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Lived Experiences of Women from the Odi community in Nigeria of Female Genital Mutilation

Doris Atibinye Dotimi
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Walden University

College of Health Sciences

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Doris Dotimi

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Walden University
2016

Abstract

Lived Experiences of Women from the Odi community in Nigeria of Female Genital
Mutilation

by

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M.ED, University of Port Harcourt, 2011

PGD, Imo State University, 2007

Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
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Walden University

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Abstract

Female genital mutilation (FGM) is a public health challenge because it jeopardizes the health of women and girls. FGM is condemned worldwide but, it is still practiced in the Odi community of Nigeria. The literature on women's lived experiences of FGM in other parts of the world was reviewed, but knowledge is lacking on the lived experiences of women from Odi community in Nigeria. The purpose of this phenomenological study was to explore their lived experiences, their perspectives on the current legislation for the prevention of FGM, and their perspectives on the cultural myths surrounding the practice. The phenomenological lens was used both as the study design and as the theoretical framework which states that humans know the world through their experiences. This theory guided the study on how the women of Odi community attached meaning to their experiences with FGM. Nine women, 18 and older, who had experienced FGM, were recruited through a snowball technique. Data were collected through semi-structured, in-depth, face-to-face interviews. Colaizzi's method was used for data analysis. Five major themes emerged: (a) FGM is a traditional rite, (b) challenges of FGM, (c) FGM cultural myth instills fear, (d) ignorance of legislation against FGM, and (e) needs government intervention to halt FGM. Participants recommended the enforcement of the legislation against FGM. The findings of this study will be communicated to stakeholders of FGM in the Odi community and in public health journals to serve as a basis for further research. The implication for social change is that maternal and child health will be improved.

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Dedication

I dedicate this work to my God, family and friends who stood by me through this journey.

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Chapter 1: Introduction to the Study

Introduction

Female genital mutilation (FGM) is recognized as one of the traditional practices in the Africa that violate the rights of women and children (Wadsesango, Rembe, & Chabaya, 2011). The grave consequence of FGM is that it puts the health and wellbeing of women and girls at risk. The World Health Organization (WHO, 2011) defined FGM as the partial or total removal of the external female genitalia for nonmedical reasons. Consequences of FGM include excruciating pain, excessive bleeding, shock, childbirth issues, infections, sexual problems, urinary problems, and death (Lundberg & Gereziher, 2008). In spite of the campaign against this harmful traditional practice by the government and nongovernmental organizations, FGM still exists in most communities in Africa (Okeke, Anyaehie, & Ezenyeaku, 2012). The knowledge that this practice continues leaves a gap in the literature as to the perspectives of girls and women who have been forced to participate in FGM.

The perception of Africans about FGM also influences the practice of FGM among African immigrants. Research indicated that the African immigrants in Sweden practiced FGM because they perceived FGM as a means of ensuring virginity and family honor (Isman, Ekeus, & Berggren, 2013). African women in the United Kingdom who experienced the 3rd degree of FGM (infibulation) indicated that they go through excruciating pain, but must continue the practice because it is a traditional rite that must be upheld to bring dignity to women (Safari, 2013). While there is awareness of this

worldwide experience, there seems to be little progress toward creating and enforcing laws to ban such practices.

In Nigeria, the existing legislation against FGM is not being enforced therefore regions in the country still practice FGM (Kolawole & Kwaak 2010). The prevalence of FGM in the Northern part of Nigeria is 60 -70% and in the Southern part it is 80 - 90% (Kandala, Nwakeze, & Kandala, 2009); it is suggested that religious, cultural and social grounds sustain the practice (Okeke, et.al., 2012). Odi is a community located in the Southern Region of Nigeria with no record of the prevalence of FGM because no research has been conducted and no data collected.

In an attempt to seek a solution for the ending of FGM, several authors have suggested that cultural and social factors sustain the practice. Such sociocultural factors include the following: (a) it is a rite of passage for women, (b) it enables women to maintain their virginity until marriage, (c) it prevents the anger of the gods of fertility, (d) it beautifies the vulva, (e) it prevents foul odor, (f) it gives males sexual satisfaction (Abiodun, Oyejola, & Job, 2011). And since the clitoris is viewed as a rival of the male penis, it should be chopped off. Some also claimed that the physical pains experienced during the mutilation bond all mutilated females in the community together for life (Bjalkander et al., 2012; Abiodun, Oyejola, & Job, 2011). However, few of these studies asked the women who were mutilated how they feel or what made them do it. The gap in the literature is that there is little knowledge about the women who experience FGM and their belief systems. Such knowledge is needed for further research into giving up the practice. The knowledge may also inform policy decisions on FGM.

In this chapter, I discuss the historical view of FGM, consequences of FGM, and the prevalence of FGM in Africa. I also explain the legislation against the practice of FGM and how the Odi people view the cultural myths about FGM. There is a brief discussion on phenomenology as the theoretical framework that was used to explore the FGM experiences of women of the Odi community.

Background of the Study

Much is being done to combat FGM (Abiodun, 2011; Blanton, 2011; International Women's Issues, 2001). This traditional African practice has jeopardized the health of women and girls; it can have grave consequences (Okeke et al., 2012). Government, nongovernmental organizations, and international agencies sought to create awareness of the complications of FGM in Africa and how it violates the rights of women and children. Their aim was to discourage continuation of the practice, yet little was achieved (International Women's Issues, 2001; NHS, 2004). Although the United States Federal Prohibition of Female Genital Mutilation Acts of 1995 states that it is unlawful to perform FGM on any female younger than 18 years, most African children below the age of 18 are mutilated in Africa and in the United States (Blanton, 2011). A total of 130-140 million girls and women have been mutilated in Africa, and 3 million are at risk of being mutilated yearly (WHO, 2011). This indicates that achieving the 4th and 5th millennium development goals of reducing child mortality and improving maternal health by year 2015 would not be achieved since FGM would still be putting the life of women and girls at risk in Nigeria (Okeke, Anyaehie, & Ezenyeaku, 2012). In the Odi community, as in every other Izon-speaking community that perpetuates FGM, the

practice is accorded a lot of respect and ceremony; and it is considered a way of life (Yanga, 2006). It is the belief of the Odi people that FGM denotes maturity and the first step into the institution of marriage (Yanga, 2006). Any female who is not mutilated is considered to be unclean, incomplete, and is ridiculed. It is also the belief of the Odi community that the mutilated girl or woman is well nurtured and not barren (Yanga, 2006).

The Odi community is part of the Izon speaking community in the Niger-Delta Region of Nigeria (Yanga, 2006). It is situated in the Southern part of Nigeria and a community in the Kolokuma/Opokuma Local Government Area of Bayelsa State. The Odi community is made up of 9 compounds: Oborigbeingha, Isounbiri, Ubaka, Koloni, Ifidi, Ogian-ama, Amakiri-ebi-ama, Ise-dani, and Kayama, with an estimated population of 4000 (National Population Commission, 2006). The major occupation of the Odi people is fishing. Decision making is solely in the hands of the council of chiefs, which includes the paramount ruler of the community chiefs (Yanga, 2006).

There has been no research to determine the statistics on mutilated females and their lived experiences in the Odi community; therefore it is necessary to explore the lived experiences of these women of Odi community to gain an in-depth understanding of their belief systems and perspective on the legislation against FGM. This will enhance further research into the termination of the practice and also inform policy decisions on FGM in the Odi community.

Problem Statement

FGM is a traditional practice that increases the morbidity and mortality rate of women and children in any community that practices it (Okeke et al., 2012). Currently, it appears difficult to halt FGM in African countries due to common belief systems. The problem is that most research that have investigated into FGM and its abandonment did not study the belief system of the practitioners (Abiodun, Oyejola, & Job, 2011; Kandala, Nwakeze, & Kandala, 2009). African belief systems affect most African practices, and until one understands the belief system of the practitioner, it would be difficult to proffer solutions that would lead to the abandonment of the practice in Africa. This study would enhance the knowledge needed to address the phenomenon of FGM in Odi community. The study would also illuminate the lived experiences of mutilated women and their perspective towards the impact of cultural myths on FGM and the current legislation that are meant to prevent FGM.

Purpose of the Study

The purpose of the study was to explore the lived experiences of women of the Odi community about FGM victims, cultural myths surrounding the practice and their perspective towards the current legislation on the prevention of FGM. FGM affects the health and economic status of any nation that perpetuates it (Gele, Kumar, Hjelde, & Sundby, 2012; WHO, 2011). This research sought to understand the belief system of the women and girls who underwent FGM in the Odi community. Evidence suggested that the belief systems of Africans affect the existence of traditional practices in Africa (Heather, 2013; Mazzucco, 1998). When researchers understand the belief system of

African women about FGM, they would have a basis for investigating strategies that could lead to termination of the practice. Implications for positive change includes a better understanding of the belief system of the Odi women on FGM, its cultural myths, the current legislation for the prevention of the FGM and also the improved morbidity and mortality of women and children.

Research Questions

This study had one overarching research question and two subquestions:

Research question: What are lived experiences of women in Odi community in Nigeria surrounding female genital mutilation?

Subquestion 1: What are the perspectives of women in the Odi community on the impact of cultural myths on the practice of female genital mutilation?

Subquestion 2: What are the perspectives of women in the Odi community on the current legislation that is meant to prevent female genital mutilation?

Theoretical Framework

The study was guided by a theoretical framework which states that humans know the world through their experiences, where the focus is on the experience of the participants (Ogbe, 2009). The origin of phenomenological theory stems from the philosophical work of Edmund Husserl who investigated psychological subjects (Amedeo, 2009). Phenomenology is used to study the subjective experience of a participant about a phenomenon (Langdrige, 2006). The use of phenomenology to study the experiences of women of the Odi community would illuminate their lived experiences. The FGM experiences of the mutilated women in the Odi community on

were not known. In addition, the perspectives of the women on the cultural myths and current legislation on the prevention of FGM were not known. Thus, the focus of this study was on the mutilated women of Odi Community. Since government and nongovernmental organizations focus on reducing maternal and child morbidity and mortality rate caused by FGM, it made sense to explore the lived experience of these women on FGM to inform decision making about the termination of FGM in the Odi community. The theoretical framework was a lens used to explore the perspective of the people about FGM that influenced the existence of FGM in spite of its consequences in the Odi community. This theory was used to explore how these people made sense of their experience with FGM (Reeves, Albert, Kuper, & Hodges, 2008). The study brought to light through interview the meaning each participant attached to their experiences with FGM.

Phenomenology theory has been used by other authors in their studies. Halic, Greenberg, and Paulus (2009) and Windsor, Parker, and Tewfik (2010) are leading contributors in phenomenological studies. Their work explored the use of a phenomenological approach to obtain the lived experiences of students and women, and to explore the common themes that emerged from their experiences. Heather (2013) and Mazzucco (1998) in their studies also investigated the relationship between African believe system and traditional African practices. Thus, a need was identified for more studies to take into account of the meaning of this belief system about FGM.

Phenomenology theory is quite appropriate to obtain the belief system of participants about the phenomenon under study. The phenomenological approach uses

open-ended questions to understand the perspectives of the participants and how they make sense of their experience.

Nature of the Study

This phenomenological study sought to understand human behavior and the reasons that govern such behaviors (Creswell, 2013). The phenomenological approach tends to describe common lived experiences of several individuals regarding a phenomenon (Creswell, 2013). The phenomenologist collects data on what all participants in a study have in common, identifies themes and patterns in the data, and develops a composite description of the essence of the experience for all participants (Creswell, 2013).

FGM is defined as a traditional practice that involves the partial or total removal of the female external genitalia for nonmedical reasons (WHO, 2011). It is a traditional practice that jeopardizes the health of women and girls due to its deadly consequences (Gele et al., 2012; WHO, 2011). It is estimated that one-third of the girls and women undergoing FGM in areas where antibiotics are not available dies or experience adverse health effect from FGM (Yoder, Abderrahim, & Zhuxhuni, 2004). FGM is defined as a traditional practice that involves the partial or total remove of the female external genitalia for non-medical reasons (WHO, 2011). The elimination of FGM requires an understanding of the lived experiences of the victims and their belief system on the legislation against the practice.

Participants were selected with the snowball technique. Mutilated females were contacted through their peers. During the initial contact, I visited the participants with a

research assistant (interpreter) who could interpret the Izon language. The description of the study, terms of confidentiality, the research questions, and contents of the consent form were explained to the woman who had been recommended, and any who agreed to participate in the study were given the consent form. They were also advised to come to the office of the Girl-Child Education within 2 weeks to give verbal consent. A verbal consent was given by participants before the interview began. The sample size was 9 mutilated women who were at least 18 years old, who were living in the Odi community at the time of the study.

Data collection used an in-depth, face-to-face interview, which was conducted in the office of the Girl-Child Education, and tape recorded with permission from the participants. Though there was an interview guide, questions that developed through the conversation with participants were addressed. The format included open-ended, detailed-oriented probes, elaboration probes, and clarification probes to enhance the understanding and clarity of statements as appropriate. Open-ended questions were used to obtain data from the participants. This gave participants opportunity to express themselves to their satisfaction. They spoke of their experiences with FGM, and myths about FGM through their words, actions and gesticulations. I maintained a field notes during the interview sessions.

Colaizzi's phenomenological method was used for the data analysis (Creswell, 2013). All transcripts were reread several times in order to have a holistic understanding of the participants' experiences (Creswell, 2013).

Definitions

FGM: Female Genital Mutilation and also known as Female circumcision (Abiodun, Oyejola, & Job, 2011).

Lived experience: For purpose of this study, lived experience is the experience of the women that may be physical, emotional, cultural or social (Lewis-Beck, Bryman & Liao, 2004).

Odi community: An Izon speaking community in Kolokuma/Opokuma Local Government of Bayelsa State of Nigeria (Yanga, 2006).

Women: Females in Odi community who have experienced FGM and resides in Odi community (Yanga, 2006).

Assumptions

For the purpose of the study, I assumed that the women of the Odi community were honest during the interview. I also assumed that the perceptions of the participants were valid as the truth they know as at the time of the data collection. No participant was victimized for making any comment and I did not influence the participants lived experience. Another assumption was that all participants resided in Odi community during the period of the study. The reason for these assumptions was to ensure readers understand the research experience and can better assess the validity of the findings.

Scope and Delimitations

The study was delimited to exploring the lived experiences of women of the Odi community of FGM. In-depth interviews were conducted on women, age 18 and above, who may be pregnant, must have experienced FGM either as a child or an adult, and who

are fluent in English or Izon language. It means that the participants at the time of the interview may have experienced FGM in the past or may be experiencing complications now.

The study confined itself to researching the lived experiences of women about FGM in the Odi community. A review of literatures on FGM in Nigeria indicated that a large population of women from the Southern and Northern part of Nigeria has experienced FGM. The participants in this study were women who have experienced FGM. The reason for this selection was as follows: these women were in a better position to express (a) their perception, (b) the impact of cultural myths on the practice of FGM, and (c) their perspectives on current legislation to prevent FGM. The theoretical framework for the study was the phenomenological theory which derives its strength from the first-person experiences.

The use of Odi community was convenient because the community is located in Nigeria, where the researcher lives, and they practice FGM as a traditional rite for every female in the community. The study confined itself to searching for women who have experienced FGM. A consent form and a stipend of [^]1000 (\$10) (Nigerian currency) were given to the women who were recommended. The study was confined only to women who came to the office of Girl-Child Education to give their verbal consent to participate in the study. To ensure transferability, solid descriptive data were provided to enable future research into FGM and its termination.

Limitations

The potential limitation of the phenomenological approach was the inability to generalize the findings to a larger population. The result can only be used to describe the lived experiences of participants in the Odi community. However, it can serve as potential significant variables for future studies. The result that was provided can only enhance further research on FGM in the Odi community, which is a limitation of transferability. A bias that would have existed during the data collection was the inclusion of the researcher's expectation of the reactions of participants which is common with qualitative study. To address this, I bracketed my expectations and ensured that only the participants' experiences were recorded.

Significance of the Study

The study illuminated the lived experiences of women who had experienced FGM. An understanding of these lived experiences could enable researchers to investigate strategies for terminating the practice in the Odi community. FGM increases the mortality and morbidity rate of two vulnerable groups in Africa: women and children (WHO, 2011). Without an understanding of the lived experiences of the mutilated women it may be difficult to achieve the 4th and 5th Millennium Development Goal of reducing child mortality and improving maternal health by year 2016.

A review of relevant literatures suggested that this was the first study to explore the lived experiences of women of the Odi Community about FGM. The implication for social change included (a) a better understanding of the lived experiences of the women of Odi about FGM, (b) their perspective of the impact of cultural myths on the practice of

FGM, and (c) their perspective of the current legislation that is meant to prevent FGM.

This understanding may inform policy decisions.

Summary

FGM is a traditional practice that involves the partial or total removal of the female external genitalia for nonmedical reasons. Research have implicated social and cultural factors for the existence of FGM. The gap in this literature is the absence of the lived experiences of the mutilated females. This study will contribute to the body of knowledge by illuminating the lived experiences of women about FGM in the Odi community.

In the chapter 2, the study will provide a detailed picture of the lived experiences of women with FGM. Chapter 2 will also provide details on the perspectives of women of the impact of cultural myths on the practice of FGM and towards current legislation that was passed on 5th of May 2015, which is meant to prevent FGM.

The phenomenological paradigm for the study will be discussed in Chapter 3. Based on the review of relevant literature this is the first study to examine the lived experiences of Odi women of FGM. Colaizzi's method of analysis is expected to produce rich information based on relevant themes that emerge from the data.

The implication for positive social change will be an understanding of the lived experience of the women of the Odi community about FGM, their perspective towards the impact of cultural myths on the practice of FGM and current legislation that is meant to prevent FGM. If these three were understood, the morbidity and mortality of the women and children of Odi community would be improved.

Chapter 2 will provide detailed picture of FGM, including the types, legal implications of the practice, cultural myths influencing the practice, and the consequences. Chapter 3 will focus on the methodology for the conduct of the research, the advantage and disadvantages of the study design, research instrument and ethical consideration. Chapter 4 will focus on the results of the study and Chapter 5 will focus on a detailed discussion on the findings, the conclusion and recommendations of the study.

Chapter 2: Literature Review

Introduction

FGM is a traditional practice that involves the total or partial removal of the external female genitalia for nonmedical reasons (WHO, 2011). FGM is a public health challenge that jeopardizes the health of girls and women due to its harmful complications in Africa (Okeke et al., 2012). In spite of the worldwide legislation against the practice, FGM is still practiced in the Southern region of Nigeria making it difficult to achieve the 4th and 5th millennium development goals (Okeke et al., 2012) in the region. Much has been studied about FGM but the gap in the literature is lack of knowledge about (a) women of the Odi community who have experienced FGM, and (b) their belief systems. An in-depth understanding of the lived experiences of the mutilated women and their belief systems is needed for further research into ending the practice.

The literature review will explore researches surrounding the lived experiences of women with FGM. The literature review will also examine FGM as a traditional practice and the need for further research into the lived experiences of women with FGM, their perspectives on the cultural myths surrounding the practice, and law to prevent FGM. Thus, the review of current literature is divided into three sections. The first section provides the search strategy that was used to secure appropriate articles for this chapter. The second section investigates the history of FGM, its classifications, and the consequences and legislations against FGM. The third section presents the literature that supports the need for the study.

A phenomenological approach is considered the planned method to be used to explore the lived experiences of the women from the Odi community about FGM. Phenomenology study conscious experiences from the first-person point of view, not only passive experiences, but also active experiences as in walking, pains, etc (Stanford Encyclopedia of Philosophy, 2013). The conscious experience makes it unique because the individual experience the phenomenon, live through the phenomenon or perform the phenomenon (Stanford Encyclopedia of Philosophy, 2013). Therefore, phenomenological approach is considered approach to ensure an in-depth understanding of the lived experiences of the Odi women about FGM.

Search Strategy

There are many current research articles on FGM, its types, its consequences and the factors that influence the practice. The following databases were searched for current literature (2008 to the present) on FGM, women who have experienced FGM, and their perspective on the practice: Google Scholar, Medline, MedScape, SAGE and ProQuest. The following search terms were used: *female genital mutilation, cultural myths, the Odi community, legislations against FGM, types of FGM, FGM in Nigeria, FGM southern Nigeri, FGM in Bayelsa State, and lived experiences*. I reviewed the available literature with reviewed dates from 2008 to present. Data were sourced for the theoretical component with Phenomenology and lived experience with no restriction on publication date. All articles were published in English.

Theoretical Foundation

The theoretical foundation states that humans know the world through their experiences. Phenomenology has to do with a focus on the first person experience (Creswell, 2013). It allows the participants to express their lived experience as regards the phenomenon under study and then describe what participants have in common (Creswell, 2013; Moustakas, 1994). The basic purpose of the phenomenology is to bring to the barest minimum individual experience in order to describe the universal essence of the phenomenon (Creswell, 2013).

Phenomenological theory has its origin from the philosophical work of Edmund Husserl, Jean-Paul Sartre and Maurice Merleau-Ponty on consciousness in the early 20th century (Osborne, 1990). Edmund Husserl and colleagues argued that since consciousness is the window to see the world, human knowledge can only be understood when human consciousness is understood (Osborne, 1990). Their study influenced the main phenomenological psychological approach (Amedeo, 2009). Phenomenology is a theory that shows close affinity with human experience (Osborne, 1990). Experience is paramount in phenomenology, therefore the person being in the world of the phenomenon stands the better chance of describing the phenomenon (Varela, 1996).

Phenomenological research aimed to have an in-depth understanding of the phenomenon by allowing the data to speak and bracketing one's preconceptions (Creswell, 2013). The researcher interprets the description of the participants' experiences through a theoretical perspective (Osborne, 1990). The data collection method should be any way the participants can best describe their phenomena as regard

the subject under study (Waters, n.d). Data collection method could be interview, written or oral report of the participants, and aesthetic experiences such as art, narratives or poetry (Waters, n.d). Analysis of the data requires the first principle of the use of emergent strategy for the method of analysis, this is to follow the nature of the data to be collected (Waters, n.d). Irrespective of the method of data collection in a phenomenological research, the understanding of the meaning of the description should be the focus. To achieve this purpose, a common approach is to abstract out the individual or collective themes which makes the experience the same. The individual theme is unique to one person and the collective themes occur across the group of participants (Waters, n.d). The results section will provide the findings by labeling and defining the themes.

To improve analysis transferability, raw data usage and odds of relevance of the work for future research, phenomenological research provides a thick description or solid descriptive data of participants experience (Patton, 1990). The researcher ensures validity in a phenomenological research through bracketing of his perceptions or views about the phenomenon under study and provides opportunity for readers to understand the interpretation of data through careful description of the procedure and data analysis (Osborne, 1990). The reliability of phenomenological approach is context bound. It focuses on the meaning the participants attach to the phenomenon rather than the facts.

Grund and Hannick (2012) used phenomenological approach to explore the perception of men on sexual behavior change and risk compensation following adult male circumcision in urban Swaziland. The aim of the study was to obtain the lived

experiences of men who experienced circumcision within previous 12 months on their sexual attitude and behavior after circumcision. In-depth interview was used as a method of data collection. Result indicated that most men experience a change in sexual attitude and behavior after circumcision which could be both protective and risk behavior for the transmission of HIV infection. The protective behavior includes more responsible attitude towards safe sex, a reduction in sexual temptation and partners, and easier condom use. The risk behavior includes increase in sexual experiment shortly after circumcision.

Degni et al., (2013) also used a phenomenological approach to explore reproductive and maternity health care services in Finland. The objective of the study was to explore the lived experiences of Somali women about reproductive and maternity health care services and the service providers. Purposeful sampling technique was used to recruit 70 married women between the ages of 18 and 50, who have given birth to number of children between 2 to 10. Eighteen of the participants were from Kenya, 32 from Mogadishu and 20 from Hargeysa. The result indicated that the women revealed that the quality of reproductive and maternal health care services was good. However there was poor communication technique and the health care workers attitude were unfriendly.

Wallace (2013) is another author who used phenomenological approach to explore the differences between IB and non-IB Graduates on International Mindedness. The study explored the lived experiences of IB and non-IB graduates on the concept of international mindedness. Methods of data collection were in-depth interview and focus group discussions. Data were collected from eight IB graduates and eight non-IB

graduates. The result revealed the emergent of three themes which includes: (a) IB students' beliefs and attitude, (b) experience in understanding culture, and (c) the impact of the school environment on understanding differences. The result also indicated that there was a difference in the experience of the different group of graduates on the way they perceive the world around them and the development of values.

Ortiz (2013) also used phenomenological approach to explore the lived experiences of the nonoffending Latin caregivers on caring for sexually abused children. The study included three Latino mothers whose children were victims of child abused. In-depth face-to-face interview was the method of data collection. Mothers were asked on their lived experiences in caring for their abused children and three themes emerged which were connected to trauma, they include (a) sexual abuse disclosure; (b) loss; (c) emotional response. The author concluded that the women experienced trauma while caring for the abused children.

Safari (2012) used phenomenological theory to describe women's lived experience after deinfibulation in the UK. In-depth semi-structured interview was used as a method of data collection. His study discovered that women who discussed deinfibulation with their spouses reported fewer problems afterward because their spouses were supportive.

Phenomenology theory was selected because of the need to understand the experiences of these mutilated women. Data will be collected from the individuals who have experience the phenomenon and a common essence will be described from their experiences (Moustakas, 1996). Since the theory focuses on the person's experience,

applying it in the study will provide opportunity to answer the research questions that borders on their lived experiences about FGM, their perspectives on the cultural myths and the legislation to prevent FGM. A clear understanding of their experiences will enhance policy decisions that may lead to the abandonment of the practice.

Literature Review on Key Variables

Historical Overview on Female Genital Mutilation

The origin of FGM is unknown because it is concealed in secrecy, uncertainty and confusion, but it was suggested by Gerry Mackie that it began with the Meriote Civilization in Sudan with origin of infibulations and imperial polygyny before the rise of Islam, to increase confidence in paternity (Okeke et al., 2012; Mackie, 2000; Mackie, 1999). Another study indicated that it has been in existence since the time of Pharaoh in Egypt that was why it is called Pharoanic circumcision (Abdulcadira et al., 2011). Even the Romans are also implicated when infibulations (Type III) was derived from a Latin word *fibula*, which is a brooch used by the Romans to fix the Toga and also on the genitals of their slaves to prevent them from indulging in sexual intercourse (Abdulcadira et al., 2011). The origin of FGM couldn't have been from one origin because the practice is so widespread (Ashimi & Amole, 2014). In Nigeria, FGM is accompanied with so much stress and controversy on either to consider it as an initiation into womanhood, ensure virginity, protect modesty and chastity, and curb promiscuity among girls and women (Ashimi & Amole, 2014). Therefore, one cannot categorically state when or where FGM started in the world.

FGM is defined by WHO (2011) as all procedure that involves the partial or total removal of the female external genitalia for nonmedical reasons. It also involves other intentional injuries to the female external genitalia either for cultural or other nontherapeutic intentions (Wadesango et al., 2011). The Population Reference Bureau (2010) indicated that an estimated figure of about 130 – 140 million girls and women have undergone FGM in the world of which one-third came from Nigeria, and about 3 million are at risk of being mutilated yearly in Africa. In Africa, the traditional practice is usually performed on girls between the ages of 4-12 years in some culture, others perform it at birth and some others at when the woman is 7 months pregnant (Population Reference Bureau, 2010). In Sierra Leone, FGM is considered as the first activity in an initiation ceremony for women and girls. It takes several weeks of activities which involve the women and girls to being secluded in an isolated area far away from any nearby village (Bjalkander, Bangura, Leigh, Berggren, Bergstrom, & Almroth, 2012). So many things take place there which may be dangerous to the health of the victims but they are made to believe that it is a necessity if the woman must be integrated into womanhood (Bjalkander, Bangura, Leigh, Berggren, Bergstrom, & Almroth, 2012).

Prevalence of FGM

FGM is practiced almost everywhere in the world where Africans live as citizens or immigrants (Kontoyannis & Katsetos, 2010). FGM is found in continents like Africa, Europe, US, Australia due to population migration (Wadesango et al., 2011). Out of the 54 independent countries in Africa, the 2008 demographic survey indicated that 30 practice FGM of which Nigeria is one of them. Studies indicated that the countries in

Africa with the highest prevalence of FGM includes Somalia (97.9% of women), Egypt (95.8%), Guinea (95.6%), Sierra Leone (94%), Djibouti (93.1%), Mali (91.6%) and Eritrea (88.7%) (Abdulcadira et al., 2011).

The prevalence of FGM in Africa is 75% and Nigeria is one of the African countries battling FGM with the prevalence rate of 30% as at 2008 demographic survey (Okeke et al., 2012). The highest prevalence (77%) is recorded in the study area, the South-South region of Nigeria where the Odi Community is situated (Okeke et al., 2012; Yanga, 2006). This makes one to wonder if it is possible to achieve the 4th and 5th millennium development goal by the year 2015.

Classification of FGM

According to the classification of WHO (2008), four types of FGM are performed in Africa. They include clitoridectomy, excision, infibulations and pricking or any other form of injury to the genitalia (Wadesango et al., 2011; WHO, 2008). Clitoridectomy (Type I) involves the removal of the hood of the clitoris (prepuce) and/or the entire clitoris (Bjalkander et al, 2012; WHO, 2008). In some cultures the type I are further distinguished into type Ia which involves the removal of the prepuce only and the type Ib is removal of the clitoris with the prepuce. Excision (type II) involves the removal of the clitoris and the labia minora with or without the removal of the labia majora (WHO, 2008; Rey et al., 2000). Type II is also subdivided into type IIa as removal of the labia minora only; type IIb is removal of the clitoris and labia minora; and type IIc is removal of the clitoris, labia minora and majora (Bjalkander et. al, 2012). Infibulation (Type III) involves the narrowing of the vaginal orifice and providing a covering seal with the

repositioning of the labia minora and/or the labia majora. This is done with or without the excision of the clitoris (Bjalkander et. al, 2012; WHO, 2008). Type III is also subdivided into type IIIa which is removal and appositioning the labia minora; and type IIIb is removal and appositioning of the labia majora. Type IV which is unclassified involves any pricking or harmful procedure to the female genitalia for non-medical reasons which may also include the introduction of corrosive substances into the vagina (Bjalkander et al., 2012; WHO, 2008). These types of FGM are performed by traditional circumcisers in unhygienic environment with the use of unsterilized instruments, but recently the Population Reference Bureau (2010) indicated that medical personnel are also involved in performing FGM on women and girls in the community.

The prevalence of the types of FGM in the various States of Nigeria was classified by Okeke et al., (2012) as follows:

Table 1

Prevalence of the types of FGM in various States of Nigeria

State	Type	Percentage
Abia	No study	No study
Adamawa	IV	60 - 70
Akwa-Ibom	II	65 - 75
Anambra	II	40 - 60
Bayelsa	No study	No study
Bauchi	IV	50 - 60
Benue	II	90 - 100
Borno	I, III, IV	10 - 90
Cross River	No study	No study
Delta	II	80 - 90
Edo	II	30-40
Enugu	No study	No study
Imo	II	40-50
Jigawa	IV	60-70
Kaduna	IV	50-70

State	Type	Percentage
Kano	No study	No study
Kebbi	IV	90-100
Kogi	IV	1
Kwara	I, II	60-70
Lagos	I	20-30
Niger	No study	No study
Ogun	I, II	35-45
Ondo	II	90-98
Osun	I	80-90
Oyo	I	60-70
Plateau	I, IV	30-90
Rivers	I, II	60-70
Sokoto	No study	No study
Taraba	No study	No study
Yobe	IV	I
Zamfara	No study	No study
FCT (Abuja)	No study	No study

Note. Type I: Removal of the hood of the clitoris. Type II: Removal of the clitoris and the labia minora with or without the removal of the labia majora. Type III: involves the narrowing of the vaginal orifice and providing a covering seal with the repositioning of the labia minora and/or the labia majora. Type IV: which is unclassified involves any pricking or harmful procedure to the female genitalia for non-medical reasons which may also include the introduction of corrosive substances into the vagina. Adapted from “The spatial distribution of female genital mutilation in Nigeria,” by Kandala, N.B., Nwakeze, N., & Kandala, S.N, 2009, *American Journal of Tropical Medicine and Hygiene* 81(15):784-92.

These statistics revealed that FGM is in existence in Nigeria and types I, II, and IV was prevalent. Some States including Bayelsa State where the study area is situated have no statistics because there has been no study in these states.

Procedure

The procedure for FGM is usually performed by traditional circumcisers and health care practitioners (Okeke, Anyaehie & Ezenyeaku, 2012). When performed by traditional circumcisers, it is done mostly in an unhygienic environment without anesthesia and with unsterilized instrument such as a knife, razor blade, scissors, sharp

rocks, and fingernails (WHO, 2011). One unsterilized instrument could be used on more than one person depending on the number of girls and women to be mutilated. After the operation, cow dung, and leaves are placed over the wound to stop bleeding; typically this leads to infection (Abiodun, Oyejola, & Job, 2011).

Consequences of FGM

FGM also known as female circumcision is of public health concern due to its harmful consequences that jeopardizes the health of the girls and women in Africa (Kaplan et al., 2011). These consequences depend on the (a) hygienic condition of the environment; (b) the nutritional status of the women and girls; (c) the modality of execution; (d) type of mutilation; and (e) and possible psychophysical, psychological, and physical complications (Abdulcadira et al., 2011). All types of FGM expose the victim to consequences that may be immediate or long term. These immediate or long term consequences depends on the type, expertise of the circumciser, nature of the environment it is performed, the health of the woman or girl at the time of mutilation (Kontoyannis, & Katsetos, 2010).

The immediate consequences occur within 10 days of the mutilation and they include hemorrhage, excruciating pain, shock, death, urinary burning and acute urinary retention, injury and dehiscence of injury which can be stitched several times, acute anemia, infections such as tetanus, HIV, septicemia, hepatitis in the case of unsterilized instruments used on more than one operation without disinfection, vulvovaginitis, cystitis (Kaplan et al., 2011). The long-term consequences occur after 10days post-mutilation and include recurrent bladder and recurrent urinary tract infection, drop-by- drop and

prolong micturation, painful menstruation, fibrosis, keloids, synecha, tissue rotation, organic dispareunia, infertility, childbirth complications, need for later surgeries, depression due to frigidity and anxiety etc (Ebhomele, 2015, Berg & Denison, 2013; Anderson et al., 2012; Kaplan et al., 2011). This means that the 140 million women and girls worldwide who are victims of FGM (Population Reference Bureau, 2010) have had their rights and liberty of sexual satisfaction taken away from them.

Legislation against FGM

FGM is considered a violation of human right because it deprives the mutilated girls and women of healthy sexual organs and exposes them to harmful consequences that deprive them of health (Center for Reproductive Rights of Women, 2015). Apart from the physical and psychological trauma it deprives the girls and women of right of nondiscrimination, health, integrity, liberty and security of persons (Center for Reproductive Rights of Women, 2015). It is also considered to be discriminatory against women and the girl child. In 2001, the UN General Assembly made a resolution that States has the responsibility to adopt policies to outlaw traditional practices that jeopardize the health and rights of women and children; and to prosecute all who perpetrate such practices (Wadsesango et al., 2011). In the United States, the legislation against FGM in North Dakota, Oregon, Rhoda Island, Tennessee, Texas, West Virginia, and Wisconsin is clearly spelt out and with penalties for defaulters ranging from 3 years suspended sentence to 12 years imprisonments and payment of \$5000 fine (Rey et al., 2000).

In Africa, different nongovernmental Organizations has campaigned against FGM. The Inter-African Committee on Traditional Practices in collaboration with local Nongovernmental Organizations launched educational campaign aimed at abolishing the practice of FGM in African Countries (Rey et al., 2000). As regards the legislation against FGM in African countries, UNICEF (2013) stated that 20 countries out of the 36 African countries that practice FGM has a legislation against FGM, but no indication of the law being enforced. Ghana, Senegal, Djibouti, Tanzania, Ivory Coast, Togo, Kenya, Burkina Faso, Benin, Chad, Niger, Ethiopia and Egypt enacted the law against FGM/FC between 1994 and 2008, but FGM is still practiced secretly in these countries (Abdulcadira et al., 2011).

In Nigeria, before May, 2015, there was no federal law against FGM but a bill was before the Senate which was yet to be passed into law. Nongovernmental organizations campaigning against FGM do that based on Section 34 (1) (a) of the 1999 Constitution of the Federal Republic of Nigeria states “no person shall be subjected to torture or inhuman or degrading treatment” (Okeke et al., 2012). Currently, few states in Nigeria (Edo, Abia, Bayelsa-the study are, Cross River, Delta, Ogun, Osun and Rivers State) have existing legislation against FGM based on this section of the Constitution but none has been prosecuted (Leo, 2012) but there is no record of anyone being prosecuted (Okeke et al., 2012), unlike in France where about forty FGM cases were brought to court between 1985 and 2006 (Abdulcadira et al., 2011). Edo State placed a banned on FGM in October 1999 and convicts are to pay a fine of ^1000 (\$10) at that time and also sentenced to 6 months imprisonment, but lack of enforcement has made the law as good

as not in existence (Rey et al., 2000). There is a need for further studies into why the law against FGM is not enforced in these states. Although a study indicated that circumcisers make mockery of the law and threaten law enforcement agents who dare to arrest them claiming that FGM is their cultural practice which must be upheld.

Cultural Myths of FGM

Cultural myths are usually traditional stories of ostensibly historical events that serve to unfold part of the world view of a people or explain a practice, belief, or natural phenomenon (Heather, 2013). In most cases, it's usually a story of one superhuman being in early age taken to be the reason for a particular phenomenon. These stories are learnt in the family, community, and some are taught in schools (Smith, 1991). Cultural myths might take the approach of encouragement, fear, scary, or threat but there is always a lesson to learn from it (Murfin, & Ray, 2003). Despite the advancement in technology, cultural myths are still part of our everyday life especially in Africa. These cultural myths influences the way the Africans do things and practice their culture (Heather, 2013). Most cultural myths do not have any scientific backing, but are mere set of ideas surrounding the existence of a phenomenon that are transferred from one generation to another. Members of the culture practice or believe these myths due to fear of the unknown (Murfin, & Ray, 2003). The existence of FGM and other demeaning practices against women and children in Africa are implicated on cultural myths and other social factors.

Studies indicated that despite the education and legislation against FGM the existence of the harmful practice is implicated on cultural myth (Gele et al., 2012; Mandara, 2003). Though these cultural myths are from different ethnic groups there are

common themes about their belief system. They believe that FGM ensures honor, pride, value, identity and a sense of belonging to the culture (Abdulcadira et al., 2011). Studies conducted in Somalia, Sierra Leone, and Kenya indicated that it is the belief of the people that FGM prevents promiscuity; therefore all females must be mutilated before marriage so that they will be faithful to their husband (Bjalkander et al., 2012; Romanzi, 2011; Mandara, 2003). FGM is also considered as a rite of passage to full social acceptability and without it the woman will not be integrated into community activity, which affects the male head of the family (Bjalkander et al., 2012; Kontoyannis & Katsetos, 2010; Mandara, 2003).

In some communities in Africa where FGM is practiced, the traditional ritual is credited with healing powers for hysteria, depression or nymphomania (Kontoyannis & Katsetos, 2010). It is also the belief of the practitioners of FGM that the male has the sole right to control ejaculation; therefore any form of control coming from the woman as a result of additional excitement caused by the clitoris leading to premature ejaculation during sexual intercourse is called “insubordination.” For this reason, the clitoris must be cut off to prevent premature ejaculation (Kontoyannis & Katsetos, 2010).

In Sudan, Infibulations is also done to reduce the size of the vaginal orifice to bring pleasure to the male during intercourse and if a girl dies during FGM, it will be attributed to punishment from the gods for wrongs which the girl committed in the past (Kontoyannis, & Katsetos, 2010; Mandara, 2003). Study also indicated that infibulations is done to make the genitalia attractive and free from odor (Abdulcadira et al., 2011). In Somalia, the excruciating pain that follows after mutilation is believed to bring about

bonding between girls who are mutilated thereby ensuring unity among the females (Bjalkander et al., 2012). To maintain this unity peers encourage each other to be mutilated.

In the Western part of Nigeria, the beliefs associated with FGM are manifold. The clitoris is cut off before a woman gives birth to prevent the head of the baby coming in contact with the clitoris which is belief to cause the death of the baby during childbirth (Oguntuyi, 1979; Okeke et al., 2012). They also consider FGM as a mark of loyalty to the god of fertility, preserve virginity and prevent promiscuity; therefore every female must go through the procedure (Okeke et al., 2012). Female circumcision also qualifies the girl to be married and the parents of the girl to receive the bride price (Oguntuyi, 1979). In some communities, women understand that FGM is deadly but cannot stop it because they want their daughters to be married and integrated into the society (Abdulcadira et al., 2011). This is to prevent their daughters to be termed an outcast.

In Bayelsa State where the Odi community is found there has been little research into the cultural myths of the people as regards FGM, but Yanga (2006) suggested that the Izon people practice FGM to protect virginity, and to qualify the woman for marriage. Any woman who is not mutilated is considered incomplete and ridiculed.

Existing Literature Related to the Study

FGM is harmful practice that is condemned worldwide due to its complications but is secretly practiced in the South-South region of Nigeria. Ashimi and Amole (2014) conducted a research to explore the perception and attitude of pregnant women in a rural community north-west Nigeria to FGM. The research was based on the fact that most

studies on the perception of pregnant women about FGM have been in the urban area; therefore it is expedient to know the perception and attitude of pregnant women in the rural area about FGM. Study participants were 323 pregnant women who attended antenatal care in two different health facilities during the period of study. It was a cross-sectional study with the use of a questionnaire to assess the types of FGM known, reasons for performing FGM and willingness to support or perform FGM. In conclusion the researchers indicated that although a majority of the pregnant women (256, 79.3%) perceived FGM to be associated with difficult childbirth, they would subject their daughters to FGM because they don't want to be ostracized and for the daughters to have better marriage prospect.

Another study conducted by Isman, Ekeus and Berggren (2013) explored the perceptions and experiences of FGM after immigration to Sweden. The aim of the study is to explore how women from part of the world where FGM is normative perceive and experience FGM after immigrating to Sweden. The method of data collection was semi-structured interview. The participants were eight women from Djibouti, Eritrea, Ethiopia and Somalia. Qualitative content analysis was used to analyze the data. In conclusion, the researchers indicated that Immigrant women who originated from countries where FGM is practice residing in Sweden view FGM as a necessary aspect of life even after immigration.

Ballesteros et al., (2014) used phenomenological approach to explore the impact of FGM on the sexual and reproductive health of 9 Sub-saharan African who underwent FGM and had lived in Spain for 1-14 years. A socio-demographic survey and an in-depth,

structured personal interview were used as method for data collection. The result indicated that FGM affects the sexual and reproductive health of the participants as demonstrated by anorgasmia and dyspareunia.

However, RezaeeAhan (2013) also studied the lived experiences of women of Somalia living in Sweden on FGM. The aim of the study was to explore the belief, flashbacks, circumstances before and later consequences, religious views as well as their perspectives on human right. Interview was used as the method of data collection. The result indicated that the women considered FGM to be a traditional practice with physical, psychological, social and sexual harmful experiences. They also considered FGM to be a violation of the rights of women and girls; therefore it should be abolished from the tradition. The result also indicated that the women considers community based awareness program that are accessible to everyone as the best way to eradicate the practice in Somalia.

Summary

The summary will provide an overview of the FGM. The literature revealed that FGM is a traditional practice that involves the partial or total removal of the female external genitalia for nonmedical reasons but rather put girls and women into grave danger (WHO, 2011; Kandala et al., 2009). Unfortunately this barbaric traditional practice exists in the southern region of Nigeria where there is no legislation against it in the Nigerian constitution.

There are four types of FGM which includes clitoridectomy, excision, infibulations, and all kinds of injury to the external genitalia for nonmedical reasons

(Wadesango et al., 2011; WHO, 2008). These types of FGM put the lives of girls and women in the practicing community in danger. Complications of FGM includes immediate and long term complications which includes excessive bleeding, excruciating pain, shock, urinary tract infections, sepsis, HIV, child birth complications, sexual intercourse complications, death (Kaplan et al., 2011; International Women's Issues, 2001).

There is legislation against FGM in other parts of the world and in Africa, but in Nigeria constitution before May, 2015, there was no law against FGM though some states in Nigeria enacted a law against it based on Section 34 (1) (a) of the 1999 Constitution of the Federal Republic of Nigeria that states “no person shall be subjected to torture or inhuman or degrading treatment” (Okeke et al., 2012). Despite this law, none has been prosecuted for subjecting their daughters to such barbaric rite.

The reason for the existence of FGM is deep rooted in cultural myths which include loyalty to the god of fertility, preservation of virginity, prevention of promiscuity, and preparation of womanhood (Oguntuyi, 1979; Okeke et al., 2012). Some cultural myths recognize the clitoris as a rival to the penis therefore it should be cut off.

Much research has been done on FGM, the types, consequences, and legal implications. The gap in these researches is the lived experiences of the women of the Odi community. Hence there is a need to explore lived experiences of women of Odi community about FGM, their perception on the cultural myths and the legislations against FGM. An in-depth understanding of the lived experiences of the mutilated

women and their belief systems is needed for further research into the abandonment of the practice. It may also inform policy decisions on FGM.

The chapter 3 will present the methodology that will be used to conduct the research. The chapter will include the research design and rationale, role of the researcher, sample size, Instrumentation, data analysis, and ethical consideration.

Chapter 3: Research Method

Introduction

The purpose of this study was to explore the lived experiences of women of the Odi community about FGM, cultural myths surrounding the practice and their perspective on the current legislation for the preventing FGM. The phenomenological paradigm was used to obtain rich information, describe and summarize the experiences of the women of Odi community about FGM. The implication for positive social change included an in-depth understanding of the lived experiences of women about FGM, their perspectives towards the impact of cultural myths on the practice of FGM and current legislation that is meant to prevent female genital mutilation. This knowledge will lead to improvement in the morbidity and mortality rate of women and children. The result could serve as a basis for further investigations into strategies that would lead to the termination of FGM in the Odi community and also inform policy decisions on FGM to improve maternal and child health.

Examination of several studies indicated that FGM is a traditional practice with no medical benefit rather it jeopardizes the health of women and girls (Okeke et al., 2012; Blanton, 2011). These studies also indicated that about 130 -140 million females have been mutilated in Africa and about 3 million are at the risk of being mutilated yearly (Okeke et al., 2012; WHO, 2011). Gele et al., (2012), and Kandala et al., (2009) implicated social and cultural factors for the existence of FGM in Nigeria countries. However, no research work has explored the specific lived experiences of the women of Odi about FGM.

The chapter includes the methodology used and why phenomenological theory was appropriate to answer the research question. The phenomenological paradigm enhanced the development of understanding of the lived experiences of people from a unique point of view (Moustakas, 1996). The use of a phenomenological approach illuminated the first-person experience (Creswell, 2013). It utilized open-ended questions to give each participant a chance to express herself fully. It also provides an understanding on the perspectives of the participants and how they make sense of their experience.

Research Design and Rationale

The following research questions guided this study: What are the lived-experiences of women in the Odi Community surrounding female genital mutilation?
SUBQUESTION 1-What are the perspectives of women in the Odi Community towards the impact of cultural myths on the practice of female genital mutilation?
SUBQUESTION 2-What are the perspectives of women in the Odi Community towards current legislation that is meant to prevent female genital mutilation?

This phenomenological study sought to understand human behavior and the reasons that govern such behaviors (Maxwell, 2013). Phenomenology was also used to explore concerns of interest without having to be locked into closed short answers, as is the case with quantitative research (Flood, 2010). Qualitative method also allows the researcher to describe terms that explains the phenomenon under study (Flood, 2010). The phenomenological approach tends to describe the common lived experiences of several individuals on a phenomenon and allow researchers to use vivid descriptive terms

to understand the issues (Creswell, 2013). The phenomenologist collects data on what all participants in a study have in common, identifies themes and patterns in the data and develops a composite description of the essence of the experience for all the participants (Creswell, 2013). This study used a phenomenological approach to explore the lived experiences of women from the Odi community about FGM. A qualitative design was considered appropriate because it brings out the first person experience and gave the participants the privilege to express their feelings about FGM through the use of open ended questions.

Data were collected from women and girls, 18 and older who had experienced FGM. Out of the 9 participants, one is pregnant and one is physically challenged (floppy lower limbs). The data collection tool was an in-depth interview that lasted for 1 hour. I drafted the interview guide.

Role of the Researcher

I played the role of an observer/interviewer. To understand the lived experiences of the women of Odi about FGM and glean meaning from their experience as an interviewer, I bracketed my feelings so that it does not interfere with the study result. According to Creswell (2013) bracketing allows the researcher to put aside personal and professional feelings or experiences in order to have an open mind to explore the phenomenon under study. I showed understanding and not judgmental irrespective of the participants' perspectives. In order to rule out or control bias in this study, I recorded my interview; reviewed the responses by participants and also reviewed my conclusions. I also ensured that light refreshment and a stipend of ^1000 (\$10) were

given to participants at the before and after the interview, but this was not made known to them until they had agreed and accepted the consent form.

Methodology

The population of study was women who had experienced FGM and lives in the Odi community during the period of study. A snowball sampling technique was used to find and contact 10 participants who had experienced FGM for the study by peers. A snowball technique is a technique where participants are recruited based on recommendation from their peers (Explorable.com, 2009). The technique enables researchers to recruit participants in a population that is difficult to sample. The inclusion criteria included: (a) a female age 18 and above, (b) must be an indigene of the Odi community and resides in the Odi community, (c) women who may be pregnant, (d) must have experienced female circumcision either as a child or an adult, and (e) fluent in English or Izon language.

Following the approval of the Walden University IRB, Kolokuma/Opokuma Constituency office, and the office of the Girl-Child Education, I made a courtesy visit to the ruler of the Odi community to acquaint him of the study and obtained his approval to gain entry into the Odi community for the recruitment of participants. The sample included 9 mutilated women between the ages of 18 and above. A sample size of ten is recommended when an in-depth interview that will last for a period of one hour is used as a method of data collection (Creswell, 2013). I contacted recommended participants by visiting them in their homes. During the visitation, I briefed them on the interview date, the research questions, methods, procedures and consent form. They were also informed

that they are free to end the participation at any stage they no longer feel comfortable with the study. Only participants who met the inclusion criteria, accepted the consent form, and visited the office of the Girl-Child Education to give verbal consent were recruited for the study.

Saturation and sample size enabled the researcher to continue to recruit participants until enough information on the phenomenon under study was sufficient to develop the study (Creswell, 2013).

Instrumentation

An interview guide which I constructed after the review of several literatures was used to conduct a face-to-face interview session with the participants that lasted for a period of one hour each (Appendix B). The interview took place in the Office of the Girl-Child Education to ensure privacy and safety. The interview started with a discussion that enabled me to obtain the demographic data (age, educational level, age at mutilation) of participants (Table 1). An observational field note was also used for data collection. Interview questions were basically open-ended questions to enable participants express themselves to the fullest. Though there was an interview guide, opportunity was also given to address questions that emerged through evolution of conversations with participants. All face-to-face interview session were tape-recorded.

I established saturation in data collection when there was a repeat of answers, and the themes suggested a conclusion as demonstrated by other phenomenological study researchers (Windsor et al., 2010; Williams et al., 2004). Transcription was done manually by me and the research assistant who speaks Izon and English fluently. This

was verified by me through comparison with the audio version. Participants were invited to the office of the Girl-Child Education for further verification of the transcripts.

Data Analysis Plan

At the end of the interview session with all participants, recorded interview were transcribed and individual transcripts were created for each participant. The Colaizzi's phenomenological method was used for the data analysis (Creswell, 2013). Using this method, all written transcripts were reread severally to have a holistic understanding of the participants' experiences (Creswell, 2013). I intended using the NVivo software to categorize, merge patterns and themes, but was disappointed by the emergence of technical difficulties during the downloading of the software. Therefore, I had to manually develop significant phrases or sentences from each transcript that pertain to the lived experiences of the participants on FGM and myths in relation to FGM were identified (Creswell, 2013). Meanings were formulated from these significant phrases and statements. The formulated meanings were clustered into themes (ideas) common to all participants' transcripts. These themes were presented inform of sentences or phrases. The results were then integrated into an in-depth, exhaustive description of the phenomenon. After I have obtained the descriptions and themes, the final step involved approaching some participants the second time to validate the findings.

Issues of Trustworthiness

Validity is the outcome goal of a research work and in phenomenological study it is based on trustworthiness (Creswell, 2013). Credibility, transferability, dependability and confirmability were employed to address the issue of trustworthiness.

Credibility

This means the internal validity of the research. To establish credibility, I employ triangulation, member check and saturation. In triangulation, I located evidence to document a code from different sources to provide validity of the findings. Participants were also given the opportunity to verify the findings and interpretation (Member check). Verification of the findings by the participants is the first step in achieving validity of a research project in qualitative study (Creswell. 2013). There was continuous recruitment of participants until rich information were gathered (Saturation).

Transferability

Transferability ensures the stimulation of future research (Patton, 1990). To ensure future work on FGM, I produced a thick description of participants' experiences on FGM, their perceptions on the cultural myth and legislation against FGM. This will enable readers to transfer the information to other settings.

Dependability

Dependability is a qualitative word for reliability. To ensure dependability, triangulation was employed through the use of multiple data collection strategies like interview and observations. Dependability was also enhanced through the use of a tape recorder and field note.

Confirmability

This is to establish the truth, accuracy and genuineness of the actions and perceptions of participants. One strategy that I employed to ensure confirmability was the reflexivity strategy. This is the ability to make my position explicit by being

conscious of the biases, values and experiences I bring into the study (Creswell, 2013). I was conscious not to influence any participant's opinion and to allow the data speak for itself. Confirmability was also ensured by submitting the study to my committee members. These various strategies, when employed ensured trustworthiness in the study.

Ethical Procedure

Ethical procedures in research start with the researcher's plan being reviewed by the IRB of a university to ensure the enforcement of federal regulations that protects research participants (Creswell, 2013). I applied for and obtained Walden University IRB approval. Secondly, I also obtained approval from the Kolokuma/Opokuma Constituency Office which is responsible for the approval of research work in the Odi community. This approval letter was presented to the paramount ruler of the Odi community and his council of chiefs, in order to gain entry into the community for recruitment of participants. Furthermore, an application and approval was obtained from the office of the Girl-Child Education for support and availability of the office for the conduct of the interview to ensure privacy.

Participants who were identified through the snowball technique were given an informed consent form (Appendix C) and a stipend to come to the office of the Girl-Child Education to give their verbal consent and interview. Informed consent is an important procedure a researcher must observe before the conduct of a research with human participants (Maxwell, 2013). Verbal consents were obtained from the participants who visited the Office of the Girl-Child Education. The participants were also advised to quit at any stage of the data collection if they no longer felt comfortable. To ensure

confidentiality, only the first letters of the first and last names of participants were used for identification which is not included in the final study. Participants were also informed that the research was for academic purpose to fulfill a doctoral degree requirement. All participants were treated with dignity and respect. The recordings are stored in a password protected laptop. Ethical standards of data collection were strictly observed in the conduct of this research.

Summary

FGM is a harmful practice that is of public health concern but exist in the Odi Community. At the time of this study it was difficult to determine the lived experiences of women of the Odi Community about FGM. The purpose of this qualitative study with a phenomenological approach was to explore the lived experiences of women from the Odi Community about FGM. The phenomenological paradigm was designed to provide rich information that will describe the lived experiences of women about FGM. Snowball technique was used to recruit 10 participants. Participants were given a consent form and a verbal consent was given by the participant before the commencement of data collection. In-depth interview was used for data collection and Colaizzi's method was used for data analysis. Results of this study will make information available for further studies into FGM. Chapter 4 presents the results and findings of this study.

Chapter 4: Results

Introduction

The purpose of this phenomenological study was to explore the lived experiences of women of the Odi community about FGM, their perspectives on the impact of the cultural myths and their perspective on the current legislation for preventing FGM. Chapter 4 presents the results and analysis of the study data.

The overarching research question for the study was as follows: What are the lived-experiences of women in the Odi community surrounding female genital mutilation?

Subquestion 1. What are the perspectives of women in the Odi community towards the impact of cultural myths on the practice of female genital mutilation?

Sub-question 2. What are the perspectives of women in the Odi community towards current legislation that is meant to prevent female genital mutilation?

The implications for positive social change would include an in-depth understanding of the lived experiences of women about FGM, their perspectives on the impact of cultural myths on the practice of FGM and their perspectives on current legislation meant to prevent FGM. The results could serve as a basis for further investigations into strategies that would lead to the termination of the FGM in Odi community and also inform policy decisions on FGM in order to improve maternal and child health.

Prior to the interview, I welcomed all participants to the office of the Girl-Child Education and thanked them for creating time to come to the office. I also asked if they

were willing to participate in the study and to be interviewed on tape. They all gave their verbal consent and permission. I reminded participants that they could stop the interview at any time they no longer feel comfortable to continue.

A face-to-face in-depth interview that lasted for one hour was conducted and recorded with permission from the participants. Field notes were also collected to record my thoughts during the interview session. At the end of the summary of the results, participants were also contacted through phone calls for confirmation of their opinions. The participants validated the findings via member checking process. The interview data were presented in five ways: (a) two demographic characteristics, (b) awareness of FGM, (c) perception about cultural myths of FGM, (d) legislation against FGM, and (e) and social implications. During the session, the interview guide was used to ensure consistency and all comments were repeated to clarify meaning as appropriate. I allowed participants to discuss issues with appropriate examples.

Study Setting

FGM is condemned globally, but held in high esteem and practiced secretly by the people of the Odi community. This made it difficult for the participants to volunteer for the study. I chose to conduct the interview in the office of the Girl-Child Education, which is away from the Odi community to ensure privacy for those who willingly participated in the study and thus avoid back lashing from other community members. My interpreter and I underwent the NIH course, and we were the interviewers and transcribers throughout the data collection. A stipend of ^1000 (\$10) was presented once

to participants during recruitment and refreshments were offered before, during, and after the interview session for appreciation.

Demographics

The study sample included nine women who had undergone FGM, of which five were mutilated when they were 5-7 months pregnant with their first child; one was mutilated when she was 2yrs old and three who were mutilated between the ages of 15 and 20. Although the sample shared similarities in location, all lived in Odi community, they reflected a difference in age, which ranged from 26 to 55. All participants were indigenes of Odi community and speak Izon and English languages fluently. The self-reported highest levels of education were as follows: Post Graduate Diploma (1), West African Examination Council (WAEC) certificate (5), Primary School Attempted (1), and illiterate (2). Five of the participants had full time jobs with the Odi Local Government Council, one was a trader, one was a home-maker, one was an undergraduate and one was a Traditional Birth Attendant.

Table 2

Participants' Demographic Information

Participants	Age	Educational	Employment Status	where are you from?	When where mutilated?
P1	39	WAEC	Civil Servant	Odi community	2years
P2	40	WAEC	Trader	Odi Community	20years
P3	55	Illiterate	Traditional Birth Attendants	Odi community	5 months pregnant with my first child
P4	26	WAEC	Student (under graduate)	Odi community	15 years
P5	29	WAEC	Home Maker	Odi Community	18 years
P6	27	WAEC	Civil Servant	Odi community	6 month pregnant with my first child
P7	27	WAEC	Civil Servant	Odi community	7 months pregnant with my first child
P8	45	Illiterate	Civil Servant	Odi community	7 months pregnant with my first child
P9	30 ⁺	Post Graduate Diploma	Civil Servant	Odi community	6 months pregnant with my first child

Biological Sketches

The biological sketches of the participants are provided in numerical order from 1 to 9. This section contains participants influence for being mutilated.

Participant 1. Participant 1 is a West African Educational Certificate (WAEC) holder and 39 years old. She is a civil servant working with the Kolokuma/Opokuma

Local Government Council. She is a native of the Odi community and was mutilated at the age of 2 years. When asked what influenced her being mutilated (circumcised), she stated:

I was a child and could not make decisions for myself, but when I grew up, I asked my parents why they mutilated me. Their response was that it is a tradition for females in the Odi community to be circumcised to prevent promiscuity.

Participant 2. Participant 2 attempted primary school and stopped at primary 4. She is 40 years old and a trader. She is a native of the Odi community and was mutilated at the age of 20 years. When asked what influenced her being mutilated (circumcised), she stated:

I was very active and attractive to men. So, I got married at a very tender age but was unable to achieve pregnancy despite unprotected sexual intercourse with my husband for 5 years. Then the elderly women in the community advised me to be circumcised if I want to be pregnant. I adhere to their advice and allowed myself to be circumcised. True to their words, I became pregnant.

Participant 3. Participant 3 did not attend any formal school. She is 55 years and a Traditional Birth Attendant. She is a native of the Odi community and was mutilated when she was 5 months pregnant with her first child. When asked what influenced her being mutilated (circumcised), she stated:

The reason is to prevent the clitoris from covering the head of the baby, because if the clitoris is not removed the baby will not be born alive.

Participant 4. Participant 4 is an undergraduate in one of the State Universities.

She is 26 years old and a native of the Odi community. She was mutilated at the age of 15 years. When asked what influenced her being mutilated (circumcised), she stated:

I was circumcised at the age of 15 years when my immediate elder sister was to be circumcised. I appealed to them not to circumcise me, but they refused to listen to my appeal and quoted from the Bible that when “Abraham wanted to look for a wife for his son Isaac, he commanded his servants not to get a woman from an uncircumcised people”. They over powered me, with two men holding my legs apart and I was circumcised without my consent.

Participant 5. Participant 5 is a WAEC holder. She is 29 years and a native of the Odi community. She was circumcised at the age of 18 years. When asked what influenced her being mutilated (circumcised), she stated:

I was circumcised at the age of 18 years because I was told no man will marry me if I am not circumcised. They also said if I eventually get married, I will be unfaithful to my spouse. I had to do it because I want to be married and be faithful to my husband too.

Participant 6. Participant 6 is a WAEC holder and a Civil Servant working with the Kolokuma/Opokuma Local Government Council. She is 27 years old and a native of the Odi community. She was circumcised at the age of 18 years. When asked what influenced her being mutilated (circumcised), she stated:

I was circumcised at the age of 18 because I was 6 months’ pregnant. According to our culture, if you are not circumcised and the clitoris touches the head of the baby, the baby will die.

Participant 7. Participant 7 is a WAEC holder and a Civil Servant working with the Kolokuma/Opokuma Local Government Council. She is 27 years old and a native of the Odi community. She was circumcised when she was 7 months pregnant with her first child. When asked what influenced her being mutilated (circumcised), she stated:

I had to allow myself to be circumcised because it is the culture to circumcise the female when she is pregnant with her first child to preserve the life of the child and the mother.

Participant 8. Participant 8 did not attend any formal school. She is 45 years old and a native of the Odi community. She is working as a cleaner in a University. She was circumcised when she was 7 months pregnant. When asked what influenced her being mutilated, she stated:

I allowed them to circumcise me because I was afraid of stigmatization and losing my baby to death. If you are not immunized and you give birth, you and your child will be stigmatized and seen as an outcast in the community.

Participant 9. Participant 9 is a Post Graduate Diploma holder, working as a tutor in a Health College. She is a native of the Odi community and is 30⁺ years old (she refused to give her exact age). She was mutilated when she was 6months pregnant with her first child. When asked what influenced her being mutilated (circumcised), she stated:

The gifts they usually give to the circumcised woman was what influenced me to be circumcised. When a woman is circumcised, she will have a little girl called “Okoti” in kolokuma (Izon) language, who will move with her from one end of the community to another with women singing along. Any compound she gets to,

the people in that compound will come out to shower gifts and money to her.

After that, they will escort her to her husband's house. It is very interesting.

Biographical Summary

Participants reported different ages of mutilation and the reasons why they were mutilated. They are all from Odi community and are mostly civil servants, students, traders and a homemaker. The emerging themes were illuminated in the following section.

Data Collection

The recruitment of the participants took about two weeks after approval was obtained from the Walden University IRB (10-27-15-0345868), Office of the Kolokuma/Opokuma Constituency and the Office of the Girl-Child Education. The recruitment of participant started after I presented the approvals of the Walden IRB and the Office of the Kolokuma/Opokuma Constituency to the Chief of the Odi community for his permission to gain entry into the community. Snowball technique was used to recruit participants and those who met the inclusion criteria were given the consent form and a stipend of ₦1000 to come to the office of the Girl-Child Education within 2 weeks and between 9am and 5pm on working days to give a verbal consent of their willingness to participate in the study.

Unfortunately, the weeks scheduled for the interview were campaign weeks for the Gubernatorial Election in Bayelsa State, and the office of the Girl Child which is situated in the block of the Ministry of Women Affairs was fully booked for the Campaign from November to December. This made it impossible to use the Office for

the interview as stated in Chapter 3. I had to move over to an alternative plan by making an apartment in my building available for the interview session. Secondly, because of the busy city and heavy traffic due to the campaigns, we had to schedule a day for the interview and all participants were expected to come for the interview on that day, but the Participant 9 came 2 days after. Ten participants were given consent forms but only 9 came to give their verbal consent. All nine participants came at their own time that was convenient for them. On arrival, they were welcomed by the interpreter and all 9 participants gave verbal consent to participate in the study. Before the commencement of the interview, light refreshment was presented to each participant in the waiting room by the interpreter and they were also advised to use the first letters of their first and last names for identification, before they move into the room provided for the interview. Immediately they moved into the interview room the researcher engaged each participant in a discussion that led to the collection of their demographic data. Identification codes were assigned to participants using the first letter of their first and last names. Participants also gave approval for the interview to be tape recorded. They were also informed that the interview will last for a maximum of 1 hour and at the end of the interview, participants were informed that the findings of the study will be presented to them for confirmation. No unusual circumstance was identified during the interview session. I transcribed the audio version of the interview myself and the findings were developed. When findings were presented to participants during member checking, all participants confirmed that the findings were true representation of their lived

experiences. After analysis, data was presented to a Professor in Public Health who is also into qualitative studies to review the data for missing themes.

Data Analysis

Colaizzi's method was used for data analysis (Creswell, 2013). After reviewing each participant's statement, their lived experiences about FGM, their perceptions on the cultural myths and legislations against FGM came to life (Creswell, 2013). A list of the statement of their perceptions was made. Next, I made themes from the statements and synthesized them into textual description of their lived experiences about FGM.

The step was repeated for each participant's lived experiences on FGM (Creswell, 2013). I read through each participant's transcript severally and selected specific statements. Though, I indicated that NVivo software will be used for imputation of the interview scripts in Chapter 3, I was unable to use it due to an inability to download the software. Therefore, coding was done manually by me. Each participant's statements were grouped into themes (Creswell, 2013), and as was described by Moustakas (1994), themes emerged from the data. For each core theme, I reflect on the phenomenology theory, the literature review and my personal experience of FGM (Abiodun, et al., 2011; Amedeo, 2009; Kandala, et al., 2009).

The participants' experience about FGM was described in the theme analysis, and the structural and textual description was synthesized into a compound description of the lived experiences of FGM (Creswell, 2013). These became the essential framework for the lived experiences of women of the Odi community about FGM. The analysis process started with special attention on the general text that reflects the experiences of the

participants and ended with reflections on findings in light with the scientific literature. Every theme that was identified was supported with a text description of the participant's experience and how they experience it in their own words. Finally, I submitted the transcripts and themes to a Prof of Public Health to review again for missing themes or combination of themes, where necessary.

Evidence of Trustworthiness

Precautions were taken to ensure that every threat to trustworthiness was ruled out during the study. Participants were allowed to express themselves to the fullest for the emergences of rich information. During the interview, some of statements of the participants were paraphrased for the participants to agree or disagree in order to achieve greater understanding of the participants' experience. Member checking was also done by presenting the findings and interpretation to each participant for their confirmation of the reflection of their perceptions and experiences. Opportunity was also given to the participants to make changes where necessary

Results

Meaning Units or Themes

According to Creswell (2013), the next step is to identify significant statements. These statements were organized into themes and subthemes. The subthemes were responses of participants to questions that were asked. The themes that emerged were: (a) FGM is a traditional rite, (b) challenges of FGM, (c) FGM cultural myth instills fear, (d) ignorance of legislation against FGM, and (e) needs government intervention to halt FGM.

Table 3*Themes and subthemes*

Themes	Subthemes
FGM is a Traditional rite	Adolescent.
	During pregnancy.
	To avoid stigmatization.
	Total removal of my clitoris.
Challenges of FGM	Bleeding.
	Pains.
	Lack of sexual urges and satisfaction.
Cultural myths of FGM instills fear	A traditional rite for all females.
	An uncircumcised woman is promiscuous.
	The clitoris can kill the baby.
	It is not true and not good.
Ignorance of legislation against FGM	Females should not be circumcised.
	Good announcement, but not enforced.
Needs government intervention to halt FGM	Embark on aggressive campaign against FGM.
	Prosecute those who violates the law.

Each theme and subtheme is presented with evidence from statements made by participants. The overarching research question that was asked in order to achieve the purpose of the study is: What are lived experiences of women in the Odi community surrounding female genital mutilation?

Subquestion 1. What are the perspectives of women in the Odi community towards the impact of cultural myths on the practice of female genital mutilation?

Subquestion 2. What are the perspectives of women in the Odi community towards current legislation that is meant to prevent female genital mutilation?

A semi-structured interview guide was used to provoke responses that will illuminate the lived experiences of women of Odi about FGM (Appendix B) and answer the research questions.

Themes

This study was designed to explore the lived experiences of women of Odi about FGM. The first two questions on the interview list were to ensure that the demographic data of participants correspond with the inclusion criteria. Participants were asked series of questions to answer the overarching research question of what are the lived experiences of women from the Odi community about FGM? Their responses illuminated the shared lived experiences of participants about FGM in the Odi community. The theme and subtheme that evolved from these overarching questions were as follows:

Theme 1: FGM is a Traditional Rite

This study was designed to explore the lived experiences of women of Odi about FGM. Participants were asked series of questions to illuminate their shared experiences on female in the Odi community. All participants said FGM is a traditional rite for all women, the period it is performs and the reason the mutilation. The following subthemes emerged: (a) adolescent, (b) during pregnancy, (c) to avoid stigmatization, (d) to avoid excommunication

Subtheme 1 Adolescent: Three of the participants were mutilated when they were adolescents. This means that Odi community also performs FGM during the adolescence period.

Participant 4:

Female circumcision is our tradition for every female. I was circumcised at the age of 15 when my immediate elder sister was circumcised because she was pregnant. I pleaded with my parents that I do not want to be circumcised, but they

brought men who over powered and circumcised me. They said if I am not circumcised I will not be allowed to join the female group. Though, they circumcised me without my consent.

Participant 5:

I was 18 years old when I was circumcised because it is our tradition for all women to do female circumcision. I was told I will not be married because no man will come to me if I am not circumcised, and if I eventually get married, I will be unfaithful to my husband.

Participant 2:

Female circumcision is our tradition....., so I was 20 years old years old when I was circumcised. I was very active and attractive to men back then. I went into relationships but no pregnancy. They convinced me that I will never be pregnant if I am not circumcised.

Subtheme 2: During pregnancy. Five participants were mutilated when they were pregnant with their first children. The Odi community also performs FGM on pregnant women.

Participant 3:

I was circumcised when I was 5 months pregnant with my first child because it is our tradition to circumcise women who are pregnant before they deliver. If you were not circumcised before you became pregnant, circumcision will be done on you when you are pregnant to prevent the clitoris from covering the head of the child.

Participant 6:

It is the tradition of the Odi community to circumcise pregnant women. I was circumcised at the age of 18 years when I was 6 months pregnant with my first child. I had to do it because it is our tradition.

Participant 7:

My pregnancy was 7 months old when I was circumcised. They cut off my clitoris; I experienced pain and bled profusely. It is our tradition and if you refuse to do it you will be excommunicated and your child will not be valued.

Participant 8:

I was 7 months pregnant when I was circumcised. I allowed them to circumcise me because I don't want them to laugh at me. I want them to see me as a complete woman.

Participant 9:

I was 6 months pregnant when I was circumcised. I allowed them to circumcise me because of the gifts that will be presented to me as I move from one end of the community to another. If a pregnant woman delivers without being circumcised, the child will not be recognized and she will not associate with the women of the community.

Subtheme 3: Clitoridectomy: (removal of the clitoris). Out of the 9

Participants, 8 said their clitorises were removed in the circumcision. This means that the Odi community practice clitoridectomy which is the type 1 form of FGM.

Participant 1:

The Odi community practice female circumcision as a traditional rite. During my time, my clitoris was removed but I did not know because I was circumcised at the age of 2 years. I grew up not having clitoris. I noticed it while bathing with my school mates in the boarding school. My private part looks different from theirs. When I asked my mother she said they removed the clitoris when I was a child because it makes the girls to be promiscuous.

Participant 2:

In the Odi community circumcision is done to remove the clitoris because if the clitoris touches the head of the child during delivery, the child will die and the woman will be promiscuous.....this is the tradition.

Participant 3:

If you are pregnant they will circumcise you to prevent the clitoris from covering the head of the child during delivery. If the clitoris is not cut off the child will not be born. As a pregnant mother, my clitoris was removed.

Participant 4:

I was very angry because I was circumcised out of my will. I bled profusely and in pains. I was not happy with the circumcision because my clitoris was removed. They said it is the tradition, but it is annoying.

Participant 5:

I was circumcised when I was 18 years old and my clitoris was removed during the circumcision to prevent promiscuity when I am married. That is our tradition.

Participant 6:

The Odi community performs female circumcision and the clitoris is cut off to prevent the woman from being promiscuous. It was done on me.

Participant 7:

I was 7 months pregnant when I was circumcised. The circumcision involves the removal of the clitoris. It is very painful but we have to endure it because it is the tradition.

Participant 8:

I was circumcised when I was 7 months pregnant. I had a sore on the spot where the clitoris was cut off. When it began to heal, it became itchy and I scratched it until another sore developed on that same spot.

Subtheme 4: Stigmatization. Three participants said any woman who is not mutilated will experience stigmatization from the community members.

Participant 3

The community members stigmatize females who are not circumcised and no value is placed on their children. Since I am pregnant, to avoid the stigmatization, I had to accept the circumcision.

Participant 6

I allowed myself to be circumcised because all females who are not circumcised will be excommunicated and stigmatized in the community. She will not partake in the age group meetings and she is treated as an outcast which keeps the uncircumcised female uncomfortable.

Participant 8

I allowed them to circumcise me because of the fear of being stigmatized and losing my baby. Stigmatization will keep you uncomfortable in the midst of the community members.

Theme 2: Challenges of FGM: Consequences associated with FGM

Subtheme 1: Bleeding. After the FGM, two participants had excessive bleeding as a challenge.

Participant 5:

After the circumcision, I bled profusely. I also discovered that I don't enjoy sexual intercourse.

Participant 6:

After the circumcision, I had excessive bleeding. I don't know what caused it but they applied something on the wound and the bleeding stopped the next day.

Subtheme 2: Pains: Two participants responded that they experience pains after the circumcision.

Participant 7:

I had severe pain after the circumcision. The site where the clitoris was removed was swollen and I could not move without opening my legs.

Participant 9:

After the circumcision I experienced pain, but no bleeding. The site of the clitoris was swollen, but if one bleeds, according to my grandmother, they will apply herbal fluids on the bleeding site to stop the bleeding.

Subtheme 3: Lack of sexual satisfaction. More than half of the participant sample felt that they lack sexual satisfaction due to FGM that involves the cutting off of the clitoris.

Participant 1:

One challenge I can notice as a woman who was circumcised during childhood is that I don't enjoy sexual intercourse. I have not experienced orgasm and there is nothing I can do about it. I just have to live with it.

Participant 3

I had no challenge during delivery, but I don't enjoy sex anymore and I can't even tell if I experience sexual urges. I notice that I don't bother about sex even if my husband does not come to me for months.

Participant 4

The challenge I'm experiencing since after the circumcision is that I don't enjoy sexual intercourse and I am not happy about it.

Participant 5

The challenges I had were excessive bleeding and after the circumcision I discovered that I lack sexual urge and fulfillment.

Participant 6

After the circumcision, I felt severe pain and bled profusely. When I got married, I discovered that I no longer enjoy sex. It has happened, and there is nothing I can do about it.

Participant 8

My challenge is that my clitoris was chopped off and I am no longer attractive to men on bed..... because I am not exciting to be with on bed.

The subquestion 1 explored the perspective of the women towards the impact of the cultural myths surrounding FGM. A series of questions were asked to illuminate their perspective on the impact of the myths and how they perceive it. Themes and subthemes that emerged were as follows:

Theme 3: Cultural Myths Instills Fear

The view of the participants on the impact of the cultural myths was that it instills fear into the people. They stated that some females do not want to be circumcised, but the fear of the negative circumstance of the cultural myth influences them to be circumcised. When asked about the cultural belief people in the Odi community have about FGM, subthemes that emerged includes: (a) a traditional rite for all females, (b) uncircumcised woman is promiscuous; (d) the clitoris can kill the baby.

Subtheme 1: A traditional rite for all females: this is to ensure recognition and acceptance. Two participants responded that the cultural belief surrounding FGM is that it is a traditional rite that must be performed by all females for them to be recognized and accepted in all cultural activities.

Participant 1

In my community, it is the cultural belief that a woman must be circumcised when she is pregnant for her and her child to be recognized and accepted in the community and among her folks. Any woman who is not circumcised is not valued and she will lose the child. This cultural belief put fear into the people.

Participant 9

Circumcision is a traditional rite for all females who want to be recognized, because it is the cultural belief that an uncircumcised woman cannot partake in the ceremony that involves appeasing the gods of the land. She will not be welcomed among her fellow women and her child will be considered an outcast. The fear of being excommunicated or losing my baby and the gift they give during the ceremony made me to go for circumcision.

Subtheme 2: The uncircumcised woman is promiscuous. More than half of the participants said it is the cultural belief that an uncircumcised woman is promiscuous and will not be faithful in marriage.

Participant 2

It is the cultural belief of the Odi people that female circumcision prevents promiscuity; therefore any female who is not circumcised is promiscuous and incomplete. No man wants to marry a woman who will run after other men. The fear of this belief makes women to go for circumcision.

Participant 4

It is the cultural belief that the uncircumcised woman is promiscuous and will be unfaithful in marriage therefore she will not be married.

Participant 5

The cultural belief surrounding female circumcision in the Odi community is that without circumcision there will be no marriage because the woman will be promiscuous.

Participant 7

According to the tradition, the woman who is not circumcised is promiscuous because of the clitoris that looks like the penis.

Subtheme 3: The clitoris can kill the baby: if not cut off. Three of the participants stated that one of the cultural beliefs is that the clitoris is deadly and can kill the baby during delivery.

Participant 3

In the Odi community, if you are pregnant they will circumcise you to prevent the clitoris from touching the head of the child, because it is the cultural belief that if the clitoris is not cut off the child will die. This fear makes us to practice circumcision.

Participant 4

It is the cultural belief that an uncircumcised woman can never give birth to a life baby. They also believe that an uncircumcised woman is promiscuous and unfaithful in marriage.

Participant 8

In the past, the cultural belief is that if a pregnant woman is not circumcised she or her baby will die during child birth because of the head of the clitoris.

Sub-theme 4: Cultural belief is not true and not good. When asked about their personal perspective concerning the cultural belief, almost all participants had a negative perception towards the cultural myths. They said the belief is not true and not good because it puts the female in grave danger due to the consequences associated with FGM.

Participant 1

I don't like the cultural belief surrounding female circumcision because it is not good. It put fears in the people and makes them to do the circumcision that takes away valuable part from them.

Participant 2

Personally, I don't like the cultural belief and I am no longer afraid. I have stopped circumcising my female children and will not practice it again because it is not good. I don't believe in the lies.

Participant 3

This belief is not good and I don't like the cultural belief because of the danger associated with the circumcision. This belief made them to circumcise me. I no longer feel like a woman because the sensitive area of my reproductive organ has been removed. I feel bad when I hear the uncircumcised women from other tribe talk about how enjoyable sexual intercourse is.

Participant 4

I don't like the cultural believe and I don't believe in it because I have a friend from another tribe who is not circumcised, but have three kids and they are all alive.

Participant 5

The cultural beliefs of female circumcision are not true and I have no belief on them. I will never subject my daughters or advice any female to be circumcised, but if any of my child wants to do it, that is her decision and not mine.

Participant 6

I perceive the cultural belief to be wrong and I will not advice any young girl to be circumcised because it can kill and can deprive a girl of sexual satisfaction.

Participant 7

The cultural belief is not true. I don't like it because it deprived me from feeling like a woman during sexual intercourse.

Participant 9

The cultural belief is barbaric. Things are changing. It is a violation against the right of the woman. Especially, the belief that the clitoris is like penis, if not circumcised can make a woman not to control her urges when she comes in contact with a handsome man.

Subquestion 2 explored the perspective of the women towards the current legislation against FGM. Participants were asked series of questions to address the inquiry. Questions bordered on their awareness of the legislation and their perception about it. The following themes and subthemes emerged:

Theme 4: Ignorance of Legislation against FGM.

In an attempt to answer the research subquestion 2 that borders on the perspectives of women in the Odi community towards current legislation that is meant to prevent FGM, most of the participants are ignorant of the current legislation because they mistaken what was announced on radio to be the legislation against FGM. They also perceive that the announcement was good, but not good enough to stop the practice because it is not enforced. The following subtheme emerged:

Subtheme 1: Females should not be circumcised: It is good. When the participants were asked about the current legislation against FGM they know, all participants said they have not seen the law against FGM, but they have heard from the radio that females should not be circumcised. Participants also consider the legislation to be appropriate.

Participant 1

I have heard about the law against female circumcision on the radio and the dangers associated with it, but it is still practiced in the Odi community, because they believe it is the culture. The law is good, and I wish the government can stop female circumcision.

Participant 2

One of the laws I heard said no female should be circumcised. I heard people say they always announce it on the radio. I consider the law to be good because it will save the life of our females. It will prevent excessive bleeding that led to the death of most girls who were circumcised.

Participant 3

I heard about the law against female circumcision over the radio. It said females should not be circumcised. The law is good because it will prevent women from suffering. I personally stopped my children from being circumcised, and I also advised my sister's children not to go for circumcision.

Participant 5

To be sincere, I have not heard from the government, but I have heard people say they have heard from radio that government is trying to stop female circumcision, so no woman should be circumcised. The government law against female circumcision is good because it will stop the circumcision of female sexual part.

Participant 6

I have not heard from the government, but some people said they always announce it on radio that women should not be circumcised. I don't have time to listen to radio, but when I heard the government made a law against female circumcision, I was happy.

Participant 9

I have heard of the legislation against female circumcision, but not in Bayelsa State. The legislation is good if it is enforced. I have heard some time ago that the first lady wanted to stop female circumcision.

Theme 5: Needs Government Intervention to Halt FGM.

When participants were asked of the approved policy they think will lead to the abolishment of female circumcision. In their response, it appears they don't know of any approved policy, but all participants said female circumcision can be stopped in the Odi community through the government embarking on aggressive campaign against female circumcision with the opinion leaders of the community, and prosecuting those who breach the law.

Participant 1

The government should engage in aggressive campaign against female circumcision and educate the community and its leaders of the danger associated with it. If government can stop female circumcision, it will prevent the unborn children from being circumcised.

Participant 3

Government should provide a leaflet on the dangers of female circumcision and distribute it during a campaign to every member of the community. They should try to convince the leaders of the Odi community not to allow circumcision of females in the community.

Participant 4

Female circumcision is very painful. I want government to enforce the law against female circumcision and sentence practitioners to serve a jail term. It will serve as a deterrent to others.

Participant 5

The government should enforce the law. They should go to the Odi community, make a call to the chiefs and elders to embark on a campaign to inform them of the dangers of female circumcision. Any who violates the law should be put in jail.

Participant 6

To abolish female circumcision in the Odi community, the government should inform the chiefs and the people of the Odi community of the danger and arrest any who violates the law.

Participant 7

The government should inform all the communities that practice female circumcision to stop and arrest all that violates the law. Female circumcision is not practiced in the Odi community alone. Other communities in this Bayelsa State also practice female circumcision.

Participant 8

If the government should enforce the law against female circumcision and arrest those that violate the law, I believe others will learn and stop the practice. It is

because nobody has been arrested for practicing female circumcision, that is why it is practiced in the community.

Participant 9

The government should convince the opinion leaders especially the women leaders and the chiefs to stop the practice, because without the consent of the opinion leaders, it will be difficult to stop female circumcision.

Summary

The participants were sincere in expressing their lived experiences about FGM. Some of their perspective towards the impact of the cultural myths of FGM were that the fear of being excommunicated for not fulfilling their traditional rite, being promiscuous, and losing their babies makes them to keep practicing FGM. This has exposed them to challenges like excruciating pains, excessive bleeding and reduced sexual pleasure. All participants perceived the cultural myths to be barbaric, not true and not good for the health of the Odi woman. They therefore, urge the government to convince the opinion leaders and embark on an aggressive campaign against FGM in the community. They also wished that the legislation against FGM be enforced and violators be prosecuted. In Chapter 5, I provided discussions of the final themes, conclusions, and recommendations for the study based on the findings in this chapter.

Chapter 5: Discussions, Conclusions, and Recommendations

Introduction

This chapter provides an interpretation of the findings of this phenomenological study, which was designed to explore, via interviews, the lived experiences of 9 women of the Odi community with FGM. The analyzed data indicated that FGM is a traditional practice in the Odi community that is influenced by cultural myths which the people consider neither true nor good for the health of the women.

The study findings are presented in the following sections: the review of the purpose of the study, interpretations of the findings compared to those reviewed in Chapter 2, the interpretation of the findings in the context of phenomenology (Creswell, 2013) and the limitations of the study. Finally, recommendations for further research and implications for positive social change for the women of the Odi community, government and schools were made. The purpose of the study was to explore the lived experiences of women from the Odi community about FGM, their perspective on the impact of the cultural myths of FGM, and their perspective on the legislation against FGM. The findings of the study generated themes and subthemes of their lived experiences which are important in understanding their lived experiences. Positive social change from this study may inform a future seminar on the findings of the study to policy makers. The participants expressed how they feel about FGM in the Odi community, which makes it very expedient to stop FGM in the community from the upstream (Policy makers).

The purpose of this phenomenological study was to explore the lived experiences of women from the Odi community about FGM, their perspective on the impact of the

cultural myths and their perspective on the legislation against FGM in Africa. Several studies have implicated cultural and social factors for the existence of FGM in Africa, few have explored the lived experiences of women in other countries such as Sudan and South Africa. There is lack of information about FGM in the Odi community in Nigeria. The gap provided an opportunity to explore the lived experiences of the women of Odi about FGM. The results of the study and current literature on FGM will illuminate the lived experiences of the women of Odi community on FGM. An overarching question and two subquestions guided this qualitative study. Participants responded to the questions based on their individual perceptions of their lived experiences with FGM.

Nine in-depth face-to-face interviews were conducted to answer the research questions. Colaizzi's method was used in analyzing the data. The transcripts were analyzed manually. A written interview guide was used to enable participants respond to the same question. I protected the privacy of participants by following the Walden University guidelines. Face-to-face interviews were audio recorded and entered into a password-protected computer file accessible to the researcher only. The interpretation of the findings presented in the following section is organized according to the research questions.

Interpretation of the Findings

Overarching questions: What are lived experiences of women from the Odi community about FGM?

All research participants were willing to express their experiences irrespective of the sensitive nature of the study. They also could understand the English language and

speaks the “Pigeon English” (the lingua franca) fluently which makes it easier for the researcher to communicate effectively with participants and reduced the work of the interpreter, who could have interpreted in the Izon language if they were not able to understand and speak the English language. The study started with the participants narrating their lived experiences of FGM. The study developed gradually from what female circumcision is, when it is done in the Odi community, how it is done, the cultural myths and challenges surrounding female circumcision, their perception about it, the legislation, and their perception about the legislation, to lastly what can be done to abolish female circumcision in the Odi community (Figure 2). As the participants expressed their lived experiences on FGM, Participant 5 stated:

Female circumcision is a traditional rite that is performed by all females in the Odi community. In the past, it was done on children but presently, it is performed on young girls and females whose first pregnancy is between 5 to 7 months old. It involves the removal of the clitoris which according to the belief is considered a threat to the life of the baby and the mother, and seen as making the woman to be promiscuous. I was circumcised at age 18, because I was 6 months pregnant with my first child. After the circumcision, I felt severe pain and had excessive bleeding which made me so weak. I had to do it because any female who don't do it is stigmatized and excommunicated from the female folk. I don't want that disgrace. After I delivered my baby, I discovered that any time I tried to have sex with my husband; I no longer enjoy the sex because I don't feel anything. I am not happy about it, but it has happened and there is nothing I can do anymore to

feel like a woman. I have to live with it. Government always announces on radio that females should not be circumcised, but we do it in Odi and nobody has been arrested for doing it.

This narration rang through five more participants. They considered FGM as a traditional rite for every woman in the Odi community, and their clitoris were cut off to fulfill the rite. This confirmed what Nkanatha and Kanuri (2014) stated that FGM is a traditional rite for females in Africa, the tradition influences the existence of the practice in the community irrespective of the consequences associated with it. They further stated that it is considered traditional rite that is equated with male circumcision. The traditional rite has cultural and social factors influencing it in any community where it is practice, which is in conformity to the reasons why people are mutilated in the Odi community (RezaeeAhan, 2013; Abiodun, 2011). Ashimi and Amole (2014) said in some part of Nigeria, FGM is accompanied with so much stress and controversy on either to consider it as an initiation into womanhood, ensure virginity, protect modesty and chastity, and curb promiscuity among women. Bjalkander, et al. (2012) also confirmed that FGM is considered an initiation ceremony for girls and women into womanhood in Sierra Leone. This could be the reason why it is celebrated in some part of African.

Another significant finding is that FGM is presently conducted in the Odi community on the females during their adolescent age and when they are 5- 7 months pregnant with their first child. However, only one participant indicated that she was mutilated when she was 2 years old. This is in contrast to what is being done in some parts of Africa where mutilation is done on babies (Lundberg & Gerezqiher, 2008). The

Population Reference Bureau, (2010) on the other hand, indicated in their study that in Africa, FGM is usually performed on girls between the ages of 4-12 years in some culture, others perform it at birth and some others at when a woman is 7 months pregnant.

A significant finding indicated that the Odi community practice clitoridectomy (Type 1) which involves the removal of the hood of the clitoris (prepuce) and/or the entire clitoris (Bjalkander et al, 2012; WHO, 2008). The clitoris is one of the sensitive organs that enhance orgasm during sexual intercourse (Vukadinovic et al., 2014). The clitoris is so important in a woman's sexual satisfaction because the clitoris extends backward into a woman's body and wraps round her vagina, and it plays an important role in how enjoyable just about any kind of sexual activity feels (Kenner, 2015). That could be the reason why most of the participants narrated that sexual dissatisfaction is one of the challenges they experience after mutilation (Hussein, 2010). This confirms what Kaplan et al., (2011) opined that sexual dissatisfaction is one of the consequences of FGM due to the removal of the clitoris and in some cases, the labia minora and majora.

A significant finding also indicated that the women in Odi who are not mutilated are stigmatized, and their children considered as an outcast if they survive after delivery. Due to this stigmatization even those who don't want to be mutilated subject themselves to mutilation. This confirms what Leo, (2012) said that women who refuse to be mutilated in communities where FGM is practiced go through stigmatization and are excommunicated from community activities. Kontoyannis and Katsetos (2010) also confirmed in their study that the uncircumcised woman and her child are seen as outcast in the community. The stigmatize them and would not associate with them or include

them in the ceremony for the gods because it is believed that their presence disorganizes the gods of the land.

The findings also indicated that excessive bleeding, pain and sexual dissatisfaction are part of the challenges the mutilated women of the Odi community experience after mutilation. Kaplan et al., (2011) confirmed in their study that victims of FGM experience excruciating pain and anemia due to excessive bleeding as immediate consequences after mutilation. Nkanatha and Kanuri (2014) confirmed that the mutilated women in Meru community in Kenya also reported lack of sexual satisfaction as a long-term consequence after mutilation. In Swaziland, the mutilated women also reported sexual behavior change after mutilation (Jonathan & Monique, 2012). The women of Odi believe that they do not experience sexual satisfaction because their clitorises were cut off. However, three participants narrated that they never felt pain or bleeding after circumcision because anesthesia was applied on two before the mutilation and the other participant was 2yrs old when she was mutilated, therefore, cannot tell if she experienced those immediate consequences.

Subquestion 1: What are the perspectives of women towards the impact of the cultural myths surrounding FGM?

The cultural belief is not true and not good (Figure 2). A unique aspect of this study, compared to other studies is that the participants were able to express themselves freely on how they perceive the cultural myths. All 9 participants narrated that the cultural belief is not good because it instills fear into them. They said it is the fear of

suffering the consequences of the belief that made them to go for circumcision. As the participants express their lived experiences on the cultural myths, Participant 8 stated:

Female circumcision is the cultural practice of the Odi people for every woman.....the cultural belief of female circumcision is thatthe child of the uncircumcised female always die in the battle field, that is, if they escaped death during delivery. If the mother is not circumcised the baby is an outcast. The uncircumcised woman is promiscuous, because the clitoris is like a penis and cannot be tamed or controlled in the presence of a handsome man. Therefore to prevent promiscuity every female must go through circumcision. To me, these cultural beliefs are barbaric. Things are changing. It is a violation against women. Though I allowed them to circumcise me, I will not recommend female circumcision to any female.

Cultural myths surrounding FGM in the Odi community appears to be weird, and they are made up of ideas that instill fear into the people (Murfin & Ray, 2003). These cultural beliefs may not be scientifically proven, but they have a firm grip on the people and influence all their activities (Heather, 2013). Most of the participants allowed themselves to be mutilated due to the cultural belief. This confirms that, despite the harmful implications of FGM, the fear of the cultural myths influence the people to go for mutilated (Gele et al., 2012; Mandara, 2003).

The findings indicated that it is a cultural myth in the Odi community that the clitoris is a dangerous organ that can kill and make women promiscuous. In the culture of the Odi community, the clitoris is seen as a harmful organ that must be cut off to preserve

the life of the mother and baby, and also to control sexual excitement that can lead to promiscuity. This confirms what Kontoyannis and Katsetos, (2010) indicated in a study that in the African culture, the male has the sole responsibility to control ejaculation; any excitement that comes from the angle of the woman leading to premature ejaculation due to the presence of the clitoris is a mark of “insubordination”, therefore the clitoris must be cut off to prevent premature ejaculation. By implication, this means that the African culture does not expect the woman to experience sexual pleasure; they see it as an act of insubordination to the authority of the man, but everything will be done to the woman in order for the man to achieve sexual pleasure (Hussein, 2010). This confirms what happens in Sudan where the woman is subjected to infibulations (the 3rd degree of FGM) in order to narrow the orifice of the vagina for the man to achieve sexual pleasure; if she dies in the process, it will be attributed to punishment from the gods for wrongs which the woman committed in the past (Kontoyannis, & Katsetos, 2010; Mandara, 2003).

Another finding indicated that the women of the Odi community perceived these cultural myths are not true and not good. They said the cultural myths are not true and not good, because they instill fear into the people and leads to the removal of a vital organ from their body. Participant 4 said:

I don't like the cultural belief of female circumcision and I don't also believe in it. I have a friend who is from another tribe who is not circumcised. She has three kids, she is alive, she is not even promiscuous and have a happy home. I feel different from her. I feel sad that my clitoris is taken away from me..... it is very painful to lose an important part of your body due to culture.

In the Odi community, women perceived the cultural myth as a means of violation against women, because the FGM has some psychological effect on them and makes them feel they are not complete and different from other females who are not circumcised. This confirms what Ahanonu and Victor (2014) said that FGM has psychological effect on the victims which makes them to look different from their fellow women who are not mutilated. According to Hussein (2010), the various myths and beliefs surrounding the practice of FGM in the UK is an abomination which has no place anywhere, let alone in a civilized world. Though the women of the Odi community do not agree with the myths surrounding FGM, they had to do it because it is a norm and they cannot question it. They consider FGM as a wound that will stay with them all through their lives.

Subquestion 2: What are the perspectives of women in the Odi community towards current legislation that is meant to prevent FGM?

Before 2015, there has been no law against FGM in Nigeria (Okeke et al., 2012). When participants were asked if they are aware of any law against FGM in Nigeria?. Eight out of Nine participants could not actually state if there is a law against FGM in Nigeria or in Bayelsa State, but said they have heard on the radio that the government said females should not be circumcised. Participant 2 said:

Sincerely, I cannot state the government law against female circumcision, but I heard from radio that government said females should not be circumcised. I actually like what government said because it will stop the cutting off of women sexual parts.

This was exactly what other participants know about the law against FGM. A finding in this study indicated that majority of the women are not aware of the presence of a legislation against FGM. It confirms what Okeke et al., (2012) said that there has been no legislation against FGM in Nigeria. All the nongovernmental organization fighting against FGM do that based on the legislation in Section 34 (1) (a) of the 1999 Constitution of the Federal Republic of Nigeria states “no person shall be subjected to torture or inhuman or degrading treatment” (Okeke et al., 2012). Fortunately, in May 25, 2015 the Federal Republic of Nigeria officially banned the practice of FGM in Nigeria. According to Shoaff (2015) , the President of Nigeria President Jonathan went out on a high note when he signed the Violence Against Persons (Prohibition) act into law on May 25, 2015, which bans FGM in Nigeria and forbids men from leaving their families without providing financial support. FGM is now seen as a criminal act in Nigeria due to the law, but the question is, will this law be enough to stop FGM in Nigeria and in the Odi community? Outlawing the practice is the first step to make it culturally unacceptable, but FGM is so ingrained in the culture of the Odi people that only a change of attitude can put a stop to the practice of FGM (Okeke et al., 2012).

A finding in the study indicated that all participants supported the law against FGM. This could be the reason why they were excited to participate in the study. This disconfirmed what the findings of the study conducted by Hussein (2010) indicated that the women of Somalia were ashamed to talk about FGM, because they accepted the norm and cannot question it. The participants perceive the legislation to stop FGM as good and will help to stop the practice in the Odi community, but they feel the families in the Odi

community cannot abandon the practice without the support of the government (Ofor, 2015). When the participants were asked what government policy do they feel will lead to the abolishment of FGM? They seem not to be aware of any active policy that could lead to the abandonment of the practice. They all perceive that the government has a major role to play for the abolishment of FGM in the Odi community. They all responded that the government should work with the community leaders to embark on awareness campaign against FGM by propagating the law, sharing leaflets on the dangers associated with FGM and prosecuting all those who violates the law. Participant 4 said,

The government should enforce the law against female circumcision if they want it to stop. Government should go to the Odi community to make an advocacy call on the traditional rulers and especially the women's leaders and educate them on the dangers of female circumcision.....distribute leaflets on the dangers of female circumcision to the community members and arrest all those who will break the law. This will serve as a deterrent to others.

This statement rang true for all participants. Findings of this study indicated that the participants shifted the bulk of the responsibility of stopping FGM on the shoulders of the government. They perceived that the government should be able to convince their traditional rulers to stop the practice. This disconfirmed what Segun-amao (2015) said that though the law against FGM is passed, it requires the activities of the law enforcement agents, opinion builders, NGO's and health care providers, media houses to propagate this law and embark on enlightenment campaigns to enlighten the traditional holders of this belief on the dangers associated with it and the stance of the government

against FGM In Segun-amao (2015) study, the government alone cannot stop FGM, but a collaborating effort of media, NGOs, traditional rulers, the law enforcement agent and the community will enhance the abolishment of FGM.

Another interesting finding indicated that the law against FGM is not enforced and violators are not jailed to serve as a deterrent to others. This confirms what Rey et al., (2000) opined that FGM was still in existence in States where there is legislation against the practice because the laws are not enforced. In Nigeria (Edo, Abia, Cross River, Delta, Ogun, Osun and Rivers States) have existing legislation against FGM based on Section 34 (1) (a) of the 1999 Constitution of the Federal Republic of Nigeria which states “no person shall be subjected to torture or inhuman or degrading treatment”, but there is no record of anyone being prosecuted (Okeke et al., 2012). Now that a new legislation is enacted in Nigeria to clearly outlaw the practice of FGM, participants perceive it appropriate to enforce the law and prosecute violators. Haggai (2015) has a contrary view that punishment is not as effective as education. He opined that an undue focus on legislation and penalizing the violators may lead the practitioners to go further underground. Those who are mutilated may not seek medical attention because their parents or guardians will be arrested.

The findings in the study have actually portrayed the meaning of phenomenology which focuses on the first person’s experience (Creswell, 2013). Phenomenology brings out the person’s perception about the event under study and understands how people construct meaning (Creswell, 2013). The participants were able to express their experiences about FGM, their perspectives towards the cultural myths and the legislation

against FGM. The phenomenology theory has enabled the researcher to obtain rich data from the experiences of the mutilated women in the Odi community, and also have an in-depth understanding of how individuals experience FGM.

The potential limitation of the study with a phenomenological approach was the inability to generalize the findings to a larger population. The result can only be used to describe the lived experiences of women in the Odi Community. However, it would serve as potential significant variables for future studies. The information that was provided can only enhance further research on FGM in the Odi community which is a limitation of transferability. A bias that would have existed was the inclusion of the researcher's expectation which is common with qualitative study. To address this bias, the researcher bracketed her expectations that only the participants' experiences were recorded.

Recommendations

Recommendation For Action

The government, law enforcement agents, opinion builders, NGO's and health care providers, media houses and religious organizations should be involved to propagate the law against FGM and embark on enlightenment campaigns to educate the Odi community on the dangers associated with it and the stance of the government against FGM (Hussein, 2010). Continuous enlightenment on the dangers of FGM will be of great importance in the abolishment of FGM, because ignorance of the dangers associated with FGM also enhances the existence of the practice (Kaplan, 2011).

Pupils and students need to be made aware of the dangers of FGM. Therefore, it is recommended that FGM should be incorporated into the primary and secondary school

curriculum to get students abreast of the dangers and legislations of FGM; and penalties meted for those who subjects their wards to be mutilated. The rights of the girl-child and women should also be taught in schools. Most females in Nigeria are ignorant of the fact that the law also protects the women from violence and oppression (International Women's Issues, 2001).

It is also recommended that the government should enforce the laws against FGM so that those involved in this practice should be punished. This is very important because when a law is not enforced it is as good as not in existence. Efforts should also be made by the government to protect young girls who do not want to be mutilated by providing a rescue camp for them. When there is a safe place to run to, most of them can escape to the camp when there are attempts to mutilate them.

Health practitioners should act as advocates to increase professional and public awareness of FGM among men in the FGM practicing communities. To encourage the men to get married to women who are not mutilated by providing a greater understanding of the issues involved in FGM. Where possible, work in partnership with men to protect their daughters and wives by increasing the men's awareness of the harm caused to their daughters and wives, through education and support. This is very important because one of the cultural beliefs is that uncircumcised women are promiscuous, so men do not want to marry them because of the fear of unfaithfulness in marriage. When men are convinced they will not encourage their daughters and wives to go for the circumcision (Momoh, 2010).

Psychologist should provide sexual counseling for mutilated women in the Odi community to help them find sexual pleasure with their spouses, despite the absence of the clitoris.

Recommendation for Future Research

There is need for further research into why the legislation against FGM is not enforced in the Odi community. Kaplan (2011) confirmed that none has been prosecuted in areas where there are legislations against FGM in Nigeria. The study will identify reasons why it is difficult to enforce the law against FGM. Identification of these reasons will assist in proffering solution to the problem.

Implications

The findings of the study have several implications for positive social change. I sought to fill a gap in the literature on the lived experiences of women in the Odi community about FGM, their perspectives on the cultural myths of FGM and their perspectives on the legislations against FGM. For once the voice of the women of Odi was heard about FGM, and it is important for the Legislative Arm of Government of Bayelsa State, The Leaders of the Kolokuma/Opokuma Constituency, the Odi Council of Chiefs, Ministry of Women Affairs and The Girl-Child Education to hear about the findings of the study in an oral presentation for the deliberation of the way forward. There is also the need to publish the findings of the study in public health journal for the benefits of the public health personnel.

The study suggests that there is need to create awareness of the Federal legislation against FGM. Several participants in this study indicated that they only heard about the

announcement on the radio that females should not be circumcised, but the announcement was not strong enough to stop the practice in the Odi community. The law enforcement agents, media, traditional leaders, health personnel, religious leaders, and nongovernmental organizations should embark on enlightenment campaign to create awareness on the dangers of FGM, federal legislation against FGM, and the penalties for violators in the Odi community. Another implication for schools would be to incorporate the teaching of the dangers of FGM, and the rights of the girl-child/women into the primary and secondary school curriculum. This will prepare the girl-child and women to fight for their right to safeguard their natural endowments.

The government should enforce the law against FGM. Several participants indicated that the government should arrest parents and guardians who subject their daughters to mutilation. They should be made to serve a jail sentence and this will serve as a deterrent to others. Another implication for the government is to provide a rescue camp for girls who do not want to be mutilated. This is to ensure that there is a place of safety to run to if the house is not safe for the girl. The government can consider having a continuous awareness program with the traditional leaders of the Odi community on dangers associated with FGM, and make them to sign an undertaking that no female in the community will be compelled to be mutilated. The government should also support psychologist to attend to the mutilated women in the Odi community who are living with the challenge of unsatisfied sexual intercourse due to FGM. To enable them identify another means of achieving sexual satisfaction with their spouses.

Conclusion

The purpose of this phenomenological study was to explore the lived experiences of women of the Odi community about FGM, their perspective on the cultural myths and legislations against FGM. Semi-structured interview questions were used to answer the overarching research question and two subquestions. In-depth face-to-face interview sessions were used to obtain data. FGM is a traditional rite in African communities (Ashimi, & Amole, 2015). In the Odi community it involves the removal of the clitoris to preserve the life of the baby and prevent promiscuity. Due to this cultural belief, the community subject their children and women who are 5-7months pregnant with their first child to mutilation. The immediate consequences of the mutilation were pain and excessive bleeding; and the long term consequence is lack of sexual satisfaction.

These participants do not consider the cultural myths surrounding the practice to be true, but they had to do it to prevent stigmatization and excommunication from community activities. They indicated that they will not subject their daughters to mutilation due to the consequences associated with it. Though they are not conversant with the legislation against FGM, but appreciate the information from the radio that females should not be circumcised. They suggested that the government should embark on campaigns to create awareness among the traditional rulers and community members on the dangers associated with FGM; and also to enforce the law against FGM.

The findings of the study will create a better understanding on the lived experiences of the people of Odi about FGM. It will serve as a basis for policy decisions and to enhance further research into FGM in the Odi community.

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Appendix A: Interview Guide for Lived Experiences of Mutilated Women

Table 1: Interview Guide

1. Are you an indigene of the Odi community?
2. How old are you?

Awareness of FGM

3. What do you know about Female Circumcision?
4. At what age were you circumcised?
5. What influenced your being circumcised?
6. What challenges have you experienced after circumcision and how have you handled it?

Perceptions about cultural myths of FGM

7. What cultural believe do people in your area have about female circumcision?
8. How do you perceive the cultural believe about female circumcision?

Legislations against FGM

9. What legislation against female circumcision do you know?
10. What are your perceptions about the legislations?

Social Implications

11. What government approved policy do you think will lead to the abolishment of female circumcision?
12. How do you feel about recommending female circumcision to someone?
13. What should I have asked you that I didn't ask?

Appendix B: Confidentiality Agreement

Name of Signer:

During the course of my activity in collecting data for this research: “Lived experiences of women of Odi Community about Female Genital Mutilation” I will have access to information, which is confidential and should not be disclosed. I acknowledge that the information must remain confidential, and that improper disclosure of confidential information can be damaging to the participant.

By signing this Confidentiality Agreement I acknowledge and agree that:

1. I will not disclose or discuss any confidential information with others, including friends or family.
2. I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant’s name is not used.
4. I will not make any unauthorized transmissions, inquiries, modification or purging of confidential information.
5. I agree that my obligations under this agreement will continue after termination of the job that I will perform.
6. I understand that violation of this agreement will have legal implications.
7. I will only access or use systems or devices I’m officially authorized to access and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

Signing this document, I acknowledge that I have read the agreement and I agree to comply with all the terms and conditions stated above.

Signature:

Date: