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# The Effects of Female Genital Mutilation on Women of Sierra Leone

Nenneh Kalokoh Kalokoh
*Walden University*

# Walden University

College of Social and Behavioral Sciences

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Nenneh Kalokoh

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Review Committee
Dr. Grant Rich, Committee Chairperson, Psychology Faculty
Dr. Denise Horton, Committee Member, Psychology Faculty
Dr. Debra Wilson, University Reviewer, Psychology Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

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Abstract

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Female genital mutilation or cutting (FGM/C) is a common practice among Sierra Leonean women with significant psychological and physical risks. Prior to this study, a substantial need existed for inquiry and understanding of the experiences and belief systems at play within this cultural group to better understand the effects of FGM/C on women and girls. The goal of this research was to review the cultural perspectives and experiences of Sierra Leonean women who underwent FGM/C in order to investigate their concerns about safety and their perceptions of the practices. In addition, I explored concerns among Sierra Leonean women had about having the procedure done on their daughters, and to what they attributed the continued practice of FGM/C. Feminist theory and the theory of cultural relativism formed the theoretical framework of the investigation. The nature of the study was qualitative and followed a phenomenological design. Participants included a purposeful sample of 12 women from Sierra Leone who had experienced FGM/C. Data were collected via in-person, semistructured interviews and analyzed thematically. Analysis revealed the following five themes related to participants' perceptions, experiences, and attitudes toward FGM/C: (a) participant definition of FGM/C, (b) lived experiences of FGM/C, (c) cultural and social aspects, (d) differing personal beliefs of the procedures, and (d) diverse perceptions on FGM/C. Positive social change from this investigation may occur via proper education on FGM/C to help women understand the risks associated with the practice, and to provide them with the autonomy to make their own informed decisions regarding the procedure.

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# Chapter 1: Introduction to the Study

## Introduction

Female genital mutilation (FGM), also known as female genital cutting (FGC) and female circumcision, refers to the partial or full removal of external female genitalia, or intentional injury to the female genitals for non-medical reasons (Ahanonu & Victor, 2014). The practice is most common in areas of Africa, the Middle East, and parts of Asia (Ahanonu & Victor, 2014). An estimated 100 to 140 million women and girls have had some form of FGM or FGC (FGM/C; Population Reference Bureau, 2010; World Health Organization [WHO], 2012). According to UNICEF (2013), an estimated 30 million girls between the ages of 15 and 19 have undergone the procedure. Although the practice has no health benefits, it does pose significant health threats, including pain, shock, hemorrhage, psychological trauma, chronic pain, keloid formation, and infection (Abdulcadir, Margairaz, Boulvain, & Irion, 2011; Ahanonu & Victor, 2014; Dare, Oboro, Fadioro, Oriji, & Olabode, 2004).

The cultural beliefs and reasons for the continued practice of FGM/C throughout the world include social acceptance, honor, cleanliness, aesthetics, increased pleasure for male partners, enhanced fertility, and improved marriage prospects (Dike, Ojiyi, Chukwulebe, & Egwuatu, 2012; Federal Ministry of Health Nigeria, 2007; Omolase, Akinsanya, Faturoti, Omotayo, & Omolase, 2012). FGM/C is also thought to deter women and girls from behaviors considered sexually deviant, and to ensure male control over them (Hathout, 1963; Kluge, 2009). Thus, in this study, the practice of FGM/C was presented in terms of its sociological, psychological, and physical health-related effects

on individuals and communities. Researchers and scholars have documented anthropological and historical accounts of the traditional norms that foster these surgical procedures, to some degree. However, a significant need exists to identify the contemporary influence of societal standards and individual behaviors on the practices of FGM/C (Hathout, 1963; Kluge, 2009).

The goal of this research was to review the cultural perspectives and experiences of Sierra Leone women who have undergone FGM/C in order to investigate their concerns about safety and their perceptions of the practices. In addition, I explored any concerns that mothers in Sierra Leone have regarding having the procedure done on their daughters, and what they attribute the continued practice of FGM/C to. Data from this study provides new understandings to help health and human rights organizations implement proactive safety measures for these young girls. This study was needed to further awareness regarding the trends and patterns associated with this practice on individuals and across societies.

This introductory chapter begins by providing background information to contextualize the research problem. The problem and purpose statements are followed by the research questions, theoretical framework, and nature of the study. Key terms, assumptions, scope, delimitations, and limitations are also presented. Finally, the chapter closes with a discussion of the study's significance and a brief summary.

## Background

An extensive body of literature exists on FGM/C (e.g., Abdulcadir et al., 2011; Ahanonu & Victor, 2014; Dare et al., 2004; Dike et al., 2012; Omolase et al., 2012).

According to Brown, Beechum, and Barrett (2013), FGM/C adversely affects the health and well-being of women and girls worldwide, and the practices are unrestricted in many countries. Despite the adverse effects of FGM/C, such as pain, shock, hemorrhage, psychological trauma, chronic pain, keloid formation, and infection (Abdulcadir et al., 2011; Ahanonu & Victor, 2014; Dare et al., 2004), little has been done to put an end to the practice (Brown et al., 2013). Brown et al. argued that a variety of approaches may be required to deter FGM/C practices, including decision-theoretic, community-changing, and individualistic approaches. Thus, further research is needed to explore the complex web of social and community functions that keep the practice of FGM/C firmly rooted in many parts of Africa, the Middle East, and Asia (Gele, Bø, & Sunby, 2013).

The practice of FGM/C is strongly bound by cultural norms and traditions, such as the rite of passage into womanhood (Gele et al., 2013). The removal of female genitals is an ancient tradition in many parts of Africa; the worldwide practice of FGM/C has persisted, despite the potential for political penalties (Gele et al., 2013). Many researchers have attempted to explore the reasons for the continued practice of FGM/C. For example, Gele et al. (2013) utilized unstructured interviews to investigate the experiences, perceptions, and attitudes of people who engaged in FGM/C practices in Africa. Participants were asked to discuss their understandings and perspectives of these practices and their thoughts on the potential discontinuation of FGM on community and cultural levels. These methods were valuable for gathering first-hand accounts that were free from a priori researcher bias (Gele et al., 2013). This was important because it

expanded on previous attempts to research behavioral and social aspects of FGM/C within communities (Gele et al., 2013).

In another study, Edwards (2002) and Fourcroy (2006) provided information regarding the use of FGM/C practices to ensure virginity, enhance marriage prospects, and to emphasize gender and the history of these procedures by midwives, traditional healers, birth attendants, physicians, and elderly women. The researchers explored related issues of sexual health as fundamental human rights. The cultural and traditional influences of FGM/C on women's sexuality and experiences were diverse and documented by Edwards (2002) and Fourcroy (2006). A review of the sexual satisfaction literature and other information about FGM/C presented to women suggested the procedure has numerous benefits for well-being and future psychological and sexual abilities (Fourcroy, 2006). Fourcroy's research shed light on the need for future investigation and suggested the allocation of increased initiatives for research and firsthand observations regarding this phenomenon among women.

Although many researchers have explored issues related to FGM/C within localized regions, Little (2003) provided information on the origins and history of FGM/C throughout the world. This global perspective alluded to the widespread problems associated with these procedures, including the aforementioned physical and psychological injuries. Religious reasons for FGM/C reveal culturally dichotomous viewpoints associated with this procedure at a global level, as well. For instance, an examination of the legal and ethical issues inherent to FGM/C, as well as historical and cultural considerations, allow for a contextualization of the phenomenon (Little, 2003).

The WHO (2005) provided information regarding the ethical concerns and safety recommendations for FGM/C, and discussed the abolishment of the practices. Additionally, the WHO (2010) provided information regarding health effects of FGM/C. Based on a comprehensive review of work by academics and scientists in the area of FGM/C, which is presented at length in Chapter 2, the complex and multidimensional implications of these practices on the lives of young women worldwide become evident.

## Problem Statement

FGM/C is a practice continued from generations of cultural acceptance in Africa, the Middle East, and Asia (WHO, 2010). This problem affects millions of women globally, because of the lack of implemented standards to prevent harmful, nontherapeutic medical operations from being carried out on women. Based on initiatives by the WHO (2012), as well as comprehensive sociological and anthropological research, evidence exists of the psychological and physical damage caused by FGM/C procedures (Gele et al., 2013; Little, 2003). However, a substantial need also existed for continued inquiry and understanding of the experiences and belief systems at play within specific cultural groups to better understand the effects of FGM/C on women and girls. Previously, few researchers have conducted study on FGM/C in Sierra Leone. Because these practices are strongly entrenched in individual cultural mores and norms, it is essential to investigate the practices within each culture, separately.

A gap in the body of literature existed regarding how women who have undergone FGM/C generally perceive the practice, how they perceive the relative safety of the practice, and how the mothers of the girls who underwent FGM/C feel about their

daughters going through the same procedures. Although many researchers have examined the practice and procedures of FGM/C, to date, an extensive review of the literature revealed no studies regarding the unique perspectives of women in Sierra Leone who have undergone FGM/C prior to this study. In addition to the gap in the literature, this population was chosen because of the researcher's personal generational connection with this culture.

## Purpose of the Study

The aim of this study was to explore the lived experiences of FGM/C among women from Sierra Leone, including their resiliency to overcome the physical and emotional effects of the practice. To accomplish this, I conducted semistructured, open-ended interviews, utilizing techniques of analytical observation described by Finlay (2013) and Gele et al. (2013). Through these systematic and holistic observations, I obtained evidence of the unique and pre-existing belief systems inherent to women from the Sierra Leone community that served as the study site.

Through in-depth interviews, I explored women's lived experiences to better understand the perceptions these women have concerning the practice of FGM/C. Through this inquiry, I hoped to shed light on the persistence of the practice and the resiliency of the women to overcome the trauma of the procedure. A thoughtful consideration of these objectives and a thorough review of the existing literature led to the development of the following four research questions.

## Research Questions

The research questions that guided the study include:

**RQ1.** How do Sierra Leone women who have undergone FGM perceive the practice?

**RQ2.** What concerns, if any, do Sierra Leone women who have undergone FGM have about the relative safety of the practice?

**RQ3.** How do Sierra Leone women who have undergone FGM feel about having FGM performed on their daughters?

**RQ4.** To what factors do women who have undergone FGM attribute the continued persistence of the practice?

## Theoretical Framework

The theoretical framework for the current study includes Mitchell and Oakley's (Oxford, 1986) feminist theory and Boas' (1942) theory of cultural relativism. The following sections briefly detail each of these theories. Chapter 2 includes an in-depth explication of the influence and use of these theories in existing FGM/C research.

### Feminist Theory

Feminist theory suggests that in a society, gender is the primary organizing characteristic. According to Flax (1979, 1996), feminist theory and its evolution are based on the different experiences of men and women, the oppression of women as an excluded group within society, and structure of the female oppression as a function of cultural organization (Ropers-Huilman & Winters, 2011). The concept of feminist theory can be applied to FGM/C. According to Article 5 of the Universal Declaration of Human Rights, "No one shall be subjected to torture or to cruel, inhuman, or degrading treatment or punishment" (Wynter, 1997). Mugo (1997) described FGM/C, in the name of a ritual, as a form of physical abuse. Baum (2004) stated women, as fundamentally different from

men, are subjected to androcentric cultural norms that privilege men and restrict women. The literature on feminism theory, which includes an exploration of the exploitation and oppression of women, coincided with the aim of this study. However, a challenge to this thinking is the consideration of the African worldviews and systems of thought regarding traditional and cultural standards of FGM/C practices (Ropers-Hulman & Winters, 2011). Thus, feminist theory, alone, could not provide a sufficient framework for exploring the research question of this study. Accordingly, I used cultural relativism theory in conjunction with feminist theory to create a comprehensive theoretical framework.

**Cultural Relativism Theory**

Boas first introduced the concept of cultural relativism in the 1920s. Cultural relativism theory suggests that "cultures each have their own values and ways of understanding the world and therefore each ethnic group needs to be understood in its own, culture-specific terms" (Tennekes, 1971, p. 107). Essentially, cultural relativists argue that all customs and institutions are equally valid, when considered within a cultural context (Kanarek, 2013). Cultural relativism has been used across many disciplines, especially in the social sciences (Kanarek, 2013). Given the strong cultural context within which FGM/C must be considered, cultural relativism theory provided a strong theoretical foundation for the study.

Cassman (2007) suggested in the context of FGC, unless an understanding of the ethnic, cultural, and religious rationales to the practice are considered, the international movement toward elimination of this practice is unlikely. Mitchum (2013) explained, "The process of FGM highlights many complex universal human rights and cultural

relativism arguments including, but not limited to, perspective, creation, and acceptance" (p. 587). Other researchers, such as Martínez (2005), described FGM as a matter of family honor and proper marriage, and argued that patriarchal society supports FGM as a method of maintaining women's subordination. Martínez posited that not until the families of the women, as the keepers of the tradition, eliminate the practice of FGM, will the abandonment of FGM be realized. Those interested in ending the practice cannot view FGM/C within the context or interests of Western cultural norms (Martíne, 2005). Without utilizing a cultural relativist perspective, it can be difficult to determine whether FGM/C is a human rights violation, or if the charges against the practices are an example of cultural imperialism (Oba, 2008). Together, feminism theory and cultural relativism incorporate different theoretical perspectives regarding this ritual.

## Nature of the Study

The nature of the study was qualitative and followed a phenomenological design. I explored the lived experiences of women from Sierra Leone who have undergone FGM/C to understand their perceptions and experiences related to the practice, as well as their feelings toward having their daughters experience the practice. By developing a deeper appreciation of their unique perspectives, this study sheds more light on the reasons for the continued practice of FGM/C in Sierra Leone. Phenomenology is a philosophical standpoint as well as an approach to qualitative design (Finlay, 2013). Phenomenology is a school of thought that emphasizes individuals' unique, personal perceptions and experiences in the real world (Kitson & Zietz, 2012). To gather data, I developed an interview protocol consisting of semistructured, open-ended questions,

which served as a guide when interviewing participants (see Appendix A). The aim of the interviews was to obtain detailed accounts of participants' experiences and perceptions relating to FGM/C, and to understand participants' resilience to overcome the effect of this practice. The interview protocol was the sole method of data collection in this study. By synthesizing the similarities among the varied accounts offered by participants, and analyzing this composite account, a researcher is able to reduce the phenomenon to its core essence (Wilson, 2011).

The target population in this study consisted of women originally from Sierra Leone who have undergone FGM/C. According to estimates, approximately 60% of adult women in the country have undergone the practice (Integrated Regional Information Networks, 2012). I recruited participants from within this population via emails, Skype conferences, and telephone contacts.

## Definitions

**Clitoridectomy.** Type I FGM/C that involves partial or total removal of the clitoris (Mohammed et al., 2014).

**Cultural relativism.** A way of exploring aspects of a culture through the culture-specific terms of a group or society (Tennekes, 1971). Cultural relativists argue all customs and institutions are equally valid, when considered within a cultural context (Kanarek, 2013).

**Female genital mutilation/cutting (FGM/C).** "All procedures which involve partial, or total removal of the female external genitalia, or other injury to the female genital organs for cultural or other non-therapeutic reasons" (WHO, 2008).

**Infibulation.** Partial or total removal of the external genitalia and narrowing of vaginal orifice. Also referred to as Type III FGM/C (Mohammed et al., 2014).

**Type II FGM/C.** Partial or total removal of clitoris or labia minora (Mohammed et al., 2014).

**Type IV FGM/C.** Any other international harm to the female genitalia, including cutting, scraping, burning, or piercing (Mohammed et al., 2014).

## Assumptions

A few assumptions were inherent to the study. First, I assumed all participants would be able to communicate their experiences and perceptions with regard to FGM/C. Another assumption was that the interview questions used to gather study data were appropriate for a phenomenological study, free of bias, and not leading. To ensure that the interview questions were appropriate and effectively assessed the research questions, a panel of subject matter experts validated the interview protocol prior to data collection. I assumed all participants answered interview questions fully, openly, and honestly. To encourage honest and forthcoming responses, the identities of all participants was protected. A final assumption was all participants possess the mental capacity and experience to answer interview questions.

## Scope and Delimitations

Delimitations describe the boundaries of a study (Bloomberg & Volpe, 2012). This research was restricted to approximately 20 participants from Sierra Leone who have experienced FGM/C. Although FGM/C is practiced in many cultures throughout the world, this study only pertained to the related perceptions and experiences of women

from Sierra Leone. Results of this study depended solely on participants' responses to interview questions. Although generalization is not a goal of qualitative research, similarities in participant responses and emerging themes from interview analysis may produce useful insights with wider implications (Pringle, Hendry, & McLafferty, 2011).

**Limitations**

Limitations are inherent to this study because of the broad nature of the topic itself. Within the methodology, I accounted for several weaknesses in the rationale and design. Because clear intentions existed to address the feminist perspective as well as psychological- and health-related objectives that participants may have expressed during interviews, the results were qualitative. One limitation was the collection of the appropriate number of observational reports to create substantial conclusions at the end of the project. For example, because the focus was on women from Sierra Leone, results may differ with samples of women from other nations.

The issues most related to transferability and dependability present weaknesses as well. Although specific communities were targeted for completion of the project guidelines and parameters, it is possible researcher bias influenced the way results were collected and interpreted. This limitation can be addressed in the future by the use of multiple researchers in the analysis process. Nevertheless, this is a consideration that could affect the development and transferability of responses collected from the study.

Several biases were present that may change the way that the study outcomes can be addressed and realized. Because of the use of different languages in the targeted country, translation may require someone who speaks languages in addition to those

spoken by the researcher to have a significant content or strategy behind the analysis process. This include certain elements of conversation being translated to the closest possible definition in English. In addition to researcher bias, the cultural specificity of language may have involved translator biases as well. Topics that promote biased responses relate to the economic, social, or commonly accepted beliefs about FGM/C.

However, I undertook reasonable measures to address limitations that influenced how the study was conducted. The methods of accomplishing this are detailed throughout the project with the use of careful sample collecting as well as the use of multiple investigators during the interview process to limit the potential for biases in observation. Further, the use of peer reviewed standards in collecting and analyzing data allowed for the highest quality of results.

## Significance

FGM/C is a significant problem of concern to men and women who believe in fairness, dignity, and justice to all individuals, despite religion, race, gender, and ethnicity. FGM/C evaluation must be free of cultural bias (Little, 2003). Issues related to the practice of this technique affect women and men alike at psychological and sociocultural levels. The personal experiences documented in this research study contribute to the increased understanding of traditional norms and cultural identities among women from Sierra Leone and attest to some of the characteristic behavior and decision-making practices that have lead to the propagation of FGM/C.

Although the scope of this study was limited to one cultural group, many cultures continue to practice FGM/C. The study was particularly significant because it involved

an examination of the underlying cultural and traditional reasons for the continuation of the practice, women and girls' resilience to overcome the physical and emotional consequences of the procedure, and the safety and health concerns involved with the procedure from the perspectives of the women who have undergone the procedure. I also explored mothers' perspectives of the girls who go through the procedure, and their understanding of the health consequences involved. When investigating practice, such as FGM/C, the aim must be education in order maintain sensitivity to cultural traditions and customs. FGM/C must be explored from the perspectives of the women affected by the custom to shed light on human rights violations, while remaining free of ethnocentric judgements. Because so much misinformation is propagated throughout cultures that practice FGM/C, the first step in preventing unnecessary procedures that may cause physical and psychological harm to women and girls is to provide individuals with education regarding the practice. However, to do so, women's perceptions and experiences of the practice must be understood. Education is the root of this study's possible social change implications.

## Summary

This study was a phenomenological design to explore the topic of FGM/C among women from Sierra Leone who have undergone the procedure. The cumulative evidence of past researchers suggests the existence of diversified opinions and behaviors throughout the countries that practice FGM/C. This study built on the work of contemporary scientists because of the focus on a sample of women from Sierra Leone and carefully selected questions. Each of the four research questions allow for

investigation of personal beliefs and values that women from Sierra Leone have regarding FGM/C and the implications of traditional belief systems.

This introductory chapter provided an overview of the problem. The background of the problem was presented to contextualize the study's problem, purpose, and research questions. I presented the theoretical framework, followed by a discussion of the study's nature, key terms, assumptions, scope, delimitations, and limitations. The chapter closed with a presentation of the study's significance. Chapter 2 provides a comprehensive analysis and synthesis of the existing body of related literature. In chapter 3, I detail the methodology. Study results are presented in Chapter 4, followed by a discussion of study findings, implications, and recommendations in Chapter 5.

# Chapter 2: Literature Review

## Introduction

FGM/C has become an important human rights issue to many people in the world. Still, few books or articles on international social work, psychology, and social development refer to it, even though thousands of books and articles exist on the subject (WHO, 2011). However, within anthropology it is a central moral issue, and anthropologists debate its implications frequently. In addition, few psychologists have looked at the vast literature on the subject, and thus remain uninformed about it. This review of literature offers an informed understanding about FGM/C in relation to social development and offers a scholarly review rather than a common sense understanding of this phenomenon. The review is also meant to help those who deal with the growing number of immigrants, refugees, and people seeking asylum who come from areas where it is practiced.

## Literature Search Strategy

It is essential to perform a search of the literature to acquire the information that delivers adequate information regarding the context of the study. Therefore, I performed a literature search by searching the grey literature and electronic databases. Grey literature is essential for observing the knowledge that has not been published or officially printed in journals and is not controlled by commercial publishers. This means that grey literature is disseminated faster and often offers more detail. These resources include newspapers**,** unprinted tutorials, and conference proceedings, among other sources. I also identified eligible studies through searching peer-reviewed journal articles.

A search of the electronic databases MEDLINE, CINAHL plus, PsychINFO, and PubMed electronic databases occurred along with the search of health databases and Saudi Medical Journal. The use of subject-specific databases allows a researcher to gain information in that particular field. Moreover, these databases are more refined in gathering the background information about the current topic as compared to general or multidisciplinary databases. In this study, the literature occurred by using more refined terms and key words. I also searched the grey literature, including conference papers and unpublished research articles from university library databases. These databases were selected because the university catalogue contains literature material that is extensive in a variety of topics concerning the present study.

**Inclusion and Exclusion Criteria**

Only articles published in English were included in the review. Studies targeted at the child population were included, thus excluding the studies that contain samples of the elderly population. All the studies selected for this review were full text retrievals, found using a checklist for ensuring the quality of the research. Furthermore, research that included a discussion of ethical standards and studies published in peer-reviewed journals were included in the final selection of the articles for this study. I independently reviewed and assessed the titles and abstracts to categorize the studies for the possible inclusion and exclusion criteria. The inclusion criteria depended on the selection of articles in which researchers stated the obvious reasons for implementing the framework in dealing with the issue of genital mutilation in women. Those articles that were outside the research topic and the journals written in languages other than English were excluded

from this systematic review. The articles were also considered by their recommendations and evaluated for their appropriateness to the topic under research. The keywords used were *female genital mutation*, *FGM/FGC*, *FGM in Sierra Leone*, *female circumcision*, *clitoridectomy*, *gynaecological complications*, and *infibulation*.

## Theoretical Foundation

Female oppression has been entrenched in the social fabric for generations. FGM is a form of oppression within societies. This form of oppression seems to be unique to the cultures of the Middle East and Africa, just as foot binding was to Asia (Mgbako, Saxena, Cave, Shin, & Farjad, 2010). Similarities between FGM and foot binding include, (a) both practices are universally accepted in areas that they are practiced in, even by those who do not agree with them; (b) both practices control sexual access to females and ensure chastity; (c) both are deemed necessary for proper marriage and to maintain family honor; (d) both are associated with tradition and religion; and (e) both are viewed as an ethnic marker by some. Overall, FGM and foot binding are centrally geared towards the control of women. Neurobiology or physiology and social learning theory capture the essence of FGM performed on women by women. These theoretical perspectives explain the phenomenon when the victims become the perpetrators of abuse. Conflict theory of sexual stratification explains the presence of FGM because of patriarchy or misogyny and adultarchy. According to Kallon and Dundes (2010), childhood experiences create the individual's paradigm. Different forms of trauma and neglect affect the development of the brain in different ways. Thus, this form of physical and sexual abuse lead to the overdevelopment of the brainstem and the midbrain causing

hyperarousal and hostility. Often FGM is performed on girls between birth and age 15 (WHO, 2010).

During this malleable stage in girls' lives, exposure to such extreme physical and sexual abuse often becomes cyclical so that victims ultimately perform FGM on others. Social learning theory has explained the aptitude of children to replicate the behavior of their parents or other adults. Thus, when the mother or other adult performs FGM on the child, they model the behavior by carrying out the same practice on their own children (Abdulcadir et al., 2011). Social learning theory supports the belief that those who have been mutilated will be more likely to view it as socially acceptable and, in turn, perform FGM on others. Parents and adults are supposed to nurture children and protect them from harm's way; thus, children absorb the message that this is an acceptable form of violence and continue the cycle of abuse.

Conflict theory of sexual stratification addresses the necessary components for understanding the presence of FGM within these societies (Mathews, 2011). In addition, three overarching ideologies explain the practice of FGM/C: patriarchy, misogyny, and adultarchy. These perspectives essentially deem women and children as property. Krasa (2010) purported FGM has been considered a form of child abuse, an infringement of basic human rights that is gender-based violence, and in terms of gender dynamics, is a deliberate attempt to curtail the sexuality of women in some patriarchy-dominated societies. This property can be mutilated at the will of the "owner" (men). Bewley, Creighton, and Momoh (2010) posited conflict theory of sexual stratification is instrumental in understanding the high prevalence of FGM in some places.

Conflict theory is based upon the premise that resources equate to power. Thus, solely based upon sex, men are able to obtain domination and power over women (Kontoyannis & Katsertos, 2010). The literature suggested the higher the educational achievement of women, the more reduced was the prevalence of FGM (Kontoyannis & Katsertos, 2010). The patriarchal structure has created a consciousness that has led women to believe that their main resource is their sexuality and without this resource, they have no bargaining power with a man. Kontoyannis and Katsetos (2010) stated men use sexual domination and control over women; in this case, FGM is just an extension of this form of control. Men use rape and sexual violence to exert control over women and therefore remove their resource. As stated by Momoh (2010), FGM (commonly known as female circumcision) is an extreme example of a method to manipulate women's sexuality, ensure their subjugation, and control their reproductive functions, and is common in some societies around the world. Conflict theory of sexual stratification creates the foundation for explaining ideologies, such as patriarchy and misogyny. Patriarchy has been entrenched in society for centuries. Ray (2011) asserted patriarchy, as both a structural institution and intentional deed, is often used to explain the practice of FGM/C.

Alsibiani and Rouzi (2010) make a strong argument for the presence of such a structure in the Middle East. The roots of the patriarchal structure of society thus are to be found deep in the social history of southwest Asia. According to Alsibiani and Rouzi, the society created by man dictates all behaviors and actions of men and women. The sexist ideal of men states that women are less valuable, incompetent, and inferior

(Alsibiani & Rouzi, 2010). Control and domination is the key in a patriarchal society. This view fundamentally finds women to be disposable. This sense of domination occurs from men toward two members of society: women and children. These members of society are deemed weak and dependent on men (Alsibiani & Rouzi, 2010). The patriarchal structure utilizes various practices to restrain and oppress women and children (Adam et al., 2010). The practice of FGM is a component of this patriarchal structure (Adam et al., 2010). The cutting of female genitalia is a way to obtain control of a woman both physically and mentally. This practice ensures a man the ultimate power in deciding an action that is personal and painful.

When the level of violence reaches such extreme proportions, like cutting off female genitalia, then the problem has escalated beyond discrimination and gender inequalities. The female is objectified and not viewed as a human being (Abdulcadir et al., 2011). The acceptance of this mutilation is rooted in the low level of respect and honor for the female gender. Only a strong hatred for women can condone a practice that leaves physical and psychological scars. Conflict theory can be applied to the stratification between adults and children, known as adultarchy. As stated before, conflict theory equates resources with power; therefore, it is clear that children are an oppressed group and easy targets based on their lack of power. Children are dependent upon adults for basic necessities. This leaves them helpless in society to protect themselves from abuse by adults. It is a societal norm to exert control and power over children (Chibber, El-Saleh, & El Harmi, 2011). Therefore, because men use sexual violence to oppress women, FGM is utilized to oppress female children. Adultarchy exists in societies that

are dominated by adults who do not consider the consequences that certain decisions or actions make on the youth. Societies, which are adult centered, may lead to higher rates of child sexual abuse like FGM (Chibber et al., 2011). This is because the children are deemed insignificant and their needs are not considered. These societies neglect to address issues that involve children, such as FGM. The prevalence of adultarchy explains why policies are not created to prevent and cope with FGM (Chibber et al., 2011). If prevention policies are created, it is the enforcement of the policies that is lacking.

The theoretical perspectives illustrate women and children as an inferior group dominated by men (Dalal, Lawoko, & Jansson, 2010). The patriarchal structure is entrenched into the minds of these children and causes them to become perpetrators in adulthood. In addition, this explains how acts, such as FGM, can exists and continue for centuries. Through the literature review, researchers established certain factors, such as women's education, household wealth, and place of residence, religion, ethnic group, and level of patriarchy, are linked to the practice of FGM. The reasons perpetrators of FGM give for its validation are that it preserves virginity, prevents promiscuity, increases marriage prospects, brings pleasure to the husband, and promotes hygiene. The contribution of the current research is to provide data regarding the prevalence of FGM in countries lacking data, particularly the Middle East and the southern regions of Sub Saharan Africa. Furthermore, this research was exploratory to determine if countries lacking data in the Middle East and Africa are consistent with the prevalence and correlates of FGM found in countries that do have data. From the data collected from the

survey, I was able to understand why FGM continues in some countries and why it does not in others, and this information will help with policy implications.

Although this research was exploratory, it sheds light on this practice and promotes further research in the area. It was hypothesized that FGM will be present in all of the 29 countries in the Middle East and Africa, where estimates were secured. These rates were to be in line with their neighboring countries; therefore, it was postulated that countries in the Middle East have low rates of FGM, countries in North Africa have high rates of FGM, and countries in Sub Saharan Africa have medium rates of FGM (Monagan, 2010). While keeping this literature and theoretical grounding in mind, I attempted to determine estimates of FGM and reasons for its continuation for countries lacking data on FGM in the Middle East and Africa, and to help shed a light on this detrimental and oppressive practice. The next chapter further presents the methodology used to address these areas of interest.

## Conceptual Framework

The practice of FGM is motivated by different complex sociocultural factors that are interlinked. These factors can vary between regions and countries, as well as within a country, and between practicing communities. The most important reasons given by practitioners and cultures that condone FGM are that it protects virginity, marks the passage into womanhood, curbs sexual desire, improves marriageability, and the socio-religious reasons (Davis, 2010). FGM is considered a social convention, and it is inextricably linked with the fear of facing inaccessible resources and opportunities for young women. FGM as a social convention is also linked to having multiple prospects of

marriage, social acceptance, and peer pressure (Davis, 2010). The actions of individuals are dependent on the actions of others. Different sociocultural perceptions are linked to the perception of gender, religion, and sexuality, all of which are connected to the social convention. For example, it is often believed by FGM practitioners that the clitoris needs to be removed from the women's body in order for her to become fully female. The clitoris is also perceived to be the origin of desire, and therefore it is thought that by removing it, sexual desire will decrease and lead to "decent" behavior, such as premarital virginity, marital fidelity, and ultimately, family honor (Davis, 2010). It is also perceived that the practice of FGM initiates girls into womanhood and is necessary for social cohesion and social integration. Finally, FGM is interwoven with religion and is often considered a religious requirement (Davis, 2010).

**Conceptualizing Female Genital Mutilation Through a Feminist Lens**

Feminist theory seeks to illuminate societal processes such as oppression, diversity, culture, and power differentials. No single feminist theory exists, but rather inextricably interwoven theories consisting of a broad range of perspectives. Davis (2010) stated feminist theory is, in addition to a political movement, a social vision equipped with specialized tools and knowledge that will help to encounter the root and end the subordination of women, as well as related patterns of subordination based on social class, race, ethnicity, age and sexual orientation. Similarly, Fahmy, El-Mouelhy, and Ragab (2010) viewed feminism as an analysis of women's submission for the purpose of figuring out how to alter it in progression.

In this definition, Rasheed, Abd-ellah, and Yousef (2011) identified areas that require thorough understanding and scrutiny. The first is the experiences of women and girls. Feminist theory seeks to make women's experiences visible, consequently illuminating gaps, myths, and misconceptions in knowledge that assert to be inclusive, but are actually based on White, heterosexual men with Eurocentric ideals (Rasheed et al., 2011). Feminist theory, therefore, seeks to acknowledge the negative and difficult experiences women have undergone and continue to experience. The second area of focus is the oppression women face under existing social arrangements. Rasheed et al. (2011) proposed the socialization of traditional gender roles tends to predominantly place women in a disadvantaged position. Researchers are beginning to highlight power disparities and inequalities hidden in social and cultural expectations of gender taken for granted in daily interactions. This leads to another indispensable theme that emerges from feminist theories. This third theme pertains to gender and gender associations as central to social life. This theme not only looks at the oppression of women or simply illuminates women's experiences, but also focuses on benefiting both genders by addressing and focusing on their interactions with a vision of equality.

**Conceptual Perspectives with Regard to Beauty and Appearance**

Researchers have not yet determined or studied the origin of FGM. Some perceived benefits cited by women and men who believe in continuing the practice include aesthetic beauty and increasing chances for marriage. FGM, beauty, social status or wealth, and marriage are inseparable terms in the minds of most Sierra Leone women and men regarding the attractiveness of the female gender.

Of surveyed participants, 27% of women and 21% of men believed the advantages of FGM are to show the social status of the family. In 2011, Sierra Leone was ranked 114 out of 135 countries, and scored 0.616 for the global gender gap index (WHO, 2011). This index was created to capture the magnitude and scope of gender-based disparities and track the country's progress in addressing gender disparities. National gender gaps existed in economic, political, and educational contexts as well as in health-based criteria. Country rankings based on this index made comparisons across regions and income groups, possibly spanning various time periods. In all four subindexes, Sierra Leone demonstrated substantial gender inequality. Women lag far behind men in all four indicators of economy, health, education, and politics. Sierra Leone ranked eighth among Middle Eastern and North African countries in terms of regional performance (Kaplan-Marcusan et al., 2010). Sierra Leone, like most Arab and African countries, has a social system built upon segregation of sexes and partial exclusion of females. Sierra Leone is also a patriarchal society that reflects patterns of behavior and thinking inspired by a value system based on honor as dictated by men. Although this characteristic is apparent at the societal level, White Moorish women have substantial power at the household level compared to women from other ethnic groups. A famous Hassaniya proverb states, "What a woman decides during the night, a man will execute it in the next day" (Krasa, 2010, p. 271). This proverb is also reinforced by the fact that men in Sierra Leone play little or no role in the decision treatment of girls. The decision to enact FGM is usually a female one (Krasa, 2010). Based on these perceived benefits, a decision is usually made within the family, usually the mother or grandmother.

## Literature Review Related to Key Variables and Concepts

### Influence of Gendered Power and Culture on FGM

Culture, gender, and power are some of the social processes linked to the perpetuation of FGM (UNICEF, 2010). Therefore, it is crucial to identify and recognize how these societal processes contribute to relationship functioning and, ultimately, the eradication of this practice (UNICEF, 2010). Researchers also need to recognize that accepted social patterns exist in places that traditionally have placed women at a disadvantaged position in most societies that carry out FGM. Through the exploration of the concepts of gender role attitudes, power, and collectivist cultures, I employed a feminist ideology to establish how concepts, such as patriarchy and subjugation to cultural influence, the practice of FGM, and consequently, the effect of this practice on women and its effects on marital satisfaction.

### FGM and Gendered Power

Akin to other sociocultural preferences, FGM is practiced under the implicit or explicit blessings of the patriarchal authority structures that ubiquitously prevail in most societies. Throughout history and across diverse cultures, the structural context of FGM and other types of harmful rituals, such as abortion of female fetuses, female infanticide, and foot-binding, have been accepted and acknowledged privately or publicly both by laymen and political patriarchal powers (Oloo, Wanjiru, & Newell-Jones, 2011). Kenyan culture is predominantly patriarchal, and men continue to hold dominant positions in the political arena, whereas women are mostly relegated to the private-domestic sphere in which their activities are limited to childcare and household chores (Oloo et al., 2011).

Women are therefore consigned to subordinate positions and males to influential positions of power and decision-making at large. The perpetuation of FGM is closely linked to a woman's survival within her community and family in a multigenerational context of male dominance (Uhl, Nessler, & Schneider, 2010). Considering some of the reasons put forth for the perpetuation of FGM are based on patriarchal perceptions and needs, such as to improve marriageability, male pleasure, and loyalty to husband, it is of paramount importance that the eradication of FGM be considered within a broader context that integrates patriarchy. Men are at the helm of the hierarchical power structure in most societies that practice FGM. Consequently, it is imperative to integrate this substantive influence in efforts both to understand and eradicate FGM.

**Collectivist Culture**

Mgbako et al. (2010) stated culture is to society what memory is to individuals. These researchers stated that culture consists of transmitting those experiences that worked to future generations. These experiences may consist of norms, traditions, rituals, and unstated assumptions. They are transmitted using time, place, and language. According to Mgbako et al. (2010), in the first aspect, the group and the self are reliant on each other and share resources among group members. The second aspect places the group's goals above individual ones. In the third aspect, social behavior is guided by a sense of obligation, duty, and responsibility in the execution of cultural principles in an obligatory manner. The last aspect puts emphasis on relationship, even at the disadvantage of individual group members (Mgbako et al., 2010). These definitions guide the discussion regarding how a collectivist culture influences FGM.

**FGM and Collectivist Culture**

Berer (2010) noted cultural belief and collective problem solving contribute significantly to the wherewithal of Kenyan families. This means that resources for emotional, financial, and spiritual well-being are obtained through sustained harmony between cultural belief and collectivism. Additionally, the literature suggests the African self-concept is defined by feelings toward riches, properties, family, and position in the community (Kizilhan, 2011). Consequently, it is through the comparison of oneself with the outer world that the individual is best understood, because changes in the outer world delineate the solidity of the self. Thus, the African self-concept consists of seeking peace and harmony with others, instead of mastery of self and things. This view likely influences how people think of marital satisfaction. As a result, family, kin, cultural beliefs, traditions, and status in community become the most significant features of one's life (Feldman-Jacobs & Clifton, 2010). Therefore, the perpetuation of such harmful practices, such as FGM, are the result of such collectivist ideologies where community systems of socialization and organization are centered on tradition and rituals, a subjugation to culture and tradition that oppresses and harms women. In these collectivist FGM practicing cultures, women are discouraged to speak up or to be noticed, and above all, they are discouraged from questioning the rules and roles in place within a traditional gender and cultural structure. Consequently, women in these cultures are taught to value harmony, avoid arguments, and use indirect styles of dealing with conflict, struggle, and pain. Hence, even if they may disagree or hate the practice of FGM, they are unlikely to

speak out. Women in patriarchal and collectivist cultures are treated as second class and are taught to be subordinates to men.

**Sexual Effects of FGM**

When viewed through the feminist framework, FGM unnecessarily perpetuates women's sexual oppression. Belluck (2010) conducted a sexual function comparison between women who had undergone FGM and those who had not in Jeddah, Saudi Arabia using an Arabic version in translation of the Female Sexual Index Questionnaire. In this investigation, FGM was found to be more likely to negatively affect women's sexual experiences by affecting arousal, lubrication, orgasm, and satisfaction. Additionally, approximately 70% of genitally mutilated females were fearful of their initial sexual encounter because they expected it to be painful. Infibulated women in Alo and Gbadebo's (2011) study experienced long-term painful sexual intercourse and menstrual periods. More than 21.6% of mothers in Sharkia governorate, Egypt considered FGM to be a cause of sexual dissatisfaction for them (Dave, Sethi, & Morrone, 2011).

**Psychosexual and Psychological Effects of FGM on Women**

According to the study on psychosexual effect of FGM conducted on Egyptian women in Ismailia, Egypt, circumcised women reported significant psychosexual difficulties, such as less sexual activity, decreased enjoyment of sex, decreased frequency of orgasm, less synchronization of orgasm with their husbands, and a general sexual phobia. Additionally, women in the Niger Delta in Nigeria who had undergone FGM described the practice as painful, causing frigidity and a lack of sexual satisfaction, and wished they never had gone through the experience (Fahmy et al., 2010). Victims of

FGM were found to exhibit frustrations and psychological disorders and further experienced increased vulnerability and marginalization as foreigners according to Somali FGM victims in Pennsylvania. An increased pervasiveness of post-traumatic stress disorder (PTSD) and other psychiatric syndromes were exhibited among circumcised Senegalese women than uncircumcised ones. In addition to PTSD, victims of FGM also experienced memory problems. Other psychological effects, such as sexual phobia, fear of gynecological examination, and horrible memories, were also recorded among FGM victims. Of particular interest is the observation made by Herbenick et al. (2011) that women who had undergone FGM were not only likely to perpetuate FGM, but they also accepted and justified wife battering. This implies that FGM strongly exacerbates psychological challenges that beleaguer the female gender in most societies. The psychological and psychosexual types of oppression stemming from the investigations highlighted here are effortlessly recognizable via the feminist framework. Moreover, these psychological and psychosexual oppressive effects of FGM further contribute to the maintenance of the oppression of the FGM victim's desire to circumcise their daughters.

**Medical Effects of FGM**

The medical effects of FGM clearly demonstrates the oppressive nature of FGM as recognized through a feminist lens. Additionally, the varying traumatic medical effects associated with the four types of FGM procedures are synonymous with levels of oppression. Consequently, infibulated women are perceived to be more oppressed than those who have undergone a clitoridectomy or excision procedure. Diverse medical

complications are reported in the FGM literature. Johnsdotter and Essen (2010) noted the immediate health consequences in genitally mutilated women tend to include pain, swelling, recurring infection, bleeding, and fluid retention. Long-term health consequences included perineal tears, perineal scaring and cysts, urinary retention, infections, and pelvic infections. Other observed medical problems were dyspareunia, dysmenorrhea, obstetrical difficulties, urinary tract-related problems, severe pain and hemorrhaging, labia adhesion, excision of a paraclitoral cyst, adnexal pathology, urinary problems, defecation problems, immobilization, menstrual problems, and tearing in the scar resulting in a new infibulation. Other researchers have found women who have undergone FGM tend to have more complicated deliveries, usually by caesarean section. These deliveries often also include postpartum hemorrhage, episiotomy, death of mother, extensive maternal hospital stay, and resuscitation of the infant compared to deliveries by women who have not undergone FGM (Barber, 2010). Severe bleeding and pain are the main short-term medical complications associated with FGM with the long-term effects varying significantly.

**Effect of FGM on Relationships**

Although much of the research regarding the effects of FGM has focused on the individual in regards to physical, psychological, and psychosexual outcomes, a need exists to examine the effect on relationships. Currently, many gaps exist in the literature regarding how the practice of FGM influences relationships' health. Before identifying these specific gaps, it is important to frame the concept of relationship health. One such definition can be found in feminist theories (Khaja, Lay, & Boys, 2010). Feminist

theorists advocate gender equality as the agent of overall relationship success. Relationship success cannot take place without equality, as these two are closely linked. One of the foremost feminist concerns is the heavier burden women carry in caring for the relationship. With the carrying of this heavier load, along with power issues ingrained in couples, women's personal health and well-being are jeopardized, leaving women feeling overwhelmed, stressed, and isolated in the relationship. Therefore, the link between equality and relationship success is crucial because inequality in the relationship results in partners hiding their innermost thoughts and feelings. Recent research pertaining to gender has focused on how gender role attitudes explain the connection between spousal support and relationship satisfaction. Khaja et al. (2010) examined the relationship between gender and gender role attitudes on spousal support and marital quality. The researchers found marital satisfaction was improved by emotional support from the spouse and resulted in less conflict for traditional women and men who believed in gender equality, but instrumental and emotional support resulted in marital satisfaction for women who believed in equality and traditional men (Khaja et al., 2010).

The results of the Khaja et al. (2010) study suggest spousal support contributes significantly to relationship satisfaction and quality. This research shows that more often than not, "emotional work" is driven by women, negatively affecting women's psychological and physical well-being (p. 119). Women taking on this emotional work are often associated with societal expectations "to be caring and nurturing" rather than to be "cared for" (p. 211). Aside from the "emotional work," Ahmed and Abushama (2011) coined the term, *second shift* to describe the dual responsibility women have in earning

income in addition to running an efficient household (p. 209). The researchers also detailed the negative effect this burdening dual role has on women while shedding light on the negative effect of traditional belief systems around gender roles and "men's and women's work" (Ahmed & Abushama, 2011, p. 247). Spousal support therefore extends from instrumental (division of household labor, financial) to emotional support (caring and mutual relational responsibility) in understanding relationship satisfaction.

Elsayed, Elamin, and Sulaiman (2011) found emotional support to be a significant predictor of couple relationship satisfaction and decreased conflict more for women than for men. In another study, Oloo et al. (2011) concluded that when it comes to understanding relationship satisfaction and quality, knowing an individual's gender alone is insufficient. It is vital to know his or her gender role attitudes to understand the link between spousal support and relationship satisfaction. When viewing the literature on FGM through this lens of feminism, a number of concerns exist to be addressed and explored empirically. The following areas are issues proposed to be affected by the practice of FGM.

**Relationship Satisfaction and FGM**

Reasons for FGM by those who believe in the practice include the initiation of girls into womanhood, prevention of promiscuity, suppression of libido in females, better marriage prospects, and enhancement of male sexuality. Generally, FGM practicing communities believe that undergoing FGM guarantees premarital virginity and postmarital monogamy. These ideas are then generalized in these cultures to relationship health and satisfaction. Across diverse cultures and throughout history, FGM and other

similar detrimental rituals have been reported to result in marital and relational problems in families. Cultural feminists would argue practices, such as FGM, are oppressive in nature and are cultural manifestations of gender-based oppression that violate women's rights. Because of the paucity in the literature regarding the effect of FGM on relationship satisfaction, I proposed to explore this phenomenon.

**Sexual Satisfaction and FGM**

FGM continues to have a significant negative effect on families and on couples' sexuality. In a study on the psychosexual effect of FGM, researchers found circumcised women to have significant psychosexual difficulties, such as decreased sexual activity and enjoyment of sex, lower frequency of orgasm, less synchronization of orgasm with their husbands, and a general sexual phobia (Dattijo, Nyango, & Osagie, 2010). Additionally, women in the Niger Delta in Nigeria who had undergone FGM described the practice as painful, causing sexual aversion and lack of sexual satisfaction. The women also wished they never had gone through the experience. Using the Female Sexual Index Questionnaire translated into Arabic, Vloeberghs, Knipscheer, van der Kwaak, Naleie, and van den Muijsenbergh (2010) compared sexual function between women who had undergone FGM and those who had not in Jeddah, Saudi Arabia. No significant statistical differences existed between the two groups in the desire and pain score. However, statistically significant differences occurred in the arousal, lubrication, orgasm, and satisfaction scores. Furthermore, approximately 70% of genitally mutilated females had fearful and painful initial sexual intercourse expectations, as cited in another study by Dattijo et al. (2010).

Infibulated women in Suardi, Mishkin, and Henderson's (2010) study experienced long-term painful sexual intercourse and menstrual periods. More than 21.6% of mothers in Sharkia governorate, Egypt considered FGM to be a cause of sexual dissatisfaction. In the investigation of effects of FGM on the onset of sexual activity and marriage in Guinea (with a 97.9% FGM prevalence), Raya (2010) found only a minority of people believed FGM is important as a means of sexual control and to enhance marriageability. Hence, FGM appears to fall short of its purported objectives, such as sexual control and enhancing marriageability, but unnecessarily contributes toward women's sexual dissatisfaction.

**Intimacy and FGM**

In a study conducted in Ismailia, Egypt, 250 women patients of Maternal and Childhood Centers (a family planning center) were randomly selected, gynecologically examined, informed of the nature of the study, and interviewed to investigate their intimate sexual activity. The study results showed 80% of circumcised women had dysmenorrhea (no menses), 48.5% had vaginal dryness during intercourse, 45% had a lack of sexual desire, 28% had lowered sexual desire per week, 11% had less initiative during sex, 49% were less pleased by sex, 39% were less orgasmic, 25% had lowered frequency of orgasm, and 60.5% reported difficulty reaching orgasm (Suardi et al., 2010). These reports point clearly at the negative effect of FGM on couples' sexual intimacy. Women who experience painful intercourse have been known to "fake orgasms," wishing that the sexual activity was over quickly to bring an end to the physical and emotional pain they experience (Suardi et al., 2010).

Enjoyment for both the woman and her partner is diminished during intercourse, reducing the woman to a masturbatory object during sex, and robbing the couple of true and mutual relational intimacy (British Medical Association, 2011). This assault of the female organs may have a profound effect on both the woman's psyche and consequently on her intimacy with her partner, as it leads to psychological disturbances and impaired sexual desire and performance. When a woman believes a part of her is missing and it is irretrievable, her self-esteem is decreased and her self-worth diminished. As a result, a couple may experience relational problems in their intimacy if their sexual activity consists of intercourse and the woman is reluctant to engage based discomfort and negative emotions.

**Gender Role Attitudes and FGM**

Akin to other sociocultural preferences, FGM is practiced under the implicit or explicit blessings of the patriarchal authority structures that ubiquitously prevail in most societies. Throughout history and across diverse cultures, the structural context of FGM and other types of harmful rituals, such as abortion of female fetuses, female infanticide, and foot-binding, has been accepted and acknowledged privately or publicly both by laymen and political patriarchal powers. Because Kenya is predominantly a patriarchal society, men continue to hold dominant positions in the political arena, whereas women are relegated to the private-domestic sphere, in which their activities are limited to childcare and household chores. Women are therefore relegated to subordinate positions and males to influential positions of power and decision-making at large (McVeigh & Sutton, 2010). The perpetuation of FGM is closely linked to a woman's survival within

her community and family in a multigenerational context of male dominance. Considering that some of the reasons put forth for the perpetuation of FGM are marriageability, male pleasure, and loyalty to husband, it is of paramount importance that the eradication of FGM be considered within a broader context that integrates the patriarchy in eradicating it. Even a cursory glance reveals men to be at the helm of the hierarchical power structure in most societies that practice FGM. Consequently, I integrated the gender role attitudes variable in this study, as it has been known to have a substantive influence in efforts of eradication and perpetuation of FGM.

**Spousal Support and FGM**

In addition, the majority of health care providers in FGM prevalent countries are either victims of the practice, FGM practitioners, or, if males, condone and perpetuate the practice. No researchers have conducted studies on the role of spousal support and FGM. This study filled the gap in the literature. In the present study, I hypothesized that couples who demonstrate mutual support are more likely to have a healthier and happier marriage as opposed to those who do not. McVeigh and Sutton (2010) indicated four components healthy couples demonstrate in their interactions: mutual attunement, shared vulnerability, shared relationship responsibility, and mutual influence. Through the investigation of the spousal support variable, it is hypothesized that individuals with higher scores of spousal support will also have a higher level of marital satisfaction.

**Location, Education, SES and FGM**

Socioeconomic status (SES), geographical location, and ethnic background are among the chief factors that largely influence the eradication and perpetuation of FGM.

The Kenya Demographic and Health Survey (KDHS, 2008) showed regions with lower educational levels and lower SES had higher FGM prevalence. Communities with more than a secondary education had a prevalence of 26.0% in 1998 and 19.1% in 2008, as opposed to no education (50% in 1998 and 53.7% in 2008). An increased level of education among women is observed to decrease their tendency to perform FGM on their daughters as investigations by Rahlenbeck, Mekonnen, and Melkamu (2010) revealed. In addition, women in rural areas were shown to be more likely than women living in the urban areas to carry out FGM on their daughters. Geographically, levels of FGM prevalence were higher in rural areas than in urban areas. Ethnically, specific groups were known to practice FGM more than others were. In Kenya, examples of such groups are the Masaai, Kisii, and Somali at approximately 96% in 2008 versus the Luhya, Luo, and Mijikenda at lower than 10% in 2008. Consequently, the reasons for undertaking female circumcision vary significantly depending on factors, such as geographical location, cultural heritage, demographic description, and SES.

**Physical Consequences of FGM**

Complications of FGM, both short-term and long-term, tend to be disastrous for the female victim. Although physical sequelae are most common in the medical literature, the sexual and mental effects and the frequency of the complications are neglected. Complications of FGM depend on type (degree or classification) performed, ability of the circumciser, age of the girl, operating conditions (lighting and sanitary environment), instruments used (razors, knives, or jagged rocks), presence of antiseptics, and use of traditional bleeding-reducing products, in addition to other variables. Complications can

also be classified as physical (immediate, late, and obstetrical), psychological, and psychosexual. According to UNICEF (2010), two forms of complications occur during and after the procedure: (a) immediate complications, which include hemorrhage, shock, severe pain, infection, damage to adjacent tissue, tetanus, urinary problems, incontinence, dribbling, recurrent infections, broken bones, sepsis and septicemia, HIV, and Hepatitis B infection; and (b) late complications, which include obstetric complications, such as long, obstructed, painful and difficult labor, fetal brain damage and fetal loss, urethro-vaginal and recto-vaginal fistulae in all instances of the procedure. In addition, death is always a possibility.

**FGM in Gynecological Practice**

Type III infibulation causes late complications, such as inclusion cysts, recurrent vaginal and urinary infections, and coital problems and infertility. Although gynecologists are familiar with such pathologies, they may be unaware of the cause and circumstances. Chronic urinary and reproductive tract infections and pelvic inflammatory disease are also linked to FGM, and are of particular importance because they are among the leading causes of infertility. According to Kizilhan (2011), a relationship exists between FGM and long-term reproductive morbidity; prevalence of maternal mortality among women 15–54-years-old who had undergone FGM showed damage to the anus, vulval tumors (cysts, keloid), and reproductive tract infections (RTIs). Women with FGM have an increased risk of HIV transmission, because of scar tissue and the small vaginal opening resulting from infibulation, which together make cuts and tears during sexual intercourse more likely. HIV may also be transmitted when groups of children are

mutilated using the same instruments (Kizilhan, 2011). In practicing nations, defibulation is performed during childbirth using instruments that are not properly sterilized, and could result in the transmission of HIV from infected individuals. Prevention of the practice of FGM, which exposes women and girls to such fatal risks, is the central solution to avoid this risk.

**Psychological Consequences**

FGM is a highly traumatic and bloody experience performed on a female, usually a child, often without anesthesia. It is often accompanied with physical violence perpetuated by the child's mother and members of the family. As a result, this horrifying act can be seen as abuse, which bears severe consequences, both short- and long-term for the victim, and whether physically, psychologically, knowingly or unknowingly to the victim. According to Mgbako et al. (2010), this practice can be compared to an incest situation, as both occur within a domestic setting, with the consent and possible help of those family members meant to protect children, rather than perpetuating torture by supporting the circumciser. The delayed complications of FGM may trigger the onset of emotional trauma, anxiety, depression, fear of sexual relations, chronic irritability, hallucinations, and PTSD. FGM complications may also interfere with a girl's social life, as health problems and incontinence are not conducive to full, attentive participation in social activities.

In sexual relations, difficult penetration and suspicion of infertility may come to be arguments for divorce. Psychosexual consequences result, as mentioned earlier, and intercourse and conception tend to be highly difficult for women with Type II FGM

because of tough fibrotic skin closing the vaginal opening or severe scarring in the vaginal region. These issues are all related to cases of infertility, which, as mentioned earlier, can have unfortunate social consequences for women in regions where FGM is practiced. In an Egyptian study, researchers examined women who had experienced the procedure and found 10% felt less female; 30% had less libido, were more passive, and felt repulsive; 60% had low scores for frequency of sex; 25% felt no arousal during intercourse; 50% felt pain during intercourse; 56% experienced no orgasm; 1% engaged in exclusively anal sex; 5% suffered from depression because of relationship issues; and 6% eventually divorced, compared to 1% in their uncircumcised counterparts (Berer, 2010).

**Epidemiology**

The practice of FGM is deep-rooted in many countries: approximately 6,000 girls per day undergo circumcision, most of which is performed by non-medical personnel and involve severe health risks, including death. Proponents of FGM present various rationalizations for the act:

1. It is a fertility rite: clitorial incision and apparition of a blood drop symbolize fertility. It is a correction of a natural aberration of the uselessness of male foreskin and female clitoris.
2. It is deemed as a fight against nymphomania.
3. It is believed to prevent birth trauma.
4. It is associated with social and political control and ties.

5. It is regarded as an important cultural ritual of passage that must be preserved to maintain cultural identity as required by the Koran or Bible.
6. It is deemed that the clitoris is dirty and evil.
7. It is believed that the clitoris causes male impotence.
8. It is believed that the clitoris contains a poisonous substance that kills babies during childbirth.
9. Practitioners believe excisions prevent the production of foul-smelling secretion.
10. Proponents believe FGM ensures virginity and chastity.
11. Proponents believe uncircumcised women will be rejected as marriage partners and have no social value.
12. FGM is believed to increase women's femininity.
13. Among some societies, FGM prevents social ostracism, stigmatization, and scapegoating.
14. It is believed FGM produces more male sexual satisfaction.

The ritual of FGM is unfortunately a clandestine global phenomenon. Worldwide, 100–140 million girls and women have undergone FGM in approximately 40 countries, 28 of which are African, a few in Asian countries (such as Indonesia, Malaysia, Maldives, and the Philippines), and increasingly amongst immigrant population groups in Europe, United States, Canada, parts of Brazil, Australia, and New Zealand. Despite the implied religious correlation thought to contribute to the act, FGM is not commonly practiced in Iran, Iraq, Jordan, Libya, Pakistan, Saudi Arabia, Yemen, and Turkey. This

indicates FGM is not inherently a religious practice based on the Muslim faith, but is rather a phenomenon dependent on cultural interpretation. Thus, communities that identify as Christian (Copts, Orthodox, Protestants), certain Jewish sects (Falashas in Ethiopia and their descendants in Israel), or members of indigenous religions may also practice the ritual. These miscorrelations may have been drawn from the view that the principal religion in countries where the practice is widespread tends to be Islam. However, religious leaders view the ritual as a cultural trait and not religious dogma (WHO, 2011).

**Epidemiological Findings**

Countries with laws or regulations against FGM include Burkina Faso, Cameroon, Cote d'Ivoire, Senegal, Togo, Ethiopia, Gambia, Benin, Eritrea, Kenya, Niger, Tanzania, Uganda, Central African Republic, Djibouti, Ghana, Great Britain, Guinea, Sudan, Sweden, and the United States. Laws against assault and child abuse, including FGM, exist in Canada, France, and the United Kingdom (WHO, 2010). Historically, FGM results in high maternal mortality. In traditional settings, untrained midwives perform the procedure on girls between 1 week and 17 years old, with the norm occurring at puberty (WHO, 2010). The procedure typically occurs without antibiotics, anesthetics, antiseptics, or analgesics, and with the victim typically restrained by family members. Instruments of choice, which may be without sterilization and in mass ceremonies back-to-back, range from razor blades, sharp stones, broken glass, and kitchen knives, to even the teeth of the midwives. The female is then infibulated with thorns, adhesives made of eggs or sugar (WHO, 2011). According to a study reviewed by Rasheed et al. (2011),

among a group of 290 Somali women, 88% had undergone Type III; 39% experienced immediate complications, such as hemorrhage, infection, and urinary retention; and late effects were seen in 37% of these women, such as dysuria, clitoral cysts, and poor urinary flow.

The mortality of girls having undergone genital mutilation is unknown, as few death records are kept because the practices are typically not reported. According to the World Health Organization (WHO; 2010), the mortality rate is estimated to be as high as 1%. In a morbidity and mortality study in Egypt, where the majority of the interventions are of Types I and II, researchers reported that 1,300 girls died annually because of FGM. This means that approximately one in every 500 to 1,000 circumcisions end with the girl's death. According to Krause, Brandner, Mueller, and Kuhn (2011), evidence exists of the association between FGM and health complications. The severity of the complication depends on various factors, such as the skill of the practitioner, the condition of the women undergoing the procedure, sanitary conditions, and the degree of excision performed. Evidence shows that the higher the degree of excision (for instance Type III is higher than Type II), the higher the risk and degree of complication, and women who had not experienced the operation were significantly less likely to experience health complications than their circumcised counterparts.

**FGM in Sierra Leone**

The overall prevalence of FGM in Sierra Leone is 71%. This rate varies depending on location, region, education, and the ethnic group (Kallon & Dundes, 2010). For example, the prevalence rate of FGM in rural areas is 77%, and in the southeast zone

it is 97%. The prevalence among women without education is 72%, and the rate is 80% among those with only Koranic education (Kallon & Dundes, 2010). Among the many ethnic groups of Sierra Leone, the rates vary. The prevalence rate among the Soninke is 92%, and the Poular (71%) and the Arabs (72%) have similar prevalence rates. Only 28% of the Wolof, on the other hand, perform FGM. The majority of FGM practiced in Sierra Leone are Types I and II and it typically occurs at an early age ranging from a few weeks old to 3 years of age (Kallon & Dundes 2010). The vast majority of surveyed women (71%) were cut by traditional circumcisers, 37% were cut by an old woman, 28% by a circumciser, 6% by a traditional childbirth attendant, and only 1% of FGMs were carried out by health care provider (Kallon & Dundes 2010). Women whose daughters were cut reported that more than a half (52.3%) had at least one medical complication during or after the procedure, and more than a quarter (27%) had at least two complications (Rasheed et al., 2011). Almost a quarter (24.6%) of these victims suffered from excessive bleeding (hemorrhage), 25% had difficulties passing urine, more than one fifth (23%) had some cicatrization problems, 17% experienced an infection, and 12% had a swelling of the genital organs (WHO, 2011).

**Legal Issues**

In the 20th century, there have been several attempts to eradicate the practice of FGM/C. During the early part of the century, Christian missionaries in Africa tried to stop the tradition, but their attempts were largely unsuccessful. Additionally, some African and Colonial governments also attempted to ban it, but their efforts were unsuccessful as well. The earliest law banning female circumcision was passed in Sudan

in 1946, but the law had almost no success and Sudan's current infibulation rate is 89%. In 1982, Kenya's President Daniel Arap Hoi outlawed FGM/C after the deaths of 14 girls who had been excised. However, the present excision rate in Kenya is 50%. In Egypt, President Mubarak agreed to push through legislation banning the procedure; however, the Egyptian health minister, Dr. Ali Abdul Fatah Omaar, declared they had no plans to ban the practice and stated Egypt was attempting to create a system in which the operation would be done exclusively by qualified doctors, with proper medical supervision. Egypt's excision rate is also 50%.

In Europe, the United Kingdom banned FGM/C in 1984. Both Sweden and Switzerland have enacted legislation against it and France, Belgium, and the Netherlands, while having no specific legislation against it, have all taken a position against the procedure. More recently, international agencies, including the U.N. Population Fund, the U.N. Children's Fund, and the U.N. Convention on the Rights of the Child, have adopted resolutions against FGM/C. Additionally, the International Federation of Gynecology and Obstetrics and the WHO published a joint statement in 1992 calling for the practice of female circumcision to be abolished. In September 1996, U.S. Congress passed a law that makes the performance of FGM/C illegal on any one under the age of 18. Many states in the United States have followed suit, as well. California, Minnesota, Tennessee, Rhode Island, and North Dakota have passed laws that specifically criminalize FGM/C. The WHO (2011) further noted it is widely believed that criminalization of FGM/C is only one step towards eliminating the procedure and that criminalization alone will not eradicate it.

**Health and Social Care Needs**

According to Mathews (2011), for a practice that has occurred for such a long period, an unusually small body of literature exists that explores FGM/C. In the 1930s and 1940s, the first known English-language literature was written by British colonial physicians who observed FGM/C from a medical perspective and subsequently wrote about their experiences. Later in the century, the examination of FGM/C was found within general texts on the role of women in Arab Society. However, in the 1990s, because of the influence of the feminist movement and a growing focus on women's health issues, attention has turned to the practice (Mathews, 2011). The early literature almost exclusively pertained to FGM/C as a tradition occurring in other countries. Most researchers also examined the severe health complications from FGM/C, especially infibulation. Additionally, most of the previous literature regarding FGM described the different types of operations and the medical consequences, especially from infibulation.

More recently, gynecologists and, especially, nurses and midwives, have begun to examine the issue of FGM/C with more focus turned to the necessity for health care workers to understand the medical protocol for managing FGM/C of women and girls (WHO, 2011). Furthermore, although the literature addresses the health complications from FGM/C, most of the literature does not identify health care providers' knowledge or their training needs on the subject. In fact, only within the past few years, has more literature emerged that shows the lack of education that health care workers have regarding the subject of FGM/C (Mathews 2011).

Evidence is also emerging indicating that health care workers not only have inadequate information about the medical procedures necessary for FGM/FC patients, but that they also lack the necessary cultural information to interact with those patients in a culturally sensitive manner. Research shows health care providers need to be culturally educated with regards to FGM/FC. Mathews (2011) found health care professionals need to gain an understanding of some of the cultural issues influencing the practice of FGM/FC. The researcher stated for effective care, health care professionals and social workers must demonstrate an understanding of FGM/FC to those who are affected (Mathews, 2011). Health care practitioners are confronted with many challenges when facing this population: language barriers, a lack of cultural understanding, and a lack of knowledge as to the appropriate medical procedures. Furthermore, where FGM/FC women are entering hospitals and clinics, clinicians may be faced with additional distinct problems, such as women who have been circumcised themselves and require care, and women who want to be reinfibulated after childbirth. Research also points to some of the other difficulties health care providers face. The health care worker must weigh the legal and ethical issues along with sensitivity to the cultural issues the family presents.

Mathews (2011) further stated those same providers do not condone the procedure, but can be sympathetic to the woman who has had it done to her. Research also shows that health care workers may be shocked or dismayed when they encounter women who have been circumcised. Health care workers may also react to seeing those who have been infibulated with anger and consider the practice "barbaric and abusive." One woman reported, when entering a U.S. hospital to give birth, the nurse entered the

room to prepare her for the delivery and subsequently screamed and dropped a bowl of water on her bed upon seeing her infibulated vagina (Hess, Weinland, & Saalinger, 2010). Infibulated women who require care may also experience reasons for anxiety: those Western health care workers will not know how to address their problems and concerns. In one study, Hess et al. (2010) asserted women feared receiving poor care at the time of delivery because few health care practitioners knew how to provide care for an infibulated woman. Likewise, other studies of Somali women in San Diego showed these women wanted a health practitioner who was informed about their infibulation. In addition, infibulated women have entered hospitals in Europe and the United States where medical practitioners did not understand the medical care required by FGM/FC women (Hess et al., 2010). In England, Jane Wright (UNICEF, 2010) noted there continues to be a needed increase in awareness and education for nurses and midwives who may encounter FGM. UNICEF (2010) urges health care practitioners to become familiar with the cultural issues around FGM/FC.

**Future Data Needs**

Health care practitioners as well as those women affected by FGM/FC need to be educated about the consequences of the practice. The likelihood that Somali girls have been circumcised was shown by a WHO (2010) study of Somali women. The study indicated most had already or were planning on having their daughters circumcised. Chibber et al. (2011) stated health care workers should be aware that Somali girls over the age of 7 have probably been circumcised. Besides difficulties associated with the initial operation, the consequences of FGM/FC are unknown in young girls and further

research needs to be conducted regarding the difficulties that infibulated adolescent girls are likely to experience. It has been asserted that adolescent girls who have been infibulated are likely to present specific challenges, especially to social workers. The WHO (2011) stated these girls are especially vulnerable to developing psychosexual identity problems because they are in settings different than their peers. Psychological difficulties for adult women were noted as well in an interview with Dr. G. Parham (personal communication, April 27, 1994) from the University of Arkansas Medical Center, who practiced in the Sudan and has performed de-infibulations in the United States (Elsayed et al., 2011). Dr. Parham stated women who had already been circumcised and then immigrated to the United States had more severe psychological consequences, presumably because of the increased awareness of what had been done to them. The doctor also noted the low self-esteem of women who had been infibulated. This occurred because of the pervasive belief in societies that routinely perform FGM/FC—that women are less clean and filled with insatiable lust. This teaching role presented by the issues surrounding FGM/FC may be filled by perinatal care providers, public health educators, and social workers. Researchers have noted professions need to be sympathetic with these women, instead of being straightforward in the context of Western culture and referring to this procedure as a form of sexual mutilation (Momoh, 2010).

Recording methods for FGM/FC must be developed to accurately assess the number of affected women and girls and the medical complications that result. Momoh (2010) suggested a possible approach to assessing the effects of FGM/FC can be adding a

specific code to the International Classification of Diseases Clinical Modification (Version 9 is in use, referred to as ICD-9-CM). This system would then enable researchers to conduct an automated computer search of the appropriate codes, which would allow monitoring of the health effects of FGM/FC. However, this approach is limited in its comprehensiveness because it only measures the health effects of FGM/FC and does not reflect the prevalence of the practice (Momoh, 2010). Social workers must go hand-in-hand with obstetrical nursing practitioners in developing training plans for FGM/FC affected women and their families (Momomh, 2010). Obstetrical nurses, doctors, and social workers are three professions in which workers will initially come into contact with FGM/FC women. However, little attention has been paid to the training needs of these three groups (Momoh, 2010).

Through this literature review, I found materials on FGM/FC in health, public health, mental health, anthropological, and law journals. However, no literature regarding FGM/FC exists in social work journals. The psychology and social work fields have not directly addressed this issue, but will need to address it in the future. However, some researchers mentioned the need for psychologists and social workers to become informed and knowledgeable on this issue (Hamoudi & Shier, 2010).

**Justifications for the Practice of FGM**

The traditional cutting and mutilation of the genitalia in female infants, girls, and women has been in existence since antiquity. The practice of FGM is approximately 2,500 years old, predating both Christianity and Islam (WHO, 2010). The British Museum houses a Greek papyrus that acknowledges that girls in Egypt were circumcised

when they received their dowries. In 25 B.C., Greek geographer Strabo reported circumcision of males and excision of females in Egypt. Similarly, Greek historian Herodotus also reported FGM was performed in Egypt in the 5th century B.C. Early documents suggest the custom originated in either Ethiopia or Egypt, although no engravings indicate its existence. FGM is practiced across socioeconomic classes and different ethnic and religious groups, in approximately 40 Middle Eastern and African countries in Sub-Saharan and northeastern regions. It may be performed during infancy, childhood, adolescence, at the time of marriage, or during the first pregnancy. It is most commonly performed between the ages of 4 and 12. Approximately 150 million women have undergone FGM in their lifetimes, and roughly 5 million procedures are performed annually. It is estimated that more than 5 million girls a year are at risk of FGM, globally.

As with most traditional practices, the reasons, justifications, and ideological premise behind the practice of FGM are often complex and vary throughout different cultures and regions (WHO, 2011). However, most often they are divided into four categories: spiritual and religious, sociocultural, hygienic and aesthetic, and psychosexual (Chibber et al., 2011). The majority of communities that practice FGM believe the procedure is an approved religious practice of Islam, however that position is rejected by some members of practicing communities as not being mandated by any religious precept. Similarly, orthodox Christians, Ethiopian Falashas, and Muslims alike practice FGM, despite the fact that neither the Bible, Torah, nor the Quran necessitate the commissioning of the ritual. Sociocultural justifications for the procedure usually involve

marriage and childbirth. FGM is viewed by the community as a rite-of-passage into womanhood (Chibber et al., 2011).

Members of the community, where FGM is performed, believe a girl will not develop into a functional woman unless her clitoris has been removed. It also formally introduces her into the community as a member of the society, while also announcing her eligibility for marriage. FGM is often demanded as a prerequisite for marriage in order to ensure purity and virginity, thereby securing and potentially increasing the bride price from the groom's family (Chibber et al., 2011). If it is discovered that the woman is not a virgin, the husband to-be and his family has full authority to reject her and refuse to proceed with marriage, and are completely entitled to a refund of the dowry and all bride price gifts (Chibber et al., 2011). An additional fear is that the clitoris can harm or kill the husband during intercourse. The clitoris is viewed as detrimental to childbirth. Some traditional beliefs are that a woman's external genitalia may kill her newborn, or cause mental or physical deformities in the newborn (Chibber et al., 2011). Even more extreme is the belief by some groups that the clitoris has the power to blind both the newborn and medical personnel during delivery (Chibber et al., 2011).

Other beliefs surrounding the practice of FGM are that it ensures cleanliness and is aesthetically pleasing. Young girls are viewed as ugly, dirty, and abnormal if they have not undergone the procedure (Chibber et al., 2011). FGM is also used as a method to suppress and oppress a female's desire for, and expression of, sexuality (Chibber et al., 2011). Some cultures believe sexual pleasure and enjoyment is exclusive to men, thus performing the surgery prevents promiscuity, female satisfaction, and enhances male

gratification during intercourse. FGM is also used a means to enforce submissiveness and servitude. Women in FGM-practicing communities are usually personally, financially, and socially dependent upon a male figure. Therefore, their family, friends, and neighbors create an environment in which FGM becomes a component of social conformity. Failure to undergo FGM can cause severe economic and social consequences for the young girls, and their families, as the girls are ostracized by the community and labeled as outcasts and misfits in the society (Abdulcadir et al., 2011).

Because of this, they are often unable to marry. Inability to marry can have devastating economic consequences because marriage is a primary path to social and economic survival and advancement. The factor most frequently identified as being responsible for the continuation of FGM in these communities is the belief that the procedure is a sacred and immutable tradition contributing to the maintenance of a group identity. The ability to identify with one's heritage and enjoy the recognition that accompanies being fully accepted as a legitimate member of one's ethnic or cultural group is priceless to the members of that group (Abdulcadir et al., 2011). Acceptance accompanies the deserved claims to the social privileges and benefits associated with that particular cultural group. This is highly revered and sacred to most African families. Breaking tradition in these cultures is perceived as directly being linked with angering God (Abdulcadir et al., 2011). Among those who practice FGM, adhering to tradition is pivotal in maintaining a balanced and respectable position within the community. Consequently, disdain or rejection of the practice of FGM is viewed as an intolerable deviation from the social mores of the community (Abdulcadir et al., 2011). The fear of

community judgment and influence of familial pressures produces an intensified level of obligation and conformity. The belief that FGM is necessary for social homogeneity and acceptance manipulates reasoning, skews judgment, and fuels the support for this procedure by increasing its significance in these communities while the lives of young women are uncertain.

**Complications, Controversy, and Concern**

The controversy surrounding the practice of FGM exists because there are no documented medical benefits. Additionally, the environment and instruments used for these procedures are harsh and unsterile. The individuals performing the procedure are not medical practitioners and the nature of the procedure is highly invasive and forced. The procedure has both immediate and long-term complications that are significantly detrimental and in some cases lethal. Many participants experience an array of physical and psychological ailments, both during the procedure and throughout the remainder of their lives. The health risks and complications of FGM depend mainly on the extent of the mutilation. A Kenyan study revealed more than 80% of women reported a minimum of one medical complication after undergoing FGM (Oloo et al., 2011). Although the exact number of girls who die from undergoing FGM is not known, a sample poll of Sudan estimated one-third of the girls will die because of unavailability of antibiotics necessary for treatment after the procedure. Similar reports estimate that between 15–30% of all girls and women who endure FGM die from bleeding or infections (WHO, 2010). Immediate complications include extreme discomfort, unbearable pain, anxiety, and hemorrhaging. This level of trauma may potentially induce shock. Infections, damage

to adjoining organs, swelling, rupture of the vaginal walls, and urine retention are also common immediate complications (Dalal et al., 2010). Long terms complications have been documented, such as discomfort during menstruation, vaginal cysts, and frequent urinary tract infections (Dalal et al., 2010).

Diseases, such as tetanus, gangrene, AIDS, and psychological disorders have been acquired from the procedure (Dalal et al., 2010). An example a frequent long-term side effect is hematocolpos. Hematocolpos is the acute retention of urine and menstrual blood resulting from infibulations (Dalal et al., 2010). This condition is highly dangerous and may lead to chronic pelvic infections, crippling back pain, dysmenorrheal, urinary stones, kidney damage, and infertility. The most common long-term complication is the formation of dermoid cysts that form in the scar tissue, also referred to as dermoid tumors. Although they are benign tumors, they can grow to sizes potentially dangerous and outwardly visible and deforming. This tumor results from an abnormal embryonic development occurring in the ovaries and consists of displaced ectodermal structures along the lines of embryonic fusion (Dalal et al., 2010).

The development of keloids is an additional disfiguring complication. Keloids are thick scars resulting from excessive growth of fibrous tissue. Similar to dermoid cysts, keloids may cause anxiety and shame. Some women become overwhelmed with fear and confusion and assume that their genitals are healing in monstrous shapes, or that they have cancer or similar life-threatening ailments (Dalal et al., 2010). Keloids can also cause ongoing, painful sexual intercourse and difficult child labor. If the vaginal opening is too small, a woman must be physically cut open on her wedding night to allow

penetration by her husband. During childbirth, she is often further forced open to allow the baby to pass through her. Childbirth also presents a possible increase in the risks of maternal morbidity, stillbirths, future infertility, hemorrhage, and infections (Dalal et al., 2010). Both procedures result in extreme pain and additional scar tissue, which only enhances the development of keloids.

According to the Program for Appropriate Technology in Health, the practice of FGC has higher infant and maternal incidence rates. If delivery is being performed in the United States, immigrant women who have undergone FGM in their home country are exposed to a higher risk because Western physicians are not educated in, and generally not exposed to, the childbirth of infibulated women. American physicians may unnecessarily perform cesarean sections or further damage vaginal scar tissue by improperly cutting open an infibulation to allow for the vaginal birth of the child. It is imperative that an infibulated woman is adequately cared for during childbirth (Rasheed et al., 2011).

Lack of specific and appropriate care can result in complications, such as perineal tears or a vesicovaginal fistula (Raheed et al., 2011). A vesicovaginal fistula is an abnormal tube like passage between the bladder to the vagina that usually occurs because of some form of injury and in some cases fetal death may result. In an effort to prevent painful childbirth, some mutilated women eat less during pregnancy under the mistaken belief that if they ingest less food, their baby will be smaller and be able to fit through their mutilated and constricted vagina with less pain (Rasheed et al., 2011). Because of their starvation, nutritional deficiencies occur. These women may suffer from anemia as a

result, and also increase the risk of experiencing hemorrhages, infections, preterm deliveries, and having low birth with infants. Contrastingly, the Universalist approach defines FGM as an act of international violence; therefore, intervention is necessary on the grounds that morality transcends national boundaries and cultural beliefs (Rasheed et al., 2011). Feminist scholars and antiFGM activists interpret FGM as an assault on women's sexuality as well as an oppressive and brutal act that has grave and catastrophic effects on the health of women and young girls (Herbenick et al., 2011). These scholars associate FGM with a patriarchal desire and ability to dominate women, their bodies, and their sexuality to ensure female chastity and fidelity. Women, over time, have been encouraged and manipulated to attribute exceptional and unrealistic significance to female circumcision, motherhood, and housekeeping as a means to perpetuate male domination in patriarchal societies (Herbenick et al., 2011). Social entities in different countries often are not aware of the Universal Declaration of Human Rights; therefore, they substitute it with their own cultural beliefs in place of international human rights standards. In 1979, the WHO organized a seminar in Khartoum, Sudan, regarding the direction for renewed international initiatives (WHO, 2011).

The interests of nongovernmental organizations (NGOs) resurfaced during the U.N. Decade for Women, from 1975 to 1985. NGO meetings in 1992 held in Bangkok reflected the position that human rights afford protection to all humankind (WHO, 2010). Cultural practices that minimize universally accepted human rights, including women's rights, are not to be tolerated. A human rights platform asserts that women inherently, as men do, have the right to physical and mental integrity, to freedom from discrimination

and abuse, and to the highest degree of health (UNICEF, 2010). Thus, any violation of these rights, on any level, should never be justified. A critical hurdle presented in international intervention, is the issue of sovereignty. Sovereignty extends much further than a state's physical parameters, and also represents a state's preferences in areas of politics, economics, and culture (UNICEF, 2010). International Law mandates states are permitted to choose the structures and ideologies that are parallel to their origins and beliefs (Krasa, 2010). Advocates therefore argue that states should freely be able to express their sovereignty without interference or intrusion. The debate between the platform of cultural sovereignty and international human rights is inherent and continues to be a contentious topic.

**Human Rights Efforts and International Law**

The framework of international human rights law is based on the notion that each state has the responsibility to honor the inalienable and irrevocable human rights designated to all its citizens (WHO, 2011). Human rights are defined in the Universal Declaration of Human Rights as those inherent, inalienable, and imprescriptible rights that allow human beings to live dignified and just lives (WHO, 2010, 2011, p. 221). Additionally, human rights are considered universal to all humans, regardless of political or international status (WHO, 2011, p. 217). Certain limitations on the exercise of human rights are set to assure respect for the rights of others for the sake of public order and general welfare in a democratic society (Kontoyannis & Katsetos, 2010, p. 156). However, cultural practices, such FGM, impede on the rights of women and young girls to maintain "bodily integrity" and access to necessary health provisions, academic

opportunity, and self-realization and therefore provoke international intervention (Kontoyannis & Katsetos, 2010).

**United Nations and FGM, Conventions, Charters and Declarations**

The United Nations' involvement in human rights can be traced back as early as 1942 with combat against Hitler and his regime. The United Nations officially institutionalized in 1945 and developed an integral human rights stance. The United Nations' Charter asserted that its mission was to solve humanitarian international problems that were economic, social, or cultural in nature. Additionally, the Charter was intended to increase the advocacy for the reverence of human rights and basic freedoms for each individual, irrespective of language, race, religion, or sex. The Universal Declaration of Human rights (UDHR) was proclaimed in 1948, resulting in a structured and cohesive meaning of the term *human rights* (Krasa, 2010, p. 276). The Universal Declaration does not specifically address violations of human rights by cultural and religious practices, such as the practice of FGM, however the act of FGM can be interpreted to violate Articles 1–of the declaration. Article 1 affirms the innate freedoms belonging to all human beings (WHO, 2011). A woman or young girl forced to undergo a practice that puts her life and overall well-being in jeopardy is an individual in bondage. These individuals are not afforded the freedom of choice, the freedom of expressing an alternative view, or the freedom of expressing confidently their innate rights. Article 2 describes that no prejudices be administered in matters involving these innate freedoms (WHO, 2011).

Women and young girls are targeted for this practice. A prejudice against the value and purpose of young girls is displayed, which is why they are solely required to have FGM done, and are discriminated against because they are women. Article 3 ensures the right of every individual "to life liberty and security" (p. 269). Women and young female girls in FGM-practicing communities are confined to the precepts set by tradition and their security is compromised because this act is often forced upon these females (Kontoyannis, & Katsetos, 2010).

Article 4 rebukes all forms of slavery and oppression, while Article 5 assures no human being are subjected to torture or to cruel, inhuman, or degrading treatment or punishment. FGM is a clear form of torture and it oppresses and punishes the women who endure it (Hess et al., 2010). The type of torture applied is cruel and degrading in nature because it is forced, intrusive, and made public. The manner in which these rituals are carried out is unhygienic and lacks medicinal support both during and post-mutilation. The agony and terror experienced from the pain is indescribable and the effects mentally and physically are irreversible (Hess et al., 2010). The Declaration is used by United Nations' conventions and human rights legislation to underpin the elimination of FGM and protect the rights of women and children globally. The use of the Declaration in conventions and legislation is evident in the International Covenant on Civil and Political Rights. The U.N. High Commissioner for Refugees Executive Committee, in conjunction with the U.N. Sub-Commission on Harmful Traditional Practices, has affirmed that FGM can be considered as equal to persecution (p. 19).

Therefore, a woman can be considered a refugee if she or her daughter fear being compelled to undergo FGM against their will or if they fear persecution for resisting the practice. This sentiment reaffirms earlier opinions by the U.N. Committee on the Elimination on all Forms of Discrimination against Women and the U.N. Population Fund (WHO, 2010a), who defined FGM as a grave concern and a major lifelong risk to women's sexual and reproductive health, and a violation of the human rights of girls and women. Another element supporting opposition and the abolition of FGM is the notion that FGM constitutes a violation of human rights when performed on infants and young girls. The fundamental basis of this violation is the principle of consent. An adult woman can willingly comply with a ritual or a tradition being fully cognizant of what the act entails. A child, however, is vulnerable and has no established judgment or clear comprehension of what is required of them and therefore does not consent, but simply succumbs to the irreversible mutilation (Kontoyannis & Katsetos, 2010).

Descriptions of the reactions of the children, often panic and shock from extreme pain and the forcefulness of administering the procedure, indicate a practice comparable to torture (Kontoyannis & Katsetos, 2010). The U.N. Convention on the Rights of the Child (1989) requires nations to extinguish any traditional practices that may threaten the health of children. Article 16 affirms that no child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, or correspondence, nor to unlawful attacks on his or her honor and reputation. Furthermore, Article 19 states parties should take measures to protect the child from violence, injury, neglect, exploitation, and sexual abuse.

Article 24 highlights children have the right to the highest possible level of health and medical centers for treatment of sickness and other health needs. The Article also asserted states must take responsibility to decrease infant and child mortality, and also provide adequate antenatal and postnatal medical services for women. FGM inhibits these provisions as the practice endangers the life of women and their young children. Additionally, Article 37 instructs children should not be subjected to torture, degrading treatment, or punishment (Hess et al., 2010, p. 268). The African Charter on the Rights and Welfare of the Child represents a standard of the treatment of a child that facilitates the positive mental, physical, social, and moral developmental and welfare of a child. Additionally, the charter asserts the fundamental rights stated must be protected and upheld by all means necessary, including the establishment of proper legislation in conditions of freedom, dignity, and security (Kontoyannis & Katsetos, 2010). Article 1 of the declaration clearly outlines the obligation of states and member parties to acknowledge rights of those listed in the charter. Furthermore, any cultural or religious practice that does not comply with these rights listed in the charter is discouraged. Article 3 dictates the importance of nondiscrimination for every child. The Article states every child is entitled to rights guaranteed in the charter regardless of the child's parents' race, sex, religion, political orientation, or national origin.

More resounding is the clear and specific declaration in Article 5 of the charter. Article 5 is centered on the development and survival of children, and states inherently every child has the right to life. The practice of FGM on young girls meets the stipulations necessary to qualify as a violation of human rights. It violates the right to

expression and freedom of life and dignity, which are all the things the African Charter denotes. The uniqueness of this charter stems from the fact that it is directed towards Africans by Africans themselves. The unifying element, therefore, is intensified. This charter significantly removes the inclination that Western ideologies are imposing their standards and beliefs a position often taken by cultural relativists (Mgbako et al., 2010). This Charter reflects a level of global cooperation to an issue recognized as fundamentally inhumane and unjust. The premise of FGM is rooted in a cultural system that is discriminatory against women. It is an abuse of human rights that simultaneously functions as an instrument of socialization for girls. Young girls are predisposed to gender roles within the family and community without a means to express opposition or to object to any proposition requested of them. A clear correlation can be made with societies in which FGM is performed and an inferior status of women in areas of politics, economics, and social structures (Mgbako et al., 2010).

The U.N. Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and The U.N. Declaration on Violence against Women (DEVAW), acknowledge physical injustice towards women strip them of deserved political and civil rights, as well as social and economic rights (Kontoyannis & Katsetos, 2010). The Declaration states socially structured assumptions lead to gender-based violence, keep women in subordinate roles, contribute to women's limited participation in political events, and limit their level of education and work opportunities. The CEDAW reinforces that the U.N. Charter reasserts confidence in preserving the dignity and overall value of each individual, and the equal rights of women. Even more critical is the Convention's

definition of discrimination against women that distinguishes this ideas a states' exclusion on the basis of sex and inhibition of women's human rights and fundamental freedoms in the political, economic, social, or cultural domain (Kontoyannis & Katsetos, 2010). FGM is a representation of a gender-based human rights infringement that is visible in all cultures that strive to control women's sexuality and autonomy. Consequently, women are denied the enjoyment of experiencing a healthy and satisfying sex life. This inability to achieve sexual gratification, and the glaring sexual complications which accompany FGM and re-infibulation, are blatant violations of the CEDAW (Chibber et al., 2011). The Declaration iterates that states should not establish custom, tradition, or religious principle that threaten their responsibility to eradicate violence against women.

The Declaration implores states with the responsibility to perform due diligence in investigating and enforcing punishments for acts of violence, while constituting adequate methods of protection and security. Article 5 section (a) of the Women's Convention instructed members to construct measures that will alter cultural activities that weaken women's rights with the goal eliminating prejudices and customs that place women in an inferior position based on stereotyped roles of men and women. The Women's Convention created the CEDAW to measure the effectiveness of states' execution of ascribed guidelines. General Recommendation No. 19 was adopted by the CEDAW in 1992 and defines violence directed against women as making women a target because they are female, and this violence against women is defined as affecting women disproportionately. This violence includes acts that cause physical, mental, or sexual

harm and includes threats of those acts as well as coercion and hindrances to liberty. It intricately lists the factors that constitute gender-based discrimination and violence and the legislation that should be administered to overcome and punish all forms of violence against women. The high level of detail and specificity in The DEVAW not only defines what constitutes violence against women, but also outlines how prevention of this violence should be applied to ensure safety for women (Kontoyannis & Katsetos, 2010). This Declaration is a universal statement that violence against women prevents equality, development, and peace. Article 1 of the DEVAW defines violence against women as gender-based violence causing physical, sexual, or psychological harm to women (Dalal et al., 2010).

The DEVAW represented a shift in the manner in which academics and activists interpreted violence against women. The support for this revised prospective was substantially intensified after the World Conference on Human Rights in Vienna in 1993. During this era, scholars and activists alike altered their perspectives toward violence against women as a human rights matter, as opposed to being solely an issue of public health or criminal justice. Article 2 explains violence against women must be interpreted to include, but should not be limited to, domestic violence which in itself involves battering, pedophilic tendencies towards female children, dowry-related violence, marital rape, FGM, other traditional practices proven to be harmful to women, and exploitation-related violence (Ray, 2011). Additionally, violence within the larger community, outside of the individual home, including rape, sexual abuse, sexual harassment and intimidation in the workplace and educational institutions, and human trafficking were also listed as

clear forms of violence against women (Raya, 2010). The central motif of the definition of violence against women and paradigms of instances in which violence may occur not only sheds light on the devastating consequences of physical and sexual violence committed against women, but also illustrates this violence can be executed by multiple actors, such as a spouse, nuclear family members in their homes, in addition to extended family units and even strangers and figures within the community. The Declaration also elaborates on the social settings and circumstances that qualify as violence perpetrated against women. These settings include rape by soldiers serving in war and internal conflict, sexual assaults committed against women in the custody of law enforcement officials, rape and sexual assaults against women in refugee camps, the trafficking of women for sexual exploitation, and harmful traditional and cultural practices, such as FGM.

In addition to defining violence against women, the DEVAW goes much further and actually codifies the appropriate actions that should be taken by states to eliminate FGM and all related acts of violence against women. Specifically, Article 4 encourages states to denounce violence and not consider any excuse, whether it be for tradition or religion's sake, as to its eradication. The Declaration codifies FGM as an act of violence endured by women, which states should abolish. The DEVAW Article 6 explains the Declaration consists of the minimum level of protection for women and any provision that is more conductive to the eradication of violence against women that may be contained in the legislation of a state.

In 1966, the International Covenant on Civil and Political Rights (ICCPR) was adopted and put into effect a decade later. The ICCPR imposes upon states a duty to protect people from unlawful attacks on honor, and prohibits punishments, such as cruelty, torture, dehumanizing, and degrading of women. The ICCPR calls on states to administer laws or other legislative measures as deemed necessary to give effect to the rights recognized in the Covenant. It additionally stipulates all its members accomplish the primary responsibilities of enabling themselves with the right to self-determination within their territories, as well as respecting this right on par with the standards set by the U.N. Charter (Kontoyannis & Katsetos, 2010). This position reaffirms the responsibility of states to ensure steps are taken to eradicate FGM. Thus, actions or inactions allowing the practice to continue should be considered a dismissal of the precepts and an infringement on the obligation to protect woman and young girls under this Covenant (Mgbako et al., 2010).

Similarly, the International Covenant on Economic, Social, and Cultural Rights also insists states implement protocol in a legislative capacity to ensure that all the rights enumerated within the Covenant are enjoyed by all individuals. Article 2 is specifically vital in comprehending fully the magnitude of the Covenant and the cohesion it reflects when taken with the remaining provisions. This Article explains the nature of the general legal obligations necessary for states to implement Article 2; each State Party to the present Covenant is responsible for the progressive continuation of the rights recognized by the Covenant, including the adoption of legislative measures, by any means possible.

Article 12 further poses that everyone has a right to the highest attainable standard of health, both physically and mentally, and that this right includes making strides toward reducing the rates of stillborns and infant mortality, as well as for the healthy development of children (Kontoyannis & Katsetos, 2010). The Protocol on the Rights of Women in Africa is a protocol to the African Charter on Human and People's Rights. The Protocol outlines declarations in supporting the avid protection and security of women in Africa. The Protocol consists of a wide spectrum of considerations for the protection of economic, social, and cultural rights of women—the most valuable right being the assurance of the freedom to select their own occupation and all their human rights as acknowledged by international conventions. It is then the responsibility of states to develop environments conducive to the encouragement and development of women, while also rejecting and penalizing all types of exploitation of children, especially female children.

## Summary and Conclusion of the Chapter

Overall, a review of available published empirical investigations on FGM revealed the literature to be relatively dominated by empirical studies regarding the prevalence, psychological, and medical consequences of FGM (Vloeberghs et al., 2010), Currently, no empirical studies exist in which researchers investigated how FGM effects marital satisfaction. Consequently, the relational effects of this practice are unknown. This lack of knowledge may be contributing to the global perpetuation of this practice. I addressed most of these issues by studying how FGM affects the marital satisfaction of Sierra Leonean females residing both in Kenya and in the United States. Certain myths

shared by communities that practice FGM include (a) some communities insist that FGM should be done for religious reasons, believing that their faith requires the practice; (b) others believe the removal of the external genitalia makes a woman more hygienic and aesthetically pleasing; and (c) some believe that FGM actually enhances a woman's fertility, while others believe that women who have gone through the procedure have a better chance for their children's survival (Alo, & Gbadebo, 2011).

In addition, some defenders of FGM argue that if the official aim of defining FGM as a human rights violation is to protect political prisoners from torture, then African parents are classified as torturers and their children defined as political prisoners held captive, coerced into torture, and mutilated by their blood relatives (Bewley et al., 2010). Numerous approaches for eliminating FGM have been developed during the years by nonprofit and international organizations. Some of these approaches are linked to selected target groups or a specific aspect of FGM, but the elimination process of FGM will take a long time to reach each and every individual it is supposed to reach (UNICEF, 2010). There can be many policies, seminars, and conferences, but if practitioners of FGM cannot be reached, it is all fruitless. To reach practitioners intercultural interactions have to be improved. There are also social pressures associated with the practice. In some communities where most women are circumcised, family, friends, and other members of the community create an environment in which the practice of FGM becomes a normalized component of social conformity. Many steps need to be taken for FGM to be eradicated and this includes more than passing legislation, as evidence has shown (WHO, 2011) that the practice still exists and thousands of girls and women are still being

mutilated each day. An understanding of culture cannot be emphasized enough, and more importantly, the culture of the people involved in this practice. Attitudes need to be changed through dialogue, especially in societies in which men refuse to marry uncircumcised women and women are judged for not being circumcised.

# Chapter 3: Methodology

The aim of this study was to explore the lived experiences of FGM/C among women from Sierra Leone, including their resiliency to overcome the physical and emotional effects of the practice. To accomplish this, I conducted semistructured, open-ended interviews, utilizing techniques of analytical observation described by Finlay (2013) and Gele et al. (2013). These systematic and holistic observations, allowed me to obtain evidence of the unique and pre-existing belief systems inherent to women from the Sierra Leone community that served as the study site.

Through in-depth interviews, I explored women's lived experiences to better understand the perceptions these women have concerning the practice of FGM/C. Through this inquiry, I hoped to shed light on the persistence of the practice and the resiliency of the women to overcome the trauma of the procedure. A thoughtful consideration of these objectives and a thorough review of the existing literature led to the development of the following four research questions. The research questions used to guide this study were:

**RQ1.** How do Sierra Leone women who have undergone FGM perceive the practice?

**RQ2.** What concerns, if any, do Sierra Leone women who have undergone FGM have about the relative safety of the practice?

**RQ3.** How do Sierra Leone women who have undergone FGM feel about having FGM performed on their daughters?

**RQ4.** To what factors do women who have undergone FGM attribute the continued persistence of the practice?

This chapter begins with a description of the research design and the rationale behind the choice of design. Also included in the chapter are a (a) description of the research methodology of this study, b) the sample selection, (c) a description of the procedure used in designing the instrument and collecting the data, and (d) the role of the researcher. Other topics covered include data analysis, issues of trustworthiness, and ethical concerns.

## Research Design and Rationale

Although research topic or discipline alone is not the sole determinant of the nature of the research method, certain aspects of the total inquiry related to the topic may lead to the choice of one methodology instead of another. The choice between different research methods should depend on what the researcher is attempting to learn (Silverman, 2004). Based on the research questions, I chose a qualitative phenomenological design.

Qualitative research is considered descriptive in nature. Researchers employ these designs when they seek to describe and explore phenomena from the perspective of the experiences and perceptions of the participants. Rather than trying to prove or disprove a hypothesis, or measure and find correlations, researchers seek to explore a specific phenomenon (Tracy, 2013). Participants in qualitative research may describe in detail their views, activities, or the process of a lived experience (Moen, 2003) through use of a number of possible tools, such as interviews, observations, questionnaires, surveys, journals, artifacts, and artwork.

I considered a quantitative methodology for this study. The aim of a quantitative study was to identify measurable outcomes, count them and create statistical constructs

employed to provide an explanation of the phenomenon under study (McCusker & Gunaydin, 2015). Quantitative studies require the researcher know specifically the outcome sought, and that outcome is expressed in the form of hypotheses that can be proven or disproven. Researchers use statistical methods to find answers. Researchers design quantitative studies in order to efficiently test hypothesis, however, using these methods do not enable inclusion of contextual details (McCusker & Gunaydin, 2015). Quantitative methodology was not suited for this study, because the aim of this research was to explore the experiences and perceptions of the participants. Rather than trying to prove or disprove a hypothesis, I sought to explore the phenomenon under study.

I also considered a mixed method approach. Although "researchers have been conducting mixed methods research for several decades, and referring to it by an array of names…multi-method, integrated, hybrid, combined, and mixed methodology research" (Driscoll et al., 2007, p.19). This definition fits any research project where quantitative and qualitative data are gathered and used during the same study. Researchers can use both methods sequentially or concurrently. As the focus of this study was to understand the experiences and perceptions of the participants, use of quantitative methods was not appropriate. Thus, a mixed method design was not chosen.

I chose the remaining research method, qualitative methodology, for this study. Qualitative research is descriptive and inductive, in that the researchers seek to explore a phenomenon with the answers arising from the data (Tracy, 2013). Individuals who participate in qualitative research studies describe in detail their views, activities, and the process of a given experience (Moen, 1998). According to Magilvy and Thomas (2009),

participants' descriptions to their experiences make useful data for researchers who seek to understand the participants' point of views. In this qualitative research study, participants presented their views and perceptions regarding the identified phenomenon through the use of semistructured, open-ended interviews (Rubin & Rubin, 2012). The interview questions formulated for this study were drawn from the research questions and the theoretical framework and were designed to elicit the information required to describe and explore the phenomenon focused on in this study. These questions enabled participants to provide a thorough description of the experience, which included the social, psychological, and personal aspects of the experience.

Narrative research involves any text or discourse that focuses on the stories of individuals (Tracy, 2013). Narrative researchers look to place their inquiry in a three dimensional space that encompasses personal and social interactions; that are looked at from the perspectives of past, present, and future; and that include the situation where the phenomenon occurs (Clandinin, 2006; Trahar, 2009). Narrative inquiry is based on the idea that knowledge can be gathered from personal stories and people make meaning of their lives by creating stories (Fry, 2002). As this study pertains to examining a specific experience, rather than a story that involves the experience, narrative analysis was not chosen.

Grounded theory researchers seek to create a theory that explains a phenomenon (Corbin & Strauss, 2014). Researchers who employ grounded theory explore a phenomenon using the constant comparison method of analysis. Interviews occur in rounds with each round shaped by the data found in previous rounds (Corbin & Strauss,

2014). At the end of the analysis, the data are used to help the researcher form a theory regarding the phenomenon under study.

Ethnography is the study of cultures or groups. Ethnographers focus on learning about the society or group from the point of view of a member of that society. Ethnographers typically embed themselves during a period of time in the group they study (Tracy, 2013). An individual seeking to conduct an ethnographic study can carry multiple roles including observer, participant, and researcher (Herr, 2015). The goal of this study was not to understand the culture surrounding FGM, but rather, to explore and describe the experiences of women relating to FGM. For this reason, an ethnographic design was deemed to be inappropriate.

For this study, I selected a phenomenological design. Researchers who employ phenomenology seek to understand the lived experiences and perceptions of individuals with the phenomenon under study (Moustakas, 1994). The central focus of a phenomenological study is an exploration of the phenomenon in the natural world (Moustakas, 1994). The goal of researchers who employ a phenomenological study is to be able to describe the ultimate essence of the phenomenon being studied (Giorgi, 2002). In phenomenological studies, the focus is on the thoughts, ideas, and emotions connected with the phenomenon. A phenomenological researcher uses this information, employing an inductive analysis approach, to arrive at a description of the phenomenon (Groenwald, 2004).

## Role of the Researcher

In qualitative studies, the researcher functions as an instrument. All the information in the study flows through the researcher (Tracy, 2013). Phenomenology is "an inductive process that involves shaping the instrument of research, the researcher, as a medium for the discovery and interpretation of meanings" (Barrett, 2007, p. 418). In either event, however, the researcher should not guide or predetermine answers, but instead accept them as they flow from interviewees or observations (Tracy, 2013). Because I am involved in every stage of the study, it is essential for me to engage in bracketing (Moustakas, 1994). The act of bracketing involves identifying any preconceived notions, thoughts, ideas, or biases, and setting them aside in order to enter the world of the participants (Moustakas, 1994). By doing this when the researcher enters the participants' world, a true picture of the respondents lived experiences can be found (Hycner, 1999).

As a researcher, remaining neutral was the main focus throughout the study to avoid any biases, thoughts, or perceptions. Before the study was completed, I practiced with a research interviewer? who is this? to obtain the skills necessary to conduct the study. I obtained training and certification on human subject research.

## Methodology

### Participant Selection Logic

In this study, I explored perceptions of women in Sierra Leone regarding several aspects related to FGM/C. It is of the utmost importance to ensure that a well thought-out roadmap for sample selection is created (Wilmont, 2005). Therefore, because researchers

want to select participants who can articulate meaningfully (Lane & Arnold, 2011) and from their own experience (Magilvy & Thomas, 2009), I limited my selection population to women who have experienced FGM/C. To locate appropriate participants, I employed a purposive sampling method. This type of sampling is appropriate for use when a researcher seeks participants who have experience with phenomenon being explored (Petty, Thompson, & Stew, 2014). The selection criteria for this study were (a) participant must be older than the age of 18, (b) participants had undergone FGM, and (c) participant were willing to speak about the experience.

This study included a sample size of 12 female participants in the interview and observation portion. The sample size of participants in qualitative research could be as small as five or as many as 20 participants, according to Polkinghorne (2013), because sampling in qualitative research is purposeful in nature (Leedy & Ormrod, 2010). Participants in a descriptive qualitative study must have experience with the problem under study and possess the ability to describe accurately their experience to the researcher (Magilvy & Thomas, 2009). The goal is to collect meaningful data from participants and ensure saturation (Lane & Arnold, 2011; Mason, 2010). Saturation occurs when interview data from participants becomes redundant, thus interviewing additional participants will add no novel information about the phenomenon (Marshall, Cardon, Poddar, & Fontenot, 2013).

I worked with work with a Sowei, a female leader who used to conduct FGM ceremonies and lives in her local area, to find participants. A biography of the Sowei is located in Appendix A. The Sowie did not function as a coresearcher or speak about or be

involved in the data gathering process. She only shared the study flyer with possible participants. The Sowie handed out flyers about the study and made them available for anyone who might ask for information. If individuals had questions about the study, she did not answer, but instead directed them to contact me for further information. The flyer contained a brief description of the study, criteria for inclusion, and my contact information.

**Instrumentation**

In qualitative research, the researcher is considered the primary instrument in the study as all data flow through the researcher (Tracy, 2013). As the researcher, I was responsible for collecting, recording, organizing, and analyzing all information (Tracy, 2013). To ensure that the data are untainted, it is essential to practice reflexivity and be aware of all preconceived, idea, thoughts, and biases, in order to set aside these ideas (Berger, 2015). A semistructured, open-ended interview protocol guided the interviews conducted for this study (see Appendix B). Using established design guidelines, all questions used in this study were open ended, neutral in tone, clearly worded, and not combined (Rubin & Rubin, 2012). To draw out information, the questions were constructed to enable me to circle around and ask questions for a more detailed response regarding the entire phenomenon under exploration (Rubin & Rubin, 2012). The questions created ask for narrative statements, emotional responses, perceptions, thoughts, ideas, and sensations (Rubin & Rubin, 2012).

The use of open-ended questions aids in ensuring credibility, eases data analysis, and lessens any researcher bias (Moustakas, 1994). Objectivity is reinforced because of

the fact that open-ended interviews use broad questions, enabling respondents to elaborate on the questions by sharing experiences, perceptions, and opinions however they feel comfortable (Olsen, 2011). I kept a field log to record her personal thoughts and ideas, as well as to keep analytical observations as supplemental information during data analysis, as recommended by Tracy (2013). Any notes, artifacts, or mementos remained in the sole custody of the researcher, were used solely for academic purposes, and will be destroyed after 3 years following dissertation approval.

Hyrkas, Appelqvist-Schmidlechner, and Oksa (2003) recommended this practice to ensure the questions are clear, easy to understand, focused on the phenomenon under study, and appropriate. Any feedback received helped to modify the protocol before being used in the research study.

**Procedures for Recruitment, Participation, and Data Collection**

For this phenomenological research study, I found participants through purposeful criterion sampling with the assistance of the Sowei. If the participant indicated interest in the study, the Sowei provide my contact information, including my name, e-mail address, and phone number. Once the participant contacted me to indicate interest in participating in the study, I first ensured that she met the selection criteria. I e-mailed the participant a copy of the informed consent (see Appendix C) to review before the interview, and set an appointment for the interview. The interview occurred in a private location chosen in conjunction with the participant or using GotoMeeting. Before the interview commenced, I explained the informed consent and answered any questions about the study. Once all

questions were answered, the participants signed the informed consent and received a copy to keep.

For interviews that occurred using GoToMeeting, the participant e-mailed me a copy of the signed consent before the meeting began. All participation in the study was fully voluntary and confidential, and the participants were informed that they could leave the study at any time and for any reason without fear of repercussion. I used an audio recorder for the interview, as long as the participant agreed. Otherwise, I took hand-written notes, and allowed the participant to review the notes following the interview. The entire interview lasted approximately one hour. Once the interview concluded, the participant had the opportunity to ask any further questions. She also received a list of local resources for free support in case the participant felt any distress after the interview.

**Data Analysis Plan**

Using Braun and Clarke's (2013) thematic analysis method, I analyzed the data. This method was created to aid researchers who seek a method free from the use of a theoretical framework, is formalized, and is not connected with any specific research (Braun, Clarke, & Terry, 2014). Braun and Clarke (2006) created the thematic analysis method to enable researchers to work with thick and rich data in a manner laid out step-by- step. This data analysis method occurs in six stages. The stages are presented in a linear manner; however, the analysis itself is recursive, with movement occurring between stages throughout the process (Braun et al., 2014).

The six stages of thematic analysis are:

1. Reading and re-reading data.

2. Generation of initial codes.

3. Combining codes into themes.

4. Analyzing how themes support the data and theoretical perspective.

5. Definition of each theme.

6. Writing the results (Braun & Clarke, 2006).

During Stage 1, the researcher reads transcripts of the recorded interviews repeatedly to become deeply familiar with the collected data. In Stage 2, the researcher begins to break the data into separate chunks. Each chunk consists of words, phrases, or paragraphs that contain a specific meaning. The researcher assigns a code, which is a descriptive phrase, to each chunk of data (Braun & Clarke, 2006). I analyzed and assigned a code to all collected data. The codes can be interpretive or descriptive, and it is essential to remember that the code expresses the meaning of the data in a manner that conveys meaning clearly enough that reference to the data is not required (Braun & Clarke, 2006).

In the following stage, the researcher merges the codes into groups. Each group forms an overarching umbrella of meaning. This grouping continues until all pertinent codes are assigned. Once categorization is complete, the researcher explores the groups to assess if groups can be combined or if a group of data is strong enough to stand on its own and form a theme (Braun et al., 2014). Three factors should be considered when creating themes: (a) does the theme apply to a research question, (b) has the theme crossed three or more interviews, and (c) is there a central organizing idea that ties the themes together (Clarke & Braun, 2013). During Stage 4, all themes are reviewed for

quality, cohesiveness, and depth. The researcher reviews and analyzes themes for depth and quality (Braun et al., 2014). Stage 5 includes describing and defining the themes and creating a name for each theme (Braun & Clarke, 2006). In the final stage, all themes are reported, written, and edited (Braun & Clarke, 2014).

To facilitate analysis, I uploaded all data into NVivo 11, which also aided in the organization of the data. Tasks associated with the use of Nvivo 11 include organization, coding, analysis of word usage, and analysis word frequency (Bazeley & Jackson, 2013). The use of NVivo 11 allowed me to manage the data in an organized manner.

## Issues of Trustworthiness

When conducting qualitative research, it is essential to ensure the trustworthiness of the information shared. Lincoln and Guba (1985) stated qualitative research must reflect, as accurately as possible, the actual views of the participants. Lincoln and Guba indicated high quality qualitative research should possess credibility, transferability, dependability, and confirmability.

*Credibility* is a measure of how well the results of the research study reflect the essential meaning of what participants were sharing during the study process (Lincoln & Guba, 1985). Qualitative interpretations must reflect a clear description of the participants' experiences (Drisco, 1997). Risks that can affect the interpretation of the data gathered during the course of the study include reactivity and bias. The concept of reactivity is the idea that the researcher has an effect on participants that could possibly alter the findings (Padgett, 2008). To ensure this does not occur, a researcher must be aware of his or her own actions and always consider how he or she may influence

participants. A researcher should always be mindful of verbal and nonverbal communication, the phrasing of the interview questions, and how to engage with the participant. These steps can all aid in reducing any possible reactivity. In addition, researchers need to be aware of biases. To isolate any biases, engaging in bracketing, or the setting aside of a researcher's worldview to enter the world of the participant, is essential (Moustakas, 1994). Other strategies employed to enhance the credibility of this study included the use of thick description and member checking. Thick description is when the descriptions from the participants' interview data are rich enough for the reader to feel the truth of what is stated (Shenton, 2004). I encouraged the participants to speak in as much detail as possible using effective interview questions, and probes when necessary. I engaged in member checking and invited participants to review and comment on the analysis of their interviews (Shenton, 2004).

Merriam (2002) defined *transferability* as results that are generalizable. Qualitative experts agree that assessing the transferability of a study is the responsibility of the reader (Tracy, 2013). Methods of ensuring transferability include having thick description and as much variability among participants as possible. In addition, Shenton (2004) recommended including the following information in any report of the data:
A list of any organizations taking part or sponsoring any study

1. Restrictions in the sampling process;
2. Listing the number of participants;
3. Describing each step of the data collection process;
4. Reporting the number and length of all interviews;

5. Recording the length of time required to gather all data.

Assessing the "notion of producing truly transferable results from a single study is a realistic aim or whether it disregards the importance of context…a key factor in qualitative research" is also essential (Shenton, 2004, p. 71).

*Dependability* is the capacity to display how, if given the same context, methods, and participants, future researchers would arrive at similar results (Shenton, 2004). Researchers should record all steps and choices in enough detail to allow another researcher to easily replicate the study (Thomas & Magilvy, 2011). Lincoln and Guba (1986) reported credibility and dependability are interrelated. Thus, if a study is replicable, the validity of the study results increases. To ensure dependability, I kept a detailed log and field notes throughout the study.

*Confirmability* "occurs when credibility, transferability, and dependability have been established" (Thomas & Magilvy, 2011, p. 154). Any results of the study need to reflect the participants' voices. All themes should arise from their lived experiences. An essential component of confirmability is reflexivity. A researcher should place biases and preconceived ideas aside and enter the life world of the participants (van Manen, 2014). As a researcher, I followed rather than lead the conversation. My role was to not be the center of the conversation, but rather to get as much detail as possible from the participants and ask for clarification when necessary (Thomas & Magilvy, 2011). After every interview, I immediately recorded my thoughts and observations in my field journal.

## Ethical Procedures

Before any data were collected and any participants approached, I obtained IRB approval. In addition, whenever research involves human beings as the subjects, certain ethical issues can arise. Researchers must ensure that the study complies with any possible or operational, legal, and statutory provisions regarding the collection, confidentiality, handling, and disposal of data.

In addition, I sought the consent of the respondents involved before approaching to participate in the study. Every respondent was asked to participate in the study out of her own free will. Additionally, I assured the respondents assured that they would be able to leave the study at any point without fear of any repercussion. I also explained to the respondents the primary purpose of the study and guaranteed that the data would only be used for academic purposes.

The study was conducted with a high level of care for the participants. As the participants are considered to be members of a potentially vulnerable population, I took several precautions to create protection and to ensure confidentiality. Participants were recruited through trusted third party. I did not directly approach any participant. All participants were allowed to self-identify as a member of the target population.

To ensure understanding, I reviewed the informed consent before the interview commenced. Participants had the opportunity to ask questions or raise concerns before signing the consent form. I informed the participant that they could decide not to participate in the study at any time, without any reason, and with no repercussions. The participants had an opportunity to ask questions and discuss the study. After explaining

the informed consent and answering all questions, the participants signed the form and received a copy for their records. Each potential participant was assigned a pseudonym for the duration of the study. To avoid any possibility of a biased response, participants did not receive any incentives. All data from the individuals who decided to participate in the research study will remain confidential. Any information connected with the study is stored in the researcher's home office in a locked file cabinet. All electronic data are stored on a thumb drive. At the end of 7 years, I will destroy all data connected to the project.

## Summary

The purpose of this chapter was to describe the research methodology of this study, explain the sample selection, describe the procedure used in designing the instrument and collecting the data, and provide an explanation of the qualitative procedures used to analyze the data. The study method was qualitative and phenomenological, with FMG/C as the phenomenon studied. Four research questions guided this discussion.

Approximately 12 women who have undergone FMG were selected from Sierra Leone (where the total number of the female population eligible for inclusion exceeds 60%) to participate in both interviews and analytic observations. The interviews involved informed consent, knowledge of confidentiality, and assurances that the contents were used only for academic purposes would be destroyed. The women were contacted by trustworthy figures from the community, such as clergy and health care providers. The data collected was subject to thematic analysis, honing in on the most common responses.

Chapter 4 includes a report of the results of the research study and Chapter 5 is a discussion of the findings.

# Chapter 4: Results

The aim of this study was to explore the lived experiences of FGM/C among women from Sierra Leone, including their resiliency to overcome the physical and emotional effects of the practice. To accomplish this, I conducted semistructured, open-ended interviews, utilizing techniques of analytical observation described by Finlay (2013) and Gele et al. (2013). Through these systematic and holistic observations, I obtained evidence of the unique and pre-existing belief systems inherent to women from the Sierra Leone community.

Through in-depth interviews, I explored women's lived experiences to better understand the perceptions these women had concerning the practice of FGM/C. Through this inquiry, I hoped to shed light on the persistence of the practice and the resiliency of the women to overcome the trauma of the procedure. A thoughtful consideration of these objectives and a thorough review of the existing literature led to the development of the following four research questions.

## Research Questions

The following research questions guided the study.

**RQ1.** How do Sierra Leone women who have undergone FGM perceive the practice?

**RQ2.** What concerns, if any, do Sierra Leone women who have undergone FGM have about the relative safety of the practice?

**RQ3.** How do Sierra Leone women who have undergone FGM feel about having FGM performed on their daughters?

**RQ4.** To what factors do women who have undergone FGM attribute the continued persistence of the practice?

## Setting

Sierra Leone is located in the western hemisphere of the African continent with a population of 6 million. Sierra Leone is one of the poorest countries in the world, and recently struggled with the Ebola crisis. Currently, the All People's Congress Party govern the country. Sierra Leone has two major tribes, the Temne in the northern part of the country, and the Mende in the southern region of Sierra Leone. Sierra Leone has a total of 12 tribes, including the ex-slaves who returned and settled in the western part of Sierra Leone (the krios). The krios were not considered part of Sierra Leone and are not granted any political head of state position. Krios do not undergo FGM. Only the indigenous people from the north, south, and east of Sierra Leone perform FGM. Krios are considered outcasts and were never part of secret societies associated with FGM.

## Demographics

The sample for this study consisted of 12 women originally from Sierra Leone who had experienced FGM. The selection criteria for this study were (a) participants older than 18 years of age, (b) participants had undergone FGM, and (c) participants were willing to speak about their experience. The respondents who participated in this study resided in Europe, the United States, Sierra Leone, and Australia. Their ages ranged between 20 and 60. The participants belonged to two tribes—Mende and Temne. Three of the participants were married, four were divorced, and five were single. Three of the participants identified themselves as Sowei, or women who conduct FGM rituals. No

more specific demographic information was shared to protect the participants' confidentiality. Pseudonyms were used to add a further layer of protection for the participants.

## Data Collection

Data collection started by first posting flyers on the Internet about the study. Interested participants telephoned and contacted me. I obtained names and contact information, and e-mailed informed consent forms and an explanation of the study to each participant. A date and time were scheduled for each participant to be interviewed. The participants e-mailed a copy of their signed consent form before the interview began. Participants then received a GoToMeeting logon to use for the interview.

Each participant logged on to GoToMeeting.com with an ID for the interview. The meeting began with an introduction. Next, I reviewed the informed consents and answered any questions the participants had. Several participants were concerned with how the data would be used and concerned with confidentiality. I carefully explained confidentiality and informed the participants that any identifiable information would be removed and not reported in the study. The participants were told many of their responses would be conflated to further hide their identity and to protect the participants' confidentiality. Once participants were satisfied, the interviews commenced. The interviews lasted for 30–60 minutes.

All participation in the study was voluntary and confidential, and the participants were informed that they were able leave the study at any time and for any reason without fear of repercussion. The meetings were recorded using the GoToMeeting technology,

with the participants consent. Once the interviews were completed, the participants were given the opportunity to ask any further questions. The participants also received a list of local resources for free support in case they felt any distress after the interview was finished. Once the interviews were complete, I download and transcribed the data in preparation for the analysis process.

## Data Analysis

Using Braun and Clarke's (2013) thematic analysis method, I analyzed the data. During Stage 1, I repeatedly read the transcripts of the recorded interviews to become deeply familiar with the collected data. During this time, notes and observations were made to help guide later analysis. I made comments on emergent patterns, word usage, and other points of interest while reading. Table 1 provides a sample of this process.

Table 1

*Transcript Commentary*

| Raw Data | Researcher Notes |
|---|---|
| The culture is that is what it is, that's how it was, that's how it's been. To us, people think ... Most people who have been through it think we are victims, but we regard ourselves as members. | 1. Very strong emotions about not being called a victim.<br>2. Culture was accepted. |
| All right. We laid down and that's all I did, I just complied, laid down and they ripped whatever they were ripping off. Actually I didn't know what was it. I didn't scream 'cause I was so terrified. | 1. Was very compliant.<br>2. Did not really understand what was occurring.<br>3. Did not scream because of fright. |

In Stage 2, all data were uploaded into NVivo 11 to aid in the organization of the data. Tasks associated with the use of NVivo 11 included organization, coding, analysis of word usage, and analysis of word frequency. I then began to break down the data into separate chunks. Each chunk consisted of words, phrases, or paragraphs that contained a

specific meaning. A code, which is a descriptive phrase, was assigned to each chunk of data (Braun & Clarke, 2006). I coded 337 units of data into 79 different codes (see Table 2 for a representative sample of codes and assigned data).

Table 2

*Codes and Associated Raw Data*

| Code | Raw Data |
|---|---|
| It was painful | It was painful and I had to cry.<br>All you felt was pain. Not too much pain, because it was very fast.<br>It was always painful for a few days and after that the pain subsided |
| It is not good | Otherwise I don't see no importance of really cutting off the clitoris. I have nothing, you know, nothing good about it.<br>I don't think they should be doing such I don't think so, because the clitoris means a lot for the woman. |

The codes were interpretive or descriptive. Each code expressed the meaning of the data in a manner that conveyed the meaning clearly enough and reference to the data was not required.

In the following stage, I merged the codes into groups. Each group formed an overarching umbrella of meaning. This grouping continued until all pertinent codes were assigned. Table 3 lists an example of combining codes into categories.

Table 3

*Categories and Associated Codes*

| Categories | Codes |
|---|---|
| Personal experience with FGM | Age<br>Bleeding<br>Was scared<br>Did not know what would happen<br>Festival<br>I cried<br>It was horrible<br>It was painful<br>Knew what they were going to do<br>No issues<br>No power to refuse<br>Time to heal<br>Learning<br>Celebration time |

Once categorization was completed, I explored the groups to assess if groups could combine or if a group of data was strong enough to stand on its own and form themes. Three factors were considered when creating themes: (a) did the theme apply to a research question, (b) did the theme crossed three or more, and (c) was there a central organizing idea that tied the theme together. Table 4 contains a list of themes and associated subthemes. Some themes had subthemes to better organize and display the complexity of responses that made up a theme.

Table 4

*Themes and Subthemes*

| Themes | Subthemes |
|---|---|
| Participant definition of FGM | |
| The lived experience of FGM | |
| FGM has many cultural and social aspects | Rituals associated with FGM<br>Participants had strong social and cultural beliefs connected with FGM |
| Participants had different personal beliefs about FGM. | |
| Views about FGM are diverse | Men's viewpoint on FGM |

During Stage 4, I reviewed all themes for quality, cohesiveness, and depth. Stage 5 included describing and defining the themes and creating a name for each theme. In the final stage, I reported, wrote, and edited all themes.

## Evidence of Trustworthiness

### Credibility

To ensure the credibility of the study, I engaged bracketing, or the setting aside of my personal worldview to enter the world of the participant (Moustakas, 1994). In my field journal, I identified my thoughts, feelings, and beliefs about FGM to acknowledge those thoughts and then remain mindful, which ensured I did not impose my own worldview onto the experiences of the participants. Other strategies employed to enhance the credibility of this was the use of thick description and member checking. I encouraged the participants to speak in as much detail as possible using effective interview questions, and probes when necessary. I engaged in member checking and invited participants to thoroughly review and comment upon the analysis of their interviews. No changes were requested by any of the participants.

**Transferability and Dependability**

Assessing the transferability of a study is the responsibility of the reader (Tracy, 2013). Methods of ensuring transferability included having thick description and as much variability across participants as possible. In addition, I restricted the sampling process using purposeful sampling, listed the number of participants, described each step of the data collection process, reported the number and length of all interviews, and kept a record of the length of time required to gather all data. This information should help other researchers make accurate judgments regarding the transferability of the results to other populations. I recorded all steps and choices in my field journal in enough detail to allow another researcher to easily replicate my study. Throughout the study, I kept a detailed log and field notes throughout the study.

**Confirmability**

The results of this study reflected the participants' voices. All themes arose from the lived experiences of the participants. An essential component of confirmability is reflexivity. I placed my biases and preconceived ideas aside and entered the life world of the participants. As a researcher, I followed rather than led the conversations with the participants. My role in the interview process was to get as much detail as possible from the participants and ask for clarification when necessary. After every interview that I completed, I immediately recorded my thoughts and observations in my field journal.

## Results

The results of the analysis are organized by theme, as represented in Figure 1.

**Definition of FGM.**

All 12 participants in the study were asked to provide their personal definitions of FGM. The responses were equally divided and are reported in Table 5.

Table 5

*Participant's Definitions of FGM*

| Participant | FGM Definition |
|---|---|
| Participant A | In my own words, I will describe female genital mutilation as the cutting of the clitoris. |
| Participant B | I think it's defined as genital mutilation as. . . like cutting your genitalia, isn't it? |
| Participant C | Right of passage. |
| Participant D | It's bad. It is bad. I will not even support it, for nobody. when you are there, it is traditional but it is not even about sex. You see what I mean? Even after female mutilation. Up until now, I can feel and enjoy sex without any circumcision but I don't think it is right and I don't think it is safe. Why would you remove somebody's clitoris? Because of what? I don't even know the fact why they remove it. I really don't understand why they remove it. Why the removal? Well, for me, it doesn't even make sense to me. They continue doing it and it doesn't matter. Why people are doing this non-sense? Believe in me, I think it's non-sense. I think it is non-sense. |
| Participant E | It's a secret society. When they initiate female- It's an organization, a society. |
| Participant F | Our society. In other words, Participant F is saying that in her experience, the family comes together and it's a pleasure time, it's happiness, when you're about to go through the society |
| Participant G | It's just basically the removal of the clitoris. Like cutting it off. |
| Participant H | Female genital mutilation is the cutting of the clitoris to maintain virginity. |
| Participant I | Yeah. Female genital mutilation is when they cut the clitoris. The cutting of the clitoris. |
| Participant J | What comes in my mind, it's like when they take you in the forest, and go through the pain, we call that the pain, because when they cut the clitoris, it's a pain to you. That's what comes in my mind. |
| Participant K | Well, this is what I'm going to say. If it was something I know, I know I was not going to do it, I did it because I didn't understand and I didn't know. It hurts me greatly because if they did not, for my own personnel, I know, if you're not circumcised as a woman, it's something in your head that, "Oh! I need a man, I'm not," you know. When they take that thing off, you really actually don't have feelings that much for a man, that's the kind of way I feel. Like is said, yeah. |
| Participant L | Cutting out the clitoris. |

Participants either offered a brief clinical definition, such as "cutting out the clitoris (Participant L)" or went into more depth and spoke about the cultural and social

connections associated with FGM. Six participants offered the short definition describing the actual act of FGM. Two of the participants did not mention the physical aspect of FGM. Instead, these participants focused on the cultural aspects, with Participant E saying, "It's a secret society. When they initiate female- It's an organization, a society." For her, the physical act of FGM did not figure into the definition, the focus was on the initiation and belonging to a larger group. Participant F did not speak about the physical aspect of FGM and also focused on the culture and rituals surrounding the practice. She said, "the family comes together and it's a pleasure time, it's happiness, when you're about to go through to the womensociety."

Two of the participants focused on the negative aspects of FGM. They talked about the pain involved, and spoke about the practice in highly negative terms. Participant J said, "What comes in my mind, it's like when they take you in the forest, and go through the pain, we call that the pain, because when they cut the clitoris, it's a pain to you." Participant D agreed and said, "That is just in itself, because female mutilation is something that I would not teach."

**The Lived Experience of FGM**

Participants in the study spoke about their personal experiences with FGM. They explored the decision-making process, the actual physical experience, and their thoughts and feelings at the time. This theme represented their experiences with the practice from their point of view. The age range when the participants underwent FGM varied from 10 to 28 years old. Because the participants spoke in detail and at length about their highly

personal experiences, in order to protect confidentiality, I conflated and paraphrased the reported data, which were then used to create an overall description of the experience.

For most participants, the experience of FGM began with little notice. They generally received little information or time to prepare. The women were woken up by a senior member of their family and told to prepare for a journey into the bush. For some, the trip was frightening, but for others, it was filled with excitement. Many of the participants did not know what would occur—they simply understood it as a ritual used to welcome them into adulthood. The participants who were aware of the process did not feel they had the power to refuse. They believed their family had the power to mandate FGM and there was no one to gainsay that decision.

Some participants remembered it as a time where they received presents, new clothing, make-up, and were made to feel special and pretty; for others, the actual process of FGM ruled their memories. The participants spoke about the entire process of FGM, which involved the procedure and rituals surrounding it. The length of stay in the bush varied from a few days to a few weeks. The bush is the wilderness. Participants go there to get away from the village and daily life.

The women were highly detailed when describing the actual process of FGM. Most participants were blindfolded and told to lay still and not cry out. They were given no medication or pain relievers. The participants reported laying on the bare ground and the next thing they were aware of was a sharp pain. The pain was described as a sharp cut and some participants screamed out, while others were silent. Many reported bleeding heavily, with infection being a common concern. The participants spoke about how some

girls died during the process from infection, or bleeding. The women reported the use of indigenous roots or plants that were supposed to ease pain, however, none indicated that the homeopathic remedies were efficacious. Many described the healing process as terrible and lengthy. For some women, the initial procedure was not deemed effective and was redone in the following days.

Once the procedure was completed, the women recalled being given time to heal. For some, this was a time of rejoicing, for they had joined a society of like women. The participants spoke about being spoiled and taken care of by the adult women. They were feasted and taught secrets associated with being a woman. This included learning to cook, sewing, and oral histories. The participants spoke of this as a time of growth and rejoicing. Many participants indicated they had fun and spent time singing and dancing once they had healed from the procedure.

Some of the women indicated they were happy and excited. Even if later in life, when they came to regret the procedure, many still found value in the attendant rituals and ceremonies. Some of the women regarded the entire process as positive. They believed in the process and wished for their children to follow in their footsteps.

Other women reported being traumatized by the entire experience. They believed the FGM should stop, though a few wished to keep the associated culture and rituals. For these women, the quality of their lives were profoundly affected and they were determined that their daughters would never undergo FGM. These participants spoke about the pain they felt and how difficult the healing process was for them. The women indicated that it was horrible, with some likening it to kidnapping, being tied down, and

forced to undergo a procedure with no form of consent. For the participants who did not know what would occur, the experience is one they indicated they would not have consented to if they had an understanding of FGM.

Women spoke in detail about how FGM left them with little desire for sexual relationships. Many of them saw this as a significant detriment to their overall levels of life satisfaction. Participant G said, "we are the ones struggling with their sexuality." She acknowledged that because of FGM, she had difficulty enjoying a sexual relationship, "Our sexual libido is very low.… It really has to take a good man that understand your body to really be patient to even arouse you in bed." Participant H agreed and said, "women that went to FGM are the ones that complain about not enjoying sex. It takes longer for them to reach orgasm, if any." The participants talked to women who had not undergone FGM and found that their counterparts were able to have a much more satisfying sexual life than they were. Isabel described this feeling as, "kind of traumatizing." Other participants did not seem to mind this lack of desire. Participant K said, "I really don't care, I don't worry about having sex with a man, it's something that doesn't… If I have to do it, that's fine, but if I don't have to do it, I don't care. I'm good with it, and I thank God they did it." She was grateful for FGM and felt that she was not missing anything. She was satisfied with her life as it stood and was grateful that she did not have to deal with sexual desire.

Overall, opinion was sharply divided regarding FGM. For some, it was part of a ritual that they felt positively about. They believed it was important to undergo FGM with all attendant rituals and were proud to have the experience. For other participants, it

was highly traumatic and violating. They would not have agreed to the procedure, and some felt forced into acquiescing to a mutilation they did not believe in because they did not have the power to refuse.

**FGM: Cultural and Social Aspects**

Participants in the study spoke at length about the rituals associated with FGM, their social beliefs, and cultural connotations of the practice. This theme was broken down into a series of subthemes to better tease out the complexities of the experiences, perceptions, and beliefs of the participants. The subthemes included rituals associated with FGM and participants had strong social and cultural beliefs connected with FGM.

**Rituals associated with FGM.** FGM was described a rite of passage by some of the women in the study. Participant K spoke about it and said, "it's a traditional thing." She went on to compare FGM to the western idea of a sweet 16 party, or the Hispanic Quinceanera, which represent a time to celebrate the first steps into adulthood. Participant C agreed and said, "For us, I think it's like the rite of passage. That's the impression it gives the girls when we're growing up, like the right of passage." FGM was regarded as an important step on the path to fully functioning as a woman. Emmeline agreed and spoke about why being part of the women's society was so important. She said, "they will be proud of themselves… Having been initiated by the secret society. Wherever I am going I can most of that, but to my friends, anybody that comes around you [and mentions them knows that you are a member]." Several of the women indicated that to not be a part of the society was to forever be an outsider within your own culture. Participation in FGM and the associated rituals was seen as the passkey to the society.

Without it, women could be denied access to the social and cultural aspects of their communities.

Some of the participants in the study had a strong belief in FGM. These participants felt it was necessary and a part of their culture. Other participants valued the culture, but not the FGM procedure. Regardless of their opinion about FGM, all participants believed that the rituals and culture associated with FGM were important. Participant B spoke about this and said being part of human society was important. She said, "it's a big shame if you are named as a woman that is not part of the society. You need to be a part of it. If not you will just be like nothing." Participant C agreed with her and said,

> it's like you're accepted now in certain parts of the society. You're acceptance in certain parts of the society, you can talk where all the women talk, you can go where? all the women go. You're allowed to go a lot of places, you're not ostracized.

By undergoing the FGM ritual, women were initiated into a society of womanhood. Without this initiation, the individual would be constantly on the outside looking in.

Many traditions were associated with FGM. Participant G shared a conversation she had with her daughter and said:

> I'm still fascinated about and am still passionate about is the culture. The dancing, the singing which I'm involved, that I'm a cultural dancer. I like to, you know, tell her about my culture. . . If we can just keep the culture and the teaching that they do, you know, trying to become a better wife, teach you how to cook, teach

> you how to clean up, those are really good. I mean, don't get me wrong, I love the culture. I love everything about the culture, because it is like raising a child to become a better person. Manners, they teach us manners and morals.

She believed in the values associated with the culture and wished to pass on and share the rituals associated with FGM without the actual procedure. Other participants had similar feelings. They found significant value in their cultural beliefs and felt it was important to carry on those traditions associated with FGM.

Some participants spoke about a few of the important traditions included with the practice of FGM. Participant A said, "after three days, there are some teachers who would teach us how to sing. How to cook. How to do some basic stuff like women's stuff. That's the reason why we have to stay there for one month." The time following the procedure was regarded as a period of education. Girls were taught how to be women. They learned skills, shared experiences, and became prepared for adulthood. Participant A believed it was a period of growth and reflection marked with joy expressed by singing and games. She found that part of the FGM ritual to be valuable and important.

Although Participant B did not have a positive experience, she did speak about the intentions behind the rituals associated with FGM:

> Other women, some other girls, they are happy, because they kept it sacred and they think it's all about pleasure and happiness, and other things, like magical things, the way they explain it to you sometimes, like magical things happened.

A spiritual connection to the rituals exists, which was regarded as highly important. Participant C spoke about the emotions and feeling associated with the ritual and said, "it

was just like jubilation and just eating food and being pampered and spoiled." It was a time to celebrate being a woman. No men were allowed and the focus was upon women and womanhood. She went on to speak about this and said, "[they tell] stories, experiences and all sorts of things about womanhood, where they grew up." Participant G also spoke about the associated rituals and said, "the only importance about FGM is just the social interaction and the teaching, how they teach us how to take care of your household. How to behave as a woman. How to speak. How to compose yourself." She went on to clearly state, "The only thought I have about it is the culture, the dance, the ceremony, people coming together, the fun. Otherwise I don't see no importance of really cutting off the clitoris." Participant G was clear in her dislike of the actual procedure of FGM, and separated it from the associated rituals.

**Participants had strong social and cultural beliefs connected with FGM.** The participants in the study carried many different social beliefs regarding the practice of FGM and the reasons behind the practice. One of the strongest beliefs expressed by women in the study was that women cannot control their own desire. This was the reason the participants believed the practice of FGM was essential. Participant A spoke in some detail about the reasoning for the practice of FGM:

> Social aspects of the female genital mutilation is that… They are trying to limit young girls from chasing after men. It's like we are preserving them to wait, to preserve their virginity to wait for their husbands. These people, our people, they believe that by performing this procedure on them, it will take away their sexual desires from them so they will not think about men. They will just stay focused

> with their deeds in school for doing something else until their time to get married arrives.

The belief system surrounding female desire was extensive. The participants indicated they thought women were incapable of controlling their sexuality. Through FGM, they believed women would be able to focus on their lives rather than their desires. Participant A went on to say, "They [women] can't control their feelings and stuff like that and women who did the procedure, they would tell you, we felt good. We did it."

Participant C spoke about this topic and took it one step further. She said, "I think women who have not been through FGM over sex." Women seem to regard women's sexual desire as a force that was not controllable. Women were perceived to be at the mercy of those feelings. Participant F spoke about this in a slightly different context and said, "they [girls] grew up with a family that can actually control them. Once you go through the tradition, the practice itself, the circumcision, it's a whole different ballgame, where you have to listen and follow the direction of others." The participants seemed to perceive women as needing strict boundaries and guidelines to manage their behavior. FGM was linked to this control. Participant H agreed and said, "women that never went to the bush or have the FGM are sexually active, they are always itchy."

Participant A spoke about the perceived link between prostitution and FGM. Like others in the study, she believed a lack of FGM increased prostitution. She said:

> I think, another reason is they want to limit prostitution because some of these girls, they believe that if they are not circumcised they will go out to be chasing men for money as what is happening in Sierra Leone. We are seeing a high rate of

> prostitution there. The reason being is because of poverty and most of these girls now, I believe a huge percentage of them did not do the procedure.

Although she acknowledged that poverty existed and could be a contributing issue, she believed the lack of FGM was the main reason for the increase in rates of prostitution.

Participant K spoke about her personal experience with FGM and said, "you can't just go sleep with any kind of man, those kind of people, they need men as much as they want, they want to sleep with the men at any time." She believed she was fortunate to have undergone FGM because it protected her from her own desires. She went on to speak state, "I'm grateful because sometimes I don't have feelings for men.… I'm not desperate. That's the difference with women who are circumcised and women were not circumcised. They need men at any time." She had a foundational belief that the only thing that reined in her desires was FGM. She went on to speak about her nephew and his girlfriend who had not undergone FGM, and criticized her for an excess of sexual desire.

Participant G also spoke about FGM in relation to what other people thought. She specified she believed women who were illiterate carried these ideas. She said, "our people. . . They think women who are not circumcised are very loose, like they are not sexually satisfied easily. They tend to go around sleeping with every man." Participant G did not agree with this viewpoint and said, "I don't really want to agree with people that think women who don't have FGM are loose." She went on to say she found the entire belief offensive and did not see any justification for the idea that women needed to be controlled because of their sexual desire.

The underlying thought that the participants expressed was women who did not undergo FGM had no self-control. They were at the mercy of their own sexual desire and would be unable to commit to a single person because of their inability to be free of desire. Many of these women believed without FGM, they would be regarded as loose and they would not be able to concentrate on anything else other than having their desires gratified. For this reason, they advocated the use of FGM and felt fortunate that they did not have to manage unruly sexual feelings.

Many of the women who spoke about women's desire in connection with FGM believed the ritual was important because it removed female desire. Participant L said, "the difference is those who went through it have less desire, and those that did not go through it have high interest of sexual desire." Other participants spoke about this as well. They indicated one of the reasons for removing the clitoris was to reduce the amount of desire women felt. Participant I spoke about how this was important because often men had multiple wives, thus women who had lower levels of desire would not complain about a lack of sexual attention.

Another strongly held social belief was that to become a woman, it was necessary to undergo FGM. Connected to this thought was the idea that undergoing FGM was linked to a sense of pride and belonging. A part of being a woman was being a member of women's society. To gain membership, undergoing FGM was required. Emmeline said, "they'll be proud of themselves in society." She believed membership in the group enhanced participants own sense of pride and accomplishment. Participant F indicated the skills associated with being a woman were taught in the period of time that girls

underwent FGM. They returned to their villages with a series of skills they did not have previously. Participant J indicated being a member of the society enabled participants to access traditional female wisdom. She stated they were taught about managing a household, bearing children, and sex. She went on to speak in detail about being accepted as a woman:

> If you didn't go to society you're not a full woman. We have some tribes that never go to society… Sometimes when we are talking, we can't allow them to come closer, sometimes when we are in gathering, those are going to society, and those that are not, we cannot mix together, because we always have that demarcation among ourselves.

Thus, for the women who do not undergo FGM and the associated rituals, life as a woman in society can be significantly limited. Not undergoing FGM can mean the individual has not taken the first step into full adulthood.

Some of the women in the study shared the belief that the clitoris is unclean. Participant A spoke about this in some detail and said:

> those who went to the cutting, they will tell you that's okay, we are clean and those who did go to the procedure, they would tell them. They are clean, they cannot even clean themselves because there is a lot when people are talking about the clitoris, they will tell you that is needed to be done. Sometimes it is itchy. . . you have to be warming yourself like you have to soak it a towel and hot water to warm it.

The women were taught the clitoris was associated with uncleanliness. They were raised to believe that having a clitoris required a large deal of care and grooming. Participant H spoke about this and said,

> these women who did not undergo FGM women were unclean because they believed that they need too much work to be done between their legs, they need to be cleaning themselves, they believe that the clitoris is making the women dirty.

Some of the participants spoke about how the cultural aspect of FGM is deeply intertwined with the social aspect. They believe in FGM or feel others believe in FGM because of their traditions. Participant C spoke about the belief and repeated a conversation. She said, "This is my culture, this is what I grew up in, grew up knowing. I don't know, you get caught in between because you really don't know." For many individuals, it was difficult to separate their established feelings and beliefs about FGM. Participant A spoke about this and said:

> When you talk about the traditional aspect of it. It's like people just want to maintain their culture. It's not good or they are talking bad against it. They just want to belong in a group to preserve this FGM thing. There is more to the cutting than what people are seeing. They have like all these other things that women come together to empower themselves. Among them, they have like hierarchical structure where they give themselves powers on what to do and what's not to do or when there is something who takes the lead who should not. A lot of things that they are doing there. The cultural aspect again is tied with the social parts.

The participants indicated their cultural and social lives were tied together. It was not possible to separate one from the other as most of their social interactions and beliefs were shaped by cultural practices. Participant C said, "The culture is that is what it is, that's how it was, that's how it's been. To us, people think ... Most people who have been through it think we are victims, but we regard ourselves as members." She saw FGM as an integral part of their culture and did not feel as if she needed to apologize for her belief.

The women expressed that people valued and wished to retain many aspects of FGM. Many people believed the procedure was essential to maintain social balance. Virginity in a bride is prized and it is thought that FGM helped preserve virginity until marriage. Participant A said, "it's a pride to be married while you are still a virgin." Social values were connected to pride in family and a part of that pride was virginity in a woman. Culturally, the practice of FGM was thought to encourage chastity in women, help them control desire, and maintain balance. To be a part of women's society, FGM was considered mandatory.

**Participants Had Different Personal Beliefs About FGM**

The participants in this study had differing beliefs regarding the practice of FGM. Some participants believed in FGM and felt the practice should continue, others were against the practice of FGM, and a third group crossed both groups with a desire to preserve the rituals associated with FGM. Participant A spoke about the divide and said:

> Well, they have like divided opinion. Some of them, they don't want to talk about it because of their experiences. Some of them like to talk about it to share their

> experiences with other people. A quite percentage of them, they don't like the idea. They just don't like the practice because they see it as a brutal and unfair to girls. They believe that they should not do any cutting from the girls. They should leave them the way they were born and let them be like, let them enjoy their sexual life. They see it as an interference in their personal life.

The views about FGM often differed depending on personal experience. Some of the participants were adamantly against the practice of FGM. They did not believe in the practice and felt it ruined lives. Participant D said, "I don't think you should get cutting. I mean, our tradition. That is one part of our traditional culture that should never exist. We should eliminate it." She did not see any value in the practice. Participant E believed FGM was against the "will of God." This participant believed the practice was "not good" and wanted to effect changes in the practice.

Participant I spoke about the dangers associated with FGM as a reason to cease the practice. She spoke directly:

> I think this kind of thing should not continue. If there's a way I can stop it, or like you have started your research, you can help to push it forward, to put it forward, together, and tell them the advantages and disadvantages of it.

She worried about the infection, blood loss, and death associated with FGM. She felt the practice of FGM was highly painful and served no real purpose. Participant D spoke about FGM as, "the most useless thing any woman can go to." She was very angry about FGM and said,

> No anesthesia, no, nothing. You will bleed and bleed and bleed to death if they are not careful. If you do not have anybody that is concern about you. Why do they do that? I mean, I don't know and understand why do that. No. Honestly. That is the worst thing anybody can do to anybody.

Participant D could see no reason for the practice and did not support its use for anyone.

Some participants felt that FGM should be a choice. They believed that no one should be forced to undergo FGM, but if a woman wished to engage in the practice, she should not be stopped. Participant G spoke about this and said, "if they want to continue, if you want to do willingly, fine, but I will encourage them to teach them the hygiene and the dangers of, you know, the infection, the effect of losing blood." Personally, she wished to see the procedure eradicated. She was strongly in favor of keeping the culture but wished to see an end to the procedure of FGM.

Participant A spoke in support of the practice of FGM. She spoke about her own experiences and said, "Yes, I have no regret doing it but the thing I don't like is my parents will have wait for me until probably I am old enough to ask for my consent." Her only wish was to have been able to consent to the procedure rather than having her parents make the decision for her. She went on to say, "Oh, it's normal. Even after when they did the procedure, everything is normal. I believe those who are saying it is normal." Participant L also was in favor of FGM and said, "With me, I think I'm for it, since I've gone through it. . . To tell you the truth, I don't really have any concerns about it." These women found the practice to be normal. They felt it to be positive, and were in favor of the practice.

The women were also divided on whether they would have their daughters undergo FGM. Participant L said, "Since I have girls, I would let them go through that [FGM]." She believed in the practice and felt it would be beneficial for her daughters. Participant F said she was carrying on the tradition, she liked to keep the tradition going, and would like her daughters to go into the *bondo*—the entire tradition of FGM, which includes the ceremony, the cutting, and the teaching during the time spent when taken away to the bush. Participant F indicated the main reason she wished to have a daughter was to have her go through FGM as she had in order to keep the tradition alive. Participant H also wished for her daughter to undergo FGM she said,

> I will explain to her the advantages and disadvantages of female genital mutilation. Mostly people just see the cutting part as the whole thing of the female genital mutilation, but there are a lot of benefits about this FGM, which people don't know and people don't want to talk about it.

Some of the participants indicated undergoing FGM should be a choice. They were willing to offer that choice to their daughters and let them make the decision. Participant C said, "If she wants to, she can. Really, if my daughter wants to, she can." Participant C believed undergoing FGM would bring her daughter a better understanding of her culture, but believed the decision should be made by her. She went on to speak in more detail about the process:

> I believe if they try to educate the population about the advantages and disadvantages of the female genital mutilation, it will be nice to know so that they will not even run away, they will know when it is right and when it is not right for

> them to do. It's their body. I also suggest that they should allow these girls to reach age of consent to do the practice on them.

She believed in the practice, but also felt it should not be performed on those who cannot give consent. Participant H felt the FGM was a good thing, and if people were educated about FGM, they would choose to undergo the procedure.

Some participants were strongly in favor of abolishing the practice of FGM and would not let their daughters take part in the procedure, even if they wished to do so. Participant D said,

> I am like, "No." None of my daughters, they won't even ask me. As well as my grandkids. They would never, never go into that. I would not let every woman in Africa go to all of that. This female mutilation that is crazy, that is the worst thing anybody can go through.

Participant D found the entire concept to be wrong and believed that no one, including her children or grandchildren, should even be offered the choice. Participant E agreed and said she would not let her daughter undergo FGM. She said even if her daughter approached her and wished to undergo FGM she would "stop her."

The participants had many concerns with the actual procedure. One of the primary concerns was infection. Participant A spoke about this and said, "Some of them they end up having infections. Some of them, I had another woman complaining that she cannot give birth to children because she went to the procedure." She believed practitioners should be educated and learn to do the procedure safely. They needed to learn modern techniques and use them to ensure safety for the girls undergoing FGM.

Participant C also spoke about this and indicated the hygiene associated with FGM needed to be improved. Other issues included concerns with sexual transmitted diseases, such as HIV, and excessive bleeding. Participant A spoke about the issue of possible death. She believed deaths occurred because of a lack of medical facilities. Participants believed safety needed to be increased to protect girls who underwent FGM.

**Views About FGM are Diverse**

The women indicated FGM was seen differently depending on the region, culture, and personal experiences. Several participants reported girls no longer wished to undergo FGM. Participant C believed girls did not want FGM because they were already knowledgeable about sex. She said, "The younger ones coming up right now, really, most of them, they don't want to be part of it, because of the sexual experience at our age, they don't think people should tamper with their bodies." She compared this to her experience and said she had less knowledge as a child and did not know what the difference was between having FGM and not having FGM.

Participant H spoke about current practices and said, "Because of the negative thoughts about FGM, a lot of girls are running away from the practice." She went on to offer more information and said,

> Once they realize that they are going to take them to be initiated into this FGM, some of them will leave that particular [village] and run away to some other place to be rescued so they will not do the practice on them.

She personally believed this occurred because of a lack of education. She felt if girls were educated regarding the procedure, they would wish to undergo the procedure and be glad it was done.

**Men's viewpoint on FGM.** The participants in the study spoke about FGM in relation to men's views of the practice. The viewpoints offered were as diverse as the views women had regarding the practice of FGM. Many of the participants indicated men were against the practice of FGM. Participant A said men did not know a significant deal about FGM. She said they did not "want to talk about it and they are always angry."

Participant H reported men had mixed views on FGM. She said, "Some men like it and some men don't. Those that don't like it report that their wives are having difficulties enjoying sex. They are numb in bed." She said that, in general, men believed that the practice was brutal and they did not like it. Participant K said, "Well, it's something that they didn't like, but like I said, there are men, when the kids are growing up [have their daughters undergo FGM], it's a traditional thing."

Some of the participants indicated men did not like FGM because it negatively affected their marriages. Participant G said,

> Out of my own personal experience I've been speaking about few men about the FGM and especially men living in the western world now like here in America, they don't really think that it should be done. There is no importance to them.

They did not feel FGM was necessary and believed that their sexual lives were negatively affected.

In contrast, some participants reported men had increased respect for women who had undergone FGM. Participant B said, "They respect that women have their own organization. They have their regards, their honor." Participant C agreed with her and stated, "The men I have spoken to, the men from the provinces, they still appreciate women who. . . really hold it dear for women who have been circumcised. They have a lot of respect." She went on to say that many times, men did not wish to discuss FGM out of respect for their wives. The men found FGM a part of their traditions and deserving of respect. Some participants indicated men preferred women with FGM. Participant E said, "It's okay to the majority of the men, some of them are proud. . . they will boast of their wife." The men were happy their wives had undergone FGM and proud that their wives were part of the women's society.

## Summary

Through this chapter, I presented the results of the study. Discussed in this chapter were the setting of the study, participants' demographics, data collection, issues of trustworthiness, and data analysis. The results of the analysis were presented and organized by theme. Chapter 5 contains a discussion of the results, implications for practice, areas for further research and limitations of the study.

# Chapter 5: Discussion

## Introduction

Based on initiatives by the WHO (2012), as well as comprehensive sociological and anthropological research, evidence exists of the psychological and physical damage caused by FGM/C procedures (Gele et al., 2013; Little, 2003). Prior to the current study, a substantial need existed for continued inquiry into the cultural experiences and belief systems surrounding FGM/C to better understand the effects of FGM/C on women and girls. Such study was also needed to help develop culturally sensitive strategies to ensure autonomy regarding decisions to participate in such risky practices. Thus, the goal of this phenomenological investigation was to review the cultural perspectives and experiences of Sierra Leonean women who underwent FGM/C to investigate their perceptions and safety concerns. In addition, I explored concerns among Sierra Leonean mothers regarding having their daughters undergo FGM/C, and to what they attributed the continued practice of FGM/C. Data from this study provided new understandings to help health and human rights organizations implement proactive safety measures for these women and girls.

Analysis of interview data revealed five themes related to participants' perceptions, experiences, and attitudes toward FGM/C. These themes included (a) participant definition of FGM/C, (b) lived experiences of FGM/C, (c) cultural and social aspects, (d) differing personal beliefs of the procedures, and (d) diverse perceptions on FGM/C. The aim of this chapter was to present a discussion of research findings and implications. The chapter begins with my interpretation of the findings, followed by a

discussion of study limitations, recommendations, and implications. The chapter closes with concluding remarks pertaining to the importance of this research and future investigation of the topic.

## Interpretation of Findings

### Participant Definition of FGM/C

Definitions for FGM/C given by participants indicated somewhat polarizing perspectives of the procedure. Some participants described the procedure quite literally, as "cutting out the clitoris" or "removal of the clitoris," and others described it positively, as a "rite of passage" or "a pleasure time." These straightforward, and even positive, definitions of FGM/C were likely the result of the norms and rituals surrounding the procedures in collectivist cultures (Mgbako et al., 2010). In collectivist cultures, such as those in Sierra Leone, emotional, financial, and spiritual resources are obtained through the maintenance of harmony with cultural norms and beliefs, such as FGM/C (Berer, 2010). African cultures are founded on peace and harmony with others, rather than independence and self-mastery. Thus, cultural norms, traditions, and status within one's community are important features that can perpetuate rituals, such as FGM/C.

Other participants provided more poignant definitions that revealed the physical and emotional wounds they associated with the procedure. In some of these more emotional responses, participants described the procedure as "bad" or painful. These descriptions mirrored reports from previous researchers (Fahmy et al., 2010), who found that Nigerian women who had undergone FGM/C regretted it and associated physical and psychological pain with the procedure. In addition, previous researchers who studied the

medical effects of FGM/C (Johnsdotter & Essen, 2010) substantiated the physical pain described by these participants.

**Lived Experiences of FGM/C**

Just as the definitions of FGM/C provided by participants were strongly divided, so were participants' lived experiences with the procedure. Some of the women described the experience as traumatic and regrettable, while others supported the ritual and were glad they underwent it. Although all the women described the actual process as painful, their perceptions of FGM/C varied. Many of the participants welcomed the procedure because it indicated a coming of age or rite of passage into womanhood. Undergoing FGM/C helped some of the participants feel more integrated into their communities and feel more connected with other women. Previous researchers indicated similar findings regarding African women's strong cultural connection with FGM/C (Ogunsiji, 2015; WHO, 1998). Participants described the period following the procedure as one in which they were celebrated and spoiled, and taught how to cook and sew. Even among participants who regretted the procedure later in life, the time following FGM/C was viewed as positive and exciting.

Much of the information participants shared regarding their lived experiences of FGM/C mirrored past scholarship. For example, previous researchers reported on the excessive pain, bleeding, and risks of infection associated with FGM/C (Johnsdotter & Essen, 2010). According to UNICEF (2010), two forms of complications occur during and after the procedure: (a) immediate complications, which include hemorrhage, shock, severe pain, infection, damage to adjacent tissue, tetanus, urinary problems, incontinence,

dribbling, recurrent infections, broken bones, sepsis and septicemia, HIV, and Hepatitis B infection; and (b) late complications, which include obstetric complications such as long, obstructed, painful and difficult labor, fetal brain damage and fetal loss, urethro-vaginal and recto-vaginal fistulae in all instances of the procedure. Death is also always a possibility. Because the procedure typically occurs without pain medication or antiseptic (WHO, 2010), it can be an excruciating experience that results in sometimes deadly infections. The instruments used for FGM/C can include a variety of unsterile tools, such as razor blades, sharp stones, broken glass, and kitchen knives (WHO, 2011). Often, procedures are performed back-to-back on multiple girls without cleaning or sterilization of instrument, increasing risk for infection. Yousef (2011) reported that among a group of 290 Somali women, 88% had undergone infibulation; 39% experienced immediate complications, such as hemorrhage, infection, and urinary retention; and late effects were seen in 37% of these women, such as dysuria, clitoral cysts, and poor urinary flow.

Some participants also discussed the effects that FGM/C had on their sexual relationships and satisfaction. Participants discussed how FGM/C created significantly low libido and women who had undergone the procedure were unlikely to want or enjoy sex. However, a lack of libido was not something that all the women felt loss over. In fact, some participants described feeling free from sexual desire and were glad they had undergone FGM/C because it kept them from wanting sex. Other participants, however, viewed their lack of libido as a significant detriment to their overall level of life satisfaction.

The effect of FGM/C on libido has been substantiated in previous scholarship. For example, Dattijo et al. (2010) found circumcised women to have significant psychosexual difficulties, such as decreased sexual activity and enjoyment of sex, lower frequency of orgasm, less synchronization of orgasm with their husbands, and a general sexual phobia. Vloeberghs et al. (2010) found significant differences in the arousal, lubrication, orgasm, and satisfaction levels between women who had undergone FGM/C and those who had not.

Regarding the positive perceptions that some of the women had of FGM/C, it is likely that culture and tradition were the reasons for such support. As mentioned earlier, positive perceptions of FGM/C are likely the result of the norms and rituals surrounding the procedures in collectivist cultures (Mgbako et al., 2010). The sharp contrast in views toward the procedure, then, may indicate differences in the value and importance that women assign to their culture. This contrast in views may also be an indication of orientation toward a more individualistic outlook, in which individuals are more concerned with their individual well-being and happiness, as opposed to collectivist orientations that value the common good of the group.

**Cultural and Social Aspects**

Many participants spoke considerably about the cultural and social aspects associated with FGM/C. The subthemes that emerged included (a) rituals associated with FGM/C and (b) strong social and cultural beliefs regarding the procedure.

Some of the women described FGM/C as a rite of passage or tradition. One likened it to a sweet 16 party, or the Hispanic Quinceanera. Women generally regarded

FGM/C as a culturally accepted aspect of growing from a girl to a woman. Key words used to describe the social and cultural aspects of FGM/C were "tradition," "rite of passage," "initiated," and "secret society." Women felt that to deny the practice would have meant denying their cultures, and the punishment could include denial of access to social and cultural community resources. Refusing to participate in FGM/C would place a Sierra Leonean woman in the position of an outsider in her own community, as she would be unable to fit in with the initiated women, and men may find her undesirable.

As mentioned earlier, FGM/C appeared to be a highly divisive topic among the Sierra Leonean participants. Some felt it was essential to emerging into womanhood, while others expressed resistance to the procedure. However, even among the women who spoke out against FGM/C, all still valued their culture. Thus, regardless of their opinions about the procedure, participants believed the associated rituals and culture were of significant importance.

In addition to the strongly held cultural beliefs associated with the actual procedure of FGM/C, women shared strong cultural beliefs for the reasons associated with the procedure. A common belief was women did not have the power to control their own desire. They believed without the procedure, women would have a hard time remaining chaste and refraining from promiscuous behaviors. Their uncontrolled sexual desires, then, could serve as a distraction that hindered them in school or other more important aspects of their lives. Participants seemed to regard women's sexual desire as a force that would exceed their control if they had not undergone FGM/C. Some participants even associated lack of circumcision with involvement in prostitution.

Through the procedure, participants believed women would be able to focus on their lives rather than their desires.

Another strongly held social belief was that to become a woman, it was necessary to undergo FGM. The skills they were taught, and the way they were ushered into the community of woman after the procedure, made many women believe FGM/C was essential to womanhood. Thus, for the women who do not undergo FGM/C and the associated rituals, life as a woman in communities that condone the procedure can be limited. Not undergoing FGM/C can be interpreted as the failure to take initial steps into full adulthood.

**Differing Personal Beliefs**

As mentioned earlier, FGM/C was a polarizing topic for participants. They either welcomed and supported it or were strongly opposed to it. Those who supported it spoke of FGM/C as normal and acceptable, while those in opposition discussed associated feelings of physical pain and emotional disempowerment. Regardless of their opinions of FGM/C, however, most participants desired to preserve the rituals associated with the procedure. Participants' views about FGM/C differed based on their personal experiences. Those against the procedure felt it was purposeless and painful, mentioning the risks of infection and uncontrolled bleeding. Other participants believed women should be able to choose whether to participate in the procedure. Even among those who supported the procedure, they wished they would have been given the opportunity to personally consent to the procedure rather than have their parents make that decision for them. These sentiments reflected participants' lack of autonomy with the procedure.

Another point of division among participants' personal beliefs surrounding FGM/C was whether they would make their daughters undergo the procedure. Most of the participants who supported the procedure expressed the desire to have their daughters circumcised, feeling it would ultimately be of benefit to the girls. Others shared the intention to allow their daughters to decide whether to undergo circumcision. Finally, a third group of participants wanted to see the practice abolished altogether and had no intentions of putting their daughters through it.

**Diverse Views on FGM/C**

Differing views on FGM/C seemed to be the result of differences in participants' regions, cultures, and personal experiences. An important finding revealed through this theme was that many Sierra Leonean girls no longer wish to undergo FGM/C. The reasons participants gave for girls' resistance to FGM/C included increased knowledge of sex and understandings of the procedure. Many of the participants explained they did not understand the procedure or what would happen to them when they went into the bush with other women to participate in FGM/C; thus, they did not resist. In the 21st century, however, many girls understand what the procedure entails and do not wish to participate. Consequently, participants explained girls will resist participation in FGM/C by running away from their villages. Generational differences in perceptions of FGM/C may indicate cultural shifts surrounding FGM/C in Sierra Leone. More research is needed to understand what prompts some women and girls to resist the practice, and if the social implications for resisting this cultural tradition are shifting.

Another significant finding was that many participants shared Sierra Leonean men were also divided on FGM/C. Just as the women were divided, some men supported the procedure while others did not. One participant who personally supported FGM/C believed men who opposed the procedure must not truly understand it. Men who opposed the practice did not like that their wives who had undergone FGM/C were unable to enjoy sex. Other participants believed men generally have more respect for women who undergo the procedure.

## Limitations of the Study

Several limitations were inherent to this research. First, this study was limited to the perspectives of Sierra Leonean women who had undergone FGM/C. Although opinions of the procedure were sharply divided among participants, it is likely that the viewpoints of women who had not undergone FGM/C would include another set of perspectives and attitudes. Additionally, participants in this study included women who now lived outside Sierra Leone, including Australia, Europe, and the United States. Thus, geographic removal from their native countries and cultures may have influenced respondents' perceptions and attitudes. Relocation to other countries presents the added factor of cultural assimilation, in which the values of the individualistic cultures, which are not supportive of FGM/C, may contradict or override the collectivist cultural values associated with the procedure in Sierra Leone.

This research may have also contained a degree of unintentional bias, as I am Sierra Leonean. I took measures, including bracketing and epoché, to prevent any personal opinions or biases from influencing the data analysis or presentation. Because of

the highly sensitive nature of the study, a possibility existed that participants may have held back from fully sharing their perspectives, or the details of their experiences that contributed to their perspectives. The diverse demographic characteristics of participants was also a limiting factor. While this diversity captured a variety of perspectives, it also broadened the scope and made it difficult to assess how certain demographic characteristics, such as generation or marital status, may have influenced women's attitudes toward FGM/C. I intentionally refrained from exploring the effect that these features may have had on participants' perspectives and attitudes to ensure the confidentiality of all participants.

## Recommendations

Findings from this investigation indicate several possible directions for future research. A particularly interesting theme that arose from this study was the divisiveness among men's attitudes toward FGM/C, as reported by participating women. In a patriarchal culture with a deeply engrained tradition of female circumcision, it would seem that men would likely support the procedure. Although some participants expressed the belief that men had higher respect for women who participated in the ritual, others shared that some men opposed the practice because it prevented their wives from desiring and enjoying sex. Future researchers could explore the attitudes and perceptions of FGM/C among men from cultures that support the procedure. Further, it would be interesting to explore specific demographic characteristics, such as generation and marital status, which may influence men's attitudes toward the practice. Because the practice of FGM/C is a deeply patriarchal one, changing attitudes toward the procedure among men

in the cultures who practice it could indicate a shift away from FGM/C. Human rights activists and others concerned about the emotional and physical dangers that FGM/C pose to women may be particularly interested in the influence of male attitudes toward the procedure and the rate at which it is practiced.

Although the protection of participants' confidentiality in the current study precluded an analysis of the influence of demographic characteristics on women's attitudes and perceptions of FGM/C, this does represent an opportunity for future research. Participants ranged in age from 20 to 60 and had different marital statuses (married, divorced, single), and these factors may have influenced their perspectives on FGM/C. Thus, future researchers may conduct large empirical investigations that utilize surveys to explore the influence of different demographic characteristics on women's attitudes toward the practice. An anonymous survey design could be employed to gather highly sensitive information without compromising the protection of participants' identities.

Another area of future study is the influence of cultural assimilation on women's attitudes toward FGM/C. Just as concerns for participant confidentiality precluded an analysis of the effect of demographic characteristics on attitudes toward FGM/C, those concerns also prevented an analysis of the effect of cultural assimilation. Respondents resided in four regions: Sierra Leone, Australia, Europe, and the United States. Thus, many of the women had left their home cultures of Sierra Leone that supported the ritual. Physically leaving those communities and becoming assimilated into other outside cultures, especially those with an individualistic orientation, such as the United States,

could influence women's perspectives toward the practice. It is possible that participants who left Sierra Leone and became submersed into other cultures had attitudes that became less supportive of FGM/C over time. Similarly, women who remained in the communities that practice FGM/C may be more likely to remain supportive of it. Thus, future researchers may consider a confidential survey design to explore the effect of assimilation to outside cultures on women's attitudes toward FGM/C. Specific considerations with such investigations may include the countries that individuals relocate to and the characteristics of the cultures that women assimilate into, according to culture models, such as Hofstede's (1984) cultural dimensions theory

Future researchers may also investigate differences in attitudes toward FGM/C between women who had undergone the procedure and those who had not. Because all women in this study had personally experienced FGM/C, I was unable to capture the perceptions and attitudes among women who had resisted the procedure. Future researchers could investigate attitudes among women who had not undergone FGM/C to explore factors that may encourage women to resist the procedure, as well as attitudinal differences that may exist between women who are circumcised and those who are not.

Finally, future researchers may explore the effect of exposure to information about FGM/C via the Internet and social media on individuals' attitudes and perceptions toward the procedure. If a growing awareness of the dangers of FGM/C is associated with increased resistance, this may indicate an influence of education or social networks on decisions to participate in or resist FGM/C. Researchers could also explore possible relationships between generation, access to technology, and attitudes toward FGM/C.

## Implications

Important positive social change and practical implications emerged from the current investigation. Women discussed the physical and psychological hazards of FGM/C, supporting findings from previous investigators (Gele et al., 2013; Little, 2003). Although many of the women were aware of the hazards associated with the practice at the time of the interviews, few were aware of these hazards prior to undergoing FGM/C. Further, most of the women had little control of the decision to participate in the practice. Among those who supported FGM/C, despite the psychological and physical pain of the practice, significant misinformation surrounding the practice existed. Such misinformation included the belief that uncircumcised women are unable to control their sexual desires.

The main social change implication that emerged from this study is the education of women and girls from cultures that practice FGM/C. Findings from this study indicate that proper education on FGM/C is needed to help women understand the risks associated with the practice, and to provide them with the autonomy to make their own informed decisions regarding the procedure. The dissemination of findings from this investigation may help policy makers better understand the experiences of FGM/C and how to educate individuals about the hazards of the practice. The social implications of educating women about the practices of FGM/C are profound. Education can enhance autonomy and empower women to make their own decisions, rather than to comply with the cultural status quo that is often shrouded in misinformation and secrecy.

## Conclusion

Although this study shed important light on the attitudes and perceptions toward FGM/C held by Sierra Leonean women, analysis also revealed many opportunities for future research. Research is needed to understand the effect of men's attitudes on FGM/C and the influence of demographic factors and cultural assimilation on women's attitudes toward the procedure. In addition, little is currently known regarding the effect that exposure to information about FGM/C via the Internet and social media may have on attitudes and perceptions toward the procedure.

As with all research involving highly sensitive cultural traditions and norms, this study on FGM/C among Sierra Leonean women required me to practice a high level of cultural sensitivity. Because I am from Sierra Leone originally, I was able to demonstrate an understanding and tolerance toward attitudes supportive of FGM/C, which may have been difficult for an outside researcher to do. Maintaining a balance between cultural sensitivity, health, and safety concerns for women who undergo FGM/C is difficult. The difficulty of this balance represents a challenge with addressing traditions, such as FGM/C. These procedures pose real risks to the health and well-being of women, but are deeply embedded in cultures and accepted, even celebrated, by the people who endure the rituals.

Perhaps the best way to address concerns regarding the dangers of FGM/C is simply to educate people about the procedure and ensure that they are provided with autonomy regarding decisions to participate. It is important that women are provided with access to information about FGM/C and are given the right to decide whether to undergo

the procedure. Because of the many risks associated with FGM/C, it is essential that women and men alike understand those risks. In addition, women need to be educated to understand the truth about the clitoris—its function in sexuality, and its unfair demonization as an organ that makes women fall victim to uncontrolled sexual desires. Although much room still exists for future research on the phenomenon of FGM/C, findings from this study indicated that the most powerful strategy for protecting women's health and well-being may be to educate them on the facts of the procedure. Thus, as is the case with many topics of human rights and cultural traditions, knowledge is power.

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# Appendix A: Sowie Biography

The Sowei is a 60-year-old woman who hails from a traditional ruling house and is the eldest daughter of a Paramount Chief. She was initiated into the FGM Bondo Society at the age of 16. This practice was mandatory for her in order to uphold the tradition of her people. She said, “Going thru FGM was a badge of honor,” especially at the all female High School she attended.

It was not until she went to the UK to further her studies that she first realized FGM could be embarrassing. This happened when she was being examined by a gynecologist for the first time. She didn't like the strange look on the doctor's face. Eight years ago, she was on holidays in her town where her brother is now Paramount Chief, when a group of ladies who had NGOs went to her town to educate traditional rulers, the Sowei and young girls according about hygiene and the disadvantages of FGM practice. Being an educated woman who had been exposed to Western way of life, the Sowei was very vocal and took an active part in the meeting. After a while, the tempo of the meeting changed and some of the chiefdom people, men as well as women became very angry that women who are not even country women would enter their town and engage in such discussions in the presence of their Chief and elders. The ladies were asked to leave which they did.

The Sowei was reprimanded for engaging in such an abomination. She was fined some money, some of which, the women used to perform rituals to appease the ancestors. They felt the need to do this because she hails from the ruling family and she may one

day be Paramount Chief. They believed it is her duty to protect and uphold their traditions which they hold sacred.

Whenever the topic comes up, one thing most women who've been thru FGM say is that they are members of a Secret Society and not victims. In fact, most women from her tribe do not think female circumcision affects them negatively. Most people from her tribe, men as well as women, are known for their sexuality thru their music or dance. Most people whether the Sowei or NGO holders stand to gain through the use of FGM. The Sowei get money, new clothing (lappas), chicken, new rice, palm oil etc. The NGOs are given thousands of dollars to eradicate the practice.