the practice of FC. In all, 38 Somalis (17 male and 21 female) between the ages of 19 and 56 were sampled for the study. From the research, the authors found out that Somalis in Oslo had largely changed their attitudes towards the practice of FC. All types of FC were rejected for health reasons by 36 out 38 participants. The authors concluded that parents from Somalia made choices to stop their daughters from traditional practices perceived as harmful, similar to foot binding in China; consequently strategies used to end foot binding can be used to end female circumcision in practicing countries. The study involved men, however, which was not the case with my study. My study involved only women who underwent FC.

The new Somali Constitution has banned FC, as it is seen as a form of torture to women although it is still being carried out in war torn areas in Somalia as a tradition to prepare women for marriage (Warsameh 2013). However, people in these areas have shifted their culture of FC practice from the more severe type of female circumcision to a less severe type of female circumcision (type III to type I). Shifting to a less severe form of FC practice does not mean that Somali people are ready to abandon the practice completely, however. But according to Warsameh (2013), this change is a major step towards the elimination of FC in Somalia. In an interview conducted in Somalia's

northern region of Puntland and the breakaway state of Somaliland this year, Warsameh found that only 25% of girls between the ages of 1 to 4 were circumcised, as compared to 90% who underwent FC before the intervention was put in place. In addition to banning of FC practices in Somalia, UNICEF is working with religious leaders and community leaders in Somali to try to change the attitudes towards FC (Straziuso, 2013).

In another study, Mitike and Deressa (2009) found that many Somali refugees still supported FC practices. In a cross-sectional study of 492 respondents from three refugee camps in the Somali Regional State and Eastern Ethiopia, 84% of the respondents were of the opinion that FC should continue. However, in another research study conducted in Tanzania by Msuya et al. (2002), 76% of women who underwent circumcision disfavored the practice. In a study conducted by Jones (2012), participants favored the discontinuation of FC despite many reasons given for the practice. Both studies involved men and women from countries where FC has been practiced but failed to address those Somali women who underwent FC. In this study, I focused only on Somali women who underwent FC.

Eliminating FC

Despite national and international pressure to eliminate FC, many countries still continue the practice. Many communities in Somalia are against total eradication of female circumcision because they believe it will disrupt their cultural and religious beliefs (Gele, Kumar, et al., 2012). To practicing communities in Somalia, this is an attack on their culture that usually leads to a defensive reaction (Cruenbaum, 2001; WHO, 1999). For example, in a quantitative study to assess knowledge and attitudes of

157 midwives towards FC in Eastern Sudan, 30 midwives claimed that all forms of FC are harmful, while 120 participants did not consider FC practices to be harmful and insisted that the practice should continue for cultural reasons (Ali, 2012). When parents refuse FC for their girls, traditional practitioners and relatives with financial interest may continue to resist change (Afewerki, 2010), and they may continue to perform FC in secret for fear of being punished (Mudege, Egondi, Beguy, & Zulu, 2012).

Eliminating FC through Education

The key to eliminating FC practices is educating the people and providing them with safe alternatives without disrespecting their cultures' use of FC (Jones et al., 2004). Public education through the use of radio, community and religious leaders, television, and print media that is aimed at changing the current notions supporting FC practice may play an important part in changing women's attitudes towards FC (Dalal et al.,, 2010). Kontoyannis and Katsetos (2010) cited education as a major factor that brings about social change. In the case where people think religion is a factor that influences FC practice, it will be necessary to educate female religious leaders more than males in interpreting religious texts for women, as they are the ones affected most by the practice (Waris, 2005).

Eliminating FC Through Legislation

Some countries in Africa, including Sudan and Egypt in the1940s and 1950s, have had laws against the practice of FC for many years. These laws did not work because of lack of public awareness (Rahman & Tobia, 2000). These laws, including those established during the 1979 WHO's conference in Khartoum, brought attention to some

local, national and international communities about health and human rights issues associated with FC (Toubia & Sharief, 2003). Canada, the United States, France, the United Kingdom, and all other countries with large immigrant populations from countries that practice FC have legislation in place that prohibits FC practices and have granted asylum to many women who claimed that they would be prosecuted if they returned to their countries of origin (UNICEF, 2013). Although the United States defines FC as a form of persecution, the federal courts and the Board of Immigration Appeals does not agree that women who underwent FC should be given asylum as a result of their persecution (Kim, 2008).

Although the Female Genital Mutilation Act of 2003 outlawed the practice of FC in England and Wales, individuals continue to transport their children out of the country to perform FC (Momoh, 2011; Robinson, 2011), and no single prosecution has been reported since it was introduced. To close the loophole, the FC Act of 2005 was created in the United Kingdom, making FC an offense for all UK nationals or permanent residents who carry out the practice in the country or abroad, even in a where it is legal (Momoh, 2011; Robinson, 2011). Those who commit or aid others in committing the offense will receive a maximum penalty from 5 to 14 years imprisonment with a fine (Momoh, 2011; Robinson, 2011).

To better control the practice of FC in Somalia, Somali leaders adopted a constitution that prohibits the practice of FC while also permitting women to have abortions when necessary to save their lives (Tatu, 2012). Furthermore, the constitution

permits 30% of women representatives in all public roles so they can take part in decision-making in women's health, rather than only men.

Multi-agency Practice Guidelines on FGM for health professionals, social workers, and other agencies who work closely with girls at risk of circumcision in the United Kingdom were also established (Momoh, 2011). These guidelines, in addition to the London Safeguarding Children Board (LSCB), explained issues surrounding FC, identified girls at risk and those who are already affected by FC, and outlined actions that health professionals should take (Robinson, 2011).

Summary and Conclusions

In summary, FC is a worldwide issue that affects more than 140 million women, with approximately 92 million in Africa and 3 million girls worldwide at the risk of undergoing female circumcision each year (Momoh, 2006; Rasaq, 2012; Serour, 2006; UNICEF, 2007;WHO, 2008; WHO 2008b). Because of immigration, the prevalence of FC is emerging among refugee populations in Europe and North America (Ismail, 2002). Presently, Somalia has the highest FC rate in the world with 98% of women between the ages of 15 and 49 years experiencing FC, and in some cases girls as young as six years old reported to had undergone FC in one or more forms, the most common of these is the cutting of the labia minora (type II and infilbulation or *pharaonic*, (type III) (Jones, et al., 2004; Rasaq, 2012; UNICEF, 2007; Weir, 2000). Eighty present of all circumcision performed on women and girls in Somalia is Type III, and in rare cases, Type II is practiced in coastal areas of Mogadishu, Merca, and Kismayu (United States Department of States, 2001). This suggests that FC is practiced in all parts of Somalia.

Various communities practice FC for different reasons, which include cultural, social, marital, and religious, fidelity, and gender identification (Braddy & Files, 2007; Hernlund & Shell-Duncan 2007; Yoder et al., 2004; WHO, 2013). Many Somalis believe that female circumcision is either a religious obligation to ensure virginity, and/or to increase bride wealth for the family (USDS, 2001), and many Somali men believe that FC heightens their sexual enjoyment and should be practiced for social reasons. The above reasons can be problematic for communities that choose to abandon the practice and can motivate communities that want to continue the practice.

There are many complications associated with the practice of FC, which depend on the type of FC performed and why it was performed. Pain, hemorrhage, keloids, and death, to name a few, are some of the complication (Braddy, & Files, 2007; Hamoudi & Shier, 2010, WHO, 2013). Most women who underwent type III circumcision have been reported to have problems with penetration, especially during their first experience with intercourse, and danger during delivery (Royal College of Nursing, 2006). Type I circumcision causes no major obstruction unless there was infection during the time of the procedure (cite). However, this type of less severe FC is rare to nonexistent in Somalia.

Many communities in Somalia continue to practice FC despite national and international pressure to abandon this practice. The Somali Women's Democratic Association (SWDA) suggested pricking of the clitoris, which should be done in hospitals, as an alternative to types II and III (USDS, 2001). The idea of shifting from types II and III FC to *Sunna* (the mildest form) is that it might be a better way to slow

down the practice in Somalia (Gele et al., 2013). The idea here according to Gele et al., (2013) is not actually to promote a shift to the *Sunna* type but to ultimately emerge with a harmless practice that still respects the cultural heritage of communities who traditionally practiced FC.

In conclusion, research is needed to explore the lived experiences of women from Somalia living in the United States who underwent FC, as only a few qualitative studies have been done to address FC practices. Results from this study might help health care professionals to provide culturally appropriate care to populations who have undergone FC and promote programs that might be used to reduce or eliminate FC practices. Research is needed to find out ways to improve the lives and health of women and the communities they live in, as well as means to reduce or eliminate some of the negative consequences such as pain, childbirth complications, and deaths as a result of FC.

To avoid bias, I did not be interview Somali women directly, but allowed them to provide their responses to my research questions in a completely free and anonymous format. The nature of this study was qualitative with a phenomenological approach, the goal of which is to gain a deeper understanding of experience of a person or group studied. Chapter 3 will discuss the methodology that was used to find out how circumcised Somali women thought and felt about circumcision.

Chapter 3: Methodology

Introduction

A review of the literature revealed a need for more qualitative studies that explore the lived experiences of Somali women who underwent FC and live in the United States. The purpose of this phenomenological research study is to explore the lived experiences of women in the United States who underwent FC. The study is significant because its findings could spur future research in FC-related prevention and policy programs, as well as reduce or eliminate some of the negative consequences of FC such as pain, childbirth complications, and death. The results could enable policy makers to establish and promote policies that will be sensitive to the views and concerns of affected women, who better understand the causes and repercussions of FC. This study could enable health care professionals to provide appropriate cultural care to women from various cultural backgrounds who have experienced FC, which could improve the lives of women and the health of the communities in which they live.

In Chapter 3, I will provide an explanation of the research design and rationale, research questions, the content of the study, recruitment strategy, and how data was collected and analyzed. I will explain the reason for conducting a pilot study and ethical concerns in this study. The used of the phenomenological research method is appropriate for this study, as the scope of the research extended to the participants' personal perspectives and philosophical points of view.

Research Design and Rationale

Research Question

The purpose of this research study was to explore the lived experiences of Somali women who underwent FC and now live in the United States. One question was used for this study: What is the lived experience of Somali Women currently living in the US who experienced circumcision in Somalia? In order to determine consensual validity of the questions to gather data, questions were sent to a team of three experts for validation. Questions were validated and approved (Appendix A). The questions were then administered for testing to non-Somali women who underwent FC. A pilot study was conducted after IRB approval and feedback was sent to the experts on the panel for validation. Some changes were made in the original questions after feedback from the experts on the panel was received.

Research Design

According to Creswell (2009), phenomenology, case study, ethnography, narrative, and grounded theory are five qualitative approaches that are frequently used by researchers working in the interpretive tradition. All of the five approaches involve data collection, analysis, interpretation of data collected, and communication of results in one or more communication media such as a written report. Any one of these approaches could be used to answer the question to explore the lived experiences of Somali women who underwent FC and were living in the United States at the time of the study. However, the phenomenological approach stood out as appropriate for this study for

various reasons that will be elaborated on below. Questionnaires that consisted of open-ended questions were posted online to collect information from participants.

Case study. Case study approach is an explanatory research method that is conducted to develop a causal explanation of some social phenomenon; for example, investigating a crime in a city (McNabb, 2008). Patton (2002) asserted that a case study approach could incorporate an individual, groups, program, countries, cultures, religions, or organizations. He further added that with an ethnographic case study there is only one unit of analysis, which is a community, tribe, or village. Explanatory questions such as "What is different about this type of group?" are asked and investigated through observations, personal interviews, and documents that are studied, rather than dealing with variables (McNabb, 2008). A case study was not suitable for this study because case study would involve exploring one or more cases through detailed in-depth data collection without focusing on an individual's life.

Ethnography. The ethnographic research approach focuses on a detailed and accurate description of an entire cultural group in a natural setting, rather than seeking an explanation (Creswell, 2009). Ethnographic researchers want to know the values of a particular group and what behavior is and is not acceptable within the group. Ethnographic research is conducted through participant observation, unstructured interviews, and analysis of cultural artifacts (McNabb, 2008). According to McNabb (2008), the primary data collection technique used by ethnographers is participant observation. To fully learn about the social life of people in a particular setting, ethnographers have to become insiders by immersing themselves with the group through

working or playing for a long period of time with members of the study group (McNabb, 2008; Patton, 2002). Ethnographic study was not appropriate for this study, as I was not interested in the day-to-day life of Somali women who underwent FC and also was not allowed this kind of access to the participants. I instead used a phenomenological approach to study the lived experiences of Somali women who underwent FC and were living in the United States.

Narrative. Narrative research is the means of representing a past experience of a participant with focus on his or her stories and then arranging them chronologically (Creswell, 2007; Creswell, 2009). McNabb (2008) added that a narrative has a beginning, middle, and end and is the best approach for capturing the life experiences of an individual or small number of individuals. Narrative researchers need a lot of interview training skills, drawing, and listening skills, as a narrative study can either be in an oral or written form (Chase, 2005). Narrative study was not appropriate for this study because this kind of research involves the past events in the life of one individual, rather than the 12 individuals upon whom I focused in a phenomenological approach.

Grounded theory. Grounded theory is a valuable set of qualitative research approaches to social life that attempts to generate theory from the constant comparing of unfolding observations of file notes, intensive interview transcripts, or historical documents (Babbie, 2008; LaRossa, 2005). Grounded theory has its roots in sociology and social psychology, and its primary aim is to generate a theory out of information gathered from the participants' experiences rather than the testing of existing theories through a process of experimentation (McNabb, 2008). Grounded theory was not suitable

for this study as this methodology attempts to develop or discover a theory rather than describing a phenomenon, which was my goal.

Phenomenology. I selected the phenomenological approach for this study to examine experiences as lived by Somali women who underwent FC and were living in the United States. With a phenomenological approach, the researcher identifies participants' experiences about phenomena in a natural setting as described by participants (Creswell, 2009). I used phenomenology with the hope of gaining understanding of the essential truth of lived experiences of Somali women living in the United States who underwent FC. The phenomenological approach treats inquiry first as a process of looking and discovering rather than assuming and deducing (Creswell, 2007). Researchers are particular about participants' perceptions and experiences in connection to their lives. The phenomenologist searches for commonalities across individual participants rather than focusing on what is unique to a single participant (Creswell, 2009).

The value of a research study is significantly reduced if the researcher does not follow a clearly identified approach (Annells, 2007; Crist & Tanner, 2003; Dowling, 2004); therefore, I sought precision in identifying and explaining my approach. The main types of phenomenology are descriptive and interpretive phenomenology. Descriptively, the researcher has to put aside what he or she already knows about the phenomenon being investigated and approach the data with no preconceptions about the phenomenon (Dowling, 2004; Husseri, 1970; Lopez & Willis, 2004). In other words, participants' daily conscious experiences are described in detail while the researcher's preconceived

opinions are bracketed (Dahlberg, Drew, & Nystrom, 2008). According to Moustakas (1994), bracketing is very importing in understanding how participants think and not how the researcher thinks about the phenomenon. It is very important to use bracketing, as it reduces biased opinions in research studies. In the context of this study, bracketing meant that, as the researcher, I had to set aside my own assumptions about FC and its harmful effects in order to understand how the Somali women thought and felt about it.

Furthermore, Husserl (1859-1938), who is considered a founder of the philosophical movement of phenomenology, believed that phenomenology is descriptive and related to consciousness and based on an individual's experience (Rudestam & Newton, 2007). This means that deduction or induction is required in a descriptive phenomenological study in order to find meaning in the phenomenon being studied. On the other hand, Heidegger (1889-1976), a student of Husserl, rejected the theory of epistemology and adopted ontology (the science of being), which led to the development of interpretive phenomenology (Reiners, 2012). According to Heidegger, it is important to be in the world rather than knowing the world. Interpretive phenomenology allows researchers to seek the meaning of what is embedded in everyday occurrences. Interpretive researchers focus on interpreting narratives provided by participants rather than following any preconceptions (Lopez & Wills, 2004).

Role of the Researcher

Unlike quantitative research, where the role of the researcher is theoretically nonexistent, the researcher in a qualitative study is the primary instrument in the collection and analysis of data (Denzin & Lincoln, 2003). Rudestam & Newton (2007)

emphasized that the role of a researcher in a phenomenological research study is to collect data from open-ended questions. The researcher in a qualitative study is the primary instrument in the collection and analysis of data and addressing biases, assumptions, and expectations (Greenbank, 2003). Although this research is qualitative, the population of study is difficult to interview face-to-face due to cultural conventions.

I was a midwife for 17 years, working with women in rural Africa where traditional culture is quite different from mainstream United States culture. I have also previously studied cultural diversity in health care facilities in the United States that outlined some of the problems that immigrants faced when they went to health care facilities with health problems. My role as a researcher in this phenomenological study was to engage Somalia women who underwent FC with open-ended questions. However, due to the sensitive nature of this study and the fact that this population was harder to reach, I used an instrument to collect the data and was not able to interact with participants, as is the case with other qualitative research methods. I further minimized biases by employing credibility checking and analyzing only the information provided by participants during the survey (Miles & Huberman, 1994). I set aside my personal experiences so that I could better understand the lived experiences of the participants in the study.

Methodology

Qualitative Research Strategy

Qualitative research methods use an inductive approach, the goal of which goal is to gain a deeper understanding of the experiences of a person or group being studied

(Creswell, 2009). The main features that characterize qualitative research designs are their recursiveness and flexibility (Padgett, 2008). Qualitative researchers often move back and forth between research questions, data collection, and data analysis. For example, the researcher may reformulate research questions in response to new findings, seek a new sample of respondents, or pose new questions to existing study participants. According to Gill, Stewart, Treasure, and Chadwick (2008) observations, textual or visual analysis, and interviews (structured, semi-structured, and unstructured) are some of the many methods used for collecting qualitative data. With structured interviews, the researcher asks predetermined questions "with little or no variation and with no scope for follow-up questions to responses that warrant further elaboration" (Gill, et al., 2008, p.291). Qualitative research methods involve analysis of data such as words, pictures, or objects, in which the researcher is the data-gathering instrument. Qualitative research uses words rather than numbers to examine and interpret observations for the purpose of discovering underlying meanings and patterns of relationships (Maxwell, 1996; Trochim, 2001). In other words, qualitative research is the collection of symbols, words, pictures, nonnumerical records, artifacts, or other materials that have been collected by researchers to describe events and phenomena (McNabb, 2008). McNabb (2008) added that qualitative researchers are particularly concerned with what takes place in a given environment or organization while quantitative researchers attempt to generalize or apply study results to other situations. The strength of qualitative research, according to Maxwell (1996), is the inductive approach. This research study of Somali women who underwent female circumcision used an inductive approach, in which I used my analysis

to develop broader generalizations with conclusions based on the information provided by the participants.

Participation Selection Logic

According to Lodico, Spaulding, and Voegtle (2010), the purpose of sampling in qualitative research is to enable the researcher to select a wide variety of data sources. Data sources that may be sampled by qualitative researchers include textbooks, audio, video, visual art, documents, or newspapers. Purposive sampling is useful in such a situation where the researcher needs to quickly reach a targeted sample, such as women who underwent FC.

According to Miles and Huberman (1994), unlike quantitative research that works with larger numbers of samples, qualitative research uses smaller samples of cases. The sampling procedure that is most often used in qualitative research is referred to as purposeful sampling (Padgett, 2008). The objective of this procedure is to select respondents based on their ability to provide the needed information.

Although phenomenological research allows researchers to use smaller number of participants such as 10 and below (Rudestam and Newton,2007), I administered open-ended questionnaires to a purposive sample of 18 Somali women, age 18 or greater, who livedin Rochester and Buffalo New York in the United States and who represented a sample of women who had undergone FC, to attend to issues of data saturation. Participants were contacted through mail or through the Somali Community group of Western New York.

Instrumentation

The purpose of this section is to describe the type of tool used for gathering data for this study. The study in question was a qualitative research study with a phenomenological approach. One of the reasons for conducting a qualitative study is to develop some understanding about a small sample of participants being studied (Maxwell, 2005). The researcher in qualitative research is the primary instrument for data collection and analysis (Merriam, 2002). Moustakes (1994) warned that, as an instrument, the researcher should focus on participants' consciousness rather than looking at things from the researcher's point of view to avoid bias. There are many methods used in qualitative research for collecting data, with interview being the most common (Grbich, 1999). Open-ended questions that I developed were mailed to the participants who voluntarily agreed to participate in this study. Before I administered the open-ended questionnaires, a pilot study was conducted in order to validate the questions. After the IRB approval, through the Somali Community Outreach and Education Center group of Northeastern New York, questionnaires were mailed to participants who resided in the United States. I used 35 questions in order to adequately explore the experiences of Somali women who underwent FC.

Pilot Study

Due to the sensitive nature of this research study of Somali women who underwent FC, I was not able to find any existing questionnaire or instrument designed by another researcher, and therefore, I conducted a pilot study after receiving IRB approval. The purpose of a pilot study is to determine whether the interview questions

can provide the type of responses that they are intended to and to practice skills for using open-ended questions in a qualitative research study. A panel of three experts consensually validated and approved the open-ended questions that were mailed to participants for data collection. Before carrying out the actual study, the pilot study was used to further validate the questions and discard questions that did not provide useful data. It is important that the sample size was representative of the group that was to be studied, and I needed to take caution to ensure that key features in the main study were preserved (Thabane et al. 2010). I used 3 participants in the pilot study to adequately address content issues (Rubio, Berg-Weger, Tebb, Lee, & Rauch, 2003). After the pilot study was completed, the results were sent to the panel of experts for further validity checking. I used the suggestions that were made to revise the instrument and used the revised instrument in my study. However, completing a pilot study did not mean that it was easy to complete the full-scale-survey (Van Teijlingen & Hundley, 2001). Creating an instrument and successfully testing the instrument in a pilot study made a greater contribution in this research study than using an existing instrument.

Research Site and Recruitment Strategy

Data for this study was collected from 12 Somali women 18 years old and above throughout the Northeastern region of the United States who underwent FC. They had no prior access to the questions. Participants had the opportunity to suggest additional questions that I did not include in the study. Short open-ended questionnaires included the participant's age, marital status, place of residence, educational level, the age FC was

performed, employment, religion, number of children, where she resided during the last 5 years, and cultural beliefs, as well as the consequences of female circumcision.

Participants were contacted by mail, through Somali community groups, or through an NGO that works with the Somali population. The research used a snowball sampling technique to recruit participants. Snowball sampling involves the selection of participants with certain characteristics or experiences, and then other participants are referred from this network. This technique is employed when trying to reach a "hidden" population (Osuji & Hirst, 2013). Circumcised Somali women are a hard to reach population because of their cultural backgrounds.

Data Analysis

Data collected from participants was described and analyzed in detail as said by participants. Data was arranged into common patterns through coding immediately, to identify themes, patterns, and relationships that existed within the data. The data was then analyzed using Interpretive Phenomenological Analysis (IPA). Using IPA, I read the transcripts a number of times to look for themes, connect emerging themes, use the emerging themes to analyze the other transcripts, and prepare the final write up that outlined the meaning from participants' lived experiences (Smith, 2007). As new themes emerged during data analysis, I looked back at earlier interviews to check whether these themes were missed during earlier analysis.

Issues of Trustworthiness

Trustworthiness is established when results from the study closely reflect what participants described to the researcher. In qualitative research, trustworthiness consists

of the traits of credibility, dependability, conformability, and transferability (Lincoln & Guba, 1985).

Credibility in a qualitative study corresponds to the concept ofinternal validity in quantitative research and depends on three distinct but related elements; (1) Rigorous techniques and methods for gathering high-quality data that are carefully analyzed, with attention to issues of validity, reliability, and triangulation; (2) The credibility of the researcher, and (3) Philosophical belief in the value of qualitative inquiry. While the credibility in quantitative research depends on instrument construction, in qualitative research, “the researcher is the instrument" (Patton, 2002, p. 14). Credibility depends mostly on the skill and competency of the researcher as an instrument. Any research without rigor is a fiction and cannot be used in any circumstance (Morse, Barrett, Mayan, Olson, & Spiers, 2008). For credibility to be established, I had to make sure that participants were identified and described accurately (Elo et al., 2014). One of the ways I did so was to validate questions to determine clarity through a pilot study with 3 non-Somali women who underwent FC to determine clarity. Another method I used to establish trustworthiness will be member checking, referred to as respondent validation (Maxwell, 2005). Data collected from participants and the initial interpretation of these data was taken back to participants to find out if the interpretations are credible (Maxwell, 2005; Merriam, 1995).

Transferability, which corresponds to external validity in quantitative research studies, is the ability to which a study can be applied to other situations, (Patton, 2002). In other words, it is the ability to which the results obtained from one study can be

generalized, transferred to other settings, or used by other researchers. Transferability was enhanced in this study by describing the research context and assumptions that are central to this research. I assumed that participants for this study are Somali women, age 18 and above, who had undergone FC, and I gnerated a sample size of 18 in order for this study to be considered transferable.

Dependability, which is closely related to reliability in quantitative research, is used to examine the process and product of research for consistency over time under different conditions (Lincoln & Guba, 1985). In order to address dependability, I established an audit trail to report in detail processes within this study so that future researchers who repeat this study should be able to replicate it successfully (Shenton, 2004; Patton, 2002). Audit trails are frequently used by qualitative researchers to establish rigor by providing detail of data analysis of the study. They help the researcher to review and verify the path followed from the beginning of the research processes to the final research write up (Wolf, 2003). In this study, notes, questionnaires, and transcripts, which include the raw data and how they were reduced and analyzed, were preserved and maintained for review when necessary. This will allow any other researcher to trace the whole process of the research study from start to finish.

Another way to establish trustworthiness is through confirmability or objectivity. Data was checked and rechecked throughout the process to minimize biases and establish trustworthiness. According to Creswell (2009), phenomenologists should set aside their individual judgment and biases by linking data to their original sources, the concept known as bracketing.

Ethical Procedures

A qualitative researcher faces many ethical issues during the data collection and analysis process, such as honesty, objectivity, integrity, openness, carefulness, respect for intellectual property, confidentiality, competency, human subject protection, and social responsibility, among others (Resnik, 2010). Participants for this study were volunteer adult Somali women living in the United States aged 18 or greater who underwent FC and who were willing to share their lived experiences. I surveyed a purposive sample of 18 participants. IRB approval was obtained before interviewing human participants. Questions were sent to all participants in an electronic format. Participants were provided with an explanation of the voluntary nature of the study, expectations of participants, the risks and benefits, and confidentiality issues. Participants had the right to withdraw from the study at any time and withdraw any information they previously provided. Completing and returning the questionnaire was considered to be implied consent. As it concerns privacy and confidentiality, participants did not provide their names or any information that may have identified or exposed them at any point of the study. Participants were assigned numbers during transcription, and only these numbers were used during data analysis. A copy of summary of the findings of this research study was mailed back to the Somali Community Center for general distribution to participants.

Summary

Chapter 3 introduced the topic of study, methodology, rationale for selecting method of study, participants and criteria for selecting participants, ethical considerations, data collection and analysis, and trustworthiness. The chapter also

introduced the administration of a pilot study that was conducted prior to the actual study to validate research questions with approval from IRB. The purpose of this phenomenological study was to explore the lived experiences of Somali women in the United States who underwent FC.

Chapter 4: Results

Introduction

This section of the research presents the results of the study, organized into nine subsections as described by the Somali women who underwent FC before coming to the United States. After approval from the Institutional Review Board of Walden University, I sent a letter to the CEO of the Somali Community Outreach and Education Center in Northeastern New York, who then contacted participants for this study. The subsections of this chapter include the pilot study, setting, demographics, data collection, data analysis, evidence of trustworthiness, results of the study, and summary of the study along with an introduction to Chapter 5. Common descriptions are sorted and grouped into five themes that represent the phenomena.

Purpose.

The purpose of this phenomenological study was to explore the lived experiences of Somali women who underwent circumcision while in Somalia and were living in the United States at the time of the study. Throughout this study, I documented viewpoints of circumcised Somali women who answered the online open-ended survey questions. Through a phenomenological approach, I explored the thoughts and feelings of circumcised Somali women living in Northeastern New York in the United States.

Research Question

The phenomenological research was based on one research question that was focused on the lived experiences of Somali women who were circumcised in their home country before coming to the United States. The research question was: What are the

lived experiences of Somali women currently living in the United States who experienced circumcision in Somalia?

Pilot Study

The pilot study was completed after the Institutional Review Board approval of the actual study. The IRB approval number for the study is 01-06-15-0286290. A panel of three experts, Reem S. Abu-Rustum, MD, FACOG, FACS, of the Center for Advanced Fetal Care, Tripoli, Lebanon; Professor Amany Refaat MD, MSc, MHPE, PhD Core Faculty, Public Health, School of Health Sciences, College of Health Sciences, Walden University; and Earla White, PhD RHIA Contributing Faculty, College of Health Sciences, School of Health Sciences, Walden University, consensually validated and approved the open-ended questions that were emailed to participants for data collection. The pilot study consisted of three participants who fit the study criteria. Participants for the pilot study were non-Somalis from Liberia, a country in West Africa where FC is practiced. All the participants underwent FC before coming to the United States. They were contacted via their community organizations, and the survey was conducted using the online survey tool supported by SurveyMonkey. Participants' identities were not made known to the researcher or to each other.

The primary goal of the pilot study was not to collect research data, but to test research procedures such as data analysis so that adjustments could be made before collecting the dissertation data. According to Creswell (2003), a pilot study allows the researcher to improve on the survey questions and format. The purpose was thus to test the usability of the interview questions and to see if the questions would provide the type

of answers needed for the study. The results from the pilot study indicated no need for any change or adjustment to the interview questions and therefore they were deemed suitable for use for the dissertation study.

The pilot study ensured that the questions, such as why FC is still practiced in Somali, the particpants' feelings about FC, and consequences that resulted from FC, were clear to elicit the type of responses desired from the participants in this study, thereby contributing to the reliability and validity of this study (Creswell, 2003).

Setting

Initially, I was going to collect data from one of the Somali groups in Western New York, who later refused to participate in the study. I spent additional weeks contacting the President and CEO of the Somali Community Outreach & Education Center, Inc., another Somali group in Rochester, New York, who accepted my invitation to let his members participate in the study. Because it was difficult to conduct a face-to-face interview with participants because of the sensitive nature of the study, questions for the open-ended survey were posted online through SurveyMonkey.

Demographics

All participants for the pilot and dissertation study completed the demographic data, which included age of participants, age at circumcision, marital status, country of origin of husband if married, age of first menstrual period (to find out the age of puberty and the timing of FC), number of pregnancies, number of deliveries, number of children, educational level, occupation if employed, length of stay in the United States, and religion. Participants for the study were Somali women who were circumcised before

coming to the United States and were able to read and write in English, 18 years of age and above, and living in Rochester, New York, in the United States. Demographic questions were meant to find out the onset of puberty, timing of FC, the influence on the data as related to level of education, and complications of FC as related to pregnancies and deliveries. The participants were between the ages of 23 and 53, and all had married, although one had lost her husband afew years ago. All the participants had children. Of the 12 participants, 10 were married to Somali husbands, 11 had a college degree or above, and 11 were employed.

Summary of Participants' Profiles

Participant 1. Participant 1 was 53 years old and married to a man from the Ivory Coast. She was circumcised when she was 5 years old, had her first menstrual period at the age of 13, and had four pregnancies, one delivery, three miscarriages and one child. She received a two year college education, worked as a Certified Nursing Assistant, and was a Christian. She had been living in the United States for 11 years.

Participant 2. Participant 2 was 47 years old, was circumcised at the age of 7 years, was married to a Somali husband, and said she had her first menstrual period when she was 14 years old. She had 6 pregnancies, six deliveries, and six children, with no miscarriages, attended some college, worked as a home health care worker, and was a Muslim. She had been living in the United States for 12 years.

Participant 3. Participant 3 was 41 years old, said she was circumcised between the ages of 7 and 10 years, was married to a Somali husband, and had her first menstrual period when she was between 14 and 16 years old. She had four pregnancies, two

deliveries, with two children and two miscarriages. She was a high school graduate, a seamstress, and a Christian. She had been living in the United States for 10 years.

Participant 4. Participant 4 was 34 years old. She provided no information about when she was circumcised, was married to a Somali husband, and said she had her first menstrual period when she was 14 years old. She had five pregnancies, five deliveries, four children, and one miscarriage, had a bachelor's degree, worked as a nurse, and was a Muslim. She had been living in the United States for 12 years.

Participant 5. Participant 5 was 53 years old and was circumcised at the age of 9 years. She was married to a Somali husband and said she had her first menstrual period when she was 16 years old. She had seven pregnancies, five deliveries and five children with 2 miscarriages, had an undergraduate degree, worked as nurse, and was a Muslim. She had been living in the United States for 14 years.

Participant 6. Participant 6 was 29 years old, was circumcised at the age of 9 years, was married to an American husband, and said she had her first menstrual period when she was 16 years old. She had two pregnancies, two deliveries and three children, had an associate's degree, worked as a customer service representative, and practiced Christianity. She had been living in the United States for 13 years.

Participant 7. Participant 7 was a 32-year- old who was circumcised at the age of 7 years, married to a Somali husband, and said she had her first menstrual period when she was 13 years old. She had two pregnancies, one delivery and a child, with one miscarriage. She had an associate's degree, worked in human services, practiced Islam, and had been living in the United States for the past 9 years.

Participant 8. Participant 8 was 24 years old, was circumcised at the age of 10 years, was married to a Somali husband, and said she had her first menstrual period when she was 12 years old. She had three pregnancies, a delivery and a child with two miscarriages, had a college degree, was unemployed, practiced Islam as a religion, and had been living in the United States for 9 years.

Participant 9. Participant 9 was 52 years old, was circumcised when she was 6 years old, married to a Somali husband, and said she had her first menstrual period at the age of 16. She had six pregnancies, six deliveries, and six children, was a college graduate who worked as a sales associate, and practiced Islam as a religion. She had been living in the United States for 18 years.

Participant 10. Participant 10 was 34 years old, was circumcised at the at of 7 years, married to a Somali husband, and said she had her first menstrual period when she was 13 years old. She had two pregnancies, one delivery, and one child, with one miscarriage. She had a bachelor's degree, worked as a medical assistant, and practiced Islam as a religion. She had been living in the United States for 10 years.

Participant 11. Participant 11 was 47 years old, was circumcised at the age of 14 years, was married to a Somali husband, and said she had her first menstrual period when she was 14 years old. She had three pregnancies, three deliveries, and three children, attended some college, worked as a housekeeper, and was a Muslim who had been living in the United States for 11 years.

Participant 12. Participant 12 was 28 years old, was circumcised at the age of 12 years, was married to a Somali husband, and said she had her first menstrual period when

she was 15 years old. She had two pregnancies, two deliveries, and two children, was a college graduate who was a teacher by profession, and was a Muslim who had been living in the United States for 12 years.

Data Collection

Data for this study were collected online from 12 participants of Somali origin, October 2, 2014 to February 21, 2015, using open-ended questions. Participants responded once to survey questions when they wanted to without the influence of the researcher and were able to save it and return to whenever they want to. I estimated it took about 25 minutes to answer the survey.

Questions were posted online through Survey Monkey, and the link to the questions was sent by email to the leader of the Somali community in Rochester, New York for distribution. When answers to the questions were provided, they were sent to the Survey Monkey website without the names or email addresses of participants.

The initial Somali group for the study turned down my invitation to participate in the survey, so I had to search for another Somali group in Rochester, New York who would accept my invitation to participate. This took me another month or so to build up the trust with the leaders to encourage participants to participate in the study.

Data Analysis

Once I obtained the data, I read each transcript in its entirety more than once to understand the meaning of the experience (Moustakes, 1994). I noted anything that was interesting or significant about what the participants said. Secondly, I highlighted statements from the text that had specific relevance to FC and grouped them into clusters

and themes. In this case, I attempted to extract statements from the text in order to understand the lived experiences of Somali women who underwent FC before coming to the United States. I clustered similar themes together.

After reading and understanding each transcript in its entirety, I read the transcript again and then divided the emerging themes into meaning units. I coded each meaning unit to describe the essence of the lived experiences of Somali women who underwent FC before coming to the United States. The process of coding each transcript separately enabled me to find out what each participant experienced based on her responses (Smith & Dunworth, 2003). I completed a single transcription before moving on to another, which is consistent with the interpretive phenomenological analysis (IPA) methodology. According to Smith (2007), IPA is concerned with trying to understand what an experience is like from the point of the participant, and the assumption "is that the analyst is interested in learning something about the respondent's psychological world" (p. 66). I did not take into consideration themes that occurred in only one interview, as I was interested in robust themes that emerged in multiple responses. At this step of the process, it was very important to bracket researcher bias and interpretation in order to allow new themes to emerge from each transcript (Creswell, 2009).

Specific Codes and Themes That Emerged From the Data

Somali women who underwent FC before coming to the United States were asked to talk about their lived experiences with circumcision. The women's accounts clustered around five themes. I explicated five master themes from the qualitative data collected online via SurveyMonkey: *(1), Experience of FC, (2), Consequences of FC, (3),*

Religious, cultural, and social factors, (4), FC practices in cities versus villages, and (5) FC awareness. Table 1 below contains 35 subthemes and five themes that emerged from the study.

Table 1
Emerging Themes and Subthemes.

Initial 35 subthemes	**Final 5 themes**
Abused or tortured Ashamed Live with it for forever or rest of life, Not have sexual pleasure, not want to talk about circumcision	Experience of FC: abuse
Pain and difficulties having sex Pain during monthly menstrual period, Difficulty delivering baby Lacerations with all deliveries Tears Painful labor Prolonged bleeding Urinary Tract Infection	Consequences of FC
Clitoris motivates women to have uncontrolled sexual intercourse with men Promotes prostitution Rite of passage to womanhood Sign of maturity Proof of virginity Difficult to get married if not circumcised Easier to get married Defines our culture All girls must be circumcised	Religious, cultural, and social factors
Razor vs. knifes Use of painkiller vs. no pain killer	FC practices in cities versus villages
Start at childhood At home, churches Community places Media At individual homes	FC awareness

Evidence of Trustworthiness

Credibility

I assumed that all participants responded to the questions willingly and at ease, were all Somali women who underwent FC, were 18 years old and above, and were able to read and write in English because I sent the invitation only to certain members of the Somali community in northeastern NY. Another way that credibility was ensured was that questions were validated with three experts to determine clarity through a pilot study that was not connected to any Somali women who underwent FC.

Transferability

Transferability is the ability to which one study can be applied to other situations, (Patton, 2002). In other words, it is the ability to which the results obtained from one study can be generalized, transferred to other settings, or used by other researchers. Transferability was enhanced in this study by describing the research context and assumptions that are central to this research. I obtained a sample size of 12 participants whom I assumed were Somali women, age 18 and above, who underwent FC and responded to the survey. Future researchers may be able to build on the results of this study with other populations, although IPA is not meant for generalization or transferability.

Dependability

Dependability is used to examine the process and product of research for consistency over time under different conditions (Lincoln & Guba, 1985). In order to address dependability, I established an audit trail to report in detail the processes within

this study so that future researchers who repeat this study should be able to replicate it successfully (Patton, 2002;Shenton, 2004). I developed audit trails, coding, and themes to ensure reliability from the beginning of the research processes to the data analysis stage. I will preserve and maintain notes, questionnaires, and transcripts, which include the raw data and how they were reduced and analyzed, for review when necessary by other researchers to trace the whole process of the research study from start to finish.

Confirmability

A key criterion for confirmabilty, according to Miles and Huberman (1994), is the extent to which the researcher admits his or her own predispositions. It is important to note that the aim of this research was to find out the lived experiences of Somali women who underwent FC before coming to the United States and not to confirm or support my thoughts or bias as a medical professional (Bloomberg & Volpe, 2008). In order to establish confirmability, data collected from participant was checked and rechecked throughout the process to minimize bias. I had someone else code the data using NVivo, and that coding was compared to what I did. The external reviewer agreed with my themes. As a nurse, it was important and necessary for me to attempt to bracket my experiences with people from different cultural backgrounds. I set aside my individual judgment about FC and linked data collected to in its original sources. Additionally, the original transcripts of participants' responses have been saved on my password-protected computer and will be kept for review at any time by other researchers for a period of not less than 5 years.

Results

This phenomenological study to find out the lived experiences of twelve Somali women who underwent FC before coming to the Unites States revealed five themes, as shown in table 1 above. The themes include: (a), experience of FC, (b) consequences of FC, (c) religious, cultural, and social factors, (d) FC practices in cities versus villages, and (e) FC awareness.

Theme 1. Experience of FC: Abuse

The interview questions that generated the "abuse" phenomenon included questions about the lived experiences of FC and the meaning of FC. The majority of the participants said that FC was an abuse or torture, something that they will live with forever and do not want to talk about, and that they did not have sexual pleasure due to circumcision. They also reported that they feel ashamed when people ask them about FC. Following are several excerpts that illustrate this theme.

> Participant 5: I lived with fear and stigma due to what was taken out of me during circumcision and think that I was treated like an animal. Even though I am a nurse, I am still uncomfortable to talking about female circumcision to my colleagues or any other woman that is not from my tribe. I will live with it for the rest of my life. Whenever I am pregnant, and towards the end of my pregnancy, I am always psychologically disturbed because of the pains that will be associated with my delivery. One of the problems is that I had two vagina cuts (episiotomy) for the last two deliveries in the United States because the Doctor did not want me to sustain the types of tears I had with the other deliveries in Somalia. With all

deliveries I had in Somalia before coming to the United States, my vagina was open to allow the child out and re-stitched to close the opening. I am speaking out now because I want the practice to stop. "Circumcision means torture, abuse, mistreatment of women, frustration, and every bad thing that can be done to a woman.

Participant 9: Female circumcision is like hell. I will live with it forever and will never be whom I was meant to be because my female part has been cut out. I do not want talk about circumcision especially with people from countries where circumcision is not practice. I discuss it with my children all the time what I went through and pray that none of them experiences what I went through….as I mentioned to you, I think I was abuse as a women. God made me the way he thought I should be and no human being should determine my destiny.

Participant 12: I do not have any sexual pleasure because I am afraid that my incision will start bleeding. My rights and freedoms were violated when I was circumcised. I had lacerations with all deliveries I had. *FC is* [emphasis added]…Violation of my rights as a woman when I was circumcised without my consent. It is an abuse to *all* [emphasis added] Somali girls and women.

Theme 2. Consequences of FC

All participants reported that they suffered one of more problems due to FC: pain during sexual intercourse, bleeding after sex, prolonged bleeding after delivery, keloids and lacerations at the point of circumcision, episiotomy, and childbirth complications. Psychological problems were also one of the problems mentioned during the study, while

two of the women mentioned that they had two miscarriages. Below are some key excerpts that highlight this theme.

> Participant 3: I was given some medication for dilation during delivery and because of the tightness of my vagina*, and* [emphasis added] my vagina was increased. It happened to all my deliveries.
>
> Participant 5: Every time I have sex, I feel as if I am going to die especially around the area where the circumcision took place.
>
> Participant 9: I had pain because my genital area was too small that my husband had to cut and increase it. I experienced pain for up to 3 weeks because I … had sex during the healing period. *During child labor* [emphasis added] I had prolonged labor that I was told by my doctor *that it was* [emphasis added] a result or circumcision. I was psychologically disturbed because I was worried about the tears that I will have after each delivery**.**

Some participants reported they experienced pain during sex, labor, and delivery and they do not know wither it was due to FC. One of them had mixed feeling about whether the pain she had was due FC but believed the pain night have come from the circumcision because of the sexual habits of her circumcised and uncircumcised children. The participants described this pain as follows:

> Participant 1: I had pain during my first sexual intercourse but do not know is it was as a result of me been circumcised.
>
> Participant 2: I do not know if the pain I had was because of the circumcision. My other children who *were never* [emphasis added] circumcised; they have sex more

than those who were circumcised which makes me believe that it might be they do not have pain during sex

Theme 3. Religious, Cultural, and Social Factors,

Participants had differing opinions on the role of religious, cultural, and social factors that relates to in circumcision, though there seemed to be general agreement that society and culture played a much larger role than religion. Christian and Muslim Somalis equally circumcised their girls, although some women said religious leaders are actually against the practice. Following are key excerpts regarding this theme.

> I do not think religion has anything to do with circumcision. Christians and Muslims in our country all undergo circumcision when it time to do so. I think it is more cultural than religious. Our society plays a part in circumcision as it is almost done to every body in the society…. Circumcision is practice in Somalia because many men will not married a girl that was not circumcised. It is… our culture to circumcised girls because it is done in a ceremonial way. Family members and friends will offer so many gifts to us. (Participant 2)
>
> I come from a tribe that has mix religion. There are some families that are Christian and others that are Muslim but each of them has to circumcise their girls to prepare them for marriage. Circumcision is more cultural and societal issue. *Circumcision* [emphasis added]…is our tradition and culture to circumcise every…girl in preparation for marriage. It has been going on forever. (Participant 5)

> Religion does not play a role in circumcision because every girl whether Christian or Muslim must be circumcised as it is our culture and tradition. It is more of a social factor because all circumcised girls and their family will gain respect in the society wills uncircumcised girls and there family will face rejection. (Participant 9)

Nonetheless, two participants reported that although FC is a cultural and social problem, the Muslim religion supports the practice more than any other religion:

> I think that the Muslim religion reinforce this practice, but it is a tradition. (Participant 6)

> All women must be circumcised when according to our religion and culture to be considered a *Matured* [emphasis added] woman. (Participant 7)

Theme 4. FC Practices in Cities Versus Villages.

Participants were asked about the contrast in how FC is practiced in villages versus the city and if any anesthesia was given. The vast majority of participants said in the city, painkillers are given before and after circumcision, trained medical staff performed the circumcision, and it was done in a clean and sterile environment. Representative responses from participants are as follows:

> In the city, painkiller or injection is given but in the villages no pain medication is given. Apart from that there is no different between cities and villages. *At the time of my circumcision* [emphasis added]…some pain medication was injected as my mother later on told me. (Participant 3)

In most villages circumcision is still performed the way it was done to me but in cities, some girls receive medical attention after the traditional circumcision, and few others these days are circumcised in health centers. (Participant 4)

There are similar except that midwives do some of the cuttings in cities, which is very expensive for the average population. One of the [*traditional cutters* [emphasis added]…applied some herbs over the area that was to be cut and told me that I was not going to feel pain but I was feeling pain throughout the procedure and after the procedure. (Participant 5)

The same is done in both the cities and villages. The difference may be pain killer availability in the cities. (Participant 6)

In the cities is a little bit more easier rather then villages because it in the village there is no medicine and the cut it a little more. (Participant 7)

It is done the same in villages and cities except that in cities, midwives who used painkillers, one instrument per individual and some antibiotics while in villages, untrained women who do not use any pain medication do it and they will use one knife or razor to all the girls perform it. (Participant 9)

The differences on how FC is done in villages and cities is "…the tools and pain medicine" used. (Participant 10)

In the village, no painkiller is used; a single knife or blade is used to circumcise all the girls. In hospitals, a single blade is used per girl and medications for pain are given before and after the circumcision. (Participant 11)

> In villages, circumcision is done to so many girls at once and special food is prepared and given to all circumcised girls. Knifes and blades are used in villages to all the girls. While in the cities, blades are used per patient, it is not done in a group and no special occasion is organized although there will be an after party when the girl return to the village. Painkiller is used in cities and the victim is kept in hospital for days to heal. (Participant 12)

Theme 5. FC Awareness.

When asked about whether participants would promote or discourage FC, the vast majority of participants supported the fact that FC should be discouraged in all forms:

> I will discourage the practices of female circumcision as a victim, because of the medical and psychological problems associated with. (Participant 5)
>
> I would discourage circumcision by all means necessary. It takes freedom, joy, and proud from women. (Participant 6)
>
> I will discourage female circumcision because it does not have any benefits but dangers. So many girls have died after they were circumcised. (Participant 12)

When the question of at what age FC awareness should begin and where the awareness should take place was asked, the majority of the participants said that FC awareness should start at an early age and in individual homes as well as in public places. The ages they suggested to start FC awareness were between infancy and the age of 6 years:

> I think all ages. Women should start talking to their children, both boys and girls about the dangers of circumcision immediately when they are born [and this should be done] … by women who had never been circumcised and are married, accepted in the community, or are successful in live. (Participant 2)
>
> I think it would be great to start at age 5-6 years. (Participant 10)
>
> Awareness campaign should start immediately when the parents got married. They should start talking about the dangers of circumcising their girls if any [by]… educating all Somali men and women about the dangers and outcomes of circumcision …some of our boy has dated American girls who are not circumcised and should be in the front line of the fight against circumcision. (Participant 12)

Some women disagreed that awareness programs should start at an earlier age and felt it should wait till a certain, older age:

> I would like to suggest that an awareness program starts from childhood although an 11 years old child will not even understand genital cutting. (Participant 9)

Summary

Participants in the study described lived their experiences with FC; consequences of FC; religious, cultural, and social factors; FC practices in cities versus villages; and FC awareness programs. In regard to their lived experiences, the vast majority of the participants said they were tortured and refused their rights as women, were ashamed to talk about FC in the public, and did not have sexual pleasure at all. They mentioned prolonged labor, vaginal bleeding, childbirth difficulties, and painful sexual intercourse,

among others, as some of the consequences of FC. Most participants said FC was culturally motivated and that culture was one of the reasons it is still practiced in Somalia. From the analysis, FC practices in cities versus villages are different. In cities, participants are provided painkillers before the circumcision takes place, the circumcision is practiced in a clean and safe environment, and it is performed by trained health providers, whereas in the villages, it is the opposite. Finally, most participants wanted FC awareness to take place at all public and community places as well as individual homes, and they believed it should begin when the baby is delivered.

In chapter 5, I discuss the findings of the study, limitations of the study, recommendations, implications that may lead to social change, and conclusion of the study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative research study was to better understand the experiences of Somali women who underwent female circumcision before coming to the United States. The main research question was, What is the lived experience of Somali women currently living in the United State who experienced circumcision in Somalia? In order to answer the research question, I collected data using a phenomenological approach in which I documented the experiences of circumcision from the viewpoints of women. To do this, I interviewed 12 circumcised Somali women living in Northeastern New York using online structural in-depth interviews distributed through SurveyMonkey. The study utilized the phenomenological approach in order to provide a detailed description of the lived experiences of the participants through in-depth interviews. I conducted an analysis of the interview transcripts using interpretative phenomenological analysis (IPA), which examines how participants make sense of their lived experiences. I analyzed the women's individual accounts in detail, and in this chapter, I present and discuss the generic themes found, as well as my interpretation (Pietkiewicz & Smith, 2014). Key findings for this study include:

- The experience of FC: The participants overwhelmingly used negative language to describe their experiences and discussed it as a traumatic event.

- The consequences of FC: The women who had undergone FC described negative physical, mental, and emotional consequences associated with the experience.
- Religious, cultural, and social factors: Women discussed the cultural expectations for FC in their communities and the reasons it was practiced.
- FC practices in cities versus villages: The participants pointed out differences between the practice in the different locations.
- FC awareness: The women described what they thought would be the best ways to make young people aware of FC and its negative consequences, including the age at which they thought awareness campaigns should begin.

I determined these main themes by clustering smaller, related subthemes.

Interpretation of the Findings

Thirty-seven questions guided the study and collectively answered the main research question, "What are the lived experiences of Somali women currently living in the United States who experienced circumcision in Somalia?" In order to answer the research question, participants discussed their lived experiences based on the circumcision they experienced in Somalia before coming to the United States. I identified five themes (the experience of FC; consequences of FC; religious, cultural, and social factors; FC practices in cities verses villages; and FC awareness) and 35 subthemes in the phenomenological qualitative study. A detailed description of each theme and its subthemes follows.

Theme 1. Experience of FC

Theme 1 emerged from the following five subthemes: (a) feelings of having been abused or tortured, (b) feeling ashamed, (c) the knowledge that they will live with it for the rest of their lives, (d) a lack of sexual pleasure, and (e) no desire to talk about circumcision.

The majority of the participants said that FC was abuse or torture, something that they will live with forever and do not want to talk about, and that they did not experience sexual pleasure due to circumcision. As an example of how women described their experiences, Participant 1, in particular, indicated, "I feel as if I was tortured and feel ashamed being with women who had not been circumcised. I had bad experiences when I was circumcised." These sub-themes all contributed to a major theme indicating that the emotional experience of FC is primarily negative. This finding shows that despite practitioner's arguments or beliefs that FC is culturally beneficial, the practice is actually harmful to individual women. Given these findings, community health workers should be aware that despite the prevalence of FC in certain communities, the women who undergo this procedure do in fact experience it as a negative. This suggests a point of departure for awareness campaigns, in that community health workers might be able to emphasize the negative individual consequences despite the social norms surrounding it. Previous studies (Abusharaf, 2013; Wadesango, Rembe, & Chabaya, 2011; Western, 2013) considered FC to be a form of abuse and a violation of women's basic rights that has caused many women to migrate to other countries out of fear. Western (2013) posited that there are negative consequences of FC. Wadesango et al. (2011) added that some of

these negative consequences include shock, severe pain, hemorrhage, and other injuries near the female genitals. The UN General Assembly implemented a resolution in 2001 that obliged states to develop policies and programs that prohibit traditional practices that endanger the health of women and girls, such as FC (Wadesango et al., 2011).

Theme 2. Consequences of FC

Theme 2 emerged from six other subthemes that participants mentioned during the study. These subthemes were (a) pain and difficulties having sex, (b) pain during menstrual periods, (c) difficult and excessively painful labor, (d) prolonged bleeding, (e) urinary tract infection (UTI), and (f) decreased size of birth canal. This theme connects to the previous theme in that the initial emotionally traumatic experience of FC evolves into lasting negative physical effects for the women who undergo it.

The findings showed that all participants in this study reported one or more physical consequences of FC, with the majority of them thus supporting the idea that FC should be eradicated. The consequences of FC for the participants included lack of sexual pleasure, pain, medical consequences, and difficulties with pregnancy and childbirth. For example, Participant 12 indicated, "I do not have any sexual pleasure because I am afraid that my incision will start bleeding." This finding is important because it highlights the voices of individual women who have experienced FC and believe that it is a negative experience with very real medical implications. However, since the sample for this research study was drawn from Somali-American women, they may have different perspectives, having been exposed to Western beliefs and values about the practice in addition to possibly receiving more information about FC's consequences. It is an open

question as to whether women living outside of developed countries understand that the physical complications such as excessively painful labor or miscarriages are a direct result of FC.

Consistent with the findings of the World Health Organization (WHO, 2013), complications and consequences of FC are reflected in Theme 2. Moreover, WHO (2013) reported that the severity of complications also depends on the type of FC—Type I, which is partial or total removal of the clitoris; Type II, which is partial or total removal or the clitoris and the labia minora; Type III, which is infibulation or narrowing of the vaginal opening with or without excision of the clitoris; and Type IV, which is all other forms for nonmedical actions such as pricking, piercing, and incising—the individual's physical conditions, the skill of the person who performed the circumcision, and the sterility of the conditions in which the circumcision was performed. Practitioners in Somalia perform the most radical type of circumcision, known as pharaonic or Type III. Several participants in the study mentioned that they experienced pain during and after circumcision, prolonged bleeding during and after circumcision, and urinary tract infections as short-term complications.

Short-term complications of FC also include pain from lack of anesthesia; however, even when anesthesia is used, it is not always effective, as the duration of the procedure may be longer than expected, in which cases the intensity and duration of pain are more extensive (WHO, 2013). Others include hemorrhage, shock as a result of pain and hemorrhage, difficulties passing urine or urine retention, infections, the risk of transmission of HIV due to the repeated use of unsterilized surgical tools among girls or

through blood transfusion from an infected person due to hemorrhage, psychological consequences, and death (Brandy, 1999; WHO, 2013). Short-term complications might progress to long-term complications, depending on the age of the girl, where the circumcision was done, and how it was done (WHO, 2013).

Consistent with Connor et al.'s study (2016), some circumcised women reported no sexual desire and pain during sex as long term complications, though it was difficult for the researchers to measure this complication. Long-term complications include keloids (hardening of the vaginal scars), sexually transmitted disease, reproductive tract infections, and quality of sexual life, birth complications, and danger to the newborn (WHO, 2013). Type III circumcision can cause prolonged or obstructive labor due to tightness, which can result in fetal distress and death. Participants systematically highlighted their difficulties with pregnancy and labor, including miscarriages.

Participant 5 described needing two episiotomies during childbirth in the United States, while she had torn during deliveries in Somalia. She explained that in Somalia, her vagina was cut open for childbirth but then stitched closed afterwards. Participant 7 connected the experience of FC to a stillbirth. "My first child passed because my birth canal was narrow, so the child death from lack of oxygen." Participant 8 echoed this experience saying, "I had two miscarriages, prolong labors that resulted in two episiotomies, and prolong bleeding."

Other nonphysical complications included depression, psychosis, anxiety, and post-traumatic stress disorder (Wadesango et al., 2011). While the participants often used language to suggest that the experience of FC was traumatic (e.g., Participant 1: "I feel as

if I was tortured"; Participant 3: "I feel as if I was abused"), their answers did not suggest that they understood the physical consequences in this way as it seems unlikely that they have talked about FC with a psychologist or counselor before.

In a study that sought to assess the risk factors of cervical cancer in Khartoum, Sudan, researchers Ibrahim, Rasch, Pukkala, and Aro (2011) concluded that women who underwent FC are at higher risk of cervical cancer as traumas to female genital area are risk factors for cervical cancer, especially during pregnancy or delivery. Again, the participants in this study did not mention the increased cancer risk related to FC. This suggests another aspect of FC that needs attention from experts interacting with communities that continue to practice FC, as victims and practitioners may not be aware of this potential consequence.

Another long-term consequence of FC is the contraction of HIV (Ali, 2012; Brewer et al., 2007; Ibrahim, Oyeyemi & Ekine, 2013). Moreover, women may suffer from accumulation of menstrual blood in the abdomen (haematocolpos), which can cause serious abdominal distention (Momoh, 2011). Haematocolpos can prevent menstrual flow, causing severe lower abdominal pain or dysmenorrhea during menstruation (Momoh, 2011). While the participants did not indicate their awareness of official medical diagnoses involving FC and menstruation, many indicated that they had difficult and/or painful periods.

Theme 3. Religious, Cultural, and Social Factors.

When participants were asked the reason why FC is still practiced in Somalia, the subthemes that arose were (a) the clitoris motivates women to have uncontrolled sexual

intercourse with men and promotes prostitution, (b) it is a rite of passage to womanhood, (c) it is a sign of maturity, (d) it is proof of virginity, (e) it is difficult to get married if not circumcised, (f) it defines the culture, and (g) all girls must be circumcised. These eight subthemes were compressed to come up with the main theme of religious, cultural, and social factors. This theme indicates the complexity of the issues, in that despite the participants' negative emotional experiences and serious physical consequences of FC described in the previous themes, they started that FC is important in their cultures.

Participants highlighted FC as an identifying feature of their culture and something that young women were essentially required to undergo in order to be considered members of their society and to be eligible for marriage. Chikhungu and Madise (2015) posited that religion is one of the factors affecting FC. Ahmed (2015) added that religion plays a major role in the practicing of FC. The majority of female participants said that infibulation, which is known as *haram*, is central to Islam but continued that Type 1, known as *Sunnah* circumcision, was acceptable under Islamic practice. However, despite the widespread belief in the West that FC is a purely Islamic practice, the participants in this study shed light on the fact that both Christians and Muslims engaged in FC for example, Participant 5 indicated,

> I come from a tribe that has mix religion. There are some families that are Christian and others that are Muslim but each of them has to circumcise their girls to prepare them for marriage. Circumcision is more cultural and societal issue. *Circumcision* [emphasis added] is our tradition and culture to circumcise every…girl in preparation for marriage. It has been going on forever.

Some participants said that the clitoris motivated women to have uncontrolled sexual intercourse, which promotes prostitution. For the participants, circumcision was also indicative of a passage to womanhood in Somali culture, (Krása, 2010; USAID, 2007) and increased a girl's chances of getting married, (Braddy & Files, 2007; Morison el al., 2004), because girls who are not circumcised are rejected within the society and are considered to be outcasts (Ahmadu, 2000).

All participants mentioned culture and tradition as some of the reasons FC is still practiced in Somalia. For example, one participant explained, "Somali culture and social factors means the same thing to me. Circumcision defines our culture and allows people to know that most Somali girls are virgins" (P12).

According to Johnsdotter (2009), cultural integrity and identity of a cultural society is critical to people's culture, and members of their societies believe their cultural heritage should be maintained at all costs. FC can therefore be seen as a practice which separates a Somali woman, especially one now living in the Western world, from another cultural or tribal group. Although Participant 11mentioned that all religions are in support of FC in Somalia, she continued that, "our identity is defined by our culture, although I do not agree with that, and as for social factors, Somali as a society supported circumcision by the time I was circumcised." This study's findings were consistent with those in prior studies including the 95 percent of participants in Utz-Billings (2008) study who said that cultural and social factors were some of the reasons that push them to be circumcised, 49 percent who said it was to prevent prostitution, and 18 percent who said it was to reconstruct their vagina to look beautiful.

There was much variety in participants' responses; it should be noted that this was not a homogenous group of women with universal responses to any or all of the questions. I consider this to be an important point, as Westerners may be prone to think of Somali women as a homogeneous group, either as victims of FC or as complicit in and supportive of the practice. The women revealed that the truth is more subtle; for example, when participants were told about their impending circumcisions, their reactions ranged from "happy" to running away and crying/screaming, to simply not even knowing what circumcision was. This variety of reactions can be seen in response to the question of circumcising their own daughters or nieces; some women said that they have had their girls circumcised, or planned to or would like to, while others were opposed to the idea.

Female circumcision as a cultural practice is similar to foot binding in China, which was practiced some 1,000 years ago until the twentieth century; over two million women had their feet bound (Wilson, 2013). Female circumcision and foot binding both result in pain and other health complications such as death (Wilson, 2013). Both FC and foot binding are part of a society's expected behavior and beliefs that result from independency of action of different agents (Wilson, 2013). Foot binding was abandoned through collective action, which implies that FC could similarly be abandoned successfully, (Wilson, 2013).

Theme 4. FC Practices in Cities Versus Villages.

Participants described some significant differences between the way that FC is practiced in cities and villages. The subthemes were (a) use of razor blades versus knives, and (b) use of painkillers versus no pain killers. The participants said that FC in cities

was performed by trained health care professionals, girls were cut using one blade per patient, pain medication was given before and after the procedure, and no special ceremony was performed before and after circumcision. In villages, it was the opposite, as no pain medication was given before and after the circumcision, one razor blade was used for multiple patients, and special ceremonies were organized during circumcision. The theme shows that FC is practiced differently in villages and cities.

When participants were asked about the differences between circumcision practices in cities versus villages, the two things they described were that in villages, knifes are used as the tool for circumcision while in cities, razor blades are used. Medications to reduce pain and inflammation are administered to girls before or after circumcisions in cities, and in villages, no pain medications are administered to participants. The same knife may be used in villages on other girls without sterilization, the cost of circumcision is cheap and affordable, untrained traditional cutters perform it, and after circumcision girls are sent home to be cared for by their families. Participants mentioned that in cities, trained medical professionals perform FC, razor blades are used, one blade is used per person, patients are kept in hospitals for healing, and the procedure is expensive. One participant described the experience of FC in villages:

In villages, circumcision is done to so many girls at one and special food is prepared and given to all circumcised girls. Knifes and blades are used in villages to all the girls. While in the cities, blades are used per patient, it is not done in a group and no special occasion is organized although there will be an after party when the girl return to the village. Painkiller is used in cities and the victim is kept in hospital for days to heal. (P12) Theme 5. FC Awareness.

Although participants disagreed about the ages at which young people should be made aware of FC, they agreed that awareness of FC and its consequences is important. Some subthemes were (a) start in childhood, (b) educate at home, (c) educate in churches, (d) educate in community places, and (e) raise awareness through the media. This theme indicates that FC awareness programs can take place in many different places with or without the support of international organizations. However, awareness will spread easily when the combination of international organizations, media, religious groups, and social groups work together.

In contrast to the findings of Gele et al. (2012), in which many communities in Somalia were reported as against the total eradication of FC because they believed it would disrupt their cultural and religious beliefs, participants in this research study discouraged the practice of FC in all forms and suggested that awareness programs should start as early as possible. This finding also echoes Connor et al.'s study (2016), in which the majority of participants indicated that they would not have their daughter undergo FC, and two participants whose daughters had already undergone the practice actually said they regretted it. Some of the participants indicated that awareness of FC

and its dangers needed to be increased, although they disagreed about how to do this and when in a child's life education about FC should occur. Combined with the theme of religion, culture, and social practices, this theme indicates the contradictions and difficulties inherent in attempts to eradicate FC. While the respondents argued that the practice should be eradicated, some of the participants nevertheless identified it as an important cultural practice that sets them apart from other groups and some had their own daughters and nieces circumcised. This speaks to the complexity of culture, wherein people may recognize the injurious effects of a cultural practice as in the case of foot binding, and want to stop it, but at an individual level, they may seem compelled or forced into doing it anyway.

However, the majority of the participants mentioned that they would want all forms of FC abandoned through awareness programs in individual houses, community meetings, religious organizations, and government agencies. Abandonment of this practice can be achieved through a collective decision from members of the community (Shell-Duncan et al., 2011). As indicated by the study of Gele et al. (2012), a single family that abandons the practice of FC would likely find it difficult, and may face sanctions from their community.

According to Ayenigbara et al.(2013), FC awareness can be included in discussions in the media about basic human biology, sexuality, and the practice of healthy hygiene for women. These modes of communication can be used to promote awareness programs that target rural dwellers about the health consequences of FC (Ayenigbara et al., 2013). Moreover, social agencies and international organizations

should be involved in the eradication of FC (Ayenigbara et al., 2013). For instance, some countries in Africa, including Sudan and Egypt, had laws against the practice of FC in the 1940s and 1950s. However, these laws did not work because of a lack of public awareness (Ayenigbara et al., 2013). For example, Participant 12 indicated that, "Awareness should also be done through the radio, newspapers, international organizations, and maybe donor countries." Thus, it can be concluded that awareness of FC consequences may be lacking among Somali women and that there is a strong need for further education in the Somali American community. In their study of Somali women's sexual values, attitudes, and behavior, Connor el al. (2016) found that the majority of their participants were interested in obtaining more information about HIV, particularly in a class that included other Somali women. Connor et al.'s findings indicate that Somali women living in the United States may be eager to learn more about sex and sexuality, despite cultural taboos about talking about this topic outside of marriage. Researchers working in public health may therefore find that awareness programs and campaigns have a willing audience.

Limitations of the Study

The study had several limitations. A small purposive sample of 12 participants (N=12) was used for this study, which may not be representative of the entire population of Somali women in the United States who underwent FC, and which makes it impossible for the result of this study to be generalizable. While qualitative research better explores the perceptions and lived experiences of the respondents, the generalizability of the

findings to the entire population under study is limited due to the small number of participants.

Secondly, the used of an online survey tool supported by SurveyMonkey did not provide an in-depth dialogue compared to face-to-face interviews. Although the population of this study was limited to Somali women 18 years and older who underwent FC and were living in the United States, there was no mechanism in place to validate participants' true age, sex, and residence. I had to assume that the participants were honest about their identities and experiences.

I used various methods to establish trustworthiness. Trustworthiness is established when results of the study closely reflect what participants described to the researcher. In qualitative research, trustworthiness consists of credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985). To assure credibility, I identified and described the participants as accurately as was possible given the circumstances of the study (Elo et al., 2014). I validated questions to determine clarity through a pilot study with non-Somali women who underwent FC. I also utilized member checking, which is sometimes referred to as respondent validation (Loh, 2013). I provided the initial interpretation of the data to participants, who verified if my interpretations were credible (Loh, 2013).

For transferability, I will describe the research context and assumptions that are central to this research. I assumed that the participants for this study are Somali women, age 18 and above, who have undergone FC. To assure dependability, I established an audit trail to report processes within this study, so that future researchers who repeat this

study are able to replicate it successfully (Loh, 2013). Notes, questionnaires, and transcripts that included the raw data and its analysis were preserved and maintained for review. Paper copies were kept in a filling cabinet and data obtained electronically using my computer were secured using encryption and passwords protection and stored in a lucked cabinet in my home office..

I also established trustworthiness through confirmability or objectivity. Data were checked and rechecked throughout the process to minimize biases and establish trustworthiness. According to Loh (2013), phenomenologists should set aside their individual judgment and biases by linking data to their original sources (bracketing). Given the sensitive nature of the dissertation topic, as also discussed by Connor et al. (2016) as they address the difficulty of addressing sex and sexuality with women who underwent FC by researchers, especially with a male researcher, and the qualitative, exploratory nature of the research question, and despite the attempts that were made to reduce bias and increase trustworthiness and transferability, these limitations were expected. Data collected were stored in a locked cabinet in my home office for verification as mentioned above to ensure confirmability

Recommendations

I recommend that future studies consider modifying the research methodology. Specifically, I recommend that future researchers consider utilizing a quantitative methodology, in order to establish stronger conclusions through statistical relationships between the study variables. While the perceptions and lived experiences of Somali women who underwent female circumcision before coming to the United States were

examined in this study, the relationship between the study variables may also be significant. The results of this study indicate there is a need to further educates women about serious effects of FC such as HIV or other sexually transmittable diseases. Furthermore, future researchers should consider using a mixed-methods design, in order to establish a deeper understanding of the phenomenon. The generalizability of findings may be enhanced through quantitative and mixed-methods research.

Considering the limitations of the current study, I recommend that future qualitative studies seek to expand the sample size, in order to increase generalizability. Additionally, future researchers may seek to investigate this phenomenon in person, using the results of this study to inform their work. Moreover, since the scope of the study was limited to 12 Somali women of 18 years of age and above, living in the United States, who can read and write in English, I recommend that a future study may be extended to a larger number of other Somali women who underwent FC living in other countries. I recommend further questions such as, "Does length of stay in the United States influence the way Somali women think about FC practices?" "How does education play a part in the way Somali women think about circumcising or not circumcising their daughters or nieces?" and "How do Somali women who underwent FC and are married to non-Somali husbands think about circumcision, as opposed to Somali women who are married to Somali men?"

I also recommend that further research focus on other variables that may have affected the findings of the current study. I posit that asking women about their lived experiences after FC might involve feelings that had not been shared before, and which

might facilitate participants' self-discovery and acceptance of their body image, even if they would not opt to attempt to reverse the FC. Women who underwent FC should be put into contact with counselors who have been trained to work with individuals who have posttraumatic stress disorder (PTSD).

The Somali women in this study expressed negative consequences associated with FC practice, such as pain, miscarriages, and heavy bleeding, which should be taken into consideration. Although the ultimate goal may be eradication of the practice, at the very least I recommend that communities that wish to continue to practice FC should circumcise their females in hospitals or medical centers that have trained staff, or have trained cutters to perform circumcision in a clean environment. In the United States, the American Academy of Pediatrics suggested that American doctors should be provided with permission to perform a "nick" or pinprick as an alternative to avoid a much more extreme procedure. Secondly, this might prevent families from sending their girls to their native counties for circumcision (Belluck, 2010).

I noticed that while a few women said their mother was present for the circumcision, in many of the cases, their mother was not. In one case, the mother was not allowed to be present at the ceremony at all. Without the chance to follow up with participants, guesses and speculations about the reasons for these discrepancies it would be just speculation; thus, I recommend more qualitative research to follow up on the role of mothers in their daughters' circumcisions.

Considering the fact that some of the participants identified FC as an important part of their cultural practice even though others wanted the practice to be eradicated, this

seeming contradiction suggests to those working in public health policy that attempts to eradicate FC must be undertaken carefully and with cultural sensitivity.

In a situation in which a family has to make a decision as to whether to circumcise their daughter, social convention can help us understand why they allow her to undergo FC. Social change leading to FC abandonment, while making it easy for daughters to get married, and while still maintaining social status of families who do not want to circumcise their daughters, can be achieved through social convention. Social Convention theory indicates that social norms change when a group of individuals widely observes a regularity that solves society's coordinated problems, even if they do not agree upon such regularity (Verbeek, 2002). If a social rule that everyone in the community has to follow can be avoided without breaking from the community, other families will make the same decision.

Implications

The primary implication of the current research is the positive social change that could be generated. Positive social change may initially be reflected in the respondents and other women who experienced this practice after undergoing counseling. The results of this study may inform the ways in which future social research may be conducted in the area of FC. If those who have undergone FC believe that there are solutions to this problem, such as vaginal reconstruction, their perspectives about their condition will be more positive.

There is limited literature on FC, especially regarding Somali women; this research study will add to the existing research base of FC practices. Through the

recommendations proposed in this study, communities that practice FC can develop FC awareness programs at schools, individual homes, the media, and religious settings, aimed at reducing or eliminating some of the negative consequences of FC such as pain, childbirth complications, and death. Policymakers may establish and promote policies that will be sensitive to the views and concerns of affected women and better understand the causes and repercussions of FC. Moreover, the findings of the current study may provide governments with the information needed to create policies and procedures to change FC practices, such as the prohibition of FC in a community because it endangers women's health. Furthermore, the negative consequences of FC reported in this study may encourage healthcare professionals to provide appropriate cultural care to circumcised women from various cultural backgrounds.

Countries and communities that practice FC, healthcare practitioners, social workers, immigration authorities, religious personnel, and human right groups should consider the findings of this research study, as it will help them provide care to people of different cultural backgrounds. Immigration authorities should take special precautions when granting visas to families moving during summer vacations to countries where FC is practiced. In particular, people who work with women who may have experienced FC need to be aware of the mixed feelings about the practice.

Conclusion

This qualitative study was designed to understand the lived experiences of Somali women who underwent FC before coming to the United States,. Findings from this study showed negative consequences of FC, and the majority of the women in the

study supported the eradication of FC in all forms. Participants agreed that interventions to abandon this harmful tradition should begin as early as possible, essentially starting when a child is born. Participants listed venues for informing parents and relatives of the need for the abandonment of the tradition, including religious institutions, schools, marketplaces, and the media. Through the findings of the study, it can be concluded that while traditions and religious beliefs are closely bonded in culture, considerations of the public health—especially women's health—should be prioritized. In consideration of the negative consequences reflected in the findings, it can be concluded that eradication of female circumcision should be implemented.

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Appendix A: Respondents Instructions

Hello, my name is Emmanuel Fai, and I am a student at Walden University, working on my doctoral degree in Health Science, and specializing in Public Health Policy. As a partial fulfillment of the requirements for my degree, I am engaged in a study titled "Female Circumcision: Phenomenological Study of Somalia Immigrants to the United States." I have found out that many African women from countries where female circumcision is practiced have much to say about their lived experiences. As such, I will like to invite you to participate in this study, as your contribution to this study will bring more light in understanding female circumcision for research and educational purposes. Criteria and parameters for inclusion into the study are:

- At least18 years of age
- A female immigrant from Somalia and living in the United States
- Able to read and write English
- Have undergone circumcision

Questions will be posted through a website that will be accessible by clicking the link at the bottom of this page. You are asked to participate only once in this study which takes 30-60 minutes to complete. You will be asked to return your answers to the questions within 2 days from the day you open the link. You will not be required to answer all questions. Answer only those questions that are applicable to you and you are comfortable answering. You may ask any question about the study whenever you want in the space provided. There will be no monetary compensation for participating in this study but free online counseling from http://www.livetherapy.com/?gclid=CKau-

bHGscACFSpp7Aod8SkAbA or free counseling and consultation from http://www.sanctuaryforfamilies.org/index.php?option=com_contact&task=view&contact_id=1&Itemid=141 is available for those who may be in need.

If you have any question about the study, you can reach me at 585-771-7365 or by email at emmanuel.fai2@waldenu.edu or email my dissertation chair, Dr. Peter B. Anderson at peter.anderson@waldenu.edu or call Toll Free 1-800-925-3368 ex. 1011448 or call Dr. Leilani Endicott for any ethical questions or questions that concern your privacy in this study at 1-800-925-3368, extension 1210 or email her at leilani.endicott@waldenu.edu.

Emmanuel Fai PhD Candidate

Appendix B: Female Circumcision: Open-Ended Questionnaire

1- Demography:

a- Background information:

1- Age……

2- Age at circumcision……

3- Marital status……a). Married, 2). Single 3). Divorced

4- Tell me what country your husband is from (if married/divorced)

5- The age you had your fist menstrual period

6- Number of pregnancies…

7- Number of deliveries…

8- Number of children……

9- Your educational level…….

10- Employment…….

11- Length of stay in the United States

12- Religion----------

Main question: What are the lived experiences of Somali women in the United States who experienced circumcision in Somalia?

b- The circumcision experience:

1- What does your circumcision mean to you?

2- What were your feelings when you were told that you were to undergo circumcision?

3- What were some of the reasons you underwent circumcision?

4- Who was present when you underwent circumcision?

5- Who made the decision for you to be circumcised?

6- Who performed your circumcision?

7- What were your feelings before and after the circumcision?

8- Was anesthesia or pain killer used for your circumcision?

9- What are similarities and differences that you know about on how circumcision is done in cities and villages in Somalia?

10- What type or level of circumcision was done to you, or what parts of your genitalia were cut?

11- What instrument was used for cutting?

c- Cultural beliefs:

1- What are some of the reasons circumcision is still practiced in Somalia?

2- How did religion, culture, or social factors play a role in your circumcision process?

3- Which members in your family underwent circumcision?

4- Did being circumcised make it easier, difficult, or make no difference to getting married? Why?

5- What is your opinion about circumcision?

6- What do you think about circumcising your daughter, niece, or Somali girls in general?

d- Medical ramifications:

1- What difficulties if any, did you have that were related to your circumcision?

2- Did you have any urinary tract infection(s) after the circumcision?

3- What are some medical problems, if any, you had or have as a result of circumcision?

4- Tell me if you had pain as a result of genital scarring.

5- Describe to me some of the problems, if any, you had during your first menstrual flow as a result of circumcision?

6- What age did you have sexual intercourse?

7- Describe to me if you had pain during sexual intercourse that you believe was as a result of circumcision?

8- Describe to me some of the problems, if any, you had during labor?

9- Describe the type of delivery(ies) you had?

10- What are your feelings when you have to be examined by a Western health care provider during obstetrical and gynecological examination or during delivery?

e- Psychological ramification:

1- Please explain to me what circumcision has done to your life today that would have been different if you had not undergone circumcision.

2- How do you feel about discussing circumcision with other females who come from communities that do not practice circumcision?

3- What, if anything, would you change about yourself in related to female circumcision?

4- To what extent do you consider yourself a woman in Somalia where female circumcision is done and here in the United States where female circumcision is not allowed?

f- Participant Insight:

1- How do you think female circumcision should be discouraged or encouraged?

2- Would you promote/discourage female circumcision? Why?

3- At what age do you think awareness campaign for or against circumcision practice should be started?

4- What are some of the area that you think can be used to create awareness for or against circumcision practices?