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Heroes or Victims: The Lived Experiences of Women on Female Genital Mutilation/Cutting in Northwestern Nigeria

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Abstract

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by

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Abstract

The custom of female genital mutilation/cutting (FGM/C) is a traditional practice inimical to women's health with profound implications. There is a gap in the literature on the lived experiences of women who have undergone FGM/C and their statuses within their communities. Guided by the social cognitive theory and the ecological model, this qualitative study aimed at explicating the attitudes and perceptions of women in the northwest region of Nigeria towards the practice of FGM/C, to illuminate how the women view themselves in their society and the inspiration for the continued practice of FGM/C. Interview and observation data were gathered from 10 women ages 18 to 59 who had undergone FGM/C. Participants were voluntarily recruited using purposeful snowball sampling techniques. Data were analyzed through inductive coding techniques to extract and compare recurrent themes and patterns. Four major themes emerged: (a) traditional beliefs; (b)pain, happy, and approval; (c)pain, distress, and disapproval; and (e)ignorance of the law. Results indicated that ethnocultural beliefs, religion, and customs had a strong influence on the decision to undergo FGM/C. Women who viewed themselves as heroes of the practice strongly supported the continuation of FGM/C. The women who viewed themselves as victims of FGM/C disapproved the practice as an instrument to instill fear and control. The potential for social change could improve the knowledge of public health professionals, international organizations, federal, state, and local governments to influence policies on decreasing FGM/C without undermining the culture of communities regardless of any personal belief that sees FGM/C as detrimental to women.

Dedication

I dedicate my dissertation work to God the Father from Whom all blessings flow. His grace empowered me to survive this doctorate program. I dedicate this work to my father, Maiganga Kurah whose words inspired and gave me the tenacity to reach my goal.

I also dedicate this study to my grandson Samari Philips for placing a flower painting and balloon in my study area. The shinning sun on the flower gave me hope to persevere. Thank you for reminding Grandma to take a break. To my husband, Elijah Philips and children; Edward Philips, Ezra Philips, and Jerry Philips thank you for your sacrifice and support. My special thanks go to Jerry Philips for being a diligent IT support to me.

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I am truly thankful to the ten research participants who were not ashamed to talk about their lived experiences and exposed their feelings on a delicate subject matter. You all are heroes and I am proud of you. Thank you for making this study a reality.

Lastly, I will like to acknowledge my classmates for being a useful resource and for their support throughout the dissertation process. Another big thank you goes to the Walden University Community for their services and resources which were instrumental to accomplishing this study.

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Chapter 1: Introduction to Study

Introduction

In every society, there are both positive and negative traditions. These traditions become the beliefs and values of the people, inherent in the communities and are handed down from one generation to the other (Berkes, Colding & Folke, 2000). Although most traditions have no health benefits, societies continue to maintain and practice them. The lack of education is a contributing factor to the reason most societies with unfavorable traditional practices against women continue to imbibe them (Aja-Okorie, 2013).

In African culture and communities, harmful traditional practices (HTP) continue to be a public health concern (UNICEF, 2005). These practices have not only hindered the progress of women but have to a great extent impacted women's reproductive and psychological health (Ojua, Ishor & Ndom, 2013; Igberase, 2012). The lists of HTPs are endless: wife battering, scarring, early girl marriage, forced marriage, hot bath (wankan jeko), gishiri and angurya cuts (Denniston, Hodges & Fayre, 2014).

Typically, the girls who undergo the gishiri cut are married between the age of 10 and 15 years when they are not fully developed or matured to cope with childbearing tasks. For some of these young girls, their complications have culminated into virginal vesicle fistulae (VVF) (Ashimi, Aliyu, Shittu, & Amole, 2014). Usually, when their condition reaches this stage, their husbands will reject them, and they become outcasts in the society (Melah, Massa, Yahaya, Bukar, Kizaya, & El-Nafaty, 2007). Although these practices constitute violence against women and children, some societies continue to hold on them in spite of efforts by interventionists to discourage the practices (Allen, 2014).

Female genital mutilation or cutting (FGM/C) is a prominent traditional practice inimical to the health of women and a global public health concern (Okeke, Anyaehie & Ezenyeaku, 2012).

The main focus of this case study is to try to understand the experiences and feelings of women who have undergone FGM/C in the Northwest region of Nigeria by exploring their lived experiences to explicate the motivations behind this practice. It is necessary to gain insight into the reasons why the women undergo the practice to understand their identity in the society. This could enhance the role of professionals working with women in different cultures by providing them with data to increase their knowledge of FGM/C. As discussed in succeeding sections, the practice of FGM/C is common to many African cultures including Nigeria.

Background

FGM/C is considered an important public health concern (World Health Organization [WHO], 2013). The practice thrives in most African cultures including Nigeria (UNICEF, 2013). FGM/C has been found to present with both psychological and physical health difficulties from cutting to sexuality, childbirth, and adulthood (Berg, Odgaard-Jensen, Fretheim, Underland & Vist, 2014). The challenges associated with FGM/C are many, and the practice appears to continue to blossom (WHO, 2013).

In Nigeria, the practice of FGM/C is still important to some cultures with the present estimates put at 58% (Feldman-Jacobs & Clifton, 2014). There are four categories of FGM/C and all the forms are practiced in the country by both Christians and Muslims but predominantly among Christian areas (Okeke, Anyaehie & Ezenueaku, 2012).

However, in the Northwest region of Nigeria, the more aggressive type IV (gishiri and angurya cuts) of FGM/C is practiced in this area. There is a high cultural value of FGM/C for it to endure a half-century of propaganda crusades (Kontoyannis & Katsetos, 2010).

The problem of FGM/C is well discussed in the literature. In Nigeria and some other parts of the world, professional health workers who are conducting FGM/C exacerbate the prevalence of FGM/C(Umar & Oche, 2014). This medicalization of FGM/C is an additional cause for concern as it has encouraged the continuation of the practice. FGM/C has yet to be well understood. This lack of understanding is the reasons why advocacy activities by international organizations, nongovernmental organizations (NGOs) and community-based organizations (CBOs) have not eliminated the practice. Also, the media do not appear to show any enthusiasm for their propaganda against the practice (Yoder & Khan, 2007; Isiaka & Yusuff, 2013).

There is no understanding whether women who have undergone FGM/C see themselves as heroes or victims in their cultures. Hence, the purpose of this study is to explore the lived experiences of women in the Northwest region of Nigeria to gain an insight into how they view themselves, as heroes or victims. This therapeutic violence (Thompson, 2015) and other traditional and culturally justified practices have bedeviled the region and are worth investigating. Additionally, the goal for selecting this study location is because the more extensive and aggressive form of FGM/C, popularly known as Type IV is performed in this region(Allen, 2014). The study provides up-to-date information that could be used by practitioners to revise their communication tactics and

or educational programs about FGM/C. The study is also relevant because the information could be applied to programs targeted at eradicating the practice.

Problem Statement

FGM/C has been extensively researched. It is found to be an unhealthy traditional practice detrimental to women and girls worldwide (WHO, 2013). FGM/C is found to be a common practice in some parts of Africa and the West among some immigrant communities who are medicalizing the practice (Hodes, Armitage, Robinson & Creighton, 2015; WHO, 2013).Statistics from UNICEF (2013) and Okeke et al., (2013) indicate that 140 million young girls and women all over the world are victims of FGM/C. They are living with health consequences such as infection, acute urinary retention, shock from pain and hemorrhage, damage to the urethra or anus, vulvar adhesion, chronic pelvic infection, acquired gynatresia resulting in hematocolpos, dysmenorrhea, retention cysts, sexual difficulties with anorgasmia, and increased risk of complications during child birth including surgeries (Berg et al., 2014; WHO, 2013). In another report, the number of girls who have undergone FGM/C is estimated to be approximately 101 million in Africa alone(WHO, 2013). Incidences are intense in some swath countries and the Horn of Africa is having the highest number (WHO, 2008).

Table 1 below shows the prevalence of FGM/C among 8 African countries. Egypt has the highest rate of FGM/C among women ages 45 – 49 years old and women between 15 – 19 years old. The lowest rate is in Senegal among women ages 45-49 and in Central African Republic among women between the ages of 15 – 19.

Table 1:

Population Reference Bureau. Female Genital Mutilation/Cutting

Countries	Women Ages 45-49	Women Ages 15-19
Egypt	96%	81%
Sierra Leone	96%	70%
Ethiopia	81%	62%
Chad	48%	41%
Nigeria	39%	19%
Central African Rep.	34%	18%
Senegal	29%	24%

The current global predictions reveal that 30 million girls from infancy to age 15 are currently at risk of FGM/C (WHO, 2013). Nigeria, like any African country, has a host of traditional practices found to be destructive to women and children (United Nations [UN], 2006) but promising to men. In practicing communities in Nigeria, FGM is done at a young age when the individual is unable to make an informed decision or provide consent (Allen, 2014). Geographically, FGM/C differs in the country. There are less harmful types; I and II are more widespread in the South and West than the risky types; III and IV in the North (Allen, 2014).

Table 2 below provides the most current data of FGM/C in Nigeria by age, geographic location, and type that appear to suggest that the practice of FGM/C is decreasing (Fieldman-Jacobs & Clinton, 2014). Nigeria's Multiple Indicator Cluster Survey (MICS) of 2011 indicated the highest prevalence of FGM/C to be 38.0% of

women ages 45 to 49 years old. Prevalence by geographic area shows 73.4% in the highest region and 32.6% in the urban areas (Fieldman-Jacobs & Clinton, 2014).

Table 2:

Female Genital Mutilation/Cutting: Data and Trends Update 2014

Survey/ Year	Prevalence by age (%)			Prevalence by Geographic Area (%)				Types of FGM/C (%)			
	15 – 49	15 -19	45 - 49	Urban	Rural	Lowest Region	Highest Region	Naked, No Flesh Removed	Flesh Removed	Sewn Closed	Not Determined
MICS 2011	27.0	18.7	38.0	32.6	23.8	0.2	73.4	8.1	48.1	4.4	39.6

Note: Fieldman-Jacobs & Clinton (2014)

It is assumed that because Nigeria is highly populated, so also is the practice of FGM/C. It is more prevalent on the African continent with one-quarter of the estimated 140 million of women and girls who have been cut (Okeke, 2013). In the Northwest region of Nigeria, data on FGM/C are mainly from Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and hearsay accounts (Okeke, 2013). The findings from this study provide an authentic data and closer understanding of the motives behind the continued practice of FGM/C to guide the strategic allocation of resources.

While the Western cultures view the practice of FGM/C as barbaric and human rights violation (UN, 2006); this may not be the case in African cultures (UNICEF, 2005). It is not clear as to whether the people we consider affected by the FGM/C

practice in this part of the world view themselves as victims or heroes. The notion of the victim or hero has been explored in this study. As seen in the review of the literature, there are numerous problems resulting from FGM/C including health and psychological discomfort of women. However, there has been little attempt as far as this researcher is concerned, to examine whether women who have undergone the exercise have a positive or negative view of themselves and their status in the society. Answering this question could enhance the efforts of interventionists to more accurately target messages and other educational programs for a positive reception by women of various cultures.

Purpose of the study

The purpose of the study was to explore the lived experiences of 10women in the Northwestern Nigeria as it relates to FGM/C. An understanding of the perceptions of women in this community could provide insight into how the women view themselves as victims of the practice or heroes in their society and the motivations for the continued practice of FGM/C. A review of the literature has shown that there is a lack knowledge of the lived experiences of women who have undergone FGM/C, or their status within their communities. The literature has also failed to provide validation to those who perceive the practice as a valuable cultural tradition (Kontoyannis & Katsetos, 2010). This dissertation was undertaken to address the knowledge gaps so that public health professionals and advocates could use data from the study for appropriate strategies to be effective agents of change regardless of any personal belief that sees FGM as detrimental to women.

The paradigm for the study was qualitative because qualitative approaches facilitate a deeper understanding of social phenomena instead from quantitative data, as they dig deep into the feelings, perceptions, and opinions of individuals being researched (Patton, 2002). Additionally, a qualitative study aims at discovering the subjective meaning of social reality and how individuals view their social environment within which they conduct their activities (Creswell, 2013). Similarly, the research paradigm is descriptive in that it describes how women perceive themselves as heroes or victims in their community and it is exploratory because the aim is to investigate the lived experiences of circumcised women.

Research questions

The research questions consist of a central question, "What are the lived experiences of women in northwestern Nigeria toward the practice of female genital mutilation?" I also used the following related questions:

1. What are the perceptions of women in Northwestern Nigeria towards FGM/C?
2. What factors influence the decision of women in Northwestern Nigerian to undergo FGM?
3. How do women describe their experiences regarding FGM/C?
4. Do you approve or disprove the continuation of FGM/C? What are the reasons for approving or disapproving the continuation of FGM/C?

Conceptual Framework for the Study

The study was guided by a combination of theoretical frameworks; the Social Cognitive Theory (SCT) of Bandura (1986) and the Ecological Model (EM) by McLeroy

(1988). The core concepts of psychological and environmental determinants of behavior provided insight into how the environment and personal influences interact and cause an impact on individual behaviors (Glanz, Rimer, & Viswanath, 2008). The elements of outcome expectations are the likelihood that a person will choose to perform an action to maximize benefits and minimize cost based on the value of social outcomes (Glanz et al., 2008). The concept further explained how different people and one's willingness to be guided by their evaluations evaluate individual behaviors (Glanz et al., 2008). On the other hand, the concept of the ecological model suggests that an individual's health behaviors are a product of many factors intermingling at multiple levels to influence the behaviors (Glanz et al., 2008). Applying the ecological model to this study did not only guide the study but suggested appropriate interventions. Therefore, these theories explained why the women I investigated were mutilated, the basis for the practice, their attitude towards the practice, whether negative or positive or whether they have had to submit to the attitude and norms of their social environment (Glanz et al., 2008). The framework revealed how individuals are predisposed by the society to think and engage in FGM/C.

The environment in which people live and interact can have an impact on their behavior as well as shape their perceptions. By understanding the views of these individuals, this research provided the comprehension of why the women subjected themselves to FGM/C and the associated reasons for its continued practice. This is a qualitative case study. A mixture of elements of the social cognitive theory and ecological model were applied to facilitate an understanding of the lived experiences of

women in the Northwest region of Nigeria about FGM/C. The social cognitive theory and the ecological model are deliberated at length in Chapter 2.

Nature of the study

This is a qualitative phenomenological study. This method investigated the lived experiences of 10women in Kaduna state, in northwestern Nigeria who have undergone mutilation. The emphasis was an in-depth investigation through one-on-one face-to-face interviews and observation to gather rich information on the issue of FGM/C (Patton, 2002). I coded and analyzed the data to ascertain the emergent themes.

This approach helped to understand FGM/C from an individual's point of view, their reactions, feelings, thoughts, memories, and perceptions. The information gathered from the interviews and observation described the process of FGM/C, the after effect, and confirmed or refuted the assertions made by literature about FGM/C. Furthermore, understanding the perceptions of undergoing FGM/C is imperative for understanding the identity, status and views of women to improve the knowledge of practitioners and the efficacy of their intervention programs (Shabila, Saleh & Jawad, 2014) among cultures of the Northwest region. The findings are systematically defined in Chapter 4.

Definitions

This researcher used the following terms to pinpoint key components: female genitival mutilation/cutting, harmful traditional practices, gishiri and angurya cuts, social cognitive theory, and ecological model:

Angurya cut: The scraping of the tissue around the vaginal opening (Ashimi et al., 2014).

Ecological Model: Explains how individual behavior is impacted by five levels of interactions; interpersonal, intrapersonal, institutional, community and policy (McLeroy, 1988).

Female genital mutilation/cutting: The partial or total removal of the external female genitalia or other injuries to the female genital organs for nonmedical reasons (UNICEF, 2015).

Gishiri cut: Gishiri cuts are posterior (or backward) cuts from the vagina into the perineum as an attempt to increase the vaginal outlet to relieve obstructed labor that usually result in vesico vaginal fistulae (VVF) and damage to the anal sphincter (Ashimi, Aliyu, Shittu, & Amole, 2014).

Harmful traditional practices: Are practices that damage the health of women and children. These include; FGM/C, facial scarring, wife inheritance, widowhood rites, force-feeding of women, early or forced marriage, bride price, nutritional taboos, traditional practices associated with childbirth, dowry-related crimes, virginity tests, honor crimes and son preference(UNHCHR, 1948).

Social Cognitive Theory: Describes how people acquire and maintain certain behavioral patterns by observing others and explains how personal factors, behavior, and environmental factors interplay to influence human behavior (Bandura, 1986).

Assumptions

In conducting this study, I assumed that everyone investigated during this study honestly communicated their feelings and perceptions about FGM/C Second, that irrespective of marital status, women in the study are residents of Kaduna North and

South Local Government Areas (LGA) at the time of the study and freely expressed their feelings and perceptions about genital mutilation/cutting without coercion through a one on one discussion.

Another assumption is that the educational level of the women investigated by this study affected the quality of their interaction with this researcher. These assumptions suggested that the findings by this researcher are valid and could provide a rich resource for those seeking to develop or refine initiatives for improving the knowledge of men and women on the FGM/C phenomenon.

Scope and Delimitations

The topic of investigating the lived experiences of Nigerian women who have undergone FGM/C was carefully chosen to have an insight into how they view themselves in their communities heroes or victims of the practice of FGM/C and a want or necessity. The Northwest region of Nigeria, the area for study, includes Sokoto, Kebbi, Jigawa, Zamfara, Katsina, Kano, and Kaduna states. However, the site for the investigation is Kaduna North and Kaduna South LGAs in Kaduna State. The literacy level among women and girls in the Northwest region is considered low (Erulkar & Bello, 2007) due to an interaction between government, gender roles, culture, poverty, inequality, and different levels of respect for women and their rights (Callaghan, Gambo & Fellin, 2015; Watkins, 2013). These women live and operate within social backgrounds and base their decisions on those backgrounds. For example, being poor, rural, and a female carries a triple handicap and girls in this category average less than 1year in school, while wealthy urban males get 9 years (Watkins, 2013).

The multiple sociocultural practices in the Northwest region account for many harmful traditional practices against women and girls (Okeke et al., 2012). This is another reason for selecting the study location and population. By applying elements of the SCT and ecological model explained the theoretical foundations on which the women underwent FGM/C and pinpointed the needs of each woman resulting in FGM/C.

Kaduna North and Kaduna South local governments were chosen for the study because of the lack of a most recent data to address FGM/C in the area. Base on a state-by-state study of FGM/C in Nigeria, 148,000 women and girls from 31 communities were sampled by the Inter-African Committee on Nigeria on Harmful Traditional Practices Affecting the Health of Women and Children [IAC]). The prevalence of FGM/C, Type IV in Kaduna State stood at 50-70 % (Kandala, Nwakeze & Kandala, 2009). However, experts indicated that the results are from fragmented data, and that figures may be much higher (Nigerian Report on FGM/C, 2015). While this research is qualitative and focuses on discovering and recounting why women view themselves as heroes or victims of FGM/C in Kaduna state, a quantitative study is suggested to determine the percentage of current rates of FGM/C in the State.

Although, the women selected for the study reside in Kaduna State, they do not exemplify the whole population. Nevertheless, their lived experiences provided some insight into the motivations for the practice of FGM/C. This understanding could improve the knowledge of practitioners and effectiveness of programs.

Limitations

One of the major limitations of the study is that the findings cannot be generalized to the entire region due to the choice of Kaduna State that is only one of the seven states in the Northwest region. Nevertheless, the findings have defined the experiences of women on FGM/C in Kaduna North and Kaduna South local government areas and function as a platform for further research. There are two biases that could have influence the result: the researcher's previous opinion on FGM/C and relationship with people who have undergone FGM/C. The problem was resolved through bracketing my anticipations and focused solely on recording experiences from the participants. Secondly, self-report bias could arise from the participants who may not adequately recall their feelings as well as not being open and honest in providing complete information (Pannucci, & Wilkins, 2010). Staying focused on the interview procedure and avoiding personal comments and pretesting the questionnaire before they are administered are some ways I addressed the biases.

Significance

This study highlighted the lived experiences of women about FGM/C. Understanding these experiences underscored some of the reasons behind the practice whether the women see themselves as heroes instead of victims or whether FGM/C is a want or necessity. The study further explored the actual motivations that negate the abolition of FGM/C. The findings could provide an understanding of how FGM/C may be an important and valuable part of the culture for it to survive 50 years of criminalization and numerous propaganda campaigns (Kontoyannis & Katsetos, 2010).

Subsequently, policy makers and interventionists could use the information to design appropriate advocacy strategies that could not undermine the culture of the community.

This study's potential for social change is not only to add to the body of literature of FGM/C but also to augment the quality of understanding in the field and the motives for undergoing FGM/C. The ability of the study to provide a basis for future research into the hero versus victim notion of FGM/C is equally important. The study also has direct implications for public health professionals and decision-makers and the public to result in policies on decreasing FGM/C. Finally, the research could benefit communities, individuals and nongovernmental organizations with updated information on FGM/C to serve as a baseline for future studies in the Northwestern region.

Summary

Chapter 1 establishes both relevance and the need for additional study and examination of lived experiences of women on FGM/C in the Northwest region of Nigeria. The framework used to develop questions for the interview to explore the reasons necessitating FGM/C and contributed to its continued practice was the social cognitive theory and the ecological model by Bandura and McLeroy.

The succeeding chapters provide an in-depth description of the study. I discuss the literature in Chapter 2 the methodology in Chapter 3, and the results in Chapter 4. Lastly, in Chapter 5 I provide deliberation on the results and suggest recommendations for possible action and research in the future.

Chapter 2: Literature Review

Introduction

As discussed in the previous chapter, this research targeted the lived experiences of women who have undergone female genital mutilation/cutting (FGM/C). The goal was to understand the overall perception of this exercise. FGM/C is condemned as a heinous act against women and a deprivation of their fundamental human rights by international organizations like UNICEF, WHO, UN, human rights and feminist's movements, and many NGOs at the national and local levels in Nigeria. However, my objective was to answer a question not quite discussed in the literature: do women who have undergone FGM/C consider themselves victims of the act, or heroes for having experienced a particular initiation into womanhood?

In this chapter, I discussed current findings on FGM/C, explored various reasons why those advocating a worldwide band of the exercise frown at this practice. I also deliberated on the current knowledge of FGM/C in Nigeria to explain the necessity of investigating the lived experiences of women in the Northwest region. Having insight into the lived experiences could advance the understanding of the socio-cultural factors that sustain the practice. Lastly, the chapter devoted attention at exploring theoretical concepts that informed the basis for the study and ensured replication on grounds already covered by previous researchers was avoided. This research has fulfilled my desire to enlarge the data and knowledge on the subject of FGM/C in Nigeria. Additionally, it could improve the quality of initiatives advocated by well-meaning individuals and organizations for lessening the adverse impact of the practice of FGM/C on women.

Literature Search Strategy

The Walden University Library was the primary search engine use to access other databases like the Cochrane Database of Systematic Reviews, EBSCO, EMBASE, MEDLINE, PsycINFO, Proquest Central, EPOC, PILOTS, POPLINE, SAGE and Google Scholar for articles, dissertations, and theses. Other key sources included organizations like UNICEF, WHO, and the UN because these establishments have a strategic role, agenda on FGM/C and the sources are frequently updated. Keywords used were *female genital mutilation, mutilation, circumcision, infibulation, cutting, culture, violence against women and gender issues Most of the databases carried similar information on the prevalence, effects and attitudes* and *practices of FGM/C*.

Definition and Origins

FGM/C is a traditional practice that involves the partial or complete removal or other injuries to the female genital organs for reasons other than to satisfy a medical requirement (WHO, 2008). The WHO(2013) and UN (2006) describe four types of FGM/C. In the first type, (clitoridectomy) is the partial or total removal of the clitoris and the prepuce (WHO, 2013). In Type 2 (excision) there is a partial or total removal of the clitoris and the labia minora without the excision of the labia majora (WHO, 2013). Type 3 (infibulation) involves the narrowing of the vaginal orifice with the creation of a covering seal by cutting and a positioning the labia minora and the labia majora, with or without excision of the clitoris (WHO, 2013). Infibulation is considered the most invasive type of FGM/C (Gele, Johansen & Sundby, 2012). Defibulation, which is the opening of the covering seal, is deemed necessary before the birth of a child (Onomerhieyurho

&Mercy, 2015). Reinfibulation refers to the recreation of an infibulation after defibulation (Muteshi, Miller & Belizan, 2016). The fourth type involves all other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping and cauterizing (WHO, 2013).

FGM/C is practiced in more than 28 countries in Africa, and in some countries in the Middle East and Asia and usually on prepubescent girls (Gele, Johansen & Sundby, 2012). On a global basis, an estimated 140 million women have been subjected to FGM/C, with 3million girls being at risk for the practice every year (Okeke et al., 2012; WHO, 2013), the majority of them live in 28 African countries and some parts of Asia. The most recent figures on FGM for African countries show that there is a 70% prevalence of FGM/C in Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, Guinea, Mali, Mauritania, Northern Sudan, Sierra Leone, and Somalia (Fieldman-Jacobs & Clinton, 2014). The prevalence of the practice varies between and within countries, reflecting ethnicity and tradition (Allen, 2014). However, FGM/C has gone far beyond its traditional borders through migration because of the political unrest in some practicing countries in both Africa and Asia resulting in many Western nations being confronted with a massive influx of immigrants from countries who subscribe to FGM/C (Gele et al., 2012). Scandinavia, the Netherlands, United Kingdom and the United States are countries that come to mind (Gele et al., 2012).

The term infibulation originates from ancient Rome, where female slaves had fibulae (brooches) pierced through the labia to prevent them from getting. Another general assumption states that FGM/C originates in pharaonic Egypt (Kouba & Muasher,

1985). This is supported by the contemporary term "pharaonic circumcision" who suggested that it was not a common practice in ancient Egypt because no physical evidence exists in mummies and nothing in the art or literature to imply FGM/C in the ancient kingdom (Kouba & Muasher, 1985).

History has the first mention of FGM/C in the writings by the Greek geographer Strabo, around 25 B.C., who indicated that Egyptians valued the custom of FGM/C (Kouba & Muasher, 1985). A Greek papyrus dated 163 B.C. stated the operation is done on girls in Memphis, Egypt, at the age when they received their dowries, supporting theories that FGM originated as a form of initiation of young women (Gruenbaum, 2001). Other writers later explained that the procedure was for other reasons. On the other hand, others wrote FGM/C was necessary to avoid a large clitoris from robbing against a woman's clothes and stimulate the desire for intercourse(Aslan, 2015, p. 31). On this account, it seemed proper to the Egyptians to remove it before it became enlarged when the girls are ready to marry (Aslan, 2015 n.d). Many centuries later, 19th-century gynecologists in England and the United States would perform clitoridectomies to treat the various psychological symptom as well as "masturbation and nymphomania because many disorders like depression and neurasthenia originated in genital inflammation (Gollaher, 2001, p. 680.). This data attest to the many health problems that could result from FGM/C.

Women are reported to have many physical and psychological and health problems (Berg et al., 2014) after having any of the types discussed above. These include the transmission of HIV, as the same unsanitary tools such as unclean shards of glass,

razor blades are used to perform the surgery on many different women without sterilizing them (Okeke et al., 2012). The performance of the surgery is done most often without anesthesia, causing the woman extreme amount of pain (Okeke et al., 2012). They can experience excessive blood loss that can lead to possible death, as well as high infection rates, pregnancy conflicts and psychological damage among many other things (WHO, 2013). A report states that one-third of the Sudanese girls who undergo the surgery do not survive it (Koonce, 2015). The pains a woman goes through after her surgery are referred to as the "three feminine sorrows" (Okeke et al., 2012, p.72). Not only does the woman feel extreme pain on the day of her surgery, but will also experience much pain on the night of her marriage when her vagina is opened again and the day she gives birth (Okeke et al, 2012).

Following the cutting of a woman, she may find it difficult or impossible to urinate and her urinary canal may be partially or entirely obstructed (Ashimi et al., 2014).As a result, pain or fear of pain during urination may prevent natural flow and Edema or other wound reactions like granulation tissue or fibrosis may contribute to obstruction and urine retention can lead to infection (Ashimi et al., 2014). Although infibulation may be successful after it the surgery, it can still create problems. Virtual closure of the vaginal introits makes obstetrical and gynecological examination difficult because inserting a catheter during the examination may no longer proceed readily (Berg et al., 2014).

In Nigeria, there is a greater prevalence of Type I excision in the south, with extreme forms of FGM/C prevalent in the north (Okeke et al., 2012). The practice is

found among both Muslims and Christians but widely spread in Christian predominated parts of Nigeria (Okeke et al., 2012).Relying on data from Ashimi et al., (2014) found that the prevalence of FGM in Nigeria is between 20%-30% but adds that some other researchers report the magnitude of FGM in the country as high as 41% among women and girls. This figure appears to be reasonable given the fact that existing policies have not banned the practice of FGM. However, he notes that there exist wide variations within and between the six geopolitical zones of Nigeria regarding the magnitude of the FGM (Ashimi et al., (2014). For example, the prevalence is highest in the southern part of Nigeria, with 77%, 68%, and 65% of women in the south, southeast, and southwest geopolitical zones having been genitally mutilate (Okeke et al., 2012, p. 70). These percentages more than double what is recorded in the three northern geopolitical zones. Umar and Oche (2014). agreed with Okeke et al.,(2012) when he argued that the northern region has the worse forms of FGM.

Enwereji and Enwereji (2013) argued that individual factors militate against the eradication of FGM/C in Nigeria. For instance, in the western part of Nigeria, the general belief that circumcised women marry much easier than the uncircumcised females is an impediment to abolish FGM/C. They argued that the notion of easy marrying off of circumcised daughters is an important economic consideration for most parents and an important limiting factor to abolish the practice (Enwereji & Enwereji, 2013).According to them, the gifts the families of circumcised girls receive as well as the likelihood of the circumcised girls being quickly betrothed than others are the motivating factors that delay the eradication of female genital mutilation (Enwereji & Enwereji, 2013).

Okeke et al., (2012) indicated that respondents in their studies regarded FGM/Cas "a good custom and has to be protected" (p. 71). Other reasons include family honor, hygiene, esthetic reasons, and protection of virginity and prevention of promiscuity, increasing sexual pleasure of husband, enhancing fertility and increasing matrimonial opportunities (Allen, 2014; Okeke et al., 2012).

Mothers in Lagos, Nigeria were reported to have ambivalent perceptions of the practice of FGM/C in that majority of participants (56.8%) indicated that they do not perceive the practice as being beneficial to the female, yet almost half of them (44.2%) thought that uncircumcised women will become sexually promiscuous (Ahanonu & Victor, 2014).This latter finding is similar to a study from Nigerian, which found mothers were of the opinion FGM/C prevents sexual promiscuity (Allen, 2014; Isiaka & Yusuf, 2013).It could be that the mothers who shared the view that FGM/C had no benefits for women were brainwashed by campaigns against the practice because these mothers were interviewed by healthcare professionals involved in championing the fight against FGM/C in the country (Ahanonu & Victor, 2014). To hold the belief that uncircumcised females will become sexually promiscuous is a widely-held perception in the community where this study was carried out (Isiaka & Yusuf, 2013). This reflects their true feelings about the practice even though they also alluded that the practice has no benefits.

Empirically, there is little or no evidence to validate the belief that FGM/C inhibits sexual promiscuity among women; nonetheless, sexual promiscuity has been reported to be associated with early childhood sexual abuse in both males and females (Okeke et al., 2013). Also, to indicate the presence of misconceptions among the mothers,

30.5% (one-third) reported that FGM/C promotes a woman's faithfulness to her husband, and a similar proportion believed that the practice prevents sexual promiscuity (Ahanonu & Victor, 2014). This finding corresponded with survey conducted in Egypt. The study reported that 34% of the women interviewed were in support of the continuation of FGM/C because it could prevent adultery" (Gele, Bø, & Sundby, 2013; Mohammed, 2015; Yirga, Kassa, Gebremichael & Aro, 2012), and less supervision by husbands (Coyne, & Coyne, 2014).

Fourteen percent of female health workers at Usman Dan Fodio University in Sokoto state, Nigeria had a positive attitude towards the practice (Umar & Oche, 2014). However, 86% considered FGM/C as a form of violence against women, although, more than a quarter of them believe it is in line with their religious beliefs (Umar & Oche, 2014). Only 7% of the females indicated that they partook in the decision-making process, and or directly in the conduct of FGM/C (Umar & Oche, 2014). The reasons cited included reduction of the unsafe procedure compared to traditional methods (33%) (Umar & Oche, 2014). Others included promiscuity (26%), religious' injunctions (15%); ethnic cultural norms (10%) and an admixture of promiscuity, religious injunctions and ethnic cultural norms (16%) (Umar & Oche, 2014).

The results from Nigeria resembled studies in Somalia that reported that the parts of the body that are cut off are considered childish and unclean (Lien & Schultz, 2013). They had to be removed to humanize and feminize the woman, to secure her moral uprightness, and physical beauty (Lien & Schultz, 2013). It elevated her body to an aesthetic ideal and only as a sewn woman could she represent her family later in life at

marriage (Lien & Schultz, 2013). Some Somali women stated the case in religious terms, seeing circumcision as a cleansing ritual that allows them to be true Muslims and helps them to pray properly (Lien & Schultz, 2013).

Theoretical and Conceptual Framework

The significance of SCT and ecological model provided a comprehensive understanding of the context, the meaning individuals gave to FGM/C and how it operates. Some essential elements of the frameworks; psychological and environmental determinants, self-efficacy, observational learning and policy (Glanz et al., 2008) were used to examine why a woman would make a decision to undergo FGM/C notwithstanding the numerous effects. Based on this premise, I discussed the various elements of the theory to inform international and local programs and interventionist to appreciate the cultural significance of FGM/C to individuals, their families, communities that choose to carry on FGM/C.

I used concepts from the social cognitive theory and ecological model to explain behavior. I provided an additional graphic presentation of the interrelationship among variables of behaviors for clarity. The emphasis is on self-efficacy, which is the ability to control events that affect a person's live based on one's past success or failure in a given action (Bandura, 1989). That is to say, an individual's self-efficacy predicts the effort and motivation one will expend to act a behavior or change it. Therefore, one cannot focus only on the individual behavior while excluding the influence of other factors.

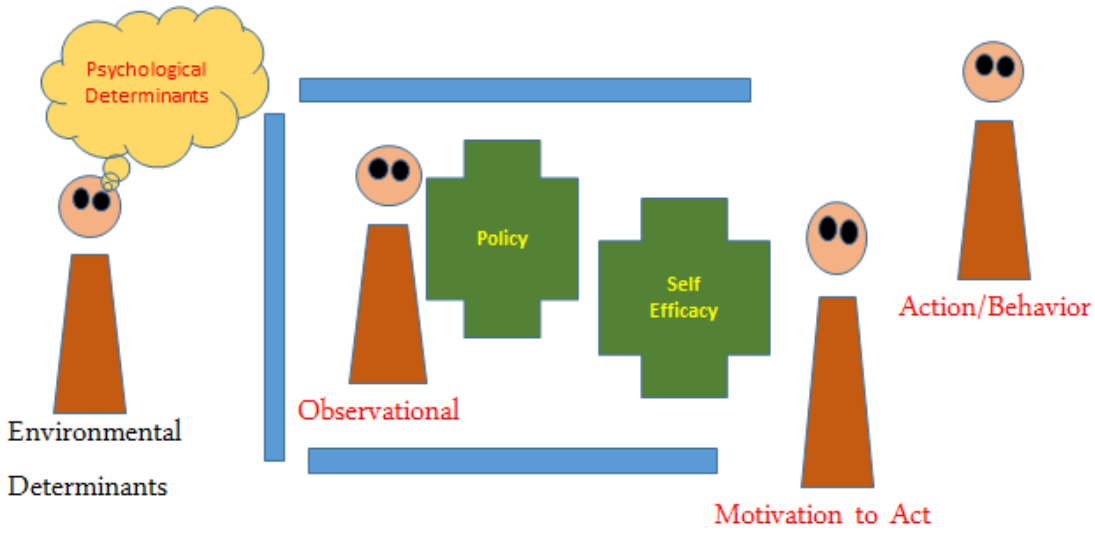

Figure 1: Concepts from the Social Cognitive Theory and Ecological Models Explaining Behavior.

I thought of using other health behavior models by Rodgers (1983), Ajen (1991), Fisbein (1985) and Prochaska (2013). However, these were not an appropriate fit for this study either because they did not address various factors that inform decisions for FGM/C or deter individuals or community decisions to engage in the practice. They did not provide a portrait of levels of interaction among different elements that sustain the practice of FGM/C. The models did not help readers to understand why there is need to validate those whose decision is to undergo FGM/C. A fuller understand of the reasons for FGM/C is necessary to help interventionists plan appropriate programs for behavior change. To underscore the value of FGM/C, individuals, and their communities are implementing modern medical techniques to lessen some of the complications and concerns attributed to FGM/C (Bjalkender, 2012).

Psychological Determinants

The SCT and ecological models describe how the environment influence behavior (Glanz et al., 2008). Those who advocate this theory hypothesize that behavioral change does not occur unless the environment in which the observer supports the new behavior. The idea that people act to maximize benefits and minimize costs are based on their perception of reality and not solely on a set of objective criteria (p.172). Hence, human beings expect to have their behaviors evaluated by others and react to these evaluations based on their willingness to be guided by those who evaluate them (Glanz et al., 2008).

Environmental Determinants and Observational Learning

The ecology model expands on the supportive role of a woman's network of relationships by suggesting that a woman who chooses to abandon FGM/C must understand that her decision impacts not only her immediate family but the various social relationships and networks to which she belongs and is also influenced by their reaction. The model is a framework for understanding the multifaceted and interactive effects of personal and environmental factors that determine behaviors (Glanz et al., 2008). The model looks at the transaction that goes on between people and their environment as well as the policies that support people to make healthy or harmful choices (Glanz et al., 2008).

Self-Efficacy

The models lead one to conclude that an individual wishing to abandon FGM/C must decide whether the decision will cost her the relationships she has formed with family and friends (environment). That is, will she gain more respect from friends and

family, or be considered an outcast if she does not allow herself to be cut. In other words, she will fail alone. Is she confident to enough to decide to go against the norms of the society? She must gain the support of the community to which she belongs because she is part of a variety of networks that give her community its identity (Glanz et al., 2008).

Policies

Prior to May 25, 2015, there was no legislation against the practice of FGM/C in Nigeria (Allen, 2014; Okeke et al., 2012). Ahanonu and Victor (2013) validated the claim and revealed that of the 36 states including the Federal Capital Territory in Nigeria, only 8 states passed laws forbidding the practice (UN, 2006). I interpreted the models to mean that when a woman abandons the idea of FGM/C her family, friends and other societal institutions can either support her decision by respecting her decision or condemn her for going contrary to the societal norms. If she is rejected for her decision to abandon the idea, she will likely change her mind. However, if there is support for her decision, the ecology model postulates that institutions that matter would have to develop policies to aid in the abandonment process (Glanze et al., 2008). That is to say, her society could make laws against the practice, or look the other way as she chooses to be cut.

Researcher's Analysis

It is my belief that a clear understanding of the attitudes, behaviors and dynamics of those who practice FGM/C, could yield an honest rapport among professionals. Individuals and their communities could stop the practice and not view it as the imposition of Western views, ideologies or a human right approach (Brown et al., 2013). The reason I used these models was to expand the understanding of professionals to

determine and customize programs to effectively communicate messages to decrease FGM/C.

Women may oppose FGM/C. However, they may be unable to stop it because the demand from the environment and support systems, they maintain the practice to maximize benefits and minimize costs (Glanz et al., 2008, p. 174). Such women are caught in a "belief trap" or set of ideas difficult to reverse (Mackenzie & LeJeune, 2009 p. 24). It is appropriate to investigate the opinions and motivations for engaging in FGM/C to increase the understanding of health professionals on why women view themselves as victims or heroes of the practice. The relevance of FGM/C to these cultures could help to educate organizations and interventionist to modify and reframe messages on FGM/C.

In their studies, Enwereji and Enwereji (2013), Kontoyannis and Katsetos (2010), Okeke et al., (2013), and UNICEF (2005) observed FGM/C has a strong cultural value. It may appear absurd or destructive from the opinion of others but has a meaning and satisfies a purpose for those who practice it. I noticed majority of research examined the physical, medical, and psychological consequences of FGM/C and others investigated the inhuman treatment of women, violation and abuse of rights, and factors that fight against abolishing the practice (Berg et al., 2014; UN, 2006; Vloeberghs, van der Kwaak, Knipscheer, & van den Muijsenbergh, 2012). The supporters of human rights approach to ending FGM/C appeared not to be sensitive to the rights cultures that condone the practice (Brown, Beecham & Barrett, 2013).

To buttress these arguments, Visandjee et al (2013) wrote, "The reason for FGM/C is to make her polite, to prevent her from becoming hyper, to prevent her from looking for extramarital sex, to keep her from misbehaving (p.7). The authors indicated a woman is naturally wired to suffer as such, FGM/C practicing communities perform the exercise without anesthesia and the women endure the pain to meet the expectations of family and community (Visandjee et al., 2013).

The SCT highlighted societal inequalities and the desire to improve access to social and economic resources contributes to the continuation of FGM/C (Brown et al., 2013). In FGM/C communities, it is believed circumcised women maintained their virginity to increase chances of getting married (Allen, 2014; Okeke et al., 2013). This theory suggest FGM/C is an acceptable social norm because no family wants to have a daughter unqualified for marriage (Brown, Beecham & Barrett, 2013). This means that families will have their daughters cut because they want to increase their prospects of obtaining a suitable suitor. Hence, to abolish FGM/C require individuals at different levels to cooperate to renounce it (Boddy, Obiora, Talle, Johnsdotter, Rogers, Piot ... & Ahmadu, 2007).

Western feminists view the clitoris as a symbol of female sexuality and view FGM/C as against women's sexual freedom and expression (Johansen, 2007). Nevertheless, communities who practice FGM/C belief it makes women sexually vulnerable (Brown, Beecham & Barrett, 2013) and argue on the to control their sexual cravings (Ahmady, 2015). The communities regard the bodily integrity approach to sexuality as a threat to their tradition (Brown et al., 2013).

Brown et al., (2013) observed that messages on women sexual pleasure depend on individual personality. Therefore, to accept that sexual enjoyment is designed, facilitated, and controlled through social institutions (Barrett, Brown, Beecham, Otoo-Oyortey, & Naleie, 2011) will mean enjoying sex based on experiences within those sociocultural environments (Brown et al., 2013). It appears, circumcised women experience sexual pleasure differently depending on the type of FGM/C which makes the credibility of this approach questionable for women who enjoy sexual intimacy (Makhlouf Obermeyer, 2005).

Other researchers revealed inconsistencies about the sexual feelings and experiences of women and recommended further research (Balk, 2000). Makhlouf Obermeyer (2005) observed that there is no evidence to substantiate the assumption that FGM/C interferes with the ability to enjoy sex. Additionally, Gruenbaum (2001) argued that sexual pleasure and response are not damaged in women who have undergone FGM/C but instead, communities who perform Type 3 known as infibulating belief intercourse is more enjoyable for men (Gruenbaum, 2001). In another study of 137 women with a variety of FGM/C by Catania (2007) and his peers,86% respondents reported almost having an orgasm and 69.23% always reported having an orgasm. Another study showed out of 58 circumcised young women, 91.43% reported orgasm, and8.57% reported they always have an orgasm, and 14 out of 15 women reported orgasm after deinfibulation (Catania, Abdulcadir, Puppo, Verde, Abdulcadir& Abdulcadir, 2007). In another study, the sexual functioning of 57 infibulated was measured between a group of control in desire; arousal, orgasm, and satisfaction. The

mean scores were higher in the group of circumcised women (Catania et al., 2007). This discrepancy and messages on women sexual interests from Western perspective may not be acceptable with communities who practice FGM/C and view the bodily and sexual integrity messages as a threat to their deeply held religious beliefs and conservative values regarding women's sexuality (Brown et al., 2013, p. 2).

The campaigns emphasizing the damaging health consequences of FGM/C began in 1980 by UN, WHO, and UNICEF (Boyle, 2005). It is argued that this approach was not political or to impose Western ideas (Boyle, 2005). Those who choose to use the health consequences approach to design messages did not provide a clear distinction between the severe and less severe forms of FGM/C (WHO, 2012). It is argued that distinguishing between the types of FGM/C could be seen as condoning a less severe form of the practice and undermines eradication struggles (Leye, Powell, Nienhuis, Claeys & Temmerman, 2006).

The REPLACE project found an increase in health problems from the more invasive forms of cutting because campaign messages do not make clear difference between the types of FGM/C (Dustin, 2010). It is not unreasonable to assume these health messages that focus on infibulation have resulted in an increase in medicalizing the less invasive forms of FGM/C (Gele et al., 2012). For example, WHO (2011) reported an increase in the number of parents seeking medical practitioners to carry out the procedure (WHO, 2011) based on the theory that it reduces harm if performed medically (Bjälkander et al., 2012). Brown et al., (2013) suggested medicalizing FGM/C as a sympathetic approach to improve the health of in communities where stopping the

practice is not attainable. They observed communities were accepting health messages regarding infibulation but are unable to relate the messages to other types of FGM (Brown et al., 2013). However, some individuals and communities involved in the REPLACE project believed FGM/C improves health and hygiene (Berrett et al., 2011; Berg et al., 2010).

It is safe to assume that there are different beliefs regarding the continuation of FGM/C and these beliefs have been impacted by inconsistent messages aimed at achieving change (Brown et al., 2013). To make health messages useful, they need to represent accurately the lived realities of women who have experienced different forms of FGM/C to avoid credibility problems (Shell-Duncan et al. 2010).

The question whether religion perpetuates FGM/C has been debated extensively by scholars. Some supporters of religion theorized that FGM/C is appropriate and should not be condemned because it enhances purity, faithfulness and the ability to pray (Gemignani & Wodon, 2015). On the other hand, others feel it is a cover to maintain the practice because there are no scriptures to validate the claim as a religious responsibility (Kontoyannis and Katsetos (2010).

Mackie & LeJuene (2009) suggested some authors legitimized FGM/C under the pretext of religion to control and dominate women (Mackie & LeJuene, 2009). These inconsistencies and divergent views have questioned the credibility of successful anti-FGM/C programs by religious leaders (Østebø, & Østebø, 2014). However, a study on the Afar religion practicing the worst form of FGM/C in Ethiopia revealed religious leaders played a significant role maintaining FGM/C (Andarge, 2014; Kaplan et al.,

2013). Hafiz (2012) in his paper concluded that Sharia's maxims appear to support practices like FGM/C but does not approve harmful actions to individuals and communities.

There are contradictions in the manner theorists view the practice of FGM/C through the eyes of women. The assertion that the practice is a world of women is questionable because women in most cultures have no control over their bodies. Men also seem to be divided on decision-making for FGM/C. In Sierra Leone, the majority of the decision makers (65.9%) were women; however, significant proportions (30.7%) were males (Bjalkander et al., 2012). In Gambia, men's perception and attitude depended on their culture, beliefs and ethnic groups (Kaplan et al., 2013). In most FGM/C practicing communities, the families of girls to be circumcised will only receive a visit from the excisors to be told when the ceremony will take place (Bjalkander et al., 2012). Shell-Duncan and Hernlund (2010) noted that fathers, depending on the family appear to have the power to make decisions about FGM/C. This diversity in opinions is a clue that the decision regarding FGM/C does not solely lie on women. Moreover, if the women view the practice as a positive part of their lives and culture the issue of objection will not arise because she has been brainwashed to believe so (Shabila et al., 2014).

These theoretical perspectives are drawn from the functionalist approach to society and expounded by Durkheim (2014) who was primarily interested in how social order is possible and how society remains relatively stable. Functionalism define society based on how each part functions to keep the whole system stable (Durkheim, 2014). The interaction between the parts have consequences on the society and depend on each other

to fill different needs (Brinkerhoff, Ortega & Weitz, 2013).For example, the government, or state, provides education for the children of families who pays taxes for government to run its activities. The family is dependent upon the school to help children grow up to have good jobs to raise and support their families. In the process, the children become law abiding taxpaying citizens, who support the state.

To sum up the above analysis, one may say that an act is criminal when it opposes the well-being community (Durkheim 2013). This is not the case with how some societies view FGM/C. A critical analysis of the theoretical perspectives by me showed the ritual of FGM/C represent a shared societal value and function to foster unity in society (Durkheim 2012). That is to say FGM/C could be abandoned by a community if it ceases to satisfy the need for societal cohesion.

I agree with Schultz and Lien (2013) on insufficient research about individuals who have undergone FGM/C and what it means to them. There is little insight on how women receive teaching and develop understanding of FGM/C, or how they to integrate their experience of FGM/C and develop an identity as circumcised women (Lien & Schultz, 2013). There are no research findings exploring factors other than societal and cultural arguments that might shape the perception of women who have been cut.

That is the reason for investigating the lived experiences of women in Northwest region Nigeria to understand why a woman views herself as a hero or victim of FGM/C. At the beginning of the chapter, I stated that the study was to uncover the overall perception of women who have undergone FGM/C by describing the motivations that culminate in their decision to be cut. The findings could contribute to a clearer

understanding of the practice, shape policies, and strategies sensitive to the needs of communities who condone FGM/C.

Summary

In this chapter, I indicated the desire to discover the overall perception of women regarding FGM/C. Particularly, I am interested in whether women see themselves as heroes or victims of the practice by explicating factors that impact the views women hold about themselves.

I reviewed several conceptual frameworks to understand the practice of FGM/C. I concluded theories from the functionalist approach see society consisting of institutions, shared values, and norms that promote a sense of cohesion within the community (Durkheim, 2014; Parsons, 2013; Merton, 1968). With a dearth of research on the overall perception of women about FGM/C, the findings of this research could improve understanding practice and shape policies and sensitive strategies to the needs of women who condone FGM/C.

Chapter 3: Methodology

Introduction

The purpose of the study was to explore and describe the lived experiences of 10 women in the Northwest region of Nigeria as it relates to FGM/C. The aim was to investigate the factors that would culminate in a woman's decision to consider herself a hero or a victim. In this chapter, I discussed the research design and rationale, paying particular attention to my role as an independent observer. I also elaborated on the methodology, instruments, interview protocol, and data analysis, as well as issues of trustworthiness reliability, confirmability, internal/external validity, and ethical procedures culminating in a summary of the chapter's main points.

Emphasis was placed on gathering personal descriptions of participants' perceptions to present a comprehensive understanding of their experiences, feelings, and motivations (Creswell, 2007), which shape the worldview and dictates the way individuals respond and react to their environment (Inglehart & Welzel, 2005).

Research Design and Rationale

I used these research questions to explore the lived experiences of women about FGM/C in the Northwestern region:

1. What are the perceptions of women in Northwestern Nigerian towards FGM/C?
2. What factors influence the decision of women in Northwestern Nigeria to perform FGM/C?
3. How do women describe their experiences regarding FGM/C?

4. Do they approve or disapprove the continuation of FGM/C? What are the reasons for approving or disapproving the continuation of FGM/C?

The social cognitive theory of Bandura (1986) and ecological model of McLeroy (1988) were combined to gain insight into how the interaction of different factors within the environment impact the individuals and how their perception had an influenced on their decision to engage in a health behavior (Bandura, 1986; McLeroy, 1988). I used relevant components of the model for the study. I used face-to-face interviews and participants' observation to gather the secret beliefs and reasons (Kawulich, 2005) of Nigerian women for undergoing FGM/C.

Role of the Researcher

I exercised caution to avoid bias and remained neutral during data collection. I personally interviewed the participants regarding their lived experiences on FGM/C using the interview protocol I developed (Appendix B). I conducted face-to-face interviews with each participant for approximately 25 to 30 minutes. As the discussion progressed, I observed the behavior of the participants, their mannerisms, facial expressions including body language and tone of voice. I did not find guidelines on how to code behaviors, mannerisms, or facial expressions. Therefore, I categorized the patterns of behaviors, manners, and facial expressions that emerged from observing each participant. I took notes, transcribed, and coded for themes. Interviews were thoroughly conducted and did not require follow-up visits. I did not have prior relationship of any kind with the participants to influence the selection process. Participants were volunteers from different parts of Kaduna North and Kaduna South (LGAs). I used the purposive snowball

sampling method to recruit participants (Miles, Huberman & Saldana, 2014). I was aware of how personal biases could impact the validity of the findings. Consequently, I avoid my own biases by not introducing personal opinions during the interview. There was no existing conflict of interest or power differentials.

Methodology

This study aimed at understanding the factors that informed the decision to undergo FGM/C. This is a case study with a phenomenological approach. Phenomenological research seeks to capture the meaning of a phenomenon under investigation by carefully selecting participants who have experienced that phenomenon (Addison, 1989). The study is comprised of in-depth interviews and observation of a small number of participants to get their lived experiences and capture core experiences (Creswell, 2013) of women who underwent FGM/C and understand how FGM/C function in the Northwestern Nigeria

Participant Selection Logic

The participants were circumcised women ages 18 to 59. A study indicates FGM/C in Nigeria is more predominant among this age group (Fieldman-Jacobs & Clinton (2014). This is the reason I selected this population for the study. The participants were obtained through purposive snowball sampling (Patton, 2002) from the communities in Kaduna North and Kaduna South LGAs. The reason for choosing the purposive snowball technique was to inspire the participant at the end of the interview to inform others who may be suitable and show interest to be interviewed. This approach facilitated additional interviews to accommodate participants drop out until data

saturation was reached. Purposeful sampling allows a researcher to undertake a thorough investigation of a phenomenon to "describe multiple perspectives about the cases" (Creswell, 2007, p. 129; Patton, 2002, p. 46). Most importantly, the purposive snowball sampling method gave a voice to women who have been cut and may not usually take part in an interview or disclose that they have been cut.

As previously mentioned, the 10 potential participants who responded to the announcement of the study and met the criteria were enrolled in the study. It is typical of case studies to have a small sample and a common practice in most qualitative studies (Laureate Education, 2013). The criteria for selecting participants included (a) being a female; (b) have undergone FGM/C; (c) being 18 to 59 years old, and (d) spoke and understood English. The central objective was to locate information-rich key informants (Maxwell, 2013; Patton, 2002) and concentrate on specific experiences and perceptions of women who have been mutilated to better answer the research question, "*What are the lived experiences of women in northwestern Nigeria toward the practice of female genital mutilation*."

Elements such as past experiences of FGM/C, ethnicity, age, education, and religion were investigated for emergent themes and analyzed based on similarities (Miles, Huberman & Saldana, 2014) as described by the women. I developed emerging themes (Creswell, 2013) during the interview process by clustering similar comments from the participants and their responses until data saturation was reached. The participants underwent a process of screening to establish the criteria. Applying the case study using the phenomenological methodology was realistic in gaining insight into the opinions of

participants and their experiences of FGM/C. I decided on this method to comprehend the lived experiences of the women and how it impacted their choices to undergo FGM/C.

A flyer (Appendix A) including my contact information was posted and distributed seeking participants with the Kaduna State branches of nongovernmental organizations through the National Council of Women Societies (NCWS). I wrote a letter to the Kaduna State Ministry of Health announcing the study and permission for entry into the communities. Information such as; names, addresses, and telephone numbers of women who responded were kept confidential. I provided participants with a consent form and dates for the interview. The goal was to find individuals that would insight into the particular situation under study, regardless of the general population (Laureate Education, 2013). These individuals added value to the study.

Pilot Study

To improve the internal validity of the research instrument, I conducted a pilot study after approval from the Walden University Institutional Review Board (IRB) was obtained. The process guaranteed the statements and questions in the interview protocol were clear, accurate and asked for the right information as anticipated. A sample of five women participated in the pilot study. I recruited them from the Kaduna North and Kaduna South LGAs of Kaduna State.

I interviewed the participants in the pilot study with a questionnaire. I asked additional questions to facilitate their understanding and to determine the ease in administering the questions. As previously mentioned, the primary reason for the pilot study was to corroborate the reliability and validity of the questionnaire. From the pilot

study, I determined the need to reframe, repeat and paraphrase the questions based on the outcome of the pilot study. The data obtained from the pilot study is incorporated in the data acquired from the primary research.

Data Collection Instrumentation

I conducted face-to-face interviews using unstructured questions (Maxwell, 2013) designed before the interview (Appendix B- interview protocol). The procedure is flexible and enables the interviewee to provide much interpretation, new relationships, and patterns when describing their lived experiences (Miles, Huberman & Saldana, 2014). I discussed the date and time for the interview individually with participants. I provided them with the informed consent to sign. An agreement to record the interview with an audio tape was requested from and granted by each of the participants. I took written notes as the discussion progressed with consent from every participant. I assigned an identification number to each participants.

I edited, manually transcribed and coded the interviews for themes. The analysis showed how the perceptions and experiences might have influenced the way women feel about their status, whether as heroes or victims in their society. The findings could increase the understanding of FGM/C, as a need or necessity.

The interview protocol for the study was designed based on a study of FGM/C conducted in Nigeria by UNICEF in 2005. The researchers observed that cultural practices of people may appear absurd or damaging from the standpoint of other people but may have a meaning and fulfill a function for those who practice them (UNICEF,

2005). The questions and the use of the instrument were based on the SCT, ecological model and literature sources.

Interview Protocol

The conceptual lenses that directed the exploration of FGM/C included; psychological and environmental determinants, observational learning, self-efficacy and policy levels (Glanz, Rimer, & Viswanath, 2008).

Before the interview, I provided participants the questions to clear any gray areas and for the participants to pay particular attention during the interview on the perceptions and inspirations for undergoing FGM/C. I briefed participants on the purpose of the study. The consent forms further explained to the participants to feel free to participate or decline. Additionally, I reiterated to participants their identity will be kept confidential. Given that in-depth interviews were conducted face-to-face, there was no need for follow-up meetings. I only made phone calls to participants to confirm transcribed information from their responses.

I requested participants to talk about their lived experiences as it relates to FGM/C. The face-to-face interviews for data collection was an appropriate instrument because it addressed the substance of what the study was about (Hatch, 2002). I used the same protocol across all the participants. I had an opportunity to probe deeper and ask for clarification, which made the data easy to analyze (Creswell, 2013). I complimented the interview protocol with participants' observation. I recorded the data which made the information easy to retrieve. I was conscious and guarded against adding personal biases,

values and experiences to the responses from participant (Pannucci, & Wilkins, 2010) as these could impact the quality of the study.

Data Analysis Plan

This study is qualitative in nature. The technique for data or content analysis was identifying and comparing the themes and patterns that emerged from the data. Thematic analysis captured the detail of meaning within the data (Guest, 2012, p. 11). The themes are the predominant patterns from the interview responses that provided insight and described participants' feelings, opinions, and understanding about FGM/C. The questions investigated were;

1. What are the perceptions of women in the Northwestern Nigeria towards FGM/C?
2. What factors influence the decision of women in Northwestern Nigerian to undergo FGM/C?
3. How do women describe their experiences regarding FGM/C?
4. Do you approve or disprove the continuation of FGM/C? What are the reasons for approving or disapproving the continuation of FGM/C?

The responses from these questions uncovered deep-seated emotions and attitudes of past experiences (Rudestam & Newton, 2015) and furthered understanding of the reasons for undergoing FGM/C. The relationships and patterns were revealed (Miles, Huberman,& Saldana, 2014). Using the less structured approach of interviews provided an opportunity to probe participants for additional information. Therefore, I took detailed notes, developed themes manually, and pinpointed the critical facts. My initial plan was to use the QRS NVivo computer software to identify themes and code participants'

responses. I categorized the responses to create themes. I was responsible for all the data collected and safeguarded data by keeping it in a locked cabinet at home. I will shred data after 5 years in accordance with Walden's IRB requirement. The approach I used for treating discrepancies was to review and compare emergent themes from the participants' responses.

Issues of Trustworthiness

To establish the credibility of the study, I followed the research design, interview protocol with each participant, data collection and analysis to ensure consistency of information (Creswell, 2013). I recorded field notes manually and used a tape recorder to ensure credibility. I used a peer debriefed to check the accuracy of the findings for reliability to ensure the information is correct (Creswell, 2013) and for the study to meet the goals and objectives. I provided participants with copies of the notes to review the recorded information during the interview to verify the explanation was accurate (Harper & Cole, 2012; Harvey, 2014). I measured internal validity by aligning participants with their narrations, topic, and themes to understand the responses and relationship to the research problem. This strategy was a good safeguard for the credibility of the study.

Likewise, reliability or dependability was established through the one-on-one interviews. Interview questions were designed in an unstructured format to obtain comprehensive information on the different perceptions of FGM. Interviews help a researcher to achieve reliability. The researcher is able to control the sequence of the questions and modify questions to corroborate the accuracy of responses from participants (Stevenson & Mahmut, 2013). I addressed transferability issues or external

validity through an in-depth description (Polit & Beck, 2010) of the past experiences of participants regarding FGM/C. I was open to variation in participant selection approach by concentrating on interviewees with direct experience with FGM/C.

I was neutral and transparent during the study and kept to the measures establishing validity and reliability to avoid personal biases (Singh, 2014). I allowed participants to describe their lived experiences without interference in the process or with the responses. The responses are recognized as true. I took detailed notes, coded for themes manually and checked several times for consistency.

Ethical Procedures

To maintain the ethical integrity of this dissertation, I obtained approval from the Institutional Review Board of Walden University before the research began. I am a practicing Marriage and Family Therapist with extensive mental health training added to the training I received in the present PhD program of study. Consequently, I followed all ethical guidelines outlined by the American Psychological Association Code of Ethics (Fisher, 2003). Participants received compensation of N2000 (local currency) as assistance for transportation. Participation was strictly on a voluntary basis. Information on the participants was kept confidential. Consent forms were given to the participants to obtain their signatures. I explained the procedure for participants to make an informed decision to participate in the research. A copy of the consent form is attached as appendix D.

I assigned each participant number for confidentiality. I coded the responses they provided from the interview using their numbers. There was no conflict of interest or

power differential arising during the study. I avoided information that could damage the study. I collected data through one-on-one, face-to-face interviews. I did not pressure any participant to respond to any of the research questions. I informed them, they were at liberty to withdraw at any time during the process. I am the only one with access to the information stored in a cabinet and locked for five years at my home. I will destroy the data thereafter.

An ethical problem I could have confronted from this type of research is respect for the participants and the community. I respected the culture and norms of participants by obtaining permission into the community to interview them. I was culturally sensitive by taking into consideration fasting for the month of Ramadan for Muslim participants and scheduled their interviews early in the morning. I asked participants to ascertain that their spouses consented to their participation.

Summary

In this Chapter, I discussed and laid out the methodology for the research and rationale for the approach. I provided a thorough description of the research design and procedure. Furthermore, I discussed the section process, setting, sample, data collection tools, and instruments used for data analysis. I addressed ethical concerns likely to impact the study and ways to mitigate them. Lastly, I examined issues of credibility and transferability in the chapter.

Chapter 4 is the results of the findings from the data collected. In Chapter 5, I evaluated the purpose of the research, methodology, results, and how I analyzed the data.

I discussed the limitations of the study and suggested recommendations for further research.

Chapter 4: Results

Introduction

As stated in previous chapters, the purpose of this investigation was to explore the lived experiences of women who had undergone FGM/C to understand their perceptions of the phenomenon. In particular, sought to know whether those who had undergone the procedure see themselves as heroes or victims. Understanding the motivations and experiences for FGM/C could improve policy prescriptions for abolishing FGM/C. I gathered data from women who had undergone FGM/C between ages 18–59 and resided in the Kaduna North and Kaduna South LGAs of Kaduna State.

The participants provided responses to questions overarching the research question for this study, "What are the lived experiences of women in northwestern Nigeria toward the practice of female genital mutilation?" Participants also responded to the following related questions:

1. What are the perceptions of women in Northwestern Nigeria towards FGM/C?
2. What factors influence the decision of women in Northwestern Nigerian to undergo FGM/C?
3. How do women describe their experiences regarding FGM/C?
4. Do you approve or disprove the continuation of FGM/C?
5. What are the reasons for approving or disapproving the continuation of FGM/C?

This chapter contains and interpretation of the participants' experience including their understanding of FGM/C. I presented the setting, demographics, data collection, and

analysis. I explained emerging themes from participants' narratives, results, and summary.

Pilot Study

The pilot study was conducted with five participants selected through the process of purposive snowball sampling. This ushered in four participants earmarked in the following categories:

- A Christina/Igbo woman, 40 years old, and a resident of K/South Local Government Area (LGA) with a diploma as her highest educational qualification. She was circumcised at the age of 15 years. She perceived herself as a victim of FGM/C based the testimony of her lived experiences. She had no knowledge of any law prohibiting the practice of FGM/C in Nigeria. She disapproved of the practice and its continuation.
- A 53-year-old woman of south-south Nigeria residing in K/South, LGA, and a Christian. She completed Primary School and was circumcised at the age of 19 years. She disapproved of the practice of FGM/C, though; her children were circumcised in the hospital. This participant was aware of the law prohibiting FGM/C in Nigeria.
- A40-year-old Muslim/Yoruba woman residing in Kaduna South LGA and holds a National Diploma in Education. She was circumcised at the age of 10. Her experience regarding FGM/C was of anguish and pain. She disapproved the continuation of the practice. She was also knowledgeable of the law prohibiting the FGM/C.

- An 18-year-old woman, Hausa by ethnicity. She had a secondary school certificate of education. According to her report, she was circumcised at birth and was unable to report any experiences regarding FGM/C. However, she informed this researcher that FGM/C is practiced in the area where she resides. She was not sure whether FGM/C should be continued or stopped.
- A Christian and Bassa-nge woman. She resides in K/South L.G.A and holds a Diploma. She is 45years old and was circumcised at the age of 22 years. Her perception of FGM/C was that it is prevalence among the Hausa ethnic group and that most circumcised women are proud to have undergone the process. She was of the view that FGM/C should continue but was not aware of any law that forbids the practice.

This pilot study did not present any reason to adopt a different sampling method for the selection of research participants for the main study. Consequently, I screened and selected participants within the study area from the Northwestern region. The predominant ethnic groups in the region are the Hausa/ Fulani who are mostly Muslims. However, the region has a widespread distribution of other ethnic groups coexisting and sharing cultural and traditional identities with the Hausa/Fulani. Therefore, the experiences of women of other ethnicities in the pilot study necessitated the consideration to deliberately screen for 10 participants based on ethnic and religious backgrounds. The significance of the pilot study was in the use of instrumentation which was interview and observation. Prior to my interaction with the participants, they had no knowledge or

involvement with research. This manifested in minor difficulties comprehending the interview protocol, especially with participants whose ethnicity was Hausa. This required repeating, reframing, and paraphrasing some questions several times.

Data Collection

Following the Walden University IRB approval (05 -25-16-0299977) and approval by the Kaduna State Ministry of Health Ethics Committee, I recruited participants at the office of the National Council of Women Societies located in Barnawa in Kaduna South LGA. I used the purposive snowball sampling method to recruit participants who met the inclusion criteria. All participants provided written consents indicative of their readiness to participate in the study. I gave them a stipend of N2000 as assistance for transportation. I scheduled the interviews between 9.00am to 1.00pm and completed collecting data within 15 days. I took into consideration the fasting for the Muslim month of Ramadan. I completed data collection from 10 women who had been cut. I collected data collection through face-to-face interview and observation. I met with each participant and conducted the interview in a private room at the office of the NCWS. I administered the interview protocol to each of the subjects between 25 to 30 minutes in a one-session meeting.

Given the potential to bring up distressing emotions, because of the topic, I provided each participant with the local telephone number to the Federal Neuropsychiatric Hospital in Barnawa, Kaduna before the interview. I encouraged participants to contact a mental health professional or licensed psychiatrist at this number should the need arise.

I recorded the interviews with an audio tape on a Mac computer laptop, following a signed consent by each of the participants agreeing to the recording. After each interview, I transcribed data into a Microsoft Word document from each participant and labelled at the top of the document: P1, P2, P3, P4, P5, P6, P7, P8 P9 and P10. Each participant's phone number was also added to the document. I created an electronic file folder for each participant using a USB flash drive. At the end of the day, the USB was stored in a safe place and locked in a box with the questionnaire and consent forms at my researcher.

The only variations in the data collection different from the original plan presented in Chapter 3 of the proposal was adjusting the age range of participants from 18 – 49 to 59, a difference of 10 years. I did not encounter any unusual circumstances other than collecting data during the month of fasting for Ramadan. This impacted the availability of participants and influenced the adjustment of the age range of participants.

Demographics

I gathered data from women who had undergone FGM/C between the ages 18-59; and resided in the Kaduna North and Kaduna South Local Government Areas (LGA) of Kaduna State. They reported different ages at circumcision with most of them holders of diploma certificates in Bachelors in Education (B. ED), Higher National Diploma (HND), National Certificate of Education (NCE), Senior Secondary School Certificate of Education (SSCE), Junior Secondary School (JSS), and Islamic School Education (ISE) popularly called Islamiyah. The majority of these participants were from the Hausa ethnic group as shown in Table3 below.

Table 3

Demographic Characteristics of Participants

Participants #	Age	Local Government Area	Educational Level	Age when circumcised	Ethnicity	Religion
1	21	K/North	ISE	7 days after birth	Hausa	Muslim
2	57	K/North	NCE	At Birth	Fulani	Muslim
3	42	K/South	HND	At birth	Hausa	Christian
4	44	K/South	NCE	At birth	Hausa	Muslim
5	18	K/North	SSCE	At birth	Hausa	Muslim
6	38	K/South	ISE	At birth	Hausa	Muslim
7	25	K/South	JSS	At 17	Gbagyi	Christian
8	18	K/South	SSCE	At birth	Hausa	Muslim
9	48	K/North	B. ED	At 6	Jaba	Christian
10	47	K/South	NCE	At birth	Kagoro	Christian

Table 3 is the distribution of the participants based on age group, Local Government Area (LGA), educational level, the age when circumcised, ethnicity, and religion. The ethnic composition of the participants from the Hausa, Gbagyi, Jaba, Kagoro, and Fulani ethnic groups grounded the study with a variety of information on the lived experiences of women from diverse ethnocultural groups in Northwestern Nigeria. The varied educational background of the respondents ranging from B. ED, HND, NCE, and Islamic school education, SSCE to JSS provided rich, in-depth and diverse

experiences with FGM/C. This researcher observed the majority of the participants were circumcised at a young age "to reduce pain and facilitate healing" as reported by some participants (P5). They could not recall their feelings at the time of circumcision, but indicated that their responses were based on their lived experiences as individuals who have undergone FGM/C.

Table 4

Analysis of Research Participants Based on Age Distribution

s/n	Age Range	No of Participants	Age when circumcised	Local Government Area (LGA)	Educational Level	Religion
1	18-28yrs	4 people	At birth (3), at 17yrs (1)	Kaduna North (2), Kaduna South (2)	Islamic Education, SSCE (2), JSS	Muslim (3), Christian (1)
2	29-39yrs	1 person	At birth	Kaduna South	Islamic Education	Muslim (1)
3	40-50yrs	4 people	At birth (3), at 6yrs (1)	Kaduna North (3), Kaduna South (1)	HND, NCE, B. ED, NCE	Muslim (1), Christian (3)
4	51-61yrs	1 person	At birth (1)	Kaduna North	NCE	Muslim (1)

Table 4 revealed the age distribution; four participants were between ages 18 – 28 years, another four fell between ages 40 – 50 years. One participant was between the age of 29 – 30 years and one participant between the ages of 51 – 61 years. Of the 10 circumcised participants, eight were circumcised at birth, one at 17 years and one at the age of 6 years. A total of six participants were residents of Kaduna North and four resided in the Kaduna South LGA. The highest educational qualification of the

participants was B. ED (1) followed by those with the NCE (3) HND (1) and SSCE (2) ISE (2), and JSS (1). Their religious background revealed that six participants were Muslims while four were Christians.

Table 5

Tone of Voice

Tone of Voice							
Participants	**Calm**	**Low**	**Humorous**	**Cautious**	**Approving/ Disapproving**	**Indifferent**	**Critical**
Participant 1	Yes	Yes	Yes	Nil	Approving	Nil	Nil
Participant 2	Yes	Yes	Nil	Nil	Disapproving	Nil	Yes
Participant 3	Yes	Nil	Yes	Yes	Approving	Nil	Nil
Participant 4	Yes	Yes	Nil	Yes	Disapproving	Nil	Yes
Participant 5	Yes	Yes	Nil	Yes	Approving	Yes	Nil
Participant 6	Yes	Nil	Yes	Nil	Approving	Nil	Nil
Participant 7	Yes	Yes	Nil	Nil	Approving	Nil	Yes
Participant 8	Yes	Yes	Yes	Nil	Disapproving	Nil	Yes
Participant 9	Yes	Nil	Nil	Nil	Disapproving	Nil	Yes
Participant 10	Yes	Yes	Nil	Nil	Disapproving	Nil	Nil

Table 5 shows all 10 participants were calm throughout the duration of the interview session. Although, they all maintained eye contact with the researcher, seven out of 10 of the participants spoke in low tones. The researcher is of the opinion that these participants lowered their voices to reflect the fact that Nigerian ethnic groups regard the subject of sex as taboo, and cannot be openly discussed. Out of the 10 participants, three were cautious, four were humorous, and three spoke with a normal tone of voice. Five approved the continuation of FGM/C whiteface the participants

argued against its continuation. Only 1 participant appeared to be indifferent during the interview. Five participants were critical of FGM and five were not.

Table 6

Body Language/Mannerism

Participants	Eye Contact	Posture	Frown/Smile	Hypersensitive	Shy	Withdrawn	Head Nodding
Participant 1	Yes	Arms crossed	Smile	No	No	Yes	No
Participant 2	Yes	Good	Smile	Yes	No	No	Yes
Participant 3	Yes	Arms crossed	Smile	No	No	No	Yes
Participant 4	Yes	Good	Frown	Yes	No	Yes	Yes
Participant 5	Yes	Good	Smile	No	Yes	No	Yes
Participant 6	Yes	Good	Smile	No	No	No	Yes
Participant 7	Yes	Good	Smile	No	No	No	Yes
Participant 8	Yes	Good	Smile	No	No	Yes	Yes
Participant 9	Yes	Good	Smile	No	No	No	Yes
Participant 10	Yes	Arms crossed	Smile	No	No	No	Yes

Table 6reveals that one participant was shy during the interview, possibly because of her age (18years). Three participants were withdrawn, nine communicated by nodding their heads intermittently as the interview progressed. Five participants (one Christians, four Muslims) approved the continuation of FGM/C.

Data Analysis

The initial plan was to use QSR International NVIVO software to analyze data. Given the technical hitches encountered, I analyzed the data manually and identified themes from the responses the participants provided to the research questions. I categorized responses from participants according to the similarities of their lived experiences and description of FGM/C. The following categories were found: (a)

experiences of circumcised women happily living with FGM/C, (b) experiences of circumcised women who were not happy living with FGM/C, and(c) experiences of women who were undecided about their experience or feelings with FGM/C were the recurrent subthemes I observed. Five participants approved of the continuation of FGM/C due to its importance and five disapproved of its continuation. The study procedure was for participants to describe their lived experiences and perceptions based on the research questions.

1. Have you heard about female circumcision?

   P1 stated, "Yes as a child, you cannot know. I know it is carried out on children, and it is still being done in our area. P2 reported, "I have heard they often take children to the hospital to perform it, I heard that the rate or the frequency is dropping now not like before." P3 stated, "Yes, I circumcised my first and second child but stopped at number 3." P4 said, "Yes, I had mine when I was young, but I did not circumcise my daughters." P5 said, "Yes. They did it on me when I was a child." P6 said, "Yes." P7 stated, "Yes among our tribal group, it is a tradition and ritual still prevailing." P8 said, "Yes." P9 said, "Yes. I am aware of FGM because my parents circumcised me." P10 stated, "Is a tradition of circumcising a newborn baby at the earliest days of his/her birth."

2. In this community, are women circumcised?

   Participant 1 stated, "It is still being done in our area. Of recent I observed it being performed on a child delivered by a neighbor in the house I stay." P2 informed, "Yes as children." P3 said, "Maybe in the hospital but not much at

homes, I don't see much." P4 narrated, "Yes but my husband's family don't do it as they are educated and informed. The reason we are immune for now is because we stayed here in the city (Kaduna). Not over there (Katsina) the practice is rampant. Though I believe the practice is subsiding, I had mine there when I was a child which I had no control or say in the decisions. A person has no control to refuse it. The parents take the decision to do it." P5 stated, "Yes, it is being done, and even now in my area Tudun Nupawa they are still doing it." P6 said, "In my culture, the tradition is for a baby to be circumcised in the vagina and removal of what they call Belun Kasa (Clitoridectomy) after 7days after birth, which is not harmful. I was circumcised, and my children are all circumcised." P7 said, "Yes. It is a tradition and ritual still prevailing. Yes, it is because of its importance as a cultural requirement. P8 stated, "I know it is the removal of something from a girl-child private part (vagina). P9 said, "It is still happening. No one will know." P10 reported, "I heard that it is still going on in the rural areas, here in Sabo-Tasha I don't hear much about it. But I am pretty sure of the villages around."

3. Are you circumcised?

   Participant 1 answered, "Yes it has been carried out on me when I was a young girl." P2 stated, "Yes, I was young, as a baby when it was performed. I had no control over it. It is not a choice because it is done at birth." P3 said, "I was circumcised at birth." P4, stated, "I had mine when I was young but I did not circumcise my daughters." P5 said, "Yes, I have six girls, and I circumcise all of them. I learned at a young age and I was told then that it will help me later in my

life during delivery." P6 said, "Yes and I have circumcised all my children. Yes, all 4 and there is no problem." P7 stated, "Yes when I was 17years old and I have circumcised my girl. We do a traditional one, where the Wanzan (Local Barber) will come to our homes and perform the operation. I had mine at adolescent, and it was a painful and horrible experience, I thought I could be helping to reduce my child pain if she had hers now as a child. I prefer to do it when a child is small." P8 narrated, "I don't know whether I was circumcised or not, but my mother informed me that I was circumcised. I was confused, surprised and keep staring at her." P9 said, "Yes, at the age of 6 years." P10 said, "Yes. Often it is performed at birth and I believe I must have had mine at birth."

4. How do you feel as a circumcised woman?

   P1 stated, "Actually I cannot describe such feelings as I was young. I could say that I am a hero. I am healed, can now have sex. Initially I was ashamed but latter, I am not ashamed anymore. P2 said, "I have lost the urge for sex, most times to me sex is depreciating. I am still not happy." P3 said, "Now I don't have much desire for a man and I don't miss much of my husband's absence. No urge for my husband. I don't enjoy sex. It makes me unhappy. It reached a stage in our marital life that he had to ask me of whether I was circumcised as we are two wives with him. I suspect perhaps his experiences with the other woman suggested something about her or me to him. I don't really enjoy sex. The feeling makes me sad and unhappy as it is not only food that keeps a woman at home. But I don't regret it. I do not feel bad. I like it; I will do it again." P4 reported, "Base

on my experience I don't like the practice because it is very dangerous and has a lot of dangers associated with." P5 remarked, "I have been married for 30 years, and I feel being circumcised make me enjoy a stable home. I will not be ashamed to do that anytime." P6 stated, "I feel ok. I have six births and one miscarriage. Up till now I can't say I have any problem associated with my being circumcised." P7 said, "It was just painful, but I am proud because of the enormous amount of pain I had to endure." P8 said, "Not really? I don't feel anything. I am not ashamed." P9 narrated, "Very bad, having intercourse is a problem. I bled and was once re-stitched by the Doctor because I was tampered with. I was tender at the time. I feel bad, I have no sensation. It interfered at child birth when I had my children." P10 remarked, "Then I don't feel anything, but I later realized that it is painful. Currently, I have a depreciating urge for sex. I am married sometimes we fight with my husband over sex. My husband asks me to consult with others on my predicament, and I was often told that it maybe the effects of the circumcision. Yes, the sex routine may be painful, but I manage the deliveries. The last one was difficult though it was delivered. I am happy to express my problem to you."

5. What are the perceptions towards FGM/C in this area?

   P1 reported, "Such women often raise their head-high and often brag about being healed of their illness and now capable of having enough fun with their husband without any stress or difficulties compared to their pre-FGM/C state. Since the cause of fear is removed women will have a power of total control of their

spouses. P2 said, “One woman just exclaimed that she doesn’t want the process or be repeated in her life. When such thing is conducted, we are celebrated by all members of the community.” P3 said, “Those not circumcised are harlots. The belief is that they are not satisfied and will still go out to test other men.” P4 stated, “Most of the reactions I got were skewed towards the perception of the practice of the phenomena in communities. Our people like having children, so such act that could facilitate it is seriously condoned. Some people still like it. It is important, or some people will not have children when married. It is not a reality.” Such a belief to me is in the imagination of the people, and the case of my daughter is a clear test to the baseless ground of such allegations and harmful belief. My daughter got married and comfortably gave birth to her first child. The tradition to me has no footing. It is to dominate and spread base on the capacity to instill fear in the ignorant that is why it thrives and persisted. P5 stated, “They always express the same feelings of enjoying their status as circumcised women and have no reservation for it to be done to their children. They will like it to be done on their children.” P6 narrated, “I live with women not circumcised where I stay; that is those often given pills or drugs as a supplement for circumcision as children. I found out that such women have problems coping with male (husband). To some, I saw revisiting of the practice on them at later years they were circumcised after they have grown-up before they could now cope with matrimony. I came to know that women not circumcised experience a lot of issues and problems.” P7 stated, “It is a tradition; it is an important cultural

requirement." P8 said, "If not removed a woman cannot give birth to a baby." P9 stated, "The same with my experience. I talk with other women, and they feel bad." "P10 said, "Prevention for unguarded sexual behavior of the female child that may lead to prostitution. Others contend that doing so attract high bride-price for the girl at marriage. But the general view and reasons were of the protection and potency against prostitution."

6. What factors influence the decision of women to perform FGM/C?

Participant 1 said, "To stay with your husband, it smoothens and enhances the marriage. To stay with your husband and be responsible." P2 answered, "The reasons or what girls are often told is that the exercise will make them not to be promiscuous or end up as a prostitute in later life. You will not be following men. "According to P3, "the parents will be sure that the child stays and respect her matrimonial home and by not having an unusual or unnecessary sexual orgy or desires that could lead to fornication, adultery or prostitution which could terminate marriage. The parents will be sure their daughter settles in her husband's home and does not flirt." P4 stated, "Belief and tradition." P5 said, "To avoid urination, sex, and problems. It helps to restrain a woman so she will not flirt. The parents will be at peace when the child is circumcised." P6 stated, "I know some who encounter such problem at the point of marriage, and did not like to get married, or those who encountered it after the marriage, such is demonstrated by the perpetual fear of absconding from the matrimonial home. Early dictation of the cause and the conduction of the circumcision normalize the

situation and things will fall into place naturally." P7 said, "To stop prostitution and reduce urge. I also had is for good dowry." P8 said, "Well, I believe such explanations are based on beliefs of people. All my father said is that it is beautiful. All will go well if removed. Your life will go well. The parents want us to be responsible." P9 said, "They tell you that it is to preserve virginity." P10 said, "Prevent unguided sexual behavior and protection against prostitution. I often talk to my mother about it for answers and solutions. Even at the time of coming for this interview, I ask her, and she cautiously told me to forget about the question."

7. How do women describe their experiences regarding FGM/C?

   Participant 1 stated, "It makes a woman responsible; she has respect. It is healing to the woman." P2 said, "Our position towards the choice of being a hero or victim of the phenomena is grounded in the nature and tradition of the society when such thing is conducted we are celebrated by all members of the community." P3 said, "The women claim that they are more aroused when they are sexually engaged with their spouse, contrary to my feelings. I thought the contradictory claims with my sensations might be due to my nature which suppresses such satisfactions." P4 said, "Sad because they have no control to refuse circumcision." P5 stated, "They are proud and feel like a hero." P6 said, "Proud." P7 said, "Painful, others, good." P8 said, "I don't know." P9 said, "The same with my experience. I talk with other women, and they feel bad, very bad. No woman will like this to happen to her. My husband knew about it and was the

one that got me help." P10 said, "Painful. I often even talk to my mother about it for answers and solutions. Even at the time of coming for this interview, I ask her and she cautiously told me to forget about the question. Yes, but people don't want to talk about it as it involves some secrecy to be closely guarded here. People keep to themselves."

8. Do you approve or disapprove the continuation of FGM/C?

   P1 stated, "To me it is good, and it can be continued, but if it is not good it can be stopped and abolished." P2 remarked, "No I won't support that. Circumcision is bad. But without it your man can go after other women, that is what I mean." P3 stated, "Yes, I approve it, I feel proud." P4 said, "I don't like it. It should stop." P5 stated, "It is good. I don't perceive diseases or infection can affect or be contacted in the process of conducting the act because the practitioners over the years have learned to use sterilized objects, are well trained and experienced in the act. I am proud and will do it again." P6 stated, "This is part of our tradition and practices and we should be allowed to continue doing it" P7 stated, "Yes, it is important. I found one neighbor of mine preferring the hospital type for their children." P8 said, "It should stop. It is only for men not women. As educated people, we should not do circumcision. I think it is dangerous, because of the tendencies for infection, lack of good, clean and effective instruments." P9 remarked, "I disapprove. "Ko da wasa" meaning "No joke." P10 stated, "It should stop. I will encourage no woman to do it.

9. Do you know any law that forbids female circumcision?

P1 remarked, “I don’t Know.” P2 stated, “No I am not aware, but its presence could be a very good development. The Government could make compulsory to stop circumcision if not good. It is good to have a law. P3 said, “No.” According to P4, “No, I don’t know.” P5 stated, “Sincerely I don’t know if we could comply, if some people will stop the practice because of the coming of the law, I don’t think others will stop it.” P6 said, “No but if the government wants to insist, we may not resist it as no individual or group can confront government in Nigeria. In our religion (Islam) obedience to constituted authority is ordained and mandatory. P7 stated, “No.” P8 reported, “No.” P9 said, “Yes. I heard President Jonathan spoke about something like that. It is good because it is still happening. No one will know.” P10 said, “Yes I know, and I want it enforced.”

10. What benefit do women get if they are circumcised?

P1 stated, “The general assertion is that such practice enhances conjugal relations between couples and thus stabilizes marriage and homes. To this end, it can be said to be good. Like me and others it can be seen, we have stayed in our homes peacefully with our husbands, this is a great benefit. I can add that it is correct and enhances matrimonial tranquility.” P2 stated, “Yes it appears as a deterrent to the issues of promiscuity among girls, I have seen a girl not circumcised and ends up following men around in the barracks here in Kaduna. As stated by P3, “Parents will be sure their child is settled in her husband’s house.” P4 said, “It has no benefit. It causes Tetanus, loss of blood and even death.” P5 remarked, “Because as for us (community) it doesn’t bring any problem to the children who have

married and given births and are living happily in their homes." According to P6 said, "They will not be promiscuous." According to P7, "It prevents prostitution, it leads to decent maturity, made a woman more suitable for sex and also attract good dowry." P8 stated, "May be because I am not sure. All my father said is that it is beautiful. All will go well if removed. Your life will go well. The parents want us to be responsible" P9 said, "No benefit. They tell you that it is to preserve virginity." P 10 stated, "No benefit."

Evidence of Trustworthiness

For the study to be valid, took caution to ensure trustworthiness between the respondents and myself. I encouraged participants to express their views without interference. I repeated, rephrased or paraphrased some questions to enable participants to express themselves to achieve greater understanding of their experience. I presented participants individually with the findings and my interpretation to confirm if those were a true reflection their responses. I requested for changes as needed.

To safeguard reliability and validity, I checked to ensure data accurate with participants' transcripts throughout the research process (Creswell 2009). As previously mentioned, I exercised caution not to allow personal biases or opinions about FGM/C to interfere with the data I collected. I also took comprehensive notes and frequently compared participants and their experiences as a means of establishing credibility and reliability.

I was neutral throughout stages of the study, from recruiting participants, to interviews, observation and the subsequent analysis and interpretation. The participants are responded in the following manner to the research question.

Results

RQ1: What are the perceptions of women in the Northwestern Nigeria towards FGM/C?

The perception of women in northwestern Nigeria about FGMC/C suggest a living reality occasioned by the birth of a female child and the inevitability of meeting a cultural or traditional need; either at birth, adolescent or adulthood, at home or in a medical institution. Results from the data showed the different views about FGM/C in the study. P4 stated, "Our people like having children so such act (FGM/C) that could facilitate it is seriously condoned. Some people still like it. It is important, or some people will not have children when married." On the other hand, there appeared to be a conflict in the manner in which P4 viewed FGM/C. She said, "It is to dominate and … instill fear in the ignorant that is why it thrives and persisted." P7indicated, "It is a tradition; it is an essential cultural requirement." P8 said, "If not removed a woman cannot give birth to a baby." However, P2 expressed reservation in talking about the perceptions of women because she had no opinion, interaction or talked about FGM/C with other women. She remarked, "I am still not happy talking, but we can still continue to talk, I believe you are a professional and while I mirror now my experiences I feel happy." P1 supported the reservation to speak or interact with women who have undergone FGM/C by saying, "I don't chat with women who have experienced this similar cultural practice." However,

she described the perception of women in the following word; “Such women raise their head high and brag about being healed of their illness and now capable of having enough fun with their husband without any stress or difficulties compared to their pre-FGM/C state. This is because the cause of fear is removed and women have the power of total control of their spouses.” In addition, P1 made the following remark about her experiences, “Now I don’t feel anything as in pains. I could say I am proud to meet a cultural requirement.” P5 stated, “They are proud and feel like a hero.” P6 said, “Proud.” P7 said, “Painful, others, good.” According to P8, “P8 narrated, “My mother informed me that I was circumcised. I was confused, surprised and keep looking at her.” From participants’ submissions it appears the perceptions of women on FGM/C is that of pain, confusion yet happy, proud and approval. It is a traditional or cultural requirement that must be met.

The experience of P9 regarding FGM/C appears to contradict the preceding assertions. She informed that she interacts and talk with other circumcised women in the following manner, “The same with my experience. I talk with other women, and they feel bad, very bad. No woman will like this to happen to her.” P9 added, “Very bad, having intercourse is a problem. I bled and was once re-stitched by the Doctor because I was tampered with. I was tender at the time. I feel bad, I have no sensation. It interfered at childbirth when I had my children. “She appeared unhappy as she narrated her experience.

In the same manner, P10 described the perception of women as, “Painful.” She recounted, “I often even talk to my mother about it for answers and solutions. Even at the

time of coming for this interview, I ask her, and she cautiously told me to forget about the question. Yes, but people don't want to talk about it as it involves some secrecy to be closely guarded here. People keep to themselves." P4 said, "Sad because they have no control to refuse circumcision." It appears the perceptions of other women regarding FGM/C is that of pain, torture, and disapproval is clearly presented from these participants, responses.

RQ2: What influence the decision of women in Northwestern Nigerian to undergo FGM/C?

Participants revealed a mix-bag of information on the rationale or motives for the conduct and continuation of FGM/C. P1 in her ignorance of the reasons for FGM/C said, "I don't know because this is what has been going on for long." When probed further, she said, "What I often heard is that it smoothens and enhances marriage, especially as relates to intercourse and other forms of women sexualities with the opposite sex, especially couples. It is good for it to be removed to stay with your husband and be responsible." P2 shared the same naivety of P1 and states, "I don't even know that because I was young as a baby when it was performed. I had no control over it. It is not a choice because it is done at birth." She went on to say, "the reasons or what girls are told is that the exercise will make them not to be promiscuous or end up as a prostitute in later life. You will not be following men." P5 agreed with P1 and P2 by saying, "I learned at a young age and I was told then that it would help me later in my life during delivery, and I have come to realize that I deliver my children with much ease, my labor-period don't exceed

10minutes in most cases. I am married for 30 years, and I feel circumcision makes me enjoy a stable home." Her statements reinforced her belief of a stable marriage.

According to P3, "The parents will be sure that the child stays and respect her matrimonial home and by not having an unusual or unnecessary urge or sexual desire. The parents will be sure their daughter settles in her husband's home and does not flirt." P4 stated, "Belief and tradition." P5 said, "To avoid urination, sex, and problems. It helps to restrain a woman so she will not flirt. It will also serve as a restraint to extra-marital sex and other youth exuberance. They will be confident of meeting the conjugal duties of their men (husband). The parents will be at peace when the child is circumcised." Again, suggesting FGM/C enhances family peace.

Most of the participants gave similar reasons for FGM/C by reinforcing the submissions of P1, P2, P3, P4, and P5. For example, P6 reported, "The general assertion is that such practice enhances conjugal relations between couples and thus stabilizes marriages and homes… Like me and others it can be seen, we have stayed in our homes peacefully with our husbands, this is a great benefit. I can add that it is correct and enhances matrimonial tranquility." P8 said, "Well, I believe such explanations are based on beliefs of people. All my father said is that it is beautiful. All will go well if removed. Your life will go well. The parents want us to be responsible." P9 said, "They tell you that it is to preserve virginity." P10 said, "Prevent unguided sexual behavior and protection against prostitution." It was only P7 and P10 that added a different dimension to the reasons for FGM/C. P7 said, "To stop prostitution and reduce urge. What I also had is for good dowry." P10 substantiated by saying, "Others contend that doing so attract

high bride-price for the girl at marriage. But the general view and reason was to prevent prostitution.

Additional factors that influenced the decision to undergo FGM/C by women is best captured in the words of P6:

> In my culture, the tradition is for a baby to be circumcised in the vagina and removal of what they call *Belun Kasa* (Clitoridectomy) seven days after birth, which is not harmful. I was circumcised and my children, four are all circumcised. I have six births and one miscarriage. Up till now I can't say I have any problem associated with being circumcised. I live with women not circumcised where I stay; that is those often given pills or drugs as a supplement for circumcision as children. I found out that such women have problems coping with male husbands. To some, I saw revisiting of the practice on them at later years they were circumcised after they have grown-up before they could cope with matrimony (P6).

Factors like education appeared to have influenced the decision for FGM/C. P4 revealed the following:

> We didn't circumcise the children because my husband's family doesn't do it as they are educated and informed. My husband is from Kastina, which doesn't mean in Katsina the phenomena is not done or not rampant, it is not like that, the reason we are immune for now is because we stay here in the city (Kaduna). Not over there the practice is rampant. Though I believe the practice is subsiding, I had mine there when I was a child

> which I had no control or say in the decisions. A person has no control to refuse it. The parents take the decision to do it (P4).

P8 is a third-year student in the Senior Secondary School and states, "I say it should stop. We are educated, people." Some of the participants agreed on the fact tradition play a role in the decision to undergo FGM/C. P6 stated, "In my culture, the tradition is for a baby to be circumcised in the vagina and removal of what they call Belun Kasa (Clitoridectomy) after seven days after birth, which is not harmful. I was circumcised, and my children are all circumcised."P7 said, "Yes, among our tribal group. It is a tradition and ritual still prevailing. It is because of its importance as a cultural requirement." P10states, "Is a tradition of circumcising a newborn baby at the earliest days of his/her birth, as prevention for unguarded sexual behavior of the female child that may lead to prostitution "which reiterated the idea that FGM/C prevents prostitution.

Although, tradition was used to justify the need for FGM/C, P4 was critical of it in the following manner:

> Such a belief to me is in the imagination of the people, and the case of my daughter is a clear test to the baseless ground of such allegations and harmful belief. My daughter got married, and comfortable gave birth to her first child. The tradition to me has no footing. It is to dominate and spread abuse and the capacity to instill fear in the ignorant. That is why it thrived and persisted (P4).

P8in her opinion remarked, “Well, I belief such explanations are based on beliefs of a people…all my father said is that it is beautiful. All will go well if removed.” The statements by P8 confirmed the role of tradition played in facilitating FGM/C.

RQ3: How do women describe their experiences regarding FGM/C?

The following is the progression of how participants described their experiences and the experiences of other women in the study area. P1 is a teenager and said she was circumcised at birth. She stated, “Actually I cannot describe such feelings as I was young, thus I could not imagine and explain the sensations now.” P2, recalled, **“**During the first birth I have severe pains and had to be expanded by a medical procedure for the delivery. With the second daughter there was no problem, but in the last birth I had the same experience of the first birth.” Also, she recounted “I have lost the urge for six-month times to me sex is depreciating. I have five children and three girls. I circumcised the first and second but I stopped at the third because of the effects. I will not circumcise my children again.” The result of the data revealed a rare development with P3. She painted a terrible picture of her experiences but is proud and enjoys her status as a circumcised woman. She narrated the following:

> Now I don’t have much desire for a man, and I don’t miss much of my husband absence. No urge for my husband. I don’t enjoy sex. It makes me unhappy. It reached a stage in our marital life that he had to ask me whether I was circumcised as we are two wives with him. I suspect perhaps his experiences with the other woman suggested something about

> her or me to him. I don't enjoy sex. The feeling makes me sad and unhappy as it is not only food that keeps a woman at home (P3).

And, reversibly, P3 continued, "We are proud because of the thought of the remedial impacts of the practice on preventing us the risk of promiscuity or invariably prostitution. I believe those not circumcised are harlots. I believe they are not satisfied." However, about the experiences of other circumcised women, P3 remarked, "The women claim that they are more aroused when they are sexually engaged with their spouse, this is contrary to my feelings." P4 states, "Heavy loss of blood and death in some cases. I will always remember the case of our neighbor's child who was circumcised which led to heavy flow of blood, and on route to the hospital died." P4 further summed up her description by saying, "Each time I imagine myself in the position of the girl, I feel sensations," and expressed her dissatisfaction for the practice.

On the experiences of other women, P4 states, "But most of the reactions I got were skewed regarding the practice of the FGM/C in communities. Our people like having children. Any action that could facilitate it is seriously condoned." Participant 10 narrated her experience in the following way:

> When it was performed on me, I don't feel anything, but I later realized that it is painful. Currently, I have a depreciating urge for sex. I am married sometimes we fight with my husband over sex. My husband asked me to consult with others on my predicament, and I was often told that it maybe the effects of the circumcision (P10).

Participant 10 appeared to be concerned with her sexual predicaments and attempt to find answers: "I often even talk to my mother about it for answers and solutions. Even at the time of coming for this interview, I ask her, and she (mother) cautiously told me to forget about the question." P10 further described her experience of pain during sex and said, "The sex routine may be painful, but I manage the deliveries. The last one was difficult though it was delivered." She lamented, "…but people don't want to talk about it as it involves some secrecy to be closely guarded here." This research was an avenue for most participants to speak out about their experiences for the first time.

The experiences of other women showed that circumcision does not prevent sex. P3 said, "Yes, but other women circumcised also exhibit strong desire that made one man unable to satisfy them which made them flirt. Some women circumcised still go out; they still test other men." P3 appeared to be confused about the inconsistency of information that FGM/C prevents prostitution. P5 informed, "They always express that they enjoy their statuses circumcised women and have no reservation if it is done to their children." P5 reiterated, "They will like it done on their children." P8 described her experience when her mother informed that she was circumcised in the following manner, "I was confused, surprised and keep staring at her." P9 described it as, "very bad" and remarked, "No woman will like this to happen to her. "It appears from participants' responses that culture and traditional beliefs informed their decisions to undergo FGM/C.

RQ4: Do you approve or disprove the continuation of FGM/C? What are the reasons for approving or disapproving the continuation of FGM/C?

The most informed or critical dialogue came from participants with improved or had a higher level of western education. Such backgrounds appeared to have influenced participants to approve or disapproved of the continuation of the FGM/C. Other participants indicated complications led to health challenges such as; severe or complicated labor, painful menstrual periods, excessive bleeding during or after being cut (P9, P10). P1 was ambivalent with a likelihood of tilting towards approval. In her words, "If the government perceived it to be not good, it could wade in and stop the practice, but if it perceives otherwise it can be condoned and facilitate its continuation." When further questioned on the lack of a clear stance, she said:

> To me it is good, and it can be continued, but if it is not good, it can be stopped and abolished. The important thing is that the part of women that could be an obstruction to her life or marriage or adequate participation in conjugal duties can be removed. Though I perceived expansion in knowledge is increasingly broadening horizon and thus such a practice are but appreciated (P1).

The position ofP1 could be sustained as she was unaware of any legislation in Nigeria prohibiting FGM/C.P1 was of the opinion that she was a hero for being circumcised, she remarked:

> I can say that I am a hero. I am healed and can now have sex. Initially, I was ashamed but latter, I am not ashamed anymore. I was a child when I

> was operated upon, as I told you. I could not clearly understand or say what happened, but if I was a grown-up woman or was able to interact with other women I would have found out their experiences, pains or agony. I could have a clearer response (P1).

P2 supported the assertion of P1 that she was not aware of the law against FGM/C. However, she was in support of the law. She said, "No I am not aware of a law, but its presence could be a very good development. The Government could make it compulsory to stop circumcision if it is not good. It is good to have a law." The reasons she gave was because "circumcision is bad." On being either a victim or a hero, she emphasized, "Our position towards the choice of being a hero or victim of the phenomena is grounded in the nature and tradition of the society. When such thing is conducted, we are celebrated by all members of the community. Then I don't feel anything at all." It appears P2 was hesitant about her support for the legislation.

P3 was not aware of the law prohibiting FGM/C and was of the view that a law was not necessary. She remarked, "No, I like it (circumcision) and in fact, I am ok even if it affects my sexual desire. I don't regret, I like it and will do it again." P4 provided a divergent view to those above. She revealed, "Though I don't know of any law either religious or conventional that prevents the practice, based on my experience I don't like the practice because it is very dangerous and has a lot of dangers associated with it. I don't approve of it and it should be stopped." To drive home her point of view, P4 narrated an experience as follows;

> The gloomy experience of another neighbor, a married woman married for almost four years did not conceive. Then the husband suspected there was something in her private part. Maybe it was the absence of circumcision which was not perfumed on the woman. Invariably, he returned her to her parents and was made to pass through the ritual, in the hands of the local barbers (Wanzan) the specialist in the practice. Unfortunately, despite the act as a grown-up, she could not still give birth. So I ask the question of the belief that circumcision enhances or gives fertility to a woman (P4).

P5 strongly supported and showed commitment to FGM/C. She maintained: "Yes, I will not be ashamed to do that anytime." P5 did not change her perception after being aware of the dangers of FGM/C. She opined, "I don't perceive such diseases or infection can affect or be contacted in the process of conducting the act because the practitioners over the years have learned to use sterilized objects, are well trained and experienced in the act." She was not aware of any law against FGM/C. She went on to remark, "Sincerely I don't know if we could comply, if some people will stop the practice because of the coming of the law, I don't think others will stop it." P5 is not alone in her approval; others such as P6 shared her views. She said:

> One can't go against the government, but to me, this is part of our tradition and practices, and we should be allowed to continue doing it. But if the government wants to insist, we may not resist it as no individual or group can confront government in Nigeria. In our religion (Islam) obedience to constituted authority is ordained and mandatory (P6).

Despite the contending views of approval and disapproval, P7 demonstrated some readiness to reassess and decide her positions. P7 agreed FGM/C "Was painful, just painful. But I am proud because of the enormous amount of pain I had to endure." She said, "Yes, it is because of its importance as a cultural requirement." However, because of the law to stop FGM/C, P7 said, "Yes I will stop it." P8 was not aware of the law against FGM/C and is proud of her status as a circumcised woman. She said, "Not really? I don't feel anything. "I am not ashamed." However, she gave reasons why she would disapprove the continuation of FGM/C as follows, "It is dangerous because of the tendencies for infection, lack of good, clean, and effective instruments. It should be stopped because it is only for men and not women. As educated people, we should not do FGM/C." P9 was aware of the law against FGM/C. She said, "Yes. I heard President Jonathan spoke about something like that. It is good because it is still happening. No one will know." She emphasized disapproval by stating the following, "I disapprove. "Ko da wasa" meaning "No joke." Her reasons for disapproval is because FGM/C is, "Very bad and having intercourse is a problem." She added, "I bled and was once re-stitched by the Doctor because I was tampered with. I was tender at the time. I have no sensation. It interfered at childbirth when I had my children." Her view was reinforced by P10 who is also aware of the law. These are her comments, "Yes I know, and I want it enforced." According to P10,she is, "a victim "and remarked, "I don't like it. It is painful and sex routine painful." She went on to say, "Currently I have a depreciating urge for sex. Sometimes we fight with my husband over sex." The participants' responses to the

research question revealing the lived experiences of women about FGM/C is summarized below.

Table 7.

Summary of Participant Responses in Relation to Research Questions

	Participant 1	**Participant 2**	**Participant 3**	**Participant 4**	**Participant 5**
RQ1: What are the perceptions of women in Northwestern Nigeria towards FGM/C?	"They raise their head high and brag about being healed. Fear is removed. Women will have a power of total control over their spouses."	"Women are celebrated by the community."	"Uncircumcised women are harlots. The belief is that they are not satisfied and will still go out to test other men."	"People have a skewed perception of the practice in communities."	"They are proud and feel like heroes."
RQ2: What factors influence the decision of women in Northwestern Nigerian to undergo FGM/C?	"A means to smoothen and enhance sexual intercourse. A means for matrimonial stability for girls and prevention of promiscuity."	"Girls are told the exercise will make them not to be promiscuous or end up as prostitute in later life."	"To cut down unusual or unnecessary sexual urges or desires. Parents want to ensure matrimonial stability for their daughters."	"Belief and tradition."	"Prevent urinary and sex problems. To restrain a woman from prostitution. Parents to be at peace."
RQ3: How do women describe their experiences regarding FGM/C?	"It makes a woman responsible, she has respect. Is healing to the woman."	"We are celebrated by all members of the community."	"Women claim that they are more aroused when they are sexual engaged with their spouse."	"Sad, they have no control to refuse circumcision."	"Proud and feel like a hero."
RQ4: Do you approve or disprove the continuation of FGM/C? What are the reasons for approving or disapproving the continuation of FGM/C?	"Approve. It is good it can be continued if not good it can be stopped and abolished."	"Disapprove. I won't support that."	"Yes, I approve it, I feel proud."	"Disapprove. I don't like it. It should stop."	"Approve. It is good. I am proud and will do it again."

	Participant 6	Participant 7	Participant 8	Participant 9	Participant 10
RQ1: What are the perceptions of women in Northwestern Nigeria towards FGM/C?	"Uncircumcised women cannot cope with matrimony. Experience a lot of issues and problems."	"It is a tradition. It is an important cultural requirement."	"Uncircumcised women cannot no give birth to a baby."	"It is very bad."	"Prevention for unguided sexual behavior attracts high bride price."
RQ2: What factors influence the decision of women in Northwestern Nigerian to undergo	"Perpetual fears absconding from the matrimonial home and normalizing the marriage."	"To stop prostitution and reduce urge. For good dowry."	"It is a belief. It is beautiful. All will go well. Life will be beautiful. Parents want us to be responsible."	"They tell you it is to preserve virginity."	"Prevent unguided sexual behavior and prostitution."
RQ3: How do women describe their experiences regarding FGM/C?	"Proud."	"Painful, others, good."	"I don't know."	"Very bad, feel bad."	"Painful. Will not discuss the topic."
RQ4: Do you approve or disprove the continuation of FGM/C? What are the reasons for approving or disapproving the continuation of FGM/C?	"Approve. This is part of our tradition and practices and we should be allowed to continue doing it."	"Approve. Yes, it is important."	"Disapprove. It is only for men not women. We are educated."	"Disapprove Ko da wasa meaning (No joke)."	"Disapprove. It should stop. Will not encourage a woman to do it."

The findings listed in Table 7 showed the description of the lived experiences of participants regarding FGM/C. It was evident from the findings that the participants underwent the Type 1 circumcision known as Clitoridectomy which they referred to as Belun Kasa). Some participants are proud for being circumcised while others view themselves as victims and regard the practice as bad. Factors such as tradition, culture, matrimonial stability and prevention of promiscuity influence participants' decision to undergo FGM/C. The perceptions of past experiences of participants in the study regarding FGM/C did not affect their decision to abandon the practice. Their awareness of the law or the lack of it did not change the mentality of some participants to discontinue the practice (See Table 8).

Table 8.

Summary of Participant Responses to Interview Questions

	Participant 1	**Participant 2**	**Participant 3**	**Participant 4**	**Participant 5**
Q1: Have you heard about female circumcision?	Yes, as a child, you cannot know.	Yes, they often take children to the hospital to perform it.	Yes. I circumcised my 1st and 2nd child but stopped at number 3.	Yes, I had mine when I was young but did not circumcise my daughters.	Yes. They did it on me when I was a child.
Q2: In this community are women circumcised?	Yes, it is still being done in our area.	They often take children to the hospital to perform it.	Maybe in the hospital but not much at homes.	Yes, but my husband's family doesn't do it… over there the practice is rampant.	Yes, it is being done and even they are still doing it.

Q3: Are you circumcised?	Yes, when I was a young girl.	Yes, I was young as a baby… I had no control over it.	I was circumcised at birth."	Yes, when I was young.	Yes, I have 6 girls and I circumcise all of them.
Q4: How do you feel as a circumcised woman?	I am a hero. I am healed, can now have sex, Initially, I was ashamed but latter, I am not ashamed anymore.	I have lost urge for sex, sex is depreciating. I am still not happy.	I don't have much desire for a man. I don't miss much of my husband's absence.	Based on my experience I don't like the practice, because it is very dangerous.	I have been married for 30 years and being circumcised make me, enjoy a stable home. I will not be ashamed to do that anytime.

	Participant 1	**Participant 2**	**Participant 3**	**Participant 4**	**Participant 5**
Q5: What are the perceptions of women towards FGM/C in this area?	Women raise their heads high and brag about being healed of their illness. Cause of fear is removed women will have power of total control of their spouses.	Some women don't want the process. We are celebrated by all members of the community.	Those not circumcised are harlots and are not satisfied and will still go out to test other men."	I get skewed reactions and perception of the practice …our people love children… the act is seriously condoned. It is important…or some people will not have children.	They always express the same feelings of enjoying their status as circumcised women and will do it to their children.
Q6: What factors influence the decision of women to perform FGM/C?	To stay with your husband, it smoothens and enhances marriage.	Girls will not be promiscuous or end up as prostitutes in later life.	Girls to respect their matrimonial home, not have unusual or unnecessary sexual urges or desires.	Belief and tradition.	Prevent urination, sex and problems. Restrain a woman so she will not flirt.

Q7: How do the women describe their experiences regarding FGM/C?	Makes a woman responsible, she has respect. She is healed.	Women are celebrated by all members of the community.	It suppresses sexual satisfaction.	Sad, no control to refuse circumcision.	Proud, feel like a hero.
Q8: Do you approve or disprove the continuation of FGM/C?	It is good and it can be continued but if not it can be stopped.	No I won't support that.	Yes, I approve it, I feel proud.	I don't like it. It should stop.	It is good…I am proud and will do it again.
Q9: Do you know any law that forbids female circumcision?	I don't Know.	No I am not aware…It is good to have a law.	No.	No, I don't know.	I don't know if we could comply… I don't think others will stop it.
Q10: What benefit do you or women get if they are circumcised?	It enhances conjugal relations between couples and stabilizes marriage and homes.	Deterrent to promiscuity among girls.	Child is settled in her husband's house.	No benefit. It causes Tetanus, loss of blood and even death.	Live happily in their homes.

	Participant 6	Participant 7	Participant 8	Participant 9	Participant 10
Q1: Have you heard about female circumcision ?	Yes.	Yes, among our tribal group.	Yes.	Yes. I am aware about FGM, my parents circumcised me.	It is a tradition of circumcising a new-born baby.
Q2: In this community are women circumcised?	The tradition is for a baby to be circumcised in the vagina… they call Belun Kasa after 7 days after birth.	Yes. It is a tradition and ritual still prevailing. An important cultural requirement .	It is the removal of something from a girl-child private part.	It is still happening. No one will know.	Is still going on in the rural areas and here in Sabo-Tasha.

Q3: Are you circumcised?	Yes, and I have circumcised all my children.	"Yes, when I was 17years old and I have circumcised my girl.	I don't know whether I was circumcised … I was informed by my mother that I was circumcised.	Yes, at the age of 6 years.	Yes. Often it is performed at birth.
Q4: How do you feel as a circumcised woman?	Feel ok, had 6 births and 1 miscarriage, no problem with being circumcised.	Just painful but I am proud of the enormous amount of pain I had to endure.	I don't feel anything. I am not ashamed.	Very bad, intercourse is a problem… I bleed was once re-stitched… feel bad, no sensation.	Depreciating urge for sex… sex routine painful.
Q5: What are the perceptions of women towards FGM/C in this area?	Uncircumcised women have problems coping with husband and matrimony.	It is tradition and important cultural requirement.	If not removed a woman cannot give birth to a baby.	They feel bad.	Prevention for unguided sexual behavior, prostitution and high bride price.

	Participant 6	**Participant 7**	**Participant 8**	**Participant 9**	**Participant 10**
Q6: What factors influence the decision of women to perform FGM/C?	Fears of absconding matrimonial home.	Stop prostitution; reduce urge, and good dowry.	Beliefs. It is beautiful.	Preserve virginity.	Prevent unguided sexual behavior, protection against prostitution.

Q7: How do the women describe their experiences regarding FGM/C?	Proud.	Painful, others good.	I don't know.	They feel bad, very bad.	Painful, people don't want to talk about it, involves secrecy to be closely guarded here.
Q8: Do you approve or disprove the continuation of FGM/C?	Approve. This is part of our tradition and practices and we should be allowed to continue doing it.	Approve because it is important.	It should stop. It is only for men not women.	Disapprove	Should stop. I will encourage no woman to do it. .
Q9: Do you know any law that forbids female circumcision?	No, but if the government wants to insist, we may not resist it.	No.	No.	Yes. I heard President Jonathan spoke about something like that.	Yes, I know and want it enforced.
Q10: What benefit do you or women get if they are circumcised?	They will not be promiscuous.	Prevents prostitution, leads to descent maturity. The woman is more suitable for sex. It attracts good dowry.	Father said it is beautiful, will make us responsible, all will go well.	No benefit. They tell you it is to preserve virginity.	No benefit.

The findings in Table 8 are the summary of the participants' responses to each of the interview questions which provided insight into their lived experiences and their

status in the society. Factors that influenced their decisions to be circumcised, the feelings and the manner in which they presented those feelings about FGM/C were shown. The discomfort of FGM/C did not deter some participants from circumcising their children. Other participants reported awareness of the law against FGM/C. However, despite the awareness or the lack of it influenced disapproval for the continuation of FGM/C.

For a theme to be established, I observed the major remarks made by each participant to determine its inclusion in the study. After a thorough review of the participants' responses, the four salient themes that became saturated based on the research questions included: traditional beliefs; pain, happy and approval; pain, distress and disapproval; and ignorance of the law. The few responses observed as discrepant findings were not part of the major themes.

The following were the four outstanding themes identified based on the results: *Theme 1: Traditional beliefs*. The majority of the theme groupings showed that the practice of FGM/C hinged on traditional beliefs which dominated and reinforced the decision for FGM/C. Most of the patterns documented were;

- It is a tradition. It is an important cultural requirement
- Girls are told the exercise will make them not to be promiscuous or end up as prostitutes in later life.
- To restrain a woman from prostitution.
- To stop prostitution and reduce urge.
- To cut down unusual or unnecessary sexual urge or desires.

- To preserve virginity.
- A means for smoothening and enhancing sexual intercourse.
- Ensure matrimonial stability for girls
- A means for matrimonial stability for girls and prevention of promiscuity.
- It makes a woman responsible and she has respect.
- Is healing to the woman.
- Uncircumcised women cannot cope with matrimony and experience a lot of issues and problems.
- Uncircumcised women cannot give birth to a baby
- Prevention for unguided sexual behavior and attracts high bride price.
- For good dowry.
- It is beautiful. All will go well. Life will be beautiful.
- Parents will be happy a girl is settled in her husband's house.
- The woman will have control of her husband.

Theme 2: Pain, happy and approval. The cluster also revealed that some of the participants are happy with their status as circumcised women regardless the pain or effects of FGM/C. They do not have a choice against the practice. The following support the claim:

- Approve. It is good. I am proud and will do it again
- Circumcision is bad. But without it your man can go after other women.
- It is good. I don't perceive diseases or infection can affect or be contacted in the process of conducting the practice.

- This is part of our tradition and practices and we should be allowed to continue doing it.
- Proud and feel like a hero.
- They are proud and feel like heroes."
- Yes, it is important.
- Painful, others, good.
- Just painful but I am proud of the enormous amount of pain I had to endure.
- Approve. It is good it can be continued if not good it can be stopped and abolished.
- I don't feel anything. I am not ashamed.
- To me it is good and it can be continued.
- Approve. Yes, it is important.
- Women often raise their head-high and brag about being healed of their illness and now capable of having enough fun with their husbands and have power of total control of their spouses.
- We are celebrated by all members of the community.
- They enjoy their status as circumcised women and have no reservation for it to be done to their children.

Theme 3: Pain, distress and disapproval. There appeared to be a feeling of pain and distress as participants described their feelings and experiences with FGM/C. These examples validate this theme:

- Sad, they have no control to refuse circumcision.

- Very bad, intercourse is a problem. I bleed was once re-stitched.
- I feel bad, I have no sensation.
- It is very bad.
- Painful. I won't support that.
- Very bad, feel bad.
- It should stop. Will not encourage a woman to do it."
- Painful, will not discuss the topic.
- Just painful but I am proud of the enormous amount of pain I had to endure.
- Depreciating urge for sex and sex routine is painful.
- It causes Tetanus, loss of blood and even death.

Theme 4: Ignorance of the law. Quite a number of participants indicated they were not aware of the law prohibiting FGM/C. A few participants welcomed the idea of the against the practice. Others indicated it will not change their stance from continuing FGM/C. The exemplars are as follows:

- I don't know.
- No I am not aware but its presence could be a very good development.
- It is good to have a law.
- Sincerely I don't know if we could comply, if some people will stop the practice because of the coming of the law, I don't think others will stop it.
- No, but if the government wants to insist, we may not resist it.
- Yes, I know, and I want it enforced.

Summary

Participants' responses to the lived experiences of FGM/C revealed that all are aware and are personally affected by FGM/C in the study area. The experiences are those of pain and anguish which is considered by many as normal. The perceptions of women regarding the practice are with mixed emotions. Some view the practice as an integral part of cultural/tradition, religious belief, and therefore, appropriate. Others described it as an imaginary cultural/traditional encouraged by men to instill fear and sexually exploit women. Besides, the experiences of women varied as regards to FGM/C. While others view it as a horrendous, terrifying and upsetting scar on women, others were happy, proud, and viewed FGM/C as a means for curbing sexual excesses to be experienced by women. A number of participants approved the practice. A portion disapproved of it. Although, there is a law against the practice of FGM/C in the nation, few women were aware of the development. The benefits of FGM/C appeared controversial. To some, it is a cultural and traditional belief. It prevents, cures, supports fertility, smoothens delivery, and improves marital stability. To others, it is a detestable and abusive practice which inflicts pain, injury, delivery problems, and in inhibits sex.

I discussed the interpretation of the findings in Chapter 5 and highlighted on the limitations. Thereafter, I suggested recommendations and implications of the study. I outlined the implication for social change, the need for future research, and conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to explore the lived experiences of ten women in the northwestern region of Nigeria about FGM/C. Understanding the perception of women in the area could provide insight into how the women view themselves as victims of the practice or heroes of their societies, as well as the motivation for the continuation of the practice.

The finding from this study confirmed the widespread and prevalence of FGM/C among ethnic and religious groupings in the study area (Ashimi et al., 2014; Okeke, 2012). More so, the practice is deeply rooted in the culture and tradition of the people (Allen, 2014). FGM/C appears to be a lived, inevitable reality for women regardless of age, marital status, or education. The most advanced reasons for FGM/C included;(a) enhance matrimonial stability and sex; (b) prevent prostitution, promiscuity, urinary infections, pregnancy, and delivery complications, and (c) increase bride price. To justify agreeableness modern medical facilities and practitioners are increasingly involved in carrying out the practice.

The study further discovered the protected cultural traditions of the study area limited exchanges among women through the psychology of secrecy and coyness. Hence, women suffer silently and considered techniques for reduction of pain to their daughters was approve their circumcision at birth. However, the study found some exceptions to these trends. Education supported by informed spouses played a significant role in giving participants a clearer understanding of FGM/C in the study area. The study understood

that FGM/Cremains a contending issue between traditionally held views and modernity. While the cultural point of view (heroes) approved of the practice, the modern point of view (victims) disapproved the practice. I discovered that some participants were unaware of The Violence against Person (Prohibition) Act passed on May 25, 2015.

Interpretation of the Findings

The results of the findings in Chapter 4 are based on the research questions and showed similarity with past studies on FGM/C which suggested underlying influences and health difficulties such as pain, trauma, bleeding, infections, sexual dissatisfaction, urinary, and delivery complications (Allen, 2014; Ashimi et al., 2014; Berg et al., 2014;Enwereji & Enwereji, 2013; Isiaka & Yusuff, 2013; Kaplan et al., 2011;Nkanatha and Kanuri, 2014;Okeke, Anyaehie & Ezenyeaku, 2012; UN, 2006;UNICEF, 2013;Yoder & Khan, 2007; Thompson, 2015; Umar & Oche, 2014; WHO, 2013). As circumcised women, most of the participants revealed feelings of pain and delivery complications. Those who did not feel pain were cut at childhood, have yet to marry, and had no experience with FGM/C. They were also indifferent on whether FGM/C should be discontinued. Some participants narrated; “Based on my experience I don’t like the practice because it is very dangerous and has a lot of dangers associated with it” (P4). “It was a painful and horrible experience” (P7). “Very bad, having intercourse is a problem. It interfered at childbirth when I had my children. I bled and was once re-stitched by the doctor” (P9), and P10 said, “Then I don’t feel anything, but I later realized that it is painful.” Hence, enduring pain and suffering is natural and women are expected to downplay pain to meet the expectations of family and community (Visandjee et al.,

2013). Additionally, the study sample was of the opinion that the lack of sexual satisfaction was as a result of what they called “chire Belun Kasa” which means removal of the clitoris. Most of the women stated the following; “I have lost the urge for sex, most times to me sex is depreciating” (P2). “Now I don’t have much desire for a man, and I don’t miss much of my husband’s absence. No urge for my husband. I don’t enjoy sex. It makes me unhappy” (P3). “I have no sensation” (P9), and “I have a depreciating urge for sex. Sometimes I fight with my husband over sex” (P10).

As WHO, (2013) and Okeke, (2012) revealed, every year a large proportion of women passed through the ordeals of FGM/C. The findings of study noted majority of the women from Kaduna North and South LGAs would circumcise their children. For example, the statements from these respondents showed an unwavering support to continue the practice. P5 stated, “I have six girls, and I circumcise all of them.” Another narrated, “Yes and I have circumcised all my children. Yes, all four and there is no problem” (P4) “Yes when I was 17years old, and I have circumcised my girl” (P7).P5 emphatically supported the continuation of FGM/C regardless the law by saying “Sincerely I don’t know if we could comply, if some people will stop the practice because of the coming of the law, I don’t think others will stop it.” This statement revealed the tendency of women in the study area to be reticent about the legislation to hinder efforts towards abolishing FGM/C.

Significantly discovered is the lack of knowledge, understanding and definition of FGM/C among the respondents, in line with submissions that are polarized in UN, (2006), WHO, (2008) and WHO, (2013) typologies. The sample population indicated

undergoing Type I FGM/C, also called clitoridectomy (the partial or total removal of the clitoris and the prepuce) referred to as Belun Kasa. This finding is not consistent with the opinion of other studies indicating that the worst forms of FGM/C are predominant in the Northern region of Nigeria (Feldman-Jacobs & Clifton, 2014; Okeke, 2012; UN, 2006;WHO, 2013).Understanding the definition of the FGM/C phenomena is crucial to evaluations and re-evaluations of FGM/C in the Northwestern region of Nigeria.

The respondents supported other studies that found traditional beliefs of communities were the major factors that influenced the decision to be circumcised. This finding support the claim of other studies (Allen, 2014; Kontoyannis & Katsetos, 2010; Okeke et al., 2012). P5 stated, "The traditional beliefs were imagination of the people. The baseless ground of such allegations and harmful belief dominate and spread base on the capacity to instill fear in women (P5). The tradition to me has no footing" (P4). P10 narrated, "It involves some secrecy to be closely guarded."P7 said, "It is a tradition and ritual; it is an essential cultural requirement and being a hero or victim of the phenomena is grounded in the culture and tradition of the society." When such thing is conducted we are celebrated by all members of the community" (P2). Women from the study area view traditional beliefs regarding FGM/C as an integral part of communal activities to intimidate and instill fear and control women (Berkes, Colding & Folke, 2000;Heather, 2013). The findings suggest a majority of the participants were aware of the harmful repercussions of FGM/C and allowed themselves to be cut to conform to tradition. Hence, the statement, "No choice or control to refuse circumcision" (P2; P4; P10). This finding corroborate the studies by (Gele et al., 2012; Mandara, 2003) who indicated that

the fear of tradition has an influence on the decision for FGM/C despite the harmful effects. P3said, “Uncircumcised women cannot give birth to a baby” revealed her gullibility about tradition was revealed in her words.

Although, Kontoyannis and Katsetos, (2010) noted in their research that religious scriptures do not suggest FGM/C a religious obligation, Andarge (2014) and Kaplan et al., (2013) opined that religious beliefs played a significant role in valuing and maintaining FGM/C. Some women from the Kaduna State communities shared in the belief that by allowing themselves to be cut enhances faithfulness in one’s religious beliefs (Gemignani & Wodon, 2015).

The deterring capacity of FGM/C towards unwanted vices such as promiscuity, prostitution, or adultery was widely supported by all participants. The findings are similar to studies in Egypt which reported that 34% of participants supported the continuation of FGM/C because it could prevent adultery and less supervision by husbands (Coyne, & Coyne, 2014; Gele, Bø, & Sundby, 2013; Mohammed, 2015; Yirga, Kassa, Gebremichael & Aro, 2012). Several statements by the participants substantiated findings by these researchers. When asked about the factors that influence the decision for FGM/C in the study area, P3 said it would prevent, “Unnecessary sexual urges or desires that could lead to fornication, adultery, or prostitution.” P7 stated, “To stop prostitution and reduce urge,” and P10 said, “To prevent unguided sexual behavior and protection against prostitution.” Other statements that had similar undertones included; “It makes a woman responsible, and she has respect” (P1), “The parents want us to be responsible” (P8), and “They tell you that it is to preserve virginity” (P9).To authenticate some of these

arguments, Visandjee et al (2014) wrote: “The reason for FGM/C is to make her polite, to prevent her from becoming hyper, to prevent her from looking for extramarital sex, to keep her from misbehaving” (p. 11). The theme of prostitution runs through most statements by study participants and researchers.

The notion of high bride price and marriageability (Shell-Duncan & Hernlund, 2010p.105) of circumcised girls are an important economic consideration for most parents (Enwereji & Enwereji, 2013, Gruenbaum, 2001; Okeke, 2012). This belief was found to be true of the women in Kaduna North and Kaduna South LGAs when they spoke about their experiences. P2 stated, “For good dowry.” P10 recounted; “Others contend that doing so attract high bride-price for the girl at marriage.” Some women in this region believed that FGM/C stabilizes matrimonial homes as supported by P1 who said, “To stay with your husband, it smoothens and enhances marriage and women will have the power to control their spouses.” The research also found that women in these communities are “celebrated” (P2) when circumcised. This supports the idea that FGM/C in Africa in is an initiation ceremony for girls and women into womanhood (Bjalkander, et al., 2012).

A significant finding is the “medicalization” of FGM/C (Gele et al., 2012) which is increasing the practice in the communities of Kaduna State. The participants revealed that the commonest type of FGM/C performed on them is Belun Kasa (clitoridectomy). The WHO, (2011) and Bjälkander et al., (2012) found the increase in the number of parents seeking for medical practitioners to carry out the procedure is because it reduces harm. Exemplars from the findings of this study substantiate this claim. P2 reported, “I

have heard they often take children to the hospital to perform it," and P3 said, "In the hospital but not much at homes."P7 stated, "I found one neighbor of mine prefer the hospital type for their children." This raises questions on the training and ethical standards of such involving professionals. Similarly, the onerous question of instruments for performing FGM/C resonates in this study and like others (Okeke, Anyaehie & Ezenyeaku, 2012; WHO, 2013). The data will always justify embracing more hygienic practices by both local traditional and modern practitioners to decrease the rate of mistake and errors.P5 stated, "I don't perceive diseases or infection can affect or be contacted in the process of conducting the act because the practitioners over the years have learned to use sterilized objects, are well trained and experienced in the act." These participants support the continuation of FGM/C.

The belief that the FGM/C practice is a world of women when in some parts of the world continues to be questionable. A study in Sierra Leone showed that the majority of the decision makers (65.9%) were women and only (30.7%) were males (Bjalkander et al., 2012, p. 119). In Gambia, men's perception and attitude depended on their culture, beliefs, and ethnic groups(p.126). In another study, fathers, depending on the family, appeared to have the power to veto decisions about FGM/C (Bjalkander et al., 2012; Kaplan et al., 2013; Shell-Duncan& Hernlund; 2010). For communities in Kaduna State, women view FGM/C as a positive part of their lives and culture (Shabila et al., 2014) and had no control to refuse circumcision. Moreover, almost all the women were cut at birth when they had no knowledge of what was happening to them. Only P7 was cut at the age of 17 years and was still unable to make a decision to reject FGM/C. Responses from the

women revealed the following;P1 stated, “Yes as a child, you cannot know. My husband makes the decision.” “It is not a choice because it is done at birth” (P2). “My husband told me. (P3). “I had mine when I was a child. I had no control or say in the decisions” (P4). P5 narrated; “I was told to dip the child in the hot water” suggests she was unware and not part of the decision making to cut her child.

Lastly, half of this research population viewed themselves as heroes of FGM/C and approved the continuation of the practice. This finding support the assumptions of other theories that FGM/C is a shared societal value and functions to foster a sense of cohesion within society and to fill different needs (Brinkerhoff, Ortega & Weitz, 2013; Durkheim 2013; Schultz and Lien, 2013). That is to say, a community could abandon FGM/C if the phenomenon ceases to satisfy the need for societal cohesion. The other participants shared the experience of other authors who view FGM/C as inhuman treatment of women, violation, and abuse of their rights (Berg et al., 2014; UN, 2006; Vloeberghs, van der Kwaak, Knipscheer, & van den Muijsenbergh, 2012) and disapproved of the practice.

This is why it was crucial to examine the lived experiences of women in the communities of Kaduna State, to understand why a woman would feel she is a victim or a hero after having her genitals cut. The results of these findings could facilitate approaches to ending FGM/C to be sensitive to the rights of a people of the cultures that view FGM/C as a cultural value and condone the practice (Brown, Beecham & Barrett, 2013; Enwereji and Enwereji, 2013; Kontoyannis and Katsetos, 2010; Okeke et al., 2012; UNICEF, 2005).

Influence of the Conceptual Framework

The SCT and EM used in this study provided the logical foundation that funneled the development of the questions, data analysis, and findings. This is manifested in the description of how participants acquired and maintained behavioral patterns of FGM/C. The community and institutions such as; marriage, family, friends, and tradition are structured and reinforced to cater for reasons and the need for FGM/C. The transmission of the process over the years in the area of study has enhanced the survival and dynamism of FGM/C. The extent to which FGM/C is to be addressed, understood and or challenged in the society depends on how a structured web of social life is built around women. Therefore, the women live and operate within those social backgrounds and take their decisions on the basis of these backgrounds (Watkins, 2013).

The EM was more accurate on the segmented nature of interactions and structure sustaining the practice of FGM/C. The environment has a strong influence (Glanz et al., 2008) on the decision to undergo FGM/C and its maintenance regardless of the personal confidence to exercise control over one's motivation, behavior, and social environment (Glanz et al., 2008).

In particular, the assertions to the inter and intra significant network of relationship illustrated in the study combined with the lack of interaction and exchanges among women reinforced the survival of FGM/C in the study area. Health institutions, individuals and the community (Bjalkender, 2012) in the study area are also indicted as part and parcel of the environment strengthening the practice of FGM/C.

Significantly, the policy sphere identified by the EM provided a window through which state (government) regulations and legislation clearly support the prevalence and continuation of FGM/C. That is to say, the institution that matter failed to develop policies to aid the abandonment of FGM/C. It was only on May 25, 2015, that Nigeria enacted The Violence against Person (Prohibition) Act which includes the practice of FGM/C.

From the findings, the lived experiences of the women in the study area does show how the multidimensional and shared effects of both the environmental and individual factors shaped the worldview and dictated the way the women responded and reacted to their environment (Inglehart & Welzel, 2005) and the choices they made to undergo FGM/C.

Limitations of the Study

This study as previously stated is limited by the geographic location of the study in Kaduna North and Kaduna South LGAs in Kaduna state amidst the seven states comprising the Northwestern regions. All the study participants were residents of Kaduna North or Kaduna South LGAs in Kaduna State. Consequently, the results may not exemplify the geographical composition of circumcised women in the study area.

Other limitations include the sampling design and size. The use of the purposive snowball sampling clearly limits the capacity for a clear-cut representation and selection of varied and expansive interests relating to the study and restricts the capacity to generalize the findings. The sampling size of 10 participants may not be an accurate

representation of the perceptions, feelings, opinions, and beliefs of women in the entire population.

Lastly, is the possibility of recall bias or distortion of facts given that the responses to the interview questions were self-reported by the participants who appeared to be naïve, ill-prepared to recall, articulate and express their feelings and experiences relating to FGM/C.

Recommendations for Action

The findings of this research describe the experiences and what FGM/C means to the study participants. To some, FGM/C is an essential cultural requirement that they must observe and saw themselves as heroes. For other participants, FGM/C is an instrument to instill fear, and control. This group see themselves as victims of the practice. Therefore, the intention was to present these facts to the practitioners, interventionists, international organizations, and NGOs servicing these communities to expand research opportunities and intervention programs. The results will be communicated through local, national and international conferences, workshops and peer-reviewed journals.

The legislation prohibiting FGM/C must be de-compartmentalized into acceptable packages for dissemination to the public. Intensify awareness and advocacy programs talk shows with experts and have victims of FGM/C narrate their lived experiences. The state (government) should lead in this direction. Victims and spouse self-support programs should be encouraged by institutions (pharmaceutical, medical, para-medical, etc.); corporations (schools, research centers, big business, entrepreneurs, etc.) towards

facilitating exchanges on lived the experiences of FGM/C victims. This approach will significantly decrease the practice of FGM/C.

The practice of FGM/C thrives on the cultural notion of attracting substantial bride-price for circumcised woman (Allen, 2014; Okeke et al., 2012). Such a cultural philosophy has remained unchallenged in societies with poor economic opportunities for families and enhanced the ill-treatment of women.

This study proposes a critical review of the involvement of modern medical institutions and personnel performing FGM/C in hospitals and other forms of paramedical support (overt or covert) to weaken FGM/C in the study area.

Recommendations for Further Study

It is critical to expand this study into the rest of states in the Northwestern region to verify or double-check some of the submissions in this study. Another important research gap is a cultural comparative study on the efficacy of FGM/C as preventive or curative mechanism for social vices such as promiscuity and prostitutions. A comparative study between the sexual enhancement and fertility capacity of FGM/C high-level fertility condoning communities with high-level fertility FGM/C disapproving communities is necessary to expose the myth about the practice.

The bulk of the study participants in the study and similar studies have troubling traumatic experiences through their lifespans (Watkins,2013). Additional research is necessary to investigate the etiology of FGM/C in the Northwestern region and Nigeria to determine a more accurate data than what is presently available. Therefore, a

multidisciplinary approach of the different branches of academic disciplines are necessary for current data and viewpoints on FGM/C.

Forthcoming research should be aimed at designing studies for the male population to determine their perspectives, feelings, opinions and motivations for FGM/C because the majority of research on FGM/C appears to be on the female samples (Gratz et al., 2002). Consequently, males who are the decision-makers and propagate the practice of FGM/C could be assessed, educated and sensitized as vanguards in the prevention of FGM/C.

Implications for Positive Social Change

The implications for social change are many. This research has not only satisfied my aspiration to enlarge the data and knowledge on the subject of FGM/C in Nigeria. It has contributed to the body of literature and dialogue on the terrain of FGM/C. The findings are valid and represent the true voices of women who's lived experiences on FGM/C have not been heard. This could increase the awareness of the general populace and provide a rich resource for the women and individuals seeking to develop initiatives for improving the knowledge of men and women on the FGM/C. The study provides an up-to-date information about FGM/C in the study area that could be used by practitioners to revise their communication tactics and or customize programs to eradicate FGM/C effectively. Additionally, the results could improve the quality of initiatives advocated by well-meaning individuals and organizations for lessening the adverse impact of FGM/C on women.

The findings could provide insight on how FGM/C may be an important and valuable part of the culture which could enhance the efforts of interventionists to accurately target messages and other educational programs for a positive reception by women of different cultures. Furthermore, understanding the perceptions for undergoing FGM/C is concomitant to understanding the identity, status and views of women. The understanding could improve the knowledge of practitioners and the efficacy of their intervention programs (Shabila, Saleh & Jawad, 2014) without undermining the culture of the communities in the Northwestern region regardless of any personal belief that sees FGM/C as detrimental to women.

The subject of FGM/C in the study area appears to be widespread, yet shrouded in secrecy. The results of this discourse could provide researchers with authentic data and closer understanding of the motives behind FGM/C and its continued practice. Equally important is, the outcomes of this research could serve as a baseline for future studies in the Northwestern region on the hero versus victim notion of FGM/C.

Subsequently, policy makers at local, state and federal levels could use the information and knowledge from this study to design appropriate advocacy strategies to heighten awareness of the law against FGM/C. For such a convention to come to an end requires individuals at different levels to resolve jointly to renounce it (Boddy, Obiora, Talle, Johnsdotter, Rogers, Piot ... & Ahmadu, 2007).

I plan to disseminate the findings of my study through peer-reviewed journals, professional conferences, and local presentations. The Commissioner of the Kaduna State Ministry of Health has requested I share the results of the study with the Department. By

publicizing the results of this research to a wide-ranging audience will increase better awareness to the lived experiences of women regarding FGM/C in the study area

Conclusion

In conclusion, the result of the data analysis has answered the question on the perceptions of the lived experiences of women regarding FGM/C. The participants' responses indicate how traditional beliefs played a significant role in the decision to undergo FGM/C. Half of the study sample viewed themselves as heroes and half as victims of the practice. The study has filled a gap in the literature in that those women who have been cut came forward, without shame to talk about their lived experiences through a face-to-face interview and observation.

This study is exceptional because it provided a forum for women in the study area for their voices to be heard. The study participants were unique because they did not have difficulty communicating their private experiences regarding FGM/C to a professional and a woman. The goal of the study is toward social change by making available data on the reality and mystery of FGM/C to the communities and society in general.

Finally, this study was to discover what FGM/C means to every participant, their lived experiences, and their status in the society. These findings will be disseminated to the public, health professionals, interventionists, and other research communities.

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Appendix A: Invitation Flyer

School of Public Health
Walden University

PARTICIPANTS ARE NEEDED FOR RESEARCH IN FEMALE GENITAL MUTILATION/CUTTING

I am looking for volunteers to take part in a study of:
Heroes or Victims: The Lived Experiences of Women on Female Genital Mutilation/Cutting in Northwestern Nigeria

As a participant in this study all interviews and responses will be confidential and anonymous. Your participation will involve **only 1** session, each of which is approximately 25 to 30 minutes.

Criteria for participation: Women who have undergone FGM/C and are 18 to 49 years of age, reside in Kaduna North or Kaduna South Local Government Areas, speak and understand English.

In appreciation for your time **transportation will be provided**

For more information about this study, or to volunteer for this study, please contact:
Sarah Kasham Philips
School of Public Health

This study is not associated with the National Council of Women Societies or any organization in any way.

The study has been reviewed and approved by the Institutional Review Board of Walden University.

Appendix B: Interview Protocol

Opening: In some communities, a girl can only become a woman after participating in some ceremonies. I will like to discuss with you about one of the ceremonies popularly called female circumcision.

1. Have you heard about female circumcision?
2. In this community are women circumcised?
3. Are you circumcised?
4. How do you feel as a circumcised woman?
5. What are the perceptions of women towards FGM/C in this area?
6. What factors influence the decision of women to perform FGM/C?
7. How do the women describe their experiences regarding FGM/C?
8. Do you approve or disprove the continuation of FGM/C?
9. Do you know any law that forbids female circumcision?
10. What benefit do you or women get if they are circumcised?

Appendix C: Observation Checklist

Tone of Voice:

1. Calm
2. Low
3. Humorous
4. Nervous
5. Stutters
6. Hostile
7. Cautious
8. Approving/Disapproving
9. Indifferent
10. Critical

Body language/Mannerism:

1. Eye contact
2. Posture
3. Frown or smile
4. Hypersensitive
5. Shy
6. Withdrawn
7. Head nodding
8. Pauses