Lund University
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Experiences of African Migrant Women Living with Female Genital Mutilation in Sweden

A narrative Analysis.

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Bachelor Thesis: UTKVO3, 15 hp
Spring semester 2016 Supervisor: Lisa Eklund

Abstract

The term Female Genital Mutilation is often used to describe a process whereby a part or all of the external female genitalia is been cut as a result of factors generally embedded around culture and tradition. This study takes a panoramic view at FGM beginning from a historical perspective when the practice was generally regarded as a cure to the sexual "excesses" of the female to the present day in which feminists, NGOs and various governments are championing attempts to put a stop to the practice of FGM which is often viewed as an abuse of the fundamental human rights of the girl child. This study which was carried out in southern Sweden addresses the issue by giving narratives of experiences of African migrant women living with FGM in Sweden. The qualitative method using an interview guide were administered and in-depth interviews conducted. Findings were made such that the respondents reported generally not suffering from any serious negative effects as a result of FGM but instead reported a high self-esteem in which no negative psychological effects was reported.

Keywords: female genital mutilation, infibulation, African migrant women, feminist perspective

Abbreviation:

FGC	Female Genital Cutting
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation/Cutting
UN	United Nations
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Acknowledgements

The completion of this thesis was made possible by the contribution of various individuals. I would want to appreciate my female respondents for your time and the trust you had in me to be able to grant the interviews and sharing your invaluable stories.

At Lund University, I wish to express my sincere gratitude to my supervisor Lisa Eklund for your invaluable comments and support during the course of the thesis writing.

Finally to my wonderful husband for his encouragement, patience and invaluable time with the kids in my absence. And to my beautiful girls Obehi, Adesua, Annmarie and Elinor, I love you all very much.

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CHAPTER ONE

1.0 Introduction.

The Practice of Female Genital Mutilation/Cutting (FGM/C) involves "all surgical procedures comprising of partial or total removal of the external genitalia or other injuries to the female genital organs for cultural or other non-therapeutic reasons" (WHO, 2000). This practice which is largely founded in traditional beliefs and societal pressure to conform is practiced in about 28 African countries (Okeke et al, 2012) and the Middle East. It is pertinent to mention that Nigeria is said to have the highest absolute number of FGM in the world with about one-quarter of the estimated 115-130 million circumcised women worldwide (see UNICEF, 2001). The Nigerian Guardian Newspaper analysis of the 2014 UN data also confirms this with some severe cases leading to maternal death, infertility, infections and the loss of sexual pleasure (Nigerian Guardian, 2015). Not minding these adverse effects to women, the practice which emanates from the belief that FGM will make the girls remain virgins until they are married and also stay faithful to their spouse after marriage is widespread in many of the practicing societies. The subject itself hardly allows for open discussion as issues concerning sex and sexuality are in most of these societies generally considered as a private matter only to be discussed privately (Vloeberghs el ta 2012). According to the World Health Organization report (see WHO, 1997; WHO, 2006), about 125 million girls and women are living with the effects of FGM worldwide with a vast majority coming from Africa and the Middle East. The after effects on migrants women coming from countries practicing FGM with reference to Africa to the Western world is particularly painful when viewed against the backdrop that these women are coming from a society where the practice until recently is generally acceptable as a norm into a society in which the practices is seen as cruel, inhuman and against the fundamental right of women (see Vloeberghs el ta, 2012). As An-Na'im (2000) maintained, human rights are basic individual rights that applies to all human simply by virtue of our humanity without distinction as a result of race, colour, sex, religion, political opinion, language, national or social origin. In effect, these rights are alienable universal rights. Thus, the practice of FGM especially on children goes against the tenets of the Universal Declaration of Human Rights (UDHR) article 5 which states that nobody shall be made to undergo torture and punishment or any other treatment that may be deemed inhuman and degrading.[1] Moreover, FGM could negatively affect the sexual health of the girl child (WHO, 2012) since women living with FGM could more easily develop

[1] http://www.claiminghumanrights.org/udhr_article_5.html#at5

some sexual health problems as compared with women who were not subjected to it. Since FGM is particularly a practice against women, it directly violates the freedom from discrimination on the basis of gender Acts of the UDHR articles 2 and 5[2] and the United Nations Charter article 55.[3] It is pertinent to note that while the physical health consequences of FGM are well documented (see Behrendt & Moritz 2005; Dare et al. 2004; Royal College of Obstetricians and Gynecologists 2009; World Health Organization 2006), documentation on the emotional effects remain limited.

1.1 Purpose of Study

This research seeks to investigate the experiences of African migrant women living with Female Genital Mutilation (FGM) in Sweden with a view to highlighting the overall effects on such women.

1.2 Research Question

It is often common to find a whole volume of works on the physical health consequences of FGM as these are obvious effects but documentation on the emotional/ psychological effects are often not readily available especially when such study focuses on females living in countries where such practice is viewed as normal and the whole idea of sex is only to be discussed in private. With this in mind, the study focuses on female migrants from Africa to Sweden who as a result of migration now have access to better information allowing them to be more open in discussing the effects of FGM.

The research question is as follows:

What does it mean to live with female genital mutilation? How can this be understood from a feminist theory perspective?

In other to answer this question, case studies using personal narratives of migrant women from their country of origin to Sweden would be analyzed.

[2] ibid

[3] http://www.un.org/en/sections/un-charter/chapter-ix/index.html

1.3 Research Limitation

To this end, the interview stage is limited to interviewing seven African migrant women in the southern region of Sweden due to the sensitivity of the topic and the difficulty in reaching women who went through female genital mutilation especially the infibulation and other harmful procedure to the female genitalia which are the more severe types. Three would-be women opted out due to their husbands not agreeing to them participating in the interview-proper stage.

1.4 Methodology.

I conducted a pilot study in order to select my informants and then selected 10 women with a view to finding out the psychological effects of FGM on African migrant women to Sweden. After conducting the interviews, it was discovered that none of the respondents showed any negative psychological effect hence the need to modify my research questions to a narrative analysis of these African migrant women from a feminist theory perspective embedded in the idea of women empowerment. This research methodology therefore uses both the primary and secondary data with the primary data collected in form of standardized interview guide which are open-ended in nature coupled with in depth interviews among a sample of seven women who are migrants from Nigeria, Eritrea and Ethiopia to Sweden. In relation to these methods, i also had to inform my informants about the ethical principles guiding my research and also to ask for their informed consent. This I did with a copy attached in my appendix. The secondary data for this study will basically come from United Nations agencies such as World Health Organization (WHO), UNICEF and previous research works on the subject since the goal is to both understand and find meaning.

1.5 Structure of the Thesis

This thesis is divided into seven chapters. The first chapter provides an introduction and purpose of the study, followed by the research questions, the methodology and the limitation to the study. The second chapter gives a background to the subject matter FGM itself and goes on to discuss both the Swedish and international legislations against FGM. The third chapter looks at the previous research on FGM including the feminists' perspective. The fourth chapter deals with the theoretical framework for this study while the fifth chapter discusses the method of administering the interview guide and data collection. The sixth chapter discusses the findings while the seventh chapter presents conclusion drawn from the study.

CHAPTER TWO

2.0 BACKGROUND

The female genitalia can be cut using different methods which depends on the part of the genitalia which is been mutilated and the degree of the procedure (Vloeberghs et al, 2012). Basically, there are four types of FGM according to the World Health Organization (WHO, 2012):

(1) Clitoridectomy or Type 1 (the least severe form of practice according to Okeke et al, 2012) involving the removal of the prepuce or the hood of the clitoris and all or part of the clitoris.

(2) Type 2 is a more severe practice that involves the "removal of the clitoris and the labia minora with or without excision of the labia majora also known as "excision".

(3) Type 3 (infibulation) is the most severe form of FGM. This involves a process whereby the vaginal orifice is narrowed through "cutting and then closing the labia minora and/or the labia majora with or without excision of the clitoris" and leaving an opening of the size of a pin head to allow for menstrual flow and urine.

(4) Type 4 include all other forms of procedures which may be deemed "harmful" to the female genitalia often carried out for purposes other than medical purposes for example the "pricking, incising, scraping and cauterization" of the female genitalia and also the stretching of the clitoris and/or labia or the introduction of corrosive substances and herbs in the vagina.

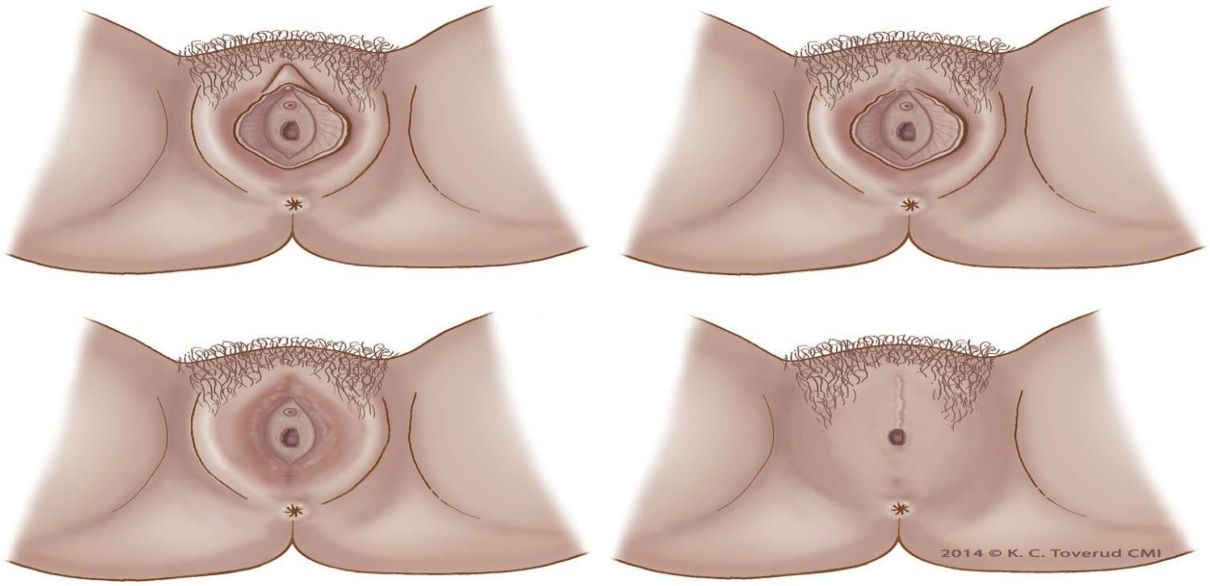

Fig 1: illustration of the unaltered external female genitalia and female genital mutilation/cutting (FGM/C) types 1-111. From top left: unaltered external female genitalia, type 1(clitoridectomy), type 11(excision) and type 111 (infibulation)

Source: downloaded from http://bmjopen.bmj.com on March 24, 2016

The most common forms of (FGM/C) are the types 1 and 2 which are also less harmful compared to the type 3 which often leads to serious physical health problems such as problems while having their babies, also increase in number of mothers having to go through caesarean sections, bleeding and increased infant mortality rate (Vloeberghs et al, 2012) not to mention the "Psychological consequences which includes but not limited to a general loss of trust, lack of bodily well-being including depression and shock which are often associated with post-traumatic experiences (Lax, 2000). These adverse aftermath effects associated with FGM becomes more obvious and apparent to migrant women who have undergone the practice when they migrate to western countries where this practice is illegal thus creating an awareness that brings about self-consciousness on the part of these migrant women.

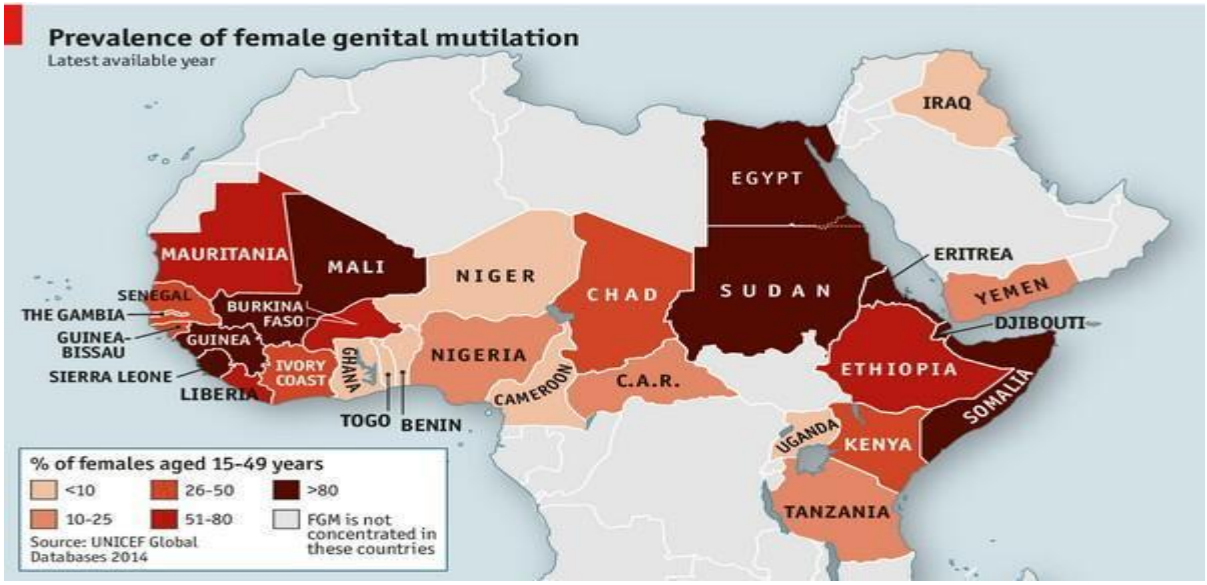

Fig 11.

Figure 11: Shows that despite the awareness that has been generated on the adverse effects of FGM, the practice is still prevalent in the regions shown above mostly amongst African countries where a woman's honor may be dependent on her being circumcised (Rising Daughters Aware, 1999).

It is pertinent to mention that despite the awareness created as to the negative health and human rights effects of FGM, the practice still persist among the immigrant communities in many western counties e.g. in the US, Britain and Sweden as well as in the Netherlands where they often send their female children back home to their countries of origin to have them undergo

FGM. In the US for instance, efforts to stop such families from sending their daughters to their home countries to be circumcised led to the 2013 law making it illegal to knowingly transport a girl out of the United States with the aim of cutting (www.theahafoundation.org). Yet in that same 2013, up to 507,000 US women and girls who were originally from countries where FGM/C is prevalent especially sub-Sahara Africa had undergone or were at risk of the procedure (ibid). This figure was more than twice the number of women and girls estimated to be at risk in year 2000 (228,000) due to the increase in immigration to the United States. The table below gives an estimate of the US women and girls who are potentially at risk of FGM/C.

Table 1
U.S. Women and Girls Potentially at Risk for FGM/C, 2013 Data

	U.S. Women and Girls at Risk of FGM/C
All Countries of Origin	**506,795**
Egypt	109,205
Ethiopia	91,768
Somalia	75,537
Nigeria	40,932
Liberia	27,289
Sierra Leone	25,372
Sudan	20,455
Kenya	18,475
Eritrea	17,478
Guinea	10,302
Other Countries of Origin	69,981

Source: Population Reference Bureau. Estimates are subject to both sampling and non-sampling error.

As can be seen from the table above. Just three sending countries-Egypt, Ethiopia and Somalia accounted for 55 percent of all US women and girls at risk of FGM in 2013. These three countries have a high FGM/C prevalence rates and a relatively large number of immigration to the United States (ibid). The FGM/C prevalence rate for women and girls ages 15 to 49 was 91 percent for Egypt, 74 percent for Ethiopia and 98 percent for Somalia and in total, 97 percent of United States women and girls at risk were from Africa countries while just 3 percent were from Asia (Iraq and Yemen).

In Sweden, the situation may not be totally different from what is obtainable in the United States as families within the migrants communities have been known to send their daughters back to their countries of origin to perform the procedure. One particularly interesting case was in

Norrkoping in eastern Sweden where 60 cases of genital mutilation was discovered in 2014. The most interesting and strange thing about this case was when it was discovered that all 30 students in a particular class were found to have undergone the procedure out of which 28 of them were subjected to the most severe form of genital mutilation-infibulation in which the clitoris and labia are completely cut away and leaving only a small vaginal opening (see The Local, 2014; see also Independent News, 2014). While it is expected that migrants have the tendency to send their children to their countries to have FGM performed on them, the general belief in Swedish society is that FGM is practiced behind closed doors among Africans (especially Somalia) immigrants (Johnsdotter, 2004) hence the numerous checks been put in place to check the trend in the Swedish society.

2.1 Legislation against FGM

Sweden in 1982 passed a law prohibiting female circumcision as FGM was then called making it the first country in the Western world to legislate against the practice (Johnsdotter 2004). Great Britain followed by passing a law making FGM illegal since 1985 although the practice still continued among some immigrant communities (see Whitehorn et al, 2002). As more and more information about the adverse effect of FGM becomes available and with NGOs, policy makers and feminists speaking out against the practice, it becomes apparent that measures needed to be taken to check and eventually eradicate the practice of FGM. In 1996 therefore, the US Congress passed a law making it illegal to perform FGM with only 23 states in the US subsequently passing the law thus making the practice illegal in those 23 states (www.ahafoundation.org , 2015). The 2012, 67th session of the UN General Assembly finally passed a resolution urging states to condemn all harmful practices that affects women and girls with special focus on FGM/C (www.unfpa.org). This was a significant milestone in the fight to end the practice of FGM worldwide.

2.2 Swedish Law on FGM

In Sweden, the use of the term "female circumcision" was changed in 1998 to Female Genital Mutilation (FGM) and allowing for stiffer penalty for breaking the law (Johnsdotter 2009). "In 1999, this law was further amended to allow for prosecution in a Swedish court of anybody performing female genital mutilation even if the act has been performed in a country where it is not considered criminal under the so-called removal of the principle of double incrimination" (see Johnsdotter 2009).

Act (1982:316) Prohibiting Genital Mutilation which states that:

Section 1: According to this act no kind of operation or mutilation on the external female genital organs which may bring about any kind of alteration may be carried out with or without the consent of the individual concerned.

Section 2: This section stipulates that anyone who contravenes the law as stated in section one is liable to a prison term of a maximum of four years. Furthermore, if this procedure leads to a situation in which the life of the individual involved is endangered resulting in what could be considered a serious crime, the penalty would be a prison term ranging from between two to ten years. "Attempts to carry out such act, Preparations and conspiring with others to carry out FGM and even any failure in reporting such crime are treated as criminal liability which is in accordance with section 23 of the Penal Code" (see from Rahman & Toubia (2000: 219) as c.f. Johnsdotter 2009).

Section 3: Violation of this law brings about liability and offenders are to be prosecuted. Such prosecution is to take place in a Swedish court even where "section 2 or 3 of Chapter 2 of the Penal Code is not applicable" (Johnsdotter, 2009). Furthermore:

Section "2 and 3 of Chapter 2 of the Penal Code concern nationality and residency" regardless of whether or not the offender or the victim are Swedish citizens. In any case, if such crime of mutilation is committed in Sweden by any person be it a Swedish citizen, asylum-seeker, an illegal immigrant etc., such must be prosecuted by a Swedish court. The very fact that offenders are residents in Sweden allows for prosecution even in a situation where the crime was committed in another country and in this case the victim and offenders do not necessarily have to be Swedish citizens.

Be this as it may, Johnsdotter (2009) argued that even though the Swedish law on FGM appears to refer to "all procedures which produce permanent changes" as prohibited but suggested that the official position was that the prohibition included ritual procedures which "do not lead to permanent changes" since the law stipulates that all types of FGM was illegal including the most extensive-where large parts of the genitals are cut off and the vaginal opening then stitched together otherwise called the type 3 or infibulation to even the use of any sharp object to pierce the clitoris. It is however unclear according to Johnsdotter (2009), what the official position is towards cosmetic genital surgery also known as "designer vaginal" often performed by plastic

surgeons and gynaecologists on women in Sweden since this procedure is often not medically motivated.

2.3 Duty to Report

The FGM Act of Sweden also stipulates that all citizens have a duty to report knowledge or suspicion of FGM to the police.

Thus, it is the duty and in fact responsibility of every citizen in Sweden to report if such citizen have knowledge or even suspect that FGM had either be performed on a child or it is likely to be carried out in accordance with the Social Services Act. This Act also mandates staff at schools and in children day care to report any suspicion of FGM to the social authority such that any official who fails to report cases or suspicion of such cases was legally liable and commits a branch of duty and could accordingly face prosecution. In addition, it is clearly stated in the Swedish Board of Health and Welfare guidelines that any citizen suspecting a performed or future FGM performance has an obligation to report, however such obligation on the citizen is limited to reporting such "real or suspected" incidence and not to try and investigate with a view to knowing for sure before reporting (Swedish Board of Health and Welfare 2002: 32 c.f. Johnsdotter, 2009). Still in pursuance of this objective, the Secrecy Act which previously forbids health personnel from disclosing information about their patient to a third party except where such information could help prevent a crime or concerns an already committed crime that could attract a prison jail term of at least two years was amended specifically to exclude FGM from the list covered by such Act. The resultant effect was that health personnel could now freely disclose information to the police and other authorities if it concerns FGM no matter how "mild" the possible sentence might be (ibid).

The social authority in furtherance to the protection of the girl child has the power and indeed responsibility to take the girl into protective custody if it is suspected that such girl was at risk of being subjected to FGM and this could be enforced with or without the approval or consent of the parents or guardian of such girl child in line with the Care of Young Persons (Special Provision). A genital examination by a physician will of necessity be recommended by the Swedish Board of Health and Welfare if grounds exist to suspect that a girl child had actually undergone FGM. In this case however, the cooperation of the parents or guardian of such child is sought but in any situation where such parents or guardian fails to provide the needed cooperation, a prosecutor may them apply for a special representative for the child in accordance with the Act regarding Special Representative for a Child. Such special

representative is then appointed for the child by a district court following the request by the prosecutor leading the police investigation. According to Wilhelmsson (2003 c.f. Johnsdotter, 2009), such a representative who should be a lawyer has the power to allow such medical investigation on the child with the child parents or guardian permission or without.

CHAPTER THREE

3.0 Previous research

From a Western cultural perspective in contemporary times, FGM is often seen as a foreign practice which is peculiar to countries of Africa, Asia and the Middle East (Utz-Billing & Kentenich H., 2008). In these countries where the practice is still a norm, many reasons have been adduced as to why this practice continue to thrive depending on culture and tradition. These reasons include the need to control the female sex drive, maintaining marital fidelity, ensuring paternity such that a man is certain he is the father of his wife's child, suppressing the female personality and also preventing the growth of clitoris which if left unchecked could grow as long as the penis (Eke & Nkanginiema, 1999; Lax, 2000, Day & Wilson, 1978). Others have argued that the need to improve hygiene on the part of the women, aesthetics and community belonging and to enhance fertility (Whitehorn et al, 2002) are some other motivating factors. Some of these explanations are arguably partly driven by "sexist" view of women which seeks to maintain the "status quo" of seeing women as subservient to men and second-class citizens of many societies (ibid). This subservient role of women in many societies still practicing FGM is reinforced by the fact that women in such societies are highly dis-empowered materially to the extent that such women partially or completely lack the "voice" to influence happenings around their environment and empowering female may thus be the most viable way to eradicating harmful practices against women such as FGM. The problem with over-emphasizing the whole concept of empowerment as it relates to women is that one must make a deliberate effort not to fall into the trap of seeing the empowerment of women as the "magic bullet" capable of putting a stop to all harmful practices such as FGM in view of the fact that the practice is deeply rooted in cultural, tradition and to a lesser extent religion. This is particularly true when viewed against the fact that FGM practice which has been illegal in Great Britain since 1985 is still practiced secretly in some immigrant communities in Britain with some immigrants sending the daughters abroad to their countries of origin with a view to circumventing legal restrictions on the procedure (Black & Debelle, 1995).

Though the origin of FGM is unknown, the first known reference dates from the fifth century BC which describes the circumcision of daughters of the higher classes in ancient Egypt and Ethiopia (Utz-Billing & Kentenich H., 2008). Thus, FGM has a history spanning well over 5000 years across different cultures (Elchalal et al., 1997) including parts of Europe and America (Whitehorn et al, 2002). In present day Western countries however, FGM is commonly viewed as a 'foreign' phenomenon practiced in some African, Asia and the Middle Eastern countries (see Utz-Billing & Kentenich H, 2008). In 19th century Britain for instance, "clitoridectomy" (which is defined as the removal of the clitoris through surgery) was a common practice used in the treatment and management of "epilepsy, sterility and female masturbation" (Kandela, 1999). As a matter of fact, some of the clinical arguments used to justify female circumcision then are very similar to what is used in many parts of the FGM practicing countries today (Whitehorn et al, 2002). The proponents of the value and ethics of FGM were challenged by the Obstetrical Society (1866) in a debate in which it was argued that removing a woman's clitoris was like removing a man's penis since both encompassed depriving the individual involved of his/her right (Moore, 1866 c.f. Whitehorn et al, 2002). Thus while some advocates of "clitoridectomy" argued that the advantage of cutting the female's clitoris is that it brings about the eradication of the evil of masturbation with surgery been a way of doing it and preventing what morals could not accomplish (Brown, 1866), some protagonists suggested that the "clitoris had a rudimentary role", with its functions and anatomical composition quite different from that of the penis (Bantock, 1866). Dr A.J. Bloch (1894) a US surgeon a few years later wrote "sexual perversion in the female and, referring to female masturbation as a "moral leprosy" cure only by "liberating the clitoris from its adhesions". One can argue therefore that a strong motivating factor for FGM was the drive to curb the "sexual drive" of women in the then predominately male dominated societies. By the twentieth and twenty-first centuries however, the increased awareness by international organizations such as the WHO and Amnesty International with all of them emphasizing that the practice violates the human rights of girls and women has helped in no small way in highlighting the negative effects of the practice leading to a number of national governments setting up legislative frameworks to abolish and criminalize FGM.

3.1 FGM- A feminist perspective

Over the past thirty years, FGM has become an example of women's oppression (Wade, 2009). The interest in FGM by feminists can be traced to 1976 when Fran Hosken began creating awareness about the topic in her writings in the women's International Network News with the

aim of eventually sensitizing the general public thus raising enough support towards the eradication of the practice in the US (Hosken, 1979). It was also Hosken who coined the term female genital mutilation to replace the old term female circumcision (Wade, 2009). Thus early literature on FGM benefited a great deal from Hosken's work with the term FGM commonly used to refer to-the disfiguring of genital cutting procedure that happens to women in Africa (ibid). The consequence of this was that a generation of Western feminist in line with Hosken's thought emerged and started to see the practice as barbaric while using terms like "cruel", "torture", "horror", "brutal" and "inhuman" to describe FGM. It was common then to hear Western feminists refer to communities practicing FGM as cruel and ignorant while the victims were simply referred to as "helpless". By the start of the 1990s however, postcolonial scholars began to criticize the Western feminists' anti-FGM position arguing that by ignoring hierarchies among women, it only serves as a vehicle for racist and imperialist ideology. These postcolonial scholars were dissatisfied with the use of the term FGM in describing the practice arguing that the term creates an impression of "disfiguring" which leaves no room for any objective consideration but rather judgemental condemnation which is both insensitive and counterproductive. These scholars then advocated a return to the term "female circumcision" or "female genital cutting" which most appropriately describes the practice instead of using the term "mutilation". Again and according to the scholars, Western feminists "anti-FGM" advocates demonizes and infantilizes people in practicing countries thereby creating further division as far as the issue of FGM is concerned between the West and the rest and eroding the fact that women in both FGM practicing and non-practicing countries are being subjected to patriarchal oppression. Lastly, the scholars wondered as to why Western feminist anti-FGM downplay the fact that African women were already engaged in anti-FGM campaign thereby creating the impression which sees members of FGM-practicing countries as objects of intervention instead of subjects in their own right.

Feminist sociologists have however questioned the idea of associating FGM with the notion of lack of freedom, choice and autonomy arguing that FGM does not always have to be associated with oppression since some girls and women deliberately make the choice to undergo the practice. In 1956, the British controlled Kenya was almost thrown into crisis when thousands of girls rebelled against the ban on FGC and in fact went ahead to purchase razor blades with which they circumcised one another themselves (Thomas, 2000). There were also cases of females in Kenya threatening to run away from home and drop out of school if their parents refused to let them perform FGC (see Njambi, 2004). Also challenging the idea that FGC should

be identified with the notion of "oppression", a scholar Ahmadu (2000) from Sierra Leone who herself went through the procedure as a young female argued in favour of the practice stating that she sees no conflict between her been an educated woman and being in support of FGC since the idea of associating the term "oppression" with the practice was something she finds hard to comprehend. Perhaps it is the use of the term "mutilation" when FGC is viewed with a western lens instead of circumcision or enhancement (Njambi, 2004) and because it is particularly associated with Africa that it attracts all the negativity for as Davis (2002) argued, when FGC is compared with labiaplasty it is seen that both practices reflect the fact that women are required to conform to certain cultural expectations for "their bodies by knife" if need be. David argues further that the differentiate evaluation of these two practices was as a result of the fact that different yardsticks are often used as a measurement which in some cases are embedded with "racial, national and global hierarchies".

Generally, the whole idea about FGM can be argued to be patriartric when one considers the fact that the practice itself is an attempt by the society to keep the woman as "pure" as possible for the man. Little wonder that feminist Morris (1992) postulated that "men's standpoint is represented as universal and neutral" which is particularly true in the case of FGM. This assertion is stated more boldly by Simone de Beauvoi a French philosopher and feminist writer when he argued that "... the relation of the two sexes is not quite like that of the two electrical poles for man represents both the positive and the neutral …whereas woman represents only the negative, defined by limiting criteria without reciprocity" (see Morris, 1992 p.). The fact that women were often excluded from making inputs to what eventually became accepted as the people's culture and tradition gives credence not only to the whole idea of the universality of man but also the subjugation and dominance of the woman hiding under cultural and traditional heritages. Marxist feminism further used the division of labour paradigm to explain gender role such that the female give birth (Morrison, 2008) while the male is left to support the family. The male therefore becomes the bourgeoisie while the female becomes the proletariat in this relationship (ibid). The basis of social relations according to the Radical feminism is male power and privilege with sexism been the ultimate tool used by men to keep the women oppressed while also controlling the norms of acceptable sexual behaviour. The socialist feminist on the other hand argued that women's oppression and inferior position was as a result of a class-based capitalism stemming from the work of women in the family and the economy. From the foregoing, it can be argued that the power structure as it were is skewed in favour of the man with the implication that the woman have little or no control over decision

effecting even her body. Patricia Hill Collins an African American who is famous for the "Outsider within" puts it succinctly in her book Feminist Thought when she stated that "Groups unequal in power are correspondingly unequal in their ability to make their standpoint known to themselves and to others" (Hill Collins, 1990, p.26) hence one can be part of a group but feels distant from that group as is often the case with women.

CHAPTER FOUR

4.0 Theoretical Framework.

Feminist theory is an outgrowth of the general movement to empower women worldwide with feminism defined as a recognition and critique of male supremacy combined with efforts to change it. The goals therefore of feminism is to show that historically and currently women have been subordinates to men and to subsequently bring about gender equity in its strong belief in the social, political and economic equality of the sexes. Barbara S. Morrison (2008) postulated that by far one of the crucial activities to feminists is the eradication of FGM which according to her was a harmful practice while also promoting the empowerment of women and allowing for integration in all societies. However, empowerment itself is abstract in nature with no mono-causal explanation (Karubi N. P., 2006) yet, Keller and Mbwewe (1991:45) describes it as "a process whereby women became able to organize themselves to increase their own self-reliance, to assert their independent right to make choices and to control resources which will assist in challenging and eliminating their own socio-political subordination". Ellen McWhirter (1991) argued that empowerment involves the process whereby people, organizations or groups who are powerless become aware of the power dynamics at work in their life, develop the skills and capacity for gaining some reasonable control over their lives and exercise this control without infringing upon the rights of others. For the World Bank, empowerment is the process of increasing the capacity of individuals or groups to make choices and to transform those choices into desired actions and outcomes. Though feminism as a concept has been diffused into different school of thoughts, the common meeting points among the different schools is that each and every one of them strive to demonstrate the importance of women and to fight that women should share equally in society's opportunities and scare resources.

Morrison (2008) postulation of feminism above and Mbwewe (1991) definition of empowerment will be used in this study given the importance of these two assertions when viewed against the fact that the main reason for FGM was the need to curtail the sexual enjoyment and if you like "excesses" of the female so as to keep her a "virgin" to a would be

husband. Granted that in nearly all the practicing countries, the role of culture and tradition in FGM cannot be over-emphasized but as the feminist Morris (1992) argued, the fact that women were often excluded from making inputs to what eventually became accepted as the people's culture and tradition gives credence to the subjugation and dominance of women by men hiding under cultural and traditional heritages. To this end, the theoretical framework of this study will be based on the whole idea of feminism and the feminist theory.

CHAPTER FIVE

5.0 Research Methodology.

The aim of this section is twofold: to discuss the techniques and methods used in collecting and analyzing the data for this research Secondly, to present and analyze data that was collected with the interview guide. The method of data collection and segmentation of the study area so as to reach the target population were of paramount importance to this author. In addition, the techniques or methods used in the analysis of data were also a crucial aspect of this study.

5.1 Methods of Data Collection.

Various methods of data collection have been used in this study but the main material for the study has been obtained through the use of an interview guide, refined observations and in-depth interviews. The use of the different methods becomes necessary when viewed against the fact that it is a highly effective method for difficult-to-reach population (see DeJong & van Ommeren 2002).

5.2 Design of the Study.

The study is designed in such a way as to understand and make appraisal. This study used the qualitative method using an interview guide which was structured in such a way as to allow for simplicity involving in-depth interviews with the subjects which in this case are the seven migrant women of African origin to Sweden.

5.3 Participants under study

The major groups of African migrants to Sweden are mainly from East Africa: Somalia, Eritrea and Ethiopia (Johnsdotter, 2009) with the highest numbers of females of African origin in Sweden who have undergone FGM also coming from Somalia followed by Ethiopia. The

persons interviewed for the study however, comprised of a sample of seven migrants of African origin to Sweden from Eritrea, Ethiopia and Nigeria.

5.4 The study population

Ordinarily, the study population should comprise of African migrant women to Sweden who have undergone the procedure.

5.5 The sample size

Originally, the purposive sampling method was used to pick ten African migrant women to Sweden but after the initial interview stage, three of the women of which one of them was from Somalia withdrew from the exercise due according to them to their husbands not too comfortable with their wives discussing FGM/C. This study therefore was carried out using seven women: 4 Nigerians; 2 Ethiopians and 1 Eritrean. Access to 8 of the original ten women was through the so-called "snowball" method which is often helpful in gaining access to hard-to-reach population (Crescenzi et al., 2002). The snowball sampling method often involves insiders in a given group or association who select individuals very often based on certain criteria who are used to contact others who meet the stated criteria. In this study, this author discussed the research topic and purpose with the pastor of her church who introduced the two of the women in the church who had undergone FGM to her and they agreed to talk to her on the subject. Through these women, this author was able to gain access to other women who met the criteria. The respondents were subsequently individually informed about the aim of the study by means of information sheets which were written in both the Swedish and English languages. None of the respondents was an illiterate thereby saving the author the effort of having to explain the content on the information sheet in great detail. However, the author deemed it fit to explain the aim of the study to each respondent thereby creating an opportunity for each one to ask question in areas that may not be too clear to the respondents. This also afforded the author the opportunity to reassure respondents about the confidentiality of any information provided and that they were not obligated to answer any question they feel uncomfortable with. Subsequently, each participant was asked to sign the Informed Consent form. A total of seven interviews were finally conducted and used for this research work. This is as a result of one Ethiopian woman, one Eritrean woman and the Somalian woman declining further participation after having initially agreed to it.

5.6 The interview guide

The interview guide was developed by the researcher with modification carried out in the course of the interview process as I realized in the first interviews that some aspects were missing. The interview guide consists of nineteen questions while a consent note was also prepared to be read either by the respondent herself or read to her by the interviewer in other for the subject to fully understand the purpose of the study and to emphasize to her that information supplied were to be treated as highly confidential.

5.7 Administration of the interview guide.

A total of seven questionnaires were administered. The responses from the respondents were used for analysis. In designing the interview guide, i followed the following procedures:

1 Deciding what type of information should be sought;
2 Deciding what type of questionnaire should be used

3 First draft of the interview guide and following suggestions from my supervisor was taking into consideration, care was taken in the wording of the second and subsequently third and final draft so as to be certain that the response received to each question was the type solicited.

5.8 The interview stage.

The interviews were performed orally by the author. All the respondents spoke the English language and majority of them spoke both English and Swedish languages with the implication that they was no language barrier at any stage of the interview. The interview was conducted in the respondent's homes. Three of them with grown up children did not mind the presence of their daughters around while the interview lasted. The interview proper lasted a total of 1 hour 20 minutes with each participants. The respondents themselves freely chose the date, time and location of the interview.

The ages of the respondents ranged between 33 to 45 years of age. The four respondents from Nigeria are holders of a Bachelor degree from Nigeria while all of the other respondents have had some forms of formal education in their country of origin before moving to Sweden. Virtually all of the women stated that they agreed to participate in this study because they

wanted to share their experiences with a view to helping in whatever way necessary in eradicating FGM.

5.9 Semi-structured interview

In addition to the interview guide, interviews lasting an estimated 20 to 25 minutes were also conducted with the respondents. Here the respondents were encouraged to talk freely on other aspects of FGM that the interview guide might not have covered such as relationship with parents after they migrated to Sweden and come to realize some of the effects of FGM. This session was also aimed at creating a much relaxing atmosphere after the anxiety often created when FGM is discussed in such details with the informants.

5.10 Ethical considerations.

A code of conduct is to create an environment such that research works are carried out from the onset within acceptable ethical considerations and principles especially when it involves very sensitive issues such as the FGM. As Kavle & Brinkmann (2009) puts it "an interview enquire is a moral enterprise-moral issues concerning the means as well as the ends of an interview enquiry. Consequently, interview research is saturated with moral and ethical issues." Bearing in mind the nature of the research topic coupled with moral and ethical considerations especially on the part of the interviewees, this author informed the participants beforehand about the aim of this study and that participation was voluntary. It was further stressed that all information obtained will be treated as strictly confidential and was to be used for purely academic purpose. Personal information of the respondents will therefore under no circumstances be published. It was further emphasized by the author to the interviewees that they have a right to decline to respond to any question they do not feel comfortable about and can indeed stop the interview at any stage of the interview if they so desired since the essence of the interview was neither to create a situation of mistrust nor to induce anxiety, stress or fear which could be counter-productive to the respondents. Thus, this author refrained from showing any emotion such as outright shock, anger and pity that could reawaken old memories. Being from the same cultural background as some the interviewees was also a key factor in helping this author overcome some of such emotions.

CHAPTER SIX

Findings

6.0 Introduction.

This chapter presents the result obtained during the interview stage beginning with the case description of each of the seven respondents. The case descriptions which is patterned after the work of Pereda N. et al (2012) gives the bio-data of each of the respondents. This is followed by a presentation of the data generated during the field study.

6.1 Case description

Origin and family

Case 1: A Nigerian woman who had grown up with her parents and three siblings. She was the only female in the family and was genitally mutilated at the age of 10. The type 1 genital mutilation was performed on her. She got married at the age of 25 and had her first child (a girl) at the age of 26. She has three children, one boy and two girls and none of the girls have been genitally mutilated. She came to Sweden in 2010 with her first daughter and husband who was then a student and have since had two other kids.

Case 2: A Nigerian woman who grew up with her aunt and 2 cousins. She went through the type 1 together with her female cousin at the age of 8. She got married when she was 28. She has one daughter who did not go through the circumcision as a result of the mother being educated. She said after reflecting on the side effects of FGM, she made up her mind to protect her daughter from the act. She came to Sweden with her husband in 2008.

Case 3: A Nigerian woman who grew up with her parents. She is the only child of her parents. She went through the type 1 procedure at the age of 8 when her grandmother insisted that she must go through the circumcision. She has 3 girls but none of the children went through the circumcision. She came to join her husband in Sweden 2006.

Case 4: A Nigerian woman who grew up with her aunt. She went through the type 1 at the age of 9. She has 2 boys but said she would not do it for her daughter even if she had one. She came to join her husband in Sweden in 2006.

Case 5: An Eritrean woman who grew up with her parent. She underwent the type 2 mutilation at the age of 11. She has 2 children a girl and a boy. She said she does not see anything wrong

in doing the procedure for her daughter according to her "the advantages outweighs the disadvantages when viewed against the fact that there is honor associated with a woman not been promiscuous till she get married especially getting married as a virgin". As a result of her getting married as a virgin, she brought honor to both her family and her husband's family thereby earning respect. She came with her husband 2008.

Case 6: A single mother from Ethiopian who grew up with her parents and 3 siblings. She did the type 2 procedure at an age she cannot remember. She has 2 daughters and would not want her daughters to undergo the procedure. She moved to Sweden in 2006.

Case 7: An Ethiopian woman who did the type 2 procedure grew up with her parents and 4 siblings-two brothers and two sisters. She and her two sisters were mutilated at a very young age. She has two daughters who were both born here in Sweden. She would not want her daughters to undergo the procedure. She moved to Sweden with her husband in 2006.

6.2 Education and Employment.

The four respondents from Nigeria all had a university education before moving to Sweden. The Eritrean and the two Ethiopians also had some level of education before moving to Sweden as evidenced from the fact that they could all read and write. All the respondents are employed in the service sector.

6.3 Data Presentation.

This section presents findings from the interview on FGM. The findings are for clarity purposes sub-divided into six sections thus: the FGM in general section, informant's narratives section, the positive effects section, the negative effects section. Living with FGM in Sweden section and the FGM of others section. As can be seen from the sample question itself, each of the sections comprise of a number of sub-questions which are designed in such a way as to make it easy to gather information which are vital and usable.

6.4 FGM in General

All the respondents knew what FGM was in general and adduced a number of reason why it is performed on female in their respective countries such as the need to keep the woman "pure, and to prevent infidelity and promiscuity as a way of controlling female sexuality" (see Cook et al. 2002; Webb & Hartley 1994 c.f. Pereda N et al 2012). The respondents did state that traditionally, women in Africa were to be presented to the husbands as a virgin and to this end,

the belief in traditional Africa culture was that circumcising the female will help in reducing the urge for sex and also ensure that such women remain faithful to one partner-their husband when they are married.

6.5 Informants narrative

Five of the respondents (Cases 1,2,3,4 and 5) remembered vividly the experience and said it was usually the female elders in their family who took the decision. Case 1 said it was her grandmother who visited and convinced her mother on the need for her to be circumcised. Each remembered that it was an old relative that performed the act using razor blade or small knife. Cases 1, 2, 3, and 4 remembered not being able to walk for some days because of the pain. Each said that their mother would rub "palm oil" on the mutilated part every morning and as many times as they complained of pains in order to help ease the pains. Case 6 and 7 could not remember the process and the person that decided that they should undergo the procedure but revealed that it was usually the female in their societies. Cases 1, 2, 3, and 4 had the type 1 procedure performed on them while Cases 5, 6, and 7 have the type 2 procedure performed on them. Cases 1 and 5 remembered the pain they felt during the process vividly and as Case 1 said "it's not the kind of pain you will want inflicted even on your enemy". She said she remembers the pain she felt on that day now that she was opening talking about FGM as if it were yesterday. For Case 2, "it was so painful that you feel like dying immediately so as to end the pain". All the respondents stated that the whole process of FGM was purely a "women's issue" in agreement with the findings by Pereda N. et al (2012)

6.6 Positive Effects?

All the respondents agreed that there were some positive sides to FGM as illustrated below:

6.6.1 Education:

Informant 1 stated that she was able to concentrate on her education without thinking of sex or wasting her time on boys. She finished her secondary school and went to the university while many of her friends dropped out of school when they got pregnant because they were derailed since they spent a great deal of their time chasing after men.

6.6.2 Re-narrating for justification purposes

Informants 1 also said that her mother was often quick to bring the news of any of her friends who got pregnant home to her and would often said "so and so girl is pregnant, I told her mother

to circumcise her but she would not listen and now she is pregnant." She confided in me that she grew up actually thinking she was far better than a few of her friends who were not circumcised.

6.6.3 Lack of sexual urge

Informants 2, 3 and 4 likewise said they were never attracted to boys, never went to "disco parties" nor had any sexual urge. Informants 3 stated that by the age of 17 she practically knew everything about sex but was never ever motivated to indulge in it. Reason?-No urge, no interest.

6.6.4 Abstinence

Informants 1, 2, 3 and 4 started further that even now that they are married, they can abstain from sex for a very long period of time with informant 2 saying she could abstain from sex for at least 6 months. Informants 5, 6, and 7 equally stated that they could abstain from sex for a very long period of time. Of particular interest was informant 6 who said that the last time she had sex was three years ago (2014). Though she is not married, she claimed that not being married was not an obstacle to sex but that she simply doesn't have the urge. She stated further that she does not see sex as particularly as exciting as it is made to look for example in X-rated movies which according to her sometimes helps to trigger a sexual urge in her. For her, the fact that she does not go after men was a positive side-effect of FGM.

6.6.5 Marriage prospects

In terms of marriage prospect, informants 1, 2, 3, and 4 stated that though it is not something that is over-emphasized in Nigeria, the prospect was often highly for a female who had undergone FGM to get a husband since the husband is often assured that the wife is not the promiscuous type. Informants 5, 6 and 7 stated that the prospect of marriage was often higher in their societies for a circumcised female.

6.7 Negative Effects:

All the respondents agreed that the main negative effect comes mainly from the feeling of been inadequate (Whitehorn et al, 2002) and deprived of sexual satisfaction each time they hear other women who had not undergone the procedure talk about such things as "sexual feelings, sexual urge and orgasm" since some of those feeling were something that was totally strange to them as a result of them never experiencing such feelings. It is only at this point the respondents

began to feel as if they are missing something and that perhaps FGM/C has affected their sex lives negatively. Of all the respondents, only Case 5 remembered having a nightmare related to her experience once in her adult life. No nightmares for the other respondents. All the respondents however, agreed that they feel a kind of anxiety and stress each time they want to have sex with a man (Vloeberghs et al, 2012). On probing further, respondent 1 stated that she could not really explain the anxiety she feels but that she is usually excited when her husband notices and stop his sexual advances towards her. Respondent number 7 did state that at times, she needed to get drunk in order to overcome her feelings of anxiety. Respondent number 2 stated that the feeling of anxiety stated from the very first day she had sex with her husband many years ago and she has resigned to the fact that it will never go away. Respondent 4 also finds succor in taking alcohol before sex "it makes you feel relax and the anxiety goes away" she stated.

6.8 Living with FGM in Sweden

As for their experiences living in Sweden, all the respondents agreed that it was a more open society where the rights of everyone is equally guaranteed to a larger extent back in their countries of origin. The issue of cultural clash as regards FGM came up and respondent 5 was particularly critical of the way and manner FGM is viewed in Sweden saying that the issue is over-blown. She went further to add that attack on FGM and countries practicing it especially African countries was a "Europe centric" thing in which Europeans are trying as always to show that their way of life is "superior" to ours. She actually used the word "imperialists" to describe western advocates against FGM. Respondent number 1 stated that she was not shocked to find that Sweden has laws against FGM but that she was a bit surprised that it was such a big issue in Sweden unlike back in Nigeria where it is hardly mentioned. Respondents 2, 3 and 4 shared the same opinion as respondent 1. Respondents 6 and 7 stated that they experienced a shock culturally as regards FGM as they observed that people seems to feel sorry for them whenever such people got to know that they are circumcised. Respondents 6 and 7 first heard the word "mutilation" in Sweden as against circumcision that they were used to hearing back home. Respondents 6 and 7 went further to state that while women who were circumcised are looked upon with respect back in their home country, they get am impression that people here see them as "victims" which they feel very uncomfortable about. As to how the respondents feel each time they visit a doctor or a midwife here whom they cannot help but show they virginals to, the respondents were unanimous in saying that they feel "racially profiled" such that the doctor or midwife appears eager to see their virginals and the moment they notice that they had been

circumcised, the doctors or midwives will slowly look at each other in such an annoying way. Respondents 1 and 4 actually said they were told on more than one occasion "oh, you were genitally mutilated" to which respondent 1 said she screamed at one occasion "circumcised"! Respondent 5 did said that on a few occasions she actually told them "well, that is why our women are not promiscuous" and she noticed the shock on their faces and then cold silence. Respondent 6 said she had learnt to ignore the stares from medical personnel whom she is "unfortunately" forced to show her "private" part to as she does not like to use the word "vaginal". Respondent 7 stated that she had learnt to telling the doctor or midwife beforehand that she was circumcised as is the tradition in her country and actually noticed that such doctor or midwife is no longer as shocked as they would have been if they had discovered it themselves. Generally, all the respondents reported a feeling of shame the first time they visited a doctor or midwife and had since developed a way to overcome such feelings.

6.9 FGM of Others

In relation to whether or not there were females in their families who did not undergo FGM, respondent 1 said she did it because she was the first daughter in her family and believes that every first daughter in her community must undergo the procedure. She knew of a few relatives who did not undergo FGM. In contrast, respondent number 2 reported that every female in her family went through the procedure but was quick to add that the situation today was different as most of the younger generation in her community do not necessarily have to do it to their daughters due largely to awareness and the influence of Christianity-a religion according to her that does not emphasis the practice. Respondent 3 says it depends on individual family in her community and she indeed know of a few cousins who did not undergo the procedure. Respondent 4 does not know of any family member who did not undergo the procedure since the topic itself does not easily allow for open discussion. Respondent 5 does not know of any family member who did not undergo FGM as it is a social norm in her country Eritrea. For respondents 6 and 7, it was simply a matter of honor and every female in their respective family was proud to undergo the procedure. As to the question as to how the respondents feel when meeting women who have not undergone FGM, all the respondents reported a high level of self-esteem (Rosenberg 1965 c.f. Pereda N. et al, 2012). The reason for the self-esteem as I gathered was basically as a result of the fact that each of them stated that they could proudly look back to their youth and can boldly say that they were not promiscuous as against some of their friends in the words of respondents 1, 2, 3, and 4 who ended up getting pregnant and bringing shame and disgrace upon their families. Respondent number 5 particularly said she

doesn't mind doing it for her daughter as she strongly believes that FGM does help in curbing sexual excesses. Their sense of self-esteem is further boosted by the fact that their husbands equally have a sense of pride that their wives will never cheat on them since they do not exhibit any "unusual" sexual drive.

6.10 DISCUSSION ON FGM

The original objective of this study was to investigate the psychological effects of FGM on African migrant women to Sweden with a view among others, of helping to better understand how FGM affect not only the lives of these women but also its effects on their relationships with their partners and families (see Retzlaff 1999) on the one hand and the effect on such women as a result of their migrating to Sweden on the other hand. The fact that this study during the interview stage, failed to find any psychological effects as a result of FGM on the respondents naturally brought about a situation in which the objective of the study was modified in such a way that it ended being a narrative analyses of the migrant women to Sweden as a result of FGM being performed on them. While it may be normal to wonder as to why it was impossible to establish any kind of psychological effects of female genital mutilation on these women, it may be relevant to point out that some of the women interviewed in this study had the FGM type 1 performed on them while the others had the type 2 performed on them. Of the seven women originally earmarked to be interviewed, 3 of them opted out at the very last minutes after discussing the issue with their husband. At the preliminary interview stage, one of the three women who by the way was from Somalia, stated that she had the type 3 FGM performed on her and she further informed me that one of the other two women also had the type 3 performed on her. Also, during the preliminary interview both the Somalian women and the second woman from Ethiopia did confide in me that FGM had a lot of negative psychological effects on them mainly due to the fact that they do not enjoy sex since they almost never get any sexual feeling coupled with the fact that they feel cheated and abused as a result of being genitally mutilated. Unfortunately, these women were not available at the interview stage proper for further investigation.

The fact however, cannot be over-emphasized that in order to eradicate the practice of FGM, women especially those who had undergone the procedure should be willing and indeed free to talk about the issue. This study discovered that the women were initially not very enthusiastic about discussing the matter. It was as Vloebergh et al (2012) discovered in their study "talking

causes harm". The respondents were initially not very comfortable about the issue and most had never ever discussed it or its effects on them with their husband. This author got the impression that these women were all "nursing a psychological wound" which they would rather be left alone to "nurse" privately and not until a relaxed atmosphere was created in which the author became a part of their "world" so to say without showing any kind of emotion such as pity or anger before each one of them opened up on the vexed issue.

Though all the respondents save one claimed that they will not allow their daughters to be circumcised, it was noticed that in general, all the women were proud of the fact that they were not promiscuous during their youths. Five of them told me that their husband married them as virgins and accounting for the "huge" respect they enjoy till date from their husband, the husband's families and even their own family whom they claimed to have honored them as a result of them staying as a "virgin" until marriage. Thus, the issue of honor becomes very relevant in the whole FGM "cult" as discovered in this study as a mother is often proud to tell her children that their father married her as a virgin and that no man ever saw her nakedness except their father. This perhaps could explain why among the Yoruba tribe of Nigeria as showed in a study by Akinsanya & Babatunde (2011), the difference in prevalence between Yoruba mothers and daughters only decreased slightly from 75% to 71% despite the fact that about 53% of the respondents were very much aware of the adverse negative health effects of FGM. Suffice to say that four out of the seven respondents in this study are of Yoruba origin.

One of the respondents maintained that there was nothing wrong in her daughter undergoing FGM even after she had lived in Sweden for eight years. Her failure to see anything wrong in the practice of FGM is due mainly to the fact that she married her husband as a virgin and brought great honor to her family coupled with the fact that she sees the whole issue, in her own words "noise about FGM in Europe" as another attempt by the West to impose their culture on Africans. This could perhaps explain why the prevalence of FGM among the immigrant community in the Western world seems to be decreasing at a somewhat arithmetic rate as families continue to send their daughters to their home country to undergo the practice.

The fact that virtually all of the women studied here reported feeling somewhat satisfied and indeed showed a high level of self-esteem (see Pereda et al 2012) may be due to the fact that none of the women in this study had the type 3 (infibulation) FGM performed on them after all, in the study on FGM among immigrant community in the Netherlands Vloeberghs et al (2012) did refer to "the traumatized" as those who have mostly been infibulated and as a result suffered

a lot of pains and sadness leading to either divorce or having a bad relationship with their husbands. Furthermore, they are often troubled by recurrent memories, sleep problems and chronic stress whenever the thought of having sex comes up etc. It is relevant to mention that the Somalia woman who opted out of this study did confide in this author at the preliminary stage of the interview that she had undergone the type 3 FGM. Initial contact and preliminary interviews with this Somalian woman however, give credence to the findings of Vloeberghs et al (2012) as regards the characteristics associated with the "traumatized"

CHAPTER SEVEN

CONCLUSION

The results of the present study shows that women who have suffered FGM/C especially the types 1 and 2 do not necessarily have to be viewed as "objects of pity" since most of them can still go through life with a positive attitude and not go through serious sexual and gynecological problems. International migration also means that FGM is no longer a problem confined to Africa and other countries (see Black & Debelle 1995) but also a reality in Western countries as evidenced from the different laws in Sweden and the United States to check the menace. Of particular interest are the views by feminists that FGM is another attempt by men in practicing society to further subjugate the women. While it may be argued that FGM is in the long run for the benefit of the men (it is the man who marries the virgin and most men are really proud of this fact in practicing countries since the wives are more likely to be faithful). Findings from this study shows that the fathers or men family members of the women who suffered from FGM were not involved in any way in the decision to have them undergo the procedure. All the women in this study stated that it was the women in their communities that perpetuated the act on them and it was usually the mothers and grandmothers who took the decisions in agreement with previous findings (see Herieka & Dhar, 2003 c.f. Pereda et al 2012) see also Morrison, 2008) and even the people doing the actual cutting were women in general. Thus, there is the need for men to be included and involved in educational programs towards eradication of FGM since in many cases, men are not in favor of this form of victimization, the consequences of which some of them suffer in marriage (Herieka & Dhar, 2003 c.f. Pereda et al 2012).

When Fran Hosken coined the term female genital mutilation to replace the old term female circumcision (see Wade, 2009), it was perhaps with a view to raising awareness to the vexed

issue. This study however shows that the term “mutilation” connotes a whole lot of negativity to the women involved since virtually every one of them insisted that this author refrained from using the word mutilation. Since it was further observed that using the term “mutilation” almost instantaneously creates a kind of defensive attitude on the parts of the women, it may perhaps be much more appropriate to stick to the old term “circumcision” if only to refer to the types 1 and 2 while referring to type 3 as “mutilation”. This may bring about a situation in which people may be more willing to discuss the topic as against when a blanket term such as “mutilation” with all the negativities it connotes is used.

On a final note, this study allows for further study in which perhaps the role of men in practicing societies may be investigated with a view to finding out the extent if any of their culpability in the whole FGM saga. Also further study could be carried out so as to investigate the severe forms which are the type 3 and 4 female genital mutilation as all my informants did the type 1 and 2. This will further contribute to the body of knowledge on the effects of the severe forms of female genital mutilation.

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APPENDIX 1:

A prototype of the interview guide

Background: tell me about yourself and your family (probe for age, family situation, education, income, arrival in Sweden

FGM in general

Question 1: Can you tell me about female genital mutilation in general? What are the major reasons FGM is practiced in your country.

Your personal experience

Question 2: Can you tell me about female genital mutilation from a person experience as someone who had undergone the procedure?

Question 3: What type of FGM did you undergo and at what age?

Question 4: Who made the decision on when, how and the kind of FGM to perform on you?

Question 5: What kind of memories do you still recall from the FGM experience?

Positive effects?

Question 6: What are the positive effects of FGM in your opinion?

Question 7: What role did FGM play when you were to get married?

Question 8: In terms of marriage prospect, do you have equal chance of getting married back home as compared to a lady who did not undergo FGM?

Negative effects?

Question 9: What negative effects of FGM can you tell me from your personal experience? Especially during childbirth?

Question 10: Do you think FGM has affected your sex life if so. How?

Question 11: Did you have nightmares as a result of the FGM procedure? Do you still have nightmares?

Question 12: What negative effects do you think could have resulted from you not performing FGM in your home country in terms of marriage and social status?

Living with FGM in Sweden

Question 13: What about experiencing living with FGM in Sweden? In comparison to home country?

Question 14: What do you feel about cultural clash since FGM is forbidden in Sweden but accepted in your country?

Question 15: When you visit the doctor or a midwife here in Sweden, how do you feel?

FGM of others

Question 16: Are there some women (girls) in your family who you know that have not undergone FGM or is it not compulsory that every female in your family undergo the procedure?

Question 17: How do you feel as someone who had gone through the practice of FGM when meeting other women who have not gone through it?

Question 18: Would you want FGM to be performed on your daughter(s) if you have any? Please give reason.

Other issues

Question 19: Are there any other experiences of feelings you would like to share?

APPENDIX 2

Consent for participation in the study

You are giving your consent below to participate in this interview that will be the basis for bachelor's degree in sociology at Lund University. The purpose of the study is to investigate the psychological effects of female genital mutilation of African migrant's women who moved to Sweden.

Please read this carefully and give your consent by signing with your signature. It is the investigators responsibility to store and process the information collected. In this way, the interview remains anonymous. The interview material will be coded so that the transcripts do not contain information that can depict the interviewee´s identity. Such information will be stored separately from the interview material.

Pseudonyms will be used in the final report/study.

Consent

-I take part in this interview voluntarily and have been informed of what the purpose of participation is.

-I agree that the material I leave in the interview may be used by Mary Imonitie for both the thesis work and possible follow- up –study.

- I am aware that I can at any time during the interview cancel my participation, but I need to explain why.

- I agree that Mary Imonitie, and only Mary Imonitie, store and process the information collected during the interview.

- I have had the opportunity to have my questions answered about the study before it started and know who to turn to with questions.

-I give my consent to be contacted again for any follow-up questions that may have arisen after the interview.

- I have been informed about the measures that will be taken to preserve anonymity.

-I am aware that no compensation will be paid.

Location…… Date: /…. 2016

Signature: …….

Printed name: ……..