THE UNIVERSITY OF HULL

The Experience of Wagogo Women Who Have Undergone Female Genital Mutilation (FGM) in Tanzania

Being a Thesis Submitted for the Degree of

Doctor of Philosophy in the University of Hull

By

Asha H. Hayeshi

October 2017

ACKNOWLEDGEMENTS

Many people deserve appreciation for the guidance and support they have given me in completing this thesis. First of all, I would like to express my gratitude to the most-high God for protecting me and my family and granting me the ability to endure the ups and downs of this PhD. Also, I would like to express my gratitude to my mother Mrs N Faraji for her unwavering love and support; in particular for taking good care of my son who was only two years old when I embarked on my PhD journey. I have enormous debts of gratitude to my wonderful son who endured life without my love and care for four good years. My special thanks go to Richard, Uncle Yahaya, Said and Maua for their unconditional love and support throughout my studies.

This thesis would not have been possible without the assistance and guidance of my supervisors Prof Julie Jomeen and Prof Fiona Cowdell. They were immensely supportive during the most difficult phases of my journey; their moral support was exceptional. Their professional advice, guidance and encouragement were very informative, greatly valued and much appreciated. I would also like to register my appreciation to the Her Majesty's Government through the University of Hull for the funding support that facilitated me to undertake the doctoral studies. I am also grateful to my employer the University of Dodoma for granting me study leave to pursue PhD. I would also like to express special thanks to the leadership of Dodoma Inter-African Committee (DIAC) and Dodoma Regional Hospital for allowing me to conduct a study in their areas of jurisdiction. In this regard I would like to thank Mrs Jennifer Chihwute for her assistance and encouragement. I thank my fellow PhD candidates for their support. Last but certainly not least, my deepest gratitude goes to all the women who spared their time and willingly, openly and honestly shared their stories with me. Without them this research would not have been possible.

DEDICATION

This thesis is dedicated to my father, Hashim R. Hayeshi
and my uncle Nasib S. Faraji
In Loving Memory

ABSTRACT

This study has been carried out amidst new developments made at global, regional and local levels regarding the practice of Female Genital Mutilations (FGM). The declarations, conventions and articles agreed and implemented by the UN member states and the regional organs such as the African Union have put in place strategies to eliminate FGM. Moreover, the respective state governments have passed legislation against FGM. Following these developments and initiatives there has been increased social paradigm shift targeting the essence of the FGM practice. The shift has discouraged some parents from sending their girls for circumcision, but also has pushed FGM underground. The open initiation rites where boys and girls were pronounced adults, and which served as a strong social support for the circumcised women have been dismantled.

Against this background, this thesis explores the experience of Wagogo women who have undergone FGM and the knowledge, attitudes and practice of former circumcisers in Dodoma Tanzania. The study has employed a constructivist-interpretivist theoretical stance, approaching it through explorative qualitative design involving 25 circumcised women and three former circumcisers. Data were gathered using semi-structured interviews within the broader feminist perspective; and were analysed thematically.

The findings suggest that, indeed women circumcised under a patriarchy experience both overt and covert pain. Within the social paradigm shift there is weakening of social support; hence, destabilization of engagement coping strategies that used to assist circumcised women to cope with the overt pain. Consequently, more women are suffering from covert pain because of untreated overt pain but also due to failed engagement coping strategies. Subsequently, more circumcised women have resorted to disengagement strategies to alleviate covert pain. While new developments safeguard girls who are yet to be circumcised, none of them consider the predicament of circumcised women. Hence, the study seeks to empower the latter so that their plight and voice can be heard.

TABLE OF CONTENTS

ORGANIZATION OF THE THESIS

This thesis is arranged into seven chapters. Chapter one gives the background to the study. Chapter Two reviews the literature on Female Genital Mutilation (FGM), and states the information gap, the research questions and the general objective of the study. Chapter Three discusses the approach used to explore the experiences of women who have undergone FGM and knowledge of former circumcisers in Dodoma, Tanzania. Chapter Four presents the findings on the knowledge, attitude and practice of former circumcisers, while Chapter Five explores the experiences of women who have undergone FGM in the study area. Chapter Six provides the discussion of the findings of both the former circumcisers and circumcised women. Chapter seven is the concluding chapter and discusses the merits of using the qualitative explorative approach, policy implications, recommendations and proposed area for further research.

CHAPTER ONE- BACKGROUND TO THE STUDY

1.1 Introduction

The aim of this study is to gain a better understanding of the experiences of Female Genital Mutilation (FGM) for Wagogo women and explore the knowledge, attitude and practice of former circumcisers in Dodoma, Tanzania. FGM is a cultural procedure that involves deliberate cutting of external genitalia (WHO, 2008). The World Health Organization (WHO) defines "FGM as all procedures which involve the partial or total removal of the external female genitalia or other injury to the female genital organs, whether for cultural or any other non-therapeutic reasons" (WHO, 2008:1).

The origin of FGM is not known. However, literature indicates that ancient societies in the world embraced the practice. Documented evidence obtained from Egyptian mummies noted that FGM was routinely practised as early as the 5th century BC (Elchalal et al., 1997). In the ancient Rome, as a method of preventing procreation during slavery, they used metal rings pieced through the labia minora. Sterility, epilepsy, and excessive masturbation were treated through removal of the clitoris in the United Kingdom during the 19th century (Kandela, 1999). Although men suffered from the same illnesses, they were not treated using the same procedure; thus, it is likely that the treatment offered to women was under the influence of men's dominant system (Kandela, 1999). The World Health Organization has made it explicit that the practice of FGM has deep roots in Africa and the Middle East dating back some centuries, although some countries like Yemen adopted FGM in the 20th century because of their contacts with societies in the Horn of Africa, where FGM had been embraced as part and parcel of their culture (WHO, 2006). Over 140 million women are estimated to have been circumcised worldwide; at the current rate of population growth, it is projected that 3 million women are circumcised annually, which translates to about 6000 girls being circumcised daily, or one girl being cut every 15 seconds (Berggren et al., 2012).

Most of the circumcised women in the world are in Africa, particularly along the FGM belt that extends from West Africa all the way to East Africa in the Horn of Africa. The FGM belt and a few other countries outside it constitute a total of 28 countries that practise FGM in Africa in different proportions, ranging from 5% in Democratic Republic of Congo and Uganda, 20% in Tanzania, 74% in Nigeria and Ghana, 92% in Mali and Egypt to almost 100% in Somalia, Sudan, Djibouti and Ethiopia. Eighteen of these have a prevalence of over 50% (Toubia et al., 2003). Outside Africa, FGM has been reported in the Middle East and Asia; the countries that practise FGM include, among others, the United Arab Emirates, South Yemen, Oman, and the Muslim populations of Indonesia, Malaysia, India and Pakistan (WHO, 2008). FGM is also reported in ethnic groups in Peru, Western Brazil, Australia and Eastern Mexico. Moreover, migrants from FGM-practising countries have maintained the tradition in the United States of America, Canada, and Europe (Magoha et al., 2000).

In all areas where women are circumcised, there is under-reporting of FGM cases; hence, the figures may not be realistic (Lockhat, 2004). Factors for under-reporting include the fact that FGM is associated with sexuality, an area that is considered to be loaded with secrecy and anxiety that cannot be discussed openly especially by the people in Africa and Arabic countries (Elnashar et al., 2007). Furthermore, laws against FGM in many African countries encourage under-reporting (Lockhat, 2004).

1.2 The Naming of the Procedure and Types of FGM

The term FGM has raised much controversy and debate among the activists and communities that practise FGM. The communities prefer the term circumcision as it equates to male circumcision, which is a cultural procedure (Obermeyer, 2005); they do not share the notion that the procedure merits the definition of mutilation. They argue that the term mutilation is judgmental and downgrades the communities that practise FGM and who perceive the procedure to be a noble tradition (Lockhat, 2004). The communities insist that even where the practice is condemned by other people who do not subscribe to it; the campaign to end the

procedure cannot be successful using language that dehumanizes the communities that perform it (Lockhat, 2004).

On the other hand, the activists and advocates for abolition of FGM prefer the term female genital mutilation, not only due to the extent of female tissue that is removed, which is far from being comparable to the tissue removed in male circumcision, but also because the tissue removed is critical to women's sexual lives (Hosken, 1993). To extend the debate on female versus male circumcision; in men, the circumcision entails removal of the fore-skin only, leaving behind an intact penis; in contrast, circumcision in women, particularly in some forms, the procedure involves extensive cutting of female genitalia (Toubia, 1994). The difference between male and female circumcision is well described by Toubia:

> The degree of cutting in female circumcision is anatomically much more extensive. The male equivalent of clitoridectomy (in which all or part of clitoris is removed) would be the amputation of most of the penis. The male equivalent of infibulation (which involves not only clitoridectomy, but also the removal or closing off the sensitive tissue around the vagina) would be removal of the entire penis, its roots of soft tissue and part of the scrotal skin (Toubia, 1994:15).

In addition, the procedure is done without the girl's consent; and the procedure carries with it several complications (WHO, 2006). The activists therefore argue that the practice should be called by its name to show the magnitude of harm involved in the procedure; thus, they prefer the term FGM (Toubia, 1994). In this thesis, the terms FGM and female circumcision will be used interchangeably. The term FGM will be used mainly when referring to the procedure at policy level as it has been used by policy organs at global, regional and local levels, while the term female circumcision (FC) will be used when reporting the participants' views regarding the practice as the term concurs with the preference and understanding of societies that perform the procedure in Tanzania, who believe that the procedure is an acceptable cultural practice (Msuya et al., 2002).

The World Health Organization (WHO) classifies FGM into four main types subject to the amount of tissue excised and the modifications of the vulvae done.

> “Type I: involves excision of the prepuce with or without excision of part or the entire clitoris. This is also known in Muslim countries as Sunna circumcision”.
>
> “Type II: is the most common and consists of the excision of the clitoris with partial or total excision of the labia minora”.
>
> “Type III: also, called Infibulation or pharaonic, involves excision of part or all the external genitalia and stitching/narrowing of the vaginal opening for passage of urine and menstrual blood”.
>
> “Type IV**:** Unclassified: Includes pricking, piercing or incision of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissues; scraping of the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding, or for the purposes of tightening or narrowing it; and any other procedure that falls under the definition of female genital mutilation given above” (WHO, 2008:12). Refer to appendix nine page XII

The predominant procedures are type I and II, estimated in the region of 85 per cent of all women circumcised; while type III FGM is estimated to be 15 per cent of all women who have experienced FGM (Morison et al., 2001).

1.3 FGM in the Global and Regional Context

This study has its roots in recent developments worldwide regarding FGM, and particularly in the countries that practise the procedure. These developments include the adoption of various international declarations and conventions made by global communities such as the United Nations and the World Health Organization; and regional organizations such as the African Union, and other organizations that are specific for FGM. Central to the declarations, policies, legislations and campaigns against FGM is the UN General Assembly in 1948, which adopted the Universal Declaration of Human Rights (WHO, 2008:5). The declaration contains

several articles that safeguard equal rights and dignity of all human beings and specifically to the health of women and girls. For example, article 5 states “No one shall be subjected to torture or to cruel inhuman, or degrading treatment or punishment”. Article 2f of the 1979 ‘Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), requires State Parties to take measures against all customs and practices which constitute discrimination against women’ (WHO, 2008).

In 1990, the then Organization of African Unity (OAU) adopted the African Charter on Human and People’s Rights which had previously been adopted by the Heads of States’ Assembly in 1981. The charter has several articles that prohibit all forms of degrading and exploitation of human beings and safeguards women against any form of discrimination and ensures the right to enjoy physical and mental health. Article 21 of the African Charter requires state members to:

> Take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child and specifically defines protection against customs and practices prejudicial to the health or life of the child and customs and practices discriminatory to the child on the grounds of sex or other status (Lockhat 2004:23).

These declarations, conventions and articles have direct relevance to FGM.

In response to the adoption of international and regional declarations and conventions to eliminate all forms of discrimination against women; and particularly the 1995 UN Beijing Declaration and Platform for action which states firmly that FGM is a practice that violate the rights of girls and women, many governments in both developed and developing countries have legislation in place against FGM. For instance, in Africa, all countries in which FGM is practised have passed laws against it (Lockhat, 2004). Hence, it is a criminal offence to perform FGM in African Union (AU) member states that embrace the practice. Nevertheless, FGM is still practised in secrecy (Lockhart 2004). There are several interventions underway to

eliminate FGM, which range from education, advocacy and outreach community programmes identifying the local community, influential community leaders and professionals. Despite these efforts, there has been slow community response and sometimes resistance to the social interventions and law enforcement against FGM because FGM is a cultural practice that is embedded in the social fabrics of the local communities (Ondiek, 2010). The experience in many African countries is that the legislation has not stopped the practice; rather it has pushed it underground (Ndiaye et al., 2010).

Concurrently, the law has also disrupted the initiation rituals where, among other activities, annual mass circumcisions of thousands of girls and boys were performed at the same period; also, teachings that prepared girls and boys to assume adult life and their respective roles in families and societies were prescribed (Manabe, 2010). During and after the initiation rite, these societies had in place strong social support that was offered to girls that enabled them to cope with any eventuality that might occur due to FGM. Social support was offered by the circumcisers, older women in the villages, parents, peer group, older siblings and a cohort of girls who had been circumcised a season earlier (Mapana, 2007). As both the FGM procedure and societal teachings were offered openly accompanied with communal cerebrations, dancing and feast, the legislation against FGM not only prohibits the procedure, but has also affected the peer support offered to circumcised women in their societies (Schultz et al., 2014).

In these contexts, where there have been developments made regarding FGM worldwide shown by increased campaigns against FGM and spearheaded by non-governmental organizations, activists and law enforcement officers, such campaigns have not only pushed the practice underground, but also have disrupted strong social support for women who have undergone FGM. Hence, this study seeks to gain understanding of the experiences of FGM for Wagogo women in Tanzania given these developments in place.

1.4 FGM in Tanzania

Tanzania is a member state of the United Nations as well as the African Union. Hence it has signed the declarations, charters and articles at global, regional and local levels against FGM. Following its commitment to the above declarations, Tanzania passed legislation against FGM in 1998 under the 'Tanzanian Sexual Offences Special Provisions Act (an amendment to the penal code) which specifically prohibits the procedure (DHS 2010:12)'. Since there are communities within some tribes in Tanzania that practice FGM, the country is suitable for exploring the experience of women who have undergone the procedure given the new developments so far made in the FGM context.

Tanzania has a FGM prevalence of 20% (DHS, 2010). The commonest type of FGM performed is type II, which "consists of the excision of the clitoris with partial or total excision of the labia minora" (WHO 2012:3); type III is performed by the Somali migrants residing in the Arusha region. FGM is performed in 10 regions out of 30 in Tanzania, where more than 150 ethnic groups live. The regions and their prevalence in brackets are as follows Manyara (71%), Dodoma (64 to 68%), Arusha (59%), Singida (51%), Mara (40%), Morogoro (21%), Kilimanjaro (22%) and Tanga (20); refer to appendix 8 page XI. There are also pockets of FGM customs in some regions where the prevalence is lower than 0.5%; Mtwara, Lindi and Zanzibar (0.3%); and Pemba (0.1%) (DHS, 2010). Refer to appendix eight page IX

Most of the tribes that perform FGM lie within the central province and north of the central line, which links the Kigoma and Dar es Salaam regions. Historically, most of these tribes were warriors, livestock breeders or business traders who spent most of their time fighting, looking for green pastures for their livestock or travelling for business. It is believed, though not proved, that FGM was performed to reduce their wives' sexual drive when men were away (Esho, 2012). Other ethnic groups in Dodoma and Singida regions perform FGM as a cure of a disease called lawalawa. The term is used to describe certain itchy fungal infections of the outer female genitalia, vaginal and urinary tract infections (Ali et al., 2012). Initiation is

another reason given for the practice of circumcision especially in Arusha and Kilimanjaro regions; as it marks the passage from one age group to another and signifies that the girl is mature and ready to take the responsibilities of an adult woman (Msuya et al., 2002). The Chagga of Kilimanjaro, Tanzania consider the procedure an important event as it gives girls the opportunity to overcome pain, a useful experience for future childbearing (Esho, 2012).

In Tanzania, the campaign against FGM is mainly the responsibility of activists and non-government organizations that are predominantly supported by non-government organizations from the West (Msuya et al., 2002). The government's intervention is minimal as there is still a belief that FGM is a cultural practice and some of the enforcement officers support the practice (Esho, 2012). Its direct involvement is when death or severe injury is reported predominantly by activists. When found guilty, a fine of up to Tanzanian shillings 300,000 (equivalent to £110) or imprisonment of up to 15 years is imposed on those who allow the practice to be carried out on minors under their care. Minors in Tanzania is defined as age between 0 and 17 years (DHS, 2010).

1.5 Motivation for Undertaking this Study

My interest and motivation in conducting this project is based on a story narrated by my friend who was circumcised. As we were exchanging ideas on different issues, she decided to share her innermost traumatic feeling of hopelessness, anger and betrayal directed towards her aunt. She narrated how she was convinced by her aunt that they were going to visit her grandfather; to her amazement, she found herself in the middle of a heavy bush, where there were other girls assembled for what was explained later as a rite of passage. The girls were about the same age ranging from 9 to 12. She recalls the fine details of the procedure, how her aunt held her down on the ground as the circumciser was cutting her genitals. She narrated the traumatic experience she went through and all the complications she has suffered so far because of the procedure. Now, at the age of 36 she still recalls the sound of her cry; not believing that her aunt who showed love and affection could be so brutal and inhumane.

As she shared her experience, she explained how she was not prepared for the procedure as she was deceived. After realizing that her aunt was not of any help, she struggled; during her struggle, the circumciser cut a large blood vessel, which led to severe blood loss and loss of consciousness. She was taken to a private hospital where her aunt had to pay handsomely to get a blood transfusion and to cover the incident. After wound recovery, she went back home prepared to tell her parents the whole incident, hoping that they would take stern measures against her aunt. To her surprise, she found the family had prepared a large banquet for her and lots of gifts and presents.

She was married at the age of 26. She described her marital experience as having low self-esteem, lack of confidence and perceiving herself not only as an inadequate woman but also a tool for her husband's sexual gratification because she had never enjoyed sex in her marriage. She approached me with this traumatic story, hoping to receive help after realizing that I am a trained community psychologist. As she was narrating this story she was crying and I could not prevent shedding tears. I promised her that I would do more than counselling her: I would carry out research on a large scale to find out the experience of other women in my tribe who have undergone FGM, aiming at empowering them to raise their voices and bring out their silent and concealed pain. My motivation to take up FGM as my PhD project was, therefore, to gain understanding of the experience of FGM for Wagogo women who are still struggling to come to terms with their experiences; and, it was the opportunity to honour my friend who courageously decided to share her painful story.

As a member of the Wagogo ethnic group which is the largest tribe in Dodoma Region in central Tanzania, my friend's story reminded me how I narrowly escaped the procedure of FGM that my grandparents had arranged. One of my parents who originates from a tribe that does not engage in FGM was against the idea and made it clear that should they decide to circumcise me secretly there would be a commotion that those concerned would never forget in their life. That was a very strong statement to have been given by my parent. No-body dared to touch me;

that is how I avoided the procedure. Thus, what saved me from the procedure was the influence of mixed culture in our family and the unshakable position of my parent. As it is a custom in my tribe that circumcised women do not share information with uncircumcised ones, I grew up with a notion that once the procedure has been carried out on girls and wounds have healed, that marks the end of suffering. It never occurred in my mind that circumcised women face some long-term difficulties, until the day when a friend of mine decided to share her story with me.

CHAPTER TWO- LITERATURE REVIEW

2.1 Introduction

This chapter has two parts. Part one reports and discusses the systematic review of the available empirical literature related to FGM with the aim of situating and providing a niche for the current study. Part two discusses a theoretical literature review. It defines and discusses, among other things, feminist theory and major concepts used in this thesis.

PART I: SYSTEMATIC LITERATURE SEARCH AND NARRATIVE REVIEW

2.2 Introduction

In this part, I discuss the process of systematic literature review that was undertaken to address the central research question of this study; and which not only strengthened my understanding of the study area but also revealed the knowledge gap that needed bridging. Within this process, the niche or research problem for this study was fully established. Part one includes, among other things, the literature search techniques used, the inclusion and exclusion criteria for the search and the outcome of that search in terms of numbers and database sources; the appraisal (quality assessment) of selected studies and the discussion that emanated from the studies included. Following the review, a clear statement of the research gap, aim, objectives and research questions was developed.

2.3 Literature Search Technique

I conducted a systematic search on the general and detailed elements relating to FGM to assess the existing knowledge on the topic. The search was extensive enough to ensure that all the studies that met the criteria were included. The search included manual and computer searches using databases subscribed to by the University of Hull. The literature search was based on subject guides. I identified five subject guides namely, health and social care, sociology,

psychology, nursing and midwifery, and gender studies; as FGM is a subject which cuts across the mentioned subject guides. From the five subject guides, the following databases were accessed; Cumulative Index to Nursing and Allied Health Literature (CINAHL), PsycINFO, Medline, IBSS, and Academic search premier. These databases were selected because articles on FGM featured more frequently in them. The search approach was complex using Boolean logic, and the following key word combinations were used; consequences OR effects OR outcomes OR complications OR sequelae OR impacts AND female* OR woman OR women OR girl OR girls AND mutilat* OR cutting OR circumcision OR excision AND genit*.

2.3.1 Inclusion Criteria

- The review included the qualitative, quantitative and mixed studies that reported on FGM.
- Study population; Women and girls who have undergone any form of FGM (Type I, II or III) as classified by WHO (2008).
- Studies with the outcomes of physical, sexual, obstetric and psychological complications of FGM.
- Articles that were published from 1990 to the current date. The reason for this criterion is two-fold.

First, articles published earlier were excluded mainly because the 1990s is regarded as an important land mark for the UN and member states to take critical measures against FGM (Lockhat, 2004). Apart from the global, regional and local declarations, conventions and articles discussed in the previous chapter, in the 1990s the world witnessed a major movement against FGM; the decade from 1990 was marked with about 10 global and regional declarations against FGM, for example, the 1990 Convention on the Rights of the Child. By then, the Organization of African Unity (OAU) had issued the African Charter on the Welfare of the Child. The 1993 Vienna Declarations and the Programme for Action of the World Conference on Human Rights and the 1999 United Nations Social, Humanitarian and Cultural Committee (Third Committee) are a few examples of global declaration against FGM. These declarations and many others,

“recommended that state parties take appropriate and effective measures to eradicate FGM and to implement legislations and policies that prohibit traditional or customary practices affecting the health of women and girls including FGM” (Lockhat, 2004:37-38). Secondly, within the same decade Tanzania enacted a law against FGM, the 1998 ‘Tanzanian Sexual Offences Special Provisions Act (an amendment to the penal code) specifically prohibiting FGM’ (DHS 2010:12).

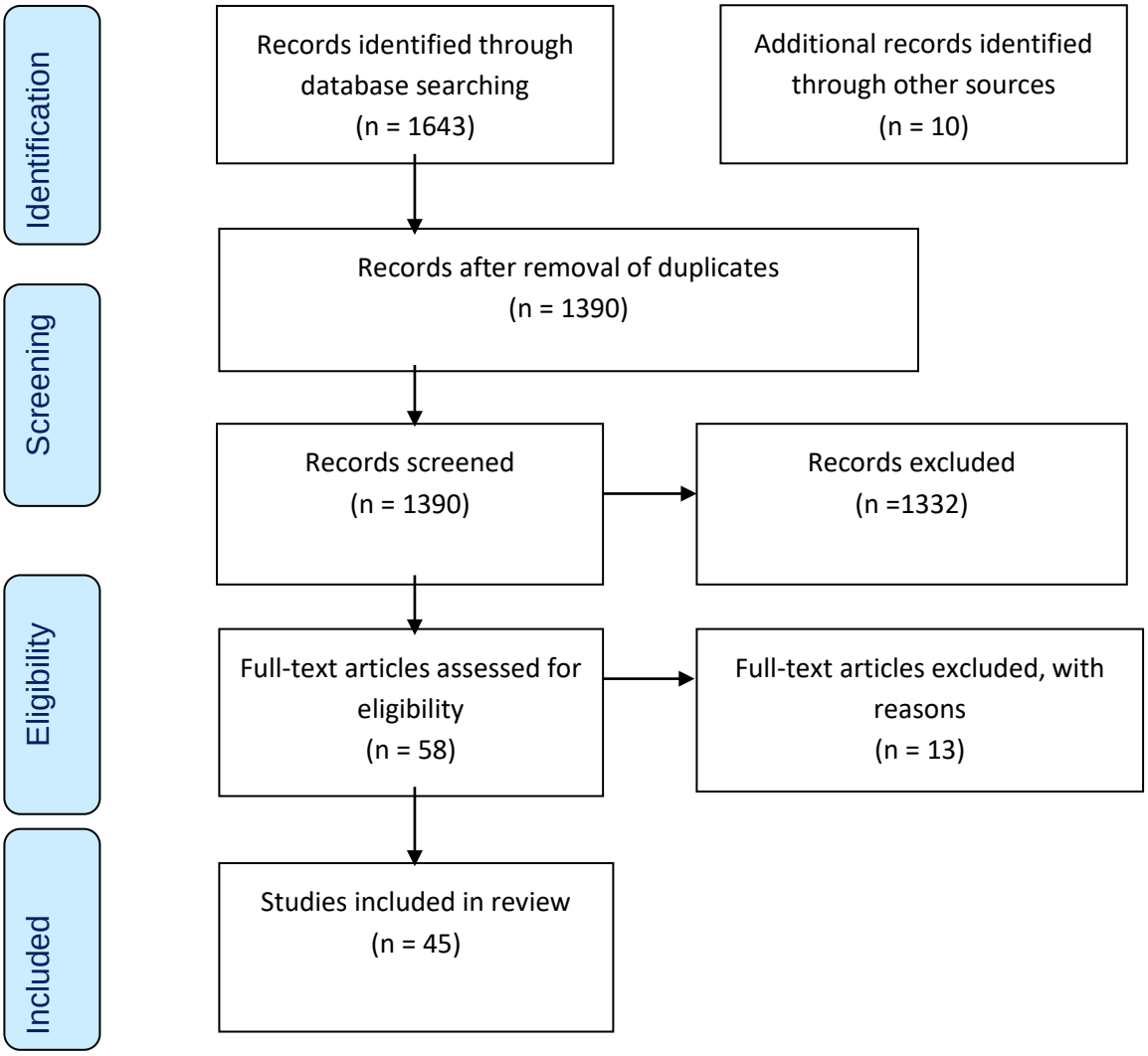
2.3.2 Exclusion Criteria

There were two exclusion criteria. First the review excluded all studies published in languages other than English as resources for translation were not available. Secondly all studies carried out before the 1990s were excluded for the reasons provided above.

2.3.3 Screening Process for Searched Records

The database search retrieved 1643 articles. The search engines and the number of articles retrieved in brackets are as follows - CINAHL (229); PsycINFO (118); Academic search premier (590); Medline (621); and IBSS (85). Additional records identified through other sources such as reference lists numbered 10 which made the total 1653 records, out of which 263 records were removed from the list as duplicates. The remaining records (1390) were screened by reviewing titles and abstracts. I excluded 1332 records as they were not related to the area of study, leaving 58 potential and relevant records. I read the full text of 58 publications, out of which 45 studies qualified for a review; while 13 studies were excluded, either for not reporting the FGM complications or because they did not qualify for the World Health Organization classifications of FGM (WHO, 2008). The screening process is summarized in figure 2.1 below.

Figure 2.1: The results of the screening process of the systematic literature search



Adapted from PRISMA 2009 flow diagram of the literature reviewing results

2.4 Description of the Included Studies

The review showed that of the 45 studies included, most were quantitative (38) which included cross sectional comparative studies and non-comparative studies. The remaining studies were qualitative (four) and mixed method (three). All the reviewed studies had been published in peer-reviewed journals. Most of them had been published in the year 2000 onwards except one study (Sayed et al., 1996) see table 2.1. The studies included involved a total of 25,520 participants from

more than 15 different countries. Thirty studies had been carried out in Africa, and the other 15 studies in other parts of the World: three each in the UK and Sweden respectively, two in the USA, and one in each of the following countries: Canada, Israel, Norway, Italy, Switzerland, Iraq and Kuwait. The majority of the studies included (22) reported on the obstetric outcomes; 13 studies reported on sexual outcomes; five studies reported on physical outcomes while four studies reported on psychological outcome. Two studies reported on more than one category of outcomes; Khaja et al. (2009) reported on all the health outcomes, while FORWARD (2010) reported on physical, sexual and psychological outcomes. The table 2.1 below shows the descriptions of all the studies included.

Table 2.1: 45 The studies included

Date	Author	Country	Design	Sample	Setting	Focus of the study	Findings of the study	Limitations of the study
1996	Sayed, El-Aty & Fadel	Egypt	Quantitative: Community survey- interview.	819 households; 1732 mothers of girls under 20 years of age	Community setting	To study the prevalence, complications and reasons for performing FGM in rural area	Serious bleeding, pain, inflammation an and genital disfigurement	Unclear description and selection of the sample.
2000	Chalmers & Omer-Hashi	Canada	Quantitative: Survey- Interviews.	432 Somali women	Hospital setting	To gain information about Somali women's perceptions of their recent care during pregnancy and birth.	Severe pain, bleeding, vaginal or urinary fluid retention, bodily oedema or swelling and infection. Traumatic sexual intercourse. More likely to experience caesarean section	It was not stated how the data was analysed.
2001	El-Dafrawi, Lofty, Dandash, Refaat & Eyada	Egypt	Quantitative: Interviews.	250 women randomly selected from the patients of Maternal and Childhood Centres in Ismailia.	Maternal and Childhood Centre	To investigate the prevalence and psychosexual impact of female circumcision in Ismailia	There were significant differences in sexual desire, enjoyment of sex, orgasm, dryness during intercourse, dyspareunia	There was insufficient number of controls selected.
2001	Morison, Scherf, Ekpo, Paine, West, Coleman & Walraven	Gambia	Quantitative: Community based survey- questionnaire and interviews.	1384 women aged 15-54.	Community setting	To provide data on the long-term reproductive consequences associated with genital cutting	The relationship between FGM and long-term reproductive morbidity is not clear where type II is predominant.	Presentation of results was not clear. Selection of control group was not well explained.

2001	Hakim	Addis Ababa	Quantitative: A cross sectional-questionnaire.	1225 mothers with and 256 without FGM who have had spontaneous, term, singleton and vertex vaginal delivery. Of these, 762 (51.5%) were primipara and 719 (48.5%) multipara.	Tikur Anbessa, St. Paul's and Ghandhi Memorial hospitals	To evaluate the impact of FGM on parturition and to create awareness of its implications for women and neonatal health.	Perineal tears, bleeding, incontinence and febrile illnesses are registered for the FGM. Study demonstrates negative impact of FGM more on maternal than neonatal outcomes.	Unclear reporting of other confounding factors (cultural influence, time of hospital arrival, labour orientation, birth weight, type of pelvic and stature) that may influence results
2002	Slanger, Snow & Okonofua	Nigeria	Quantitative: Cross sectional survey questionnaire and interview.	1107 women at three hospitals in Edo State	Hospital setting.	To examine the association between delivery complications and procedures and FGC.	No difference between cut and non-cut women's likelihood of reporting first delivery complications.	The study relied on women's self-reporting of obstetric experiences at first delivery. Therefore, there was a risk of recall bias The findings of this study cannot be generalized to the broader population.
2002	Okonofua, Larsen, Oronsaye, Snow & Slanger	Nigeria	Quantitative: Cross sectional study (Cohort)- structured questionnaire.	1836 premenopausal women cut versus uncut	3 hospitals in Edo State	To examine the association between FGC and frequency of sexual and gynaecological symptoms.	No significant differences in early arousal during sexual intercourse and experience of orgasm. Cut women reported having lower abdominal pain, yellow bad-smelling vaginal discharge and ulcers	The selection of control group was not clear.

2002	Larsen & Okonofua	Nigeria	Quantitative: cross-sectional reproductive health survey-interview.	1851 women (age 15-49) seeking family planning or antenatal care were interviewed and had a medical exam.	3 South-west Nigerian hospitals	To examine whether complications at delivery are associated with female circumcision.	There were significantly higher risks of tearing, stillbirths and obstetric complications for circumcised women. There was no significant difference between women with type 1 and type 2.	Information about complications at delivery and outcome of delivery were based on self-reporting
2002	Vangen, Stoltenberg, Johansen, Sundby & Stray-pedersen	Norway	Quantitative: Cross-sectional population-based registry study.	All births to Somali (1733) and Norwegian (702 192) mothers from 1986–98 were studied.	Hospital setting	To examine the risk of perinatal complications among ethnic Somalis and to discuss its relation to circumcision	Perinatal complications were more frequent among women of Somali origin than among ethnic Norwegians.	Sample size of control group is larger than study group. Different background between cases and control The result cannot be applied elsewhere in local population.
2002	Msuya, Mbizvo, Hussain, Sundby, Sam & Stray-Pedersen	Tanzania	Quantitative interview.	379 women who have undergone FGM	Community setting	To determine by clinical examination, the current prevalence and types of FGC among urban women of childbearing age.	There was no association between STIs, HIV or hepatitis B and FGM.	Unclear description and selection of the sample
2003	Magied & Ahmed	Sudan	Mixed study: questionnaire and interview.	Random selection of 300 Sudanese women with sexual experience.	3 cities of Khartoum state	To provide background information on the psychosexual effects of FGM/FC on Sudanese women	Majority had fearful and painful expectations of first sexual intercourse. Enjoyed sex as pleasurable and reach orgasm.	Unclear presentation of the results. The state of circumcision of the respondents was not classified according to WHO.

2003	Osinowo & Taiwo	Nigeria	Quantitative: Cross sectional study- self-reported questionnaire.	99 women,53 circumcised and 46 uncircumcised.	Ajegunle area of Lagos.	To examine the extent to which FGM influences marital instability and self-esteem.	Circumcised women significantly reported higher level of marital instability and lower self-esteem.	Participants' status of FGM (Type I, II or III) was not reported. The population from which the sample was drawn was not clearly defined.
2003	Al-Hussain	Egypt	Quantitative : Cross-sectional study- questionnaire.	254 primigravid women.	Hospital setting.	To investigate the prevalence and type of FGM and to determine its effects on perineal trauma.	Higher incidence of episiotomy and low perineal tear.	The results of this study cannot be generalized to other parts of Egypt. The sample size was small and there was no control group.
2004	Dare, Oboro, Fadiora, Orji, Sule-Odu & Olabode	Nigeria	Quantitative Cross-sectional Survey- self-administered questionnaire.	Women labouring at Obafemi Awolowo University teaching hospital, Lautech Teaching Hospital and Ogun State University Teaching Hospital.	3 University teaching hospitals: Obafemi Awolowo, Lautech and Ogun State.	To examine the external genitalia of delivering women and analyse them to study the events surrounding FGM and its complications.	Severe pain and heavy breeding were reported as the common complications during the procedure. Others were fever and swelling.	Sample size was not clearly mentioned. The findings of this study cannot be generalized to the broader population.
2005	Behrendt & Moritz	Senegal	Quantitative: Cross-sectional- interviews and questionnaire.	23 circumcised and 24 uncircumcised women.	Community setting.	To investigate the mental health status of women after genital mutilation.	Circumcised women showed a significantly higher prevalence of PTSD and other psychiatric syndromes than the uncircumcised women.	The population from which the sample was drawn was not clearly defined. Participants' status of FGM (Type I, II or III) was not reported.

2004	Mukoro	Nigeria	Quantitative: descriptive survey	Circumcised Urhobo women resident in the Niger Delta area of Nigeria. Accidental selection of sample.	Niger Delta area	To determine the psychosexual problems associated with the practice of FGM.	The practice causes dyspareunia, frigidity and lack of sexual satisfaction.	The sample was not enough to represent the whole population.
2005	Essen, Sjoberg, Gudmundsson, Ostergren & Lindqvist	Sweden	Quantitative: Cohort study-questionnaire.	68 circumcised women compared to 2486 non-circumcised	Hospital setting.	To compare the duration of the second stage of labour between circumcised and uncircumcised women.	There was no association between FGM and prolonged labour.	Sample size of control group is larger than study group. Different background between cases and control. The result cannot be applied elsewhere in local population.
2005	Johnson, Reed, Hitti & Batra	USA	Quantitative : Population-based Retrospective Cohort study-questionnaire.	579 Somali-born women, 2384 US- born black and 2435 US- born white.	Hospital Setting.	To evaluate obstetric and neonatal outcomes of a large Somali immigrant population.	Somali women were more likely to have caesarean deliveries than black and white control women respectively, experience fetal distress and failed induction in labour. Also, they were more likely to have perineal lacerations.	The birth certificate data might not be accurate. The control groups were different from the study group. The type of FGM was not mentioned.
2006	Oduro, Ansah, Hodgson, Afful, Baiden, Adongo & Koram	Ghana	Quantitative-questionnaire and secondary data.	5071 maternal deliveries.	War Memorial Hospital.	To examine the changes in trend of the practice over the period among women delivering in the district hospital and compare the delivery outcomes and FGM status.	FGM is associated with high caesarean section rate. Mean birth weight and frequency of low birth weights were not significantly associated with FGM status.	The study is based on secondary data.

2006	WHO Study group	Bukina Faso, Ghana, Kenya, Nigeria, Senegal & Sudan	Quantitative: Prospective study-interview.	28393 women presented at singleton delivery	20 obstetric centres in all the countries mentioned	To investigate the effects of different types of FGM on a range of maternal and neonatal outcome during immediately after delivery.	Women with FGM are significantly more likely to experience birth complications; such as caesarean section, postpartum haemorrhage, extended maternal hospital stay, episiotomy, resuscitation of the infant and inpatient perinatal death.	The study participants were not representative of the general population. Therefore, the absolute rates of complications might not be generalizable to women in the broader population in these countries.
2007	Catania, Abdulcadir, Puppo, Verde, Abdulcadir J & Abdulcadir D	Italy	Mixed study: Questionnaire Group D Semi structured interviews Group A, B & C	Group A: 137 adult women affected by different types of FGM/C; Group B: 58 young FGM/C women living in the West; Group C: 57 infibulated women; Group D: 15 infibulated women after the operation of defibulation.	Research Centre for Preventing and Curing the Complications of FGM/C in Florence.	To assess the results of four different investigations regarding the sexual functioning in different groups of mutilated/cut women.	All groups (A, B, C & D) reported orgasm. Group C showed significant differences in desire, arousal, orgasm, and satisfaction with mean scores higher in the group of mutilated women.	There were no reasons why some participants refused to answer some questions or stopped the interview before completing it and leaving the research study. The study was confounded by the selection of control group from other cultural background
2007	Millongo-Traore, Kaba, Thieba, Akotionga & Lankoande	Burkina Faso	Quantitative: Comparative survey.	227 pregnant women excised	CHU YO maternity Ouagadougou	To compare maternal land fetal complications of the spontaneous vaginal delivery in the excised and non-excised women.	The maternal complications were dominated by the prolonged duration of fetal expulsion and perineal tears. Neobirth asphyxia affected new-borns from excised mothers. In the group of excised mothers, the rate of peri-natal mortality was high.	It was unclear whether potential confounding factors had been considered in the design and in the analysis.

2007	Elnashar & Abdelhady	Egypt	Quantitative: Cross-sectional comparative study.	Randomly selected, 264 newly married women, 200 circumcised, and 64 non-circumcised.	Benha University Hospital	To detect the rate of FGC among a sample of newly married women and make a comparison between circumcised and non-circumcised women regarding long-term health problems.	There were significant differences in somatisation, anxiety, phobia; marital satisfaction; pain, loss of libido, orgasm between the two groups.	It was unclear whether potential confounding factors had been considered in the design and in the analysis.
2008	Lundberg & Gerezgiher	Sweden	Qualitative study using an ethnographic approach.	15 voluntary Eritrean immigrant women.	Eritrean women's homes	To explore Eritrean immigrant women's experiences of FGM during pregnancy, childbirth and the postpartum period.	Relevant themes; Fear and anxiety; extreme pain and long-term complications.	Selection of sample of circumcised women was based on self-reporting. The available participants were not representative of the whole population; therefore, the results of the study cannot be extrapolated to Eritrean women in general.
2008	Litorp, Franck & Almroth	Sweden	Quantitative: Interviews and questionnaire.	37 women who had undergone FGM	Two maternity welfare centres	To explore knowledge of, attitudes toward and practice of female genital mutilation (FGM) among women originally from countries where FGM is customary.	FGM has negative effects. Among those mentioned were obstetric, sexual, menstrual difficulties and horrible memories.	The reliability of the self-reported form of FGM is low, which may have implications on the findings of this study.
2008	Awuah	Ghana	Mixed study-Interviews and questionnaire.	70 women lived at Aboabo No. 1	Community setting	To investigate the extent to which FGM has adverse effects on the reproductive health of women in the Aboabo community.	Prolonged first stage labour, massive vaginal tears and fistula.	The presentation of results was not clear.

2008	Applebaum, Cohen, Matar, Abu Rabia & Kaplan	Israel	Quantitative: Questionnaire	37 women enrolled, 19 in ritual female genital surgery (RFGS) group and 18 in the control group	Hospital setting	To assess the mental health of Bedouin women from southern Israel after RFGS	No statistical differences were found between the two groups	No physical examination was conducted. Sample based on self-reporting. Unclear FGM status of the women. The sample is not representative of Bedouin women
2009	Wuest, Raio, Wyssmueller, Mueller, Stadlmayr, Surbek & Kuhn	Switzerland	Quantitative: A retrospective case–control study.	122 patients after FGM who gave consent to participate in this study and who delivered in the Department of Obstetrics and Gynaecology in the University Hospital of Berne and 110 controls.	Teaching Hospital	To determine whether women with FGM and non-mutilated women have different fetal and maternal outcomes.	There were no significant differences regarding fetal outcome, maternal blood loss or duration of delivery. FGM patients had significantly more often an emergency Caesarean section and third-degree vaginal tears, and significantly less first-degree and second-degree tears.	FGM patients and controls were only matched for age and not for parity, ethnicity, which may have influenced the results.
2009	Osifo & Evbuomwan	Benin	Quantitative: Interview.	51 female children aged 10 days and 18 years and 67 parents.	Paediatric Surgery Unit	To draw attention to the fact that FGM is still rampant in this sub-region, highlight the spectrum of complications and the mode of presentation so as to increase awareness and heighten public and government campaign against it.	Complications ranged from clitoral cyst formation in 21 (41.2%) to life threatening infections with one mortality due to tetanus infection	Sample selection and presentation of the result are not clear.

2009	Khaja, Barkdull, Augustine & Cunningham	North America	Qualitative: Exploratory study-interview.	17 Somali-born North American immigrant women who had undergone FGM	Community setting	To better understand the women's experiences with and views of FGC	Urination difficulties, pain at first intercourse, severe labour pain, emotional trauma and sense of loss	The findings of this study cannot be generalized to the broader population. Translators were from the same communities as the respondents, hence some respondents were cautious in revealing their views on FGM to members of their own communities
2010	Alsibiani & Rouzi	Saudi Arabia	Quantitative: A prospective case-control study. (FSFI) questionnaire.	130 sexually active women with FGM and 130 sexually active women without FGM	A tertiary referral university hospital	To compare the sexual function of women with FGM to women without FGM.	There were no statistically significant differences in scores for arousal, lubrication, orgasm, and satisfaction as well as the overall score.	Control group differed from study group in terms of geographical locations.
2010	El-Naser, Farouk, El-Nashar & Mostafa	Egypt	Quantitative: cross-sectional hospital-based study.	150 circumcised women compared with 50 uncircumcised women.	University Hospital	To investigate the effects of FGM/C on the sexual function of women.	There were no significant differences in scores of sexual desire, arousal, orgasm, satisfaction and pain. The total FSFI score demonstrated no significant difference between the groups	Investigated sample that included only women attending the gynaecological clinic for health problems. Socio-demographic variation might affect the self-assessment of sexual problems encountered.
2010	FORWARD	UK	Qualitative: Participatory Ethnographic Evaluation	Somali women's lives in Bristol	Community setting	To gain in-depth understanding of some of the experiences and perceptions of women coming from countries with high prevalence rates of FGM living in Bristol.	Physical, psychological and sexual impacts were reported.	The sample size was not clearly mentioned. The findings of this study cannot be generalized to the broader population.

2010	Ndiaye, Diongue, Faye, Ouedraogo & Dia	Burkina - Faso	Quantitative: Cross-sectional study.	All women received for delivery in Four maternity wards in Fada Ngourma	Four maternity wards in Fada Ngourma	To evaluate the prevalence of childbirth complications due to FGM.	Obstructed labour, tears; caesarean section; episiotomy and haemorrhage	Sample size was not clear. The type of FGM was not clearly mentioned.
2010	Fahmy, El-Mouelhy & Ragab	Egypt	Qualitative: Interview and focus group discussion.	102 women and 99 men	Community setting	To examine the role of female sexuality in women's and men's continued support for FGM and their perceptions of its sexual consequences	Lack of pleasure in sex and sexual dissatisfaction.	No information about the type of FGM. It was not clear how the data was analysed. Sample is too big for analysing qualitatively.
2010	Browning, Allsworth & Wall	Ethiopia	Quantitative: Case study- questionnaire.	255 fistula patients who had undergone Type I or Type II FGC and 237 patients who had not undergone such cutting.	Barhirdar Hamlin Fistula Centre	To evaluate any association between female genital cutting and vesico-vaginal fistula formation during obstructed labour.	Prolonged labour	It was unclear whether potential confounding factors have taken into account in the design and in the analysis.
2011	Chibber, El-saleh & El harmi	Kuwait	Quantitative: Case study- questionnaire.	4800 pregnant women over a 4-year period were assessed for female circumcision. Women with FGM and control group women without	University teaching hospital	To assess the incidence of FGC among pregnant women and describe the obstetrical and psychological sequelae of female circumcision.	Circumcised women were more likely to have extended hospital stay, prolonged labour, caesarean section, post-partum haemorrhage, early neonatal death, and hepatitis C infection. Psychiatric sequelae include: flashbacks to the FGC, PTSD and anxiety disorder.	It was not clear that the control group were representative of the population. It was unclear whether potential confounding factors have taken into account in the design and in the analysis.

2011	Kizilhan	Iraq	Quantitative: Case study- interview and questionnaire.	79 circumcised Kurdish girls aged between 8 and 14	Community setting	To explore the conjunction between FGM and psychiatric illnesses particularly PTSD.	The circumcised girls showed significantly higher prevalence of PTSD, depression disorder, anxiety disorder and somatic disturbances than the uncircumcised ones.	The population from which the sample was drawn was not clearly defined. Participants' status of FGM (Type I, II or III) was not reported.
2012	Anis, Gheit, Awad, Hossam, Said & Hanan	Egypt	Quantitative: Cross-sectional study- questionnaire Arabic Female Sexual Function Index (ArFSFI).	650 Egyptian females cut and uncut.	Cairo University Hospitals	To investigate the effect of FGC on the female sexual function.	Desire, arousal, lubrication, orgasm and satisfaction were significantly higher in the uncut participants. No significant differences between the cut and uncut regarding sexual pain.	Investigated sample that included only women attending the gynaecologic clinic for health problems. Socio-demographic variation might affect the self-assessment of sexual problems encountered
2012	Andersson, Rymer, Joyce, Momoh & Gayle	UK	Quantitative: Case control study: Sexual Quality of Life-Female (SQOL-F) questionnaire.	73 circumcised women and 37 control uncircumcised women.	A large central London teaching hospital.	To investigate the sexual quality of life of women who have undergone female genital mutilation (FGM).	FGM significantly reduces women's sexual quality of life, based on the results of the SQOL-F questionnaire.	Studies of human sexuality are prone to bias and have confounding factors because of the wider cultural context. Self-reporting on sexual dysfunction. No evidence that all women had female sexual dysfunction
2012	Ibrahim, Ahmed & Mostafa	Egypt	Quantitative: Cross sectional study- interview and Female Sexual Function Index (FSFI) questionnaire.	220 married women	Community setting	To clarify the impact of FGM/C on the psychosexual function of circumcised versus uncircumcised.	Scores of depression, somatisation, anxiety and phobia were higher in the circumcised group. Scores of sexual desire, lubrication, orgasm, satisfaction and pain were higher in the uncircumcised.	The available participants were not representative of the whole population; therefore, the results of the study cannot be extrapolated to Eritrean women in general.

2012	Berggren, Gottvall, Isman, Bergstro, & Ekeus	Sweden	Quantitative: Population-based cohort study.	250 491 prim parous women with a vaginal singleton birth at 37–41 completed gestational weeks during 1999–2008. This group included both women born in Sweden and women born in Africa. These women were compared with 247 572 Swedish-born women	Nationwide study in Sweden.	To investigate the risk for anal sphincter tears (AST) in infibulated women	Somalia women had the highest odds ratio for AST in all vaginal deliveries: followed by women from Eritrea-Ethiopia-Sudan and other African countries after adjustment for major risk factors.	Lack of information on infibulation status among the women. Lack of documentation regarding deinfibulations in the clinical records. Misclassification between those deinfibulated prior to delivery and episiotomy during labour among the infibulated women.
2012	Bjalkander, Bangura, Leigh, Berggren, Bergstrom & Almroth	Sierra Leone	Quantitative: Cross-sectional clinic- based study	258 girls and women	Community setting	To determine whether and which kind of health complications girls and women in Sierra Leone experience during and after FGM	Excessive bleeding, delay in wound healing and excessive pain.	The available participants were not representative of the whole population; therefore, the results of the study cannot be extrapolated to Eritrean women in general.
2013	Kaplan, Forbes, Bonhoure, Utzet, Martin, Manneh & Ceesay	The Gambia	Quantitative : Survey-questionnaire and medical examination.	588 female patients	Hospitals and Health centres of Western Health Region	To gather precise information on FGM and its associated health consequences during delivery.	Long term health problems (Dysmenorrhoea, vulva and vaginal pain), Sexual dysfunction, perineal tear, obstructed labour, episiotomy, caesarean and stillbirth, fetal distress and caput of the fetal head	The three sample groups of women differed in terms of ethnic group distribution.

2013	Frega, Puzio, Maniglio, Catalano, Milazzo, Lombardi, Nitema & Bianchi	Burkina-Faso	Quantitative: Observational study-questionnaire.	85 women with FGM and 95 women without FGM.	Hospital setting	To contribute to the spread of knowledge of obstetric and neonatal outcomes in women with FGM type one and two.	Expulsion phase was longer, high risk of episiotomy and caesarean section, more resuscitated babies and more stillbirths.	It was not clearly explained whether the participants who agreed to participate differed from those who refused to participate.

The information in table 2.1 above and 2.2 below were recorded as direct quotations from the abstracts of the reviewed articles.

2.5 Additional Review

The original review identified studies published between 1990 and 2014. The search was updated in June 2017 and yielded six more studies as shown in Table 2.2. Of these studies three were carried out in Africa, two in the US and one in Iran. As regarding the approach, three studies were quantitative (Gajaa et al., 2016; Chu et al., 2016 and Mahmoudi et al., 2017); two were qualitative (Abdelshahid et al., 2015 and Khan, 2016) and the last one used mixed methods (Bogale et al., 2014). These six studies did not provide information that was different from the original review: for example, Bogale et al. (2014) reported on physical outcomes of FGM; while Abdelshahid et al., (2015) and Chu et al. (2016) researched on the sexual outcomes of FGM. Psychosexual and psychological outcomes were reported by Mahmoudi et al. (2017) and Khan (2016) respectively. These studies along with those in the original review are discussed in the succeeding sections.

Table 2.2: Additional Reviewed Studies

Date	Author	Country	Design	Sample	Setting	Focus of the study	Outcome of the study	Limitation of study
2014	Bogale, Markos & Kaso	Ethiopia	Mixed study-community-based cross-sectional study. Questionnaire and interviews.	634 reproductive age women.	Community setting	To assess the current prevalence of FMG, its health consequences and factors underpinning the perpetuation of this practice.	Prerequisite for marriage, social acceptance, safeguard virginity, suppress sexual desire and religious recommendations were the main reasons of FGM. The reported immediate complications were excessive bleeding at the time of the procedure, infection, urine retention and swelling of genital organs.	Since FGM is a sensitive and stigmatizing social issue, the truthfulness of the participants is questioned as interviewed by unknown interviewer.
2015	Abdelshahid & Campbell	Egypt	Qualitative- in depth interviews.	11 mothers and 5 fathers.	Community setting	To challenge the common essentialist views of the community through its fundamental focus on the diversity in representations of female circumcision in Egypt.	Thematic analysis revealed the co-existence of positive (as ensuring the daughter's chastity, safeguarding her femininity and preserving community identity), negative (feel distress about its potential harms, such as pain, bleeding and terrifying experience on the daughter) and ambivalent representations of female circumcision amongst mothers and within the individuals themselves. Fathers further acknowledge its negative impact on marital sexual relationships.	As an encouragement to participate in the study, participants were given a small cash honorarium. This may lead to response bias.

2016	Gajaa, Wakgari, Kebede & Derseh	Ethiopia	Quantitative-community-based cross-sectional. Structured administered questionnaire	610 reproductive age mothers.	Community setting	To determine prevalence and associated factors of circumcision among daughters of reproductive aged women.	Reasons given for daughter's circumcision were to avoid shame, to prevent breach of traditional and religious respect, to maintain virginity, to keep the hygienic status in the vulva area and to reduce sexual desire.	Response, recall and social desirability bias.
2016	Chu & Akinsulure-Smith	USA	Quantitative-community-based audio computerised-assisted self-interviewing.	68 women from Gambia, Guinea, Mali and Sierra Leone.	Community setting.	To examine prevalence rates of FGC, as well as differences in demographic characteristics, health outcomes, and knowledge, attitudes, and beliefs among West African immigrants.	Women with FGC had a significantly higher number of live births and were more likely to report a history of vaginal pain and decreased sexual arousal, but there were no other significant differences in gynaecological and obstetric outcomes, sexual functioning, or psychological outcomes.	The sample was small and purposive in nature and thus not representative of any specific group Type of FGM was not mentioned as sample based on self-report.
2016	Kahn	USA	Qualitative- Grounded Theory.	Seven women circumcised in childhood from Bukina-Faso, Guinea, The Gambia and Chad.	Community setting.	To explore the trajectory of resistance to FGC for seven women circumcised in childhood who sought asylum in the United States as adults to protect their daughters from the practice.	Traumatic memories of the circumcision rite, combined with the capacity to reflect on "taken for granted" cultural practices and to employ critical thinking skills, may lead to resistance to FGC for some women.	Sample based on those who opposed the ritual and sought asylum in the United States. Other populations of circumcised women might have different views and perspectives on the circumcision experience.
2017	Mahmoudi & Hosseini	Iran	Quantitative- Survey Questionnaire	414 Couples (206 FGM couples and normal couple).	Community setting	To determine whether FGM versus non-FGM couples in Kermanshah in Iran vary in relationship characteristics, such as relationship satisfaction, sexual satisfaction, and mental health.	FGM is associated with frequent psychosexual difficulties in Uramanat couples; notably orgasm difficulties, sense of incomplete sexual-needs fulfilment, and neurotic symptoms.	Conclusions were based on one-time observations.

2.6 Outcome of the Review

In this section, I report on the studies reviewed, their contributions to the body of knowledge and how their inputs have created a niche, scope and focus for this study. In addition, I explain the inherent strengths and limitations of the same.

2.6.1 Critique of the Methodological Approaches of the Included Studies

In assessing the methodological quality of the qualitative studies included, I employed a ten question Critical Appraisal Skills Programme (CASP) tool (Balshem et al., 2010). As for quantitative studies, I applied a twelve question Critical Appraisal Tool developed by the Oxford Centre for Evidence Based Management (Centre for Evidence Based Management, 2014); and for mixed methods study designs I assessed the quality of evidence using the Evaluation Tool developed by the School of Healthcare, University of Leeds (Long et al., 2002). The quality of the article was based on answers to questions by a respective checklist, in which the reviewer is asked to record “yes”, “no”, or “can’t tell” in each question. The rationale for using these tools was to examine whether the studies included addressed clearly focused research questions. In addition, the tools assisted in assessing the validity of the methods used to address the question, assess the validity and importance of the results; and finally, whether the results are applicable to a wider population.

Most of the studies reviewed are quantitative in nature (41 out of 51). Collectively their strength has highlighted issues regarding the practice of FGM. There is rich information on attitudes, perceptions and knowledge of a range of people including circumcised women towards FGM. Studies have measured the impact of FGM on a range of issues such as labour, maternal health, neonatal mortality and sexual life. The strengths as well as the limitations of these articles have opened avenues for further research and has provided key information in statistical values and numbers which are critical in planning interventions, campaigning against FGM, and for provision of services related to FGM.

Despite the strengths of the quantitative studies reviewed, they each have methodological limitations. Hence, this section provides an overview of the inherent limitations of quantitative studies in this review; while specific limitations have been identified and highlighted in respective sections. Almost 50 per cent of the outcomes of the studies on FGM were measured through self-report, clinical reports and physical examination which could lead to reporting error. In some studies, researchers interviewed circumcised women using structured interviews (face-to-face). For example, Eldafrawi et al. (2001) and Catania et al. (2007) recruited 250 and 267 circumcised women respectively to investigate the prevalence and psychosexual impact of FGM. In their studies, they used closed questions which would have precluded gaining deep understanding of the experience of circumcised women.

In the same context, Behrendt et al. (2005) investigated the mental health status of women after FGM and Lundberg et al. (2007) explored the experiences of circumcised women during pregnancy and childbirth, while others, such as Okonofua et al. (2002) administered questionnaires to examine the association between Female Genital Cutting (FGC) and the frequency of sexual and gynaecological symptoms; Applebaum et al. (2008) assessed the mental health of circumcised women; Alsibiani et al. (2010), Anis et al. (2012) and Mahmodi et al. (2017) administered Female Sexual Functioning Index (FSFI) questionnaires to investigate the effects of FGM on female sexual function.

Questionnaires are considered part of a positivist paradigm that imposes pre-defined constructs (Jomeen, 2012). There is strong argument to support the use of measures/questionnaires to assess women's health (Bowker, 2001). While measuring psychological phenomena such as depression, anxiety and personality would require measurable indices, such a move has proved to be a persistent problem (Richards 2002). In Jomeen's (2012) study for example, she reported that "many instruments claimed to be valid for all populations have not been thoroughly tested in pregnant populations" (2012:337). Such indices were simply developed in non-specific populations and then employed to pregnant women; as a result, studies making use of such measures have registered methodological problems. The same could be argued regarding the Female

Sexual Function Index (FSFI). The FSFI was developed to measure arousal, pain, lubrication and orgasm in the general female population; it was not meant specifically for women who have undergone FGM. Hence, it may not yield the desired outcome when applied to circumcised women.

Given that most of the studies were quantitative in nature, their collective limitations include the fact that feminists criticized the quantitative approach as treating women as ‘‘object like subjects’’ (Unger et al, 1992:2), where the concerns and interests of the women in the study are made inferior to those of the researcher. The discourses in quantitative studies are geared towards producing data on women rather than data for women and where possible producing data with women as is the case with the qualitative approach (Ramazanoglu et al., 2002). When the focus of the study is about generating data on women rather than for women, respect for the experiences and knowledge of women is withheld and their voices are diminished (Olesen, 1994). It is argued that knowledge production in the quantitative studies reviewed is male-driven, as central to the values of these studies was to show how feminine ways of knowing can be promoted when masculine ways of knowing traditionally dominate (De Angelis, 2012). This unquestionably posed a challenge as all the 41 quantitative studies seemingly lacked a feminist touch. It follows that it seemed unfair that their experiences as women who have undergone FGM were not sought: consequently, studies have reported on the complications of FGM rather than the complications that women face due to FGM.

For instance, studies carried out by Ibrahim et al. (2012), Kaplan et al. (2013) and Frega et al. (2013) sought to understand the impact of FGM on psycho-sexual function. Sexual experience is such an intimate phenomenon that a researcher cannot obtain women’s genuine experiences using a questionnaire (De Angelis, 2012). Moreover, these studies demonstrated power relations between the researcher and the participants as the goal of the studies was to explore the impact of FGM on women rather than women’s experiences of FGM (Khan 2016). Thus, when women are made objects rather than subjects of the study, the outcome of such studies aims at using circumcised women as tools for accomplishing certain objectives (Abdelshahid et al., 2015).

The overall limitation of the studies reviewed, therefore, was their use of the "experience" of circumcised women as a tool to discourage non-circumcised women from undergoing the procedure. This assertion is given impetus when considering that most of the studies sought women's sexual and obstetric experience as their complications tend to leave behind a heavy resonance and complex emotions (Gajaa et al., 2016). As indicated earlier, the majority of studies were conducted during the time of a powerful movement against FGM. While it is clear the movement against FGM has its origin in the West (Njambi, 2004), some researchers in their effort to maintain the rigour of the movement, have found themselves drawn into elaborating inaccurately and sometimes exaggerating the effects of FGM to serve the purpose of intimidating and discouraging girls from performing the procedure (Njambi, 2004). This explains why studies on psychological aspects of FGM are few as researchers are not motivated to identify the emotional discomfort that circumcised women face. Instead they use the sexual and obstetric experience of the latter to accomplish their objective of painting a negative picture of FGM.

Some studies have highlighted certain complications of FGM, indicating that circumcised women suffer more than the uncircumcised ones, but did not include a control group in their samples. For example, Al-Hussain et. (2003) noted that circumcised women were more prone to post-partum haemorrhage when their sample did not include non-circumcised women to measure their experience. In addition, where a critical finding was recorded, there was no discussion of whether the confounding factors were considered. For example, even though they had control groups in their studies the findings of Elnashar et al. (2007), Wuest et al. (2009), Browning et al. (2010) and Anderson et al. (2012) could be a function of confounding factors because factors such as age, ethnicity and type of FGM were not accounted for. There were also methodological flaws when reporting on some complications without linkage with a respective type of FGM. Consequently, some studies have reported on complications which are rarely experienced by women who have undergone a certain form of FGM. For example, lack of sexual pleasure is a complication that women with type II and III experience, but such a complication was reported in societies that perform type I FGM.

Mechanisms to measure outcomes were not standardised in most studies. For example, some studies (Elnashar et al., 2007; Khaja et al., 2009; Kizilhan, 2011) reported on psychological consequences of FGM but failed to disclose how they arrived at that conclusion: some psychological conditions such as PTSD, pain and sexual satisfaction need a complex mechanism to measure their effects. Some of the findings on psychological emotions that circumcised women suffer were based on the participants' self-reporting rather measuring them scientifically. The succeeding sections discuss various issues related to FGM as reported by the studies reviewed.

2.6.2 Age at Which FGM is Performed

Depending on geographical location and the customs of a specific ethnic group, all the included studies showed that there was a variability in terms of the age at which women were circumcised. Some societies perform FGM shortly after birth (Kizilhan 2011), others at puberty (Ndiaye et al., 2010) or before marriage (Browning et al., 2010) as well as after childbirth (Oduro et al., 2006). The studies included revealed that circumcisers who perform FGM are elderly women who also work as traditional birth attendants, traditional healers, and barbers. In some societies where a skilled circumciser is not available, an old grandmother operates on girls (Dare et al., 2004; Frega et al., 2013). The authors emphasize that circumcisers are highly regarded in their communities; they are influential, powerful and highly respected; most people go to them for advice, counseling and mentoring. The circumcisers are known by different names; for instance, in Somalia these elderly ladies are called *'Gedda'*, and in Egypt and Sudan are known as *'Daya'* (Ibrahim et al., 2012; Abdelshahid et al., 2015), and in Tanzania they are referred to as *'Ngariba'* (Msuya et al., 2002). As circumcision is also performed on boys in the same societies that circumcise women, the studies have not considered the status of male circumcisers and explored how the two circumcisers are perceived by the societies.

Most of the studies mentioned that FGM is carried out within community settings using instruments such as knives, broken glass, scissors, old razor blades, or sharp stones (Osifo et al., 2009; Fahmy et al., 2010); refer to appendix 10 page XIII. Kaplan et al., (2013) reported that some circumcisers in

Gambia have been using finger nails to grab and cut out babies' clitoris; while in some areas in Ethiopia, women use cauterization (burning) to remove the clitoris (Browning et al., 2010; Bogale et al., 2014). In most cases the tools for circumcision (refer appendix 10 page XIII) are re-used without cleaning or sterilizing them; consequently, communicable diseases such as HIV/AIDS and hepatitis B which are spread through blood are likely to spread from one person to another (Msuya et al., 2002).

Some of the reviewed studies (Msuya et al., 2002; Litorp et al., 2008) showed that anesthesia is seldom used during the procedure: several women are required to hold a struggling girl to prevent her from injury. The management of a wound is carried out using substances such as cow dung, lemon juice, alcohol, eggs and ash; herb mixtures, Vaseline and porridge (Mukoro 2004; Abdelshahid et al., 2016). Wound treatments such as cow dung may harbour bacteria, which may in turn cause tetanus. In infibulation, following total cut of the entire clitoris, both labia minora and part of the labia majora, the edges of the raw wound are sewn together using stitches, cat gut, and sugar; or stuck with adhesives made from egg and acacia tree thorns, leaving a minor aperture for urinating and menstruation (Al-Hussain 2003; Litorp et al., 2008). To expedite healing, the girl's legs may be bound together (Ibrahim et al., 2012).

The reviewed studies (Bjalkander et al., 2012; Anis et al., 2012) revealed that the circumcision procedure takes an average of 15 to 20 minutes, depending on the type of procedure and the degree of tissue removed, the skill of the operator, and the resistance put up by the girl. It is during this struggle the cut may extend beyond the intended area and may destroy adjacent organs (Gajaa et al., 2016; Chu et al., 2016). Other studies (Fahmy et al., 2010; Chibber et al., 2011) reported the use of surgical blades and anesthesia for the procedure in hospital settings.

2.6.3 Motives for Performing FGM

The studies included revealed various motives that have been identified for the persistence of FGM in different geographical and cultural settings: the reasons range from cultural and religious to superstitious. These motives were grouped

into socio-cultural, psycho-sexual as well as spiritual and religious. Each of these motives will be described in the following sub-sections.

2.6.3.1 Socio-Cultural Reasons

Several studies have cited socio-cultural reasons as the most common reasons for the persistence of this practice (Sayed et al., 1996; Magied et al., 2003; Oduro et al., 2006); and traditions have been singled out as the main cross cutting reason for the continuation of the practice. Traditions are defined as the values, beliefs and customs of a community that rule and guide the conduct of people (Millongo-Traore et al., 2007; Gajaa et al., 2016). Traditions and learned behaviours are disseminated from one generation to another such as from grandmother to mother, and from mother to daughter; they are not easy to change as they are regularly protected by taboos. FGM-practising societies perceived the procedure as a traditional practice which has its roots in several past generations, and people adhere to such cultural norms by putting their belief in them (Kahn, 2016). Socio-cultural reasons for the persistence of FGM include the belief that FGM is attached to the initiation ritual which is the passage of a girl into womanhood, the mythology regarding the clitoris, preservation of virginity and cure of feminine diseases. These motives will be described further in the succeeding sections.

2.6.3.1 a) Initiation Ritual

In FGM-practising societies, female circumcision is the climax of the initiation ritual cerebrations where the transition from girl to woman is observed (Msuya et al., 2002; Awuah 2008; Mahmoudi et al., 2017). Depending on the traditions of the society concerned, some begin with circumcising girls followed by special teachings; while in others, the girls are gathered in isolated camps for at least two weeks where they are taught tribal social norms and codes, morality, how to be good wives, and behave well towards the elders before circumcision is performed (Slanger et al., 2002; Ndiaye et al., 2010). The initiation that is accompanied with female cutting is a sign that the girls are ready for marriage without which the chances to marry are slim (Okonofua et al., 2002). The initiated women form a social cohort in which those who have not attended are

not accepted. In Sierra Leone, for example, initiated women have formed clubs in which the membership is extended to only those initiated (Bjalkander et al., 2012). The next sub-section describes a myth about the clitoris as a social construction for the continuation of FGM.

2.6.3.1 b) Mythology about the Clitoris

Communities that perform FGM perceive the clitoris as an unpleasant organ because it represents maleness; if not removed it will grow and become longer like a penis (Osifo et al., 2009). Women are often told that without FGM, the clitoris will grow down to the ground and drag (Khaja et al., 2009). In West Africa, some societies circumcise women to differentiate female sex organs from male organs, as there is a conviction that a clitoris makes a woman look like a man because of the resemblance of a clitoris to a penis (Elnashar et al., 2007). Consequently, a clitoral fore-skin must be removed to differentiate it from penile fore-skin. Thus, female circumcision removes any reference to maleness and qualifies a woman as feminine (Applebaum et al., 2008).

Another myth regarding the clitoris in Yoruba society is that it can cause death to a new born child if the child's head encounters the tip of a clitoris during child birth (Dare et al., 2004). In addition, the clitoris can be dangerous if it touches a penis as it harbours damaging forces (Kaplan et al., 2013).

2.6.3.1 c) Preserve Virginity

Another motive for the continuation of FGM is the maintenance of virginity (Khaja et al., 2009; Gajaa et al., 2016). African societies put emphasis on virginity on the wedding day, without which the individual and her parents will suffer social consequences. A woman who has lost her virginity before her wedding day is degraded and categorized as a prostitute (FORWARD, 2010). Hence FGM ensures virginity, which serves not only as a condition for marriage and a source of family honour, but also as a vehicle for reducing women's sexual desire, which helps her to resist sexual encounters before marriage (Fahmy et al., 2010). In addition, girls who have undergone infibulation have a narrow vaginal opening, which discourages them from having sexual

relationships for fear of experiencing pain, or of their experience being identified (Gajaa et al., 2016). Furthermore, type III FGM ensures that the chances for a girl to be raped is minimal so that she can walk long distances to fetch water or fire wood without fear (FORWARD, 2010).

2.6.3.1 d) Cure of Some Feminine Related Diseases

In some areas FGM is performed as a cure of some diseases. In ancient times in America and Europe it was believed that FGM was a cure for psychological problems in women, such as insanity and hysteria. Most of the associated psychological problems were hypothesized as behaviours that were socially unacceptable (Msuya et al., 2002). In the 1950s removal of the clitoris was a treatment of choice for the behaviours that were unacceptable such as refusing to marry (Okonofua et al., 2002). Around the same era in the United Kingdom clitoridectomy was an acceptable means for the management of excessive masturbation, epilepsy and sterility (Msuya et al., 2002). In addition, FGM is perceived as being able to prevent vaginal cancer, masturbation and lesbianism (Okonofua et al., 2002); although there is no scientific investigation to prove FGM can prevent or cure such conditions.

2.6.3.1 e) Aesthetic and Hygienic

Some ethnic groups hold a belief that female circumcision adds to the purity and cleanliness of women as the terms used for mutilation are equated with purification, for example, *tahur* in Sudan and *tahara* in Egypt (Elnashar et al., 2007). Following this belief, it is considered that clitoridectomy contributes to the cleanliness and beauty of women because a woman with intact genitalia is considered dirty, impure, ugly, unrefined and non-human (Applebaum et al., 2008). This explains why women who are not circumcised are not accepted within their close families and communities at large as they lack feminine beauty.

2.6.3.2 Psycho-Sexual Reasons

There is a wide spread notion among the societies which perform FGM that the procedure reduces female sexual urges significantly (El-Naser et al., 2010).

Thus, if the genitalia are left untouched, women will act madly in their desire for men. In the absence of FGM men fear women will forcefully claim sex from them; hence, FGM is done to ensure faithfulness and keep sexual control (Fahmy et al., 2010). In addition, FGM is viewed by some cultures as the primary tool for making the female body suitable for sexuality (Anis et al., 2012); as the narrowing of the vaginal opening is said to increase the male's sexual desire during intercourse especially when the labia are removed. Hence, men enjoy sex at the expense of pain that women experience. There has been a systemic belief among men in societies that perform FGM that they can enjoy sex even in the absence of the active participation of women. They believe in one-way sexual satisfaction and are unaware that meaningful sexual gratification is mutual (Elnashar et al., 2007; Mahmoudi et al., 2017). It follows that FGM serves two opposing schools of thought: on one hand, FGM identifies with men's acknowledgement that women are sexually powerful, hence the need to suppress their sexuality by diminishing the capacity of women to enjoy sex life. On the other hand, FGM serves the desire of men to enhance their own sexual pleasure by tightening the vagina (Awuah, 2008).

2.6.3.3 Spiritual and Religious Reasons

The studies reviewed have shown that the societies that practise FGM have repeatedly associated the practice with religious reasons (Alsibiani et al., 2010; Gajaa et al., 2016). The norms have introduced a belief that FGM is a religious requirement; a notion that is not supported by any conventional religion (Kizilhan, 2011). The belief points to Islam as responsible for the continuation of the practice in some societies. This belief is made stronger by the fact that type III FGM, which is the most traumatic procedure, is practised in countries such as Somalia, Sudan, Eritrea and Djibouti which are primarily Islamic (FORWARD, 2010). This misconception has since been rejected because FGM is also practised by Jews and Christians living in these countries; and female circumcision pre-dates Islam (Abdelshahid et al., 2016). The studies reviewed have presented a view that FGM is much condemned in Saudi Arabia, a country known to be the birthplace of the Islamic faith (Ibrahim et al., 2012). Renowned Islamic leaders such as Sheikh Ahmed EI-Taher, Mufti of the Sudan have condemned female circumcision for religious reasons. El-Dafrawi et al.

(2001) reported that Islamic scholars and historians provide evidence against FGM as a religious custom. They point to several passages in the Koran that oppose FGM. God created the clitoris for the sole purpose of generating pleasure, therefore it should not be removed (Ibrahim et al., 2012). In addition, the Koran encourages a husband and wife to pleasure each other during sexual encounters (El-Dafrawi et al., 2001).

To summarize, this section has discussed the age at which FGM is performed, and the motives behind the persistence of FGM in societies that perform the procedure. From the studies reviewed FGM is perceived as an obligatory, deep-rooted tradition that is associated with social identity, respect and dignity for the circumcised woman. In addition, it is viewed as a tool for controlling women sexually; hence, patriarchy is viewed as responsible for the continuation of FGM. In-depth discussion of patriarchy is presented in Part Two of this chapter. The next section discusses the consequences of FGM as reported by the studies reviewed; it also provides critiques to the same studies

2.6.4 Consequences of FGM

All the studies included in this literature review have suggested that women who have undergone FGM have experienced social, psychological and health consequences of different magnitudes because of FGM. For example, Slanger et al. (2002); WHO (2006); FORWARD (2010); Berg et al. (2010) and Chu et al. (2016) have shown that FGM is associated with health consequences. The review showed that the consequences of FGM can be categorized into four major groups; physical, sexual, obstetric and psychological. The complications will be discussed in the subsequent sections.

2.6.4.1 Physical Consequences

Six out of 51 studies reported on physical consequences: Msuya et al. (2002), Osifo et al. (2009), Dare et al. (2004) and Bjalkander et al. (2012). Other studies (Al-Hussein, 2002; Mukoro, 2004; Sayed et al., 1996; Elnashar et al., 2006; Khaja et al., 2009; FORWARD, 2010; Kaplan et al., 2013) have reported

on physical consequences although their major concentration was on sexual and obstetric complications.

Studies in this review show that the severity of physical consequences of FGM on women's health depends on several factors. Among them are the degree and extent of the cut; the skills of circumcisers; the unhygienic conditions, the resistance and struggle of the woman during the procedure; and susceptibility of the body to infection (Dare et al., 2004; Bjalkander et al., 2012). These factors influence the degree of physical complications a woman may experience. However, it is not assumed that every woman experienced each of these factors; hence, women do not necessarily have similar experiences of FGM.

2.6.4.1 a) Immediate Sequelae

As mentioned in the introduction to this section the common immediate complications of FGM include pain, which may be unbearable depending on the pain threshold of a person, and bleeding from the cut which may cause shock or death (Sayed et al., 1996; Msuya et al., 2002; Dare et al., 2004; Osifo et al., 2009; Bjalkander et al., 2012; Bogale et al., 2016). For example, Dare et al. (2004) and Osifo et al. (2009) have pointed out a high occurrence of death due to blood loss. The limitations of these studies, however, do not rule out the existence of anaemia in the circumcised girls prior to the procedure. As the same loss of blood from a healthy girl and one with severe anaemia may lead to different outcomes. In addition, the mortality rates due to these complications may go unreported or fail to show the magnitude of the problem given the under-reporting of such cases for the sake of hiding the cause of death. In Urhobo women in Nigeria, Mukoro's (2004) study reported that haemorrhage and severe pain were the most frequent experienced complications. Whereas pain and bleeding is inevitable for any human being when cut without anaesthesia, the mechanism to judge successfully the amount of blood loss in the circumcised women is missing as the researchers relied on women's self-reporting. Damage to the adjacent organs, like the urethra and urinary bladder, vagina, and rectum because of either poor skill of the circumciser or when the girl struggles during the procedure were reported by Chalmers et al. (2000).

Such complications may lead to recto-vaginal or vesical-vaginal fistulas in some women. Whilst this complication is likely to occur, other studies Bjalkander et al. (2012) and Elnashar et al. (2006) have noted that due to the awareness of the circumcisers that the tissues cut are sensitive to pain, they do not conduct the procedure until they are sure the girl is securely stabilized by strong women so that there is no or minimum movement. That being the case this complication is not common.

As for infection, several studies reported on various infections, including wound infections (Osifo et al., 2009; Bogale et al., 2016), acute local trauma infections (Dare et al., 2004), genitourinary tract infections (Chalmers et al., 2000), urinary tract infections (Sayed et al., 1996) abscess formation and septicaemia (Okonofua et al., 2002; Bogale et al., 2016). According to the studies under review, some women were infected because of the unsterile environment and use of unsterile instruments and sharing operative instruments: hence some contracted tetanus. Also, the local treatment of the wound which often includes the use of substances like milk, eggs, cow dung, ashes or crushed herbs applied to dress the wound after the procedure or to control the blood loss was responsible for causing infection (Bogale et al., 2016). In some cases, women were susceptible to blood/fluid based transmitted infections such as hepatitis B and HIV/AIDS due to forced sexual encounters causing tearing of a FGM scar (Msuya et al., 2002). In all these studies there was a lack of definition of what comprises infection, such as that caused by unsterile instruments, that caused by the topical applications and systemic infection, as the demarcating line between them is negligible.

2.6.4.1 b) Long-Term Consequences

The findings from different studies show that there are several long-term physical consequences related to FGM (Al-Hussaini, 2002; Johansen, 2002). There is a common notion that the type of FGM determines the severity of complications. For example, it has been documented that the greater the type of the procedure, the more severe the consequences of FGM; thus, women who have undergone type III FGM are prone to experience more severe forms

of complication than those whose procedure was type II FGM. Similarly, women who experienced type II FGM have more complications than those with type I FGM (WHO, 2006). However, the experience of FGM related complications is individually related and cannot be applied to all circumcised women who have undergone a certain type of FGM; for example, a woman in type I FGM may acquire HIV during the course of the procedure. Following the procedure, women may experience chronic urinary infection (Al-Hussaini, 2002; Johansen, 2002; Bogale et al., 2016) due to untreated infections, or secondary to partial obstruction of the urethral opening due to swellings such as keloids. Large keloids around the vaginal opening may cause retention of menstrual flow and vaginal discharge which may lead to chronic pelvic infection and painful menstruation (Chalmers et al., 2000). In their study, Kaplan et al. (2013) reported on women killed for the reason of damaging family reputation after they had been accused of being pregnant before marriage. Such incidents followed a period of amenorrhea where a woman did not notice her menstrual flow because of the distorted vagina opening, causing retention of vaginal blood flow which led to the distension of the abdomen.

2.6.4.2 Sexual Consequences

Sexuality is important for the quality of life and general wellbeing of human beings (Chu et al., 2016). The sexuality of a circumcised woman may be impaired to the point of sexual dysfunction. As reported earlier, obstruction of the vaginal opening due to swellings or tightening of the vaginal opening during wound healing may cause narrowing of the vaginal opening which may prevent sexual penetration and cause pain (Kaplan et al., 2013; Abdelshahid et al., 2015). This sexual dysfunction may be mirrored by lack of sexual desire and delayed orgasm or simply dyspareunia (American Psychiatric Association, 2013).

Sixteen out of 51 studies included in this review reported on the sexual consequences of FGM. The outcomes of all these studies suggested that FGM has an impact on women's sexual functioning. The findings of 10 included studies demonstrated six outcomes of sexual functioning experienced by women who have undergone FGM as shown by the Female Sexual

Functioning Index [FSFI] (Rosen at el., 2000). In their study Rosen at el. (2000) noted that circumcised women experience significantly lower sexual arousal, impaired sexual desire, less sexual satisfaction, less lubrication, painful sex (dyspareunia) and experience orgasm less frequently than women without FGM. The limitation of such a conclusion is that other causes that could be responsible for such sexual experiences were not ruled out. In addition, the measurement and interpretations of female sexual satisfaction were not standardized. For example, the studies conducted by Sayed et al. (1996), El-dafrawi et al. (2001), Fahmy et al. (2010) and Alsibiani et al. (2010) concluded that circumcised women had lost sexual desire and pleasure compared to the uncircumcised women, while Catania et al. (2007) and Ibrahim et al. (2010) reported no significant difference in sexual satisfaction between the circumcised and non- circumcised women. Hence, female sexual gratification is subjective as the clitoris is not the only erogenous area in women and vaginal sexual satisfaction is not limited to clitoral stimulation (Abdel-Azim, 2013).

2.6.4.3 Obstetric and Gynaecological Consequences

In this review, close to 50 percent (22 out of 45) of the studies included reported on the obstetric consequences of FGM, which include tearing and blood loss during delivery, obstructed and prolonged labour, high risk for caesarean section, episiotomy, and other obstetric and antenatal complications (Hakim, 2001; Larsen et al., 2002; WHO, 2006; Awuh, 2008; Browning et al., 2010; Ndiaye et al., 2010; Chibber et al., 2011; Kaplan et al., 2013). Labour is regarded as prolonged when the delivery of a baby has not occurred after 20 hours of regular contractions (Khaled, 2003). Another source provides a range of 18 to 24 hours of regular contractions without a delivery of a baby (Larsen et al., 2002). Ten included studies have reported that women who have undergone FGM are more prone to experience prolonged labour than uncircumcised women (Hakim, 2001). The limitations of these studies are that they failed to identify which type of FGM was responsible for this outcome. For instance, the study by Chibber et al. (2011) failed to specify the type of FGM involved in the study. Furthermore, the study lacked a control group of uncircumcised women in order to qualify the statement that FGM was responsible for the prolonged labour. Women with FGM were more prone to

have the second stage of labour prolonged by more than 30 minutes than those who were not circumcised (Millongo-Traore et al., 2007). In this study the findings captured the experience of women during labour but a limitation to the study was its small sample size of one ethnic group which cannot be assumed to yield similar experiences for the groups of women in other ethnicities.

As for vaginal and perineal tears, fourteen studies established that perineal lacerations were a common phenomenon among the women who had experienced FGM. For example, Hakim (2001) reported that 171 subjects with FGM had perineal lacerations depending on the type of FGM performed on them. He identified that 59.7% of circumcised women had first degree tears, 32.7% had experienced second-degree tears, while 7.6% had suffered third degree tears, compared them with uncircumcised women who experienced tears of 20%, 7.8% and 5% respectively. These findings are supported by other studies conducted by Millongo-Traore et al. (2007) and Johnson et al. (2004). While these findings offer valuable insight, they failed to illuminate the link between the severity of tear and the type of FGM. For instance, it is not known whether those who suffered third degree of tear were those who had undergone type III FGM – infibulation.

Increased risk of childbirth through caesarean section was another consequence of FGM. In this review 14 studies showed the association between caesarean sections and FGM. For example, the study in six African countries conducted by the World Health Organization (2006) revealed that circumcised women who had singleton deliveries were significantly more susceptible to deliver through caesarean section and had higher chances of experiencing other obstetric complications during deliveries than uncircumcised women. Similarly, Chibber et al. (2011), Osifo et al. (2006) and Kaplan (2013) reported that circumcised women had twice the chances to deliver by caesarean section as uncircumcised women. However, Oduro et al. (2006) reported no significant difference regarding the rate of caesarean section between the circumcised women (8.2%) and those uncircumcised (6.7%). His findings could be attributed to including women who had undergone type I FGM, who are less likely to experience obstetric complications.

Regarding episiotomy, more than half of the studies included showed that episiotomy was more common among circumcised women than uncircumcised women. Ndiaye et al. (2007) reported that 59% of the circumcised women had an episiotomy; and it was commonly performed on the circumcised women to avoid tearing. The limitation inherent in this study was its lack of clarity whether episiotomy was necessary for all prime-gravida women or even to multipara, as in other countries episiotomy is a standard measure for all prime-gravida women (Hakim, 2001). Hakim (2001) showed that the proportion of circumcised women in need of an episiotomy incision due to foetal and/or maternal distress was estimated at 43% comparing to 24.6% of uncircumcised women. Consistent with the above findings, Al-Hussain (2002) in his prospective cross-sectional study of Egyptian women, found that 95% of women who have undergone FGM had an episiotomy, although this study was limited by the lack of a control group to inform the experience of the uncircumcised women and by its small sample size.

Concerning postpartum haemorrhage and complications related to new-born babies, the studies by the World Health Organization (2006) and Ndiaye et al. (2010) showed that circumcised women are more liable to postpartum haemorrhage than uncircumcised women in the ratio of 13.0; while circumcised women had higher rates of foetal distress during childbirth. The infibulation type of FGM was associated with increased rates of stillbirth and neonatal death (WHO, 2006). The same finding was reported by Larsen et al. (2001) and Chibber et al. (2011), who concluded that neonates born of circumcised women had high risks of developing neonatal complications ranging from foetal distress, low Apgar scores and perinatal death.

2.6.4.4 Psychological Consequences

Unlike physical complications related to FGM that have been ignored as they are perceived inevitable, researchers have paid great attention to sexual and obstetric complications. One area that has received less attention is the psychological complications of FGM (Lockhat, 2004). Psychological outcomes are hidden, silent and tend to go unnoticed; consequently, those who

experience these complications suffer inwardly and silently (Behrendt et al., 2005; Kizilhan, 2011; Kahn, 2016). Concealed emotional feelings related to FGM, coupled with the challenges of diagnosing and measuring emotional distress, and the difficulties for circumcised women to share their experiences of FGM, has rendered the psychological complications of FGM an obscure area (Lockhat, 2004). Consequently, knowledge about psychological experience of FGM is based on assumptions that have been made regarding the emotional effect of FGM, with most of the available information being gathered from surveys, case reports, and interviewing healthcare providers rather than obtaining data from circumcised women (Behrendt et al., 2005).

In the current review, out of 51 studies, five studies reported specifically on psychological consequences (Osinowo, 2003; Behrendt et al., 2005; Elnashar et al., 2007; Applebaum et al., 2008; and Kizilhan, 2011). For example, Post Traumatic Stress Disorder (PTSD) was reported by Behrendt (2005) and Kizilhan (2011): in their studies, the authors found that circumcised women recalled the fine details of the procedure and described it as traumatizing with over 80% circumcised women suffering from invasive experience of FGM that involves cutting genitals and flashbacks of the procedure.

Depression was reported by Kizilhan (2011) and Ibrahim et al. (2012) with circumcised women reporting symptoms of depression such as change of sleeping pattern, poor concentration, and panic attacks. As for anxiety disorder, its incidence was described by Lundberg et al. (2006), Elnashar et al. (2007), Kizilhan (2011) and Ibrahim et al. (2012). In their studies, they found that anxiety was associated with sexual and obstetric dysfunction due to keloid or cyst development, and fears of such swellings changing into cancer. Also, anxiety was caused by amenorrhoea caused by a narrowing of the vaginal opening, and sexual difficulties caused by the same vaginal deformity. Other psychological consequences reported were phobia, sense of loss, emotional trauma and low self-esteem (Osinowo, 2003; Elnashar et al., 2007; Kahn, 2016).

In this section, the studies reviewed have reported on the physical, sexual, obstetric and psychological complications of FGM. While researchers have taken physical complications for granted and perceived them as inevitable, sexual and obstetric complications have received great attention and constitute subjects for controversial debate. Psychological complications of FGM on the other hand is an area that has not received enough attention due to difficulties in measuring them, reluctance of circumcised women to discuss their experiences particularly related to sexuality, and the fact that psychological complications are concealed and rarely shared.

2.7 Patriarchy: An Emerging Theme from the Review

Patriarchy appears as an emerging theme from the studies reviewed due to the following factors: first, the age at which girls were circumcised, including the lack of consent and freedom to accept or reject the procedure which is engineered by men; secondly, the motives for performing FGM, which range from socio-cultural factors, psycho-sexual to spiritual ones, are male-driven aiming at dominating women; thirdly, the position and status of the female circumcisers who are more privileged at the expense of advancing the tradition of female circumcision compared to male circumcisers whose status is not valued; and finally, the tendency of men to trivialize the complications that circumcised women face. The emerging theme that befits all these circumstances is patriarchy which means men are in control over women's affairs. It refers to male oppression, exploitation and domination in all spheres of women's lives. The patriarchal system has facilitated the execution of FGM that has been built along the patrilineal system, in which men control women and the latter are submissive to the former (Parmar et al., 1999). It is important to analyse the concept of patriarchy as it encompasses the wide picture in which FGM is practised worldwide including many African societies. As an emerging theme in this review, patriarchy is discussed in detail in part II of the literature review where the theoretical literature is considered.

2.8 Conclusion

In this first part of the chapter, discussion of the literature reviewed (refer to table 2.1) has been provided. The discussion of the motives and consequences of FGM has led to patriarchy as an emerging theme that describes how power relations between men and women have influenced the persistence of FGM. Given that the review has shed light on limitations inherent in the studies, as a remedy, the objective of the current study is to explore the experiences of circumcised women with the aim of promoting the voices of women and producing knowledge that is committed to advocate broader social justice and social change for the betterment of women. Raising the voice of women who have undergone FGM will contribute to the global gender equality and discourage all forms of social injustice. The next part will discuss the theoretical literature review highlighting the feminist theory that aims at challenging the patriarchal system.

Part II: THEORETICAL PERSPECTIVE

2.9 Introduction

In the previous part, the discussion on the motives and consequences of FGM led to an emerging theme of patriarchy that describes how power relations between men and women have influenced the persistence of FGM. This part discusses patriarchy as a concept which serves as a means to understand the experiences of women regarding the complications of FGM. It also introduces the feminist theory which has guided this study. To accomplish this task, I undertook a review of the theoretical literature, considering works by Walby (1990), Sultana (2011) and Jackson et al. (1998) who have meticulously discussed the concept of patriarchy, how women have been dominated exploited and oppressed by men in all forms of life; and how various forms of feminist theories have challenged the patriarchy and empowered women.

2.10 FGM in the Context of the Patriarchal System

The literal meaning of the term ‘patriarchy’ is the ‘reign of the father’; and its original use was to describe a sort of ‘male-dominated family’ – the *patriarchal*

household that included young men, children, women and slaves, with a male being the dominant ruler (Sultana, 2011). The term, in current times is used to show male supremacy in the power relations whereby men control women, and create a system by which men are perceived as dominant and women as subordinate in various areas of life (Asiyanbola, 2005). The male domination over women under the umbrella of patriarchy can be examined in both public and private circles (Frenkel, 2008). The main setting of women's oppression in private patriarchy is household production: for example, 'expropriation of women's labour takes place primarily by individual patriarchs within the household' (Walby 1990:24); whereas public patriarchy is predominantly in public settings, for instance, the government and employment sector, 'where it is a more collective appropriation. In private patriarchy, the principal patriarchal strategy is exclusionary, in the public it is segregationist and subordinating' (Walby 1990:24).

Feminists use the word patriarchy both as a term and a concept; as a term, its use is to define the power relations between women and men. As a concept, feminists use it as a tool to assist in understanding women's experiences (Walby, 1990). Thus, in this chapter of the literature review, the word patriarchy is used as a term to describe the motives of the continuation of FGM in societies that practice it. In chapter six, the word patriarchy is used as a concept to describe the experiences of women from a feminist perspective. Different scholars have defined patriarchy differently; a feminist psychologist defines patriarchy as "kinship systems in which men exchange women" (Mitchell 1971:24). The definition by Walby (1990) states "patriarchy is a system of social structures and practices in which men dominate, oppress and exploit women" (1990:20). Considering the motives behind the persistence of FGM in the studies reviewed, the latter definition is relevant as Walby (1990) sees patriarchy as a system that creates an environment for understanding and rejecting the notion of biological determinism which perceives the biological difference between men and women as natural. Hence, it suggests that they should be assigned different roles, with men taking the dominant positions and women the subordinate ones.

In its wider picture, patriarchy can be defined as the institutionalization and demonstration of male supremacy over members of the family and the control over women generally (Essien et al., 2012). It follows that men have control over all the vital bodies of society and women lack that control. Nevertheless, Lerner (1989) asserts that “it does not entail that women are either absolutely powerless or completely disadvantaged of rights, influence and resources” (1989:239). As patriarchy promotes the systems of the institutions of male supremacy, its definition can be extended to cover “a set of social relations between men and women, which have a material base, and which, through hierarchy, establish or create independence and solidarity among men that enable them to dominate women” (Jagger et al., 1984:56).

Feminists accuse the patriarchal ideology for overstating the biological dissimilarities between women and men, that allow men to play the masculine roles that are perceived as dominant, while women always acquire feminine ones that are viewed as subordinate (Essien et al., 2012). Patriarchal system as an influential ideology is self-empowered and has succeeded to secure the consensus of the women it oppresses. Men have succeeded in their ideology by employing the institutions of the family, education, and the church; all of which rationalize and underpin men’s domination over women (Frenkel, 2008). Sultana (2011) summarizes well that patriarchy is a “system of social structures and practices that is characterized by power, dominance, hierarchy, and competition in which men dominate, oppress and exploit women.” (2011:3).

The analysis of ‘women’s subordination’ as a term can help to describe well the dominance of men over women. Patriarchal ideology suggests that women’s dependence and subordination to men in all areas of life is inevitable as it has allowed the authority and power at all levels of the family, society and the state to be dictated by men (Mahtab, 2007). Cobuild (2010) defines subordination as “something else is less important than the other thing” (2010:1559); it is about “having less power or authority than somebody else in a group or an organization” (Hornby, 2003:1296). When subordination applies to women, it entails a position of women that is inferior to men, inability of women to make decisions and their inaccessibility to material resources. It also means a

combination of restricted self-esteem, self-confidence and the feeling of discrimination and powerlessness of women (Mahtab, 2007). In the subordination of women there is a power relation in which men dominate women, which is central in all societal organization of interpersonal domination.
A few current theories expound the perspective of women's subordination; for example, Simone de Beauvoir (1997) describes that men perceived women as "The Second Sex" and therefore subordinate because they are essentially different from themselves (Beauvoir, 1997). In her theory of subordination, Millet (1977) contends that women depended on men as a sex class under the domination of patriarchal systems. Patriarchy, therefore is a system in which women are dominated in various ways which may take various forms such as oppression, violence, discrimination, exploitation, disregard, control and insult at different levels in society (Mahtab, 2007). For example, there are wife-battering, which illustrates a specific form of violence to women; lack of reproductive rights and opportunities for girls to attain education; control over women's sexuality and fertility; and sexual harassment at the workplace (Essien et al., 2012).

As described earlier, in their effort to safeguard their ideology, men in African and Middle East societies use the platform of families, religions, schools, laws and media to advance their dominant position over women (Mahtab, 2007). To express gender relationship, they technically prefer the expression of women "subordination" rather than "oppression" as the former has noticeable advantages. Subordination hides the evil intents of the oppressor; it provides room for the informal agreement between the dominant (men) and the inferior (women) (Sultana, 2011). It negotiates with women who are the subordinate the intentional acceptance of an inferior position at the expense of gaining incentives, privilege and protection; a context that paints the wide picture of the experience of women in societies that perform FGM. It is a form of paternalistic dominance in which subordination incorporates other form of relations apart from paternalistic dominance (Asiyanbola, 2005). This form of subordination is preferred because it is "neutral to the causes of subordination, which has extra advantage over oppression" (Lerner 1989:234-235).

In order to maintain their dominance of men over women, patriarchy has established some traditions, social roles and social customs by the process of socialization (Manabe, 2010). In addition, it has created masculine and feminine characteristics which are in both private and public territories. The process of socialization takes place during childhood when gender roles are prescribed, and boys and girls learn and acquire certain behaviours. The process of initiation rites where girls and boys are pronounced adults is attached with training which prepares boys to think, behave, desire and conduct themselves differently because from a tender age they have been brought up to think of femininity and masculinity by means that cultivate the difference (Manabe, 2010). All the channels of the socialization process which the hallmark of a patriarchal system is, include the systems of education, the family, religion, politics and economics (Asiyanbola, 2005). These forms of socialization constitute a social structure, which denotes criticism of both biological determinism, and the view that men occupy a leading position and women are subordinates.

In its effort to maintain supremacy, patriarchy in Africa, the Middle East and in societies that embrace FGM may use various kinds of violence to control and subdue women. Avoiding working under the umbrella of oppression, at the same time hiding under the cover of subordination, men's violence has been considered to be legitimate (Asiyanbola, 2005). For example, considering the motives of FGM, be they social-cultural, psycho-sexual, spiritual or religious, women have been subjected to FGM regardless of the complications they experience. In many societies, male violence is practically ignored and legitimated by the hesitation of the state organs to get involved except in very extraordinary contexts (Essien et al., 2012). As a result of such violence – FGM, wife-beating, sexual abuse including rape- women have demonstrated a sense of insecurity that has exploited them politically and socially and economically kept them bound to the home (Mackie, 1996). Because FGM is performed under patriarchal influence, the next section presents and discusses the feminist theory which has guided this study.

2.11 Feminist Theory

The articles reviewed have highlighted that both the motives for, and the consequences of, FGM suggest that patriarchy is central. Women are circumcised because behind underpinning it is a male influence which has been translated as tradition, norms and culture (Manabe, 2010). Patriarchy is also a tool that subjects women to FGM, which is accompanied with various complications. The complications of FGM have been trivialized by the patriarchal system and have been given descriptions such as having the functions of witchcraft, evil eye and the wrath of spirits, gods and ancestors (Schultz et al., 2014).

Since the focus of this study is to explore the experience of Wagogo women who have undergone FGM and to understand the knowledge, attitudes and practice of circumcisers in Dodoma, Tanzania; and given that the reviewed articles have shed light on the motives for, and the persistence and the complications of FGM, showing how they are related to the patriarchal system, this study will employ feminist theory as a guiding perspective. The next sub-sections address the development of feminist theory, its ecology and definition, setting a stage for discussing the debate and critique of it. This discussion is followed by an overview of the problems or challenges of employing a Western theory into an African culture. The final sub-section discusses the rationale for employing this theory despite the challenges.

2.11.1 Definition, Ecology and Development of Feminist Theory

Feminist theory has been defined differently by various feminists regardless of whether the perspective was defined in the first, second or contemporary wave. Stacey (1997) describes how feminist theory was viewed differently at different times. For example, in the early 1980s feminist theory was perceived as a “series of competing explanations of women’s oppression” (1997:54). The emphasis was to rework the theory to describe how inequality can be challenged. The aim was to challenge and change patriarchal relations in all areas of cultural, economic and social aspects. By the late 1990s, there had been proliferations of theoretical perspectives trying to describe feminist theory within diverse backgrounds and contexts. Jackson et al. (1998) define feminist

theory as one that “seeks to analyze the conditions which shape women’s lives and explore cultural understandings of what it means to be a woman” (1998:1). The three definitions have one thing in common: feminists criticize and question the notion that the imbalances between men and women are acceptable and unavoidable and emphasize that they ought to be opposed.

Feminist theory has its roots in the term feminism which refers to women’s right to have equal rights with men in social, economic and political contexts (Oyekan, 2014). Historically, feminism is divided into three “Waves”; the first wave goes back to the nineteenth century and early twentieth century where there was feminist activity in the United States and the United Kingdom. The second wave of feminism was a continuation of the first wave and came into existence in the period between the 1960s and the 1980s and was concerned with efforts to end discrimination against women (Oyekan, 2014). The third wave of feminism took place in the early 1990s, mainly to correct the weaknesses of the previous wave which was perceived to be a failure; hence it emerged as a reaction against ideas invented by the second wave (Freedman, 2003).

As a result of these three waves, several ideologies emerged that are associated with the feminist movement; for example, socialist feminism, which seeks to free women from the Marxist viewpoint of oppression, labour and exploitation (Cudd, 2006). The central emphasis of Liberal feminism is the equality of men and women in the contexts of legal and political reforms. It fights for individualistic freedom of women through making their own choices and actions on the same terms as men particularly in issues regarding sexual harassment, abortion and reproduction rights, and domestic violence against women (Hooks, 1984). Cultural feminism appreciates the fundamental personality difference between men and women; it admires that women’s differences are not only special and superior but also should be celebrated (Hines, 2008). It also advances the relationship between genders and cultures by celebrating women’s unique qualities and experiences. Cultural feminism acknowledges biological difference between men and women such as menstruation and child birth but maintains that the difference should not be

used to oppress women instead the difference should be acknowledged as unique (Abbott, 1997).

Whilst radical feminism locates itself as confronting the patriarchal system; it perceives the nuclear family as a key site of women's oppression. It partially shares the ideological stance of liberal feminism in the sense that it also questions inequalities in sexual, violence and rape, domestic violence, sexual harassment and pornography (Maynard, 1997).

2.11.2 Debates and Critique of Feminist Theory

The emergence of three different waves and various feminist ideologies which at times seem to oppose each other suggests that none of the waves or the ideologies so far developed has been successful in supporting and holding the interests of all women at any given time (Cudd, 2006). While all feminist waves and ideologies seem to view men as dominating women in political, social and economic areas, some ideologies in the pursuit of liberating women, have acted in a way that some women felt left out in the struggle to reach equality (Frenkel, 2008). Women world-wide are not homogenous, their location within the global, regional and local social settings make it hard for one ideology to cater for all their interests (Oyekan, 2014). Globally, women are different based on their sexuality, ethnicity, employment, nationality, language and education (Cudd, 2006). The differences which are mainly hierarchical have created classes among women themselves which intersect with inequality in gender. While women celebrate their commonalities among them, these differences cannot be ignored.

The same can be said about the issue of thinking alike; women do not think alike (Frenkel, 2008). Although different feminist ideologies have things in common and share some concerns, they certainly do not trigger women to think in similar manners about these shared assumptions. There is no single group of feminists that share the same perspectives (Jackson et al., 1998). Consider for example, academic feminism, it is "diverse reflecting differing political affiliations, theoretical traditions and disciplinary backgrounds which feminists bring to their theorizing" (Jackson et al., 1998:2). Moreover, black feminists have shown themselves hesitant to accept and join the feminist

movement from the West as they perceive the theory as having been developed by “hegemonic” feminists from hegemonic Western culture (Nnemeka, 2012). Writing from a black feminist perspective Hooks (2000) challenges white feminists for acting as liberators of black women as if black women were not aware of male-driven oppression of women in their societies. She argues that black women have consistently developed strategies of resistance although their efforts may not be organized or sustained. However, Hooks (2000) seems to challenge white feminism as if black feminism is homogeneous; there are diverse philosophical stances within black feminism. In accordance with Nnaemeka’s (2004) thinking, African feminism does not share the same ideology with black feminism of the West as some of them (Walker, 1983; Hudson – Weems, 1993) seemed to embrace lesbianism which is considered as an abomination and intolerable for the African women and the African culture. Nevertheless, within African feminism there emerge various perspectives, for example, Lockhat (2004) distinguishes within African feminists those who support female circumcision as a traditional ritual, against others who perceive it as violation of women’s rights.

What is clear from this debate is that feminist theory is not static, it is growing and evolving and at times it has changed or taken different course, form and direction. Nevertheless, it has remained the voice for women’s liberation from different forms of subordination (Maynard, 1995).

2.11.3 Feminist Theory: Its Application on African Culture

The application of the Western theory such as feminist theory to the African culture may be problematic for several reasons. First, considering feminism in the West is in post-patriarchal era (Hoffman, 2001) and the focus may not be on the same issues as feminism in Africa; the theory may be misinterpreted by feminists in Africa who are still struggling with patriarchy. Secondly, considering the difference of sexuality, ethnicity, education and culture (Frenkel, 2008) between the West and Africa, the applicability of the theory may be incompatible to the African context as the theory may not speak for the interests of African women.

Third, while some form of the Western feminism is fighting not only patriarchy but also heterosexual lifestyle (Zalewski, 2000), the African feminism embraces patriarchy as means of survival and considers heterosexual as the only acceptable means of matrimony (Ezeigbo, 2013). This standpoint is not only supported by the African culture but also by all great religions in the region (Essien et al., 2012). Finally, Western feminist tends to antagonize men, while African feminism advocates for 'feminism of negotiation' (Nnaemeka, 2004). It is a feminism that is built in the 'foundation of negotiating with men and shared values that involves take and give, compromise and balance' (2004:2).

As the Western and African feminisms do not share the same values and belief (Ezeigbo, 2013); and the two locations are at differing stages of development politically, economically and socially, this could be a prime reason for not adopting a western theory on African culture. However, evidence from the literature indicate that there is no single feminist perspective that has been universally accepted worldwide by all women let alone in the West (Asiyanbola, 2005). The sub-section below offers a rationale for the use of Western theory into an African culture despite the critiques and controversies raised above.

2.11.4 Rationale for Using Feminist Theory

All forms of feminist ideologies discussed above seem to view the concept of power as central. There are three key principles of power (Cudd, 2006). First, power is conceptualized as a resource to be redistributed equally among men and women. The practice of FGM is a result of unequal and unjust distribution of power between men and women. Consequently, women have been subordinated to accept the norms that oppress them (Asiyanbola, 2005). The use of this theory therefore, would be to redistribute power as a resource more equitably. Secondly, power is perceived by feminism as a relation of domination. Feminists have frequently used various names to describe this form of relation such as subjection, oppression and patriarchy; this kind of power is illegitimate and unjust (Sundaram et al., 2014). Finally, a significant number of feminists are viewing power from men, as power-over, control or domination. However, recently feminists have understood power as empowerment (Frenkel, 2008). Hence, they prefer the use of capacity or ability

that could transform or empower women. This study takes all three forms of power; power as resources, subordination and a form of empowering Wagogo women to speak freely and openly about their experiences of being circumcised.

The applicability of feminist theory in this study is therefore located in three areas. First, the theory examines the power relations/differentials between men and women in relation to FGM paying attention to violence of women and control of women's sexuality. For instance, in polygamous societies, FGM is used to diminish female sexual desire for fear that the husband will not be able to satisfy sexually all his wives (Oyekan, 2014). Secondly, feminist theory sets a framework to understand women's oppression as the procedure is done without women's consent (WHO, 2008). In addition, the theory examines how the oppression of women has changed/evolved over time and how FGM is related to other forms of oppression such as unequal opportunities for education, health and access to economic gateways. Finally, the theory illuminates the means to overcome this form of oppression, as the rationale of feminist theory is to "view the world from an alternative perspective that places woman at a centre" (Hines, 2008:54). This perspective is persuasive in examining the experience of the oppressed, voiceless and subordinated women who have undergone FGM (Parmar et al., 1999). Feminist theory aspires to transform women's experiences of FGM into questioning the procedure and the culture behind it; and to encourage women's participation in the construction of a world without FGM (Smith, 1991).

While various feminist perspectives appear to differ in their approach and at times they have changed or taken different course, form and direction they have one theme in common, they merge together in their struggle towards women's liberation, gender equality and the advancement of women. Working independently or in solidarity, they have remained the voice for women's liberation from different forms of subordination (Maynard, 1995). Hence, regardless of controversies and debates, feminist theory remains the most relevant theory for the current study because of its principles which are geared towards understanding women's subordination and marginalization in social-cultural contexts (Nayak et al., 2009).

2.12 Problem Statement

The significant limitations of the studies reviewed here was that they were conducted to obtain information about women, not for women. Hence, information such as the complications of FGM has been used to scare and discourage uncircumcised women from the procedure. Knowledge about women regarding FGM has been criticised as being masculine-driven and when used by campaigners against the practice of FGM, has sounded exploitative and subordinating for the circumcised women. As the knowledge production was not women-friendly and was not produced with the motive of creating social justice and social change, the language used to report such findings has been dehumanizing as if women were determined and insisted on having the procedure done to them.

Secondly, building on the above point, none of the 51 included studies employed a feminist approach. Hence, the studies were detached from lenses that view circumcised women as vulnerable persons (Dickson-Swift, 2007). Their approaches did not bear a feminist sensibility that regards women as having secondary status in patriarchal societies. Third, in chapter one several new developments related to FGM were discussed. These new developments include global and regional conventions and declarations, and the accompanying articles against FGM: most of the FGM-practising countries have endorsed and adopted these conventions. Almost all member States of the UN have legislation in place to stop FGM and have developed action plans to that effect. In many countries FGM is illegal and a criminal offence. While individual countries are using the legislation and research findings to discourage the practice of FGM; little is known about the experiences of the circumcised women in an era when activities related to FGM have gone underground, which include social support for circumcised women. There is no single study that has explored the experiences of women who have undergone FGM in the era of the new developments related to FGM.

This thesis, therefore, aims at bridging that information gap by obtaining the first-hand experiences of circumcised women in Dodoma, Tanzania.

2.13 Study Objective

The objective of this study is to gain a better understanding on the experiences of Wagogo women who have undergone FGM and explore the knowledge, attitudes and practices of former circumcisers in Dodoma region, Tanzania from their own perspective.

2.14 Research Questions

1. What are the experiences of Wagogo women who have undergone FGM in Dodoma, Tanzania from their own perspective?
2. What is the circumcisers' knowledge, attitudes and practices regarding FGM in Wagogo tribe in Dodoma, Tanzania from their own perspective?

CHAPTER THREE- METHODOLOGY

3.1 Introduction

Chapter Two highlighted the knowledge gap and the objective of the current study based on the available literature. In this chapter and its sections I provide the paradigm stance of this thesis, I also state my methodological choice and explain my rationale and the philosophical assumptions that underlie this study. Finally, I present the methods, which are the techniques and procedures employed to gather data and the approach used to analyse it to address the research questions.

To reiterate, this study seeks to explore the experiences of Wagogo women who have undergone FGM; and the knowledge, attitudes and practice of former circumcisers in the Wagogo tribe. This chapter, therefore, focuses on how the research questions that are driven by feminist perspective can be answered and achieve the goal of the study through an exploratory qualitative approach, which is most suitable for feminist research as it is more appropriate for bringing the experiences of women to light and comprehending them. In every choice or decision made regarding the study paradigm, methodology and methods I provide a rationale of how such a decision is linked to the wide picture of addressing the central research question.

3.2 The Paradigm Stance, Methodological Choice and Methods

When generating new knowledge, scholarship employs research paradigms to inform the study whether it is natural, social or human sciences (McGregor et al., 2010). A paradigm is defined as a “set of assumptions, concepts, values and practices that constitutes a way of viewing reality of the community that shares them, particularly in an intellectual discipline like health studies”, (McGregor et al., 2010:419). A paradigm is accompanied with associated methodology which is defined as philosophical assumptions about knowledge, values, reality and logic that inform research (Ponterotto, 2005). Methodology in turn informs the methods and techniques employed to conduct research within a paradigm (Lincoln et al., 2000).

It is crucial to be mindful of which paradigm and consequent methodology is being applied when conducting and evaluating research as it provides an account for the philosophical underpinnings of and enhancing the integrity of the study. I have opted to describe the philosophical stance of this study using the terms paradigm, methodology and methods because as McGregor et al. (2010) argue, the rigour of health studies depends on the ability of researchers to address profound subjects about the integrity of their work. McGregor et al. (2010) use the term paradigm to denote two overarching world views influencing research; these are positivism and post-positivism. The term incorporates two dimensions, first, a philosophical, basic belief and assumptions about the world; secondly, the methods and techniques embraced when conducting a study. McGregor and his colleague also use the term methodology to denote how logic, reality, values and what counts as knowledge inform the study. Methodology denotes empirical, interpretive and critical, while the term methods which are characterised as either quantitative or qualitative denote approaches to generating and analysing data and presenting results. In the sections below, I discuss the choice I have made and its rationale.

3.2.1 Paradigm Stance: Post-Positivism

It is beyond the scope of this thesis to bring on board the debate on the over-arching paradigms of positivism and post-positivism. It suffices to mention that the two paradigms can be differentiated by their theoretical underpinning and principles that inform the methods (McGregor et al., 2010). Positivistic research paradigm assumes that the only way people can be confident that the knowledge is true is when it was created using the scientific approaches; thus, it encompasses the empirical methodology where the central tenet consists of testing a proposed hypothesis through experiments and observation (Rohmann, 1999). Post-positivistic research paradigm on the other hand, contradicts positivism and encompasses interpretive and critical methodologies (Kim 2003; Alaranta 2006). The term post-positivism research paradigm originated in the mid-1960s and acknowledges that there are several means of knowing besides the scientific method. Instead of testing hypotheses, the

philosophical stance generates hypotheses by the method of induction reasoning (McGregor et al., 2010). The researchers in this paradigm strive to understand (interpret) why individuals behave in the way that they do; or identify power relationships and social structures.

In the current study I have opted for a post-positivism or non-positivism paradigm for several reasons. The paradigm assumes that research is value-laden and subjective (McGregor et al., 2010), and it provides the voice and role for the participants and researchers in the study. People are central to the research process rather than isolated from it. Hence, in the current study the participants were not isolated, studied nor controlled: rather they formed the basis of the study, activating and benefiting from the study. As the paradigm demands that the research should be carried out in the communities rather than in experimental settings, I approached my participants in their natural setting.

Thus, the intent of the research was to explore the experiences of, and knowledge of circumcised women and former circumcisers respectively by seeking commonality among the participants of the understanding and belief about FGM in Wagogo tribe. To accomplish this, I recruited a small group so that I could fulfil the intent of searching for meanings and power relations in Wagogo cultural and social contexts. Considering this scenario, my role as a researcher and that of the participants cannot remain neutral as described in the sections below.

3.2.2 Methodological Choice: Constructivism - Interpretivism

A paradigm for the study cannot be divorced from a methodological choice. As discussed earlier, the post-positivistic paradigm encompasses interpretive and critical methodologies (Kim, 2003). Considering methodology in any research invites four key principles or axioms that address the philosophical underpinnings of the research (McGregor et al., 2010). First, the epistemology, the one that signifies knowledge and how people know it; secondly, the ontology, that counts as reality, existence or nature; third, a rigour in the development of insights, logic and arguments; and finally, what signifies as essential values and moral choices and ethics. To amplify these four key

principles above, as a researcher I considered a number of things. First, whether knowledge can be identified or discovered somewhere waiting to be picked, created by a section of people within their cultures, or possibly be established in power and social traditions such as FGM. As regarding ontological stance of a study, I considered whether it is detached from people's awareness, a sum of individual and collective awareness, or whether people are currently experiencing it now. I also considered whether individuals are governed by their environment or they create the nature of reality (their environment). In addition, I reflected whether rationality is perceived true for arriving at conclusions, insights and opinions of people; and identify the axioms or processes that direct individuals' thinking so they can meet the demands of reasoning precisely eloquently and critically. And finally, I considered my role as a researcher and that of my participants in the study: whether their feelings, hopes and expectations will be met by the study or remain socially and emotionally disconnected.

Consideration of the four key axioms or principles influences the choice of methodology, as an axiom is considered a claim that needs no proof. It forms a point of departure for allowing researchers to deduce and infer truths about the study. Following the above discussion, I have adopted in the current study the methodological and epistemological position of interpretivism which is predominately combined with a constructivist ontological stance (Bryman, 2008). This theoretical perspective assumes that truth is created, there is more than one truth, and knowledge is socially constructed by individuals (Ponterotto, 2005). This philosophical stance is well-founded for this study as it acknowledges that knowledge in one cultural setting may not be accepted in another setting. Thus, knowledge that prompts Wagogo to circumcise women may not be valid in another tribe in Tanzania. This interpretive perspective also takes into consideration gender, social and cultural power and influences on knowledge. For example, in societies that perform FGM men have a great say on what are the norms of their societies. Hence in chapter two, men were perceived as the main actors behind the persistence of FGM practice and women were expected to adhere to norms prescribed mainly by men. Consequently, a theme of patriarchy was identified from the reviewed literature,

which signifies that the motives and maintenance of FGM were patriarchy-driven. Following this logic, the epistemological stance of this study is based on how the claim of knowledge from men's points of view is interpreted as opposed to women's views regarding FGM. Categorically, the adoption of the interpretive approach examines the experience of women who have undergone FGM and the attitudes and practice of former circumcisers, which allows us to gain in-depth understanding of the power relations between the male-dominating system and the female oppressed mind set (Hesse-Biber et al., 2006). Such a consideration is important as it helps to think beyond what is taken for granted: that FGM is a normal cherished tradition.

Denzin (2003) perceives the methodological perspective of constructivist-interpretivist as a symbolic interactionism that defines people's responses to things and other people. It helps to consider social interactions and the constructed meaning of things and people thoughtfully. It also considers that reality is socially constructed through the experiences of people as human nature depends mainly on how people see themselves. In this respect, this theoretical perspective will help to examine the relationship and interactions of the former circumcisers and the circumcised women on the one hand, men and former circumcisers on the other; but also, between men (husbands) and women (wives) in general.

3.2.3 Methods: Qualitative Approach

To reiterate, in this study I have employed a post-positivistic paradigm which encompasses the methodological stance of interpretivism, which in turn informs the methods. The evidence from the literature review in chapter two and the nature of the research questions suggest that there is a dearth of information about the experience of women who have undergone FGM, on the one hand; and the knowledge attitude and practice of circumcisers towards FGM. Hence these research questions require a qualitative approach. A qualitative approach is appropriate when the subject is poorly documented (Willig, 2008). When applied to the current study, a qualitative approach is suitable in revealing meanings, perception, experiences, behaviour and thoughts not only of circumcised women; but also, of the circumcisers and of the society in general

that surrounds the circumcised women. As FGM is associated with sexual and reproductive health related issues, qualitative approach is a proper strategy for probing such matters, which may be difficult to explore using an alternative approach. As stated by Holt et al. (2003) studies on women's health are best achieved through qualitative ways of knowing. A qualitative approach is appropriate for examining women's social reality, which helps in obtaining natural recounting of rich and illuminating understanding of the views and experiences of women under study.

The qualitative approach in the current study employs appropriate methodological and epistemological theories to explore Wagogo women's experience, meaning and understanding of their lives and social context (Flick, 2006). It captures the social phenomenon from the perspective of the former circumcisers being studied as it enables me as a researcher to see through the eyes of Wagogo under study (Ponterotto, 2005). As my methodological standpoint I have employed the constructivist-interpretivist perspective which works well with the qualitative approach as the goal of both is to interpret the social world from the perspectives of Wagogo under study who are the social actors in that social world (Ponterotto, 2005). It follows that the interaction between the researcher and the research subjects is actively acknowledged as they are collaborators in the research process (Holloway et al., 2002).

3.2.4 Study Design: Exploratory Qualitative Study

The choice of research design requires theoretical and practical considerations including the skill of the researcher, the availability of resources, including time to conduct the study, the type of data required and the choice of sampling technique. The philosophical positions cannot be detached from the consideration of a study strategy. The philosophical stance of the current study not only fed into the means of formulating research questions but also supported the choice of a study design. In the current study, I employed an exploratory qualitative approach (Stebbins, 2001).

Exploratory qualitative study attends to the subject of gender and its relationship to 'truth claims' and competing knowledge which is relevant for circumcised women. Under multifaceted settings of women's patriarchal and

social oppression, an exploratory qualitative study in feminist perspective that merges knowledge claims with women's experience allows negotiation for the potential creation of knowledge for the well-being of women (Ramazanoglu et al., 2000). In this way, an exploratory qualitative approach in a feminist context creates a space for a new knowledge that is likely to empower circumcised women to find new meaning in their lives (Sen, 1999).

The verb 'explore' is synonymous with the terms investigate, examine, study, or analyse (Stebbins, 2001). To gain understanding of exploratory research, Stebbins (2001) offers four descriptions of the design. First, exploration is more generally perceived as investigative in nature. Second, it is about being accustomed to a particular phenomenon by testing it; the key term here is 'innovative exploration' where the goal is to achieve an intended effect by gaining familiarity with characteristics of that phenomenon. Innovative exploration is mainly attached to artists, innovators and inventors. The third description relates to travelling through space to discover something or simply visit a place for adventure; exploration for discovery. The final description of exploration is to examine systematically an idea or a phenomenon for a diagnostic purpose. In this case, the explorers are aware of what they are searching for; this description befits limited exploration. In this type of exploration, the explorer is familiar with the expected outcome; hence, innovation and discovery become secondary aims (Stebbins, 2001).

This study has adopted a combination of the first concept of exploration (investigative exploration) and the fourth one – the diagnostic exploration (limited exploration). The nature of the current research questions requires a researcher to approach the study with an investigative mind-set aiming to diagnose or find out an ostensibly known phenomenon such as the experiences of women who have undergone FGM specifically during the era where several developments have been made regarding FGM worldwide. As FGM is associated with sex and sex organs; and given that the subject of sex is sensitive, secretive and obscured with fear and anxiety particularly in Africa, the best means to assist women to talk freely is to apply an investigative exploratory/diagnostic approach which is governed by two key orientations.

These are flexibility in looking for data and open-mindedness about where to obtain such data (Stebbins, 2001). It follows that even where the women have willingly consented to be interviewed, given the nature of information required of them which is intimate and secretive; circumcised women need a probing, persuasive but friendly approach that can motivate them to share their stories.

The critical strategy here is to avoid being rigid in asking questions that are perceived to be sensitive; where participants are hesitant to answer such questions, the same questions could be reframed to make it easier for the participants to answer. Thus, the use of these two orientations required a researcher to adopt Max Weber's model of acquiring an intimate, first-hand understanding (*Verstehen*) of human behaviour (Albrow, 1990). It calls for a researcher to search for this understanding by employing any ethical means that appear to generate data. Changing tactics of deducing data without causing harm to the participants is the hallmark of exploratory qualitative study.

The use of diagnostic exploration or limited type of exploration denotes that the goal of the study was known, which is to elicit the experiences of women who have been circumcised and explore the knowledge, attitudes and practice of former circumcisers. While the objectives denote that as a researcher, I knew what to look for in the data, such as their physical, marital and psycho-social experiences related to FGM, each participant's experience was unique, and each story builds up to the knowledge and voice of circumcised women. Hence, the strategy was supported by both practical and theoretical considerations.

There are several alternative study designs that could be employed to generate data; however, as Creswell (2007) states, the rigour and sophistication of a particular research project is enhanced by using a recognisable approach that can fully address the research question. It is worth discussing a few examples of alternative designs and why I rejected them. Taking narratives (Murray, 2003) as an example, this design could have been appropriate for the study if there were already evidence to suggest that circumcised women's voices had been ignored previously. Then, stories or narratives could serve as a reminder to conceptualize new ways of understanding the suffering and pain of circumcised women. This was not the case, as there is no evidence to show

that circumcised women in Tanzania have previously voiced out their concerns and been ignored. Instead there is evidence to show that cultural traditions of societies that perform FGM have prevented women from questioning the tradition (Msuya, 2002; Ali, et al., 2012; Pesambili, 2014). This disclosure cements the use of an exploratory qualitative approach as the efforts to encourage them to voice their concerns through narratives would be difficult given that the patriarchal system does not offer freedom of speech for women.

Another strategy which might have been an alternative is ethnography (Fetterman, 2010); this approach could have been appropriate if the objective of the study was to explore how cultural systems including patriarchy and polygamy in Wagogo society have used the procedure to oppress women. In addition, the study would have been appropriate if Wagogo were still performing the open mass initiation ceremonies including female circumcision. Then prolonged participant observation and interviews of the girls from their preparation, assembling, initiation rite to the circumcision and the post-circumcision celebrations would be the most appropriate design. The goal of this study does not favour the use of ethnography because FGM in Wagogo is no longer carried out openly as it used to be before the passage of the law against FGM; instead it has gone underground, which makes ethnography an inappropriate strategy. In addition, even where there was no law against FGM, resources such as time were not on my side to carry out ethnography. This fact strengthens the need to use an exploratory qualitative study as the procedure has gone underground which necessitates an investigative approach.

Finally, considering Interpretive Phenomenological Analysis (IPA) (Smith et al., 2009) as an alternative approach, its design demands that the group should be characteristically homogenous. Although the women in this study have one characteristic in common, that they are all circumcised, the sample included the former circumcisers and circumcised women which speaks against homogeneity of the group; also, their experiences vary. IPA is the best option when a homogenous group are willing to share their experiences. Circumcised women consenting to participate in the study is one thing, sharing information that is perceived as intimate, secretive and personal is another. It is only an

exploratory qualitative approach that probes bit by bit that can persuade a woman who perceives a researcher as a stranger to share such a hidden information. Due to the limitations inherent in other approaches, this study employed exploratory qualitative study.

3.2.5 Philosophical Stance in a Feminist Perspective

Considering the nature of this study which is about understanding the experience of women who have undergone FGM, the philosophical stance of this study which include the decision to employ the post positivistic paradigm, the methodological stance of constructivism - interpretivism and the qualitative methods cannot be divorced from the feminist perspective that guides this thesis. The perspective has constantly underlined the significance of social context, maintaining that a feminist approach should be contextual. As feminist theory emphasizes equality in power as a resource, challenges subordination and asserts the empowering of women who are disadvantaged, it justifies not only the philosophical stance of this study but also aspects of feminist epistemology of which the central idea views knowledge as situated in time and place, incomplete and embodied by cultural constructions (Kiztinger, 2004). Feminist epistemology discerns the patterns that dominate means of knowing which are oppressive and do not favour women: instead it aims at improving the condition of the oppressed women. It is important to consider whether the aspect of time and place have indeed influenced and altered the knowledge stance of key stakeholders regarding the practice of FGM and the experiences of circumcised women. For example, what is the position of knowledge of men in the era where there are new developments regarding FGM worldwide, including its outlawing. What would be the experience of circumcised women when men as the dominant part of a society have changed their knowledge stance about FGM?

3.2.6 Reflexivity and my Role as a Researcher

In chapter one, I narrated the story of my friend who motivated me to engage in this study: she was betrayed by her aunt and ended up in the hands of a circumciser. At the age of 36, almost 30 years later, the lady is still being tormented as if the incident happened recently. Her troubled mind, was not only

the beginning of the journey of my reflexivity, but also pushed me to find out if other women who have been circumcised are still suffering and struggling to come to terms with the experience. During my friend's story-telling, I learnt that the reasons for sharing her story with me were that she wanted to know how I was faring with the consequences of FGM, believing I was also circumcised. Moreover, she perceived me as a happy person and wondered how I had managed to come to terms with FGM experiences.

Reflexivity is a self-evaluation tool used by qualitative researchers throughout the entire research process. It involves the researcher's self-reflection to analyse both the self that the researcher brings into the research, and the self-created in the research (Reinharz, 1997). Etherington (2004) refers to reflexivity as 'the capacity of a researcher to acknowledge participants' own experiences and contexts which might inform the process of inquiry' (2004:31). It is a form of researchers' self-scrutiny and self-reference through acknowledging their own involvement in the research that is being conducted. The process 'encompasses continual evaluation of subjective responses, inter-subjective dynamics, and the research process itself' (Finlay, 2002:532). It is about the awareness of the relationship between research itself, the researcher and the participants.

As a woman from the Wagogo tribe, I was aware of the procedure, but I was not knowledgeable about the after-effects of the procedure: all I knew was that once it is done and healing of the wound is complete then that was the end of it. From my friend's story, I realized that the circumcision wound may heal but there is a potential psychological wound that may not heal. The blood loss from the procedure may stop, but the hearts would continue to haemorrhage with pain. I could feel anger in me and a forceful drive to do something about it. As my friend's story instilled in me the mind-set of an activist that I never intended. Being a woman, I found myself a fighter for the rights of other women. This partly explains why I picked feminist theory as the guiding perspective for my project. Finlay (2002) sees reflexivity as a process of examining the researcher's own personal experience and how that experience funnels down to the researcher's acknowledgment of the methodological process, used

based on the relationship between researcher and researched and how the research is co-constructed.

To reiterate, in the interpretivist-constructivist perspective the role of the researcher is to interpret the social world of the participants through their own lenses. Hence, the researcher's place, role and voice are vividly acknowledged; subsequently, the researcher cannot remain neutral. The usefulness of reflexivity in the process of conducting qualitative research is widely recognized by different scholars in social sciences and humanities disciplines (May, 2000; Finlay, 2002). Etherington (2004) argues that reflexivity is an essential element for good qualitative research since it increases self-consciousness and encourages the researcher to pay greater attention to reflection and bias. Before engaging with the study, I had to do a self-reflection and take stock of the bias that I might bring into the research since I had already been carried away by the story of my friend. To make sure I did not influence the direction of the study based on my experience of hearing a single story, I used reflexivity as a valuable tool to scrutinize the consequences of my existence, perspectives and position in the research process. The process of self-scrutiny in the research started as soon as I decided to engage in this project by acknowledging my sympathy to circumcised women based on the knowledge I had gained from my friend's experience but allowing data from the study to dictate and decide its direction. I was careful not to assume that all participants would share a similar story to the one given by my friend.

I made sure that any personal reflection and biases that I might bring into the study did not prevent the data from speaking by itself. Following that caution, I positioned myself as both an insider and outsider of the research (Kerstetter, 2012); as an insider, I belong to the Wagogo tribe and therefore I am aware of the norms of the tribe including the requirement for female circumcision. My insider identity assisted me to engage with all participants who accepted me as their fellow *Mgogo* woman (*Mgogo* for singular, plural: *Wagogo*), which made it easier for me to connect and engage with both former circumcisers and circumcised women; hence, I was well placed not only to recognize the experiences of participants, but also to access thick and rich data that might not have been accessed by an outsider. This is in line with Rosaldo (1993); in his

work on headhunting following bereavement of members of the Ilongot community, they identified him as an insider because at the time of the study he had similar experience of grief after the demise of his own wife.

As there are advantages of being an insider as explained above, there are also setbacks. Kanuha (2000) argues that a researcher may find it hard to separate her/his individual experience from those of participants; challenge issues related to potential bias in her/his research; and keep confidential issues related to the sensitive accounts provided by participants (Serrant-Green 2002). For me, I was careful to avoid these setbacks as I did not count myself completely an insider: instead there were other factors that identified me as an outsider. I was an outsider in the sense that I had not experienced the circumcision procedure. Hence, I was eager to learn from circumcised women about their individual experiences. The outsider school of thought gives credit to researchers who do not share the experiences of their participants, those who are neutral, and detached from the context under study (Kerstetter, 2012). Hence, they are preferred for their objectivity which facilitates the outsider to examine the experience of the participants through a lens other than that used by an insider (Kerstetter, 2012). The outsider school of thought challenges the position and effectiveness of an insider to analyse without bias the experiences in which they are part and parcel.

Despite the awareness I obtained from listening to my friend's story, which positioned me an insider, I also preferred to approach the study as an outsider to allow me to discover and consider new ideas, which may be similar or dissimilar to my friend's experience or somewhere in between the two. This mind-set helped me because even though I approached the study as a feminist, I could also criticize my fellow feminist activists and other front-liners in the fight against FGM for using the experiences of circumcised women as the basis of discouraging women from FGM, as will be discussed in the subsequent chapters.

As I reflect, I considered some insights regarding the concepts of insider/outsider. When I visited the participants to introduce myself and arrange

for logistics regarding the interviews, I presented myself as an insider, which as a strategy, helped me to gain acceptance; however, the more we talked on different issues, the more I realized that they perceived me as an outsider. There were some characteristics that demarcated me from them; my education level, my affiliation to the University of Dodoma, my status as a student studying in Europe; and the fact that I own a car even if it is a second-hand one, differentiated me from them. Hence, they did not perceive me as a simple Mgogo woman from a village visiting another Mgogo village woman. They maintained that I am a researcher from a higher social class than theirs. Arber (2006) argues that the boundary between insider and outsider schools of thought can create a tension for the researcher.

Thus, when I visited them for the interview, I had to maximize the insider identity, which had two characteristics; first, a woman interviewing a woman; second, a Mgogo talking to a fellow Mgogo woman. At the same time, I tried to minimize the outsider effects by using a bicycle as means of transport. In addition, I decided to put on ordinary shoes and dresses as worn by Wagogo women, I spoke more *'Kigogo'* (local dialect for Wagogo tribe) than Kiswahili, the national language; and I identified myself more with the village of my origin than as a lecturer from the University of Dodoma or a student from the University of Hull. I gained more confidence from participants for adopting this strategy that identified me as a member of the community under study. I felt authentically and morally accurate to adopt those strategies as truly I am a Mgogo woman and there was nothing like faking my status or undermining my participants. For example, the participants I visited could not hide their admiration to see me in the traditional outfits, carrying with me traditional foods. Consequently, Wagogo women treated me as one of them and were willing to share deep-seated information, which otherwise would have been uncomfortable for them to share with an 'outsider' researcher or a researcher from a different tribe.

My research identity and status as an insider/outsider coupled with my reflexivity, self-reflection and the biases I have contributed into the study have, to some extent, influenced the research process by the choice of theoretical

stance of the study, a sound connection between theory and practice (Watt, 2007), the approach of the study, choice of methods and the outcomes of the research. The audiences/readers have now the privilege of assessing my reflexivity and judging how it influenced the way the research was conducted, the process of knowledge construction, the analysis and interpretation of the data. This will enable open examination of the trustworthiness of the research and judge the credibility of the research findings, as validity of qualitative research is not only based on the methods used but also on the "moral integrity of the researcher as it is critical for evaluation of the quality of the scientific knowledge produced" (Kvale, 1996:241).

3.2.7 Area of the Study

The study was conducted in Dodoma region (see appendix eight map of Tanzania). The region has a geographical area of 41,311 square kilometres (15,950 square miles) comprising seven districts out of which four were involved in this study. The districts are Dodoma urban, Chamwino, Mpwapwa and Kongwa. The tribes in this region are Warangi, Wasandawe and Wagogo, which is the dominant tribe. Unlike other regions in Tanzania where FGM is performed by one or two ethnic groups in a region, in Dodoma region, all ethnic groups perform FGM (DHS, 2010). Dodoma is one of the ten regions in Tanzania that practise FGM, and it is the region in the country with the second highest prevalence of FGM, estimated at 64 to 68 per cent according to the Demographic Health Survey (DHS, 2010).

The rationale for carrying out this study in Dodoma region is three-fold. First, it was easy for me to gain access because I am a member of the Wagogo tribe as one of my parents belongs to it. Miller et al. (1997) urge that when a researcher is a member of a society to which the participants belong, it makes it easy to gain participants' trust, as they feel more relaxed to be open and share their intimate information knowing they are talking to an insider. Secondly, as a member of staff of the University of Dodoma, which is in Dodoma region, the university and its staff have a social responsibility to research on issues of interest to the society, the university and the nation. Hence, undertaking this project has the blessing and support of my university.

Recently, Corporate Social Responsibility (CSR) for Universities has seemingly been one among the preferred strategies for universities to obtain good reputation from the communities around them (Dahan, 2012). Third, with Dodoma region having the second highest prevalence of FGM in Tanzania, the region offers a unique importance particularly because Dodoma is the capital city.

The predominant type of FGM practiced in the region is type II in the World Health Organization categorization, which involves 'total excision of the clitoris and labia minora, with or without removal of labia majora' (WHO, 2013:4). The procedure is carried out on girls aged 10 to 15 years; however, a recent survey showed that the introduction of the law against FGM has sent the procedure underground. Thus, the procedure is currently done on infants who cannot testify before the court of law (DHS, 2010). The motive behind this traditional practice, among others, is to cure urinary tract disease for which Wagogo believe there is no cure except through circumcision (Waritay et al., 2010; Ali et. al., 2012).

3.2.8 Sample and Sampling of Study Participants

As the objective of the current study was to explore the experience of women who have undergone FGM and explore knowledge attitudes and practice of circumcisers with the aim of offering circumcised women an opportunity to voice their concerns and bring about change; this study recruited 25 women who have undergone FGM and three former circumcisers which made a total of 28 participants. Stebbin (2001) recommends that the sample size for qualitative - exploratory study should be between 25 and 30 participants, given that the nature of the study requires an investigative mind-set, with each participant expected to offer a unique story about her life experience. Hence, the decision on a small sample size focused more on obtaining high quality data. Dworkin (2012) asserts that the purpose of a qualitative sample is not about counting how many participants have the experience rather it is about gaining deeper understanding of the context to which the participants were exposed.

In drawing a sample, I paid attention to individuals who have knowledge about and have experienced the context under study (Creswell, 2007). The

circumcisers were knowledgeable about the history of FGM in Wagogo tribe, knew how to perform the procedure, and were part of the system that sustained it. The circumcised women, on the other hand had experienced the cut, they had a story to tell about their physical, sexual, obstetric and psychological experiences. Participants were recruited based on inclusion and exclusion criteria. The inclusion criteria for the women were: those who were circumcised; those originating from the Wagogo tribe; and those who were aged between 25 and 45 years. There are two reasons for selecting this age range. First, this range captured women in the child-bearing age who could provide their insights into physical, sexual, obstetric, and psychological experiences. Secondly, this range targeted women who had been circumcised before 1998, a period when there was no law against FGM in Tanzania. In 1998 Tanzania passed a law to prohibit FGM, since when FGM has been illegal. Hence, all women who were circumcised after 1998 were classified as having contravened the law and were likely to hide themselves as the procedure was done underground. The government, law enforcement officers and activists are actively looking for circumcised girls so that their parents and the circumcisers who were involved would be prosecuted. Consequently, it was practically difficult to recruit women who were circumcised after 1998.The exclusion criteria were; women below 25 and above 45; women without a child, women who were pregnant for the first time and women from other tribes.

As for the former circumcisers, their inclusion criteria were: they should be ex-circumcisers from the Wagogo tribe, who had performed the procedure independently without supervision and had experience of managing various complications of FGM: priority was given to those who combined practices as circumcisers, traditional healers and traditional birth attendants. The rationale of recruiting ex-circumcisers was that they were willing to discuss their experiences, something that would be difficult for continuing circumcisers as they operate underground and would appear to hide information or simply not cooperate. Therefore, active circumcisers were excluded. As for the inexperienced ones, the justification for excluding them is that they have performed few procedures and may not be knowledgeable about the

consequences of FGM; and for non-Wagogo circumcisers, they were left out because the study was limited to the Wagogo tribe.

Table 3.1 below shows the characteristics of participants in terms of age, marital status, number of children and age at which FGM was performed.

Table 3.1: Shows the characteristics of the participants

Women Who Have Undergone FGM				
Number assigned to a Participant	**Marital status**	**Age**	**No. of children**	**Age during circumcision**
Participant 1	Married	35	5	9
Participant 2	Married	32	4	10
Participant 3	Divorced	42	7	8
Participant 4	Married	36	6	9
Participant 5	Married	30	5	10
Participant 6	Single	25	3	2
Participant 7	Married	33	4	10
Participant 8	Widow	39	8	8
Participant 9	Married	40	9	15
Participant 10	Divorced	38	7	9
Participant 11	Married	31	5	9
Participant 12	Single	25	2	3
Participant 13	Married	37	6	10
Participant 14	Married	34	5	9
Participant 15	Married	30	3	9
Participant 16	Divorced	36	5	13
Participant 17	Married	39	6	8
Participant 18	Married	36	4	9

Participant 19	Divorced	39	5	10
Participant 20	Married	33	4	12
Participant 21	Single	26	3	2
Participant 22	Married	35	5	11
Participant 23	Married	38	5	10
Participant 24	Widow	40	6	9
Participant 25	Divorced	43	7	15
Former Circumcisers				
FC 1	Married	65	9	15
FC 2	Widow	68	10	12
FC3	Widow	71	12	13

3.4.4.1 Sampling Technique

This study employed purposive and snowballing sampling techniques, as the sample was drawn from the people who were likely to answer the central research question. In addition, identifying women who have undergone FGM was not easy; thus, the initial group of circumcised women were requested to invite future participants among their associates or contacts with similar exposure. The participants were recruited from two settings, a community-based setting and a hospital setting. The rationale for having these two settings was to provide a broad range for recruiting participants according to the size of the sample set for the current study. The samples from community and hospital-based settings were almost half and half (12 women from hospital-based settings and 13 women from community-based setting). The community-based sample was recruited through the Dodoma Inter-African Committee (DIAC), an International Non-Governmental Organization based in Tanzania whose primary objective is to enhance the quality of life and health of women and children by fighting against FGM practices, and abolish cultural/traditional practices that affect the health and basic human rights of women and children.

The hospital sample was recruited through the Dodoma Regional Hospital. The DIAC and the regional hospital were my gate-keepers for accessing the community- and hospital-based participants respectively. The hospital-based sample was purposively selected from women who attended antenatal clinics (ANC) at Dodoma Regional Hospital. Their circumcision status was identified and recorded in the ANC cards by a service provider who performed a first prenatal assessment during their first visit. The nurse in-charge of the ANC distributed information sheets to 20 pregnant women admitted to the ante-natal ward from which 12 women agreed to join the study.

In the community-based setting, both purposive and snowballing sampling techniques were used. The DIAC administrator introduced me to the DIAC village facilitators, who recruited women they knew were circumcised. Those circumcised women invited other women (contemporaries) who were circumcised in their respective cohorts. A total of 20 invitations to join the study were distributed among whom 13 accepted. As for the former circumcisers, I used a purposive technique with the assistance of DIAC village facilitators. Eight former circumcisers were invited to join the study; five accepted the call; however only three were accessible for an interview.

3.2.9 Gaining Access to Participants and Feminist Ethical Consideration

Ethics was a consideration that cut across the whole process of this study from the conception of the research topic to the writing of the thesis. Williamson (2007) argues that the researcher should provide the evidence in writing how s/he has addressed the rights of participants in the study as participants have their individual rights which should be observed. Participants' rights include, to be informed the purpose of the study, to withdraw anytime during the study, to be protected from harm by the study, and finally the rights for privacy, confidentially and anonymity (Williamson, 2007).

Permission to proceed for data collection was granted by The Research Ethics Committee of the Faculty of Health and Social Care in the University of Hull (see appendix one on page I). The approval letter from the Faculty Ethics Committee facilitated the University of Dodoma to issue ethical approval (see

appendix two on page II) for my project study on behalf of the National Medical Institute of Research (NIMR), the body responsible for issuing approval to all health-oriented research in Tanzania. Apart from ethical approval, the University of Dodoma issued an introduction letter (see appendix three on page III) to both gatekeepers, the DIAC authority and the Dodoma Regional Hospital. During the study, I was guided by four ethical principles as well as feminist values for carrying out research; these are: respect for privacy, informed consent, respect for anonymity and confidentiality, and beneficence (Fouka et al., 2011). These four ethical principles were well articulated in the application ethical forms to the ethical committee, and I ensured that I had taken into considerations the rights, safety, dignity and wellbeing of the participants in my study (Haigh, 2007).

Before the actual study I did a pilot interview to find out how easy or hard the women who have undergone FGM answered my questions. In addition, I wanted to test my interview guide and the sequence of questions. My decision to include the data obtained from a pilot study was made based on an ethic of feminist care. The impression of gathering accounts of women who have undergone FGM which are potentially traumatizing, and offered by individuals who are sharing their story for the first time to an outsider; and yet deciding not to offer a voice to their story in the thesis, appeared at best exploitative, and at worst, disrespectful for the individuals involved. My decision to embed their views within the current study was further compounded by the single story that my friend had voluntarily shared with me which partly formed the basis for conducting this research. How could such a deep-seated, troubling, rich and traumatic story that has been kept secret for such a long time just end up in simple conversation? As a remedy in recompense, I decided the first two participants, who had served as a pilot study and volunteered to share their stories, will be part of this thesis.

Regarding informed consent, I approached the gate-keepers, DIAC officials and Regional Hospital Nursing in-charge of Ante Natal Care. These gate-keepers communicated to all the potential participants about the study, that is women who were circumcised and met the criteria of the study and who were

obtained through the method described above. As I did not have the mandate over the selection of participants picked by the gate-keepers, I was obliged to accept them as they are; hence, there was selection bias, which I acknowledge as a limitation of this study. For those who outright declined to be included they were left out; those who showed some interest were given a participant information sheet (see appendix four) about the study for them to read, internalize and make informed decisions.

Through the gate-keepers I distributed information sheets to all potential participants for them to read and internalize. The information included the objective of the study and its significance and information about the audio-taping. The DIAC facilitator read the sheet for those who were illiterate. I allowed five to seven days for them to make an informed decision whether to join the study or not. I left my number for them to call back or text me in case they had questions or concerns about the study. Most of the participants texted me after a day or two to inform me they were willing to join the study. After seven days, I assumed those who had not called me were not interested in the study. Most Tanzanians, (85 per cent) own mobile phones (TCRA, 2012). Before the interview, I asked all potential participants to sign a consent form (see appendix five) to allow me to interview them and audio-tape the interview. I made it clear that signing the consent form was not binding, they were still free to withdraw from the study any time they wish, and no questions would be asked.

As for respect for anonymity and assurance of confidentiality I emphasized that their information would be treated with high confidentiality and their identity would be anonymous. I assured them that their personal responses will not in any way be linked to their identity. Confidentiality according to Fouka et al., (2011) means that participants are at liberty to offer and withhold as much information as they feel comfortable to share with the researcher. Due to the sensitive information that the participants shared with me, I made it clear to them that the interviews would be completely anonymous to protect the participants' confidentiality as well as their rights to withdraw from the study any time. Data storage procedures were observed.

With regard to respect for privacy, I reassured the participants that their private information, including attitudes, beliefs, records and opinions would not be shared without their consent. I also informed them that they have a right to decline to provide personal information in case they perceive it as an invasion of privacy. This includes their age, marital status and any information that they value as intimate. To make sure that I do not appear as an intruder, I asked them to allow me to visit them before the day of interview to build rapport, minimize power relations between them and me; and help them gain confidence. During the visit we agreed when, where, and how long the interview should take place. Fouka et al., (2011) posit that “privacy is the freedom an individual has to determine the time, extent, and general circumstances under which private information will be shared with or withheld from others” (2011:6).

Regarding beneficence, this was difficult to predict given the experience I had with my friend who volunteered to share her story but ended up shedding tears. This principle refers to the Hippocratic “be beneficial, do no harm”. The underlying principle was to re-assure the participants that my role would be as friendly and helpful as I could, but not so friendly as to spoil the good intention of the interview (Oakley 1981) as some participants might not take it seriously thinking it is simply a conversation. I also cautioned them that the interview might involve opening old wounds, which might cause psychological, emotional and social discomfort. I assured them of the services of a counsellor should the need arise. My role was to prevent and minimize intentional harm. As Beauchamp et al. (2001) advocate that “the principle of beneficence includes the professional mandate to do effective and significant research so as to do better serve and promote the welfare of our constituents” (2001:15).

3.2.10 Techniques of Data Generation

This section presents the methods for data generation. Guided by the theoretical stance of this study that holds the belief that knowledge is socially constructed, informed by the guiding feminist theory that seeks to empower oppressed women and bring change, and considering the approach and strategy of the study that pursues to explore the experience of circumcised

women, this study employed a semi-structured interview as its method of data generation.

3.2.10.1 The Semi Structured Interview

In this study, a semi-structured interview was used to collect data. Taylor (2000) defines interviews as “conversation with purpose aimed at exploring insider perspectives” (2000:39). Through interview, the researcher captures the experience of the participants from their own words as interview allows communication and interaction between researcher and participants to provide rich and meaningful data. Interviews are a conduit through which participants articulate their thoughts, ideas, opinions and even their concerns (Hesse-Biber et al., 2006). As this study is investigative in nature, employing a qualitative exploratory stance that aims at exploring feelings that are concealed, secretive and intimate, semi-structured interview was the appropriate method. The method is flexible for both the researcher and the participants, to phrase a question and the freedom to answer the question respectively (Creswell, 2007) as researchers may not follow the sequence of questions outlined on the schedule.

A key practical challenge for a feminist drawing in other women’s experiences rested on how I converted the semi-structured interviews from a normal talk to a focused, thorough and willing sharing of information (De Angelis, 2012). As a method to obtain a complex story on female circumcision, (Reinharz et al., 2003:229) endorsed the use of “strong listening skills”, in the interview context, as a practical means to access women’s stories. Depending heavily on open-ended questions (Edwards et al., 2013) which were the prime strategy in exploring and unpacking intimate issues relating to female circumcision, I started the interview by building rapport to create a friendly atmosphere for free expression of the research participants. Guided by a hierarchy of questioning (Edwards et al., 2013), where I began the interview by asking a few simple questions to put participants at ease then complex questions regarding the procedure itself, followed by the last ones, which were private and intimate questions concerning sexual and matrimonial relationships. Examples of these questions are:

- Can you explain to me about the way in which the initiation ritual was arranged and how you celebrated it?
- Can you shed light as to why Wagogo circumcise women?
- What was your thoughts and feelings before, and during the procedure?
- How would you describe your situation after the procedure/marriage/child birth?
- After the procedure can you tell me what made things better for you and your fellow girls?
- Can you share with me your sexual life after the procedure and your matrimonial relationship?

As a strategy of communication between the researcher and the participants, this approach of 'inviting and listening' to what participants articulate appeared to be revealing about how they defined themselves; what elements of experience were stigmatizing, victimising and exploitative for them; which opportunities and challenges including barriers both personal and structural were open to them; and why women react differently to female circumcision. Semi-structured interviews empower the participants to express themselves freely and decrease the power control of a researcher over the participants (Bryman 2008). The method enabled me to actively ask and probe, at the same time sit back and listen attentively to what was said (Hesse-Biber et al., 2006:119), simply providing a few prompts to motivate participants to talk.

3.2.10.2 Interviewing women

As reported earlier, all potential participants were given a copy of the information sheet, which among other things, informed them of the objective of the study and what was expected of their participation. Most of the community-based participants chose to be interviewed at their homes; it was interesting to note that most of the participants chose a time when their husbands were away. When I asked them whether they had informed their husbands about the study, a few admitted having informed their husbands although most did not inform them. During data collection, I only met three husbands. When introducing me, one of the participants informed her husband "these are the guests I told you about earlier, they are here to talk about women issues". The

husband simply shook my hand and replied, “you are welcome, I will leave you to discuss your things” and he left.

As for the hospital-based participants, they were happy to be interviewed at the hospital premises, especially in the hospital garden after they had been attended by the health care providers. As Green et al. (2009) pointed out, participants feel more empowered when they decide the location for the interview. The interview settings, as proposed by Creswell (2007), were quiet, friendly and free from distractions which may guarantee participants’ privacy. I developed two schedules of interviews, one for women who have undergone FGM and the other for the former circumcisers; refer appendices six and seven on page VIII and X respectively. The interview schedules were used flexibly to allow participants to narrate their story freely; I used some prompts for obtaining explanations or seeking clarifications on participant’s accounts. The questions were open-ended and expansive, those that encourage the participants to talk at length about their experience. The interview questions for the former circumcisers sought to identify their experiences as circumcisers, their attitudes, knowledge and practice of FGM; what sustained the practice and who was behind the persistence of the procedure in Wagogo tribe, while the questions directed to women who have undergone FGM were to capture their experiences of being circumcised and how they were capable of coping with the consequences of FGM. Prior to commencing the interview, I reminded the interviewees of the objective of the study and their time commitment as the interview lasted for approximately 45 to 60 minutes. The interviews were audio-taped; and each participant was interviewed once.

Interviewing women, particularly those who have been silenced by their own society, is a complex task. It requires understanding their worldview, their position in the community and the cultural restrictions they face as part of their lives (Reinharz, 2002). In this study, interviewing women whose freedom of speech was oppressed by their society created a new social order for them; hence, as a researcher, I encouraged them to talk without interruption, as their information was important for them as well as for this study. On the other hand, I considered the effect the interview might have on participants as women who

have been oppressed: Reinharz et al. (2002) warn researchers to be conscious and helpful, as women may fail to express themselves when given the opportunity due to the low self-esteem and inferiority complex that have been imposed on them by their society. The same is true when women feel distressed and anxious due to flashbacks of their experiences: the interviewer should be prepared to assist the participant by offering referral. Kvale (1996) asserts that during an interview, the researcher is ethically responsible for the safety of the participant: s/he should ensure that interview does not harm the participants.

As regards women who showed aspects of distress during interview, I was responsible for calming them down due to my background as a community psychologist, which put me in a better place to serve them. In addition, I assured them of a specialised counselling service should a need arise. There were five occasions when participants felt distressed; as a measure, with each one I stopped the interview, asked her how she was feeling and offered her a word of comfort, I would walk her to the nearest restaurant buy her a drink, change topic and discuss issues of interest to her. Once she recovered, I would offer her the chance to postpone the interview to another day, but on all occasions, they wanted to continue and finish the interview.

When asked how they felt, most of them were relieved that they had shed tears; they described shedding tears not as a sign of distress but as a gateway of unspoken mind, a release of concealed pain, a relief from congested emotional sufferings. They viewed themselves as courageous to have expressed their feelings. I could listen and hear the women's obscured voices that have never spoken before. As I encouraged them to share more, the deeper they poured out their intimate information. At the end of the interview, most women revealed that "we have shared things we have never shared with anyone before". I asked them whether they felt ashamed or guilty by sharing their information with me, their answer was no; instead they felt relief and empowered that they had aired their views.

3.2.11 Analysis of the Data: The Use of Manual Thematic Analysis and its Rationale

Analysis of the data is a process of analysing, organizing and making sense of the data, be it in text or image, to produce study findings (Creswell, 2007). It is a key part of the research process as data in its raw form cannot speak for itself (Ryan, 2006). Analysis is a continuing process as it is carried out concurrently while data is being generated, transcribed, interpreted and at the write-up stage. Ryan (2006) identified four motives of analysing data: first, analysis takes a researcher to think beyond the raw data; second, it demonstrates, with evidence, the position of knowledge as claimed by a researcher; third, analysis makes the familiar strange by unpacking what is taken for granted; and four, analysis sheds light on findings that address the central research questions (2006:93).

In this study, I analysed my data manually rather than computer-assisted qualitative data analysis (CAQDAS) for several reasons. First, for me to group the experiences of participants into clear conceptual patterns I needed to immerse myself in the data by allocating more time to it. Secondly, building intimacy with data helped me to create more codes to cover as much information about the participants as possible. Third, as this study has employed an interpretivist philosophical stance, to provide a fair interpretation of participants' accounts I analysed the data manually to develop close familiarity with it so that the interpretation did not distort the original meaning.

In this study, data were analysed by thematic analysis as described by Braun et al., (2006). There are several reasons for opting for this method; first, thematic analysis is suitable due to its flexibility in participating across several theoretical and epistemological frameworks (Braun et al., 2006). It therefore fits well with the constructivist interpretivist perspective which engages not only in describing participants' experiences regarding female circumcision, but also to examine the extent to which these experiences are interlinked with the understanding as well as making sense of broader socio-cultural ways of practising FGM. Secondly, the thematic analysis method suited the central research question, the theory that guides the study, the study design and the data derived

therefrom. As the study design sought to explore the experience of circumcised women and feminist theory emphasizes empowering women, thematic analysis was suited to reporting how the actions, experiences and social order are the result of discourses that are operating in society. That is the middle ground where thematic analysis, the key objective of exploratory qualitative study, and feminist theory converge (Braun et al., 2006). My task as a researcher was to employ women's insights by integrating their opinions and data sources to make a complete study.

3.2.11.1 Steps of Thematic Analysis

This study adopted the six-stage thematic analysis model proposed by Braun et al. (2006); Table 3:2 below shows the steps in doing thematic analysis.

Table 3.2: Steps of Thematic Analysis

No	Phase	Description
1	Familiarizing yourself with Data	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2	Generating Initial Codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3	Searching for Themes	Collating codes into potential themes, gathering all data relevant to each potential theme
4	Reviewing Themes	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5	Defining & Naming Themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6	Producing Report	The final opportunity for analysis. Selection of vivid, compelling extracts examples, final analysis of selected extracts, relating back of

		the analysis to the research question and literature, producing a scholarly report of the analysis.

Adopted from Braun et al., (2006:87)

Before considering the stages, it is imperative to define key terms used in this framework. Thematic analysis is a 'technique for identifying, analysing and reporting patterns or themes within the data set' (Braun et al., 2006:79). Codes are notes noted in the margin of a transcript; in this study, a code is in the form of a phrase. A code highlights a pattern within a set of data, but also indicates differences between one case and another; a code can also highlight relationships between cases. Hence, in a thematic analysis, a code is a central device in 'selecting, separating and sorting data (Charmaz, 2006:45). Braun et al. (2006) perceive thematic analysis technique as "a foundational method of qualitative analysis since it provides core skills that are useful for conducting many other forms of qualitative analysis" (2006:79), although many researchers hardly acknowledge it in their methodology.

The key advantage of using thematic analysis is its flexible nature in accommodating studies with, and without, a wide range of epistemological and theoretical perspectives. Hence, it is suitable for studies that originate from an epistemological stance as well as for studies that are not inherent in a particular epistemology. In thematic analysis, there are two ways themes can be identified, inductively or deductively. The difference between the two is that in the inductive method the themes are data-driven, meaning that the themes are identified direct from the data; while in the deductive method, themes are theoretically driven; meaning that the themes are influenced by the analytical and theoretical interest of the researcher. The current study applied an inductive approach whereby themes were identified from within the data. Braun et al. (2006) have meticulously expounded stage by stage all the important points and stages of analysis, which makes it easy for any researcher to apply, particularly for me as I did not have much previous experience of thematic analysis; consequently, Braun et al. (2006) have been cited often in this thesis. The six stages developed by Braun et al. (2006) illustrate a complete step-by-step process for analysing participants' transcripts.

3.2.11.1 a) Stage 1. Familiarizing with data

Familiarizing myself with the data commenced in the field when I was interviewing the participants: as participants were responding to my questions, subjects of interest began to emerge. Although questions altered from one participant to another depending on how free the participants felt to express themselves, eventually they all covered the essential themes. Hence the collection and analysis of data were iterative processes. However, deeper familiarisation was evident when I had begun to transcribe. The interviews were transcribed verbatim in Kiswahili, the national language, which was used in interviewing participants. Taping and transcription are central in thematic analysis as the process facilitates selection and reduction of data (Braun et al., 2006). During the course of transcription, I spent much time familiarising myself with the data, which drew the focus for analysis and I began generating codes as women shared their stories. In addition, I was certain that the transcripts retained the accurate information from both verbal and non-verbal accounts such as cough, long silent and laugh.

After transcription, an expert in both Kiswahili and English translated the transcriptions into English. As I am fluent in both Kiswahili and English, and to ensure the meaning was preserved, I listened to the tapes and compared them with the transcripts where more patterns and meanings started to make sense. Serious immersion into the raw data was realised when I read and re-read the transcripts to get the sense of data, meanings and patterns. I had to restrain the temptation of identifying themes from a single data item or after reading the entire data set once. Instead, I decided to read and re-read actively all the transcripts before I began to code the data. As I did so, more ideas and patterns, which I had not thought of when I first read the data set started to take shape (Braun et al., 2006). I took notes and marked ideas for coding as well as arranged some thoughts about the data in the form of words, phrases and short sentences before I commenced on a more formal coding process.

3.2.11.1 b) Stage 2. Generating Initial Codes

Stage two is a continuation of stage one, where the aim is to generate the initial thoughts. The difference between the first and second stage is that in the

former, the initial thoughts were generated through transcribing verbatim and reading the transcripts; in the latter stage ideas were generated through the actual coding process where production of codes from the data was carried out. Since I had already made a decision that themes would be data-driven, themes were identified from the data by examining the entire data set. As mentioned earlier, coding was done manually by systematically paying attention to each data item in the data set. Guided by the research objectives of the study, I demarcated segments of data by highlighting and naming them. Hence, all potential data extracts were coded and matched up with initial codes that were identified when I read and re-read the transcription. This entailed photocopying segments of data and gathering each code together using file cards to indicate a potential pattern. All codes were reviewed for consistency and reassurance that the data excerpts demonstrated a particular code. Table 3:3 and table 3:4 below show the sample for coding the transcripts for former circumcisers and women who have undergone FGM respectively.

Table 3.3: Shows Former circumcisers' extract, with codes applied.

Data Extract	Codes
Circumcision was mainly related to customs…, each Gogo woman had to undergo the procedure, but there were some other minor reasons…, like two I guess. One of which was…, when a girl is not circumcised, she could never get married, and she would be despised by her peer group. And the second reason was that…, when uncircumcised woman engages into sexual intercourse with a man, she could easily get sexually transmitted infections…, as by that time gonorrhoea was a major issue. In short…, we grew up finding all these reasons in the community (former circumciser 1).	Societal norms Marriageability Social identity Health-related issues

Source: Author (2015).

Table 3.4: Shows woman who have undergone FGM extract, with codes applied.

Data Extract	Codes
Uncircumcised women perceive us [circumcised women] as different from them, they also isolate us from their social activities as they feel we do not belong to them. We do not feel comfortable to interact with them. The uncircumcised women despise us [circumcised women] (Participant 20).	Stigma - Being a victim

Source: Author (2015).

3.2.11.1 c) Stage 3. Searching for themes

The analysis in stage three began after the process of coding had been accomplished, comparing and organizing all the data which had produced an exhaustive list of diverse codes identified across the data set. At this next stage of analysis, I focused on a wider level of patterns, rather than concentrating on codes. The process involved organizing various codes into possible themes and comparing all the pertinent coded data extracts within the recognized themes. Primarily, I was analysing codes and reflecting on how various codes constitute a major theme. All codes were reviewed to ensure that they were similar in nature and captured the same theme. Then I compared and considered 'the relationship between codes, between themes and between different levels of themes' (Braun et al., 2006:89). Thus, some codes constituted a major theme, and some formed a sub-theme. There were contrary codes that did not fit into any of the themes and were likely to be discarded; however, nothing at this point in time was discarded until all themes had been reviewed to scrutinize the relevance of their codes. Thus, a set of codes that did not fit into any of the potential themes were temporarily grouped into a 'theme' named miscellaneous or contrary codes. Some of these codes were absorbed into the existing themes, some into newly created themes after thorough review of the existing themes and formation of newly created themes

carried out in the next phase. To illustrate this process, I have developed an initial thematic map as shown in Figures 3.1 and 3.2 of former circumcisers and women who have undergone FGM respectively.

Figure 3.1; Initial thematic map of former circumcisers, showing five main themes

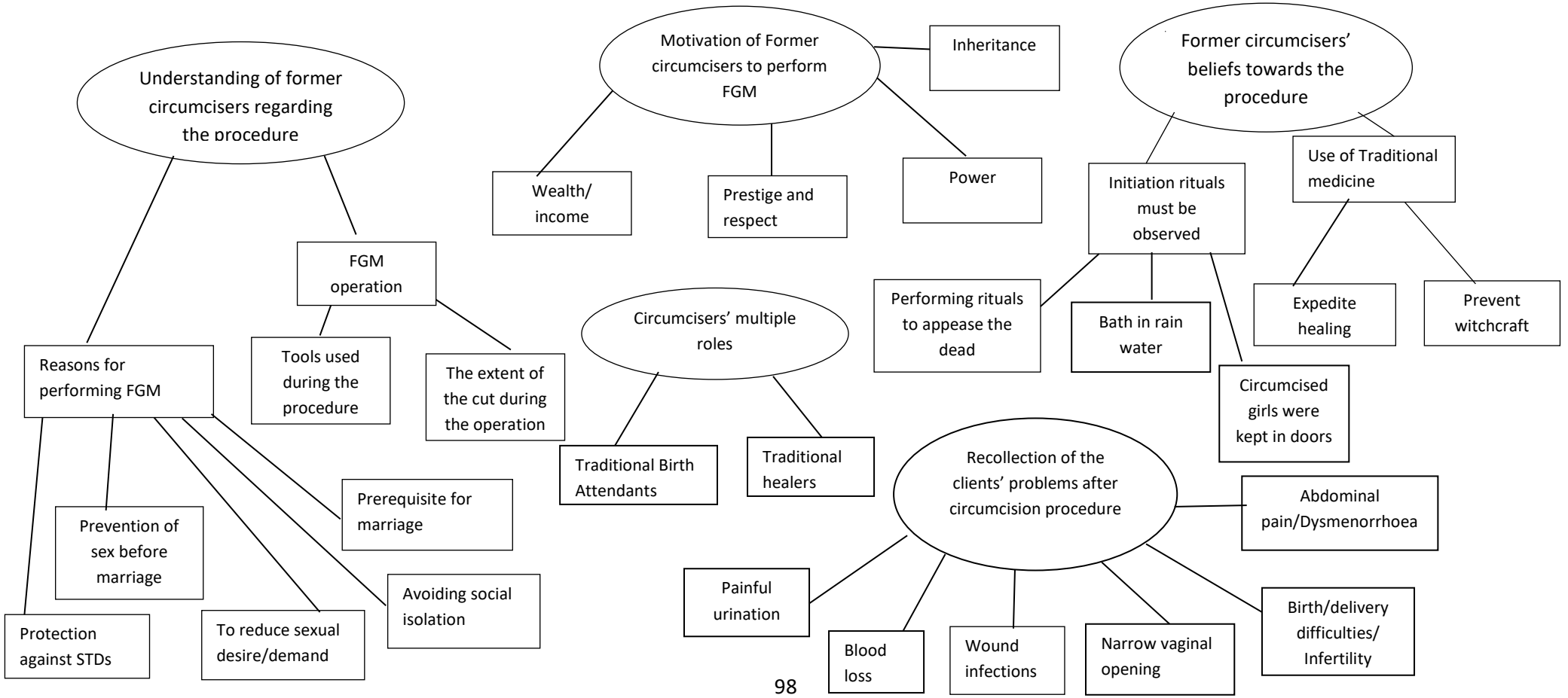
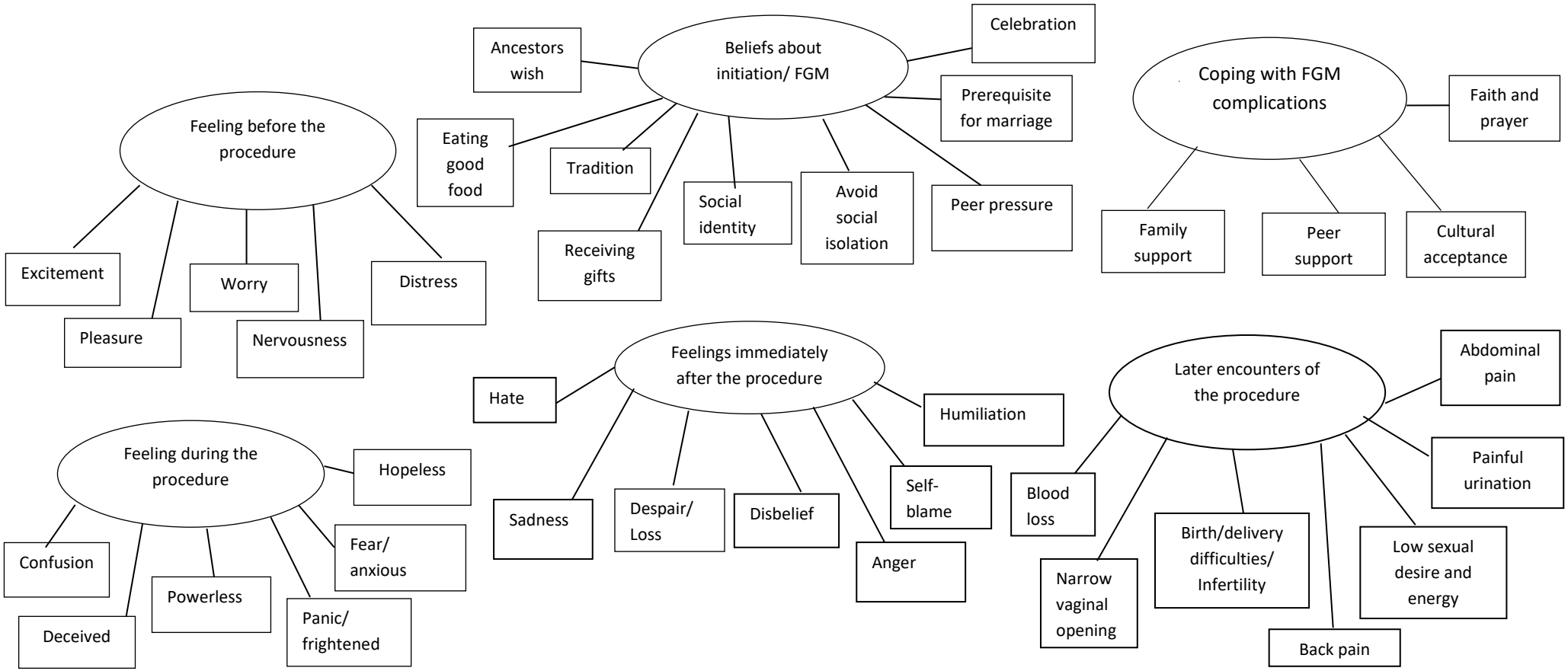


Figure 3.2; Initial Thematic Map of Women who have Undergone FGM, Showing Six Main Themes



3.2.11.1 d) Stage 4. Reviewing Themes

The beginning of this step denoted that I had a set of themes in place as shown in figures 3.1 and 3.2 above. My role in this step was to review and refine the themes. Three key decisions took place during this step. First, some themes did not qualify to be themes because they lacked the support of the data; or the data within them did not cohere together (Braun et al., 2006). Second, two potential themes were collapsed to form one theme as the two overlapped each other. Third, other themes seemed to have outgrown their size and were not manageable and it was necessary to break them into distinct themes. At this point I made it clear that themes were distinct and distinguished one from another, and the data within each theme cohered meaningfully together.

The reviewing and refining of themes was carried out at two levels; first, the review involved assessing the coded data excerpts, by reading through all the pooled and assembled excerpts for various themes to check whether excerpts were consistent with the pattern. Some themes seemed to form a logical pattern, while some did not appear to pool the data extracts that make sense. Hence, I had two options, to create a new theme, or find an appropriate theme for the displaced excerpts; I opted for the latter. At the same time, I discarded some of the themes for lack of enough data to support them; I paid attention to both internal homogeneity and external heterogeneity (Patton, 1990) to check that data excerpts come together to support the themes and the distinction between the themes was clearly detectable.

I then moved on to the second level of refining my themes which was similar to the first but this one involved the entire data set. It was about elucidating the validity of each theme and ensuring that it mirrored the meanings highlighted in the data set in general. At this stage, I also considered whether the themes embodied the theoretical and analytic approach. To accomplish the review and refinement of themes, I re-read the entire data set for two reasons: to code any data that might have escaped the first round of coding and to re-affirm that the data speak for the theme. I moved to the fifth step when I was confident that the refinements were not adding anything significant. As I was a novice in doing thematic analysis this stage was the most challenging and took most of the

analysis time. Figures, 3.3 and 3.4 below show developed thematic maps of former circumcisers and women who have undergone FGM respectively.

Figure 3.3; Developed thematic map of former circumcisers, showing four main themes

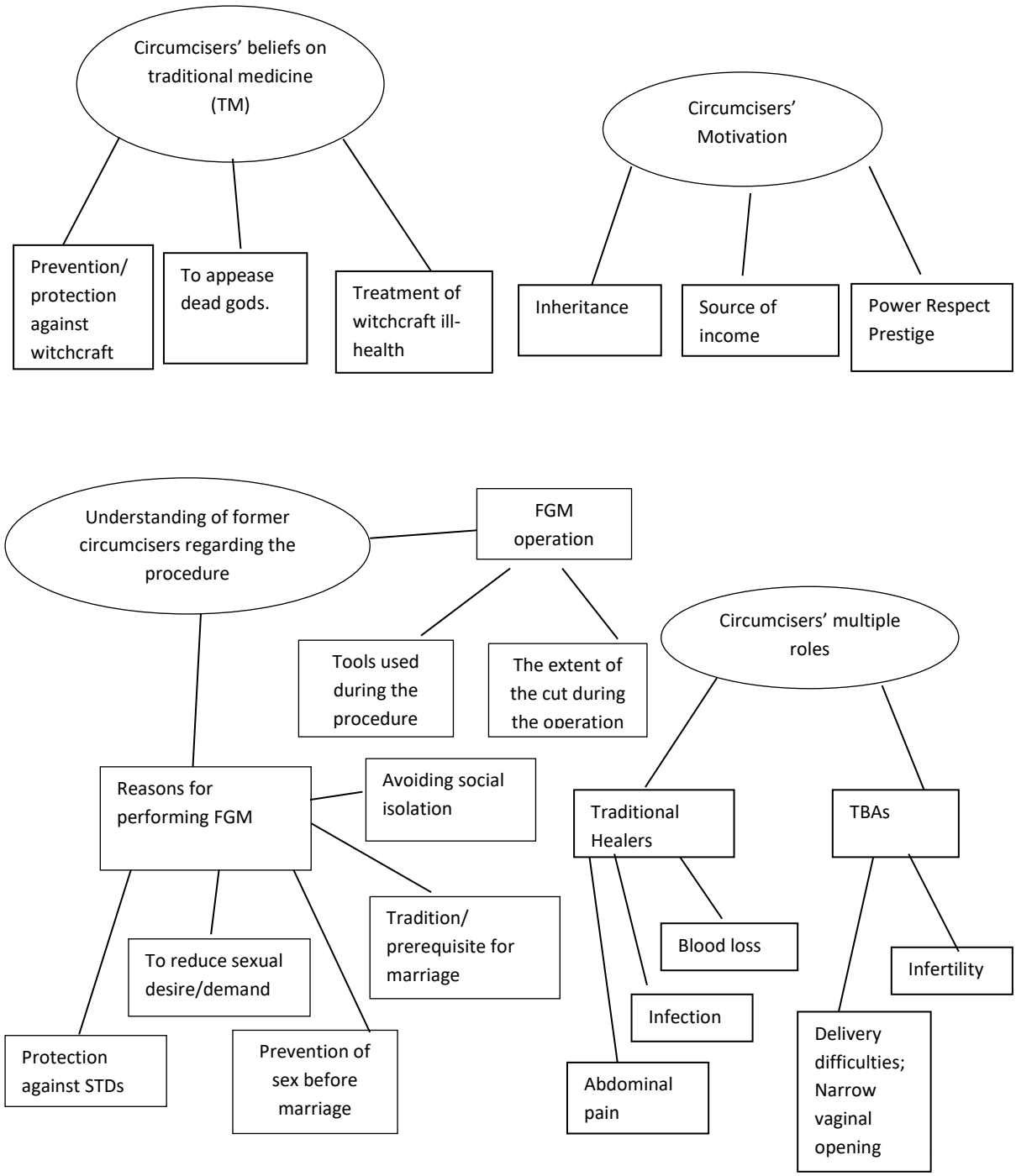
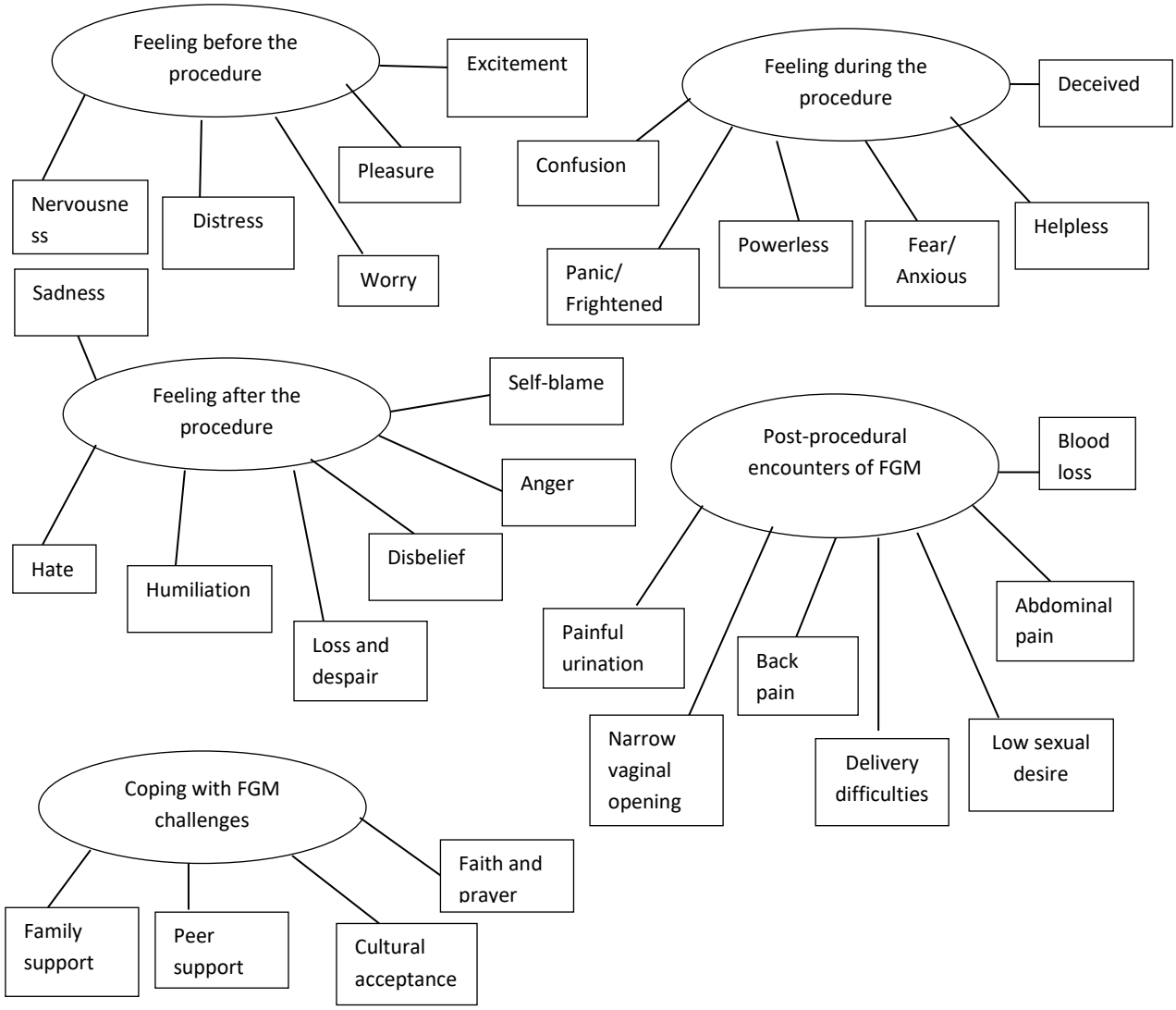


Figure 3.4; Developed thematic map of women who have undergone FGM, showing five main themes: Phase 4- Reviewing Themes



3.2.11.1 e) Step 5. Defining and Naming Themes

The beginning of this step entails that I have a convincing thematic map, as in Figures 3.3 and 3.4. My role in this stage was to define and polish the themes that I have used for analysis, at the same time analysing the data in each theme. Refining and defining at this point denoted capturing the core of each theme: what story does each theme tell as well as that told in all the themes in total. It was important to consider how the data in one theme are raising a story

that fits well with the story of other themes, which eventually describe a broader story of the study based on the central research questions. As part of the process of defining and refining, and depending on the size of the theme, I decided to break themes into sub-themes to provide a structure and establish an order of meaning in the data. I organised and wrote a comprehensive analysis for each theme while acknowledging the story that each individual theme narrates about the data. During this stage, I named the themes and their sub-themes as shown in Figures 3.5 and 3.6.

Figure 3.5 Final thematic map of former circumcisers, showing three main themes and sub-themes

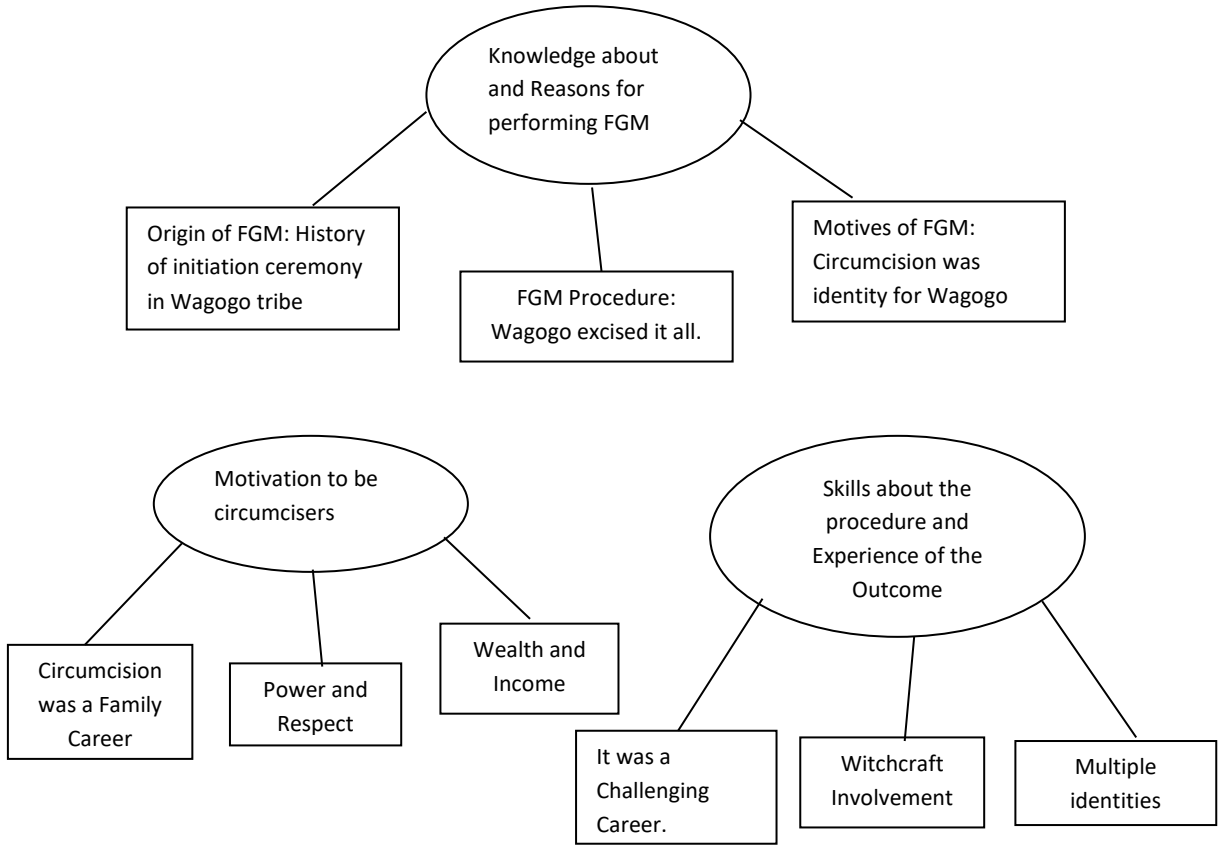
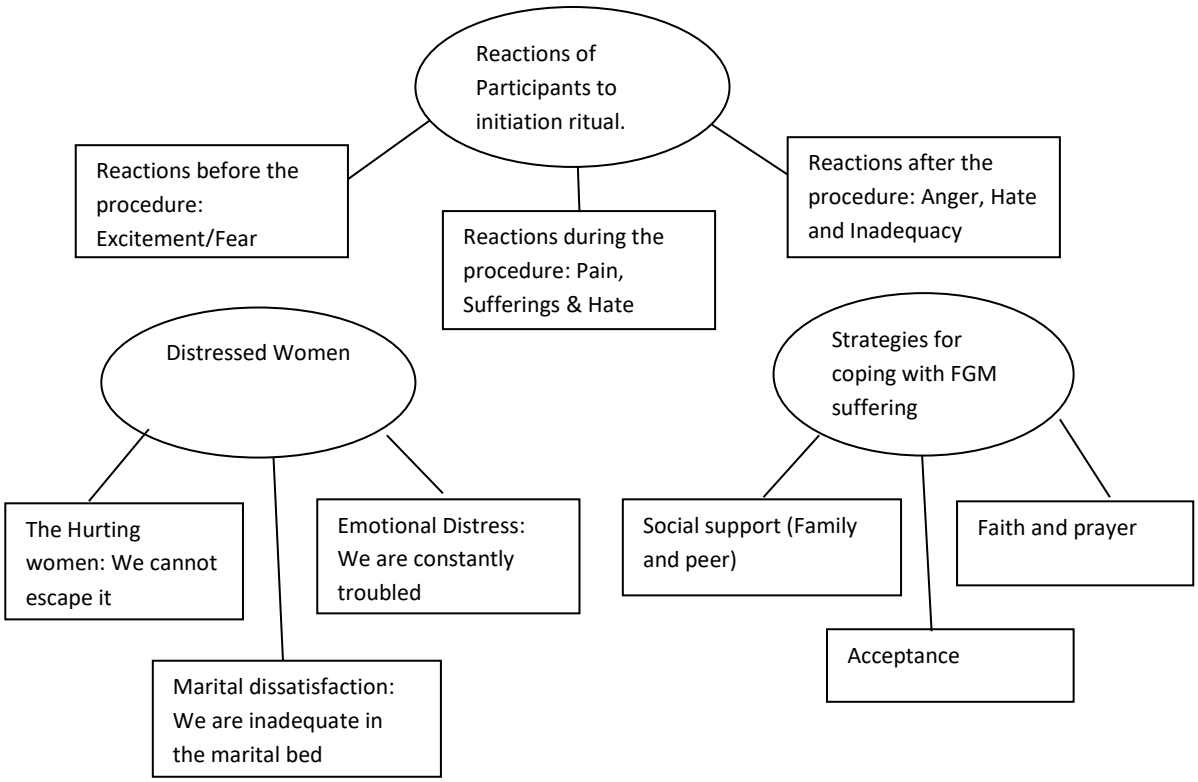


Figure 3.6; Final Thematic map of women who have undergone FGM, showing three main themes and sub-themes



3.2.11.1 f) Stage 6. Producing the Report

Embarking on this stage denoted that I had a set of well-thought out themes, and it entailed the report write-up in the succeeding chapters (chapter four to seven). In these chapters, I have presented the complex story of my data that shows the transparency, rationale and legitimacy of the analytic process used. The write-up provided adequate excerpts as evidence of the prevalence of themes. The excerpts are organized in such a way that they not only tell the overall story about the data collected in the study, but also describe beyond the data by providing a convincing argument relative to the research question for ensuring transparency and rigour of the study.

3.2.12 Rigour in Qualitative Research

The trustworthiness of qualitative studies has been an area of debate by positivists partly because their traditional ways of measuring validity, reliability

and objectivity cannot be applicable to the same degree in interpretivist qualitative research (Shenton, 2004). Nonetheless, a number of authors have suggested that qualitative research can indeed measure the same variables and have preferred to rename the concepts to reflect qualitative research. In my opinion, this is a good thing since in qualitative research we are not studying an entity or reality rather we are engaged in studying and interpreting the actions and behaviour of actors that negotiate to make meaning of the entity in question (Bryman 2008). Lincoln (1995) suggested four criteria that are worth applying in pursuance of trustworthiness in qualitative research. These are credibility, transferability, dependability and confirmability.

3.2.12.1. Credibility

Credibility is synonymous with internal validity in positivism, and it seeks to ensure truthfulness of the study, that is, it does what it claims to do in the field. Lincoln et al. (1985) contend that credibility is critical in establishing the trustworthiness of the study. Measures were taken to ensure credibility in this study; first, familiarization with DIAC and Dodoma Regional hospital, the two organizations that were my gatekeepers. I had some informal consultations with both DIAC and Dodoma Reginal Hospital even before tendering my formal request to conduct my project in their organizations, which created a 'prolonged engagement' between the field officers who introduced me to the participants but also with participants whom I met at least twice before the actual interviews as recommended by Lincoln (1995). This engagement helped me to understand the cultures of the two organizations and their clients who became my participants.

While there is potential disadvantage of prolonged engagement in that it may bring about undesirable outcomes as a researcher becomes too familiar to the extent of losing professional judgement, my early engagement with the participants helped to establish trust between them and me, which was crucial given the sensitive nature of the subject.

Second, the credibility of this study is in its strategy of using both data sources and site triangulation. As part of the analysis, data triangulation pulled data from participants from rural hard-to-reach villages and those in urban areas.

The involvement of both the former circumcisers and women who have undergone FGM helped in corroborating and enriching the data. As for site triangulation, it highlighted the variations of experience of participants depending on their location and origin. These triangulations helped to verify the experiences and accounts of one area or one individual against others, which offered a rich portrait of the experiences, behaviour and attitudes of participants.

The third strategy to ensure credibility of the study was through frequent debriefing sessions between myself and my academic supervisors. During field work I had sessions with my supervisors who were aware of every stage of my field work. This was helpful as I received prompt support whenever I needed it.

3.2.12.2 Transferability

Transferability is equated to external validity in positivist research. It seeks to establish to what degree the results of a piece of research are relevant to other contexts (Vincent, 2014). Bitsch (2005) argues that transferability can be judged by a reader through 'the evidence of thick description and purposeful sampling' (2005:85). Li (2004) claims that thick description helps to judge how the study context relates to other contexts. In this study, I have provided the details of the methodology, characteristics and context of the study such as the area of study, the inclusion and exclusion criteria of the study participants and their number; how I collected the data, the duration of sessions and period spent in the field. With this information, readers will be able to relate their context to that from which my data were collected.

3.2.12.3 Dependability

Dependability is related to the repeatability of the study. In positivist research, reliability is about asking whether the same environment, same techniques and same participants would yield the same results. Thomas et al. (2011) argue that it is difficult to achieve this in qualitative research due to the shifting reality of the phenomena. However, Lincoln et al. (1985) argue that the demonstration of credibility can take care of dependability as the demarcation between the two is fluid. As the credibility of this study gets stronger so does the dependability.

3.2.12.4 Confirmability

Confirmability in qualitative research seeks to ensure that the findings of the study are derived from the participants' accounts and are not researchers' preferences or interests (Tobin et al., 2004). The evidence of confirmability in this study was achieved through the role of data source and site triangulations; and the use of audit trial, that is, my willingness to point out the limitations of the study, my argument for the preference of one design approach over the other, and the merits for various decisions made during the study. These constitute the key criteria for confirmability (Miles et al, 1994).

3.3 Conclusion

This chapter has described the methodology of the study and has shown how all the key parts of this study, including the theoretical stance, the guiding theory and approach of the study on one hand; and the methods used to gather data, the area of study, sample and analysis on the other hand, work together to answer the central research questions of this study. This chapter has functioned as a link between the first part of this project which mainly sought to identify a gap of information in the body of knowledge and the second part of the project which is geared towards a process to bridge that gap. The next four chapters present pieces of information generated from the data to address the central research questions, beginning with presenting findings from the former circumcisers in the next chapter.

CHAPTER FOUR

STUDY FINDINGS: FORMER CIRCUMCISERS' PERSPECTIVES

4.1 Introduction

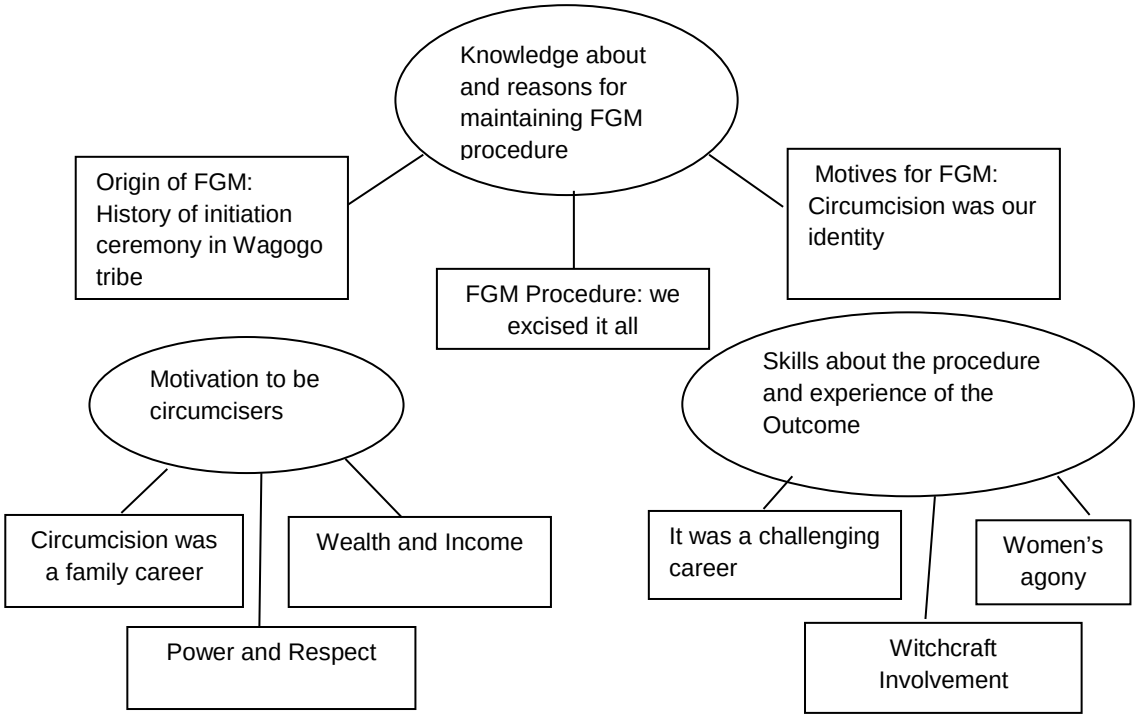
As explained earlier, this study was conducted in Dodoma region whose dominant ethnic group is the Wagogo. The region ranks second position in Tanzania, behind Arusha region for high prevalence of FGM. The objective of this study, therefore, was to explore the experiences of Wagogo women who have undergone the cultural procedure of FGM and the knowledge, attitudes and practice of former circumcisers. In addressing these objectives, the study included not only 25 women who have undergone FGM, but also 3 former circumcisers. The term circumciser in this study refers to a woman who has the knowledge and expertise to perform the procedure of FGM on girls using local instruments without anaesthesia.

The participation of circumcisers was important for several reasons. First, they are knowledgeable about the procedure as they have been involved in performing it: in that sense, they have first-hand information of the procedure, the immediate and later complications of FGM. Secondly, all former circumcisers were and are still serving as traditional birth attendants; in their accounts, they revealed that the majority of girls whom they have circumcised came to them to seek attention and care during child-birth. Consequently, they were well positioned to describe the complications that circumcised women had experienced during birth because of FGM. Thirdly, the former circumcisers served also as traditional healers. In their capacity as healers they took care of the normal healing process of girls' wounds as well as those that had been infected subsequent to an FGM procedure. Hence, they could state how they managed those cases. Finally, former circumcisers in general represent a cohort of women who had been circumcised when they were girls. Subsequently, they can articulate with accuracy their experiences as circumcisers, as well as that of women who have undergone FGM. As circumcised women, they offered their insights into the immediate, sexual,

obstetric and psychological complications of FGM. Their accounts complemented the experiences shared by the circumcised women in this study.

The term FGM in Wagogo, is meant to describe FGM procedure type II as identified by World Health Organization (WHO), which 'involves the excision of the clitoris, with partial or total excision of the labia minora' (WHO 2013:2). WHO (2013) identifies this type of FGM as the most common form of FGM practised in many societies worldwide. In presenting the former circumcisers' knowledge, attitude and experience in relation to the procedure of FGM, this chapter is divided into three major themes: first, "The Knowledge about FGM and motives for maintaining the procedure in Wagogo tribe". Second, "The motivation to be a circumciser -what inspired the circumcisers to continue the practice"; and third "The Skills about the Procedure and Experiences of the Outcomes". Each major theme was underpinned by three sub-themes as shown in figure 1 below. The themes will be described with quotations taken directly from the transcripts to illustrate each of them. The findings of this chapter set a scene for the subsequent chapter in exploring the experiences of the Wagogo women who have undergone FGM. However, in its own right, it offers concrete findings which contribute to the understanding of the experience of circumcised women.

Figure 4.1: Three major themes and sub-themes



(Source: Author (2015). The figure was generated from the data analysis).

4.2 Knowledge about FGM and Reasons for Maintaining the Procedure in Wagogo

This major theme encompasses three sub-themes (see figure 4.1 above) which are consistent with the participants' understanding of and attitude to FGM and the motives for the continuation of the procedure within the Wagogo tribe. The sub-themes are the "Origin of FGM: "history of initiation ceremony in Wagogo tribe"; FGM Procedure: "We excised it all"; and Motives of FGM in Wagogo Tribe: "Circumcision was part and parcel of our culture".

4.2.1 The Origin of FGM: "The History of Initiation Ceremony in our Tribe"

This section discusses the participants' views regarding the history and the origin of FGM in Wagogo tribe and "*makumbi ga wadala*" (literally meaning 'initiation ceremony'). *Makumbi ga wadala* denotes a stage where Wagogo boys and girls are prepared through teachings to be mature men and women. The climax of the initiation ceremony was circumcision for both male and female youths, which was perceived as the most important event in the ceremony. There was no initiation ceremony without male/female circumcision

as the two went together. Hence, the term initiation ceremony in this chapter will be used interchangeably to refer to female circumcision or FGM.

4.2.1 a) Origin *of FGM in Wagogo tribe*

Participants were asked about where and when was the origin of FGM in Wagogo. They explained that the origin of FGM is not known. All they knew was that FGM had been practised by the Wagogo for many decades. They emphasised that when they were born they found that the tradition was being practised by their female parents and was passed over from one generation to another.

> As I know…, this custom started long time ago, we found it existing [Participant 3].
>
> I found this tradition in my clan, my relatives used to perform this ritual, as well as my mother [Participant 1].
>
> The practice had been practised long time ago even before we were born…, we only inherited it from our great grandparents. If you ask me when it started, I am not sure…, some time back I asked my grandparents about this, they said even them, they found it existing when they grew up [Participant 2].

The above quotations suggest that female circumcision had been observed by the Wagogo community for an unspecified long period. None of the participants could state confidently when FGM had begun in their society, but their accounts revealed that FGM in their tribe might have started several decades or probably a few centuries ago. From their earliest memories FGM was a cultural procedure that was not only observed by their own community but also adopted by other neighbouring tribes that interacted with the Wagogo, for instance, the Wakaguru, Wabena and Wahehe. Participant three explained in the following excerpt.

> …. When we were born, we were informed that it was not the custom of Wahehe and Wabena to circumcise women and men. The Wagogo refused getting married to them since they were not circumcised…, calling them *"mlayoni"* meaning "the uncircumcised". However, men and women from Wahehe and Wabena tribes who wished to get married to Wagogo women and men had to assimilate the custom, and they begin to circumcise men and women [Participant 3].

According to participants, during that time the Wagogo were perceived as a dominant tribe over other neighbouring tribes such as the Wakaguru, Wahehe and Wabena. The Wagogo community considered the initiation ceremony as a platform to train their female children to be responsible women in the community.

4.2.1. b) *Initiation Ceremony*

As said earlier, the initiation ceremony in Wagogo tribe was an important cultural custom for both boys and girls that signified a rite of passage from childhood to adulthood. Moreover, the initiation training that was given to both girls and boys was preceded by the circumcision procedure. For the girls, the practice reflected a symbolic rebirth into adulthood, in which girls were expected to assume the roles of adult women, including shouldering family commitments, fulfilling sexual obligations as wives, as well as adhering to the social norms of Wagogo society. Articulating their understanding of the "*makumbi ga wadala*" or an initiation ceremony, participant one had this to say:

> *Makumbi ga wadala* was practised once a year involving circumcising girls followed by big celebrations. The procedure was carried out mostly in June…, In the very old days parents used to initiate their children in September, October, November, and December [Participant 1].

As the ceremony took place once a year, it was perceived by participants as a social event and also a reunion of relatives and friends to celebrate the passage of girls to womenhood. Participants revealed that the invitees came from nearby as well as distant villages. Participant three asserted that:

> In the past there was no good roads like today, to go from one village to another people had to walk long distances, so it was difficult for relatives who lived very far to visit each other regularly. Initiation ceremony was the moment relatives united together [Participant 3].

According to participants, the decision about when girls would be circumcised was left to the parents or guardians. Both parents had mutual responsibility of deciding when the girl was mature enough for the procedure; after reaching an

agreement, parents started planning for the initiation ceremony as reported by participants below:

> It was conducted like a parliament…, both parents had to discuss, agree and set plans as to when the children should go for the procedure…, it wasn't for the husband or a wife only to decide [Participant 1].
>
> Close to initiation period both parents, father and mother and grandmothers set plans on how to carry out the procedure. After both sides reached an agreement, then I as a circumciser, was informed…, then we plan when to perform the procedure [Participant 2].

As for the age at which the girls qualified for the initiation ceremony, participants pointed out that girls were initiated between the ages of 7 and 15 years. They emhasized that at that age the girl was old enough to understand the initiation messages that were given during the training sessions, as the training followed immediately after the procedure. Those younger than seven years of age were not allowed to attend the ceremony as explained by participants' accounts.

> In those days [before it was abolished]…, Ahh!!! They used to take grown up girls aging 7 to 15 years. Other girls had already had their first menstrual experience by the time they were sent in for circumcision. In those years' children of age 6 and below were still considered young, they could not understand the initiation teachings [Participant 1].
>
> …all I knew was that, they were circumcised before experiencing their first menstruation period…, but for those who had already experienced the menstruation period, , they were married soon after they were circumcised [Participant 2].
>
> Babies were never circumcised; circumcision was performed on grown up girls who could understand the subject taught [Participant 3].

The societal norms required the parents of girls who were due for initiation to start preparations in March of each year. The parents of the girls from the same clan who were of the same age group planned the initiation session together to reduce the cost of the initiation ceremony for each girl. A participant explained below:

> We used to gather all children in a village from different relatives and neighbours…, but other circumcisers used to gather children from clans only. If a girl was brought for circumcision, and was not among the clan, her parents were required to pay for the service. Those from the same clan were gathered and their grandmother or a circumciser from another village would come and circumcise them [Participant 1].

During the preparation phase, the parents would also identify a circumciser who would perform the procedure. In the event that a circumciser was part of the clan, the parents would use her to circumcise the girls, as it was convenient and cheap. For those families that had no circumciser within the clan, parents had to identify a circumciser depending on her availability, costs and reputation. Once identified, a circumciser was to be informed well in advance so that she could start preparing and organising the event, which included performing rituals associated with the ceremony. Participants emphasized that rituals were to be observed by both the girls and circumcisers to appease dead ancestors, spirits and gods, which would protect the girls from an evil eye, envious people and witchcraft: if not followed there could be some social consequences. A participant clarified as follows -

> Before taking the children for circumcision, parents had to make offerings to appease and calm down spirits of the dead from both sides of the parents, asking them to protect the child during the procedure. Indeed, other spirits used to be so cruel to the girl if they were not informed of the incident, a child could die. If the spirits declined the sacrifices…, no matter how much medicine is applied to the wound, it won't heal [Participant 1].

> A girl was taken for incarnation [a ritual where offerings and appease of gods is carried out] one day before the circumcision taking place…, and after the incarnation, the girl was then taken for circumcision [Participant 3].

Circumcisers were also required to prepare themselves before circumcising the girls. Participants claimed that witches bewitched the circumcisers and the girls during the circumcision season. Consequently, circumcisers had to be equipped with incantations (traditional medicine) against witchcraft to protect the girls as well as their own reputation.

> As circumcisers, we had to protect our work against invasion…, to prevent any failure of our work before and during circumcision procedure, we had to identify the enemies and chase them away

> from the circumcision site for our work to succeed. When June approaches, and before commencing our work, we circumcisers normally go to our fellow traditional healers to seek double protection [Participant 1].

Initiation for the girls was a big celebration for the whole community. While parents and circumcisers were busy performing some rituals as preparation for circumcision, other members of the community would continue with other preparations for the celebration. A week before circumcision, women in the village played the traditional drums called "*mphongwa/muheme*" to announce the initiation for the girls. There would be singing and dancing with joy, and preparation of local brew and food for the people attending the ceremony.

> …at this time women were preparing millet, fermenting alcohol, inviting a lot of people…, and on the material day, alcohol is served [Participant 3].

> … they [other members of the community] continue with preparations for the circumcision ceremony. Those with high-income ferment alcohol and arrange *"muheme*" traditional dances [Participant 2].

When participants were asked how the girls behaved during the preparatory period, they responded that all girls were aware that they were required to attend the initiation ceremony but were not conversant with the fact that they would be circumcised during the ceremony. Nethertheless, girls were very happy and excited as the initiation ceremony involved big celebrations and girls were rewarded with gifts.

> The girls were taken for initiation without knowing they were going to be cut. We informed them that they were going to eat honey and that during ceremony they will receive some gifts from their parents and relatives [Participant 1].

Some of the girls were told a year before that they would be taken for the initiation ceremony; hence, the girls took the initiative of reminding their parents. The participants articulated how the girls reminded their parents, "You told us, you will be taking us for initiation… When will that take place?" According to participants, some of the girls requested to be initiated because of the peer pressure from the girls who had been circumcised. Circumcised girls

told the uncircumcised girls that the initiation involved a big ceremony but they were prohibited from informing them that there was a circumcision during the ceremony. Thus they were happy to attend the ceremony without knowing its consequences.

> Older girls pressurised their parents for the initiation ceremony having experienced isolation and derision from circumcised girls. As a result they developed a desire to be initiated without knowing what it involves [Participant 3].

The quotation above emphasized that uncircumcised girls and their families were at risk of being ridiculed and isolated by the entire community. The initiation ceremony created a sense of solidarity and togetherness among the relatives in Wagogo tribe; while FGM is perceived as a positive social identity in Wagogo women, which distinguished them from other women who were not circumcised.

4.2.2 FGM Procedure: "We excised it all"

This sub-theme describes among other things, what happened on the circumcision day, the tools used for the cutting, the extent of tissue removed and rituals that were observed during and after the circumcision procedure. Participants regarded circumcision day as a vital day in the tribe as narrated below.

> We used to celebrate circumcision day with singing and dancing *muheme.* On that day, while women were dancing, initiated girls, two or more depend on their number were told to sit on a carpet made of cow skin and their hair was cut, we applied some cow oil on their bald then we took them to the bush. In the bush…, they were assembled at one place. Only one at the time was taken to the operation venue far from the rest of the group so that they don't hear the screams, cries, and shouts. After being placed in a safe place, we circumcised one after another till we were done with them all [Participant 3].

Participants emphasized that although girls were taken as a group they were circumcised one at a time. They picked a girl from the waiting area and took her to the operation venue ready for the procedure.

> After gathering them, we took them to the bush at a common spot, and we started the circumcision…, one girl at a time was circumcised. So, when it was a girl's turn, she would be led to a spot where she found several women who would ask her to undress…, yes it was a shock to the girl [Participant 1].

When responding to a question about the extent of the tissue removed during the procedure, the participants revealed that the cut 'involves the excision of the clitoris with partial or total excision of the labia minora, which is the commonest type II circumcision in the world as described by the WHO' (2014:2)

> Wagogo cut the entire parts of the external genitalia..., one starts with the clitoris…, she cuts the clitoris and then both the labia minora and majora. She makes sure nothing is left behind, and there is no chance for the organ to grow again several years later, how it will grow when they have cut everything…, nothing [Participant 1].

> We cut the entire outer part of the vagina…, the flesh that hangs from each side [labia majora]..., and we do cut that flesh like small finger [clitoris] and…, to be specific we cut all the outer part of woman's thing [both clitoris, labia minora and majora] [Participant 2].

> Wagogo remove the outer part of the vagina…, the labia majora. We cut the clitoris first, and the labia majora later. We cut and removed them all. That is why the Wasukuma tribe used to tease Wagogo that their vaginas are not closed…, they are wide open (laughing) [Participant 3].

The participants explained that in the Wagogo tribe FGM was carried out using different tools. In the past FGM was performed using traditional tools called "*nyangundu*", a small axe sharpened for cutting the girls' flesh. Participants commented on the tools used for circumcision as follows,

> We were using…, small axe…, the Wagogo axe "*nyagundu*". We sharpened them and become as sharp as razor blades…, we used it to circumcise as it was meant to cut only once…, we cut the entire labia majora and the clitoris [Participant 1].

The participants also explained that in the past circumcisers had used a traditional tool; however, during their time they were using other tools like a sharp knife and razor blades.

> I used a knife for circumcising my daughters because I could not have the proper tool that was used for circumcision, in those old days the circumcisers used a special tool known as "*nyagundu"* for circumcision..., the tool resembled a small axe. It was very sharp…, and it was the only tool circumcisers were using in those days when we were young. Later, I started using razor blades [Participant 2].

The participants emphasized that the same tool was used to circumcise all the girls regardless of their number.

> There was only one tool…, after circumcising a girl, you simply wash it, then reuse it for another one…, and the process continued the same way even if there were 20 girls or more. Later on we changed from using knives to razor blades…, the same process of using one knife for mulitiple girls, continued with a use of a razor blade…, clean a single razor blade and use it for multiple clients [Participant 3].

According to participants, circumcisers were not knowledgeable about the impact of using the same tools to cut all the girls and the risks of exposing them and their clients to infection. Their accounts revealed that circumcisers were ignorant of the mode of transmission of certain infectious diseases from one person to another through blood. However, after attaining the knowledge about the various infections and how they are being transmitted from one person to another they changed the way of doing it as illustrated below by a participant.

> …, after emergence of HIV/AIDS infections, we were educated about how it is transmitted, and it was until then we stopped using the same tool to operate multiple persons. Every parent was asked to buy a razor blade for her own child and after using it…, it was thrown away [Participant 2].

As far as the management of the circumcision wound was concerned, participants highlighted that in the past they depended much on the use of traditional medicine during the procedure. They emphasized that there were various types of traditional medicines that were used, for instance, medicines

for controlling excessive bleeding and medicines that were used to expedite the healing of the wound. The participants gave their accounts in the following quotations.

> There was this medicine that was applied just after the procedure that did not require frequent cleaning of the wound as the medicine would prevent any bleeding, so if you take proper care of her [circumcised girl], she should recover within two weeks [Participant 3].

> After a cut we applied traditional medicine to the wound…, a girl was required to be under observation for four days before removing a dressing on her wound…, after removing a dress, you will observe some discharge, you clean up the wound and apply the medicine for a second time and the wound heals…, you only watch her and take proper care of her so that the wound surface of one side doesn't heal together with the other side, this prevents sealing of the vulva/vagina opening during healing process [Participant 1].

> After circumcising a girl, we had medicines, we used to apply on the cut and she would stop bleeding… the applied medicine used to react very fast, it would take a few days for the wound to heal [Participant 2].

In Wagogo tribe, the circumcised girls must live in seclusion soon after circumcision. They were confined in the house or in the bush at a place prepared for them. Participants explained that this was among the circumcision rituals that were to be observed after circumcision. They further asserted that after circumcision, it was customary for the girls to remain indoors for a certain period, to ascertain that they have recovered completely. It was during the healing period when the girls received initiation training.

> The girls stayed indoors for a month…, Others were kept indoors for up to two months…, the grown up and matured girls were kept indoors for two months till they are completely healed and from there, they are ready to get married as they had already received the training [Participant 1].

> Circumcision went together with the training, so the girls were kept in-doors for two reasons…, first to obtain the training while they were still in pain from the wound, and secondly, to give time for the

> wound to heal so that others who were not circumcised would not know what had happened to the circumcised girls [Participant 3].

Having covered how FGM was performed in Wagogo tribe, the extent of the cut, the tools used for the procedure and the rituals that had to be observed after the operation, the next section provides the findings on the reasons why Wagogo society practiced female circumcision.

4.2.3 Motives of Maintaining FGM in Wagogo: "Female Circumcision was our identity"

Participants were asked what were the motives behind the practice of FGM in the Gogo tribe. Their responses was that the Wagogo tribe believe that traditions, marriageability, and social acceptance were the major motives for the continuation and maintainance of the practice in the tribe. Reduction of sexual desire and preventing girls from sexually transmitted diseases were also identified as other reasons for practising FGM in Wagogo tribe.

4.2.3. a) Tradition and Custom

The Wagogo tribe have similar motivations for practising FGM to those of many other societies that practise FGM worldwide. Participants believed that cultural reasons in the form of tradition and custom were the major factors for the continuation of FGM among the Wagogo. They emphasized that female circumcision was necessary and unavoidable as it was both a tradition and custom. Once a girl reached the age for initiation, it was obligatory to abide by this societal norm. One participant shared her views on this, stating:

> …In those days, female circumcision was a compulsory procedure…, it was impossible to avoid it…, it was an identity of Wagogo women [Participant 1].

To emphasize the above, participants clarified that FGM, as an important social norm, was used as a tribal identity to differentiate Wagogo women from other women. They stated that other tribes who intermingled with the Wagogo people for various reasons and purposes such as business, war or hunger had to adopt the traditions and customs of the Wagogo. Whilst, it was common to find women from other tribes who were not circumcised, it was hard to find an adult Mgogo woman who was not circumcised as articulated by a participant below.

> If you find a woman of my age was not circumcised…, then she was probably from Wanyamwezi or Wabena tribes who migrated to Dodoma…, but it was never a common occurrence for the Wagogo women to be uncircumcised [Participant 1].

The Wagogo community perceived FGM as a cultural practice which had its roots in ancient times, practised by their ancestors who passed it on from one generation to another. The participants explained that the Wagogo women embrace FGM with high esteem because the practice was a source of dignity, honour and admiration for them. The participants (the former circumcisers) admitted that they practised FGM to adhere with the tradition and custom of their ethnic group which must be observed without questioning. They considered FGM as the law that tribe members were not expected to violate. Participants reported that FGM was part of their culture as narrated below by the participants in their own words.

> …It is our tradition, every woman had to undergo circumcision…, circumcision was mainly related to customs…, it was a custom-enforced practice…, in the past it was almost a law…, was a compulsory procedure…, so we had no choice at all…, we were forced to follow the custom [Participant 1].

> We were circumcised because it was the custom. It was a must for all the Wagogo teenagers, both boys and girls were to be circumcised [Participant 3].

> This practice is within Wagogo custom…, it was compulsory for young girls to be circumcised [Participant 2].

The Wagogo tribe traditionally considered FGM as a crucial initiation rite to transform a girl into a woman. Any woman who refused to be circumcised was considered an outcast "*Mkonongo"* (a word used by Gogo women to address uncircumcised woman) and not worthy to be part of the Wagogo community. The Wagogo society perceived uncircumcised women as women with no manners because during initiation, girls were not only circumcised but also received some initiation teachings. The circumcision procedure and teachings were the main things that differentiated circumcised women from uncircumcised ones as explained below.

> If a woman is not circumcised, she is disobedient and lacks respect to the elders…, as she is not subjected to the initiations

> rituals and teachings. The initiation rite was not only for circumcision but it also provided teachings and trainings to girls…, they were taught to respect their parents, relatives, and the elders…, the uncircumcised ones were disobedient [Participant 1].

The teachings prepared the girls to respect themselves as women in the society. The girls were taught about the role of women not only in the society but also in their families as wives and mothers. After teaching, girls were expected to behave like the Wagogo adult women, instructed in the traditions and customs of the Wagogo community. Participants asserted that.

> When a girl was taken for initiation…, she would not only be circumcised but also received some teachings and guidance. The teaching covered all areas that transform a girl into womanhood. Including being a disciplined person, respecting and obeying parents and elders, regardless whether or not were related to her. For instance they were told that, if a man or a woman whose age was the same as her father or mother, she was supposed to call them father or mother respectively [Participant 2].

According to the Wagogo community, initiation teachings were offered immediately when the girls were taken to the bush for initiation and the training continued after circumcision. Participants clarified that it was a deliberate decision that training was carried out immediately after circumcision when the girls were still in pain so that they would grasp the messages taught. The timing of the teaching was important as girls were taught why they were circumcised in the first place. The trainers created an atmosphere that the training was special: if the girls did not comprehend its core meaning or contravened the guidelines given, the offenders could be subjected to another circumcision. This made the girls listen attentively to the instructors.

> The girls received the teachings when they were still in the pain. The feelings of pain made them to be obedient, as they were warned disobedience to the lessons given might result in another operation. We grew up keeping and observing what we were taught after the circumcision. We were trained to respect elders, to demonstrate good behaviour, never to be involved in prostitution…, and many more that we have kept to date [Participant 2].

> …the one who has been circumcised and experienced the pain considers the teachings with great importance [Participant 3].

One participant recited some of the words which they considered part of circumcision teachings. She explained that these words were essential during circumcision and the girls were told immediately after the cut. The reason was to emphasise the significance of the circumcision procedure to a girl. The participant narrated those words as follows:

> We told them, “You are now grown up…, do you see the flesh we have removed?” The girl replied..., yes. “You are now a woman as we throw your flesh, as we throw it away, it has to go with your childish behaviour…, let your brain mature now…, have you seen the wound?” The girl replied…, yes. We continued asking them, “Do you know the reason why we circumcised you…, was to hasten your maturity, before you were young…, as we cut it, you are now a grown up woman”. “You have to act like a grown up, have respect, be obedient, dress respectifully…, greet elders every time you wake up, always knock the door before getting in.” We taught them while they were experiencing pain from the wound. Because of the pain, it was easier for them to master the lessons [Participant 2].

The teachings were top secret for those who attended the initiation rites. Initiated girls were prohibited from telling others who were not initiated what they had been taught during circumcision rites. Participants explained that:

> We used to tell them not to share the teachings/lessons to those who never attended the training [Participant 2].

When responding to a question, how certain they were that the circumcised girls would never disclose what happened during circumcision to those who were not circumcised, their responses were as follows

> We petrified them…, we told them if they were to tell their fellow uncircumcised girls, they would be re-circumcised. They understood that it was strictly prohibited to tell a person who has not been circumcised the proceedings of initiation sessions…, and they observed the rule [Participant 3]

The above quotations illustrate that the circumcision procedure and the teachings were treated as a top secret for those who had undergone the procedure. It was taboo to discuss what transpired during the circumcision scene with someone who was not circumcised.

4.2.3. b) Marriageability and Economic Gain

According to participants, only circumcised women had the assurance of being married, the uncircumcised girl had virtually no chance of getting married. In order for a woman to be eligible for marriage it was essential that she underwent the procedure of FGM as noted by participant 3:

> If a girl has not been taken for circumcision, she could not get married…, men refused to marry the uncircumcised. They used to say, "why should I marry a woman who has not attended initiation session?" …, they used not to marry them till when they are taken for initiation session (circumcision) [Participant 3].

Participants highlighted that marriage in Wagogo tribe was and is still considered essential for women as it guarantees their social security in the community. According to participants, women were and are still denied access to land, live-stock and other resources. Only men were allowed to possess resources. Thus, the only way women could access these resources was through their husbands; and in order for the woman to get married FGM was necessary. Consequently, parents sent their girls for FGM to ensure they would be suitable for marriage as women's access to resources depended on their circumcision status. Participants stated that:

> In the Wagogo community women were not allowed to own properties, men owned everything, from land to cows. For the woman to get these things you have to be married. Wagogo men preferred circumcised women so… each woman has to undergo circumcision, without that no man will come to marry you. The Wagogo men were not allowed by the cultural norms to marry uncircumcised women. [Participant 1].

Because of its significant role in the society as a prerequisite for marriage, one participant affirmed that she was despised by other women in the community because she delayed circumcision of her daughters. She stated

> ….women from that village laughed at me saying that…, my children will rot at home, no man will be interested in marrying them [Participant 2].

She continued to explain that she had bitter relationship with her husband as he also blamed her for the same reason,

> my husband told me that I will be answerable when our daughters remained unmarried [Participant 2].

As said earlier, in the old days, circumcision was performed by a circumciser closely related on the paternal side. As the husband of participant two had moved from his village to another village, their daughters could not be circumcised in time. Consequently, the participant decided to perform the procedure herself after obtaining orientation from a circumciser in a village. This suggests how important the practice was in Wagogo tribe as a prerequisite for marriage.

As mentioned earlier, circumcision was a mandatory tradition for both men and women in the Wagogo tribe. As a result, men and women from other tribes that desired to marry Wagogo women and men respectively, were required to adhere to the custom. For instance, when a woman from another tribe wants to marry a Mgogo man, she will have to undergo FGM. Likewise, a man from another tribe who desires to marry a Mgogo woman, the man has to be circumcised in order to qualify for marriage.

> Other tribes who wanted to marry Mgogo man or women were forced to undergo the procedure…, mmh what I know by then, there was no way for Mgogo man or woman to marry an uncircumcised one [Participant 3].

The existence of the practice in this tribe placed considerable pressure on women to conform. They had to take their daughters for circumcision to ensure that they stood a chance of being married for the betterment of their future life. The uncircumcised woman stood a slim chance or no chance at all of getting married.

4.2.3. c) Social acceptance

Social acceptance was also mentioned by the participants as a driving force that maintained the practice of female circumcision in the Wagogo tribe. Circumcision was essential in order to be accepted in the society. Society had perceived uncircumcised women as imperfect and they were isolated from circumcised ones. A participant clarified that,

> A woman who was not circumcised was being discriminated and despised by her fellow women [Participant 3].

In Wagogo tribe peer pressure was one of the major factors contributing to girls and women being circumcised. Those circumcised used to ridicule the uncircumcised. Participants narrated that:

> …, we used to laugh at them to the extent that they cried all the way home. As a result they asked their parents to take them for circumcision. Other girls pressurize their parents to take them for circumcision…, if not they would run away and join their fellow neighbours who are ready to take their children for circumcision [Participant 1].

> A woman who was not circumcised was being discriminated and despised by her fellow women. In those days all women used to take shower together along the river banks or wells…, so if you are not circumcised, they will laugh at you till you shed tears, as well as being chased away by your fellow women since you still have uncut flesh hanging on your vagina [Participant 3].

One participant talked about her experience concerning her daughters and the way their fellow girls treated them:

> My children were old enough, and yet were not circumcised…, when they went for a shower with other girls, the girls laughed at them and chased them away…, came home with tears, they were teased by other girls that they are uncircumcised. They were always unhappy asking when I will circumcise them [Participant 2].

Adhering to the circumcision rituals assures that the girls would be socially accepted and respected by the community members. The parents of the girls are subjected to social isolation and humiliation if they had not adhered to the custom.

4.2.3. d) Protection and cure of diseases

Apart from other motives, circumcision was commonly perceived in Wagogo society as a way of preventing women from contracting sexually transmitted diseases (STDs). Participants reported that FGM was performed in Wagogo tribe to protect women from sexually transmitted diseases such as gonorrhea and syphilis. A participant stated that:

> …, when an uncircumcised woman engages in sexual intercourse with a man, she could easily get sexually transmitted infections…, as by that time gonorrhea was a major issue" [Participant 1].

In addition, circumcision was not only practiced as a prevention but also as a cure for a disease that might attack the girl's vulva. She explained:

> In Wagogo girls, it was common to acquire *lawalawa* fever [a vaginal infection where some organisms invade the thin skin of the vulva and turned it greenish]. To prevent a girl from that condition parents had to circumcise their daughters; circumcision was also believed to be a cure for those who already contacted the condition. My daughter suffered *lawalawa*, I had to circumcise her…, which made her clean, and free from "*lawalawa* [Participant 1].

According to participants *'lawalawa'* is a vaginal infection which was charactarized by high fever; so they believed that by removing the parts which could easily be infected, they could free the girls from that disease. Hence, FGM was a cure and prevention of *lawalawa*.

4.2.3. e) Reducing Sexual Desire and being Obedient to Marriage

According to participants there was a general belief within the Wagogo tribe that women naturally love sex. Consequently, they also believed that the best way to diminish women's sexual desires significantly was through FGM. Participants were of the opinion that in order to reduce sexual desires, FGM was practised in young girls to prevent them from engaging in promiscuity before marriage. There was a myth among the Wagogo society that if women's external genitalia were left untouched, women would act madly and be oversexed. A participant emphasized that:

> … a young girl had to be circumcised to remove that dirt, and it was when her clitoris was removed; her sexual desires toward men was reduced…, she would settle [Participant 3].

According to the participants, the community perceived uncircumcised woman as promiscuous. One participant tried to compare sexual desire for the girls who have undergone FGM and the one who did not undergo the procedure,

> uncircumcised girls have higher sexual desires than the circumcised ones, you will find them chasing men instead of men chasing them. It is girls, nowadays, that are busy approaching men [Participant 1].

The above sections have covered the first major theme and its subthemes – considering motives for embracing and continuation of FGM, such as marriageability, social acceptance and reducing women's sexuality; and also taking into consideration the extent to which the tissue is cut signifies an underlying concept of the dominance of patriarchy (Monagan, 2010), which will be discussed in detail in the discussion section of this thesis. The next sections discuss the second major theme, what inspired the circumcisers to continue with their practice.

4.3 Motivation to be a Circumciser

Motivation to be a circumciser was a major theme which describes what influenced the circumcisers to opt for the career and continue with the procedure despite the challenges they faced. The theme was divided into three sub-themes namely a 'Family Career'; 'Source of wealth and income'; and 'FGM as a Source of Power and Respect'. Female circumcision as a profession is commonly carried out by older women in the community who have the knowledge and skills to perform the procedure, in Wagogo tribe the circumcisers are known as '*Ngariba*'.

4.3.1 Circumcision: A Family Career

Two out of three participants provided their insights into how they became circumcisers. In their own words, they described circumcision as a family career that was passed over from one generation to another. They indicated that their great grandmothers were circumcisers, their grandmothers were also circumcisers, so were their mothers: as a result they ended up becoming circumcisers. In addition, they revealed that it was a tradition in the past for each clan to have its own circumciser. The decision to train a future young circumciser was made carefully by selecting an apprentice among the young daughters. The apprentice was provided with skills how to perform the procedure alongside with indigenous knowledge of natural remedies and

cultural norms of the society. Modes of imparting knowledge included observing, imitating and performing the actual procedure under the supervision of a chief circumciser who was a grandmother or mother. Participants 1 and 3 explained how they became circumcisers:

> I have been raised by my grandmother who was a circumciser. I grew up observing and learning our tradition of circumcision from my grandmother. People used to come and ask her to circumcise their children. By the time, I became a mature lady I was already an expert [Participant 3].
>
> This business was in our clan; when I grew up I found the skill to circumcise was in our family, my relatives including my great-grandmothers used to perform this tradition, as well as my mother who taught me [Participant 1].

As the career ran through the family, at the age of 15 or older, a girl who had already undergone the procedure was appointed to be an apprentice and learnt how to perform the procedure. During her apprenticeship, the apprentice gained a variety of knowledge about the procedure; first she learnt by observing and assisting the circumciser, then about the local medicine used for the wound after the procedure. In addition, an apprentice had to learn all the preparations including the rituals that are involved in female circumcision. It was an intensive practical training that involved performing the actual procedure. Participant 3 narrated how she became an apprentice and how she gained her expertise.

> …my grandmother was a traditional practitioner, she was also doing circumcision. So there were times when she asked me to help holding her working tools, so I observed her doing the procedure, I also asked her questions regarding the procedure…, she taught me how to hold a knife and which part to cut. Later on, having grown up as a mature woman, she allowed me to circumcise girls under her supervision [Participant 3].

Unlike the narratives given by the two participants above who inherited the knowledge and skills from their parents, the experience of participant 2 was different. According to the participant, in the old days, girls were circumcised by a close relative from the paternal side. There was no one in the neighbourhood from her husband's clan who could carry out the procedure on her daughters, so she was forced into the practice. She observed and learnt the procedure

from a circumciser when she was circumcising other girls in the neighbourhood. Later on, she was able to circumcise her own daughters. She emphasized that, she performed the procedure on all her four daughters and that was the entry point of her journey to be a circumciser. She noted

> My career as a circumciser started long time ago due to problems..., there was no body to circumcise my daughters. Situations forced me to be a circumciser. It was difficult for me to find someone to circumcise my four daughters after they had reached the age for circumcision. I had to do it… since then I became a circumciser [Participant 2].

The accounts by the participants given above point to the motivation for them to engage in the career as circumcisers. The quotations illustrate that the career was a family profession learnt after careful selection of the right candidate. However, according to Wagogo norms, the apprentice was not allowed to perform the practice unsupervised even after gaining the knowledge and skills to perform it. An apprentice was required to maintain her status as an assistant until the demise of her chief trainer after which she was allowed to work independently.

4.3.2 Source of Wealth and Income

Participants made it clear that apart from inheriting the practice from their relatives, the practice of FGM was their source of income. They explained that in the old days they circumcised girls for the exchange of material things such as domestic animals and farm products like sorghum, millet and maize. However later, due to low production of farm products as a result of climate change, money was used in exchange for the service. Participant 3 and 2 gave their accounts in the following excerpts.

> In the beginning, when I started this job, there were no payments in cash. Parents used to come and ask for assistance and in return they gave me a few presents as an appreciation fee. These presents were food and some piece of clothes (*kanga*) [Participant 3].

> …in those old days, cash was not the means of payment to the circumcisers…, parents used to offer food, maize, millet or

> groundnuts to circumciser. It was mostly food that was offered and not cash, and later things changed to cash rewards [Participant 2].

After some time, things changed as mentioned earlier: the procedure was no longer paid in kind or by exchanging with presents. Parents were required to pay cash for the circumcision of their daughters. Thus, circumcisers were charging money to the tune of 2000 up to 3000 Tanzanian shillings (equivalent to one Pound Sterling). This amount was considered a large sum of money in those days as narrated by the participants below:

> …Later on, they started paying us in cash. We were paid TZS. 2000 or even TZS. 1500 for circumcising a girl depending on the parents' income status. There are others who used to pay up to TZS. 3000 [Participant 3].

> Few years later, the fee was TZS 2000 per person. …it was a lot of money, imagine you have a group of 15 or 20 girls…, it was a lot of money [Participant 2].

In the past, there was no law against female circumcision: in that sense the girls were free to be circumcised. Hence, there was mass circumcision which involved a huge number of girls who were circumcised annually. When participants were asked about the precise number of girls they used to circumcise on a yearly basis, they responded as follows:

> I can't even recall the actual number…, a lot of years have passed, but I have performed numerous number of circumcision in my lifetime as we were only two circumcisers in this village…, me and my colleague who was on the other side of the village. I was operating from this locality, and she was operating from the other zone. There were times when a lot of girls wanted to be circumcised, so we had to work together…, we started in my zone and when we were done, we moved to her zone [Participant 3].

> I don't remember the exact number as I did not keep any record, I estimate that I have circumcised more than a thousand girls during the entire period of practice. During circumcision time, I used to circumcise 15 to 30 girls at one occasion [Participant 1].

As evidence to show that the money they received was a large sum, the circumcisers explained how they spent the money including building good

houses and managed a decent life because of the practice. Consequently, the career became a source of income as well as wealth.

> We were happy when we approached the circumcision season [June each year] …, because it was a season to make money for farming, paying school fees for my children and buying other basic needs [Participant 3].
>
> Through circumcision I made a lot of money…, I was rich…, I even managed to build a modern house out of the money I earned from circumcision [Participant 2].

The participants were not only satisfied with the amount of money they realized from their practice but also counted themselves as rich due to the amount of money and economic power they possessed. This was somehow strange as the Wagogo men were known to possess all the resources, power and fame. This special treatment that was extended to the circumcisers suggests one thing: the dominant patriarchal system was deliberately empowering a few women so that they might uphold the interest of men regarding the continuation of FGM. In other words, men allowed circumcisers to prosper at the expense of maintaining the tradition of FGM. This introduces the underlying concept of empowering of circumcisers and maternalism. In the same context, the findings suggest that circumcisers were not only allowed to acquire resources and wealth but also commanded respect, fame and power in exchange for upholding the tradition of female circumcision as will be discussed in the next section. This is in line with the same concept of ‘maternalism’.

4.3.3 FGM as A Source of Power and Respect

All participants were of the opinion that circumcisers were regarded as powerful, renowned and highly respected people in the society.

> We were highly respected and feared by the society including men as we were perceived to be the custodians of the tradition (Participant 1).

One of the reasons for the participants to maintain and preserve the tradition of female circumcision was the admiration and respect their grandmothers and mothers received from the public. When they were allowed to practise independently they were overwhelmed with the same level of respect and

treatment as their parents had received, as noted by participants 1 and 3 below:

> My grandmother influenced me to do the job…; I lived with her, and I always saw the way people in our village and neighbour villages treated her with respect [Participant 3].

> Respect and power that my grandmother received from the society, which was then granted to me, tempted and motivated me to continue with my job despite its challenges [Participant 1].

Participants explained how they were appreciated by the society even when they were still apprentices of their grandmothers. The demise of their grandparents signified that the responsibilities were shifted to them. Participants shared their experience regarding the treatment they received from the society after assuming the role and positions as circumcisers following the demise of their grandparents.

> Parents of girls used to see me assisting my grandmother during the procedure. So even after she had passed away they believed that I have inherited her skills. They had faith in me and treated me with respect as they did to my grandmother [Participant 3].

> I was known all over the place as we were only two circumcisers in this village…, parents in this village and nearby villages respected me and were requesting me to circumcise their children. [Participant 1].

This section has presented the findings about what motivated the participants to be circumcisers. Apart from being a family career, circumcision was a source of both wealth, power and respect. Again, as discussed above, the patriarchal system empowered a few women to acquire fame and respect so that they might continue to indorse and advocate FGM, hence the concept of empowering few women at the expense of oppressing the majority of women, which will be discussed later. The next section presents the findings on the participants' experience of being circumcisers.

4.4 Experiences of Circumcisers in Managing the Outcomes of FGM

This final major theme discusses the views of participants who had multiple identities as circumcisers, traditional healers and traditional birth attendants: their experiences in performing the procedure and managing its outcomes. The

theme has three sub-themes ‘It was a challenging career’; ‘Multiple identities of circumcisers and their roles in managing consequences of FGM’; and ‘witchcraft involvement’.

4.4.1 “It was a Challenging Career”

This theme was identified following the participants’ accounts that revealed the challenges they were facing during the procedure. Participants admitted that circumcising girls was difficult work. They described their former work as dangerous and unsafe, in that it involves cutting delicate tissues of a girl who is struggling because of pain. Participants expressed the view that circumcising females was a risky job as anything could happen during the circumcision process. For example, dealing with a struggling client, a circumciser can accidentally cut an adjacent organ or cut a large blood vessel which could lead to excessive bleeding or even death. Participant three articulated her experience:

> I remember one incident where I almost lost my client, it was the turn of my neighbour’s girl to be circumcised…, she looked terrified and scared. Seeing that, I asked my assistants to hold her down. As I started cutting her, the girl stood up, and the razor blade accidentally cut her urinary canal deeply. The bleeding was uncontrollable [Participant 3].

Furthermore, participants reported some incidents that had happened during the procedure which made their work hazardous. At times interaction between rituals performed by a circumciser and other rituals performed by ancestors, spirits or gods could result in complicated procedure. Participants shared their experiences about such incidents.

> Some time back, I circumcised an oracle girl *[mtoto wa dawa] …,* whose mother had gone to a traditional healer who gave her medicine so that she could conceive…, after the first cut, the girl bled severely, fainted and lost consciousness for three days…, the healer who performed the oracle ritual was recalled who offered sacrificial offering and the girl regained her conscious [Participant 2].

Participants identified excessive bleeding as another challenge that complicated the procedure. They pointed out that severe bleeding during circumcision could occur for no apparent reasons. Sometimes envious

traditional healers could send a concoction that could interfere with the procedure and lead to serious consequences.. One participant narrated her experience:

> There were five girls whom I circumcised with ease, however, after a short while they bled excessively to the point that I got worried, but I thank God, they didn't reach to the point of fainting though they were very weak [Participant 2].

Participants clarified that severe bleeding on the other hand was a result of an evil eye. People with bad intentions stared at the girl during circumcision which might exacerbate the blood loss. Participants explained that:

> At times, a child bled excessively because people gazed at her during the circumcision. As for me, during circumcision…, I did not allow people to be around, it was only the three of us…, one who held the child from behind, and the other who provided me with operating tools…, I didn't need too many people around me [Participant 2].

When the circumcisers were asked to estimate the blood loss during the procedure, one participant compared the blood loss during circumcision with a blood lost when a goat or a cow is slaughtered.

> …It depends where the razor blade has landed on during the struggle; if you happen to cut the upper part of the vagina the girl would bleed like a slaughtered cow [Participant 1].

In addition, participants reported that loss of consciousness as a result of severe bleeding was a common phenomenon. Participants explained that it was very challenging for them when the girl fainted for more than one day as they did not have the skills to resuscitate them.

> …, excessive bleeding that may result into fainting…, sometimes a girl fainted and gained consciousness after one day, it has happened to me when I cut a girl and she fainted until the following day [Participant 1].

> I circumcised a girl…, after the cut, she fainted and lost consciousness for three days, it was difficult for me as I thought she was going to die [Participant 2].

This section has presented participants' accounts of the challenges they faced during the circumcision procedure. Challenges were either internal originating from a struggling girl or a result of poor skills of a circumciser or external, such

as envy and evil actions from spirits, traditional healers or ordinary people who were not in good terms with the family of the girl. In the next section participants shared their views regarding their multiple identities and how their different roles assisted in managing the complications that circumcised women experienced as a result of the procedure. Their views reflect their experience as circumcisers, as well as women who have undergone FGM.

4.4.2 "Multiple Identities of Circumcisers and Their Roles in Managing Consequences of FGM"

As indicated before, circumcisers had multiple identities: apart from being circumcisers they were also traditional healers and traditional birth attendants. As circumcised women had various health issues related to FGM, the same women but in a different capacity were available to manage health consequences encountered by women who had undergone FGM. This theme, therefore, presents the participants' accounts of how they discharged their multiple roles depending on a given identity at a point in time. Participants mentioned several consequences of FGM, which are grouped into five categories. First, the immediate health concerns such as excruciating pain and blood loss experienced by participants during the procedure. Secondly, how they were involved in treating wounds after the procedure and other complications such as wound infection and abdominal conditions that developed as a result of FGM. Thirdly, they explained the sexual experience of circumcised women, in which they provided accounts of their own sexual experiences; they also explained the interventions they were required to take where there was difficulty in consummating marriage as a result of FGM. Fourth, as they were also traditional birth attendants, they articulated with accuracy how they assisted circumcised women during delivery. Lastly, they provided accounts of the psychological outcome of their clients following the procedure, and their own psychological experiences as circumcisers.

4.4.2 a) The Girls Endured Excruciating Pain Because of the Procedure

Severe pain and excessive bleeding were mentioned by the participants as incidents that were part and parcel of the procedure. The FGM procedure involved the excision of the clitoris, which is one of the most sensitive parts of a

woman's body. In the absence of anaesthesia, the operation evoked severe pain. Circumcisers clarified that during circumcision, the women endured severe pain as the operation was done without the use of a pain-killer.

> Each woman had to experience pain, which was very severe but there was no choice, we used neither anaesthesia that doctors use in hospital when they are doing operation...nor painkiller. In our tradition pain was part of us [Participant 3].

Participants added that, as girls experienced severe pain during the procedure, we had to use extra force to hold them down in order to reduce the risk of cutting other adjacent organs. Participant one explained as follows:

> They screamed and cried a lot…, those who tend to be stubborn we were using extra force by adding more people to ensure that we hold them steadily on the ground. One woman would put her thigh on girl's tummy as the circumciser continues to circumcise her…., it was a struggle and torture [Participant 1].

Participants stated that during the operation girls were expected to cooperate although there were in severe pain.

4.4.2 b) We Managed the Outcomes of Circumcision: Wound Infection and Abdominal Conditions due to FGM

Participants were asked on average how long it took for the wound to heal, they responded that it depended on the client: some took a short duration while some took quite a long duration to heal. However, those who experienced wound healing within a short span of time also had clean wounds and required few wound dressings. According to participants those who took a long duration for the wound to heal had 'rotten wounds' covered with pus, indicating that the wound was infected. They noted that wounds that were covered by greenish pus took longer to heal than those with yellowish pus.

> My young daughter's wound troubled her…, it took almost a month for her wound to heal…, the wound was oozing yellowish pus, I felt sorry for her. She blamed me for her pain "mom you are the cause of this ordeal.., it was best if you could leave me alone" [Participant 2].

Participants also mentioned another cause of longstanding infection, they argued that each and every family was required by the customs to placate gods

and spirits with sacrificial offerings. In the event that the offerings were not accepted by the spirits, the girls's wound could be infected and healing took a long time. In their accounts the participants clarified that in those circumstances, the wound infection was severe, covered with greenish foul-smelling pus.

> If the spirits deny the sacrifices…, no matter how much medicine is applied to the wound, it won't heal. The wound will rot no matter hard you try to clean and dress it…, it rots to the point that it affects the urinary and womb system. You will see greenish water and strong odour coming out [Participant 1].

Participants were of the opinion that apart from the wound infection, there were high chances that the local infection could spread to other areas. In particular they mentioned abdomen, urinary bladder and the uterus as the organs likely to be affected. Participants who assumed triple roles as circumcisers, traditional healers and traditional birth attendants gave the possible outcome of the infection when one of the organs mentioned above was affected. For example, abdominal pain was a result of two sides of the raw wound healing together leaving a minute opening for menstrual blood which could lead to a retained and confined menstrual discharge in the uterus, which could cause abdominal extension and pain. Ascending infection could involve the urinary system and cause lower abdominal pain, while there are cases that end up with infertility as the infection ascends to the fallopian tubes. Participants noted that:

> Sometimes the girls failed to urinate because of the pain…, then I know the dirt of the wound has been transported to bladder. When this happened I give medication.., traditional herbs [Participant 1].

> …, a girl may present with lower abdominal pain especially during her periods…, later on the pain may be persistent as she is unable to let out menstrual blood due to a tiny vaginal opening. If no intervention is sought in time, the girl may become barren [Participant 3].

4.4.2. c) Re-Circumcision as a Result of Sexual Difficulties

Participants informed me that women who have undergone FGM may experience sexual difficulties as a result of the procedure. These difficulties include narrowed vaginal opening and reduced sexual desire and energy. Participants described how narrowing of the vaginal opening because of

infected and poor healing of wound may lead to painful sexual penetration or inability to consummate marriage. Participants stated that:

> When the girl's wound is not cleaned properly, it may lead the two sides of the flesh to heal together. The girl needs a daily check-up after circumcision by putting a finger along the incision so as to put apart the two sides of flesh to avoid narrowing of the vaginal opening. In case there is a tightened vaginal opening, which might necessitate re-circumcision. [Participant 1].

Participants stated that a woman with narrow opening faces difficulties in her marriage as the husband may find it hard to penetrate her.

> …you will hear of the man complaining that he can't consummate the marriage…, saying the girl has "*nena lugaga*" meaning that her vagina has completely closed, he can't penetrate during sexual encounter [Participant 2].

The wound could be badly infected and in the course of healing the two sides of the vulva may join, blocking the vaginal opening. The only viable solution was to subject the girl to another operation to detach the two sides. Participant 1 expressed how she dealt with such cases.

> We did a second circumcision, immediately after the procedure she was taken back to her husband's home…, the husband was encouraged to make love to her while the wound was still raw to prevent it from narrowing again [Participant 1].

The above quotation suggest that circumcised woman was subjected to torture as she suffered both physical and psychological pain by subjecting her to a second procedure, which was done without anaesthesia. In addition, her ordeal continued when the woman was required to allow her husband to penetrate her when the wound was still raw as a means to prevent the vaginal opening from narrowing.

There was a myth among the participants that circumcised women may experience reduced sexual desire and pleasure due to severe blood loss during the procedure. They believed that blood loss was likely to lead to loss of sexual desire and energy later during her womanhood. They clarified that.

> Too much bleeding during circumcision was the cause for less sexual desire and energy. Even men nowadays deny those who

> have been circumcised, saying that they are less energetic when it comes to lovemaking [Participant 3].

Following her remark, I asked her about her own sexual experience as a circumcised women. She responded that:

> I also support this…, heavy bleeding reduces sexual energy. There are some women of my age from other tribes that can still perform sexual intercourse like young girls as they are strong and energetic, but for me…, (laugh) I totally have no sexual feelings nor desires. As you know…, for those uncircumcised women, a man plays with her clitoris till she is turned on, ready to have sex. But we, the circumcised one got no clitoris, so it's hard for us to be stimulated…, a man just penetrates an open vagina…, laugh…. [Participant 3].

4.4.2. d) We Assisted Circumcised Women in Child Deliveries

The majority of the women/girls who are circumcised went back to their circumcisers to seek obstetric assistance during labour so that the same person who had insights into how the circumcision and wound healing had taken place would handle her delivery. To demonstrate how the two skills of circumcision and birth attendant worked together, participant 1 provided her experience of assisting both circumcised and uncircumcised women during child delivery.

> Many of the women I circumcised came back to me for delivery assistance. I have experienced that assisting women with clitoris…, (uncircumcised) during child delivery is very easy. It is very hard for us to assist child delivery to the circumcised women. It is even harder to assist those with no clitoris (circumcised women) who bear a child for the first time (first pregnancy) [Participant 1].

Participant 2 echoed what was said by participant 1 that those who experienced difficulties in the delivery were the circumcised women, especially if the procedure had not been performed well:

> …there were some difficulties…, and these difficulties did arise when a woman was not well circumcised. Unlike circumcised women…, the uncircumcised ones have no difficulties during delivery [Participant 2].

The comparison between child delivery in the circumcised and uncircumcised women from the circumcisers' point of view was very enlightening as it offers in-depth understanding of circumcised women. In addition, participants reported that assisting a circumcised woman in her first pregnancy was more challenging than assisting the woman in her second delivery.

> Helping child delivery for a circumcised woman was very hard comparing to the uncircumcised one especially for those delivering for the first time. The opening of the fetal outlet was very slow for those who are circumcised due to the presence of the scar [Participant 1].

In order to assist safe child delivery, TBA had to cut the scar to allow free expansion as narrated by the participants:

> The scar does not allow free passage of a baby…, so during delivery the scar has to be cut for a baby to pass. This is a major problem faced by circumcised women [Participant 2].

Participants explained that they use their fore-finger nail to cut the scar

> During child delivery…, we normally use finger nail to open the scar. Having noticed a narrow birth canal and the baby is about to be pushed out…, I place my finger on the upper part of the vagina to tear the scar (healed wound) so as to widen the birth canal for the baby to pass [Participant 3].

However, as mentioned earlier circumcisers associated the consequences of FGM, especially the immediate and later ones, with other aspects like witchcraft, an evil eye and cruel spirits and not the procedure itself. Other consequences such as complications during labour were associated with poor technique and skills in performing FGM.

4.4.2. e) Harbouring FGM-related Pain, Hate and Anger

Participants provided their accounts regarding psychological consequences that their clients experienced as a result of FGM. Participants who were also circumcisers were able to elicit the psychological experience of their clients because of the long-term relationship that was established with them, especially with clan-appointed circumcisers. Clan-appointed circumcisers had known some of their clients since their childhood; therefore, the relationship was created long before the procedure and continued after the initiation. The

bond between the two was strengthened when the circumcised woman became pregnant and sought assistance during childbirth from the same clan circumciser. The circumcisers had also attended to some complaints and concerns that circumcised women might have. Thus, circumcisers were in a better position, sometimes more than the parents of the girls, to observe changes within girls.

As the majority of the girls were unaware of the details of the actual circumcision, there were no documented psychological complications before the procedure. Psychological experience was more evident at the actual procedure and thereafter. The participants were of the opinion that circumcised women were worried and anxious about their menstruation, complications in anticipation of a wedding night and thereafter, and complications during pregnancy and subsequent childbirth. It was interesting to note that while the participants described the psychological complications of their clients, they also provided accounts of their own psychological concerns as a result of their careers as circumcisers and as older women who had undergone FGM. According to participants, the psychological complications experienced by their clients during and after the actual procedure were pain, hate and anger as narrated below.

> I can talk from my own experience, the pain from cutting clitoris is unbearable; as you know, we cut without the use of any medication to relieve pain. Although it is more than 50 years since I was circumcised I still recall the pain [Participant 2].
>
> The pain was excruciating…, some screamed like animal, you wonder whether that scream comes from a human being. I am sure they hated us a lot as well as their parents for allowing this to happen [Participant 1].

Participants also mentioned that circumcised women were angry with circumcisers and their parents' due to a number of sequelae that developed because of FGM, for example, prolonged wound healing due to infection, repeated urinary infections, painful menstruation and anticipated painful childbirth. According to participants' accounts, one problem led to another, and each complication affected the wellbeing of the women. For example, delayed

wound healing led to narrowing of the vaginal opening, which caused painful menstruation as the menstrual flow was retained in the uterus. These complications evoked anger, frustrations and hate at different stages.

> Most of the girls were angry, chose to remain silent and reserved. When we nursed their wounds, you could read from their faces deep-seated anger, hate and betrayal especially because their parents had deceived them. [Participant 3].

In addition, participants mentioned worries and fear during courtship and following marriage, especially those who had experienced some physical complications. They were wondering how the first sexual encounter would be, given that others had narrow vaginal opening.

> First wedding night was full of worries and fear for our girls especially those who had other complications…, even me I was scared to death on my wedding night, I was not sure what will be the outcome, given that I did not have prior sexual experience [Participant 2].

Psychological distress in the anticipation of marriage was at two levels according to participants: First, in the old days a wedding night was the very first time a woman had sexual intercourse with a man. Secondly, the distress was due to a narrow vaginal opening.

> We were aware that the first night in marriage for circumcised girl is hell…, it was a night full of screams, pain and cries. Unfortunately, men like women who cry during the act (laughing)…, because of the pain, from day one a wife starts to avoid her husband [Participant 3].

Participants talked of a feeling of hopelessness for failing to accomplish the role as a wife to their husband, having low self-confidence and self-esteem due to frequent toilet visits as a result of chronic urinary infections and frequent irregular menstrual flow.

> …, I know first sexual encounter is difficult for our girls, but what can they do, that is the custom. With that pain do you think a woman has a desire to have extra-marital relationship..., she can hate even her husband leave alone another man. That is what men want [Participant 1].

Lastly, participants explained the uncertainty, doubt and worries that the circumcised girls bear before and in anticipation of childbirth. Leaving alone the

anxiety and distress caused by the pregnancy and uncertainty of the outcome of a normal pregnancy, to assist these girls during labour was a big challenge for the traditional birth attendants.

> During delivery…, the girls were worried about what would happen to them and to their baby [Participant 2].
>
> Some of the girls I circumcised were concerned…, they kept on asking me how the baby would come out when their husband was unable to penetrate them…, others asked whether it would suit them to deliver in a hospital given the problems they have experienced since the procedure [Participant 3].

This section has presented the views of participants who had multiple identities and how their multiple roles served the circumcised women. Circumcisers in their different roles became part of the lives of circumcised women. Even though circumcised women hated the circumcisers for performing the procedure they were forced to accept them as the only 'helpers' given their skills in traditional medicine and child-birth.

4.4.3 "Witchcraft Involvement."

According to participants, the season of mass circumcision in the village was the most stressful moment for the circumcisers as people who were not happy with their achievements or popularity would use witchcraft to disrupt the procedure. Hence, witchcraft was declared as the number one enermy of a successful initiation ceremony. Evil people could take advantage of the procedure to bewitch both the circumciser and the girls so that the circumciser would be held responsible for any bad outcome related to the procedure. Apart from the participants assuming multiple identities, as circumcisers, herbalists and traditional birth attendants, they also had concoctions to prevent their practice and their clients against witches and the users of witchcraft.

As is revealed below, other circumcisers out of jealousy bewitched the practices of their colleagues. Hence, it can be assumed that if a circumciser had a concoction to prevent witchcraft, s/he might as well have the ability to bewitch someone. In other word circumcisers were bewitching each other. That

is why circumcisers had to perform rituals and offer sacrifices before engaging with circumcision as the following quotations testify:

> We have strong belief on the presence of witchcraft and evil eye during the procedure…, witchcraft during circumcision is something that has existed since ancient times [Participant 2].

> Witchcraft in Wagogo tribe during circumcision is something we experienced since we were born …, people talk about it [witchcraft], so you just believe that it is there [Participant 2].

Participants reported that due to the belief in witchcraft, parents and relatives took preventive measures when their daughters were about to be taken for circumcision because of the belief that during circumcision the witches and their enemies may take advantage of the situation to harm their daughters. Participant 1 asserted that:

> At the time of taking girls for circumcision, both parents and relatives were worried for their daughters, whether the practice will be successful, or there will be some problems. They performed rituals to protect their daughters from witchcraft [Participant 1].

However, participants emphasised that their role as circumcisers made them more vulnerable than the parents because if something bad happened to a girl, it might result in a bad reputation for their work, hence, losing customers. They stated that:

> As circumcisers, we were mostly worried…, scared the child may die and we will have to bear the blame for the death. If death happened …., we ended up losing customers [Participant 1].

Furthermore, participants mentioned that the reason for using witchcraft to bewitch one another was a struggle for power and prestige among the circumcisers. For instance the witches might bewitch the girls with an intention of spoiling another circumciser's work. A participant narrated as follows:

> My friend and I were both circumcisers…, so if it happens I have a large number of girls to circumcise, I would ask her to come and help, and she won't do anything bad toward me. However, for an unfriendly one, she might use this opportunity to bewitch my work. For instance, you are about to cut a girl's flesh and you wonder the knife isn't cutting [Participant 1].

Participants described witchcraft as the most challenging problem to complicate their job. They emhasised that withcraft may be used to spoil the work of an

expert. As discussed previously immediate complications such as severe blood loss and infection of the wound were associated with witchcraft and evil eye. Circumcisers acknowledged that the use of incantation through traditional medicine was important for the better outcome of the procedure.

4.5 Conclusion

This chapter has discussed the findings of former circumcisers, their understanding of the origin of FGM, attitude towards FGM and their experience of the procedure and its consequences. A number of concepts were identified and discussed. This chapter has highlighted the potential psychological consequences of performing FGM to the circumcisers, given the uncertainty of the outcome of each client, but also due to the external forces such as witchcraft which could interfere with the outcome of the procedure. In addition, they have provided insights into the psychological distress of their clients as they related the issues of hate, pain and anger among the circumcised women. This chapter sets the scene for the next chapter, which examines the experience of the women who have undergone FGM and how they are able to cope with their condition.

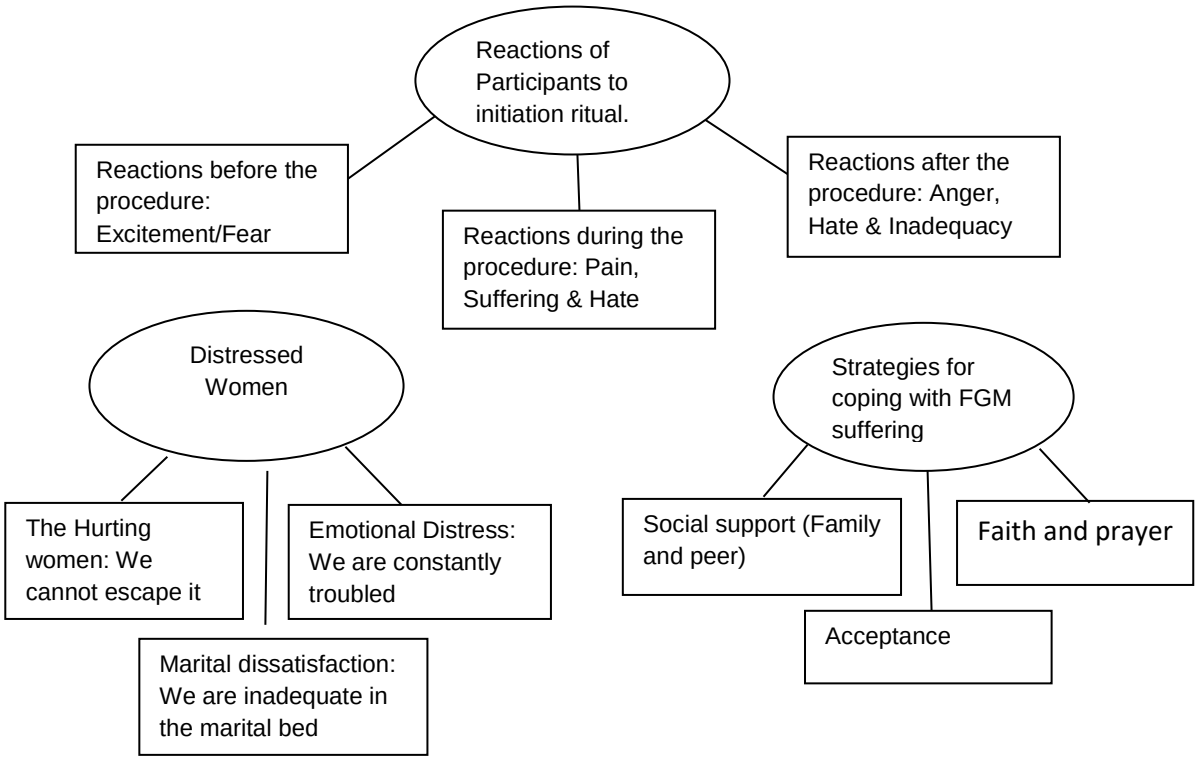
CHAPTER FIVE

STUDY FINDINGS: CIRCUMCISED WOMENS' EXPERIENCES

5.1 Introduction

The previous chapter discussed the findings regarding the knowledge, attitude and experience of the former circumcisers in relation to Female Genital Mutilation (FGM). The aim of this chapter is to present the findings related to the experiences of women who have undergone FGM. After detailed analysis of the women's accounts, this chapter presents three major themes. First, 'Reactions of Participants to Initiation Ritual'; second, 'Distressed Women' and third 'Strategies for Coping with FGM Suffering'. Each theme is underpinned by three sub-themes as shown in Figure 5.1 below.

Figure 5.1: Showing three major themes and sub-themes



(Source: Author (2015). The themes in the figure were generated from the research data).

The sub-themes will be discussed and illustrated with empirical evidence from the participants. The chapter is divided into four sections: all sections discuss the three major themes as listed above.

5.2 Reactions of Participants to Initiation Ritual

The major theme ‘Reaction of Participants to Initiation Ritual’ discusses the degree to which girls reacted to the initiation ritual, what it involves and how they were affected by it. The initiation ritual, of which circumcision was a part, involved many people. First, the parents and relatives of the girl, neighbours and villagers: their involvement was in terms of preparations for the ceremony, which includes foods, alcohol and dancing groups. Second, the circumcision procedure involved the circumciser, her assistants and facilitators who were responsible for providing teaching and training on the one hand, and the potential clients (the girls) to be circumcised on the other hand.

The major theme took into consideration the reactions of the girls during the time when they were about to be taken for initiation, during circumcision and after the procedure. The majority of the participants were familiar with the initiation rituals, although they had varied understanding of what transpires during the procedure. Participants explained in detail the preparation phase before the actual event, what happened on the day of their circumcision, recovery from the wound and thereafter the celebration following their transformation to womanhood. This theme has three sub-themes, the ‘Reactions Before the Procedure: Excitement / Fear’; ‘Reaction During the Procedure: Pain Suffering and Hate’; and ‘Reactions after the Procedure: Anger, Hate and Feeling of Inadequacy’.

5.2.1 Reactions of Participants before the Procedure

The sub-theme discusses among other things; the awareness of the participants about the initiation ritual before the actual ceremony; the meaning of the ritual, their expectations about the outcome of the ceremony and their understanding whether the initiation ritual involves circumcision.

5.2.1 a) Our Mothers and Grandmothers Informed us about the Initiation Ritual

As reported earlier, the initiation ritual in Wagogo was carried out between the ages of 7 and 15 years. At that age parents discuss and agree to send their girls for initiation rite. It was the responsibility of a mother or grandmother to inform a girl about the initiation ritual. The majority of the participants were informed by their mothers:

> …my mother told me that I had to visit my grandmother's house ready for initiation rite. She told me that I was mature enough for the initiation ceremony [Participant 14].
>
> I was informed by my mother, she said, "you are now grown up, be ready for initiation ritual [Participant 6].

Other participants reported that they were informed by their grandmother as during that period they were living with their grandmothers' due to various reasons, such as death, divorce or re-marriage of their parents:

> … I remember my grandmother simply informed me, "Today we are taking you for initiation ceremony", I could not refuse as it was normal for girls at a certain age in our community to go for initiation rite, and I was at that age [Participant 7].

Participants demonstrated different levels of understanding about what initiation is all about. Depending on the prior information they had received about the ritual, the girls portrayed mixed feelings; some received the news with pleasure, eargerness, expectations and excitement, while others were nervous and anxious.

5.2.1. b) Reaction to Notification about a Rite: Feelings of Pleasure and Excitement

The majority of participants explained that they were happy and excited before the initiation procedure because they understood that the ceremony involves among other things eating honey, a feast and receiving gifts for the occasion. In other words they were completely ignorant of the circumcision procedure that was awaiting them. Most of them did not have the details of what it takes to attend an initiation ritual or to be circumcised as they were given either incorrect information or insufficient facts regading the procedure. Some of them reported that they were deceived by their parents and older girls who had

already attended rituals before them that they were going to eat delicious foods.

> I was told that at the "*Makumbi gawadala*" [initiation ritual] we would be given honey to eat and plenty of other foods. So, I was waiting with a sense of high expectation. When the time was due my father bought a "*debe la asali*" [20 litres of honey] for me. I was happy when the time was due for circumcision. I did not know that parts of my genitals would be cut, I expected nothing but honey [Participant 4].
>
> My mother told me to go to my grandmother's house, as she has prepared honey and good food for me. I was very happy, I did not know what circumcision means. All I knew was…, something that every girl in our community had to experience [Participant 1].
>
> They used to deceive us that they have prepared for us sheep tails to eat for feast…, so we were ignorant…, I was excited as it was my turn to go and eat sheep tail. I did not experience any fear as I trusted my parents; there was no reason for panic [Participant 2].

Some of the participants were informed earlier about the initiation ritual. Nonetheless, they were not given detailed facts about the procedure. They conveyed their feelings as follows.

> I felt happy…, I had no fear, because I was informed in advance about the ritual, although I did not know it involves cutting…, I simply heard about it, but I did not know exactly what was all about [Participant 6].
>
> I was eager to attend the initiation ritual… We [participant and her sister] were informed about it although not in detail. I did not know the meaning of it until I got there [Participant 9]
>
> I was very excited not knowing that I would suffer the pain due to a cruel cut. I did not know what ritual meant; I knew it as…, a tradition that every girl in our community had to attend [Participant 10].

A few participants clarified that they were neither misled nor informed about the event, but they were happy due to the hustle and bustle whereby parents and relatives were celebrating the initiation ritual by dancing, singing and feast.

> I was happy…, or maybe I can say…, I was ignorant that's why I was happy seeing a lot of people singing, dancing and drinking local brew at our house. A day before the ritual, I could not eat…, I was excited about the coming event, I did not feel any fear for the procedure because I did not know exactly what would happen to me on that day [Participant 17].

> I was cheerful, I did not feel any fear for the ceremony because I did not suspect anything bad would happen to me [Participant 8].

Some participants explained that they were happy for two reasons, first, they envied those who had attended the ceremony before, and secondly, they were satisfied that they were conforming to the norms of the society that required Wagogo girls to attend the initiation ritual.

> I received the news with joy because the custom and tradition require us to comply with culture. I had no idea what it involves. …, however, I had been told by my childhood friends that the ritual includes remove of something from the private parts, I did not pay attention to that information [Participant 5].

> So, I knew this was a necessity because all of my sisters and my friends went through the same and my mother told me if I do not attend the ritual I won't be married…, I just received it happily and calmly [Participant 9].

The quotations above revealed that the majority of participants were not conversant with the facts about the initiation ritual and that it involves the procedure of FGM. Thus, their reaction to the anticipated initiation ceremony reflected their ignorance of the procedure. The next part will discuss the reactions of participants who were aware of the procedure and what it involves.

5.2.1. c) Reaction to Notification about a Rite Feelings of Fear, Distress and Nervousness

The procedure of female circumcision was treated as top secret in the Wagogo tribe. Circumcised girls were forbidden by traditional norms to discuss circumcision matters with uncircumcised girls. However, there were a few girls who violated this rule and had informed the girls who were not circumcised about what happened during the procedure. Thus, some uncircumcised girls were aware that circumcision involves cutting of female genitalia, and there was nothing about eating honey as some girls believed. Participants who had information at hand about the circumcision procedure presented with feelings of fear, distress and anxiety before the procedure. as explained below.

> My friend who was circumcised before me informed me about the detail of the procedure. Out of my innocence…, she told me that "she was cut like this and that and so on." Having heard this, I asked my mother "you told me when the time comes we will go to the bush to eat honey…, I have found out the truth." My mother

> was annoyed, she demanded “who told you? Stop behaving like that…, you simply listen to me and calm yourself down”. She further said you too will be offered the best honey [Participant 9].

Participants who were knowledgeable about the procedure disclosed that they were terrified and distressed about what was going to happen. Others reported that they had fallen sick as a result of fear of circumcision while others thought what would be the outcome of the cut. Participants clarified as follows.

> I was worried throughout the month of May as circumcision took place in June, since I was aware what was going to happen on that day. So…, I was so nervous that I used to fall sick now and then, in the interval of 2 to 3 days [Participant 22].

> I was disheartened and disturbed to think of the procedure awaiting me. I spent sleepless nights, tormented by deep thoughts. I was worried of the outcomes of the procedure such as blood loss, pain and the duration the wound would take to heal [Participant 3].

Some participants received contradictory information regarding the ceremony, as they received information from more than one source. Sources outside the family informed them they were going to be cut. Information within the family maintained that they were going for a feast. Subsequently, they were scared and confused not knowing whom to trust. One participant noted:

> ‘I was afraid because I knew what was going to happen to us though our parents had told us we are going to eat honey’ [Participant 15].

The above section has shown the reactions and feelings participants had before the FGM procedure. Participants’ feelings varied depending on the information they had received earlier before they were taken for the initiation ritual.

5.2.2 Reactions of Participants During the Actual Procedure

This sub-theme provides the participants’ experience concerning the time when they were waiting for their turn to be circumcised; it also reports their experience and feelings during the actual circumcision procedure.

5.2.2 a) Circumcision Site and People involved

Almost all participants recalled the details of what transpired at the circumcision scene; from the preparation and organization of the operation site to the number of people involved. They expressed this as follows:

> The local village administration was responsible for preparing a secret venue for circumcision. Three camps were kept separate from each other. The assembly area, here girls waited for their turn to be circumcised. Then, the operating site where circumcision took place; third, a recovery area where those circumcised were nursing. The operation site was set far from the other two camps and drummers were set between the waiting camp and circumcision site, they would beat the drums very hard so that it is impossible for the screaming girl to be heard by those in a waiting site [Participant 4].

When the participants responded to a question about the number of people who were involved in the procedure at the circumcision site participants stated that:

> When you get there [the circumcision site], you will find the circumciser and her two assistants, and two women that will take you to the 'operation site' while about two more would simply be watching to see what is going on. There might be six or seven people all together. In the waiting camp two women would be there to engage the waiting girls with singing and dancing [Participant 6].

The next sub-section discusses the experiences of participants at the waiting camp as well as during the operation. Even though some participants found it difficult to share the details of the procedure, a reasonable number of them shared with me their experiences describing their situation as that of panic and fear.

5.2.2. b) Panic and Fear

The participants articulated how they went to the 'waiting venue' as a group of girls who were singing and dancing with joy. They were informed that one girl at a time would be led to another spot to eat the real honey. However, after a while they noticed that those that were taken to eat honey never returned to join the group. As time went by the number of those who had left the 'waiting venue' outnumbered those who remained. Thus, some of the participants were anxious to know the plight of those who were taken away as they noticed they

were no longer a homogenous group. Anxiety was transformed into a panic when a girl that was escorted to the operation site was ordered to take off all her clothes. Participants who had no clue they were going to be cut expressed the feelings of confusion, panic and fear:

> I found an older women a [circucmiser],and her two assistants…, they told me "today you are no longer a child, soon you will become a…, beautiful women". I was confused and a bit worried as I did not have an idea what was going to happen …, they asked me to undress and lay down, I was frightened, I was about to ask the meaning of that statement when I felt a sharp pain as the circumciser begun to cut my flesh [Participant 23].

All participants were frightened and lost hope when the 'real honey' turned out to be a 'real cut'.

> I was terrified suddenly I felt someone touching my private part…, I wanted to resist the attempt but the other lady (Mary's mother) touched my hand and whispered to my ears "do not worry everything will be fine…, she added don't cry otherwise your mother will die, as I was still internalizing what I heard, I felt something sharp like a blade cutting my private part, oh … the pain was unbearable I can not explain, I couldn't open my eyes nor cry for fear that my mother would die [Participant 12].

> I was one of the last girls to be circumcised, having seen many of my friends were taken away and have not come back, I was afraid…, I sensed that there was something awful going on. After a short walk, we found out three women, the woman who brought me, asked me that I should undress and sit down, I obeyed, I was full of fear…. four women held me as the circumciser began to cut me [Participant 11].

The quotations above demonstrate the state of girls who were completely unaware of the procedure having believed their parents that they were going out for celebrations; only it turned out to be the worst day. While most of the participants experienced a state of panic, distress and fright, those who had a slight idea of the procedure presented in a state of anxiety mixed with fear, not quite sure how painful it was going to be. The next section discusses their plight.

5.2.2. c) Fear and Anxiety

During the interview, some of the participants who had an idea of what was going to happen, expressed their feelings of anxiety and fear. They were tense

and worried when they were asked to undress and lie down, with their legs held firmly and spread out ready for circumcision. Their fear was due to their ignorance of the extent to which the flesh would be removed and the duration for the procedure. The procedure triggered a strong feeling of intense fear as it seemed to be more painful and took a long time beyond their expectation. The quotations below clarify this point:

> It was a terrifying moment of my life, I was informed about the procedure by my friends, but their explanation did not match anything to the experience I came across. The extent of flesh cut was too much, and the time used for the operation was just too long [Participant 24].

Some participants testified that having realized they were going to be cut they tried to run away from the circumcision site because of fear but they were grabbed and cut.

> They told me I was the next person, since I knew I was going to be cut, I asked permission to go to the toilet," Instead of going to the toilet I run away but …, they caught me and took me back [Participant 13].

Apart from being in a state of panic, anxiety and fear; participants sum up their views by describing their experiences as one of helplessness, powerlessness and hopelessness as the next section discusses.

5.2.2. d) Helplessness, Powerlessness and Hopelessness

Helplessness, powerlessness and hopelessness were often mentioned by the participants who shared their feelings during circumcision. Participants revealed that the procedure involved the use of force as the procedure was done without prior knowledge, consent, or anaesthesia. Some reported being blindfolded by a black cloth so that they would not figure out what would happen to them. As a result, the majority stated that they were unable to resist or help themselves. Some lamented that they were treated like law-breakers who were sent to the bush to be persecuted.

> …they blindfolded me so I could not see. I was helpless, otherwise, I would have not settled down waiting to be cut, I would have fought back [Participant 1].

> … It was hard for me but, what would you expect me to do? I was young, simply receiving order from my parents. I was powerless, unable to help myself [Participant 17].

Participants explained how the use of force was applied to control girls who were struggling during the cut:

> I resisted vigorously…, they held me down forcefully, and proceeded to cut me. I was nervous, agitated and distracted. I screamed and howled without any help. Hopelessness can best describe my situation [Participant 3].

Some participants expressed that they lost hope of escaping the cut and decided to calm down and to let the circumciser do what she intended:

> I was struggling at first then a heavy woman set on my chest and held me firmly down as a thief, I could not breathe, I despaired…. So, I yielded. I simply remain calm…, although I was so angry and full of hate to the extent that I did not cry, though I felt sharp pains [Participant 9].

> … they placed me on a ridge and one of the woman positioned herself on my back and held me tight against the ground ridge, they kept me steady; and the circumciser begun to circumcise me. She used a small axe to cut my private part, the pain was unbearable [Participant 1].

Other participants explained that although they were pinned down steadily and helplessly, they resisted and expressed their anger by screaming and shouting at the circumciser and her assistants:

> Then…, it was my turn to be circumcised. When they began the operation, I remarked defencelessly “why do you cut me…, are you cutting it all away?” So…, they cut and finished the operation. …, I told the circumciser that I was going to inform my father what she did to me” …, I shouted without any help [Participant 11].

Many participants lamented about how weak and vulnerable they were during the procedure. They were not allowed to cry or scream as by doing so, they were told, their parents would die. The circumcisers used this trick to force the girls to endure pain for two reasons. First, a high-pitched scream would distract the circumciser who might end up causing damage by cutting adjacent organs. Secondly, it was likely a scream would send a warning signal to other girls that were waiting for their turn to sense that things were not safe and that they were in danger.

> I was seated, then I felt a sharp cut to my clitoris. I was then told "You have licked honey" …, It is a taboo to cry. "What goes on here is your secret, do not tell anybody else" so you have it [circumcision] done without a cry, 'do not cry at all' you are told, 'if you cry you will find your father and mother dead, who will take care of you'?. 'Consider so and so, they did not cry, their parents are still alive'. On hearing this, I never opened my mouth [Participant 4].
>
> …, I sat down my aunt was behind me, she supported me at my back. A lot of different things went through my mind, they told me I was coming here to eat sheep tail, how come they are telling me to undress…, thereafter my grandmother told me to close my eyes, if I open them or cry, my mother would die [Participant 14].

The above views of participants indicate that both groups, those who were deceived about the procedure and those who had prior information, reacted the same way to the cutting. As the procedure was done without anaesthesia they all experienced severe pain, which was accompanied with disbelief, hatred, distress and anger.

5.2.3 Reaction of Participants after the Procedure

"Reactions of participants after the procedure" is a sub-theme that presents the experiences of the participants immediately after the circumcision procedure as well as many years after. Most participants were shocked and disturbed not believing that their loved ones would undermine the trust that had been built from childhood. Participants expressed feelings of sadness, confusion, disbelief, anger and hatred as they had been circumcised without their consent.

5.2.3. a) Undermined Trust

As they had been misinformed about the procedure, most participants felt disappointed by their loved ones. They complained that the circumcision procedure was carried out without their consent, and they were not informed how it would be carried out. Participants thought that their parents took advantage of their youth to decide for them. Apart from complaining about the effects of circumcision, participants were more disturbed by their loved ones who had deliberately deceived them. In their words participants felt that their parents undermined their trust, as a result they found it difficult to trust their parents again.

> I was affected very much because they did it to me without asking me. However, that was not as painful and disturbing as undermining my trust that I had in them. They deceived me that I was going to eat honey instead of getting honey I was tortured. I find it disturbing and unforgivable [Participant 22].

> I couldn't believe that my mother did this…, allowed this to happen to me. I felt bad that she has let me down [Participant 15].

Another participant alleged that she was disappointed by her mother as she had fooled her to the extent that she carried a spoon to the circumcision site believing that she would use it for licking honey.

> Mmh what kind of deception it was…, I was told that there was honey, and they insisted that I should take a spoon with me. Instead, I found myself in a place where I was forced to undress. My whole body was trembling with pain and fear as they cut my private parts; they were disloyal to my trust [Participant 23].

While another participant admitted that they had been given some honey before the procedure; however, the honey was too little, contrary to their expectation. She noted that:

> It is true that we were offered honey, but the amount of honey was negligible…, too small, we were just being deceived in order to be circumcised [Participant 4].

The quotation provided above suggests an underlying concept of betrayal of trust which will be discussed in the discussion chapter. The next section discusses the participants' feeling of sadness and confusion as they found it difficult to comprehend how a parent would allow her daughter to suffer.

5.2.3. b) Sadness and Confusion

Immediately after circumcision participants had a sense of sadness and confusion. They felt sad because they could not believe that their parents who had always been their protectors since they were babies could change overnight and become so cruel. Participants stated that:

> On the same day, my mother came to visit me, I cried miserably, asked why she would allow other people to treat me in such a cruel way. 'It hurts' I told mama. My mother replied, "be brave, be strong, that is how you have become a mature woman" [Participant 19].

> I was shocked, and I felt sad because I could not expect my mother who loved me dearly could be the one who put me in this mess; to be honest I felt so sad and upset at her [Participant 23].

Another participant explained that she was confused and that she kept on asking herself a number of questions that had no appropriate answers.

> I was confused and asked myself…, "Why did they have to circumcise me?" At least they should have asked me first if I wanted to be circumcised or not [Participant 1].

The confusion and sadness that was shown by girls was beyond comprehension as they could not believe that their parents would allow an outsider to cause such horrible pain to their daughter. Confusion and sadness confirmed the concept of betrayal of trust and love that was introduced in the previous section. Confusion, sadness and betrayal of trust were compounded into anger, hatred and resentment as discussed in the next section.

5.2.3. c) Feelings of Anger and Hatred and Resentment

Feelings of anger and hatred were evident because of the deception involved in the whole process of circumcision. Most of the participants showed resentment at the deceit. They expressed feelings of hate towards their parents and relatives for not telling them the truth. They were also angry with the circumciser who carried out the procedure:

> I was mad at my mother and grandmother, I complained every day why they deceived me when they knew the procedure was painful. I was furious with all of them including my elder sisters for hiding the truth. Even now I do not trust them nor take their advice seriously [Participant 10].

> I still harbour strong bitterness against my grandmother although she is no longer. I hate her for deceiving me that the organ would be emitting foul smell. As a grown-up woman, I know uncircumcised girls do not emit any foul smell. I wanted to ask her why..., but she died shortly after the procedure [Participant 5].

> Up to this day I am still embracing hate and anger for that older woman who cut my private parts, though she died years ago [Participant 6].

The quotations above describe the degree of emotional pain the participants had because of hurt inflicted on them by their loved ones. The anger and

bitterness was so strong that even the demise of those who made decision for their cut could not erase the emotional pain. The experiences of the participants could be summarised by the underlying concept of unforgiveness.

5.3 Distressed Women

This major theme discusses several views and experiences of women who were circumcised. The theme reflects among other things, the experience of women at different times, from the moment they were informed, assembled, circumcised and thereafter. This major theme consists of three sub-themes, these are ‘The Hurting Women: We cannot escape it’; ‘Marital Dissatisfaction and Instability: We are inadequate in bed’; and ‘Emotional Distress: We are constantly troubled’.

5.3.1 The Hurting Women: ‘We cannot escape it’

All participants (circumcised women) experienced some sort of hurt or discomfort during and after the procedure. Women revealed four types of hurting or discomfort that circumcised women experience. These are bodily harm when the girls were cut without anaesthesia; secondly, discomfort because of delayed healing or infected wound; thirdly, discomfort brought by disturbed menstrual flow due to narrow vaginal opening; and pain during child delivery. According to participants they endured these different types of discomforts overtly but in most cases the experience was covert and silent, acknowledging it as something they cannot escape and accepting it as part of their life. Generally, participants described the discomforts as a burden they should put up with in their day-to-day life:

> For me circumcision hurt is like my label, my life is surrounded, defined and characterized by this discomfort as long as I live. I experienced it during the circumcision; I felt it every time I was in my menstrual period. I am tormented by unexplainable discomfort during childbirth. If you accept circumcision, pain will never depart you [Participant 15].

The above quotation illustrates the intense and persistent discomfort that pervades their everyday life. The intensity, frequency, duration and context of the hurt varied among the participants, but the bottom line is that life was and

still is full of discomfort caused by FGM. Participants provided their views regarding the four classifications of discomforts.

5.3.1 a) Bodily Harm

Participants articulated the bodily discomfort they had endured when they were circumcised. Given that the organ involved is highly supplied with nerve endings, the cut caused discomfort that no words can describe. They acknowledged that its intensity was unbearable due to the fact that the operation was conducted in the absence of anaesthesia.

> My friend, I have experienced several cuts in my life caused by knife, blade or a hoe. Never will I compare those discomforts with the cut of clitoris…, Oh no it is terrible. It is now more than twenty years since that awful day, yet the memory of it has never departed me, as I speak to you I can feel it now. I find it difficult to express it, the least I can say…, the procedure was overwhelmingly painful, horrible and shocking [Participant 1].

Another participant accentuated the point of hurt. She explained how women used excessive force to hold her down. The strength applied was too much that the force itself was enough torture.

> One woman…, she was our neighbour sat on my body and pressed me down to the ground, my aunt and another woman dragged my legs apart. I was devastated with fear, suddenly I felt sharp cutting my private part…, I felt severe discomfort as someone was stabbing me directly to my heart. I could hardly breathe because of the weight of that woman on my chest. After the operation, they took me inside the house. I cried all night long because of the pain [Participant 7].

> …, suddenly I was wet with a pool of blood. Oh…my sister, only God knows how hurting it was. Then they commanded me to stand up, when I stood up, it was all discomfort and dizziness I felt. [Participant 12].

The hurting was not a one-time experience: participants explained how they spent the first few sleepless nights after the procedure because of the agony from a raw wound.

> …in the first three nights I could not manage to close my eyes I had severe throbbing pain from the wound; it was like the wound was pulsating [Participant 8].

Another participant echoed this:

> The wound was hurting very much so I could never have a single moment to sleep [Participant 1].

Another form of discomfort according to participants was related to urination. As urine tends to irritate a raw wound due to its acidic and salt nature, most participants preferred to abstain from urination fearing to provoke pain in the raw wound. Subsequently, the discomfort was due to a voluntary extended urinary bladder and passing urine on a raw wound.

> I resisted passing urine for three good days after the circumcision fearing urine will trickle down to the open wound…, mmh it was extremely hurting, although we were encouraged to urinate as the urine expedites the healing process [Participant 23].

> It was a discomfort night because the bladder was full, I could not sleep, I did not want to urinate because a drop of urine on a raw wound was like another cut [Participant 7].

Furthermore, participants recounted another indirect discomfort of FGM, the backache. The discomfort was a result of an instruction given after circumcision: they were required to lie on their back and were not allowed to change position for three to four weeks in order to separate the two sides of wound (labia minora and majora). Lying on their sides would lead for the two sides of the wound to come together and that would occlude the vaginal and urethral opening, which would result into a second operation to detach the sides of the wound. Participants explained the torture of placing their body in one position for a long duration.

> …I had severe backache for sleeping on my back for weeks. I found difficult to sleep on my back. But what could I do? Contradicting the instructions is inviting another cut. Having experienced the pain of the first cut I had to be obedient. I was not ready for the second cut, but then I paid dearly by developing a bad backache. [Participant 22].

Participants were asked to clarify further their experience of sleeping in the same position when they were nursing their wound. One participant used a metaphor to express the choice of obeying the instructions, or suffer the consequences:

> …after circumcision you are given instruction to follow, it all depends on you. If you want to ‘buy one and get one free’ then the

> choice is yours. Simply close your legs or lay on your sides, you will be assured a second cut free of charge [Participant 10].

Girls were put in a common place, there would be people in shifts to ensure that the girls do sleep in such a way that the wound is left to heal undisturbed by wrong movement of thighs. The thighs must be kept separated and never brought together. It was believed that bringing the thighs together might reopen a sore and make it worse; it might also prolong the time to heal.

> Those helping the girls must ensure that everyone sleeps on her back. So, you find the attendants had no time to sleep, they must be alert and keep an eye on every girl. They did this in shifts [Participant 4].

Participants added menstrual pain as another form of discomfort caused by FGM. Participants articulated that, despite the effort to follow the instructions, there were times when the wound heals by joining the two end points of the cut, as a result the vaginal opening is considerably narrowed. This had effects on the menstrual flow as the small opening prevents the free flow of the menstrual blood which may accumulate in the vagina leading to lower abdominal discomfort. When a girl experiences this problem she had two choices, to report it and arrange for a second cut to widen the opening, or keep it a secret and endure a life-long silent discomfort. Participants had this to share regarding the experience of menstrual discomfort.

> The first menstruation following the cut was another nightmare, I experienced such a severe abdominal discomfort that was simply unbearable. Since then I experienced discomfort every month until I gave birth to my first son [Participant 25].

> My experience of MP [menstrual period] was not good at all…, it was heavy menses accompanied with abdominal discomfort…, I do not know what to say [Participant 19].

This section has thrown some light on the plights that women face due to circumcision. Bodily harm ranged from the discomfort due to a cut itself to pain of the raw wound, and discomfort associated with the management of the wound. The next section will highlight yet another hurt, the one related to child-birth.

5.3.1 b) Discomfort During Childbirth

In the views of participants, discomfort during childbirth was in three categories. First, FGM was associated with prolonged labour, hence discomfort. Secondly, FGM was linked to increased chance of local episiotomy which frequently caused heavy bleeding, and finally circumcision was associated with obstructed labour as will be discussed below. Discomfort during childbirth was somehow linked to sexual discomfort as the nature of the two problems were similar. Narrowing of the vaginal opening and a formation of a scar were reasons for sexual discomfort because they caused obstruction of free sexual engagement. Likewise, the same factors led to prolonged obstructed labour and tearing of the perineum according to participants. Their accounts tally with those of former circumcisers (refer to Chapter Four) who caution that in the absence of a skilled or trained healthcare provider a circumcised woman could end up with a bad tear. Irrespective of the number of deliveries she had experienced, a circumcised woman would need an episiotomy to relive a tight vaginal opening every time she bears a child. Participants expressed how circumcision had affected their delivery experience.

> Due to a scar formation, I had a prolonged labour, the child could not come out. I was informed later by doctor who managed my case that the head of the baby exerted pressure on my nerve and caused temporary paralysis to the area around the pelvis [Participant 1].

> Labour pains took about three days then I gave birth at home, and by that time there was no transport to go to hospital like today. However I thank God, I delivered normally, though they had to widen my vaginal opening. [Participant 4].

Some of the participants shared their experience during childbirth that involved among other things, widening of the vaginal opening to let out a child. The widening of the vaginal opening was done locally using the sharp finger nail of a traditional birth attendant. This information tallied with the accounts provided by circumcisers in the previous chapter.

> I gave birth at home, I was assisted by a traditional birth attendant, my mother and mother-in-law…, She had to widen my birth canal because the canal was not enough for baby's head. After birth, I was weak because there was excessive bleeding. [Participant 2].

> During the delivery, my birth canal was narrow, so the circumciser used her finger nail to tear the scar and widen the vaginal opening. After delivery, the cut was not repaired [Participant 6].

As for blood loss, the participants mentioned increased blood loss during labour as a consequence of FGM. The blood loss was due to a 'local episotomy' that was done by a TBA as a way to deal with the problem of narrow vaginal opening. In addition, a tear of the scarred tissue led to blood loss during labour.

> I gave birth at home, I was in labour pain for two days. During delivery, I had a rupture in the lower part, but I lost too much blood and lost my baby. I had dizziness for months [Participant 5].

> I felt intense long labour pains. I was taken to a Regional Hospital, I was able to deliver normally, though I suffered serious tear. The tear had to be repaired. However, as I was walking back home the wound gaped which caused severe blood loss [Participant 1].

In this section participants discussed discomfort related to childbirth because of FGM. Complications ranged from prolonged labour, increased blood loss and vaginal tear to death of the foetus. The next section will discuss the sexual sequelae related to FGM.

5.3.2 Marital Dissatisfaction and Instability: We are Inadequate in Bed

In this sub-theme, the participants provided their views and experiences regarding their marital life and how it was affected by FGM. In the first context, circumcised women describe sexual discomfort due to FGM. In the second, circumcised women complained that they have been victims of Wagogo men who have changed their standpoint: they now prefer uncircumcised women to those circumcised.

5.3.2 a) Sexual Discomfort

Most participants believed their sexual life was impaired because of FGM. They pointed out two major factors for not enjoying sex with their spouses. First, most of the participants had diminished desire for sex because of the discomfort that was constantly inflicted on them during sexual penetration due to a narrow vaginal opening because of an FGM scar that had distorted the elasticity of the vaginal opening. In addition, they experienced partial obstruction of the vaginal opening due to the healing of the circumcision wound

that had brought together the two sides of the incised tissues. Hence, the narrowing of a vaginal opening which led to difficult and painful sexual penetration. They reported that their husbands had to force entry, which led to bruises, tears and discomfort; thus, many women lost passion for sex. Secondly, women did not enjoy sex because they had reduced arousal and less pleasure towards sexual encounter because of the removal of the clitoris during the procedure.

Throughout the interviews participants expressed how they endured sexual discomfort and wondered whether in this world a woman can enjoy a sexual relationship with her husband. Women described their sexual experience as a horrifying moment in their life emphasizing that when they retire to bed their life entered a space of sadness, confusion and isolation. Several women conceded that they had never enjoyed sex in their lives. They described the sexual discomfort as like someone cutting the scar left behind by the procedure.

> For me…, it [sexual act] was felt like a blade cutting along the initial circumcision slit…, I experienced sexual discomfort for a year. I shared with a sister, she told me the discomfort was normal as the vaginal opening was widening up as I had not engaged in sexual affair before. [Participant 3].

> I felt intense pain during the act.., you know what, after circumcision my wound healed by forming a scar, I had significantly narrow vaginal opening, thus became the reason for intense pain when my husband tried to enter me [Participant 1].

Because of sexual discomfort, other participants argued that there were times they failed to sit or walk properly.

> I felt a lot of discomfort, it was intense suffering to the extent that it was difficult to sit down, I developed huge swelling that it became impossible to walk. To my surprise my husband did not feel any remorse to my suffering, instead, he forced me to make love saying that I will get used to the exercise…, and emphasised that was the work of adults [Participant 1].

Apart from the suffering caused by forced penetrations, other participants explained that they experienced additional torture because of a tear or bruising of a scar.

> I got married when I was still young…, On my first wedding night things were tough for me, I had tear of the circumcision scar I felt an intense discomfort [Participant 10].

According to participants, it is taboo in African culture to discuss issues related to sexuality, not only within the family, but also with those outside the family. It is considered a private matter that can be rarely shared. Some participants revealed that they chose to remain silent for fear of exposing their family and sexual affairs.

> I felt sexual discomfort each time I met my husband. Things were just like that…, I decided…, to suffer silently. I did not share with anyone. I was shy so I kept it to myself. I was prepared to face the torture [Participant 1].

The participants explained how the elderly women in the Wagogo tribe considered sexual discomfort as a normal thing that a circumcised woman should expect. In addition, they recalled the training they had received during the initiation ritual in which they were informed it is customary for a circumcised woman to experience sexual discomfort as clarified by participant seven:

> I felt pain…, but my grandmother told me before that it was normal for circumcised woman to endure sexual distress [Participant 7].

When participants were asked to comment on whether they did not enjoy sex because of the removal of the clitoris, an erotic organ in a woman, they answered as follows:

> As we were cut before we engaged in sexual affairs we cannot tell the difference between having and not having a clitoris. We are being told by women with intact clitoris that it is a pleasurable organ during sex. We have no idea …, laugh [Participants 25]

> Long laugh…, It is like asking a blind person since birth what is the difference between day and night …, laugh I hear people say clitoris makes the sexual experience sensational; we cannot comment [Participant 13]

In the accounts of the participants, one form of discomfort led to another. It was like a chain of events; accepting FGM was to engage in endless events of suffering.

5.3.2 b) 'We are being abandoned because we are inadequate in bed'

The previous sub-section provided detailed views of participants related to sexual discomfort because of FGM. They associated their circumcision status with the inability of a husband to consummate marriage because of a narrow introitus or presence of a scar that obstructs the vaginal opening. This sub-section goes deeper to discuss the participants' experience of marital relationship with their spouses. Circumcised women had complained of being deceived by a masculine system which claimed that FGM was a prerequisite for marriage. Having obeyed and conformed to the demands of the system, the Wagogo women are currently suffering another gross disappointment as most men have had their standpoint shifted as they are no longer interested in circumcised women. Consequently, many circumcised women have been divorced or abandoned by their husbands who have gone on to establish new relationships with uncircumcised women. Women talked of being incomplete or inadequate when it comes to enjoying sex with their partners.

> Young men, including older men over 60 years of age…, have completely changed, they are eager to engage sexually with uncircumcised women, they despise us who observed the tradition because we wanted marriage. I heard my brother in law complaining "These circumcised women are 'cold' in bed comparing to the uncircumcised women who are excellent in bed, what do they expect us to do?" [Participant 1].

Participants revealed their disappointment as they had undergone the procedure for the sake of men who maintained that women should be circumcised; now the same men are marginalizing circumcised women as incomplete and inadequate due to the removal of their clitoris.

> Now I feel insecure and disregarded because my husband prefers uncircumcised woman, though he has not told me directly …, I have been informed he is planning to marry another woman, uncircumcised one [Participant 17].

> I feel demoted and downgraded, there are times when he goes out and comes back at night to start an unnecessary argument. I suspect he has another woman, because they say uncircumcised women are good at romance compared to the circumcised ones. [Participant 2].

Some of the circumcised women were divorced by their husbands so that they might remarry uncircumcised woman. Participants explained that men claimed that uncircumcised women are sweeter than the circumcised. Even the uncircumcised women boasted that men preferred them because it is easier to bring them to a sexual climax than the circumcised ones. Participants recounted their experience as follows:

> Let me tell you something, there is a man in this village that has divorced his wife simply because she was circumcised in preference for one that has not been circumcised. Another man, has abandoned his wife leaving her behind with four children. I wonder whether my marriage will survive given that uncircumcised women claim they are sweeter than us [Participant 5].

To illustrate how seriously their marriages are affected simply because they are circumcised, one participant shared the story of a broken marriage in her village because the bride had undergone the procedure. Both bride and groom were from the Gogo tribe.

> There is a young man who fell in love with a girl and married her, when the man found out that the girl was circumcised, the same night the marriage broke down. The girl was divorced and returned home to her parents. Is this what we deserve from Wagogo men? [Participant 7].

> These days when a young man finds out his wife had undergone the procedure is not a sign of stable family. There will be no peace between the husband and wife as the husband has already tasted the ‘honey’ [uncircumcised woman] [Participant 1].

This section has discussed the plight of circumcised women in the marital relationship. A sense of betrayal was evident in circumcised women. They felt betrayed by men and the society at large by violating the norms and tradition of a society that respected circumcised women. Hence comes an underlying concept of betrayal that will be discussed in the next chapter. The next section discusses emotional distress caused by FGM.

5.3.3 Emotional Distress: We are Constantly Troubled

This sub-theme describes the emotional and psychological experiences of women who have undergone FGM. Emotional distress can be described as the culmination of processes that participants experienced when undergoing the

procedure of FGM. In every stage of FGM, whether at preparation, cutting or healing, its outcomes such as menstrual, sexual and childbirth discomforts participants described their emotional experiences related to these phenomena. Moreover, participants raised a pertinent issue regarding a shift of the ideological and moral standpoints of the Wagogo men. Historically, the patriarchal system of the Wagogo had maintained that it was a cultural demand that all Wagogo women should be circumcised. This moral standpoint was given impetus by men valuing, respecting and marrying circumcised women only. However, according to participants men have changed their standpoint: they now prefer uncircumcised women. This has been a source of psychological distress to most circumcised women. In every stage or aspect described above participants described their situation, which involved a number of underlying psychological concepts such as despair, disregard, betrayal, victimization and stigma that will form a basis for discussion in the next chapter.

Moreover, participants claimed that the emotional distress of FGM is something that they will experience for the rest of their life. They asserted that it will be difficult for them to forget their circumcision day. Below are the participants' accounts that depict emotional experiences after FGM procedure. The majority indicated that they still suffer the memory of the procedure even though it had been performed a long time ago. During the interviews, almost all the participants reported experiencing recurrent unpleasant memories of the circumcision procedure, and the fact that the memories had direct impact to them on mental and emotional suffering. They pointed out that soon after the procedure they used to dream about the events that took place on the day they were circumcised.

> There were times when I dreamt that I was being seized and being re-circumcised, I told my mother about the dream and she just said that it was something normal. It was nothing except my own imaginary, but the dream kept on re-occurring [Participant 5].
>
> It took me a couple of years to forget about it. The events are still in my head even when I sleep I dreamt about it, I used to scream in the mid of the night [Participant 12].
>
> I often did dream at night that I was crying out "leave me alone…, leave me alone." This was because of the strong mentally embedded fear [Participant 23].

Participants clarified that there were various things that triggered their bad memories of FGM. They stated that, they feared the tools that were used for circumcision and whenever they came across such tools, it activated the painful memories of circumcision.

> There are times I was getting frightened at the sight of anything that can cut, for instance when my mother was cutting a meat, I used to tell her to keep the knife out of my view, I felt as if the circumcision was being done on me…, or I would close my eyes or go away from the sight of a knife [Participant 3].

> Few days after the procedure my wound healed, and everything went back to normal, however I was scared and frightened when I saw a razor blade. It used to remind me the day they cut me. It persisted for many years [Participant 5].

> For a couple of years, I was very scared when I see someone holding a knife. As years passed by the degree of fear went down [Participant 4].

Other participants mentioned the circumcision scar as something that brought back the memories about the procedure.

> Whenever I touch my private parts, the scar reminds me of the day of my circumcision. I feel very bad; the thing looks very ugly. When I look at my daughter's private part, I see the difference, it is intact, but mine is an ugly scar. I hate it [Participant 17].

Some participants were full of resentment and anger when there was an initiation ceremony in the village for other girls. It reminded them of their own circumcision:

> I used to get hurt whenever there is a circumcision of the girls in the village, I felt the pain as if they were cutting me again [Participant 19].

Another critical reminder to the circumcised women which caused hatred and resentment to flare up was television programmes about FGM, particularly the peer educators who were not circumcised but pretend to describe the plight of a circumcised women as if they knew what they were going through.

> It makes me angry to watch someone who exaggerates the complications we face, as if those complications that we already experience are not enough [Participant 5].

Participants were not in favour of the campaign carried out by activists: instead of educating the mass in a dignified manner, they portray the complications of

FGM in a way that shows a circumcised woman is useless when it comes to sexual relationships. These kinds of messages are degrading as they affect the self-esteem of circumcised women and damage their confidence in their marriage.

> I do not like the way they talk about our complications in their campaigns. I know their goal is to discourage people from circumcision, but the way they present the message is dehumanised for us. For example, when they campaign on TV against female circumcision, I feel bad, angry and nervous. I ended up changing a channel or switch off the TV [Participant 20].

> Take an example of a campaign where women are told about the disadvantages of circumcision; they say circumcised women are poor in bed, they neither enjoy sex nor make a man happy. They are killing our marriages with their messages…, it is unacceptable [Participant 7]

> I hate girls to be circumcised but you cannot compare with hate I have for the activists; they have no respect of human dignity; they are worse than circumcision as they speak about us as if we are objects [Participant 11]

Probably the most disturbing event for the circumcised women is the change of moral standpoint of the Wagogo men who in the old days advocated the tradition of circumcising women. In their accounts, they preferred women who had undergone circumcision as described in the previous chapter. However, there is a wave of moral shift. Wagogo men now prefer uncircumcised women to circumcised ones. As discussed above, women feel they have been deceived, betrayed and disrespected.

> My husband has another woman; he says I am not satisfying him because I am circumcised, it is annoying because we were cut because of their demands, now they have changed their minds…, it is hurting [Participant 23].

> I wish clitorises were on sale, I could go and buy one at any cost…., laugh. I told my husband you cannot leave me, it was not my fault; when you advocated our cut didn't you know that the procedure was irreversible? Where do I get an intact clitoris when it was thrown into a bush? …, laugh [Participant 5].

> We have been victims of both men and activists who go around talking about our inadequacy and incompleteness as if we have been inviting them to watch us when we make love to our husbands. They make us feel we are disabled [Participant 13]

The above quotations where activists and Wagogo men are demeaning Wagogo women has been a source of psychological distress to most participants: some women were emotionally disturbed by the ridicule while some felt inadequate and incomplete. These quotations introduce the concepts of victimization, shame and stigmatization, and betrayal of trust that will be discussed in the next chapter.

5.4 Strategies to Cope with the Aftermath of FGM

This major theme discusses the different strategies that participants have adopted to cope with the consequences of FGM. The theme is composed of four subthemes; family support; peer and community support; acceptance; and faith and prayer.

5.4.1 Family Support

Family support was provided immediately after the procedure when the girls were still in pain. Mothers and close relatives of the circumcised girls spent some time to console and reassure the girls and explain why they had allowed them to undergo the procedure. Some participants stated that the support they received from their family members helped them to cope with the pain of circumcision.

> I got some comfort from my mother…, she kept on saying that it was our tradition and she has good intention for me to be beautiful and get married [Participant 19].

> It was hard for me but my mother, aunt and other relatives told me that I will get better, there was no need to worry, …, they have also undergone the same thing and they are OK [Participant 17].

As mentioned earlier, in the era before 1998, open ceremonies were staged for girls; the celebrations involved parents, relatives and friends offering the circumcised girls various gifts. Some participants stated that the gifts could cushioned the pain to some extent.

> Thinking of the great magnitude of people all gathered because of me; the guests were drinking local liquor, dancing and rejoicing in my honour was a great relief. I was offered new clothes, money, goats and a cow. It made me happy and forget the pain [Participant 7].

After the celebration participants continued to receive support from their elder sisters in the villages, who had undergone the procedure before them and from their peers.

5.4.2 Peer Support

Participants explained that apart from the support they received from their parents and other family members, they also received comfort from each other. Being in a group that had had similar experiences helped them to encourage each other and cope with their situation.

> Being in a group that have something in common was a positive way to mitigate or soften our experiences. Exchanging information among our group was a good coping strategy [Participant 19].

Older girls who had been circumcised before, were instrumental in guiding newly circumcised girls and helping them to view their experience as not unique but one which every woman has had or will experience. Participants shared how they were able to cope following the advice offered by the girls who had undergone FGM before them.

> After celebrations, the girls who were circumcised before us came to comfort us, they informed us that “you are grown up and would soon get married; without circumcision, forget to be married” so the feeling of resentment fade away because a new thought has been introduced [Participant 4].

Participants emphasized that in the past, girls had helped each other to cope with FGM complications. However, such support, like big banquets and gifts is no longer performed because of the introduction of the law against FGM practice in 1998. Coupled with disintegration of family support, peer support, and support from older sisters, is the fact that the preponderance of uncircumcised women in Wagogo communities is growing at the same time as the number of those circumcised is going down. Hence, social support is diminished as explained below,

> Nowadays parental, relative and friends’ support is not there. As uncircumcised women are increasing in number because of FGM ban, work of activists and change of men’s stand regarding FGM, we are being degraded; they say that we were foolish that is why we were circumcised…, we feel bad to hear such statements [Participant 12].

Participants felt good to share their experiences with other people; it helped them to ease the sufferings and emotional stress that they harboured for a long time. However, the participants' accounts show that social support that once worked nicely is losing its grip.

5.4.3 Acceptance (Adherence as a Cultural Practice)

Accepting that FGM is a cultural practice that every Mgogo woman must experience was a great coping strategy. Wagogo society had created a situation in which the pain and suffering caused by FGM was perceived as normal. This was true during the era before the introduction of the law in Tanzania against FGM, as almost all Wagogo women were circumcised. In fact, those who were not circumcised were despised and perceived as outcast. Acceptance was complemented by a social support that was effective to lessen the suffering of circumcised women.

> Circumcision was a traditional and customary practice. There was no way you can escape it as long as you were born a female. We accepted it and its consequences. It was normal to accept it as to keep in touch with social and cultural norms [Participant 13].

Participants emphasized that the best way to cope with the current situation where circumcised women are despised because of their status is simply to accept that the procedure was done, that part of the flesh was removed and there is nothing they can do about it.

5.4.4 Faith and Prayers

According to their explanations, some participants were found to be more resilient in coping with FGM consequences. Prayers were mentioned as playing an essential role in coping with FGM agony. Participants emphasized their engagement with God through prayers whenever they are in pain. They stated that God is their only solace, so they spent more time in prayer. They stressed that prayers helped them to lessen their sufferings.

> I just engaged into prayers, praying to my good Lord to erase the pain away…, I am sure what I experienced was a God's plan, if it was not his plan do you think they would have done it to me…, no I know it was his plan for me to undergo the procedure [Participant 17].

> Our village pastor taught us a verse from the Bible that if we trust in God he will help us to endure our burden and comfort us because he loves us…, I believe in him and I prayed a lot and God helped me to cope with my situation [Participant 15].

Other participants clarified that they felt shy talking about their experience with other people instead they depended on prayers hoping to get comfort from their Almighty God.

> It was my cross, so I had to carry it, I felt shy to tell my fellow women about my painful experience…, the best thing to do is to pray to Jesus to ask for comfort [Participant 5].

Faith and prayer were among the strategies that circumcised women used to cushion the suffering and pain of FGM. This strategy seems to bear more weight now as social support seems to have deteriorated following the law against FGM and destabilization of the system that embraced FGM.

5.4 Conclusion

This chapter has discussed the experiences of women who had undergone FGM. The findings show that circumcised women had several reactions, before, during and after the procedure; and how these reactions build up to paint a picture of a woman distressed physically, socially and psychologically. The accounts of circumcised women confirm the description of former circumcisers who in their accounts draw a system that is at work to sustain FGM. Women seem to express that they were circumcised to comply with the demands of societal norms. On the other hand, they appeared to perceive themselves as victims of circumstances as they were forced into the practice to comply with the demands of men but showed their amazement at the change of men's stance, from disregarding circumcised women to embracing uncircumcised women. Women see this behaviour as a deception and a betrayal of their trust.

The introduction of the law against FGM (as explained in chapter one), the negative messages of activists towards circumcised women, the change of men's stance and the destabilization of societal norms of supporting circumcised women not only are sources of emotional and psychological distress to circumcised women but have also affected negatively even those

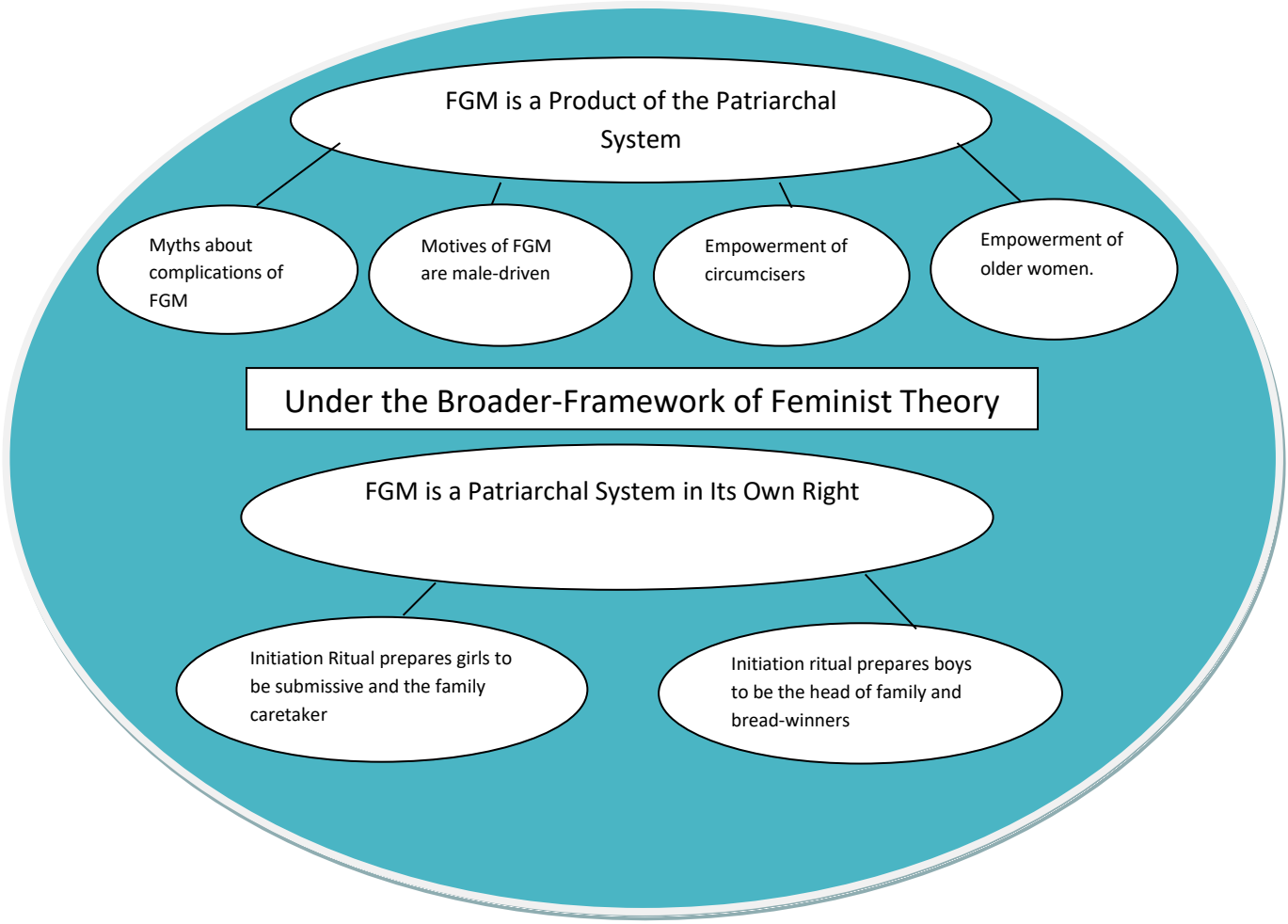
women who once thought they had successfully coped with the consequences of FGM. The lesson from this study is that the ability of women to cope with FGM is never linear or permanent. As men who have the mandate to decide the course of norms in a society change their perception regarding FGM, the reactions and ability of circumcised women to cope with FGM change also. The change of perception has turned things around: women who were once thought to be marriageable and admired by the society for being circumcised, have now become a laughing-stock. A status that once was perceived as a societal identity where those who did not own it were despised, is now perceived as a curse. This chapter and the previous chapter have provided the findings of this study; several underlying concepts have been introduced which will make a foundation for discussing the findings in the next chapter.

CHAPTER SIX: DISCUSSION

6.1 Introduction

The objective of this study was to explore the experiences of Wagogo women who have undergone FGM and explore the knowledge, attitude and practice of former circumcisers in Dodoma Tanzania. The findings of this study, therefore, serve two purposes: first, to address the research questions; and secondly, to contribute to the body of knowledge, as there is paucity of information regarding the experiences of women who have undergone FGM especially in the era where there are global and regional new developments related to FGM as shown in chapter one, and by the systematic literature review in chapter two. The current study has bridged the gap by employing an exploratory qualitative approach to capture information from both former circumcisers and women who have undergone FGM. Meanwhile, feminist theory, whose mandate is to empower women who are marginalized, stigmatized, victimized and oppressed by the patriarchal system (Kralik et al., 2008), has guided the discussion. Subsequently, this chapter presents discussion of the findings in two parts. Part I discusses the views of former circumcisers, while part II discusses the experiences of women who have undergone FGM. A conclusion is drawn at the end of the chapter. Feminist theory remains a relevant broader framework in tying together key findings as illustrated in the figure 6.1 below.

Figure 6.1: Relevance of Feminist Theory



(Source: Author 2015)

PART I: CIRCUMCISERS' VIEWS ABOUT FGM

6.2 The Former Circumcisers' Insights into FGM

The study findings in chapter four presented views of participants who are former circumcisers in the Wagogo tribe in Dodoma Tanzania regarding their knowledge about, attitude to and practice of FGM. Their accounts denote how the tradition of female circumcision is part and parcel of Wagogo culture, and aims at setting the context for discussing the experience of Wagogo women who have undergone FGM.

6.2.1 The Origin of FGM in Wagogo Tribe and Defining Gender Roles

According to former circumcisers the origin and source of FGM in Wagogo is unknown. However, circumcision in the Wagogo tribe has been practised for centuries, according to Peterson (2006) citing initial missionary publications, who states that FGM is believed to have been practised by the Wakaguru tribe as early as 1889, following its already customary status in the Wagogo. In this quotation, Peterson states.

> In 1889, a missionary Wood was disconcerted to find that some of Wakaguru girls (neighbour to Wagogo) had recently been circumcised, because Wakaguru did not normally circumcise their girls. He was informed that Wakaguru had adopted the Wagogo custom in this respect, (Wood, cited by Peterson, 2006: 990).

The former circumcisers explained how the culture of the Wagogo tribe demanded that they perform an initiation rite once a year to mark the ceremony for both boys and girls being transformed from childhood to adulthood, the climax of which witnessed their circumcision. This transformative ritual had two major purposes. First, to offer teachings that prescribe the gender roles for boys and girls and prepare them to assume adult responsibilities. Nevertheless, the training and teachings that went along with the ceremony attached different connotations to boys as compared to girls. For boys, the initiation was meant to prepare them to be adults and heads of family, how to manage resources, and how to maintain male supremacy over women; in essence, they were prepared to own a set of values that elevate men over women (Manabe, 2010). While for girls, the initiation prepared them to be submissive to their husbands and accept the traditional norms that subordinate and make them inferior without questioning. In other words, the initiation ritual and teachings aimed at introducing a social system that men used to dominate women; hence, the patriarchal system (Walby, 1990).

Secondly, the purpose of the initiation rite in Wagogo was to legitimize male dominance over women. Thus, the first purpose of the initiation ceremony gave rise to the second one. The distribution of gender roles and responsibilities where male gender is dominant, and the female gender is oppressed, reveals not only male dominance but also denies women access to resources (Teigen

at al., 2009). The findings of the current study showed that resources and wealth in terms of land, livestock keeping, housing and money were handled and managed by Wagogo men. Women were not expected to acquire any wealth, even where they were married; they remained keepers or caretakers of their husbands' properties.

This line of thinking suggests that the Wagogo men are raised to work hard to acquire wealth, property and demonstrate the ability to manage resources. In contrast, women are expected to be passive recipients (Walker 1992); underpinning, the concepts of oppression and subordination (Sultana, 2012). The findings in the current study concur with those of Manabe (2010) who found that women were docile, embracing domestic roles and responsibilities. These findings suggest that the prescription of gender roles in Wagogo tribe is a precursor for the maintenance of patriarchal system. The next section discusses how Wagogo men were responsible for the strategies to maintain FGM in Wagogo tribe, and how the tribal norms undermined women's ability to question the practice.

6.2.2 Motives for Persistence of FGM in Wagogo Tribe

All former circumcisers were of the opinion that Wagogo society has endorsed FGM as a social identity for women and regard it as a prime reason for upholding FGM. Wagogo society holds a belief that uncircumcised women are dirty, unsanctified and do not deserve honour. Thus, the respectability, admiration and acceptability of a woman in Wagogo society is measured according to her circumcision status. The decision of Wagogo men to use FGM to define a positive social identity for women is similar to the traditions of other ethnic groups that perform FGM: for example, the women of Kano (Ahmadu, 2000); Mandinga women (Johnson, 2000); and Kuria women (Ondiek, 2010). In their studies, the authors noted that FGM was perceived as a unique social identity that differentiated the circumcised from non-circumcised women. Wagogo women on the other hand, have accepted the tribal demands that their decency and valued social identity should be determined by their obedience to circumcision. However, accepting such a social identity is to

accept a power relation that identifies women as inferior to men. The acceptance of an inferior position by Wagogo women is in line with the other studies (Monagan, 2010; Vloeberghs et al., 2011; Gajaa et al., 2016) who highlighted that the continuation of FGM in the societies they studied was engineered by men who prescribed the social identity for women, who in return, accepted the requirement without questioning.

The second motive is related to the first one. The findings in this study illustrate that FGM is not only a symbol of social identity that guarantees the acceptability of a circumcised woman in a society; but also qualifies her for marriage, after being labelled a chaste, respectful and honoured woman. Thus, societies that practise FGM attach high importance to FGM as a marriage qualification, which is the only way a woman can access resources, given that wealth and resources are in the hands of men (Asiyanbola, 2005). Marriageability as a tool that subjects women to FGM has already been reported by several scholars, for example Ondiek (2010); Vloeberghs et al. (2011); Gele et al. (2013) and Bogale et al. (2014). In their views, marriage makes a woman a second-class proprietor of her husband's properties.

The third motive for sustaining FGM in Wagogo society, according to former circumcisers, is to control women's sexuality. There is a widespread myth among Wagogo that female circumcision is an antidote for sexual desire in a woman. The myth claims that a woman has uncontrollable sexual urges, and the retention of an intact clitoris will make a woman behave wildly. This finding is consistent with the experience of many societies that perform FGM, where men in a society use their dominant influence to control female sexuality (Fahmy et al., 2010; Gajaa et al., 2016). In Fahmy's study, women participants believed an "uncircumcised woman would be like a restless bull and demand a man" or would "reach orgasm while walking or even if someone holds their hand" (2010:184). Furthermore, participants in Johansen's study (2007) reported that, "an uncut woman will run after men and have sex with anyone" (2007:248). Yirga et al. (2012) reported that the community in the Kersa district believed circumcision controls women's sexual desire. While there is no evidence to substantiate the claim raised by the above studies, these

arguments are examples of male and sometimes societal driven mythologies about the clitoris, female sexual organs and their sexuality in general (Lockhat 2004). In this dominance, the male-constructed knowledge overrides that of women to the extent that women have been drawn to recite the male discourse about women's bodies without thorough proof. The findings of the current study add to the existing evidence that male dominance over women is responsible for maintaining FGM in order to control female sexuality.

6.2.3 Delegation of Power and Respect to Older Women and Circumcisers

All former circumcisers explained how older women and circumcisers were central in maintaining the tradition of female circumcision in the Wagogo tribe. The Wagogo system was structured in such a way that Wagogo men delegated some of their influence and power to a few selected women, who were the beneficiaries of benefits to which most women did not have access. In other words, they extended some privileges to a few against most women who were less privileged. Those privileged help to maintain the norms and values of society that fosters male dominance over women including enhancing the practice of FGM. Two forms of delegation of authority and influence were evident in the current study; the delegation of power to a few older women and the circumcisers.

As old women were highly respected, men used them to encourage the young couples/family to send their children for FGM. Participants explained how the older women persuaded them to circumcise their daughters. Thus, social pressure was highlighted as a factor that maintained FGM in Wagogo tribe. This finding supports the underlying concept of maternalism (Sklar, 1993). According to Sklar (1993), maternalism denotes another form of paternalism where older women exercise social pressure over other women's choices and preferences. Thus, older women are oppressing the rights of other women, similar to the pattern of male domination. It can be argued, therefore, that the male social system in its effort to conceal its dominance and oppression over women has delegated some of its power to forward the interests of men at the expense of the political, social and cultural freedom of young women (Weiner,

1993). Maternalism is a reason for continuation of FGM, transferring of old knowledge of, attitudes to and practice of FGM from one generation to the next; also, maternalism is a tool for maintaining and upholding norms that have been prescribed by men (Manabe, 2010). Consequently, older women through maternalism, are being used by men consciously or sub-consciously to exert pressure on other women to abide by the norms that please men. In most cases the strategies that the male system uses to sanction their dominance over women are camouflaged under the auspices of preserving tradition (Walker, 1992).

Apart from maternalism as a strategy to delegate power to the older women, men have also delegated some of their influence and respect to circumcisers. A better conceptual description of delegation of power to the circumcisers would be “empowerment” (Nayak et al., 2009). Nayak and his colleagues describe empowerment as a process whereby those perceived to be powerless or subordinated ‘gain greater control over the circumstances of their lives’ (Nayak et al., 2009:1). It is about having power or control over philosophy and resources (Grown et al., 2005). Empowerment broadly emphasises two elements. Firstly, it is about power to achieve desired goals and; secondly it is more applicable to those who are powerless. As described earlier, Wagogo culture, as is the case with the culture of other ethnic groups that perform FGM, has prescribed gender roles that see men as breadwinners and women as family carers (Monagan, 2010). This division of labour has enabled men to possess various resources while women are deprived of that privilege.

It has increasingly been accepted as a social norm that men in societies that perform FGM, and not women, should possess wealth. However, the current study findings and the findings of other studies (Yirga et al., 2012; Gele et al., 2013) have indicated that for male dominance over women to prevail, it would require a few key women who are strategically empowered to sustain their dominance over the majority of women. This view demonstrates that women are powerful contrary to the beliefs that men hold about women. For example, through their career as circumcisers, they were empowered to possess resources, power and honour, which other women could not. In their accounts,

the former circumcisers in the current study mentioned wealth, power and respect as the motives to continue and maintain FGM as a cultural practice, despite the strong challenges they were experiencing. A circumcision career earned them money, which assisted them to build modern houses, send their children to high school and live a decent life. Thus, it can be argued from the findings that the Wagogo male system used the strategy of divide and rule. A few women were given special status and allowed to prosper by paying back through advancement and maintenance of the dominant male system through circumcision.

To maximize the benefits of the privileges they receive from the society, circumcisers had assumed multiple identities. Apart from being respected as circumcisers, they were also recognized as traditional healers specializing in herbs and some in spiritualism. In addition, they also assumed the role of traditional birth attendants (TBAs) assisting expectant women to give birth. These roles and positions elevated their social status within the Wagogo society. It can be argued from the findings that in a patriarchal society where there is obvious predilection to allow a few women to prosper at the expense of the majority of women, that preference is set for a purpose (Grown et al., 2005). In the case of Wagogo, the decision to allow a few selected women to possess resources and power is to win their support in advancing and maintaining FGM. Olatunbosun (2000) also noted that the traditional practice of FGM is maintained by the involvement of women within the existing patriarchal system; a view also supported by other researchers (Abusharaf, 2001; Wilson, 2002). Thus, women's social, economic and political liberation is violated at the expense of a few women who are empowered by men. Those older women who are trusted by the female community as their leaders have betrayed their trust by accepting males' arguments that women circumcision is a societal tradition that should be maintained. FGM is therefore performed in the framework of a patriarchal system that underscores matrimonial faithfulness at the expense of female position but to the advantage of male honour.

A strategy of empowering circumcisers and a few old women in societies that perform FGM was meant to keep men out of the picture so that FGM would be

thought to be ‘a women business’ (World Vision, 2009). Even where men in the same societies were asked to comment on whether they would like to abolish FGM, men chose to stay away from FGM by supporting its abolition, but behind the scenes they were engaging in strategies to continue the practice (World Vision, 2009). World Vision (2009) reported an incident where the Masaai women in East Africa held a demonstration against FGM: they marched to the government and activists’ office protesting against the practice. However, when they were interviewed they said they were forced by men to carry on FGM. When men were interviewed, they supported women that FGM should stop and insisted that they had nothing to do with FGM, as it was a women’s tradition. This suggests that men do not like to be cited as promoting and supporting FGM. Instead they use a few women who have been strategically selected, positioned, elevated and privileged in the society to maintain the tradition. Consequently, it can be argued that the wealth, power and honour the circumcisers were receiving from the society was a reciprocal gesture given to them so that they would continue to maintain the submission to the patriarchal norm of FGM. The next part discusses the experience of women who have undergone FGM.

PART II: THE WOMEN’S EXPERIENCES

The discussion in this part is based on the key over-arching concept of pain and two underlying concepts of overt and covert pain, which have pulled together several concepts that were introduced in the findings chapters. These two fundamental concepts are then tied together by a higher concept of patriarchy (Walby, 1990) which has attributes of power, subordination and empowerment.

6.3 The Women’s Experiences: Pain as an Over-Arching Concept of FGM

The key findings of this study suggest that women who have undergone FGM had gone through various experiences which were almost similar, and where there was dissimilarity the difference was negligible. They described their negative experiences regarding the traditional practice of circumcision, which ranged from anxiety and fear before the procedure, distress and sufferings

during the procedure, discomforts while nursing their wounds and during their menstrual periods, to sexual dislike and mental stress. Circumcised women also reported that they have prolonged and difficult child-birth because of FGM. It is needless to mention that the psychological distress which participants experienced as a primary consequence of fear towards FGM procedure or as secondary to physical, sexual and obstetric complications is of critical importance. Pain, as propounded by Johansen (2002), is the over-arching concept that describes the sufferings, discomforts, distresses and frustrations of women who have undergone FGM. Johansen (2002) describes pain as personal suffering that is an unpleasant, distressful, unwanted and uncomfortable experience.

Following deeper reflection and insights into the findings of this thesis, two key concepts were developed, the overt pain and the covert pain which tie together initial concepts that emerged from the data. These two vital concepts form a developed version of the concept of pain proposed by Johansen (2002). Overt pain is that which circumcised women voiced, complained about or expressed symbolically or metaphorically. Overt pain was related to the pain during the cut, nursing the wound, menstrual discomfort, sexual pain and obstetric distress caused by FGM. Circumcised women also experienced a covert pain, which is unobservable, concealed, secret and silent pain. This is a pain that may have started as an overt one because of circumcision, and was left unattended, mistreated or ignored; consequently, it hibernated and persisted as a silent, concealed and lifelong pain.

6.3.1 The Overt Pain of Circumcised Women: The Physical Pain

Overt pain of the circumcised women is an accumulated experience of pain ranging from excruciating pain during the cut, heavy blood loss leading to shock, painful micturition, wound infection to backache. Other pains include, painful retention of menstrual blood flow because of a small vulvar opening to allow free flow. The current findings on pain are consistent with those of several other studies conducted in different geographical locations (Bjalkander et al., 2012; Bogale et al., 2014). Such studies lucidly illustrate that participants

experienced severe pain during the circumcision procedure and when the wound was infected. As for painful urination, FORWARD (2010) reported similar findings to those of this study; for example, one of their respondents noted that - “It is so painful as if a bee has stung you” (2010:16). Back pain and bedsores resulted from lying on their backs and lack of movement was reported by Dare’s study (2004); while dysmenorrhea was reported by El-Defrawi et al. (2001).

As for sexual experiences, the current findings demonstrated that many women reported pain during sexual encounters with variation in the degree of pain. While some participants described their sexual experience as a “torture” others referred to it as “less severe”. Participants described their sexual pain as mainly due to disfiguring and narrowing of the vaginal opening and repeated trauma inflicted during forced entry. Subsequently, a solution to a narrow vaginal opening in some cases, necessitated a second cut. Painful sex has also been reported by Rushwan (2000), Abdelshahid et al. (2015), Chu et al. (2016) and Mahmoudi et al. (2017) whose studies reported that circumcised women had higher chances of experiencing dyspareunia than women who had not undergone the procedure.

However, the findings of the current study and those reported above do not tally with the findings of Catania et al. (2007), Alisibiani et al. (2008) and El-Naser et al. (2010) who showed no significant difference in sexual pain scores between women who had undergone FGM and uncircumcised ones. The variations of the findings of the current study and other studies that elicited pain during sexual encounter against those that reported no pain experience could be due to two reasons: it is likely that their studies involved participants who had undergone a lesser form of FGM, type I, which is not associated with pain during sexual encounters. For instance, the study by Catania et al. (2007) involved women with type I FGM; whereas participants in this thesis and other studies that reported pain had experienced type II or III FGM, which make them more likely to experience painful sexual encounters than women with type I (Mahmoudi et al., 2017). Secondly, methodological issues could explain the

difference of the study findings, there could be variation of the measurement used in determining the outcome or the interpretations of pain. For example, it is important to determine whether the clinical assessment of pain is measuring the initial pain due to FGM that the circumcised woman experienced the first day she had a sexual encounter with her husband, the experience that Sherman et al. (2006) refer to as subjective pain; or is it an objectively assessable pain, the one that is observed and measured due to a real current sexual pain that is free from psychological and environmental factors related to the first experience of sexual pain as a complication of FGM (Sherman et al., 2006).

Because of painful sexual encounters, circumcised women in the current study had lost interest in sex, were not sexually satisfied and hardly ever initiated sex with their husband/partners comparing to the uncircumcised women in the same ethnic group who were described as sexually active and who would initiate sex. These findings concur with those of Alsibian et al. (2010) and Ibrahim et al. (2012) who found that the scores of sexual satisfaction, sexual desire and arousal were lower in circumcised women than in uncircumcised women. Furthermore, Vloeberghs et al. (2011) and Mahmoudi et al. (2017) reported that FGM affected the sexual act negatively and deprived women of feeling sexual pleasure, which led them to associate sex and marital life with fear and pain. This resulted in providing excuses whenever their husband/partners were displaying signs of wanting to have sex.

Regarding circumcised women in child-birth, the findings in the current study showed that they had obstetric experiences which were unique to them. The complications include tightened vaginal opening which warranted intervention in the form of episiotomy (performed by TBAs using traditional equipment): where episiotomy was not performed a tear of the perineum occurred. Other complications include prolonged labour, heavy bleeding per vagina following child-birth and increased intense pain due to inelastic scar tissue. The current findings reported how former circumcisers who doubled as TBAs found it easier to assist uncircumcised women during birth than circumcised ones. The current findings are consistent with those of other comparative studies that involved

circumcised and uncircumcised women. Prolonged labour, obstetric tears and episiotomy were reported by Khaled (2003) and Wuest et al. (2009); while Chamberlain (1996), Ndiaye et al. (2010) and Chibber et al. (2011) observed increased blood loss and increased possibility of losing both the mother and the child during birth. In the next section, the discussion is about the strategies that circumcised women used to cope with overt pain.

6.3.2 Coping with Overt Pain

From the outset, it is important to point out that the experiences and the coping strategies of women who have undergone FGM can be described within the context of two main eras, first, the traditional era from 1945 to 1980, and secondly, the contemporary era from the late 1980s to current times. Considering the traditional era is important for the current study because it marks the beginning of the campaign against FGM when the first Universal Declaration of Human Rights was adopted by the UN in 1948; since then several global and regional declarations and articles have been adopted as described earlier in chapter one. Secondly, the participants in this study, especially the circumcisers, were born as early as 1930s, so their experience goes back to the late 1940s.

The era after the 1980s marks the era of intensive campaigning, legislation and increased involvement of activists against FGM in countries that perform it. The distinction between these two periods is important in discussing the experiences of women who have undergone FGM, as will be outlined in the subsequent sections. This section presents and discusses the accounts of participants regarding how they were able to cope with overt pain and other FGM-related complications as part of the experience of women who have undergone FGM. The ability to cope with stressful situations depends on several factors. Among them are internal factors such as the motivation to accept and expect pain (Walker et al., 1995) within an affected woman, her perception and interpretation of and attitude towards, the pain. Others are external factors, such as environmental and cultural factors (Walker et al., 1995). In the same vein, circumcised women may choose to respond verbally or non-verbally. Given the factors mentioned above, circumcised women may

employ engagement or disengagement coping strategies to deal with their stressful situation (Carver et al., 2010). The next section discusses engagement coping strategies, which according to participants, were employed by circumcised women during the traditional era.

6.3.2 a) Engagement Coping Strategies

Before discussing the strategies employed by women to deal with overt pain, it is important to explore the practice of FGM in the traditional era. During the traditional era FGM was a compulsory procedure for all Wagogo women and was carried out openly as part of the initiation ceremony without any restriction. As the level of literacy and school enrolment was low, Wagogo people married immediately after the initiation ceremony because it was assumed that the next key milestone after initiation ritual was marriage as they were not enrolled in school, which could delay marriages. The movement of people was minimal: as such Wagogo men married Wagogo women; and urbanization was underdeveloped, hence did not attract movement of people (Peterson, 2006). Due to the type of communal life and togetherness of Wagogo society during this era, engagement coping strategies, also referred to as active coping responses, were the main coping approaches employed by the circumcised women.

Engagement coping strategies are deliberate efforts made by circumcised women, where women are either empowered or have strength within them, to face the stressors and related psychological distress in determining viable solutions (Carver et al., 2010). The social networking of Wagogo society made it easier for the engagement coping-strategies in the forms of social support, religious beliefs and acceptance to be the key means to support women to overcome the suffering caused by FGM.

Cheng et al. (2010) defined social support as “a social network’s provision of psychological and material resources intended to benefit an individual’s ability to cope with stress” (2010:676). In other words, social support refers to the support an individual receives from family members, peers and community members. The support could be emotional: love, caring, encouragement and sympathy. It is also about offering detailed information that explains a solution

to a problem or providing assistance that may help a person who is under emotional stress. It may also be provision of material support for practical problem solving (Uchino et al., 1996). The findings in this thesis demonstrate that social support was a major coping strategy which assisted circumcised women to face the hardships of FGM during the traditional era, when FGM was supervised by the elders of the Wagogo society and performed without restriction.

Wagogo, like other societies that perform FGM, had strategies in place to mitigate the effects of FGM by using a group of older women whose role was to comfort the girls after the circumcision procedure. They informed the girls of the importance and significance of the procedure and how proud the girls would be to have achieved such a respectable status (Helgeson et al., 1996; Schultz et al., 2014). Uchino et al. (1996) and Cheng et al. (2000) suggest that the mitigating strategies were used to rebuild the broken tie between the parents (mothers) and their daughters. Even after the assignment of the comforters, the circumcised girls were handed over to another group of mentors (a batch of senior girls who had been circumcised before them) to sustain the mitigating strategies. The group of mentors clarified to girls any concerns that they might have including answering their questions and reassuring them about any worries or anxiety they might have. Central to all these mitigating strategies was to cushion the impact of FGM and instil a sense of pride in the circumcised girls that they have fulfilled the cultural norm, attained marriageable status and can be regarded as honourable adult women (Schultz et al., 2014). Social support also was offered by circumcisers who on different occasions served as traditional healers and traditional birth attendants. Assistance and support also came from friends, siblings, peer group and husbands. As girls and later women were assured of societal and family support, they were quick to call for assistance whenever they needed it.

Apart from social support, which was an underpinning aspect of coping strategies for circumcised women during the traditional era, women also leaned on religious beliefs. It is natural when people are overwhelmed with psychological problems that they cannot deal with they tend to seek

supernatural interventions. The current findings and other studies (Lockhat, 2004; Street et al., 2005; Khaja et al., 2009) show that circumcised women, depending on their religious beliefs, pursued relief from God after realising that the procedure left them with permanent inadequacy. Whenever human interventions fell short of comforting them, they opted to seek God's intervention through a visit to church or mosque where they found considerable comfort and strength through intercessions (Vloeberghs et al., 2012).

Accepting that the cultural procedure had been performed and part of the flesh has been taken away was a coping strategy in its own right (Vloeberghs et al., 2012). Circumcised women in this study, as well as in Lockhat (2004), accepted that the procedure had been performed and there was nothing they could do to reverse the situation. This strategy was strong and effective as most of the Wagogo women were circumcised. A participant in Lockhat's study commented "because everyone had had it done, you feel as though you are part of a group...." (2004: 133). Hence, they preferred to accept the situation as a way of life and proceeded with life. The next section discusses the covert pain, the veiled pain that can only be recognized when the participant decides to share or when expert diagnoses it.

6.3.3 The Covert Pain: The Psychological Experiences of Circumcised Women

The previous section presented and discussed an overt, readable and audible pain; the pain that one can express, complain or cry out about; but also, the pain that other people can notice, feel and recognize its intensity: physical pain. This section covers the discussion on the covert, secret and silent pain; the enduring pain that can torment a circumcised woman, yet people around her may not be aware of the degree of pain she endures; the psychological pain. As indicated earlier, the covert pain can be a primary or a direct reaction of a circumcised woman towards FGM procedure, for example the pain of the cut without anaesthesia. Alternatively, covert pain could also be secondary to another complication of FGM, such as the feeling of inadequacy due to inability to enjoy sexual relationships. Most of the circumcised women in this study developed different levels of emotional distress, which will be discussed under the concepts of 'Fear and Anxiety', 'Hate and Fear', 'Betrayal and Distrust',

‘Sense of victimization’, ‘Shame, Despair and Stigmatization’, and symptoms suggestive of ‘Post-Traumatic Stress Disorder’ (PTSD).

6.3.3 a) The Covert Pain: Fear and Anxiety

The findings of the current study suggested that the circumcised women endured silent, secret and concealed pain of which only a few, and in some cases, none of the close family members were aware. Their experience of covert pain began immediately after reaching the circumcision ground, when girls were called one after the other and were taken to another place from where they did not return. Several participants experienced a sense of anxiety and uncertainty when they realized the number of girls taken away from the group were out-numbering those waiting for the procedure. Their feelings, which initially were accompanied with pleasure and expectancy, turned to anxiety and fear. The Diagnostic and Statistical Manual of Mental Disorder (DSM-5) defines fear as ‘the emotional response to real or perceived imminent threat, whereas anxiety is anticipation of future threat’ (American Psychiatric Association, 2013:189).

Participants in this study described their experiences in the remaining steps of the initiation ritual after the cut, as one full of fear and anxiety as they could not anticipate what was coming next. Hence fear and anxiety was a cross-cutting phenomenon which was reported both by girls who were aware that the procedure involves a cut and by those who were not. The difference between the two groups was how they reacted to the news about initiation: Women who were ignorant of the cut articulated how they were anxious about the initiation procedure, but they were perplexed and confused when they were ordered to undress for the cutting. Confusion led to fear, pain and a sense of disbelief how their parents could betray the trust and bond between them.

The experience of those aware of the cut was that of anxiety combined with fear or uncertainty about the procedure and its outcomes. They described the feeling as like a consuming fire. The current finding is in line with that of Behrendt et al. (2005), who revealed that 90% of circumcised women experienced feelings of extreme horror, fear, and helplessness during the FGM procedure. Fear and anxiety were also evident for those who showed signs of

wound infection, thinking that the wound might not heal and would cause a persistent foul smell. Moreover, they were afraid of having disfigured reproductive organs that could impact their marriage relationship and child-birth. The findings showed that participants were informed during the initiation teachings that they should anticipate pain at the first wedding night and during child-birth. Although, the purpose of informing them was to prepare them psychologically to 'anticipate and accept' these pains, the disclosure of that information had effects adverse to those intended. In reality, it created more anxiety and fear rather than preparing them to face the reality. These results concur with those reported by Vloeberghs et al. (2011) and Kahn (2016) whose participants testified that their wedding night was agonising and terrifying. Circumcised women also showed their fear of being socially labelled as sexually inadequate which in most cases led to victimization and stigma. In some women, the fear and anxiety led to anger and hatred.

6.3.3 b) The Covert Pain: Anger and Hatred

The findings suggested that circumcised women harboured anger and hatred towards their parents and circumcisers. The concept of anger and hatred was an accumulation of several experiences that affected the circumcised women. They were angry because they had not been informed about the procedure, which could have helped them psychologically to anticipate the pain. Their consent was not sought: it was a forced procedure. They were angry because they had been deceived; hence they regarded themselves as helpless, hopeless and powerless. Just as fear and anxiety were cross-cutting phenomena, so were anger and hatred. Participants were angry when they were cut, they were angry when the wound was delayed in healing, they were disturbed when they experienced painful menstrual flow, they were enraged when sexual experience became problematic and they were angry when they experienced difficult child-birth. Their anger was directed to those who had made decisions on their behalf and those who had circumcised them.

From the findings, there was no demarcating line between one type of covert pain and another; instead there was a spill-over of the effects of one form of pain to another. For example, there was no clear line between fear and anxiety

on the one hand and anger and hatred on the other. One form of pain led to or overlapped with another one or they all appeared simultaneously. Likewise, anger and hatred tend to overlap with betrayal and distrust. Hence, circumcised women may harbour fear and anxiety at the same time as they may be angry because they feel they have been betrayed by their loved ones as discussed below.

6.3.3 c) The Covert Pain: Betrayal as a Breach of Trust

The findings indicated that Wagogo girls were circumcised between the age 7 and 15. At that age, the girls were still under the custody of their parents, which means that they depended entirely on and put all their trust in their parents or guardians for the provision of basic needs including love, care, security and protection. The news that the girls would be taken for initiation celebrations was taken seriously by the girls who trusted their parents and had no reason to doubt them. When the initiation ceremony turned out to be a brutal experience, the girls realized that they had been deceived by their loved ones and felt the highest degree of betrayal. Betrayal is defined as an act which involves intentional harm imposed by a person who was expected to be trusted and loyal (Rachman, 2010). The existence of betrayal is strongly evident and real where there has been a breach of trust, the two must go together. Arguing from a psychological context, Fitness (2001) argue, “When those on whom we depend for love and support betray our trust, the feeling is like a stab at the heart that leaves us feeling unsafe, diminished, and alone” (2001:2).

As with anger, the participants felt they had been betrayed in three areas, all related to FGM. They were circumcised without their consent: participants wished they had been asked whether they would like to be circumcised. They were not informed about the actual meaning of FGM: instead they were deceived. These findings are in line with those of other studies (Walker, 1993; Johansen, 2002; Nazer, 2003; Schultz et al., 2014); in their studies which were quantitative in nature they reported that girls were betrayed by their loved ones by deceit or hiding the truth about the procedure.

Thirdly, they felt betrayed by the Wagogo men who have shifted their stance about marrying circumcised women, and recently prefer marrying uncircumcised ones arguing that they are sweeter than the circumcised ones. Thus, some of the circumcised women have complained that their husbands have been unfaithful in marriage. This complaint cannot be ignored as some men have been reported not only to be unfaithful to their wives but have also divorced their circumcised wives to marry the uncircumcised one. These assertions, however, may not be taken at face value as female circumcision is not the only reason of men being unfaithful or divorce.

Jacoby (2011) identified four characteristics of betrayal that are in line with this study. The characteristics are ‘deception, harm, disappointment of expectation and deliberate use of a relationship for one’ own gain’ (Jacoby, 2011:147). Deception is an essential characteristic of betrayal as ‘betrayers must deceive or mislead the ones they trust most to successfully carry out their intentions at critical moments in their relationship’ (Jacoby, 2011:147). In this study, most participants were circumcised following dishonest interaction with their parents or guardians.

The second feature of betrayal is harm. By offering girls to circumcisers, parents were subjecting them to an anticipated physical harm. The third characteristic of betrayal is disappointment of expectation, in this study, circumcised women were disappointed by the actions of their parents and guardians, which were contrary to their expectations. The girls expected love, care and protection: the act of taking them for circumcision against their will not only disappointed them but they also did not expect that such brutal actions would be approved by their parents. The action of giving away girls for circumcision affected the girls both physically and psychologically (Rachman, 2009). Deliberate use of a relationship for one’s own gain is a final characteristic of betrayal. Parents used their close attachment with the girls to consent them to FGM because they wanted to adhere to societal norms and preserve family honour and respect. These four characteristics of betrayal can have psychological consequences, which can lead to traumatic experiences commonly referred to as betrayal trauma (Freyd, 1996).

Betrayal trauma is defined as a trauma that someone experiences after his/her trust has been violated by people upon whom s/he depends for existence, such as parents, guardians or care givers (Freyd, 2008). Betrayal trauma for women that has developed since childhood can be in the form of physical, emotional, or sexual abuse committed by parents, guardians or caregivers. These abuses have the potential to cause physical and psychological effects on the victim. FGM can be considered as a form of physical abuse, which can lead to betrayal trauma. The findings in this thesis showed that most of the circumcised women suffered emotional distress that expedited traumatic experiences as a result of betrayal. As the girls were totally dependent on their parents or guardians, they were unable to complain, confront or break ties with their parents because of the nature of dependence between the two parties, the betrayer and betrayed. Consequently, the girls were forced either to 'ignore or accept the violation to preserve an apparently necessary relationship' (Freyd, 2001:84). Betrayal trauma differs from naturally occurring trauma that has been caused by natural calamity, in the sense that the former trauma has been committed by a loved one (Findling et al., 2006; Sandberg et al., 2010), hence tends to yield long-term consequences that vary in duration and intensity because the trauma has an interpersonal touch (McNally, 2007).

As presented earlier, the extent of the psychological pain is not defined or demarcated to a single outcome: it can manifest in several forms. The betrayal trauma of circumcised women in this study was overloaded with psychological distress. As it was beyond the scope of this study to evaluate and measure the intensity of the psychological and emotional distress experienced by women due to betrayal trauma, this study cannot label the participants with psychological diagnoses. However, from their descriptions it is feasible to conclude that most of the circumcised women may have developed depression, fear, anxiety and low self-esteem; while others found difficulty in trusting both the betrayers and other close relatives or friends because of a fundamental damage to the trust within relationships. Some of the women seemed to have experienced symptoms that were suggestive of post-traumatic stress disorder (PTSD). These findings are supported by several studies (Atlas et al., 1998;

DePrince, 2005; Gobin et al., 2009; Lindblom et al., 2010; Sandberg et al., 2010) which reported that women who experienced betrayal traumas in their early life suffered from physical and psychological reactions, such as depression, somatic symptoms, anxiety, post-traumatic stress disorder symptoms, substance use, altered self-concept, and insecure attachment styles. Romans et al. (2002) and Runtz (2002) revealed a strong link between betrayal trauma resulting from abuse and several problems related to both physical and psychological wellbeing. In their sample of adolescent in-patients, Atlas et al. (1998) found a greater association between betrayal trauma and post-traumatic stress disorder than between non-betrayal traumas and post-traumatic stress disorder. The next section presents another covert pain that women experienced as a result of FGM, the sense of being victimized.

6.3.3 d) The Covert Pain: Sense of Being Victimized

The findings in this study show that circumcised women were victimized in three areas; as reported earlier, the Wagogo men have changed their stance of valuing circumcised women, and now they prefer and embrace uncircumcised ones. Furthermore, the strong language used by the movement of non-government organisations, activists and campaigners against FGM was dehumanizing for the circumcised women as reported earlier. Finally, circumcised girls were victimized when their parents allowed them to be cut. These three areas are the sources of victimization for the circumcised women.

Victimization is defined by Aquino et al. (2002) as 'the individual's self-perception of having been the target, either momentarily or over time, to harmful actions emanating from one or more other persons' (2002:71), while a victim is defined as 'a person who experiences injury, loss, or misfortune because of some event or series of events done by identifiable agent such as person, group or institution' (Aquino et al., 2002:17). Aquino et al. (2012) asserts four conditions that describe or qualify a person to be a victim. First, the act must be harmful to the victimized person; second, a victim should not be held accountable for the manifestation of the harmful act; third, the victim cannot prevent the harm; and fourth, a victim should demonstrate that s/he has

suffered physically and morally from injustice done to them; and finally, the victim deserved sympathy. Considering the experience of women in the current study these characteristics applied to them; for example, the procedure was harmful because it inflicted pain and suffering on the girls as described earlier. The girls were young and helpless; hence, the girls could not prevent the action. As parents were responsible for the decision to carry out the procedure, the girls were not responsible for the occurrence. Moreover, the women in this study described FGM as a harmful act, as it left them with physical and psychological trauma; and finally, the women deserved sympathy that qualified them to be victims as the campaigners and their husbands downgraded them. Due to victimization, several psychological consequences were reported by the women in the current study; for example, a feeling of helplessness, self-pity, low self-esteem, lack of self-efficacy, and lacking sense of accountability; they also blamed themselves and felt guilt. The findings in this thesis are in line with those of other studies that established a strong association between victimization and psychological distress (Boudreaux et al., 1998; Orth et al., 2004; Salomon et al., 2004). Although the effects of victimization in their studies were similar to the current findings, the cause of victimization in their studies were mainly rape and crime. The victimization in this thesis was carried out by people trusted by victims such as the parents who granted permission for the procedure; and the decision of some of the Wagogo men to abandon their wives. The next subsection presents stigmatization of circumcised women as a covert pain.

6.3.3 e) The Covert Pain: Stigmatization

As discussed earlier, the effects of covert pain or psychological distress cannot be restricted to one area. Instead, the same exposure can lead to different responses, reactions and outcomes. For example, a phenomenon related to FGM, that which betrayed and victimized circumcised women, was also responsible for stigmatizing them. Thus, anti-FGM campaign messages such as circumcised women are ‘cold in bed’ (insufficient and inadequate) not only victimises them but also stigmatizes them. Women who have been divorced simply because they are circumcised felt stigmatized. There are several ways

of defining stigma depending on the context in which the concept is applied (Link et al., 2001). A stigmatized person is perceived by a community as an individual who belongs to a social category or group that is observed as undesirable (Crocker et al., 1998). Link et al. (2001) define stigma as 'a mark that associate a person to undesirable characteristics or stereotypes' (2001:365). Crocker et al., (1998) specify that 'stigmatized individuals are believed to possess some attributes that convey a social identity that is devalued in a particular social context' (1998:505). All definitions of stigma have one commonality; they single out an individual due to a perceived degraded and dishonoured status. The definitions seem to coincide with situations that circumcised women in this study experienced. Circumcised women felt that by having undesirable attributes, they were perceived as incomplete and inadequate women.

The concept of stigma is applicable to a person who possess five elements as described by Link et al. (2001). These are, labelling, separation, stereotyping, status loss, and discrimination. From their accounts, the circumcised women in the current study had experienced all these elements. For example, they were labelled as "woman without clitoris"; some were separated through divorce, their status was perceived to be low in sexual relationships. Consequently, they preferred to isolate themselves from the community as they felt they were different from other normal women. They did not, consequently, discuss any matter concerning FGM or interact with uncircumcised women for fear of being mocked and humiliated (Vloeberghs et al., 2011; Pesambili, 2014). Because of stigmatization, circumcised women felt a sense of hopelessness, despair, loss of trust; and lacked meaning and purpose in life (Oloo et al., 2011). The next sub-section presents discussion of participants' accounts that suggest that participants may have suffered from Posttraumatic Stress Disorder (PTSD).

6.3.3 f) The Covert Pain: Posttraumatic Stress Disorder (PTSD)

In the last four sections, several psychological conditions related to FGM were discussed. Pain, fear and anxiety were among the major experiences that almost all circumcised women in this study reported at one time or another

during their life. Pain, fear and anxiety not only were the cross-cutting phenomena that all women experienced but also suggested that circumcised women might have suffered from PTSD. As mentioned earlier, the scope of this study was not to evaluate or diagnose PTSD in women who were circumcised; rather the aim was to explore their experiences after the procedure of FGM. This section will however, offer evidence from the data suggesting that circumcised women in this study, alongside other psychological complications, might have also developed PTSD.

i) Symptoms of Post-Traumatic Stress Disorder as reported by Participants

The Diagnostic and Statistical Manual of Mental Disorders (DSM5) (2013) defines PTSD as 'a mental health condition that is triggered by a terrifying event — either experiencing or witnessing it' (2013:271). PTSD symptoms may include severe anxiety, flashbacks and nightmares also having uncontrollable thoughts about the event. In their accounts, circumcised women reported that they had experienced pain, fear, anxiety and worries. These and other psychological signs and symptoms indicate that some women might have suffered PTSD.

DSM-5 (2013) established eight criteria for diagnosing established PTSD applicable to children older than 6 years, adolescents, and adults. In the current study, all eight criteria were experienced by several participants to various degrees. As the focus of the study was not to provide data to establish full diagnostic evidence for PTSD, the argument for some PTSD criteria may not be strong enough. However, they still seem to suggest evidence of PTSD as there is a growing literature in this regard (DM-5 2013). The first criterion for PTSD states that there must be 'an exposure to actual or threatened death, serious injury, or sexual violence; the person should be directly experiencing the traumatic events' (DSM-5, 2013:271). The circumcised women in this study alleged that they felt in real danger when suddenly and without prior warning they were undressed, laid down forcefully and cut; they felt excruciating pain. Other women reported to have gone into shock or lost unconsciousness due to excessive blood loss, as such whenever they see blood it reminds them of the

cut. The experiencing of pain during sexual encounters with their husbands was associated with a recall of the cut, but also the mere presence of a naked husband in the bed-room could serve as a reminder of both the sexual pain and the pain of the cut. Consequently, they perceived the sexual relationship with their husbands as a violent act, which led to fear of sex, as sex equated to torture.

The second criterion of PTSD involves one or more invasive symptoms which are linked to the traumatic event, these symptoms may be evident immediately after the occurrence of the traumatic event. They include constant, unrestrained, unfriendly distressing memories of the upsetting event, which tend to come in recurring dreams. These dreams are associated with the upsetting event. Invasive symptoms also include flashback reactions where the individual's memories go back to the traumatic event (DSM-5, 2013). Some women in the current study experienced symptoms that are associated with traumatic event. For example, they feared sharp objects such as blades and knives. When they encountered such things, their bodies trembled with fear. Moreover, the touch of a circumcision scar acted as stimulant that triggered memory of the cut and the accompanied complications. They deliberately and persistently chose to avoid some stimuli; for example, some participants preferred to hide when a circumciser or women who had held them down during the operation were near. Their presence led to recall of the details of the circumcision procedure.

The third criterion of PTSD is a determined avoidance of incidents that are linked with the traumatic event. This tendency commences after the traumatic event and is exemplified by efforts to stay away from upsetting memories, feelings and thoughts that are related to the traumatic event (DSM-5, 2013). Most participants' experiences are congruent with the third criterion of PTSD. For example, many participants were reluctant to watch television or listen to radio about any programme related to FGM. Many of them were reluctant to attend gatherings, workshops or conferences organized by activists or Non-Governmental Organizations to raise FGM awareness. They also deliberately excused themselves from attending initiation ceremonies as all these were reminders of traumatic experiences.

The fourth PTSD criterion shows some damaging adjustments in mood, thoughts and perception related to the traumatic event, and getting worse after the traumatic event, as demonstrated by continuous undesirable emotional conditions, showing noticeable lack of interest in participating in any social activities, and feeling detached from people (DSM-5, 2013). The circumcised women in the current study developed negative emotional states after being exposed to the procedure. Some participants were in a state of shock, panic and confusion immediately after the procedure not believing that their loved ones could allow such brutality to happen to them. Others experienced feelings of anger, horror and hatred, while some expressed feelings of guilt and shame; questioning themselves why they had surrendered to the procedure. Subsequently, their ability to experience happiness, sexual satisfaction, and the ability to show love feelings were completely distorted. The findings show that after circumcision some participants preferred isolation and detachment from normal social relationship.

The fifth criterion of PTSD shows marked alterations in provocation and performance or behaviour of a victim due to awareness that they are being observed and 'associated with traumatic events beginning with or worsening after the traumatic events occurred' (DSM-5, 2013:272). Participants in the current study showed irritable behaviour sometimes with or without provocation. For example, women were angry when activists and campaigners were describing the experiences of circumcised women in a negative way. They were also disturbed when healthcare providers were curious to observe the outcome of the child birth process for circumcised women. They also complained of sleep disturbances. The sixth criterion states that 'the disturbance is not ascribed to the physiological effects of substances such as medication or alcohol' (DSM-5, 2013:273). Whilst the effects of FGM could lead to excessive use of alcohol and substances as a response to emotional stress, the participants' accounts of the symptoms of PTSD in the current study were not related to the use of medication or alcohol; rather it was directly associated with the disturbance – FGM.

In the seventh criterion of PSTD, individuals show clinically significant distress or impairment in the social area (DSM-5, 2013). Participants in the current study isolated themselves socially from people for fear of being scorned because of their status, but also because they felt inadequate and had low self-esteem compared to non-circumcised women. In addition, they were ostracised by others, which created social isolation. The final criterion of PTSD states that the duration in which the victims of emotional disturbances experience in the previous criteria should be more than one month. In the current study, this criterion was also observed as the psychological symptoms suggestive of PTSD were experienced by women from the day they were circumcised and continued to the time when I interviewed them.

As stated earlier it is hard to establish full diagnostic probability partly because the data was not intended for that, but it still appears to indicate evidence of PTSD because of a series of psychological complications as discussed above. Unlike the belief that circumcised women suffer more from physical complications, the findings in this thesis suggest the circumcised women may be more prone to suffer psychological complications than any other form of complication given the changes and development made globally, regionally and locally as discussed earlier. The next section discusses how women coped with covert pain.

6.3.4 Coping with Covert Pain

The period from the 1980s to the present is categorized as the contemporary era. It is characterized by increased awareness of life-without-FGM in the Wagogo tribe. Life without FGM has resulted in amongst other things, increased levels of literacy and increased school enrolment leading to alteration in the age of marriage, which saw Wagogo women and men getting married at a more advanced age than in the traditional era, when they used to marry immediately after the initiation ceremony. In addition, there was increased human movement, multicultural and cosmopolitan societies, inter-tribal marriage, and urbanization, which saw the degradation, devaluation and deterioration of the Wagogo norms, although some Wagogo continued to

maintain the culture. For example, there has been shift of men's ideological stance of preferring uncircumcised women to circumcised ones, which revealed women's fear of being abandoned by their husbands to remarry uncircumcised women.

Probably, the huge challenge to sustain FGM practice during this era was the adoption, execution and enforcement of various declarations, conventions and articles both global and regional against FGM as itemised in chapter one. The adoption of the law against FGM in Tanzania in 1998 that made FGM illegal was perhaps the biggest setback to the practice. The Act was accompanied by an upsurge wave of Non-Governmental Organizations, activists and campaigners who were all against FGM practice. The anti-FGM campaigns were launched using radio and television programmes, and leaflets. There was also country-wide mass education against FGM through village meetings, seminars, drama and arts (World Vision, 2009).

Although the aim of the anti-FGM campaigns was to raise awareness among the community, and discourage the circumcision rituals, the messages had negative impact and detrimental effects on the circumcised women. Their messages which aimed to show that circumcised women were sexually inadequate were not only detrimental to the circumcised women but also created temptations for extra-marital relationships for married men, which eventually led to divorce as evidenced in the current study. Moreover, when describing the complications of FGM that women experienced, some activists used the complications of a third type of FGM – infibulation to scare and discourage girls and parents from sending their girls for FGM, instead of providing correct information about type II FGM, which is the commonest form in Tanzania. Consequently, their messages became a reason for victimizing, segregating and stigmatizing circumcised women (Pesambili, 2013).

Thus, the law against FGM and the developments that were adopted and took place during the contemporary era, coupled with the strategies of anti-FGM campaigns, not only discouraged circumcisers, parents and societies from performing initiation rituals that were performed openly and were carried along

with FGM, but also weakened and destabilized the societal social support for circumcised women that had once been very effective. The mass circumcision, open social support from the elderly women, sibling and peer groups was destroyed. The social fabrics that saw circumcised women as strong, respectable and marriageable were destabilized and eroded. Men who once spearheaded FGM as prerequisite for marriage have now shifted their stance; thus, circumcision has now become a reason for divorce. The removal of the sexual organ (the clitoris) that was once considered as a symbol of chastity now has turned out to be a curse for marriageability and destabilization of families (Ondiek, 2010). Because of these changes and the destabilized social support, not only were the engagement coping strategies striped of their power to enable circumcised women to cope with both overt and covert pain but more women opted for disengagement coping strategies as will be discussed in the next section.

6.3.4 a) Disengagement Coping Strategies

Disengagement coping strategies are deliberate moves of circumcised women to voluntarily escape the stressor and its feelings of distress without confronting it (Carver et al., 2010). The decision of circumcised women to employ disengagement coping strategies is a sign that they have either exhausted all the engagement coping strategies or that they are convinced that the engagement coping strategies are no longer useful to them. Consequently, they prefer to avoid or deny the stressors, or employ social withdrawal. For example, the circumcised women in the current study preferred to avoid the subject of FGM in one-to-one discussion and in meetings that discuss FGM; they even turned off radio and television that aired FGM programmes, as the mere thoughts or discussion related to FGM was enough to remind them of their physical and psychological distress.

As explained earlier, distressed individuals can react verbally or non-verbally; most people who choose non-engagement coping strategies, prefer a non-verbal approach (Carver et al., 2010). For example, circumcised women in the current study expressed their emotions by crying, anger and distress towards

their parents, circumcisers and husbands. In addition, due to failed engagement coping strategies, circumcised women withdrew socially and preferred to isolate themselves even before they were segregated. Some favoured withdrawing from people and tried to keep their feelings to themselves while avoiding family and friends (Vloeberghs, 2012), while some preferred not to share about the experience they had gone through. This exclusion includes the closest members of the family. Some had guilt, blame and self-criticising for what happened to them; thus, they spent more time alone and avoiding people. By staying away from people, they denied the negative effects as if the procedure had never existed in the first place (Carver et al., 2010).

The evidence from this study and other studies (Clement et al., 1998) suggests that non-verbal coping strategies such as avoidance, denial and social withdrawal are symbolized by anger, fear, sadness and guilty (Skinner et al., 2007). Women who choose to employ disengagement coping strategies particularly the non-verbal ones, are associated with increased covert pain, that is psychological distress.

6.4 FGM-Related Pain: A Higher Concept and Coping Theory

In exploring the experience of women who have undergone FGM, the previous sections presented and discussed the concepts overt and covert pain and how the circumcised women struggled to cope with both pain and other FGM related complications. This section will discuss pain related to FGM as a higher concept and how it relates to the coping theory presented by Lazarus (1993).

6.4.1 Definition and Theory of Coping: Antecedents of FGM Pain

Lazarus (1993) defines coping as cognitive and behavioural responses that a person adopts to cope or deal with pain or stress. Coping strategies are the efforts an individual adopts to alleviate or minimize the negative events in the presence of physical and psychological pain (Snyder et al., 1987). When a woman is exposed to a stressful event such as FGM and its consequences, she activates coping strategies to deal with the stressor (an event that disturbs one's equilibrium). On the other hand, Lazarus' (1993) coping theory suggests that coping is central in research that deals with adaptation and health. His

theory emphasised that coping strategies can be described in two contrasting approaches. First, the style coping approach, which views coping as a personality characteristic. The second approach emphasises coping as a process, which involves efforts to manage pain or stresses that change over time and are shaped by the adaptation context.

This theory is relevant in discussing the coping strategies of the circumcised women in this study because the participants employed both approaches presented in coping theory in overcoming their FGM pain and other FGM-related complications. For example, overcoming the consequences of FGM requires a personal commitment and self-motivation to continue with life despite the inadequacy one may feel and the hardships that accompany the procedure (Vloeberghs et al., 2012). On the other hand, coping with or overcoming the difficulties of FGM is a process which is never linear and is characterized by ups and downs that may be external to the personality of a woman concerned (Calver et al., 2010).

Thus, a circumcised woman may be motivated and committed to deal with the adverse effects of FGM, but her effort may be counterproductive because of the external factors. External factors include environmental and cultural factors, to which Walker and Avant (1995) refer as antecedents. Antecedents are incidents that occur before the prevailing exposure (FGM pain), but they can also maintain, even enhance the exposure. Hence, personal, cultural and environmental ideals are the antecedents of FGM pain and are interrelated.

As far as personal factors are concerned, the personal issues which may affect a circumcised woman include her current physical and emotional state and her socio-economic status (Carver et al., 2010). The physical circumstances of a circumcised woman include her sleeping pattern and her capacity of sustaining the pain stimulus (Lazarus, 2005) as each individual has a level of pain threshold one can endure. The lower the threshold the higher the intensity of pain. The woman's emotional state includes the level of stress and anxiety she can endure. The higher the level of stress and anxiety in a circumcised woman, the more dominant the pain. Therefore, the extent to which a circumcised woman can cope with or overcome FGM-related pain depends much on her

attitude towards the pain (Fahmy et al., 2010). Women who have positive attitude towards FGM-related pain tend to perceive the pain positively, for example women who believed they need circumcision to acquire a social identity they are likely to perceive the FGM pain positively; whereas those whose attitude is negative, find it hard to accept (Vloeberghs et al., 2012). However, whether women have a positive or a negative attitude towards pain, the conclusion is subjective and immaterial as the attitude is built upon distorted information about women's anatomy and physiology.

From a socio-cultural point of view, cultural values or norms are central in describing the pain that circumcised women experience. Pain related to FGM is a societal construction, and it explains how women perceive and cope with that pain (Johansen, 2002). Culture dictates how women react to pain, live with pain and interpret it in their day-to-day lives. As stated earlier, men in a patriarchal system have used older women to uphold the social interpretation of pain related to FGM and pass it on to the young generation. Instead of perceiving the pain related to FGM as something oppressive and demeaning, the young generation view the pain as a symbol of bravery, maturity and adulthood (Leininger, 1990). Consequently, the teachings and messages given by older women to younger women has one intention: to create an attitude of pain expectancy and pain acceptance (Zborowski, 1969) among the younger generation. Zborowski (1969) describes pain expectancy and pain acceptance as avenues of articulating a woman's attitude toward FGM-related pain. He defines pain expectation as "anticipation of pain that is unavoidable in a given situation", while pain acceptance is "a willingness to experience pain" (1969:18). Thus, the patriarchal system through older women has endorsed a cultural norm that women should anticipate and willingly accept pain and other consequences related to FGM. The teachings and messages of older women emphasising that circumcised women will face sexual and obstetric pain, helps in constructing FGM-related pain, which prepares them to anticipate and accept it. Thus, making pain a perceived normality and everyday experience (Johansen, 2002).

Likewise, environment is associated with an incident that is capable of triggering pain; for example, the first wedding night for a circumcised woman

may be associate with pain. Thus, a woman's mind or body is likely to be affected by the experience of a first wedding night. In the same vein, the first wedding night experience may play a key role in the woman's knowledge and attitude towards sexual relationship with her husband (Fahmy et al., 2010). Depending on how this woman was psychologically prepared to face the first wedding night (through teachings or peer discussion or sharing of information with older sibling or friends) such knowledge and attitude is likely to dictate how this woman expects and accepts (Zborowski, 1969) sexual pain; subsequently it will also affect how she copes with such pain.

6.4.2 Coping with FGM Pain: A Higher Concept

As discussed before, pain expectancy and pain acceptance, and how that pain is perceived by a society, is culturally constructed (Sheridan, 1992). There are events or occurrences that follow the adoption of anticipation and acceptance of pain (Montes- Sandoval, 1999). For example, accepting obstetric pain due to FGM-related complications depends on a woman's reaction to and interpretation of that pain, which can have physical and biological connotations. Her reaction and interpretation to pain is viewed as pain behaviour, which can evoke both involuntary and voluntary responses (Wolff, 1986). Increased heart rate and reflex actions are examples of involuntary responses that cannot be controlled by the woman in pain but can cause a circumcised woman to have anxiety disorder (Wolff, 1986). On the other hand, a circumcised woman may demonstrate voluntary responses, which may be in a form of verbal or nonverbal reactions. Circumcised women may verbally complain of pain, cry or groan by demonstrating three levels of expression. First, an intrapersonal communication, when a woman is aware of a problem, that something is wrong; secondly, she may express herself through interpersonal communication, for example crying for assistance or letting her husband know she is in pain; and third, by means of expression through a more complex representational or symbolic communication to her friend, husband or older sibling (Wolff, 1986). They also may show non-verbal signs, such as lacking interest in sex, fear, or avoiding their husbands.

Central to understanding the consequence of pain related to FGM is how women construct the meaning of the pain they experience. Women may relocate the pain experience, label it, and denote a positive or negative meaning to it (Ross et al., 1988). The way circumcised women attach meaning to their pain, reflects how they cope with its consequences. Depending on the meaning attached to the pain caused by FGM, the social support given to the circumcised woman may fall under one of the three processes described by Ferrell (1995). First, their meaning may be linked to immediate causes – for example the pain may prevent her fulfilling her role as a wife and cause inability to consummate her marriage. Secondly, the meaning may be associated with immediate effects - the pain means “I cannot satisfy my husband sexually”. Thirdly, the meaning of pain may reflect ultimate causes – despair or giving-up, “the damage has been imposed on me, and there is nothing I can do about it”. Thus, how a woman copes with FGM pain and other consequences is not something that is obvious and straight forward (East, 1992); several things come into play such as her personal, environmental and cultural factors as pointed out by the coping theory (Lazarus, 1993).

In the same vein, depending on the response of circumcised women towards pain, their pain experience may remain unchanged, decrease or intensify (Montes-Shavedol, 1999). The same is true for the strategies that a circumcised woman uses to cope with her difficulties; a persistent pain feeds back that the coping strategy is not working, pushing the woman to re-evaluate her pain and use different coping strategies to relieve it. Thus, women’s responses to FGM pain can be active (engagement coping strategies), passive (disengagement coping strategies) or accommodative coping strategies (accepting the situation as nothing can be done to change it), (Lazarus, 1993). The next section ties together the higher concepts under the patriarchal system as a process that influences and maintains FGM in societies that practise it.

6.5 FGM: Both a Product and a System of Patriarchy in its Own Right

The findings of this study suggest that initiation rites where boys and girls are pronounced adults after going through circumcision procedures and receiving special teaching are meant to transform a man into a dominant partner and a

woman into a submissive agent. Arguing in the same line, the motives for performing and maintaining the tradition are male-dominated. As reported earlier even the ownership and accessibility of resources is male-driven which, reinforces FGM as a product of a patriarchal system.

Indeed, FGM is perceived as a product of a patriarchal system when the complications that circumcised women face as a result of FGM, which under normal circumstances would be expressed in terms of sorrow, pain and uncertainty, are interpreted in male terms as women demonstrating bravery, boldness and heroism (Schultz et al., 2014). When men control women's sexuality through the removal of the clitoris and the only reward women obtain is a compliment of cleanness, maturity and chastity, it suggests oppression of women under the umbrella of the patriarchal system (Manabe, 2010). When men insist on having sexual relationships when women are experiencing pain, it demonstrates the oppressive patriarchal mind-set that views women as tools for men's sexual gratification (Monagan, 2010).

Deeper reflection on the key findings from both former circumcisers and circumcised women suggest that FGM is not only a product of a patriarchal system but it is the patriarchal system by its own right. It means that the way the initiation rituals are arranged which include special lessons and circumcision of both boys and girls, it perpetuates the formation of a patriarchal dominance. The rituals mark the climax of gender socialization that takes place at the family level. As a system, patriarchy maintains its dominance by the process of socialization from childhood when gender roles are prescribed by establishing some traditions, social roles and social customs (Manabe, 2010). Hence, boys and girls learn, conduct themselves differently and acquire certain behaviours as they have been brought up to think of femininity and masculinity by means that cultivate the difference (Manabe, 2010).

Thus, the teachings and training that are attached to the FGM procedure are meant to prepare girls and women to accept the demands of the patriarchal system without questioning (Manabe, 2010). The system requires women to submit and be obedient even where there is clear health, social and economic

repercussions caused by FGM. The initiation ceremonies constitute a patriarchal system, as they create in boys' minds a well-defined mind-set and set of values that set them as 'first class citizen'; in the same context, the girls graduate from the ceremony with a mind-set and set of values that define their submissive role, their low profile and a potentially degraded position in society. However, unlike men's circumcision which is mainly associated with physical pain, women's experiences of the ceremony are those of physical and emotional pain, some of which remain permanently with them their entire lives as highlighted earlier. Considering the discussion above, it can be deduced that FGM is a product of the patriarchal system at the same time it is a patriarchal system in its own right.

In the broader context, patriarchy is perceived as the institutionalization and demonstration of male supremacy over family members and the continuation of male control over women (Essien et al., 2012). It is about "a set of social relations between men and women, which have a material base, and which, though hierarchical, establish or create independence and solidarity among men that enable them to dominate women" (Jagger et al., 1984:56). Their supremacy can be traced in the establishments of the family, education, and the church; all of which rationalize and underpin men's domination over women (Essien et al., 2012). Patriarchy according to Sultana (2011) is a "system of social structures and practices that is characterized by power, dominance, hierarchy, and competition in which men dominate, oppress and exploit women." (2011:3).

6.6 Feminist Theory on Patriarchal System

This section echoes the discussion given in Chapter Two and Three where feminist theory was introduced as a guiding perspective. The discussion in this section provides an insightful reflection for using feminist perspective in the current study. It has been established by the studies reviewed in Chapter Two (Sayed et al.,1996, Khaja et al., 2009, Fahmy et al., 2010) as well as in the findings of this study that patriarchal systems in the societies that have

embraced FGM as a cultural procedure are the engines behind the performance, persistence and maintenance of it.

Feminist theory is perhaps the precise theory in this study as it confronts patriarchy in all its forms of subordination, oppression and domination, and sets to empower women to stand against male supremacy (Becker, 1999). Consequently, its applicability in this study is to understand the experiences of circumcised women in an era where great development against FGM and other forms of oppression of women have been achieved through local, regional and global initiatives (Lockhat, 2004), paying attention to the coping strategies that women currently employ. In addition, the theory assists in exploring the experiences of circumcised women including their subordination and oppression within the patriarchal society. In similar vein, the perspective is persuasive in engaging with the oppressed, voiceless and subordinated women who have been affected by FGM and other forms of oppression (Parmar et al., 1999). Finally, feminist theory aspires to transform women's experiences of FGM into questioning the procedure and the culture behind it; and to encourage their participation in the construction of a world without any form of violence against women including FGM (Frenkel, 2008).

Feminist theory therefore, has set a framework for understanding the experiences of circumcised women from several angles. First, understanding the context in which the procedure was performed, including deception about the procedure and lack of consent; the motives for performing the procedure, and the teachings that go along with it which were all patriarchally driven; in addition, even where there were observable consequences of FGM that women faced, these were trivialized as inevitable outcomes; all these are the demonstration of subordination, oppression and violent actions against women (WHO, 2008). Secondly, the theory assists in examining how the coping strategies of women have changed or evolved over time from the traditional to the contemporary era. As highlighted earlier, during the traditional era social support was effective in assisting circumcised women to mitigate the effects of FGM. The new developments against FGM have eroded the social support for circumcised women. Hence, it can be argued that in the absence of social and

family support, more circumcised women may have shifted from suffering overt pain and employing engagement coping strategies to suffering covert pain and employing disengagement coping strategies respectively. That being the case it can also be concluded that more circumcised women in the contemporary era are susceptible to psychological distress because of insufficient social support.

Finally, the role of activists, NGOs, the government and campaigners against FGM; may have succeeded in discouraging parents from sending girls for circumcision, but their action and strategies are oppressing women who have undergone FGM. While it is assumed that the anti-FGM groups are working under the broader framework of a feminist perspective as they are safeguarding the rights of uncircumcised girls (World Vision, 2009); the same strategies are negatively affecting the circumcised women and are working against the principles of feminism. As the theory illuminates the means to overcome subordination, oppression and violent actions that circumcised women face, including those performed by activists, the findings of this thesis challenge activists-feminists to consider the plight of circumcised women when planning their campaign against FGM. The use of a feminist framework should empower circumcised women who are voiceless and subordinated to view their world from a different viewpoint that places them at centre stage (Jackson et al., 1998). The framework should assist them to transform their bitter experiences into opportunities and begin to question the procedure and the culture behind it. The big picture of the framework should be to encourage women's participation in the construction of a world without FGM.

To set the ground for understanding patriarchy as a concept, feminists accuse the patriarchal ideology of overstating the biological dissimilarities between men and women, making it easier for men to play the masculine roles that are perceived as dominant, while women acquire feminine ones that are viewed as subordinate (Essien et al., 2012).

Viewing from feminist perspective, patriarchy oppress women in three contexts. First, patriarchal ideology is self-empowered and influential to the extent that it has technically secured the seeming consensus of the very women it oppresses (Becker, 1999). For example, in legitimizing female circumcision, the

patriarchal system in FGM-performing societies has used old women to put pressure on young women to undergo FGM. The system has also used the motives for FGM to subject women to FGM regardless of the complications they may experience. Furthermore, the system has trivialized the complications of FGM, and has ascribed them to other alternative explanations (Schultz et al., 2014).

Secondly, the patriarchal system has been strategically avoiding the perception that it is working under the imposition of oppression (Becker, 1999). Instead, the system has preferred to operate under the cover of subordination, which help men to legitimize their violent actions (Mackie, 1996). In many societies, male violence is practically ignored and legitimated by the hesitation of the law enforcement agents to get involved except where life is in real danger (Essien et al., 2012). Thirdly, in its effort to maintain supremacy and legitimize its action, the patriarchal system may use various kinds of violence to control and subdue women (Gabriel, 2008). Men are involved in violent actions such as wife-beating, sexual harassment including rape and other forms of oppression against women whether performed privately or publicly (Mezey, 2005). In all these actions, women have demonstrated a sense of insecurity that has exploited them politically, socially, economically and kept them bound to the home (Gabriel, 2008). Thus, conceptually, feminists view patriarchy as a tool to assist in understanding women's experiences (Walby, 1990).

6.8 Conclusion

This chapter has elaborated the views of participants whose accounts suggest that FGM is a product of a patriarchal system as the system supports and promotes FGM; at the same time, FGM is a patriarchal system in its own right because during initiation process which include circumcision of women gender roles are prescribed which enhance patriarchy in a society. FGM as a patriarchal system is best understood through the broader perspective of feminist theory. The next chapter – the concluding chapter discusses feminist theory and how it ties together the higher concepts of patriarchy and

empowerment that the circumcised women may employ to free themselves from oppression.

CHAPTER SEVEN, THE CONCLUDING CHAPTER

7.1 Introduction

This chapter discusses the merits of using an exploratory design in this thesis. It highlights the link between feminist theory and the key findings, as well as offering insights that this study contributes to the body of knowledge. In addition, it highlights lessons learnt and the limitations inherent in this thesis. It explains the policy implications of this thesis; and finally, it proposes areas for further research.

7.2 Merits of using Qualitative Exploratory Approach

This study has applied a qualitative exploratory approach (Stebbins, 2001) to generate data that attempt to answer the key research questions – what the experiences of Wagogo women are who have undergone FGM in Tanzania; and what is the knowledge, attitude and practice of former circumcisers regarding FGM in Wagogo tribe. There is a dearth of information regarding the experiences of women who have undergone FGM especially in the era where there are remarkable new developments regarding women's rights and measures against FGM, as highlighted in chapter one. Most of the available studies on circumcised women have been quantitative in nature engaged in examining physical and social complications of FGM (Lockhat, 2004). The use of the phrase 'complications of FGM' as employed in quantitative approaches is perceived by feminists as lacking feminine insights and denotes that FGM is an entity capable of causing complications, and that women are simply recipients. On the contrary, the use of a qualitative exploratory approach within the broader framework of feminist theory in the current study, is aimed at exploring women's experiences towards FGM. Individually, each woman had a unique story to offer about her experience towards FGM; however, collectively and cumulatively they assisted in building a discourse about women's experiences in a feminist context.

The merits of using qualitative exploratory research include the following. First, qualitative exploratory design facilitated the description of the worldviews of the former circumcisers, their understanding, attitudes and behaviour towards

FGM. Their accounts described how men under the umbrella of a patriarchal system encourage and sustain FGM (Lockhart, 2004). Secondly, it revealed long-standing deep-seated sufferings of the circumcised women, some obvious, some hidden; their relationships with circumcisers, parents and men whom they all perceived as betrayers. The approach assisted in understanding the relationship between the circumcised women and the government, activists, and anti-FGM campaigners; it is feasible to suggest that women who have undergone FGM perceived them as agents for their stigmatizing, dehumanizing and degrading as described earlier.

In addition, the design was instrumental in surfacing new insights about a form of silent, secretive and hidden pain – covert pain, which before this study was either ignored, trivialized or taken for granted as something normal. This pain and suffering, originating directly from the effects of FGM, also arose from the roles of anti-FGM campaigns, the activists and Non-Governmental Organizations were identified as other sources of suffering for the circumcised women. Another merit of using qualitative exploratory design is that it helped me to study FGM, an area that is associated with a subject of sexual organs and sexuality. In connection with the suggestion that sexuality is loaded with anxiety and secrecy, my own experience demonstrated that interviewing Wagogo women was not an easy task. Even when I identified myself as a fellow woman from Wagogo tribe, some women found it hard to open and share their intimate sexual experience with me. To overcome that hurdle, as stated earlier in the methods chapter, I employed techniques for sensitive interviewing to study a hidden agenda by probing it, do a fact-finding and explore it gradually, but in detail which puts the participants at ease to answer. With some encouragement, participants shared and disclosed intimate information which could not have been obtained had I approached the participants using a different design.

As I reflect on the use of qualitative explorative approach, I discover more merits for its use. For example, the outcome of this study is a result of accumulation of information from former circumcisers and circumcised women. As said before, the former circumcisers had multiple identities. Consequently, the circumcised women could not detach themselves from the influence of

circumcisers; even where they had sworn they would not see or meet them again, their situations demanded they consult the circumcisers. Circumcisers became part of their lives and in some circumstances, they were the only dependable solution to their subsequent sexual and obstetric challenges they faced later in their life. While the mere presence of circumcisers was enough to trigger a recall of psychological trauma in circumcised women about the procedure; a persistent dependence on circumcisers for obstetric care and sexual counselling suggested an endless psychological torture for the women.

Alongside discussing the merits for employing qualitative exploratory design, the use of source triangulation, (Taylor, 2005; Sharkey et al., 2005) where I recruited both former circumcisers and women who have undergone FGM was one of the strong areas of this study. As other studies have sought the opinions of circumcised women only (Lockhat, 2004; Vloeberghs et al., 2012); in the current study interviewing both former circumcisers and circumcised women whose contributions, apart from being corroborative, assisted me to understand better their social context. Their inclusion in the study allowed me not only to understand how they perceive each other as the betrayer and the betrayed, but also how collectively they view men as the key betrayers of women's trust. It was remarkable to learn how the same question was interpreted and answered differently by the two groups. For example, women who have undergone FGM seemed to blame the tradition of Wagogo to embrace FGM and particularly for the circumcisers to accept their role given by men to maintain the practice. The former circumcisers on the other hand directed their blame to men who have failed to uphold the tradition that they put in place; instead they are currently in favour of uncircumcised women.

In addition, the findings of this study were enriched using site triangulation. The study area covered four out of seven districts of Dodoma region. The use of multiple sites was an added advantage for this study as some districts were close to Dodoma city, the headquarters of Dodoma region; and some were very far. Likewise, some villages that I covered were close to their district's headquarters while others were remote. The geographical variation between one site and another enriched the study as those participants who lived in remote areas depended entirely on circumcisers for health-related issues, while

those close to regional or district headquarters had several other alternatives. Hence, their experiences and coping strategies were diverse; those in remote villages were constantly reminded of their pain as their social life could not be detached from circumcisers; although the social support there, was not as fragile as that of urban areas. Those residing in urban areas, even though they were not proximate to circumcisers had also suffered psychological distress because of insufficient family and social support, and the repeated annoying messages of activists and campaigners against FGM, which were dehumanising for them.

In conclusion, the qualitative exploratory design provided some understanding and insights into the accounts of women who have undergone FGM whose voice is crucial in setting a health policy agenda that can minimize the psychological consequences of such women. The next section describes the limitation of this study.

7.3 Limitation of the Study

The limitation of this study was how the former circumcisers and circumcised women were recruited, which might have affected their freedom of expression. Women who have undergone FGM and former circumcisers were recruited through the gate-keepers of DIAC, a Non-Governmental Organization mandated to fight FGM in Dodoma region, and the Dodoma Regional Hospital. DIAC had previously cautioned me based on their experience that it could be extremely difficult to recruit participants, if I decided to undertake the assignment on my own. They added that, most women do not want to discuss their experiences as it evokes pain, and others do not want to be known that they have been circumcised. As for the hospital-based participants I suspected the experience would be the same as for the community-based participants. Furthermore, the participants were clients under the care of health providers who were my gate-keepers, and were the ones who invited participants into the study on my behalf. This might have made them accept my invitation because they were under the gate-keepers' care and therefore I might have recruited women who were negative about my study. Consequently, this might have jeopardized their freedom of expression. To minimize the effects, which could

be perceived as coercion to join the study, I asked them to exercise their free will to accept the interview or reject it. I assured them that if they chose to decline I would not report them to my gate-keepers.

As for the community-based participants, the DIAC staff accompanied me to their fieldwork (villages that are supported by DIAC) and introduced me to their village facilitators who acted as my final gatekeepers. I suspected the presence of village facilitators in the location where I was conducting the interviews might have affected the freedom of participants to express themselves. To deal with this weakness I emphasized to the participants as I did to the hospital-based participants their free will to join and withdraw from the study any time. I also asked them to inform me freely if they wanted me to come another day to interview them if they felt uncomfortable being interviewed in the presence of a village facilitator. Almost all were happy to be interviewed the same day. Another shortcoming of the study was the small number of circumcisers; I was able to recruit two former circumcisers who had joined the DIAC as anti-FGM campaigners out of three who agreed to join the study. I suspected the former circumcisers who had joined DIAC would be different from other former circumcisers. Consequently, their responses could reflect the opinion of activists rather than a genuine account of former non–campaigner circumcisers. I noted from the tone of the language they used to describe the complications was not far from the activists' language. Despite my observation, the accounts of the two former circumcisers about the circumcision procedure and its complications echoed the experience of another former circumciser who was not in the anti-FGM campaign. Moreover, the accounts of the circumcised women were also consistent with former circumcisers' submission. The next section presents the argument that the central research question is answered by this study.

7.4 The Main Research Questions Answered: The Contribution of the Study

The goal of this study was to explore the experience of Wagogo women who have undergone FGM and the knowledge, attitudes and practice of former circumcisers. This goal takes into consideration the new development in women's rights which are geared to fight against all forms of oppression of

women. A constructivist interpretivist approach was the guiding theoretical framework in the current study, which paved the way for discussing not only the accounts of participants regarding their experience with FGM, but also assisted to reflect the extent to which those accounts and experiences are intertwined with wider socio-cultural ways of perceiving female circumcision and the sufferings of circumcised women. I identify this as a reciprocal process in which the accounts of the circumcised women are informed by broader socio-cultural ideals; at the same time, their views constitute the socio-cultural perspective.

Constructivism "asserts that social phenomena and their meanings are continually being accomplished by social actors" (Bryman, 2008: 692). Individuals are constantly struggling to understand the world around them by examining their culture, history and social life. As they do so new meaning regarding their world view is being constructed. As shall be revealed later, the knowledge and meaning about FGM in Wagogo society is continually being evaluated and shifted depending on the social, political, historical and economic changes that occur within a given period (Mapana, 2007). What is interesting about these findings is that the Wagogo men's belief about FGM prevailed over women's belief; with the former showing elements of oppression over the latter. For example, when men were insisting that FGM is a prerequisite for marriage, all Wagogo women were circumcised; when they changed their stance to remarry uncircumcised women, the circumcised women became the victims.

In the same context, men's perception about FGM has not been fixed. Rather it has shifted and taken a different standpoint based on the changes that have taken place locally, regionally and worldwide. The legislation against FGM and the work of activists had an influence on men's perception and values regarding FGM and circumcised women. While the shifts in men's views regarding FGM may be perceived as a victory for the global organizations, government and activists as it reduces the incidence of FGM and therefore safeguards those girls who are yet to be circumcised; these changes have not paid attention to the consequences the changes might have brought to the women who have undergone FGM.

The increased awareness among men that having an intact clitoris is normal and pleasurable for both partners is a catalyst for men to mistreat and divorce circumcised women. The implementation of UN, regional and local declarations and state legislation means that FGM will be performed underground: the social support that was once given openly will cease. The circumcisers and old women who were the counsellors and strong advisers to circumcised women will no longer practise. All these changes add to the pain and sufferings of the circumcised women as there are no interventions in place by the global, regional or local authorities that are designed to assist circumcised women in their sufferings: they are currently perceived as having disabilities. The findings of this thesis have shed light on the complex situation the circumcised women found themselves in. Whist the UN, regional and local declarations, conventions and articles are all focused on fighting FGM, discouraging it and where possible demolishing it completely; none of them consider the plights of circumcised women.

The discussion chapter shed some light on the main underlying concepts that addressed the key research question, and how they built up to the conclusion of this study. Central to the several concepts highlighted was the term patriarchy. Patriarchy as a concept emerged in both chapters of the findings presenting the views of former circumcisers on the one hand, and women who have undergone FGM on the other. The accounts of former circumcisers offered valuable insights into the details of how the patriarchal system was central in propelling and maintaining FGM within Wagogo society. The findings showed how the motives for FGM were carefully crafted reflecting male dominance over women.

Moreover, the decision of men to empower a few women, especially the elderly and circumcisers in the society and offer them opportunities to acquire and manage resources were tactics and strategies to put them in the front line to sustain FGM. The patriarchal system has strategically offered explanations regarding the complications that women were likely to experience during the circumcision procedure and later. The descriptions responsible for the

complications that circumcised women experienced were not only alternative explanations why the women experienced them, but also were the reasons to put away the blame and guilty from the circumcisers, should death or serious injury occur to any of the girls. These findings suggest that women are subjected to FGM under the directions of men for the benefits of men at the expense of women's suffering. Although FGM was performed by women, and men were strictly not allowed even to be anywhere near the site of operation, the same men were actively pushing the practice behind the scene. Due to these explanations, it was concluded from the findings of this study that FGM is a product of the patriarchal system.

In a dissimilar but related context, the findings suggested that FGM is a patriarchal system in its own right, considering the teachings and trainings that were offered to girls and boys during initiation ceremony. In addition, women were not given options of accepting or declining the procedure, instead they were deceived and forced into the procedure. The forced practice led to a series of events and complications. The notable event was the preparation of women to accept the subordinate position in the family as well as in the society. This submissive mentality was also meant to prepare women to accept and anticipate pain that goes with FGM.

As regards pain related to FGM, two types of pain, the overt and covert, were identified and discussed. This has suggested that circumcised women suffered overt pain that was cushioned using engagement coping strategies, which are no longer effective given the new developments regarding FGM. Thus, overt pain has been transformed into covert pain; while the failure of engagement coping strategies has pushed women to resort to disengagement coping strategies. Subsequently, the findings of this thesis have suggested that more women are likely to suffer from psychological distress as they do not have a source from which they would obtain support.

Psychological distress as an outcome of FGM was elicited at three levels. The first level, was a direct response to the FGM procedure, where the girls felt powerless, helpless and hopeless. At the second level, women developed

psychological complications secondary to physical, sexual and obstetric complications. Thirdly, women experienced psychological distress because of the social, political, historical and economical changes that have occurred in their society. Those who seemed to have coped with FGM easily became victims of psychological distress when the meaning, interpretations and support for FGM changed with time. Finally, the role of the activists, NGOs, the government and change of patriarchal ideology towards FGM has led women to feel betrayed by their husbands and men in general. Thus, they feel stigmatized, victimized and disregarded by society. The role of these activists was not only another way for circumcised women to experience psychological distress but also destabilized those who had already found stable coping strategies.

The contribution of this study to the body of knowledge is three-fold. First, women who have undergone FGM do indeed suffer from psychological sequelae, unlike the belief gained from most of quantitative studies that FGM is mostly associated with physical complications. Secondly, the data in this study support fully the idea that the coping strategies of women who have undergone FGM is never linear, reliable and stable; instead they are very fragile, unstable and insecure. Women's ability to cope depends much on the balance between internal and external factors. When external factors such as the standpoint of men towards FGM change, its effects outweigh the internal factors, which would help women to cope. Hence, they are likely to develop psychological distress.

The most significant contribution of this study is that from a feminist theoretical standpoint, this study criticizes the feminist movement in Tanzania, such as the activists, campaigners and NGOs whose work discourages women from FGM. However, in their operations they have failed in one of the key principles of feminist theory - fighting all forms of oppression regardless of the social status of women (Equality Now, 2011). They have used the experiences and suffering of circumcised women as an 'object lesson' to scare those who are yet to be circumcised. While this move might have assisted in the fight against FGM, their strategies are neither sensitive to the suffering of circumcised women nor

responsive to the local culture. Consequently, they have worsened the sufferings of circumcised women instead of relieving them. While there is evidence to suggest that the activists and NGOs are influenced by feminist theory in the fight against FGM, they have paid no attention to the damage they are causing to the circumcised women. The most significant contribution of this study is that

At this point it can be strongly concluded that the central research question has been answered by this study; that indeed, women who have undergone FGM do experience not only physical, sexual and obstetric complications, but more importantly they suffer psychological distress through different avenues as discussed above.

7.4.1 Empowering Circumcised Women Under the Broader Framework of Feminist Theory

Feminist theory remains central and relevant in tying together the key findings and in highlighting the contribution of this study to the body of knowledge. These findings have emphasized that FGM is a product of the patriarchal system, and also a patriarchal system in its own right. When considering theories that can challenge the patriarchal system, feminist theory stands out as the most appropriate. Its relevance rests on the fact that its mandate is not only to fight inequalities caused by patriarchal system and end women's oppression in cultural, social and economic circles, but also that it empowers women to take positive measures against all forms of oppression (Oyekan, 2014).

Feminist theory challenges power relations between men and women, it also challenges the status quo and demands social change (Walby, 1990), it gives voice to the voiceless and it empowers the oppressed. In general, feminist theory attempts to draw a picture of women's subordination; it provides a framework for effective liberation of women; and it provides a lens through which issues and social norms can be examined (Cudd, 2006). By using the framework of feminist theory, uncircumcised girls and women can be protected and prevented from the practice of FGM as described earlier. Taking advantage of recent changes and developments that have taken place socially,

politically and economically such as increased movement of people, urbanization and increased school enrollment for girls seem to discourage the practice of FGM (Equality Now, 2011). For example, parents are required by law to enroll children in school, which has facilitated to delay or postpone the procedure. Taking advantage of this delay, the empowerment of girls could start at the grassroots where the school curriculum incorporates issues related to FGM and reproductive health. Tanzania without FGM can be instituted in the minds of school pupils who can enlighten their parents, hence, creating ripple effects of the messages the children learn at school (Handerson et al., 2016).

The activists, the government, Non-Governmental Organizations and campaigners can employ the framework of feminist theory to empower the girls by encouraging them to enroll for science subjects so that they may understand female anatomy and physiology; and impart knowledge on the biological differences between female and male; and eventually encourage them to join health-related professions, which will make it easier for them to assist other women. The government should give priority for girls to advance in education by providing 50/50 chances of enrolment from lower levels to higher learning institutions; establishing special funds for enabling girls to pay their tuition and up-keep; and providing boarding schools for them.

In the same spirit, families that have educated girls who become successful in life should assume a role model in their societies. This move will subsequently, encourage many families to send their girls to school, which will affect the age for marriage as many will prefer to marry after they have attained their education and ambitions. As circumcisers continue to practice FGM because it is a source of power, respect and money, a strategy to engage circumcisers who are also traditional healers and birth attendants to be community facilitators and primary health care providers would retain their respect in society and discourage them from practicing underground FGM. As the social support to help girls who have undergone FGM which was initially offered by old women in society, the same women could be empowered and trained to be counsellors for women who are struggling to cope with FGM-related issues. As they are aware of the complications that women face, they can be easily accepted by women. They can work as part of a home-based care unit or they

can be part of clinic-based antenatal or under-fives care, which most women attend. As inter-marriages are common these days, which reduces the insistence of Wagogo men on marrying circumcised women, multicultural schools and colleges should be encouraged where youth from different regions would study together. That way young men from tribes that perform FGM would make friendship with young ladies from tribes that do not perform the procedure. These strategies crafted under the framework of feminist theory but respecting the local culture are likely to protect girls and women who are yet to be circumcised.

7.4.2 Reflections on being an Insider/ Outsider

As discussed in Chapter Three I positioned myself as both an insider and outsider of the research (Kerstetter, 2012). My insider identity assisted me to engage with Wagogo women who accepted me as their fellow woman which made it easier for me to connect and engage with both former circumcisers and circumcised women. Hence, I was well placed not only to recognize the experiences of participants, but also to access thick and rich data that might not have been accessed by an outsider.

I was also an outsider in the sense that I had not experienced the circumcision procedure. Hence, I was eager to learn from circumcised women about their individual experiences. As an outsider it allowed me to discover and consider new ideas, which may be similar or dissimilar to my prior knowledge or somewhere in between the two. This mind-set helped me because even though I approached the study as a feminist, I could also criticize my fellow feminist activists and other front-liners in the fight against FGM for using wrongly the experiences of circumcised women as the basis of discouraging women from FGM.

As I reflect, I have gained some insights regarding the concepts of insider/outsider. Being an insider was not a static position, but it shifted as participants got to know me and as I related to them. For example, when I visited the participants in the villages to introduce myself and arrange for logistics regarding the interviews, I presented myself as an insider. A strategy

which helped me to gain acceptance; however, the more we talked on different issues, the more I realized that they perceived me as an outsider. Some characteristics demarcated me from them; my education level, my affiliation to both the Universities of Hull and Dodoma, differentiated me from them. Hence, they did not perceive me as one of women from a village. As Arber (2006) argues that the boundary between insider and outsider can shift depending on how the researcher relates to the participants. The wider the difference between the researcher and the participants the greater the tension between them.

Thus, when I visited them for the interview, I had to maximize the insider identity, which had two characteristics; first, a woman interviewing a woman; second, a Mgogo talking to a fellow Mgogo woman. I gained more confidence from participants for adopting this strategy. Participants shared information which they would have been uncomfortable to share with an 'outsider' researcher or a researcher from a different tribe.

My insider/outsider identity coupled with my reflexivity, self-reflection and the biases have to some extent, influenced the research process by the choice of philosophical stance of the study, a sound connection between theory and practice (Watt, 2007), the approach of the study, choice of methods and the outcomes of the research. The audiences/readers now have the privilege of assessing my reflexivity and judging how it influenced the way the research was conducted, the process of knowledge construction, the analysis and interpretation of the data. This will enable open examination of the trustworthiness of the research and enable judgement of the credibility of the research findings, as validity of qualitative research is not only based on the methods used but also on the "moral integrity of the researcher as it is critical for evaluation of the quality of the scientific knowledge produced" (Kvale, 1996:241).

7.5 Policy Implications of the Study

The law against FGM may have a role to play in eradicating the practice of FGM. However, the contribution of legislation may only discourage people from performing open initiation ceremonies and mass circumcision. In most cases, it is likely to push FGM underground where some communities may evade the law by taking girls to the bush to circumcise them. As a matter of policy implication, this study is suggesting that legislation alone cannot eliminate FGM as the practice has been embedded into the social fabric of some ethnic groups for a long time. Instead, mass education about facts of the anatomy of female reproductive organs, the sufferings caused by FGM and its complications is the best way to stop the vicious cycle of women's distress, pain and suffering.

The combined government efforts through the Ministry of Health, Community Development, Gender, Seniors and Children; the Ministry of Regional Administration, Local Government, Civil Service and Good Governance and the Ministry of Home Affairs should take a holistic approach in dealing with FGM. The government should make a full assessment of the unmet needs of circumcised women and provide training, information and guidelines for health care providers to address them. The Ministry of Health, Community Development, Gender, Seniors and Children should create a unit to coordinate Non-Government Organizations, activists and anti-FGM movements, so that their messages are reflecting the real situations on the ground, at the same time avoiding sensationalizing stories that dehumanize circumcised women. The government through the Ministry of Regional Administration, Local Government, Civil Service and Good Governance should coordinate at local level a holistic approach among local partners such as the department of education, religious groups and social services to pool their resources together for attainable action.

Since the mandate of feminist theory is to empower and assist oppressed women to stand up and voice their concerns; this study is suggesting, as a strategy and policy implication in its own right, that the key stakeholders in the fight against FGM in Tanzania be the advocates for the circumcised women. Using the framework of feminist theory and cultural feminism (Lockhat, 2004)

they should safeguard the interests of circumcised women by addressing their unmet needs and concerns. First and foremost, they should desist from the use of the sufferings of circumcised women as a blueprint for fighting FGM. Secondly, they should refrain from complicating the experience of circumcised women to scare girls who are yet to be circumcised. For instance, the use of complications of type III FGM, which is more severe to educate women who are engaged in performing a less traumatic type, is not being fair to the recipients. Precise and correct information is needed to inform the public. As discussed earlier, home-based or clinic-based counselling and support are critical to address the concerns and unmet needs of circumcised women. A change of tactics, strategies and approach is needed to protect the uncircumcised girls without causing harm to them. Improved wording and tone of the anti-FGM campaigns will not only initiate a healing process for the affected women but it may empower them to come out and speak for themselves and for the uncircumcised women.

7.6 Recommendations of the Study

While it is true that the law and the actions of activists, health care providers and law enforcement division may have discouraged the practice of FGM in Tanzania, their actions have had negative consequences for circumcised women. More circumcised women are reporting emotional/psychological suffering because of being the central topic when discussing the sequelae of FGM. As a matter of urgency this study recommends mass education as key in raising public awareness of the physical, sexual, obstetric and psychological complications of FGM. The anti-FGM messages should be precise and correct. For example, there is no reason to use the complications of type III FGM as examples of the consequences of FGM, when one is addressing a society who practice FGM type I or II. Likewise, it is misleading to associate a simple circumcision that removes the hood of the clitoris with the inability of a woman to enjoy sex, as other studies have shown no link between the two.

Building on the first recommendation, the activists should not only concentrate on fighting FGM, but every team of anti-FGM campaigners should also have counsellors who would offer support to women who have undergone FGM. The

counsellors would take the role of the society, siblings and peer group social supporters who originally were offering support to them. Thirdly, the counsellors and program experts should work closely with circumcised women when wording the messages for anti-FGM campaigns. This strategy will enable the team to gain understanding of the plight of circumcised women. In addition, it will assist the team to construct appropriate messages for the anti-FGM campaign that are friendly to circumcised women. In so doing it will relieve women of psychological suffering. Involvement of women who have undergone FGM is advantageous as it will empower them, lift their self-esteem and instil a sense of pride that their contribution has been valued. This kind of empowerment is likely to draw them from their hiding places to come out and speak for themselves and for the uncircumcised women.

Following the disintegration of social support for circumcised women, there is a great need for the health providers to be equipped with intervention packages for the circumcised women at normal clinics as well as at the antenatal clinics. The health providers should be knowledgeable in addressing the unmet needs of circumcised women especially, the sexual information and obstetrics services. Finally, the law enforcement department should concentrate on educating people to stop FGM rather than hunt down the newly circumcised girls and force them to name the culprits (parents and circumcisers). That approach will push circumcised women into hiding places and discourage them from joining the anti-FGM campaigns.

7.7 Proposed Areas for Further Research

Given that remarkable developments have taken place world-wide regarding FGM, as described above, the findings of this study have stimulated further areas for research: for example, this study has established that some women, indeed suffer from psychological consequences caused by FGM. It is essential to conduct a study to measure the extent of psychological consequences of FGM and particularly diagnose and establish the prevalence of PTSD caused by FGM. It is critical to assess to what extent the messages of activists are a contributing factor for development of psychological sequelae. With focus on the theoretical perspectives employed in this study, further research could use

feminist theory to study women's emotional and psychological suffering as a result of FGM. To embark on such study, the work of feminist theorists such as Lightfoot-Klein (1980); Walker (1992); Walker et al., (1993); Hosken (1993); Nazer (2003) and Lalla-Maharajh (2010) who have researched immensely on FGM and focus on women's empowerment could be employed to gain further theoretical understanding of the psychological complications of women who have undergone FGM.

While scholars in feminism have researched women's psychological experience of FGM in Western countries (Lockhat, 2004), little equivalent consideration has been given to study women in Africa. Thus, there is a dearth of literature on the subject. This is not surprising as in Africa it is assumed the society is supportive to the circumcised women; however, this study has proved otherwise. Women are suffering silently; they are harbouring endless hidden tears and are carrying heavy burdens in their chests. This can be achieved using the broader framework of feminist theory.

REFERENCES

Abbott, P., Wallace, C. (1997). An Introduction to Sociology: Feminist Perspectives 2nd Eds Routledge.

Abdelshahid, A., Campbell, C. (2015). 'Should I Circumcise My Daughter?' Exploring Diversity and Ambivalence in Egyptian Parents' Social Representations of Female Circumcision. Journal of Community & Applied Social Psychology J. Community Appl. Soc. Psychol., 25: 49–65.

Abdel-Azim S. (2013). Psychosocial and sexual aspects of female circumcision. African Journal of Urology 19, 141–142.

Abusharaf, RM. (2001). Virtuous cuts: female genital circumcision in an African ontology. Differences, a Journal of Feminist Cultural Studies, 12:112−140.

Ahmadu, F. (2000). Rites and wrongs: An insider/outsider reflects on power and excision. In B. Shell-Duncan and Y. Hernlund (Eds), Female circumcision in Africa. Culture, controversy and change (pp283-312). London: Lynne Rienner Publicashers.

Alaranta, M. (2006). Combining theory-testing and theory-building analyses of case study data. Paper presented at the European Conference on Information Systems, Göteborg, Sweden.

Albrow, M. (1990). Max Weber's Construction of Social Theory London, Mcmillan.

Al-Hussaini, TK. (2003) Female genital cutting: types, motives and perineal damage in labouring Egyptian women. Medical Principles and Practice, 12(2): 123-128.

Ali, C., Strøm, A. (2012). "It is important to know that before, there was no lawalawa." Working to stop female genital mutilation in Tanzania, Reproductive Health Matters, 20:40, 69-75.

Al-krenawi, A., Wiesel-lev, R. (1999). Attitudes toward and Perceived Psychosocial Impact of Female Circumcision as Practiced among the Bedouin-Arabs of the Negev. The Cultural Context of Families, 38:431-443.

Alsibiani, S., Rouzi, A. (2010). Sexual functioning in women with female genital mutilation. Fertility and Sterility. 93(3):722-724.

American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders (5th Edition Text Revision). Washington DC: American Psychiatric Association.

Andersson, S., Rymer, J., Joyce, W., Momoh, C., Gayle, C. (2012). Sexual quality of life in women who have undergone Female Genital Mutilation: a case-control study. BJOG.119(13):1606-11.

Anis, T., Aboul Gheit, S., Awad, H., Saied, H. (2012). Effects of Female Genital Cutting on the Sexual Function of Egyptian Women. A Cross-Sectional Study. The Journal of Sexual Medicine, 9(10); 2682-2692.

Applebaum, J., Cohen, H., Matar, M., Abu, R., Kaplan, Z. (2008) Symptoms of posttraumatic stress disorder after ritual female genital surgery among Bedouin in Israel: myth or reality? Primary Care Companion to the Journal of Clinical Psychiatry; 10(6):453-6.

Aquino, K., Byron, K. (2002). Dominating Interpersonal Behaviour and Perceived Victimization in Groups: Evidence for a Curvilinear Relationship. Journal of Management, 28(1) 69–87.

Arber, A. (2006). Reflexivity: The challenge for the researcher as practitioner, Journal of Research in Nursing, 11 (2), 147-157.

Asiyanbola, A. (2005). Patriarchy, male dominance, the role and women empowerment in Nigeria. Paper submitted for presentation as poster at the International Union for the Scientific Study of Population (IUSSP/UIESP) XXV International Population Conference Tours, France, 18-23.

Atlas, J., Ingram, D. (1998). Betrayal trauma in adolescent inpatients. Psychological Reports, 83;914.

Awuah, JB. (2008) Female genital mutilation: a study in Aboabo, a suburb of Kumasi, Ghana. West African Journal of Nursing; 19(1):26-32.

Balshem, H., Helfand, M., Schunemann, H., Oxman, AA., Kunz, R., Brozek, J. (2010). GRADE guidelines 3: Rating the quality of the evidence - introduction. Journal of Clinical Epidemiology 64(401):406.

Banks, E., Meirik, O., Farley, T., Akande, O. (2006) Female genital mutilation and obstetric outcome: WHO collaborative prospective study in se African countries.

Beauchamp, T.L., Childress, J.E. (2001). Principles of biomedical ethics. Fifth Edition. New York: Oxford University Press.

Beauvoir, Simone De. (1997). "The Second Sex." in Gould, Carol C (ed.), Gender. Atlantic Highlands: Humanities Press, pp. 3-14

Becker, M. (1999). "Patriarchy and Inequality: Towards a Substantive Feminism," University of Chicago Legal Forum: Vol. Iss. 1, Article 3.

Behrendt, A., Moritz, S. (2005). Posttraumatic Stress Disorder and Memory Problems after Female Genital Mutilation. American Journal of Psychiatry, 162, 1000-1002.

Berggren, V., Gottvall, K., Isman, E., Bergstrom, S., Ekeus, C. (2012). Infibulated women have an increased risk of anal sphincter tears at delivery: a population-based Swedish register study of 250 000 births. Acta Obstet Gynecol Scand .92(1):101–8. [22].

Bitsch, V. (2005). Qualitative research: A grounded theory example and evaluation criteria. Journal of Agribusiness, 23(1), 75-91.

Bjalkander O, Bangura L, Leigh B, Berggren V, Bergstrom S, Almroth (2012) Health complications of Female Genital Mutilation in Sierra Leone. International Journal of women's health: 4: 321-331.

Bogale, D., Markos, D., Kaso, M. (2014). Prevalence of female genital mutilation and its effect on women's health in Bale zone, Ethiopia: a cross-sectional study. BMC Public Health 14:1076.

Boudreaux, E., Kilpatrick, D. G., Resnick, H. S., Best, C. L., & Saunders, B. E. (1998). Criminal victimization, posttraumatic stress disorder and comorbid psychopathology among a community sample of women. Journal of Traumatic Stress, 11, 665–678.

Bowker, N.I. (2001). Understanding online communities through multiple methodologies combined under a postmodern research endeavour. Forum Qualitative Social Research, 2(1).

Braun, V., Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3 (2), 77-101.

Browning A, Allsworth JE, Wall LL. (2010) The relationship between female genital cutting and obstetric fistulae Obstetrics & Gynecology; 115(3):578-83.

Bryman, A. (2008). Social Research Methods, Oxford University Press.

Carver, C., & Conner-Smith, J. (2010). Personality and coping. Annual Review of Psychology, 61, 679-704.

Catania, L., Abdulcadir, O., Puppo, V., Verde, JB., Abdulcadir, J., Abdulcadir, D. (2007). Pleasure and orgasm in women with Female Genital Mutilation/Cutting (FGM/C). J Sex Med. 4(6):1666-78.

Center for Evidence Based Management (July 2014). Critical Appraisal Checklist for a Quantitative Study. Retrieved (May 10, 2015) from https://www.cebma.org

Chalmers, B., Hashi, KO. (2000). 432 Somali women's birth experiences after earlier female genital mutilation. Birth, 27: 227-234.

Chamberlain, G. (1996). Turnbull's Obstetrics (2nd eds). Edinburgh: Churchill. Livingstone.

Charmaz, K. (2006). Constructing Grounded Theory: A practical guide through qualitative analysis. Sage Publications

Cheng, TYL., Boey, KW. (2000). Coping, social support, and depressive symptoms of older adults with type II Diabetes Mellitus. Clinical Gerontologist. 22:15–30.

Chibber, R., El-Saleh, E., El Harmi, J. (2011). Female cutting: Obstetric and Psychological Sequelae continues unabated in 21st century. The Journal of Marternal-Fetal and Neonatal Medicine 24(6):833-836.

Chu, T., Akinsulure-Smith, A. (2016). Health Outcomes and Attitudes Toward Female Genital Cutting in a Community-Based Sample of West African Immigrant Women from High-Prevalence Countries in New York City, Journal of Aggression, Maltreatment & Trauma, 25:1, 63-83.

Clement, U., Schoennesson, LN. (1998). Subjective HIV attribution theories, coping, and psychological functioning among homosexual men with HIV. AIDS Care. 10:355–363.

Cobuild, C. (2010). Advanced Illustrated Dictionary. Harper Collins Publishers Ltd.: Great Britain

Creswell, J.W. (2007). Qualitative inquiry and research design: Choosing among five approaches (2nd ed.). Thousand Oaks, CA: Sage.

Crocker, J., Major, B., Steele, C. (1998). Social stigma. In D. Gilbert, S. T. Fiske, and G. Lindzey (Eds.), The handbook of social psychology (4th ed., Vol. 2, pp. 504-553). New York, NY: McGraw-Hill.

Cudd, A. (2006). Studies in Feminist Philosophy: Analysing Oppression. Oxford: Oxford University Press.

Dahan, G. S., Senol, I. (2012). Corporate social responsibility in higher education institutions: Istanbul Bilgi University case. American International Journal of Contemporary Research, 2(3), 95–103.

Dare, F., Oboro, V., Fadiora, S., Orji, E., Sule-Odu, A., Olabode, T. (2004). Female genital mutilation: an analysis of 522 cases in south-western Nigeria. Journal of Obstetrics and Gynaecology, 24(3), 281-283.

Denzin, N., Lincoln, Y. (2003). Strategies of Qualitative Inquiry. London: Sage Publications

Denzin, N., Lincoln, Y. (2005). Introduction: The discipline and practice of qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.), The sage handbook of qualitative research (2nd ed.). Thousand Oaks, CA: Sage.

De Angelis, M (2012). Human Trafficking: Women's Stories of Agency. Unpublished Dissertation, The University of Hull.

De Prince, A. (2005). Social cognition and revictimization risk. Journal of Trauma and Dissociation, 6, 125-141.

DHS, (2010). Tanzania Demographic Health Survey, National Bureau of Statistics, Dar es Salaam, Tanzania and ICF Macro, Calverton, Maryland, USA:

Dickson - Swift, V. James, E. Kippen, S., Liamputtong, P. (2007). 'Doing Sensitive Research: What Challenges Do Qualitative Researchers Face?' Qualitative Research, 2007, 7, 327-353.

Dopico, M. (2006). Infibulation, orgasm and sexual satisfaction: Sexual experience of Eritrean women, who have undergone infibulations and of Eritrean men who are, or have been married to such women. Unpublished Dissertation, James Cook University.

Drabinsky, B. (2004). www.dw.com/en/female-circumcision-threatens-girls-in Germany/ a- 1188662.

Dworkin, S. (2012). Sample Size Policy for Qualitative Studies Using In-Depth Interviews. Arch Sex Behav (2012) 41:1319–1320.

East, E. (1992). How much does it hurt? Nursing Times, 88(40): 48-49.

Edwards, R., Holland, J. (2013). What is Qualitative Interviewing? Edited by Graham Crow, University of Edinburgh. Bloomsbury Publishing Plc ISSN: 2048–6812.

Elchalal, U., Ben-Ami, B., Gillis, R., Brzezinski, A. (1997). Ritualistic Female Genital Mutilation: Current Status and Future Outlook. Obstetrical and Gynaecological Survey. 52. 643-651.

El-Defrawi, M., Lotfy, G., Dandash, K., Refaat, A., Eyada, M. (2001). Female genital mutilation and its psychosexual impact. Journal of Sex and Marital Therapy, 27: 465-473.

El Naser, A., Farouk, A., El Nashar, AR., Mostafa, T. (2010). Sexual side effects of female genital mutilation/cutting may be type dependent: a hospital-based study. Kasr Al Aini J Obstet Gynecol, 1:65–79.

Elnashar, A., Abdelhady, R. (2007). The impact of female genital cutting on health of newly married women. Int J Gynaecol Obstet; 97:234-44.

Eneyew, A., Mengistu, S. (2013). Double Marginalized Livelihoods: Invisible Gender Inequality in Pastoral Societies. Societies 3, 104–116.

Equality Now (2011). Protecting girls from undergoing Female Genital Mutilation: The experience of working with the Maasai communities in Kenya and Tanzania.

Esho, T., Enzlin, P., Wolputte, S., Temmerman, M. (2012). An exploration of the psycho-sexual experiences of women who have undergone female genital cutting: A case of Maasai in Kenya. FVV in OBGYN; 4 (2): 121-132

Essén, B., Sjöberg, N., Gudmundsson, S., Ostergren, P., Lindqvist, P. (2005). No association between female circumcision and prolonged labour: A case control study of immigrant women giving birth in Sweden. Eur J Obstet Gynecol Reprod Biol; 121:182-5.

Essien, A., Ukpong, D. (2012). Patriarchy and Gender Inequality: The Persistence of Religious and Cultural Prejudice in Contemporary Akwa Ibom State, Nigeria. International Journal of Social Science and Humanity, Vol. 2, No. 4

Etherington, K. (2004). Becoming a Reflexive Researcher: Using Our Selves in Research. London. Jessica Kingsley Publishers.

Ezeigbo, A. (2013). Snail-Sense Feminism: Building on an Indigenous Model. Nigeria: University of Lagos.

Fahmy, A., El-Mouelhy, M., Ragab, A. (2010). Female genital mutilation/cutting and issues of sexuality in Egypt; Reproductive Health Matters; 18(36):181-90.

Ferrell, B. (1995). The impact of pain on quality of life. Nursing Clinics of North America, 30(4): 609-624.

Fetterman, D. M. (2010). Ethnography: Step-by step (3rd ed.). Thousand Oaks, CA: Sage.

Findling, J., Bratton, C., Henson, R. (2006). Development of the trauma play scale: An observation-based assessment of the impact of trauma on play therapy behaviours of young children. International Journal of Play Therapy, 15, 7–36.

Finlay, L. (2002). '"Outing" the Researcher: The Provenance, Principles and Practice of Reflexivity', Qualitative Health Research 12(4): 531–45.

Finlay, L., Gough, B. (2006). Reflexivity: A Practical guide for researchers in health and social care. pp 105-119, Oxford: Blackwell Science.

Fitness, J. (2001). Betrayal, Rejection, Revenge, and Forgiveness: An Interpersonal Script Approach. In Leary, M. (Ed.) Interpersonal rejection (pp. 73-103). New York: Oxford University Press.

Fouka, G., Mantzorou, M. (2011). What are the Major Ethical Issues in Conducting Research? Is there a Conflict between the Research Ethics and the Nature of Nursing? Health Science Journal 5;1.

FORWARD, (2010). Women's experiences, perceptions and attitudes of female genital mutilation. The Bristol Peer study.

Freedman, B. (2003). No turning back: The history of feminism and the future of women. New York: Ballantine Books.

Frega, A., Puzio, G., Maniglio, P., Catalano, A., Milazzo, G., Lombardi, D., Nitiema, H., Bianchi, P. (2013). Obstetric and neonatal outcomes of women with FGM I and FGM II in San Camillo Hospital, Burkina Faso Arch Gynecol Obstet: 288: 513-519.

Frenkel, R. (2008). Feminism and Contemporary Culture in South Africa, African Studies, 67:1.

Freyd, J. (1996). Betray trauma: The logic of forgetting childhood abuse. Cambridge, MA: Harvard University Press.

Flick, U. (2009). An introduction to qualitative research, 4th edn, London: Sage Publications Ltd.

Gabriel, L. (2008). Intimate Partner Violence: The Lived Experience of an Individual's Perception of the Holistic Severing of One's Self from an Intimate Partner Violence Relationship. Unpublished Dissertation College of Saint Mary Omaha, Nebraska

Gajaa, M., Wakgari, N., Kebede, Y., Derseh, L. (2016). Prevalence and associated factors of circumcision among daughters of reproductive aged women in the Hababo Guduru District, Western Ethiopia: a cross-sectional study. BMC Women's Health 16:42.

Gele, A., Bo, B., Sundby, J. (2013). Attitudes toward Female Circumcision among Men and Women in Two Districts in Somalia: Is It Time to Rethink Our Eradication Strategy in Somalia? Obstetrics and Gynecology International. Article ID 312734, 12 pages.

Gobin, R., Freyd, J. (2009). Betrayal and revictimization: Preliminary findings. Psychological Trauma: Theory, Research, Practice, & Policy, 1, 242–257.

Green, J. and Thorogood, N., (2009). Qualitative methods for Health Research. 2nd edn. London: Sage Publications Ltd

Grown, G., Gupta, G., Pande, P. (2005). Taking action to improve women's health through gender equality and women's empowerment. Millennium Project, Lancet 365: 541–43.

Haigh, C. (2007). Getting Ethics Approval. In: T. Long and M. Johnson, (eds) Research Ethics in the Real-World Issues and solutions for health and social care. 1st edn. Edinburgh: Church Livingstone Elsevier, pp. 123-137.

Hakim, L Y. (2001). Impact of female genital mutilation on maternal and neonatal outcomes during parturition. East African Medical Journal.7 8 (5): 255-8.

Helgeson, VS., Cohen, S. (1996). Social support and adjustment to cancer: Reconciling descriptive, correlational, and intervention research. Health Psychology. 15:135–148. [PubMed: 8681922]

Hesse-Biber, S., Leavy, P. (2006). The Practice of Qualitative Research. London: Sage.

Hines, S. (2008). Chapter 2: Feminist Theories. In Richardson D and Robinson V (Eds) Introducing Gender and Women's Studies (pp 20-32) Palgrave Macmillan.

Hoffman, J. (2001) Blind Alley Defining Feminism. Blackwell Publishers.
Holloway, I., Wheeler, S. (2002) Qualitative Research in Nursing, 2nd Edition, Oxford: Blackwell.

Holloway, I., Wheeler, S. (2002). Qualitative Research in Nursing, 2nd Edition, Oxford: Blackwell.

Holt, P., Slade, P. (2003). Living with an incomplete vagina and womb: an interpretative phenomenological analysis of the experience of vaginal agenesis, Psychology, Health & Medicine, 8:1, 19-33.

Hooks, B. (2000). Feminist Theory: From margin to center (2nd ed). London Pluto Press.

Hornby A. S. (2003). Oxford Advanced Learner's Dictionary. Oxford University Press: New York.

Hosken, Fran. (1993). The Hosken Report. Lexington: Women's International Network News, Institute of Justice.

Hudson-Weems, C. (1993). Africana Womanism: Reclaiming Ourselves. Troy, MI: Bedford Publishers.

Ibrahim, Z., Ahmed, M., Mostafa, R. (2012). Psychosexual impact of female genital mutilation/cutting among Egyptian women. Human Andrology, 2 (6);36-41.

Jackson, S., Jones, J. (1998). Contemporary Feminist Theories Edinburgh University Press.

Jackson, R. (2000). The Sense and Sensiblity of Betrayal: Discovering the Meaning of Treachery through Jane Austen. Humanitas, XIII (2), 72-89.

Jacoby, B. (2011). Trust and Betrayal: A Conceptual Analysis. Unpublished Doctoral Dissertation, Faculty of Arts, Macquarie University.

Jagger, M. A., Rosenberg S. P. (1984). Feminist Frameworks (ed). New York: MC Grew-Hill.

Johansen, REB. (2002). Pain as a counterpoint to culture: toward an analysis of pain associated with infibulations among Somali immigrants in Norway. Medical Anthropology Quarterly, 16(3): 312-340.

Johansen, REB. (2007). Experiencing sex in exile—can genitals change their gender? In Hernlund Y, Shell-Duncan B, (eds). Transcultural bodies: female genital cutting in global context. New Brunswick, Rutgers University Press: 248−277.

Johnson, EB., Reed, SD., Hitti, J., Batra, M. (2005). “Increased risk of adverse pregnancy outcome among Somali immigrants in Washington state,” The American Journal of Obstetrics and Gynaecology. 193;2, pp. 475–482.

Johnson, M. (2000). Becoming a Muslim, becoming a person.: Female circumcision, religious identity and personhood in Guinea Bissau. In B. Shell-Duncan and Y. Hernlund (Eds), Female circumcision in Africa. Culture, controversy and change (pp283-312). London: Lynne Rienner Publishers.

Julie Jomeen (2012). Women’s psychological status in pregnancy and childbirth – measuring or understanding? Journal of Reproductive and Infant Psychology, 30:4, 337-340.

Kahn, S. (2016). “You see, one day they cut”: The evolution, expression, and consequences of resistance for women who oppose female genital cutting, Journal of Human Behaviour in the Social Environment, 26:7-8, 622-635.

Kandela, P. (1999). Sketches from the Lancet: Clitoridectomy. Lancet, 353, 1453.

Kanuha, Valli K. (2000). “‘Being’ Native versus ‘Going Native’: Conducting Social Work Research as an Insider.” Social Work 45:439–47

Kaplan, A., Forbes, M., Bonhoure, I., Utzet, M., Martin, M., Manneh, M., Ceesay, H. (2013). Female genital mutilation/cutting in The Gambia: long term health consequences and complications during delivery and for the newborn. Internatinal Journal of Women’s Health: 5 323-331.

Katrak, K. (2006). Decolonizing Culture: Toward a Theory for Postcolonial Women's Texts. In B. A. Ashcroft (Ed.), The Post-Colonial Studies Reader (pp. 239 – 241). London and New York: Routledge.

Kerstetter, K. (2012). Insider, Outsider, or Somewhere in Between: The Impact of Researchers' Identities on the Community-based Research Process. Journal of Rural Social Sciences, 27(2) 99–117.

Khaja, K., Barkdull, C., Augustine, M., Cunningham, D. (2009). Female genital cutting African women speak out. International Social Work 52(6): 727–741.

Khaled, M. A. (2003). Effects of female genital mutilation on childbirth. Unpublished PhD thesis, University of Glamorgan.

Kim, S. (2003). Research paradigms in organizational learning and performance: Competing modes of inquiry. Information Technology, Learning and Performance Journal, 2(1), 9- 18.

Kiztinger, C. (2004). Feminist Approaches, in Seale, C., Gobo, G., Gubrium, J.F., and Silverman, D. (eds) Qualitative Research Practice, pp. 125-140, London: Sage publications.

Kizilhan, J. (2011). Impact of Psychological disorders after female genital mutilation among Kurdish girls in northern Iraq. Eur. J. Psychiat. Vol. 25 (4): 92-100.

Kralik, D., Van Loon, A. (2008). Feminist Research in Rogers Watson, Hugh McKenna, Seamus Cowman and John Keady (ed) Nursing Research: Design and Methods, pp 35-44, Churchill Livingstone Elsevier.

Kvale, S. (1996). Interviews: an introduction to qualitative research interviewing, London: Sage.

Larsen, U., Okonofua, FE. (2002). Female circumcision and obstetric complications. Int J Gynec Obst; 77:255–65.
Lazarus, RS., Folkman, S. (1984) Stress, appraisal and coping. Springer Publishing Company, New York.

Lazarus, R. (1993). Coping theory and research: Past, present, and future. Psychosomatic Medicine. 55:234–247.

Leininger, W. (1990) Culture care diversity and university: A theory of nursing. New York, National League for Nursing Press.

Lerner, G. (1989) The Creation of Patriarchy. Oxford University Press: New York.

Li, D. (2004). Trustworthiness of think-aloud protocols in the study of translation processes. International Journal of Applied Linguistics, 14(3), 301-313.

Lightfoot-Klein, H. (1989) Prisoners of Ritual: An Odyssey into Female Genital Circumcision in Africa. New York: Haworth Press.

Lincoln, Y., Guba, E. (1985). Naturalistic Inquiry. Newbury Park, CA: Sage Publications.

Lincoln, Y. (1995). Emerging criteria for quality in qualitative and interpretive research. Qualitative Inquiry, 1, 275-289

Lincoln, Y., Guba, E. (2000). Paradigmatic Controversies, Contradictions, and Emerging Confluences in Denzin, N and Lincoln, Y (ed.). Handbook of Qualitative Research. London: Sage Publication Inc.

Lindbolm, K., Gray, M. (2010). Relationship closeness and trauma narrative detail: A critical analysis of Betrayal Trauma Theory. Applied Cognitive Psychology, 24, 1-19.

Link, B.J., Phelan, JC. (2001.) Conceptualising stigma. Annual Reviews Sociology, 27, 363-385.

Litorp, H., Franck, M., Almroth, L. (2008). Female genital mutilation among antenatal care and contraceptive advice attendees in Sweden; Acta Obstet Gynecol Scand; 87(7):716-22.

Lockhat, H. (2004). Female Genital Mutilation: Treating the Tears. England. Middlesex University Press.

Long, A., Godfrey, M., Randall, T., Brettle, A., Grant, M. (2002). Developing Evidence Based Social Care Policy and Practice. Part 3: Feasibility of Undertaking Systematic Reviews in Social Care. Leeds: Nuffield Institute for Health.

Lundberg, P., Gerezgiher, A. (2008). Experiences from pregnancy and childbirth related to female genital mutilation among Eritrean immigrant women in Sweden. Midwifery 24, 214–225.

Mackie, G. (1996). Ending foot binding and infibulation: A convention account. American Society Review. 61. 999–1017.

Magied, A.A., Ahmed, SM. (2003). Sudan: Sexual experiences and psychosexual effect of FGM. Women's International Network News, 29(3), 30.

Magoha GAO, Magoha OB. (2000). Current global status of female genital mutilation: a review. East Afr Med J. 77(5):286–272.

Mahmoudi, O., Hosseini, E. (2017). Psychosexual Complications of Female Genital Mutilation for Couples: A Comparative Study. J Kermanshah Univ Med Sci. 20(4).

Mahtab N. (2007). Women in Bangladesh from Inequality to Empowerment. A H Development Publishing House: Dhaka.

Manabe, NK. (2010). The silenced voice of initiated Venda women, Unpublished Doctoral dissertation, Faculty of Arts, University of Zululand, South Africa.

Mapana, K. (2007). Changes in performance styles: a case study of Muheme, a musical tradition of the Wagogo of Dodoma, Tanzania, Journal of African Cultural Studies, 19:1, 81-93.

May, T. (2000). A future critique? Positioning, belonging and reflexivity. European Journal of Social Theory, 3(2), 157-173.

Maynard, M., Winn, J. (1997). “Chapter 8: Women, violence and male power”. In Richardson D and Robinson V. (Eds) Introducing Gender and Women’s Studies (pp 175-197) Palgrave Macmillan.

McGregor, S., Murnane, J. (2010). Paradigm, methodology and method: intellectual integrity in consumer scholarship. International Journal of Consumer Studies 34, 419–427.

McNally, R. (2007). Betrayal trauma theory: A critical appraisal. Memory, 15, 280–294.

Mezey, G. (2005). Domestic violence, lifetime trauma and psychological health of childbearing women. British Journal of Obstetrics and Gynecology: An International Journal of Obstetrics and Gynaecology 112(2), 197-204.

Miles, M., Huberman, A. (1994). Qualitative data analysis: an expanded sourcebook, 2nd ed. California: Sage.

Miller, J., Glassner, B. (1997). The ‘Inside’ and the ‘Outside’: finding realities in interviews, in Silverman, D. (ed) (1997), Qualitative Research: theory, method and practice, pp 99-112, London: Sage publications.

Millett, K. (1970). Sexual Politics. University of Illinois Press. Urbana ana Chicago.

Millogo-Traore, F., Kaba, ST., Thieba, B., Akotionga, M., Lankoande, J. (2007). Maternal and foetal prognostic in excised women delivery. J Gynecol Obstet Biol Reprod (Paris); 36(4):393-8.

Missailidis, K., Gebre-Medhin, M. (2000). Female genital mutilation in eastern Ethiopia. Lancet; 356Ž9224:137-138.

Mitchell, J. (1971). Women's Estate. Harmondsworth: Penguin.

Monagan, S. (2010). Patriarchy: Perpetuating the Practice of Female Genital Mutilation. Journal of Alternative Perspectives in the Social Sciences. 2;1, 160-181.

Montes-Sandoval, L. (1999). An analysis of the concept of pain, Journal of Advanced Nursing, 29(4), pp. 935-941.

Morison, L., Scherf, C., Ekpo, G., Paine, K., West, B., Coleman, R., Walraven, G. (2001). The long-term reproductive health consequences of female genital cutting in rural Gambia: a community-based survey. Tropical Medicine and International Health. 6 (8). 643-653.

Msuya, SE., Mbizyo, E., Hussain, A., Sundby, J., Sam, NE., Stray-Pedersen, B. (2002). Female genital cutting in Kilimanjaro, Tanzania: Changing attitudes? Tropical Medicine and International Health, 7(2):159-165.

Mukoro, UJ. (2004). A survey of psychosexual implications of female genital mutilation on Urhobo women of the Niger Delta Communities of Nigeria. Journal of Human Ecology. 16(2):147-150.

Murray, M. (2003). Narrative psychology and narrative analysis. In P. M. Camic, J.E. Rhodes & L. Yardley (Eds.) Qualitative research in psychology: Expanding perspectives in methodology and design (pp. 95- 112). Washington DC: APA Books

Nayak. P., Mahanta, B. (2009). Women Empowerment in India. Women Empowerment, Gender gap and Human Development. Electronic Journal.

Nazer, M. (2003). Slave: My True Story. New York: Public Affairs, Print.

Ndembwike, J. (2009). Tanzania: a profile of a nation, New Africa Press, Dar es Salaam, Tanzania.

Ndiaye, P., Diongue, M., Faye, A., Ouedraogo, D., Tal, DA. (2010). Female genital mutilation and complications in childbirth in the province of Gourma (Burkina Faso). Sante Publique (Vandoeuvre-Les-Nancey) 22(5):563-70.

Njambi, W. (2004). Dualisms and female bodies in representations of African female circumcision: A feminist critique. Feminist Theory. Sage Publications5 (3): 281-303.

Nnaemeka, O. (2004). Nego-Feminism: Theorizing, Practicing, and Pruning Africa's Way. In Signs, *Development Cultures: New Environments, New Strategies* (Vol. 29, pp.377- 378). USA: The University of Chicago Press.

Oakley, A. (1981). Interviewing women: a contradiction in terms. In H. Roberts (Ed), Doing Feminist Research. London: Routledge.

Obermeyer, CM. (2005). The consequences of female circumcision for health and sexuality: An update on the evidence. Cult Health Sex 7(5):443-61.

Oduro, A., Ansah, P., Hodgson, A., Afful, T., Baiden, F., Adongo, P. (2006). Trends in the prevalence of female genital mutilation and its effect on delivery outcomes in the Kassena-Aankana district of northern Ghana. Ghana Med J; 40(3):87-92.

Okonofua, FE., Larsen, U., Oronsaye, F., Snow, RE., Slanger, TE. (2002). The association between female genital cutting and correlates of sexual and gynaecological morbidity in Edo State, Nigeria. BJOG: An International Journal of Obstetrics and Gynaecology 109, 1089–1096.

Olatunbosun, O.A. (2000). Female genital mutilation—a model for research on sexual and reproductive rights. African Journal of Reproductive Health 4(2): 14 – 16.

Olesen, V. (1994). 'Feminisms and Models of Qualitative Research', in N.K. Denzin and Y.S. Lincoln (eds) Handbook of Qualitative Research. London: Sage.

Oloo, H., Wanjiru, M. (2011). Female genital mutilation practices in Kenya: The role of alternative rites of passage: A case study of Kisii and Kuria districts.

Ondiek, CA. (2010). The persistence of female genital mutilation (FGM) and its impact on women's access to education and empowerment: A study of Kuria district, Nyanza province, Kenya. Unpublished dissertation University of South Africa.

Orth, U., Maercker, A. (2004). Do trials of perpetrators re-traumatize crime victims? Journal Interpersonal Violence, 19, 212–227.

Osifo, D., Evbuomwan, I. (2009). Female Genital Mutilation among Edo People: The Complications and Pattern of Presentation at a Pediatric Surgery Unit, Benin City. African Journal of Reproductive Health, 13, (1)17-25.

Osinowo, HO., Taiwo, AO. (2003). Impact of Female Genital Mutilation on sexual functioning, self-esteem and marital instability of women in Ajegunle; IFE Psychologia: An International Journal; 11(1):123-30.

Oyekan, A. (2014). African Feminism: Some critical considerations. African Feminism (ok) Final. pmd. Volume 15, 1.

Parmar, P., Walker, A. (1999). “Chapter 5: Interview from Warrior Marks”. In Price J and Shildrick M (Eds) Feminist Theory and the Body: A Reader Edinburgh University Press (pp 302-308).

Patton, M.Q. (1990). Qualitative evaluation and research methods. Newbury Park, London: Sage Publications.

Pesambili, J. (2014). FGM stigma in Tarime district, Tanzania: A nemesis for girls’ schooling? European Journal of Educational Studies 5(2), 209-219.

Peterson, D. (2006). Morality plays: marriage, church courts, and colonial agency in Central Tanganyika, ca. 1876–1928. American Historical Review 3 (4): 983–1010.

Ponterotto, J. (2005). Qualitative Research in Counselling Psychology: A Primer on Research Paradigms and Philosophy of Science. Journal of Counselling Vol. 52, No. 2, 126–136.

Rachman, S. (2010). Betrayal: A psychological analysis. Behaviour Research and Therapy 48 ;304–311.

Ramazanoglu, C., Holland, J. (2002). Feminist Methodology, London, Sage

Reinharz S. (1997). Who am I? The Need for a Variety of Selves in the Field. In Hertz R. (1997) Reflexivity and Voice. Sage Publications. California.

Reinharz, S., Chase, S (2002). Interviewing Women, in Gubrium, J and Holstein, J (eds) Handbook of Interview Research, 221-238, Thousand Oaks: CA, London, New Delhi, Sage.

Richards, G. (2002). Putting Psychology in its Place: A critical historical overview. (2nd ed.). Hove: Psychology Press.

Rohmann, C. (1999). The world of ideas. NY: Ballantine Books.

Romans, S., Belaise, C., Martin, J., Morris, E., Raffi, A. (2002). Childhood abuse and later medical disorders in women: An epidemiological study. Psychotherapy and Psychosomatics, 71, 141–150.

Rosen, R., Brown, C., Heiman, J., Leiblum, S., Meston, C., Shabsigh, R., Ferguson, D., D'Agostino, R. (2000). The Female Sexual Function Index (FSFI): A Multidimensional Self-Report Instrument for the Assessment of Female Sexual Function, Journal of Sex &Marital Therapy, 26:2, 191-208.

Ross, D., Ross, S. (1988). Childhood pain: Current issues, research and management. Urban and Schwarzenberg: Baltimore-Munich.

Rosaldo, R. (1993). Culture and Truth: The Remaking of Social Analysis London Routledge

Runtz, M. (2002). Health Concerns of University Women with a History of Child Physical and Sexual Maltreatment. Child Maltreatment, 7;3: 241-253.

Rushwan, H. (2000). Female genital mutilation (FGM) management during pregnancy, childbirth and the postpartum period. Int J Gynaecol Obstet. 70 (1): 99-104.

Ryan, AB. (2006). Methodology: Analysing Qualitative Data and Writing up your Findings. In: Researching and Writing your thesis: a guide for postgraduate students. Mace: Maynooth Adult and Community Education, pp. 92-108.

Sandberg, D., Suess, E., Heaton, J. (2010). Attachment anxiety as a mediator of the relationship between interpersonal trauma and posttraumatic symptomatology among college women. Journal of Interpersonal Violence, 25, 33–49.

Sayed, GH., Abdel-Aty, MA., Fadel, KA. (1996). The practice of female genital mutilation in Upper Egypt. Int J Gynaecol Obstet; 55Ž3:285-291.

Schultz, J., Lien, I. (2014). Cultural protection against traumatic stress: traditional support of children exposed to the ritual of female genital cutting. International Journal of Women's, 6 207–219.

Sen, A (1999). Development As Freedom, New York, Alfred A Knopf.

Serrant-Green, L. (2002). "Black on Black: Methodological Issues for Black Researchers Working in Minority Ethnic Communities." *Nurse Researcher* 9:30–44.

Shenton, A. (2004). Strategies for ensuring trustworthiness in qualitative research projects. Education for Information 22 (2004) 63–75 63 IOS Press.

Sheridan, M. (1992). Pain in America. Tuscaloosa: The University of Alabama Press.

Skinner, E., Zimmer-Gembeck, M. (2007). The Development of Coping. Annual Review of Psychology, 58:119–44.

Sklar, KK. (1993). The historical foundations of women's power in the creation of the American welfare state, 1830-1930. In S. Koven & S. Michel (Eds.), Mothers of a new world: Maternalist politics and the origins of welfare states. London: Routledge, 1993; 45-80.

Slanger, T., Snow, R., Okonofua, F. (2002). The impact of female genital cutting on first delivery in southwest Nigeria. Studies in Family Planning, 33(2): 173-180.

Smith, S. (1991). A feminist analysis of constructs of health. In Neil R and Watts R (Eds) Caring and nursing: Explorations in feminist perspectives. National League for Nursing. New York: 209-225.

Smith, J.A., Flowers, P. and Larkin, M., (2009). Interpretive Phenomenological Analysis. 1st edn. London: Sage Publications Ltd.

Snyder, C., Smith, T., Augelli, R., Ingram, R. (1985). On the self-serving function of social anxiety: Shyness as a self-handicapping strategy. Journal of Personality and Social Psychology. 48, 970-989.

Solomon, A., Bassuk, E., Browne, A., Bassuk, SS., Dawson, R., Huntington, N. (2004). Secondary data analysis on the etiology, course, and consequences of intimate partner violence against extremely poor women. Washington, DC: National.

Stebbins, R. (2001). Exploratory Research in the Social Sciences. Sage Publishing.

Stacey, J., (1997). Feminist Theory: Capital F, Capital T. In Richardson, D. & Robinson, V. (Ed.) Introducing Women's Studies*:* (2nd edition). (pp. 54-76). Macmillan.

Street, A., Gibson, L., Holohan, D. (2005). Impact of childhood traumatic events, trauma-related guilt, and avoidant coping strategies on PTSD symptoms in female survivors of domestic violence. Journal of Traumatic Stress, 18(3):245–252.

Sultana, A. (2011). Patriarchy and Women's Subordination: A Theoretical Analysis; The Arts Faculty Journal, University of Dhaka. July 2010-June 2011.

Sundaram, S., Sekar, M., Subburaj, A. (2014). Women Empowerment: Role of Education. International Jpurnal in Management and Social Sciences, 2; 12.

Taylor, R. (2000). Interviewing. In: B. Somekh & C. Lewin, (eds.) Research Methods in the Social Sciences (pp. 41-48). London: Sage.

Tanzania Communications Regulatory Authority (2012). Quaterly Telecom Statistics, March 2012

Teigen, M., Langvasbraten, T. (2009). The "Crisis" of Gender Equality: The Norwegian Newspaper Debate on Female Genital Cutting. Nordic Journal of Feminist and Gender Research,17;4:256–272.

Thomas, E., Magilvy, J. (2011). Qualitative rigor or research validity in qualitative research. Journal for Specialists in Pediatric Nursing, 16(2), pp.151-155.

Tobin, G. A., Begley, C. M. (2004). Methodological rigour within a qualitative framework. Journal of Advanced Nursing, 48(4), 388-396.

Toubia, N, Sharief, E. (2003). Female genital mutilation: have we made progress? International Journal of Gynecology and Obstetrics. 82:251-261.

Uchino, BN., Cacioppo, JT., Kiecolt-Glaser, KG. (1996). The relationships between social support and physiological processes: A review with emphasis on underlying mechanisms and implications for health. Psychological Bulletin. 119:488–531.

Unger, R., Crawford, M. (1992). Women and Gender: A feminist psychology. New York: McGraw- Hill.

Vangen, S., Johansen, B., Elise, R., Sundby, J., Stoltenberg, C., Stray-Pedersen, B. (2002). Perinatal complications among Ethnic Somalis in Norway. Acta Obstetricia et Gynecologica Scandinavica 84(4): 317-322.

Vincent, A. (2014). Ensuring the Quality of the Findings of Qualitative Research: Looking at Trustworthiness Criteria. Journal of Emerging Trends in Educational Research and Policy Studies (JETERAPS) 5(2): 272-281.

Vloeberghs, E., Knipscheer, J., van der Kwaak, A., Naleie, Z., van den Muijsenbergh, M. (2011). Veiled Pain. A Study in the Netherlands on the Psychological, Social and Relational Consequences of Female Genital Mutilation. Uthrech: Pharos.

Walby, S. (1990). Theorizing Patriarchy. Blackwell Publisher.

Walker, A. (1992). Possessing the Secret of Joy. New York: Harcourt Brace, Print.

Walker, I., Avant, K. (1995). Strategies for theory construction in nursing (3rd ed). Norwalk, CT; Appleton and Lange.

Waritay, J., Wilson, A. (2012). 'Working to end Female Genital Mutilation and Cutting in Tanzania – the Role and Response of the Church', commissioned by Tearfund.

Watt, D. (2007). On becoming a qualitative researcher: The value of reflexivity, The Qualitative Report, 12(1), 82-101.

Weiner, LY. (1993). Maternalism as a paradigm: Defining the issues. J Women H ist. 5(2): 96-98.

Williamson, TK. (2007). The Individual in Research. In: T. Long and M. Johnson, eds, Research Rthics in the Real-World Issues and solutions for Health and Social Care. 1st edn. Edinburgh: Churchill Livingstone Elsevier, pp. 9-28.

Willig, C. (2008). Introducing Qualitative Research in Psychology Adventures in Theory and Method. 2nd edn. England: Open University Press.

Wilson, T. (2002). Pharaonic Circumcision under patriarchy and breast augmentation under Phallocentric capitalism: Similarities and differences. Violence Against Women, vol.8.

Wolf, B. (1986). Behavioral measurement of huma pain. In R. A. Sternbach, The psychology of pain (pp. 129-168). New Yorl: Laven Press.

World Health Organization. (2000). A systematic review of the health complications of female genital mutilation including sequelae in childbirth. Geneva, World Health Organization.

World Health Organization. (2006). Study group on female genital mutilation and obstetric outcome. Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. Lancet; 367:1835–41.

World Health Organization. (2008). Eliminating female genital mutilation: an interagency statement; UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO. Geneva: World Health Organization.

World Health Organization. (2013). Female genital mutilation, Fact sheet N°241, Updated February 2013:
http://www.who.int/mediacentre/factsheets/fs241/en/

World Vision (2009). Abandonment of female genital mutilation /cutting in Kenya, Tanzania and Senegal. Report Compiled and presented by Professor Joyce Olenja: Dr Pamela Godia: Programmatic considerations.

Wuest, S., Raio, L., Wyssmueller, D., Mueller MD., Stadlmayr, W., Surbek, DV., Kuhn, A. (2009). Effects of female genital mutilation on birth outcomes in Switzerland. Department of Obstetrict and Gynaecology, University of Berne. BJOG 116:1204-1209.

Yirga, W., Kassa, N., Gebremichael, M., Aro, A. (2012). Female genital mutilation: prevalence, perceptions and effect on women's health in Kersa district of Ethiopia. International Journal of Women's Health, 4: 45–54.

Zborowski, M. (1969). People in Pain. San Fransisco: Jessey-Bass Inc. Publisher

Appendix 4- Information Sheet

INFORMATION SHEET

Title of the study: Experiences of Wagogo Women who have undergone Female Genital Mutilation (FGM) in Tanzania.

You are invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and be free to discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not to take part. Thank you for reading this.

What is the purpose of this study?

The purpose of this study is to explore the lived experiences and coping strategies of the women who have undergone female genital mutilation in Tanzania.

Why I have been chosen?

You have been chosen to take part because you were subjected to female genital mutilation procedure and you fall in the group I wish to include.

Do I have to take part?

There is no obligation to participate. It is up to you to decide whether or not to take part. If you wish to take part, you will be given this sheet information to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time without giving a reason.

What will happen to me if I take part?

You will be interviewed by ……..... (Researcher) to give share your experience. For this I will ask for your permission to audiotape the interview, which will last for no more than 60 minutes

What do I have to do?

You do not have to do anything; the interview will be done at your convenient time and place.

What is being discussed?

You will be invited to share your experience regarding the topic of the study. The conversation will be recorded on a tape recorder for analysis but it will not be made available to anybody except ……..... (a researcher) and her supervisors. The tapes will be destroyed as soon as transcription is done. You will be given the opportunity to see and approve the transcribed interview if you wish.

What are possible disadvantages and risk of taking part in the study?

As the objective of the study is geared towards gaining better understanding of the experiences and coping strategies adopted to cope with the situation from key participants like you, I do not foresee any risk or disadvantage of taking part in the study. However, should any risk or disadvantage arise the researcher is strategically prepared to minimize the effects of that risk. In addition, should you feel that you are at risk for taking part in this study, you should feel free to withdraw from the study any time you wish. If you decide to continue with the study all information you are going to provide including any inconveniences you may have felt will be strictly treated with high confidentiality. This study is part fulfilment of my PhD study and is not meant for any investigative purposes.

What are the possible benefits of taking part?

The possible benefit is that the study will unearth the experience of the women who were subjected to the procedure of FGM, so that their silent voice would be heard by different parties such as health care professionals, policy makers, activists, counsellors and the community as a whole.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the study will be kept strictly confidential. Any information about you will have an anonymous name so that you will not be recognized.

What will happen to the results of the study?

The results will be used as part of the fulfilment of my PhD study and conference presentations. It will also be used for publication so a wider audience will be informed.

Who is organizing the research?

The research is being organized by the University of Hull and the host in Tanzania is The University of Dodoma.

Who has reviewed the study?

The Local Research Ethics Committee and the Research and Development Department of the University of Hull have reviewed and approved the study. The study has also been approved by the National Medical Research Institute.

Contact for further information

……..…..... (Researcher)

The University of Dodoma
School of Social Sciences
P.O Box 365
Dodoma

Tel +255786981943

You will be given a copy of this information sheet and your signed consent form to keep

Appendix 5- Consent Form

CONSENT FORM

Title of the study: Experiences of Wagogo Women who have undergone Female Genital Mutilation (FGM) in Tanzania.

Name of Researcher: ……..

I have understood the information given to me about the research project and I have been given a copy of the information sheep to keep. The purpose of research has been explained to me and I have had opportunity to ask questions. I understand the procedures which will be involved, and these have been explained to me.

I understand that my involvement in this study, particularly the information collected will be kept confidential. It has been explained to me what will happen to the data once the research project has been completed.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving reason and without my legal rights being affected.

I agree to take part in the above study

----------	----------	----------
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature
_____	_____	_____
Researcher	Date	Signature

Appendix 6- Interview guide for women who have undergone FGM

1. Please tell me your story about the initiation process from childhood to womanhood

   Prompt: How did you receive the initiation information?

2. Tell me your experience before the procedure, what were your expectations?

   Prompts: how did you face the day?

   Prompt: How did you cope with this experience?

3. Can you give your account of the day of procedure of your circumcision?

   Prompt: Can you give details of the procedure itself?

   Prompt: What happened immediately after the procedure?

   Prompt: How did you cope with this experience?

4. What happened few days after the procedure?

   Prompt: how long did the wound heal

   Prompt: what medications did you apply for the wound

   Prompt: How did you cope with this experience?

5. Tell me your experience one to 5 years after you have been circumcised

   Prompt: How did you cope with this experience?

6. Tell me your experience about your first sexual encounter after circumcision

   Prompt: What is your sexual experience in your marriage/with someone you are living with?

Prompt: what is the quality of your sexual life being a circumcised woman?

Prompt: How did you cope with this experience?

7. Tell me your experience during pregnancy, childbirth and postpartum period

   Prompt: What was the duration of labor

   Prompt: What was the nature of deliver and its outcome?

   Prompt: What was the reaction of care providers?

   Prompt: How did you cope with this experience?

8. Can you tell me how circumcision has influenced/impacted your day to day life?

   Prompt: What values do you attach to your circumcision status? (Self-esteem)

   Prompt: Tell me your feelings about your circumcision status.

   Prompt: How would you describe your sleeping pattern?

   Prompt: How did you cope with this experience?

Appendix 7- Interview guide for former circumcisers

How did you become circumcisers?

Let us discuss your experience of being circumcisers

Why did you stop the practice?

Let us discuss why women are circumcised?

What consequences do circumcise women experience as a result of the procedure?

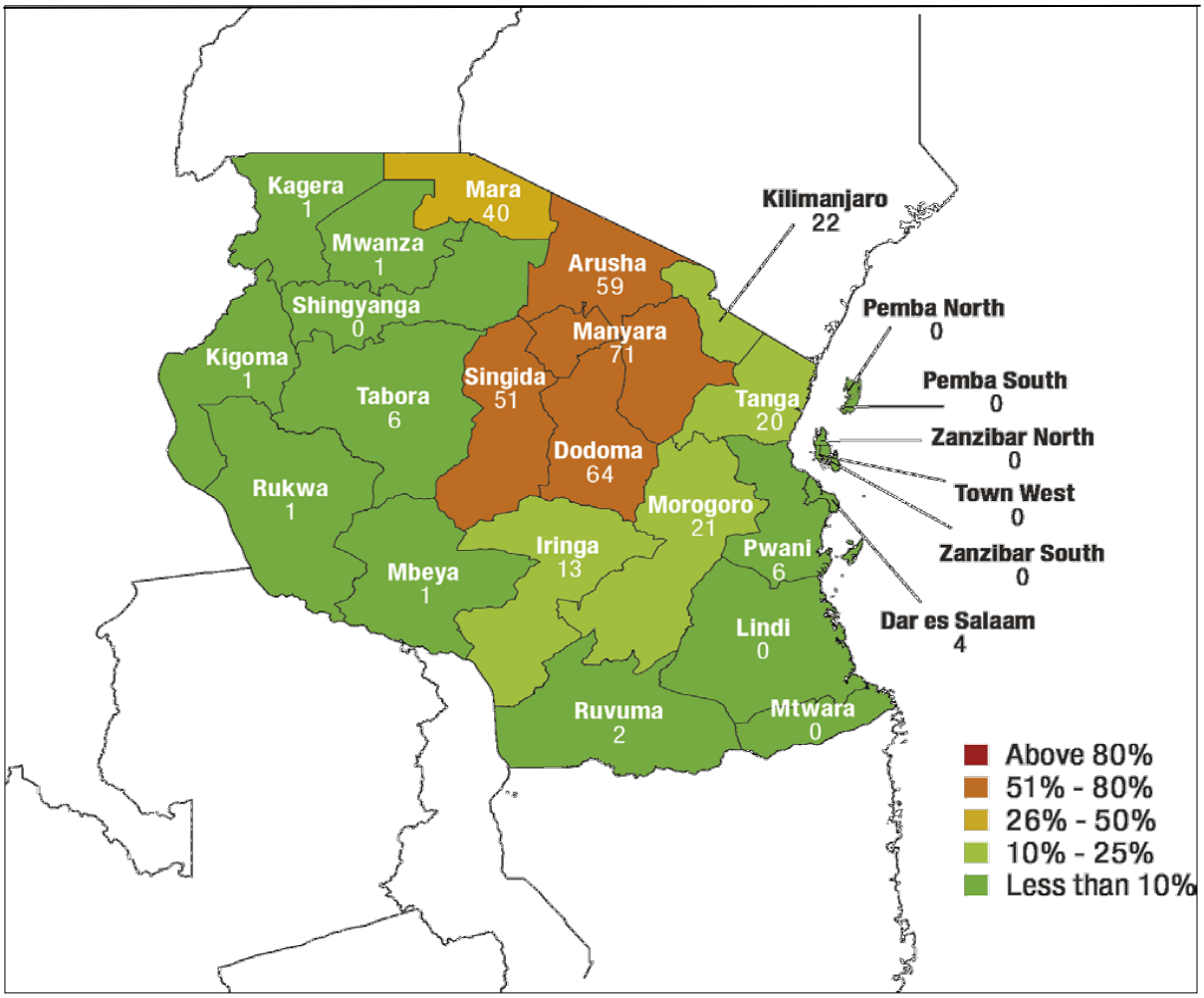
Let us discuss how the society view the procedure

Why is the society attaching great importance to female circumcision?

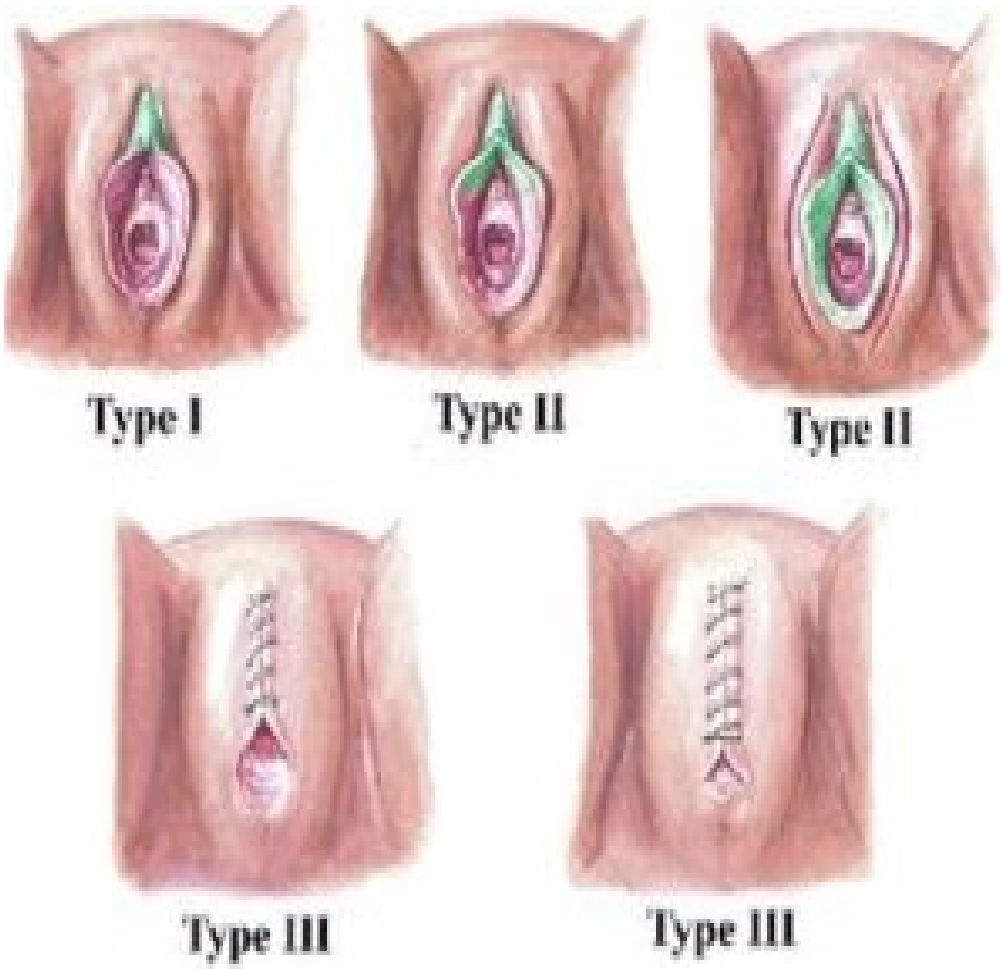
Who are pushing for the procedure to sustain?

Should the practice continue, or should it be abolished – why?

Appendix 8- Map of Tanzania shows the prevalence of FGM by region



Appendix 9- Types of Female Genital Mutilation



Source: WHO, 2013

Appendix 10- Tools that used for circumcision

Source: Drabinsky (2004)