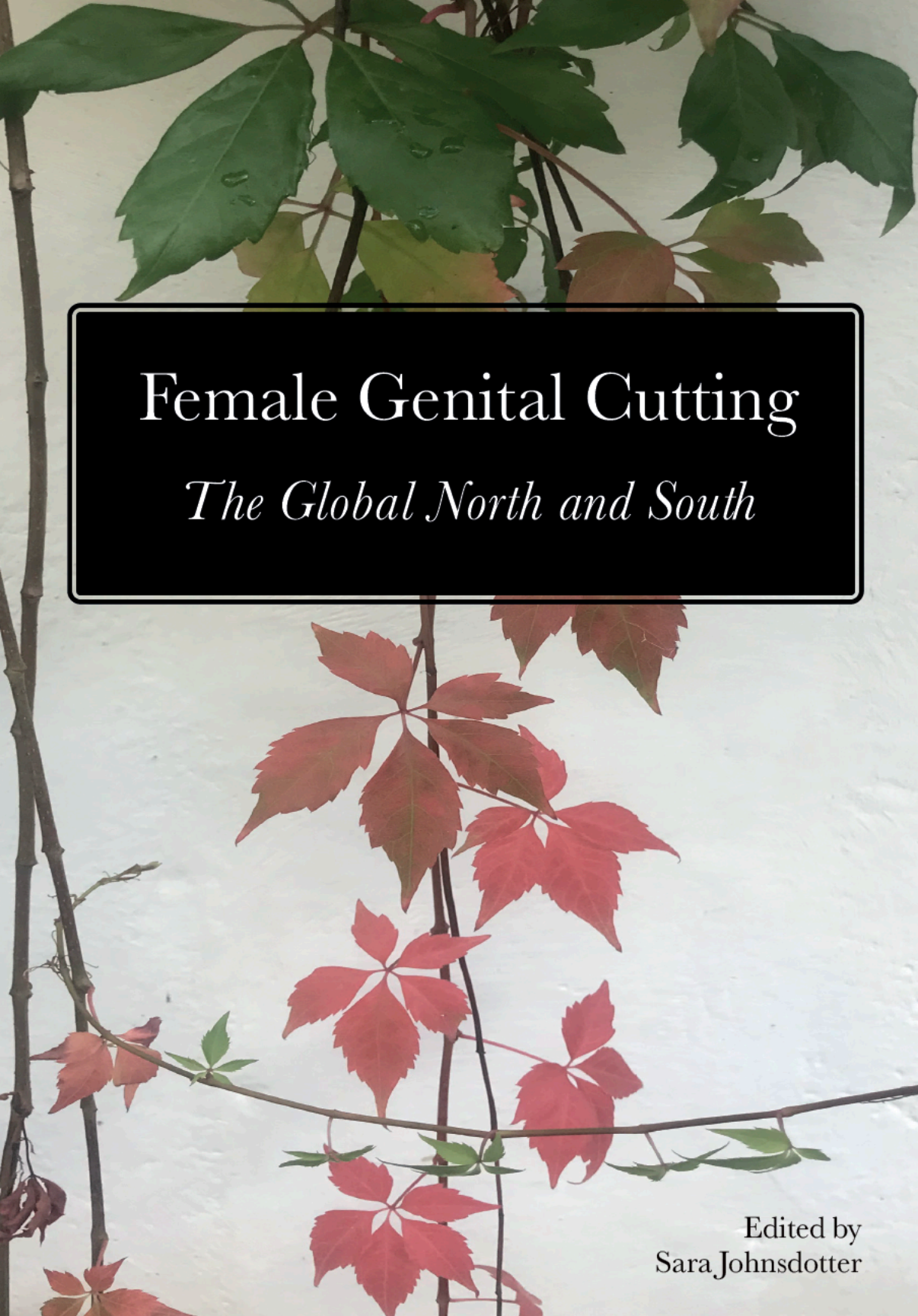

Female Genital Cutting

The Global North and South

Edited by
Sara Johnsdotter

Cover by Nille Leander and Sara Johnsdotter
ISBN 978-91-7877-123-3 (print)
ISBN 978-91-7877-124-0 (pdf)
DOI 10.24834/isbn.9789178771240
Published by the Centre for Sexology and Sexuality Studies, Malmö University
Printed at Holmbergs, Malmö 2020

FEMALE GENITAL CUTTING

The Global North and South

Edited by Sara Johnsdotter

MALMÖ UNIVERSITY
CENTRE FOR SEXOLOGY AND SEXUALITY STUDIES

The publication can be accessed
at *mau.diva-portal.org* (PDF)

Contents

Sara Johnsdotter & R. Elise B. Johansen

Introduction

The papers in this volume build upon oral presentations at the 9th conference for the Nordic Network for Research on FGC (FOKO), *Female Genital Cutting: The Global North & South*, which was arranged in Höör, Sweden, on 26-28 October 2018. The anthology can simultaneously be seen as a celebration and as marking of twenty years since the establishment of the FOKO network in 2001 and of the 10th FOKO anniversary conference scheduled for 2021, back in Oslo, Norway.

In this introductory chapter, we will start by discussing terminology. How to name this practice has been, and continues to be, a contested issue, and the various terms commonly used are associated with differences in understanding and modes of relating to the practices and the people affected. Already in the titles of the various papers published here, different approaches to terminology are displayed. We hope that our summary can be helpful to readers who are not familiar with the now half-century-long debate about terminology.

The discussion about terminology and issues of definitions and delimitations, is followed by a discussion of the current state when it comes to the practice in the Nordic countries. Finally, we end the introductory chapter with a description of the history of FOKO and its activities since this Nordic multidisciplinary research network was formed. Many of the original participants of the FOKO network are still active, but every year there are new researchers joining. Hopefully, the recollection of past conferences can give recent and future participants a glimpse of how the network operates. This introductory chapter was written by Sara Johnsdotter and R. Elise B. Johansen, together, because we, as doctoral students in Sweden and Norway twenty years ago, initiated the FOKO network.

This anthology is not a cohesive publication in the sense that the chapters have been edited to fit into one single discussion or theme; it is a series of contributions displaying what different researchers in the Nordic countries are engaged in at the moment. Some chapters are addressing the general public while other

chapters are written as to take part in the ongoing discussion among researchers in the field. The diversity of the chapters regarding theme, focus, terminology, and presumptive audience is emblematic of the FOKO network: this is an arena that welcomes Nordic researchers to discuss what they currently want and need to discuss about their research process; they can share data and findings from ongoing projects while they concurrently are offered input from colleagues from a range of disciplines. Next chapter is the keynote lecture at the conference, by the American anthropologist Professor Ellen Gruenbaum. She was given the title of what we wished her to talk about, and during the lecture she shared her knowledge and experiences from decades in the research field of female genital cutting.

Terminology

In early descriptions of these practices, they were—in analogy with non-medically motivated procedures that involve boys' genitals—called "circumcision." For example, there is a papyrus from 163 BCE in Egypt, in which it is said that since a girl is now circumcised, it is time to arrange for her dowry (Kenyon, 1893). Travelers and explorers in the 19th century repeatedly reported customs which they called "female circumcision."[1] This is not surprising, given that local names of these practices tend to be the same for girls and boys, often with an extra word to clarify whether the procedure regards a girl or a boy. For instance, in Somali, *gudniinka* refers to both sexes, and gender is specified in the expressions *gudniinka dumarka* (girls and women) and *gudniinka wiilasha* (boys and men). The term "circumcision," literally meaning "cutting around," is known from the Latin translation of the Old Testament, and was first translated into English in the 1500s. Local terms for male and female genital cutting, however, often have a more symbolic meaning, referring to the process or purpose of the procedure. For example, Somalis also use the term *halalays* which, like the Arabic term *khitan*, means "cleansing," commonly used in a religious more than hygienic sense. The Malian term *bolokoli* literally means "washing one's hands." Other terms can refer to the overall framework, for example of "going to the bush," or the context such as the Bondo secret society in Sierra Leone in which the procedure of FGC is essential for initiation (Ahmadu, 2010).

[1] For a detailed survey of early sources, see Johnsdotter (2012).

In pre-1980s scholarly work, the international community did not see any of the practices as particularly problematic (Andro & Lesclingand, 2016; Johnsdotter, 2018; Johnsdotter & Mestre i Mestre, 2017); neither the practices nor how they were named (Johansen 2015). The "mutilation" label was coined and promoted by the American journalist and activist Fran Hosken. She published *The Hosken Report: Genital and Sexual Mutilation of Females* in 1979, which she presented at the Women's Conference in Copenhagen in 1980. Her perspective and tone resonated with other radical feminists of the period, such as Mary Daly (1979), Tobe Levin (1980), and Awa Thiam (1978).

"Female Genital Mutilation" (FGM) as a denomination of these practices gained ground from then on, particularly within international organizations and those targeting the practice. The World Health Organization adopted the term "female genital mutilation" in the mid-1990s (UNICEF 2005) and governments in Europe followed, for example in laws banning the practice. Within academic research there was a divide between social science that abided by the established term "circumcision" and most medical researchers who adopted "FGM." Interestingly, it was a local UN-supported organization in Uganda, REACH, which first highlighted major drawbacks of the "mutilation" terminology:

> REACH seeks to avoid fuelling unnecessary sensitivity about the issue. Thus, for example, participants coined a new phrase for FGM: "female genital cutting." The term "female circumcision" was rejected as a misleading euphemism, but "female genital mutilation" was thought to imply excessive judgement by outsiders as well as insensitivity toward individuals who have undergone excision [UNFPA, 1996].

This compromise term, "female genital cutting," has since gained ground among both scholars and professional organizations (such as FIGO, the International Federation of Gynecology and Obstetrics). In contrast, practically all activist and campaigning organizations prefer "FGM," as do supra-state players such as the World Health Organization and the European Union.

Yet another compromise is the acronym FGM/C [female genital mutilation/cutting]. The merging of the two terms can be seen as an attempt to indicate that "mutilation" is what these practices are about, while at the same time the speaker or writer admits its shortcomings in preventive work with affected people.

Both UNFPA and UNICEF used this double term, "female genital mutilation/cutting," for more than a decade, until 2016, when they changed back to the use of "FGM" only.

Today, many scholars explain their choice of terminology when they publish their research. As noted by Sundby et al.: "Each term carries a certain value" (2013, p. 1). There are pros and cons to each way of naming these practices. Here is a summary of some of the justifications and renunciations:

• female circumcision/circumcision of girls
Proponents: It is often closest to local perceptions of the practice, as it is perceived to mirror rituals for boys [Connolly, 2018; Gruenbaum, 2001; Johnsdotter, 2018].
Opponents: The term gives the impression that circumcision of girls is no more harmful than circumcision of boys.[1] Thus, the term is "misleading" [Andro & Lesclingand, 2016; Brady et al., 2019; Connolly, 2019; Hamid, Grace & Warren, 2018].

• female genital mutilation
Proponents: The term establishes that these practices constitute a form of violence against women and a violation of women's rights to bodily integrity and health [WHO, 2008]. The term "has been instrumental in generating political will to curb the practice" [Brady et al., 2019: 2].
Opponents: The term can be seen as ethnocentric, judgmental, demeaning, offensive, and alienating [e.g., Andro & Lesclingand, 2016; Connolly, 2019; Earp & Johnsdotter, 2020; Hernlund & Shell-Duncan, 2007; Johnsdotter, 2015; Johnsdotter & Essén, 2010; Johnson-Agbakwu & Manin, 2020]. Other have criticized the use of this term because it is often understood as referring only to the most severe types, particularly type III; consequently, many FGC practicing communities do not consider this term and its legal implications as relevant for them [Johansen 2019, forthcoming]. Also, the term "mutilation" seems too strong to describe the various practices that fall under type IV [Earp & Johnsdotter, 2020; Rashid & Iguchi, 2019; Rogers, 2016; Wahlberg et al., 2019].

• female genital cutting
Proponents: This is a more neutral term as it is merely descriptive, and thus a less offensive term than "mutilation." It can avoid the stigmatization and pathologizing that the term mutilation risks inducing, and this may facilitate communication with affected women [e.g., Andro & Lesclingand, 2016; Duivenbode & Padela, 2019; Connolly, 2017; Hamid, Grace & Warren, 2017; Johnson-Agbakwu & Manin, 2020].
Opponents: Also "cutting," "cutters," and "cut" as an attribute of a person or a genital organ, is strong wording.[2] Furthermore, not all forms of FGC include cutting, and thus

[1] Of course, this argument builds upon an idea that genital modifications in girls are far more harmful than their counterpart in boys. This notion has been increasingly challenged (e.g., Brussels Collaboration on Bodily Integrity, 2019).
[2] Personal communication with Juliet Rogers and Richard A. Shweder at a seminar in Bologna in October 2019.

> the term would not be descriptive of all practices the definition often targets. Finally, genital cosmetic surgery is a form of genital cutting that is rarely meant to be included as a form of FGC, though it would be reasonable to define it as a form of genital cutting [Boddy, 2016; Earp & Johnsdotter, 2020; Johnsdotter & Essén, 2010].

Other terms that have been used include "female genital modification" (Abdulcadir, 2017; Jirovski, 2010; Ross et al., 2016; Shweder, Minow & Markus, 2002; Shweder & Power, 2013), "female genital alteration" (Arora & Jacobs, 2016; Earp, 2015; Shahvisi, 2018), and "female genital surgeries" (Lane & Rubinstein, 1996; Obermeyer, 1999; PPAN, 2012). Other authors use the local term for the practice, such as *tahâra* in Egypt (Malmström in Zangana et al., 2015).

At times writers switch between different terms according to context: for example, they may say "circumcision" when speaking about the groups that practice it and persons who have undergone the procedure in order to stay true to the actors' point of view, while saying "female genital mutilation" or FGM when discussing legislation or public discourse (e.g., Johnsdotter & Mestre i Mestre, 2017; Shell-Duncan & Hernlund, 2000).

Female genital cutting—definition and typology

In addition to a plethora of local and international terminology, there is also a wide variety of practices that are meant to be covered by the term and definition of FGC. According to the WHO, FGM "comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons" (WHO, 2020). As such, the definition could be said to include cosmetic genital surgeries that are harmful, and to exclude traditional practices that are not harmful. However, in the WHO definition and understanding of harm, FGM is not meant to include cosmetic genital surgery (WHO, 2008), a position that has been repeatedly challenged (Boddy, 2016; Earp & Johnsdotter, 2020; Johnsdotter & Essén, 2010).

The definition and the different types of genital practices subsumed under the heading is also one of the underlying reasons for the controversies about terminology. In 1995, WHO outlined a typology with four categories of genital practices, which was slightly modified in 2008. In the modified version, the main types were maintained, but there were subtypes, deemed useful for clinical studies, added. Also the section with examples of type IV, unclassified, was revised.

WHO typology 2008

Type I: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
Type Ia, removal of the clitoral hood or prepuce only;
Type Ib, removal of the clitoris with the prepuce.

Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
Type IIa, removal of the labia minora only;
Type IIb, partial or total removal of the clitoris and the labia minora;
Type IIc, partial or total removal of the clitoris, the labia minora and the labia majora.
Type IId: Excision of the clitoris with partial or total excision of the labia minora.

Type III: Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
Type IIIa: removal and apposition of the labia minora;
Type IIIb: removal and apposition of the labia majora.

Type IV: Unclassified: All other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping, and cauterization.

In this revision, there is a discussion about inclusion and exclusion criteria of practices as a form of FGM or FGC, and the major criteria for delineation. Is FGM/FGC meant to include all genital practices that are harmful? Or, those that are conducted on minors? Or, all medically unnecessary genital practices on females? Since FGC generally is conducted on minors who lack the capacity of providing informed consent, most countries who have legal prohibitions against FGC have forbidden the practice regardless of age and consent (Johansen et al., 2018). However, the issue of consent is commonly revoked as a distinction between

cosmetic genital surgery and FGM/C. Thus, definitions and delineations of inclusion and exclusion criteria are not necessarily consistent, and national laws may draw lines that differ from the WHO definition.

FGC in the Nordic countries

While FGC is a traditional practice in at least thirty countries in the global South, the issue has also become relevant to other parts of the world due to migration. In the Nordic countries, there are many migrant women from countries where FGC is a traditional practice and who have been subjected to FGC prior to migration. There are figures suggesting that 17,300 girls and women in Norway (Ziyada et al., 2015) and some 38,000 in Sweden in 2013 (The Swedish Board of Health and Welfare, 2015) are affected. Demographic data from 2011 estimated that some 8,000 girls and women living in Denmark had been subjected to FGC before immigration (Christoffersen et al., 2018). Regarding Finland, a study showed that the prevalence of FGC was 69 percent among those of Somali origin and 32 percent among those of Kurdish origin in 2012, but no further demographic details were offered (Koukkula et al., 2016; Nieminen et al., 2015). Based on the previous studies and the demographic information of Statistics Finland, it has been estimated that about 10,000 girls and women would be affected in Finland (Koukkula & Klemetti, 2019).

For various historical and political reasons, the Nordic countries have a similar pattern of immigration regarding FGC, with a disproportionately high number of girls and women coming from countries where infibulation is common, most notably Somalia and Eritrea. This may be one of the reasons why much research in the Nordic countries has been focused on Somalis, as has much policy work in terms of provision of health care. Also, the Somali migrants with type III (infibulation, often called "pharaonic circumcision") arrived in the Nordic countries rather suddenly, following the outbreak of civil war in Somalia in the early 1990s. This sudden influx of migrants caught the health services by surprise and may be one reason why the Nordic countries in general have been at the forefront among countries of migration regarding both law and policy development to prevent and prosecute FGM/C, as well as to develop specialized health services. It is thus not accidental that a research network such as FOKO was initiated in the Nordic countries. For many years, Sweden, Norway, and Finland seem to have been at

the research front regarding FGC research in diaspora contexts. In contrast, Denmark has lagged behind, both in terms of policy development (Christoffersen et al., 2018) and research engagement.

The History of FOKO: The Nordic Network on Research about Female Circumcision[1]

The idea of a research network started when the two of us, working with our PhD theses in Sweden and Norway respectively, started emailing each other about our projects some twenty years ago. We both were anthropologists, and we both were studying this phenomenon as it was perceived and discussed among Somalis in Sweden and Norway. Furthermore, both of us collaborated with gynecologists. We saw the potential in forming a multidisciplinary research network where we could discuss theory and methodology and how to merge medical and social scientific paradigms in research about the practice.

We reached out to other researchers and doctoral students working on the topic to assess interest. Some of us (Sara Johnsdotter, R. Elise B. Johansen, Lisen Dellenborg, Johanne Sundby, Birgitta Essén, Siri Vangen, Lars Almroth, and Vanja Almroth-Berggren) had already met, encouraging each other to participate so we could gather, at a workshop, *Sexual and Reproductive Health Research*, hosted by Dr. Staffan Bergström at his summer home in Gotland, Sweden in year 2000. All of us working on this topic experienced a need to meet and discuss elements of a research topic that was so far little explored. Furthermore, the substantial ethical and legal aspects of the practice had made that need stronger, as we all experienced it as very challenging to engage in meaningful scientific discussion with people not familiar with the topic. Thus, to be able to engage in scientific discussions, we decided to create a network for researchers working on this topic. Due to financial and practical reasons, and existing networks, this was decided to be a Nordic network.

In collaboration with gynecologist and supervisor Johanne Sundby, Johansen wrote an application for funding for a Nordic conference. This first application was sent to NorFa, an agency that coordinated and funded Nordic research. After securing funding, FOKO was formed as an informal network, and the first FOKO conference planned. It was held in Norway, close to Oslo (Tyriheim), with about

[1] Nordisk Nettverk for Forskning Om Kvinnelig Omskjæring.

fifteen participants, most of whom were doctoral students in the fields of social science or medicine. We all presented our ongoing work for discussion.

After this first conference, the participants decided to opt for biannual conferences rotating among the Nordic countries. Each arranging country seeks funding. The scale and format of the FOKO conferences have varied over the years, depending on financial and practical constraints, as well as the preferences in the network as perceived by the host country at the time. The core activity is always paper presentations on ongoing or completed research among FOKO participants, and in some years international guest speakers have been invited to present. Though the network has a Nordic base, some international guest speakers have become honorary members over the years. The founding participants of the network, as well as those who have joined later, have recurrently discussed the ideal format and size of the FOKO conferences. We have also reasoned about how to handle the interest among non-Nordic researchers in attending the conferences, given that a major quality of the conferences has been the space allowed for informal conversations, presentation of ongoing and unfinished research, and general scientific discussions—that is, the very same quality that creates such an interest in participation from "outsiders." These discussions will continue.

The FOKO conferences until today are listed below.

Oslo, Norway, 2001
Open theme.
About fifteen participants from Norway, Sweden, and Denmark.
Small group of gynecologists and anthropologists.

Malmö, Sweden, 2003
Open theme.
About 70 participants from Norway, Sweden, Denmark, and Finland.
Keynote speaker: Social anthropologist Ylva Hernlund, University of Washington, USA.
Invited speakers: Linda Weil-Curiel, lawyer, Paris. Medical doctor Nahid Toubia, London, UK.
In the audience there was a mix of researchers and activists.

Copenhagen, Denmark, 2005
Open theme.
About thirty-five participants from Norway, Sweden, Denmark, and Finland.
Primarily participants with a background in anthropology and medicine.

Helsinki, Finland, 2007
Theme: Female Genital Cutting in the Past and Today
About 120 participants from Norway, Sweden, Denmark, and Finland.
Keynote speaker: Anthropologist Janice Boddy, University of Toronto, Canada.
Invited speaker: Molly Melching, Tostan, Senegal.
The conference gathered both researchers and activists.

Uppsala, Sweden, 2010
Open theme.
About fifteen participants from Norway, Sweden, Denmark, and Finland.
Keynote speaker: Medical anthropologist Saida Hodžić, George Mason University, USA.
Invited speaker: Cultural anthropologist Michelle Johnson, Bucknell University, USA.
The participants were researchers in anthropology, medicine, and psychology.

Oslo, Norway, 2012
Open theme.
About forty participants from Norway, Sweden, Denmark, and Finland.
Keynote speaker: Anthropologist Janice Boddy, University of Toronto, Canada.
Keynote speaker: Anthropologist Bettina Shell-Duncan, University of Washington, USA.

Copenhagen, Denmark, 2014
Theme: International Conference on FGM/C: The Global Movement
About forty participants from Norway, Sweden, Denmark, and Finland.
Inauguration speaker: H.R.H. The Crown Princess of Denmark.

Helsinki, Finland, 2016
Day 1. Theme: Female Genital Mutilation—A Matter of Human Rights and Gender Equality
About 100 participants from Norway, Sweden, Denmark, and Finland.
The audience was a mix of researchers and activists.
Keynote speaker: Abdiqani Sheikh Omar, Ministry of Women and Human Rights, Somalia.
Keynote speaker: Medical anthropologist Adriana Kaplán, Universitat Autònoma, Barcelona, Spain.
Day 2. Theme: FGM in the European Context
About forty participants from Norway, Sweden, Denmark, and Finland.

Höör, Sweden, 2018
Theme: Female Genital Cutting: The Global North & South
About thirty participants from Norway, Sweden, Denmark, and Finland.
Keynote speaker: Anthropologist Ellen Gruenbaum, Purdue University, USA.

Oslo, Norway, 2021
Under preparation.

Acknowledgements

The Höör FOKO conference in 2018 was funded by the Centre for Sexology and Sexuality Studies, Malmö University, and Forum for Africa Studies, Uppsala University. The foundation Åke Wibergs Stiftelse funded the production of this book.

Warm thanks to Ylva Hernlund (textjouren@gmail.com), who has a PhD in Anthropology from the University of Washington—a renowned scholar in the research field of FGC and the first international keynote speaker of the FOKO conferences—for her great work with language revision and critical comments of earlier drafts of the chapters. Of course, any remaining mistakes or omissions are the responsibility of the authors.

References

Abdulcadir, J. (2017). *Psychosexual health of women living with female genital mutilation/cutting.* Doctoral thesis, Faculty of Medicine, University of Geneva, Switzerland.

Ahmadu, F.S. (2010). Empowering girls in Sierra Leone: Initiation into the Bondo society. *Journal of Developmental & Behavioral Pediatrics*, *31*, 2, 172–173.

Andro, A., & Lesclingand, M. (2016). Les mutilations génitales féminines. État des lieux et des connaissances [Female genital mutilation: Overview and current knowledge]. Translated by M. Grieve & P. Reeve. *Population, 71,* 217–296.

Arora, K.S., & Jacobs, A.J. (2016). Female genital alteration: a compromise solution. *Journal of Medical Ethics*, *42*, 3, 148–154.

Boddy, J. (2016). The normal and the aberrant in female genital cutting: Shifting paradigms. *HAU: Journal of Ethnographic Theory*, *6*, 2, 41–69.

Brady, S.S., Connor, J.J., Chaisson, N., & Mohamed, F.S. (2019). Female genital cutting and deinfibulation: Applying the theory of planned behavior to research and practice. *Archives of Sexual Behavior*, 1–15. doi: 10.1007/s10508-019-1427-4

Brussels Collaboration on Bodily Integrity (2019). Medically unnecessary genital cutting and the rights of the child: Moving toward consensus. *The American Journal of Bioethics*, 19:10, 17–28. doi: 10.1080/15265161.2019.1643945

Christoffersen, G.M., Bruhn, P.J., de Neergaard, R., Engel, S., & Naeser, V. (2018). Mapping the lack of public initiative against female genital mutilation in Denmark. *Reproductive Health, 15*, 1, 1–7.

Connolly, P. (2018). *Female genital cutting in the United Kingdom: A feminist phenomenological study of perceptions and lived experiences.* Doctoral thesis, Faculty of Health and Life Sciences, De Montfort University, Leicester, UK.

Daly, M. (1979). *Gyn/ecology: The metaethics of radical feminism*. Boston, London: The Women's Press.

Duivenbode, R. & Padela, A.I. (2019). Female Genital Cutting (FGC) and the cultural boundaries of medical practice. *The American Journal of Bioethics* 19:3, 3–6. doi: 10.1080/ 15265161.2018.1554412

Earp, B.D. (2015). Female genital mutilation and male circumcision: Toward an autonomy-based ethical framework. *Medicolegal and Bioethics* 5: 89–104.

Earp, B.D. & Johnsdotter, S. (2020, in press). Current critiques of the WHO policy on female genital mutilation. *IJIR.* Available online ahead of print at https://www.academia.edu/42281793

Gruenbaum, E. (2001). *The female circumcision controversy: An anthropological perspective.* Philadelphia: University of Pennsylvania Press.

Hamid, A., Grace, K.T., & Warren, N. (2018). A meta-synthesis of the birth experiences of african immigrant women affected by female genital cutting. *Journal of Midwifery & Women's Health, 63*, 2, 185–195.

Hernlund, Y., & Shell-Duncan, B. (2007). Transcultural positions: Negotiating rights and culture. In Y. Hernlund, B. Shell-Duncan (Eds.), *Transcultural bodies: Female genital cutting in global context* (pp. 1–45). New Brunnswick: Rutgers.

Hosken, F.P. (1979). *The Hosken report: Genital and sexual mutilation of females.* Lexington: Women's International Network News.

Jirovsky, E. (2010). Views of women and men in Bobo-Dioulasso, Burkina Faso, on three forms of female genital modification. *Reproductive Health Matters, 18*, 35, 84–93.

Johansen, R.E.B. (2015). Female genital cutting: Controversies and responses. In P. Whelehan & A. Bolin (Eds.) *The international encyclopedia of human sexuality* (pp. 374–379). Malden, MA: Wiley-Blackwell.

Johansen, R.E.B., Ziyada, M.M., Shell-Duncan, B., Kaplan, A.M., & Leye, E. (2018). Health sector involvement in the management of female genital mutilation/cutting in 30 countries. *BMC Health Services Research, 18*, 1, 1–13.

Johnsdotter, S. (2012). Projected cultural histories of the cutting of female genitalia. A poor reflection as in a mirror. *History and Anthropology, 23*, 1, 91–114.

Johnsdotter, S. (2015). Female genital cutting. In P. Whelehan and A. Bolin (Eds.), *The international encyclopedia of human sexuality* (pp. 1–4). Malden, MA: Wiley-Blackwell.

Johnsdotter, S. (2018). Girls and boys as victims: Asymmetries and dynamics in European public discourses on genital modifications in children. In M. Fusaschi, G. Cavatorta (Eds.), *FGM/C: From medicine to critical anthropology* (pp. 33–49). Torino: Meti Edizioni.

Johnsdotter, S., & Essén, B. (2010). Genitals and ethnicity: The politics of genital modifications. *Reproductive Health Matters, 18*, 35, 29–37.

Johnsdotter, S., & Mestre i Mestre, R.M. (2017). "Female genital mutilation" in Europe: Public discourse versus empirical evidence. *International Journal of Law, Crime and Justice, 51*, 14–23.

Johnson-Agbakwu, C.E., & Manin, E. (2020). Sculptors of African women's bodies: Forces reshaping the embodiment of female genital cutting in the West. *Archives of Sexual Behavior*. doi: 10.1007/s10508-020-01710-1

Kenyon, F.G. (1893). *Greek papyri in the British Museum*. Catalogue, with texts. London: Kegan Paul, Trench, Trübner and Co and the Oxford University Press.

Koukkula, M., Keskimäki, I., Koponen, P., Mölsä, M., & Klemetti, R. (2016). Female genital mutilation/cutting among women of Somali and Kurdish origin in Finland. *Birth, 43*, 3, 240–246.

Koukkula, M., & Klemetti, R. (2019a). *Action plan for the prevention of female genital mutilation (FGM)*. Publication 2019:7. Helsinki: Ministry of Social Affairs and Health.

Lane, S.D., & Rubinstein, R.A. (1996). Judging the other: Responding to traditional female genital surgeries. *Hastings Center Report, 26*, 3, 31–40.

Levin, T. (1980). "Unspeakable atrocities": The psycho-sexual etiology of female genital mutilation. *The Journal of Mind and Behavior, 1*, 2, 197–210.

Nieminen, T., Sutela, H., & Hannula, U. (2015). (eds.) *Ulkomaista syntyperää olevien työ ja hyvinvointi Suomessa* [Survey on work and well-being among people of foreign origin]. Helsinki: Statistics Finland.

Obermeyer, C.M. (1999). Female genital surgeries: the known, the unknown, and the unknowable. *Medical Anthropology Quarterly, 13*, 1, 79–106.

PPAN, The Public Policy Advisory Network on Female Genital Surgeries in Africa (2012). Seven things to know about female genital surgeries in Africa. *Hastings Center Report, 6*, 19–27.

Rashid, A., & Iguchi, Y. (2019). Female genital cutting in Malaysia: a mixed-methods study. *BMJ Open* 9(4): e025078.

Rogers, J. (2016). The first case addressing female genital mutilation in Australia: Where is the harm? *Alternative Law Journal, 41*, 4, 235–238.

Ross, C.T., Strimling, P., Ericksen, K.P., Lindenfors, P., & Mulder, M.B. (2016). The origins and maintenance of female genital modification across Africa. *Human Nature, 27*, 2, 173–200.

Shahvisi, A. (2018). Female genital alteration in the UK: a failure of pluralism and intersectionality. In K. Kuehlmeyer, C. Klingler, R. Huxtable (Eds.), *Ethical, legal and social aspects of healthcare for migrants: perspectives from the UK and Germany* (pp. 207–215). London: Routledge.

Shell-Duncan, B. & Hernlund, Y. (2000). Female "circumcision" in Africa: Dimensions of the practice and debates. In B. Shell-Duncan, Y. Hernlund (Eds.), *Female "circumcision" in Africa: Culture, controversy, and change* (pp. 1–40). Boulder, CO: Lynne Rienner Publishers.

Shweder, R.A., Minow, M., & Markus, H.R. (2002). Engaging cultural differences. R.A. Shweder, M. Minow, H.R. Marcus (Eds.), *Engaging cultural differences: The multicultural challenge in liberal democracies* (pp. 1–16). New York: Russell Sage Foundation.

Shweder, R.A., & Power, S.A. (2013). Robust cultural pluralism: An interview with professor Richard A. Shweder. *Europe's Journal of Psychology, 9*, 4, 671–686.

Sundby, J., Essén, B., & Johansen, R. (2013). Female genital mutilation, cutting, or circumcision. *Obstetrics and Gynecology International*, 240421. doi: 10.1155/2013/240421.

The Swedish Board of Health and Welfare (2015). *Flickor och kvinnor i Sverige som kan ha varit utsatta för könsstympning: En uppskattning av antalet* [Girls and women in Sweden who may have been subjected to FGM: estimation of the number]. Stockholm: Socialstyrelsen [The Swedish Board of Health and Welfare].

Thiam, A. (1978). *Black Sisters Speak Out: Feminism and Oppression in Black Africa* (transl.) *La Parole aux Negresses.* Paris: Editions Denoel.

UNICEF, United Children's Fund (2005). *Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change*. New York: United Children's Fund.

UNFPA, United Nations Population Fund (1996). *Dispatches: News from UNFPA*, No. 6, March 1996. http://www.un.org/popin/unfpa/dispatches/mar96.html

Wahlberg, A., Påfs, J., & Jordal M. (2019). Pricking in the African diaspora: current evidence and recurrent debates." *Current Sexual Health Reports, 5*, 1, 1–7.

WHO, World Health Organization (2008). *Eliminating female genital mutilation: an interagency statement—OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO*. Geneva: World Health Organization.

WHO, World Health Organization (2020). *Types of female genital mutilation*. Retrieved from https://www.who.int/sexual-and-reproductive-health/types-of-female-genital-mutilation

Zangana, G.A.S., Malmström, M.F., & Barton, F. (2015). In conversation on female genital cutting. In G. Ozyegin (Ed.), *Gender and sexuality in Muslim cultures* (pp. 183–196). Farnham, Surrey: Ashgate.

Ziyada, M.M., Norberg-Schulz, M., & Johansen, R.E.B. (2015). Estimating the magnitude of female genital mutilation/cutting in Norway: an extrapolation model. *BMC Public Health*, *16,* 1: 110.

Ellen Gruenbaum

Tensions in Motion: Female Genital Cutting in the Global North and South, Then and Now

The Global North and South

Female Genital Cutting research spans a long time period and many locations. In an attempt to join these many threads coherently, it is useful to consider the dynamic of change in terms of tensions—varying forces for continuity of practices and for more rapid change and ending practices—that have arisen at various times and places. In this chapter, I particularly draw on my own long and varied research perspective to offer insights into the ways that tensions are shaping the discourse and the changes occurring across time and place. The terms Global North and Global South, which have become popular in the current era, are not just about places. These terms are meant to reflect the political and socio-economic differences between the richer, more developed regions, and the poorer, less developed regions of the world. With Europe, North America, and Australia in the "North" and Africa, Central and South America, and much of Asia in the "South," people see correlations with other factors that they suppose might explain the divide—technological innovations from certain areas were diffused along with population movement and settler colonialism over the past 600 years, with movement into resource-rich underpopulated regions and/or creating economic and political domination over resources that could be used to feed the engines of development in the North while the South experienced social and economic distortions.

The cultural/social/religious or even physical differences between the wealthy countries and the poor countries became a part of the explanation for these differences in the past, with holdover attitudes into the future. Historically, the North imagined that they were "favored by God," and that this justified killing or dispossessing the others; or, there is a "manifest destiny" for European-originating people to take over North America; or, it is the "white man's burden" to subjugate and pursue a "civilizing mission" in the continent of Africa. Although we now see those perspectives as excuses to cover up the injustices of military conquest, genocide, enslavement, and plunder of resources that provided the additional land, labor, and raw materials from which the wealth of the North was built, those old perspectives have not died out, and are heard in new forms or embodied in the popular ignorance of how the North/South divide came about. People in the North often do not know how their current wealth is based on these historical injustices, preferring to understand their well-being and privileged positions as their ancestral right, often perceived as based on racial, ethnic, religious, or civilizational superiority. This is a troubling trend that contributes to views of "us" and "them," the enlightened "us" versus the "barbaric" or backward "them." Such views contribute to contemporary far-right, anti-immigrant, and white-superiority movements, affecting all of the countries of the North. As an example, the 2018 film by Paul Greengrass, *22 July*, which chronicles the 2011 bombing of the office of the Prime Minister of Norway and the massacre of teenagers at the Worker's Youth League summer camp on the island of Utøya, dramatizes the tension of such perspectives in action, and the deadly risks it entails.

When people of the Global North do not understand that their own privileges and well-being are derived from not just their own hard work but also unjust historical processes, they often slip into ideas of essential superiority of their race, culture, or religion. After all, most of the forebears of the Global North "us" were not at the front lines of conquest and plunder, but rather were the workers and farmers back home, or the immigrants escaping poverty to settle the "New World" from which the indigenous peoples had already been decimated, displaced, and/or denigrated. Most people of the North have learned history in the version of the victors, not from the perspective of the suffering of the conquered. As many of the chapters in this book show, that myopic "superiority" perspective has also applied to the understanding of cultural practices.

Today, the superiority perspective has serious political consequences. The Global North is experiencing large-scale immigration from the Global South, as people from the poorer countries seek to claim a piece of the Global North's prosperity by living and working in Europe, North America, or Australia, rather than struggling with the on-going deprivations, disorganized political systems, and stagnant economies of the Global South. Engagement with the immigrants and their cultural and religious practices is a challenge for North populations, not only because of ethnic identity and language differences that trigger human ethnocentrism, but also because difference serves as a ready opportunity to blame others for some damaging job losses and societal problems that are being wrought by technological change and class exploitations at home. The people of the Global North who experience instability in employment, economic insecurity, and more diversity in society are vulnerable to interpreting the situation as one of immigrants "taking our jobs," which can be used politically to stir up anti-immigrant sentiment and sometimes right-wing white nationalism.

The symbolic politics of female genital cutting falls directly into this tension. As people from the South come to the North, long-term inhabitants and the newcomers experience clashes of cultural and socio-economic difference, viewing each other with misunderstanding or fear. Things such as wearing veils, being too "macho," or building minarets are met with fear or anger, and immigrants who experience racial or ethnic discrimination, inscrutable bureaucracies, and religious intolerance seethe with annoyance. Ordinary ethnocentric reactions that could be mitigated by social interaction and learning end up as fuel for inflamed political interpretations that serve as powerful drivers of social conflict.

It is the task of scholars working on the topic of female genital cutting not only to provide perspectives to reduce ethnocentrism, but also to offer ideas for generating acceptable changes for immigrants and their new countries, informed by reasonable approaches that do not rely on inflamed rhetoric or distorted science. The work of scholars, such as those writing in this volume, is essential to engaging in a more just and thoughtful future, where human cultural behaviors can change in positive directions that ameliorate the conditions of the lives of women and girls without unjust condemnations of different ways of living. Contributions include research to understand the experiences and the process of change, engaging in clinical or social work to influence or treat those who are

affected, identifying effective, affordable, and efficient FGM/C prevention strategies, especially for the most damaging types. Programs that seem promising are evaluated, and international organizations and donors want to see results fairly quickly—or the funds will be redirected to something else. And subcontractors operating at the local level have an even shorter proposal-planning-activity-and-assessment cycle, allowing little time for the sorts of major experiments in cultural norm changes and institutional shifts that seem to be needed to change behaviors. Researchers ask, what works and what can be replicated and adapted? And what theories can guide future design of programs for prevention? Looking at "Then and Now" offers some clues.

Prevention Strategies "Then"—Lessons from the Past

The early interactions between the Global North and the Global South on the issue of FGC were in the larger context of conquest and domination. Global North conquerors and imperial colonizers saw those vanquished as the losers and thus as their "inferiors." Africa had its own dynamic history—ancient kingdoms, dominations, and migrations; the spread of Islam; profound disruptions in-land of Global North slave-trade on the coasts, as coastal peoples survived the slave trade by capturing others. During the height of the trans-Atlantic slave trade, Europeans supposed African peoples to be inferior, perhaps sub-human, and yet human enough to labor and to have souls that needed converting. In fact, for a period, slavers baptized the captured people by the boatload on the way to meeting their fates in the Americas, so that the Church would allow the trade to go on (O'Brien, 1974). During these early centuries of the slave trade, there certainly were no laws or campaigns to prevent female genital cutting and indeed current scholarship has not turned up evidence that it was continued among enslaved people in North America (Watson, 2005), even though many enslaved peoples had originated in circumcising (but not infibulating) areas.

In the Global North, as is well known among FGC scholars, clitoridectomy and even labia removal was practiced by doctors in Europe and North America in the 19th and 20th centuries for various reasons, including as a treatment for "nymphomania"—the term for women who had a high sex drive—and also to prevent masturbation, epilepsy, lesbianism, and the conditions known as hysteria, melancholia, insanity, kleptomania, and frigidity. In fact, according to Sanderson, in the U.S. thousands of such procedures were paid for by health insurance until

1977 (Sanderson, 1981). Where this idea got support may well have been related to European awareness of African practices. In any case, it is not likely to have come from enslaved Africans, who were effectively prevented from maintaining complex cultural traditions but were able to maintain fragments and to syncretize words, music, and some practices and beliefs into new religious or cultural forms. But after conquest and the division of nearly all of Africa into European dominated colonies in the 20th Century, interest in female genital cutting in the Global South increased. Efforts to stop it, or at least modify how it was practiced, originated in the North but also in the South. Efforts have moved from one approach to another, building a richer understanding of the complexity in the process of change, but also stumbling repeatedly. A century ago, the North's role in FGC focused on judgmental shaming of South practices, often embedded in missionary perspectives. Such scolding was both ineffective and inappropriate, and yet today elements of shaming persist in the North-South tensions. Looking at just a few examples of the 20th Century tensions in Africa, we see the impact of missionary teachings on the Kikuyu of Kenya in the novel of Ngugi wa Thiong'o (1965), British strategies of "civilizing women" through their training of midwives in Sudan (Boddy, 2007), indigenous Muslim religious leaders arguing for change in Sudan (Abusharaf, 2006), laws and religious edicts (*fatwas*) passed in various countries (Rahman & Toubia, 2000). By mid-century, medical risk and health education strategies were being emphasized. Later, change initiatives emphasized human rights for women and children. Then there were awareness-raising workshops aiming to shift cultural conventions and social norms. Accelerated efforts went into enacting laws to criminalize practitioners from the 1980s onward. Mobilizing community consensus and public declarations to add social pressure for change became ever more popular after the work of TOSTAN in Senegal was noticed. Engaging with religious leaders and making arguments to de-link FGM/C from religion became an important focus for UNICEF and others, because it was increasingly evident that "human rights" agreements were not as potent in family decisions as were religious teachings. If tradition was thought to protect honor and marriageability, that also needs to be de-linked, and one strategy has been through the education of girls. Medical and other professionals were drawn into the effort through professional ethics and training for midwives and doctors. Change agents also developed anti-FGC public relations messages about economic costs of health

complications, sexual dysfunction, reproductive risks, or other frightening outcomes. Change agencies added many tools to the efforts, using street theatre, posters, music videos, and other pop culture and celebrity endorsements for social marketing of new ideas. In some locations, they modeled programs on domestic violence prevention, such as providing safe houses for runaways. In some places, the sponsoring of alternative rituals without cutting caught on.

More historical research is needed to fully explain the early 20th century European efforts to suppress FGC in Africa. In some cases, it was the insights of European women involved in colonial, medical, or missionary work who became aware of the practices and wanted to stop them out of their own feelings of compassion for women and girls. But in order to become government policies that garnered support for the establishment of programs, it helped when anti-circumcision work served other purposes as well.

Sudan offers a good example. Northern Sudan's conquest in 1898 by Anglo/Egyptian forces was followed by nearly six decades of colonial ("condominium") control (1898-1956), during which the development of administrative systems and strategic placement of educational and medical facilities enhanced Britain's ability to develop and to control Sudan's strategic position and vast agricultural potential in the Nile Valley to produce raw materials for English textile factories (Gruenbaum, 1982b). As elsewhere, colonial domination justified itself on its "civilizing mission." Janice Boddy's historical research focused on one such "civilizing" activity: the expansion of midwifery training and attempts to suppress FGC (2007), including humanitarian motivations of British colonial women and the midwifery instructors who were recruited to help improve childbirth conditions for Sudanese women. But let there be no mistake: the Sudanese people were very involved in shaping their history and making many social changes before and after conquest that played a role in female genital cutting practices. The Sudanese had organized under the Mahdi, an indigenous religious leader, for a successful revolution against the Ottoman empire beginning in 1881, assembling an army from many regions of Sudan, thereby forging allegiances across ethnicities (with their differing folk rituals and circumcision practices) and with different language groups, but under a larger umbrella of Islam. There were some religious leaders working against female genital cutting in the 19th and early 20th century (Abusharaf, 2006). There was a long history of Sudanese religious education and an early 20th century movement led by Babikr Badri to promote girls' education

in regions of central Sudan. So ideas of change did not originate solely in the Global North.

Because the British chose not to challenge the well-established domination of the Islamic religion in northern Sudan (unlike their missionary aspirations, spreading Christianity to people practicing traditional African religions in the southern part Sudan, now the nation of South Sudan, bordering Uganda and Kenya), many other social patterns were not challenged—polygyny continued, religious courts governed family law, and tribal law was allowed to govern different ethnic groups, within limits imposed by administration. Traditional rituals related to spirits and supernatural protections—often syncretized into Islam or Christianity—continued without problems. Even female genital cutting continued since the midwifery training that was mobilized to work against it had only limited impact. Because the severe infibulation form predominated in Sudan, some efforts were directed against only the severe form, as when a law was passed in 1945 (in force in 1946) prohibiting the severe form, "Pharaonic circumcision." But since the Muslim religious leaders still supported the lesser form referred to as "*sunna*," the British did not try to ban all forms of FGC. In any case, the population was not willing to relinquish its control of female genital cutting, and so rebelled against the law's enforcement the following year in the so-called Rufa'a Revolution, demanding self-determination on such matters. Although the law was not repealed, it went unenforced for decades. So, although pharaonic circumcision was illegal and the Midwifery School taught against the practices, FGC continued throughout the 20th Century since most of the country was served by untrained traditional birth attendants and the trained midwives learned on their own how to do circumcisions.

In Kenya, missionaries taught against the practices and it was a much more intense situation, as the Kenyan writer Ngugi wa Thiong'o portrayed it in his novel *The River Between* (1965). In the context of the more violent colonial situation there—with active missionary conversions, suppression of cultural practices, and resistance, the Mau Mau War, etc.—circumcision became an important symbol of anti-colonial resistance. Anthropologist (and later political leader) Jomo Kenyatta, in his book on Kikuyu culture, *Facing Mount Kenya*, also portrayed the practice as an important symbol of Kenyan/Kikuyu identity (1938). Because of the missionary work, though, the Kenyans who accepted Christian teachings against female circumcision were more likely to give it up and argue against those who wanted to retain the practices. This was the tension Ngugi portrayed in his novel,

tearing apart communities and families of the Kikuyu people—between those who held to traditions, including genital cutting, and resisted colonial agendas, and those who had converted to Christianity and were adapting to colonial agendas. What is evident from these examples is tension between a Global North's moral superiority flavored with a sense of compassion for those they sought to "civilize," and the Global South's tension over how to respond—whether to accept and adapt to the dominant societies that had conquered their lands or to resist enforced, or enticed, changes to their cultures. Colonial domination was inherently unstable and proved ultimately unsustainable. Between uprisings and peaceful movements for self-determination, African countries successfully obtained their "flag independence" in the period of the 1950-1970s, but continued to be under varying degrees of economic, political, and cultural power and influence well past those dates of formal independence. Sudan's independence was in 1956, and many of the colonial/neocolonial tensions were evident when I first arrived in Sudan in 1974.

Mid-century Sudan

FGC was not my planned research direction when I started my first five years in Sudan. I had broad interests in culture, women, and health, but research on health, gender, and culture led me to FGC. In the course of my social life and ethnographic research, I encountered a great diversity of explanations of and opinions about FGC. There were different views about FGC and tensions between the ethnic groups of Garia Wahid or Abdal Galil (two of the communities where I did research) and between the social classes of the cities. But also, the families of my colleagues at the University of Khartoum helped me see the intra-family tensions that surrounded the process of change, as some held strongly to the traditional purification and others embraced lesser forms of cutting or else abandonment. There were compromises resulting in a decision for a *sunna* circumcision when spouses differed. There were strategies for not leaving the girls alone with their grandmothers, threats of divorce, and secret cutting that could not be undone and would not be punished. What I saw in the 1970s was that "female circumcision" needed to be understood as a dynamic set of cultural practices that were changing, not a uniform, static, horrifying "prisoners of ritual" image of unchanging cruelty. In fact, some well-known Sudanese educated families had made quiet changes to discontinue the practices even before the 1970s. One of these was the Badri family

of Omdurman, descendants of the historic campaigner for girls' education, Shaykh Babikr Badri. At a time when pharaonic was widely accepted as proper, the Badris—at the behest of Shaykh Babikr himself, who said that no more should be cut than what could fit through the tiny hole of a piaster coin—did only a minimal sunna circumcision instead of pharaonic. Later, by about the 1950s, the family abandoned female circumcision altogether. Although the decision was initially kept private—though rumored—it was later a source of pride and leadership for the Badris and for the Ahfad University for Women. The college was founded by Yusuf Badri (son of Shaykh Babikr Badri) in 1966 and it continues to be led by Badri family members. In the 1970s, women of the Badri family were already leaders in education, professional employment, and social research, and several of them subsequently embraced leading roles in initiatives for women's rights and to end FGC.

Another family that gave up circumcision in that mid-century period was that of long-time women's rights activist Nahid Toubia. In an interview for "Fresh Air" she described her mother's private decision (in the 1950s) to discontinue circumcision, leaving her younger daughters uncut (Toubia, 1996). In that period, the type of cutting was considered a private, family matter, and because of the Sudanese preference for close kin endogamy, other kin groups ordinarily did not need to know, since the daughters' circumcision status was relevant to families they married into, not others. Nevertheless, the fact that a circumcision had been done would be more widely known, since celebrations were sometimes quite elaborate social occasions during the 1970s. Anthropologist Wathig Kameir once commented that this was an opportunity for conspicuous consumption to elevate reputations of urban families (Kameir, 1977). I saw this in my own neighborhood of Khartoum, Sajjana, where one of my neighbors set up strings of lights, hired a band, put on a feast in the family courtyard, and even served alcohol, on the occasion of his 10-year-old daughter's circumcision.

As my awareness grew during 1974-79, I learned that the Sudan Women's Union had long favored discontinuing the practices, but had made political choices to prioritize different issues—such as independence during the 1950s and other women's issues in subsequent years. Some of my progressive friends at the university, male and female, thought female circumcision would die out when the people were ready to let it go, and in the meantime substituted the *sunna* for pharaonic. Medical professionals, who knew the risks, were often resigned to the fact

that their clients would do it despite the risks, so many agreed to perform circumcisions in their medical offices to assure lesser cutting under more hygienic conditions, in order to reduce harm.

My rural research in the 1970s brought me in contact with practitioners during a time when the main arguments against FGC had been made in the context of the medical initiatives, focusing on health risks. Besaina, the trained midwife in the community of Abdal Galil in Gezira, had not been convinced. She knew from experience about pain and the risks of infection and septicemia, but her response to that was to use excellent techniques to minimize risk. She was an enthusiastic and proud circumciser, giving girls and women after childbirth smooth and "beautiful" vulvas. She performed the circumcisions or attended childbirths using a clean protective oilcloth surface atop the local rope bed in the dirt floor homes using natural light near a window or from a lantern at night. For circumcisions she utilized boiled water, disinfectant, local injections of xylocaine to control the pain of cutting, new razor blades for each girl, suture needles and dissolving sutures, antibiotic powder, and Panadol analgesic pills if needed. She was proud of her work, and she reported excellent outcomes, with her careful follow up visits and the availability of a local clinic and nearby hospital for help when needed. Yes, she knew there were some who said circumcisions should stop, but in her view, it was an important and proud tradition, and better training and medical care were what was needed.

But even then, as I later learned, there had been tensions in that rural community. One of the local families—where both husband and wife had benefitted from the community's early efforts to provide schools for both sexes, and both were now teachers—had avoided using Besaina for their daughter's circumcision. Instead, they opted for an urban midwife, Sister Battool, who would do less severe cutting; but they kept their decision private.

I found that Sister Battool (whom I did not interview until the 1980s) was one of the medical professionals, an urban nurse midwife, who thought cutting was unnecessary and girls were better off not being circumcised. But since families were determined to circumcise, she sought to reduce the severity of the operations in her private practice. For example, she recommended to families who wanted pharaonic circumcision, that they do "*sunna*" instead. If they spoke of what a future husband would expect, she suggested delaying and letting the girl grow up first and decide with the future husband what sort of cutting to do. She realized families

considered it vital to circumcise their daughters—for purification, propriety, preservation of virginity, marriageability, a beautiful body, and being able to please a husband with a tight vagina. Some clients believed it was their duty as Muslims to follow the Hadith of the Prophet Mohamed to "ennoble" their girls with at least a *sunna* circumcision. So, Battool continued to cut, a player in the "medicalization" pattern.

In short, in the 1970s there were forces of change at work in some families and regions, but continued pride in heritage and pharaonic purification. Did the changes come about through the work of the outsiders, the British, through their midwifery training? Did the influence of women's rights in "the West" penetrate through Sudanese educators? Did exposure to British doctors and later the Sudanese doctors who graduated from the medical school founded by the British in Khartoum in the 1920s make a difference? Were some of them working for change on a small scale with their own patients without generating major Ministry of Health policies? Or was it the growing awareness of religious leaders that Sudanese Islam had something to learn from the central Middle Eastern countries' practice of Islam?

The Khartoum Seminar of 1979[1]

Into this situation arrived a major event that simultaneously exerted external (international and Global North) pressure and mobilized internal (local, Global South) participants as well. The World Health Organization's "Seminar on Traditional Practices affecting the Health of Women and Children," attended by representatives from numerous countries, was held in Khartoum on February 10-15, 1979. The presentations on female circumcision and the printed report that began to circulate after the conference launched new policies and programs in Sudan, in the international organizations, and in other countries. The report (WHO, 1979) showed agreement among participants that FGC should end, and they looked to medical experience and multi-disciplinary research for ideas on ending it. The role of the medical profession and the health risks were foremost in their thinking, but there was significant interest in a broad approach as well. Due to the importance of this event in the history of international FGC efforts, it deserves attention here. As the following examples demonstrate, from the 1970s, there has been particular

[1] Also referred to as the "Khartoum Conference."

attention paid to using health arguments to promote "eradication," but that there has also been interest in and some research that contributed to the broader approaches that were developed later.

Marie Basili Assaad, a senior research assistant from the American University in Cairo, representing UNICEF at the meeting, presented a document on "Female Circumcision in Egypt," in which she made broad social and medical recommendations for developing the process of change in Egypt and elsewhere. The report attributes to Assaad the recommendation that "Multi-disciplinary action-research" should be undertaken by "psychologists, gynaecologists and social scientists—men and women—with the purpose of defining what information will be persuasive to men and women in eradicating the practice." She advocated further: "Health practitioners, social workers, nurses, family planning workers, feminists engaged in education and outreach programmes, and educated people in general" should form the first audience of instruction. "They should be informed about the practice, its extent, reasons for its perpetuation, and how traditional and erroneous beliefs of women on women's health and sexuality can be modified. It is important to engage this group first because of their prospective leadership role." She called for "creative and imaginative" ways to convince the traditional birth attendants "to work with us and not against us." Recognizing the traditional birth attendant's "influential role as a traditional leader we need to exert special efforts to involve her in the new concerns, whether in relation to female circumcision or family planning. We must care for her as a person and guarantee for her other sources of livelihood and importance." Assaad also recommended beginning right away with whatever knowledge they had, to experiment with educational programs in family planning centers and health services, to begin to evaluate different approaches (WHO, 1979, pp. 11-12).

The "North/South" tension was also discussed, reflecting the colonial/political aspects of the question of ending female circumcision. Dr. T.A. Baasher, WHO Regional Adviser on Mental Health, commented on the rebellions against colonial efforts to impose change in his paper on the "Psycho-Social Aspects of Female Circumcision." According to the report, he "gave two examples from Kenya and Sudan in relation to politics and female circumcision, where the early efforts to abolish the practice were met with resistance from nationals who thought that the colonizers wanted to destroy the code of modesty and national solidarity when they interfere with such practices" (WHO, 1979, p. 17).

Another who included some perspectives on culture change was Dr. Gasim Badri. A member of the Badri family mentioned earlier, he later served for decades as President of Ahfad University. His presentation on "Opinions about Female Circumcision," reported on a study of 60 Sudanese gynecologists, 24 midwives, and 190 female college students, whom he asked about the attitudes each group held toward the practice, their experiences with complications, and their suggestions for "eradication," if any. He found consensus among the gynaecologists that circumcision had bad physical and psychological complications, and only 10 percent of the midwives considered it a good practice. The female college students were also in support of change: "152 of the 190 female college students said that they will not circumcise their daughters. All of them said that they do not think their grand-daughters are going to be circumcised" (WHO, 1979, p.18).

Dr. Asma Abdel Rahim El Dareer, of the Department of Community Medicine at the Faculty of Medicine, University of Khartoum, presented a preliminary report on "A Study on Prevalence and Epidemiology of Female Circumcision in Sudan Today," focused on the White Nile province, for which she was project director. (She later published a book on that research in 1983, entitled *Woman, Why Do You Weep?*) Described as "part of a broad study assisted by WHO, on female circumcision," it was probably one of the first efforts to systematically determine prevalence, even if only for one region. She found very high levels of support for the practice in its most severe form: 84 percent were pharaonic, 4 percent intermediate, and only 1% *sunna*, and many of the non-circumcising people were of a West African-originating ethnic group. She found 81% approval by husbands, but 14% of the men considered it to be prohibited by religion. Her recommendation—perhaps based on the fact that 90 percent of her female interviewees were illiterate and of low socioeconomic class—was that, "Health education seems to be the most effective method to stop the practice" (WHO, 1979, p. 18.)

Fran Hosken, who later popularized the term "female genital mutilation," also presented at the Khartoum Seminar in her role as a WHO Temporary Adviser. Her presentation "Female Circumcision in the World of Today: A Global Review," offered a grand historical perspective on female circumcision, a theme she pursued over the years in her long-term publication of *WIN News* and her articles and influential books (Hosken, 1978, 1979, 1980). The report of the conference states she claimed that:

> [G]enital operations performed on female children, mostly at an age too young to be able to make any decisions on their own, have been concealed for more than 2,000 years. As a result, these practices have spread all over Africa and are now also practised in the modern sector [WHO, 1979, p. 9].

Further, Hosken is reported to have claimed that if female circumcision was practised elsewhere in the past it had died out and that there was "no present day clinical evidence that any form of genital operations are practised anywhere except in Africa and among the Moslem [sic] population of Malaysia and Indonesia, where the mildest form of circumcision is reported" (WHO, 1979, p. 9). Her 1978 article in *Tropical Doctor*, her subsequent much-quoted books (1979, 1980), and her long-term periodical *WIN News* all used the terms "mutilation" and "FGM" with the goal of mobilizing international commitment to fighting against the practices.

In summary, the 1979 Khartoum Seminar presentations show the consensus among health leaders of international organizations that female circumcision would require serious efforts to "eradicate" it, and that health arguments were central. Yet they recognized that there was a need for research on attitudes and social contexts, and even psychological impacts and sexual questions were raised, although such research was not yet well developed. One speaker (Hosken) even pointed out that the children were "too young to be able to make any decisions on their own," anticipating the later shift to the human rights violation perspective. The Khartoum Seminar recognized the need for a multi-disciplinary approach to ending the practices, the need for research, and the need to begin trying programs for action. It is significant that UNICEF and WHO were then working together on thinking about how to approach the issue—a partnership that has not always been consistent on this issue.

For the physicians of Sudan, the Khartoum Seminar of 1979 served as a turning point. Although many had used the harm reduction strategy of performing circumcisions in their hygienic offices in the past, they now took a stronger position to oppose female circumcision and passed a resolution in the Sudan Medical Association to stop performing circumcisions in their clinics. While it is unknown whether this professional association ban achieved widespread acceptance nationally, having the medical community vote to take this position was significant for future discourse. These events and trends in the 1970s and 1980s reinforced the main argument against the FGC: that it should be abandoned because of medical/health risks. But it left open the door to future approaches.

Anthropology and female circumcision

In 1980 and 1982 there were important publications by African medical and feminist writers that began to be noticed internationally, such as Assaad's article in *Studies in Family Planning* (1980), El Saadawi's book *The Hidden Face of Eve* (1980a) and her article for *Race and Class* (1980b), El Dareer's *Woman, Why do you weep?* (1982), and Abdalla's *Sisters in Affliction* (1982). But during my encounter with female circumcision in my own ethnographic research in Sudan in the 1970s, I found that my own discipline had offered little guidance. Although anthropologists had produced a few earlier ethnographic accounts of female and male genital circumcision, the female practices received little attention. By the 1970s, several of us anthropologists were including female circumcision in our research in African contexts, and I presented a paper on the subject at the American Anthropological Association meetings my first year back in the U.S., which was later published (Gruenbaum, 1982a) in the *Medical Anthropology Newsletter*, a precursor to the *Medical Anthropology Quarterly*. The same year, Janice Boddy published her "Womb as Oasis" article about Sudanese women's spiritual and bodily practices (Boddy, 1982). My own research approached the topic through the lens of power relations—a feminist and cultural materialist approach—looking for the dynamic tensions in culture that offered both explanation and the potential for change. The key questions were about how female circumcision fit into the gender role system and competing interests of men and women, young and old? I considered who benefitted from the practices, who was motivated to make changes and why. And I considered the conditions that appeared to be necessary for people to be able to—and want to—stop doing female circumcision of their daughters.

At that time, the most pressing questions—the whys—lent themselves to qualitative, participant observation research by anthropologists, relying on families' stories and direct observation to explain the cultural dynamics of values, decisions, and dilemmas. Quantitative survey research at the time focused on stated reasons or attitudes and attempted to develop rates, but ethnography investigated the subtleties in how the practice fit with the gender system. How did female circumcision meet expectations for the good woman and the good girl, and what did families expect of mothers, wives, and daughters? How were gender roles affected by the concepts of honor, religious duties, the marriage and morality system, structures of patriarchy, female rites of passage and other rituals and their religious embeddedness; what were the intersections of gender, ethnicity, and class? Ethnography's

depth, though, was usually limited by the pattern of single-village research and the risk of over-generalizing, so trying for a wider perspective was needed also, to understand how contrasting educational, political, economic, and religious contexts affect the practices. This required a commitment to understanding complexity, through comparative work with other ethnographers and with historians, experienced doctors, educators, and quantitative researchers. Between then and now, many of us have engaged in trying to develop that more comparative, comprehensive view, both for the Global South and for the South/North picture.

As for Sudan in the 1970s—a diverse country of many languages, ethnicities, social class differences, and disruptive histories—the need for comparative work as well as deeper cultural insight was intense. Boddy's work, also starting in the 1970s, provided far deeper knowledge of a community—and later some of its members' relocations—establishing a definitive perspective on how the enclosedness of infibulations and the social patterns of women's lives, endogamous marriage, health protections, and approved social reproduction were intermeshed culturally. Symbolic systems and aesthetic norms reinforced pharaonic circumcision in ways that a simple message such as, "Don't do it because it's bad for your health," could not address. Boddy's holistic analysis showed circumcision's role in achieving smoothness, enclosedness, modesty, and propriety, and how these fit with a culture that also valued modesty, endogamy, and protection. From her analysis of how pharaonic circumcision was so deeply embedded in culture, it seemed very clear that many other elements of culture—modesty rules and women's roles, endogamous marriages, honor and shame—might stand in the way of people seeing change as acceptable. The very architecture of homes harmonized with the ethic of enclosure and propriety (Boddy, 1982, 1989).

My own research of the 1970s (and later) emphasized the diversity within the communities where I did research and also included urban social experiences and national perspectives in my thinking. I have been able to sample practices over time in original locations and broaden my experience to additional locations, observing tensions and variations that have been the focus of my publications over the years and my on-going interests. When I wrote *The Female Circumcision Controversy: An Anthropological Perspective* (2001), I used my 1970s-1990s Sudan work and information from other sources to provide sufficient breadth, depth, and comparisons that readers would see how female circumcision made sense in its contexts and yet was also contested and changing. Since then, I have continued to return

to Sudan to extend that research, and have also been able to work with UNICEF and with other scholars to expand our more comprehensive perspectives.

The "who benefits [from FGC]?" question seemed an important one, since any prospect of future change first needed to analyze the forces at work for continuity. This first required a critique of the oversimplified, "go to" explanations one often heard: "It's patriarchy." "Men want to prevent women from enjoying sex." "Men want power over women." And so on. But once the cultural and gender role complexities are better understood, the idea that all men benefit, or that only men want it to continue, is so obviously wrong. In the 1970s, however, there was almost no research on husbands, fathers, and younger men's attitudes, expectations, or experiences, and few men had taken leadership on the issue. A few doctors and religious leaders expressed opposition, but the discourse continued to attribute to "men" full support for oppression of women. The benefits men may have experienced were not necessarily sufficient to serve as a motivation. Did they benefit from more enjoyment of sex, due to constricted vaginal orifices? Sexuality research might have validated the suggestions to that effect that emerged in ethnographic conversations—that men enjoyed sex more when women had tight vaginas resulting from infibulation.[1] But it seemed doubtful that this would lead them as a gender group to insist on continuing the practice, particularly if they understood the pain and risks for girls. How much was this "benefit" worth? But in my ethnographic research I encountered both men and women who thought FGC enhanced sexual pleasure and those who found it did not. Senior women and men alike promoted FGC, and although men had more power and authority in families and in society and ultimately might be more in control of the situation, individual men were not.

The rural midwives of Sudan who performed the circumcisions—both the traditional birth attendants and those trained at midwifery schools—while appreciated in their communities, did not benefit much economically from their work. The medical establishment seemed to be content to have them attend to the childbirths and circumcisions of rural and poor women in exchange for payment in

[1] Sara Johnsdotter discussed this issue in her book based on interviews with Somalis in exile in Sweden (2002). Somali women told her that they believed Somali men preferred the tight vaginal opening resulting from pharaonic circumcision, but they also reflected that the source of that idea may have been other women, not men. Thus it's possible the idea "may emanate from the female sphere"—one woman said to her, "Maybe we just interpret … and believe that if you are tight he will never leave you" (p. 148).

kind—gifts of soap, meat from a feast, perfume—or the small cash payments voluntarily offered. The suggestion that they might deserve a Ministry of Health stipend—which might have provided them with a role in an agenda of change—was brusquely dismissed at a Khartoum Faculty of Medicine workshop I attended in the 1970s.

From anthropological research, I and others concluded that it was usually the families who were seen to benefit from female circumcision. When social norms require girls' circumcisions as protection of family honor and the marriageability of daughters and sons, the motivations to preserve the practice come from everyone in the family. Further, the possibility of women achieving respect, status, and security in old age was tied to their marriageability, establishing families, and having children: women needed roles as wives and mothers, so what was expected in the marriage market (virginity and circumcision) mattered, and would be as readily enforced by mothers and grandmothers as by the men. And since women's honorable behavior and reputations played a key role in maintaining family reputations and building security and respect, the assumed taming of sexuality by cutting girls was valued. The entire family benefitted from women meeting the societal expectations for propriety, morality, and circumcision status. This left little room to challenge the symbolic system that upheld and guaranteed access to those futures.

Another question I asked in the 1970s was, why had this practice become such a focus of attention in the late 1970s? In my thinking "Then," the growing intensity of the Global North's denunciations of this Sudanese cultural practice struck me as a smokescreen, or distraction, from the situations of poverty and the difficult conditions of underdevelopment Sudan was then facing. That did not mean that FGC did not need attention. But rather, seeing how it was embedded in socioeconomic realities of women, and seeing how rural lifeways were being altered and often undermined while inequality was growing and large groups of people were experiencing suffering and neglect, led me to ask how all of those problems might be better addressed holistically. It did not make sense that Sudanese women's rights organizations benefitted most from the grants and support of international donors only if they focused on opposing FGM and VAW.

In this period, I hoped that researchers would focus on understanding the conditions needed for change. Could public health policies have a broader focus on well-being, rather than focusing narrowly on diseases or problematic practices?

How might economic conditions be improved and more education provided so that people themselves could make good choices, send their children to school, and improve their lives? For families to decide to take a risk with the marriageability of their daughters, by not circumcising them, would require the existence of alternatives. It was a time when only about 10% of the students at the university were female, because there were so few schools for girls and because even those girls who were in school were so often being married off before they could finish the 6th grade. Even if they stayed in school, there were very few junior secondary schools for girls and they usually required a family to have the means or connections to send her away to live with relatives in another town, which was not easy, or to live in a boarding situation away from the family, which was considered an honor risk. Those girls who were fortunate enough to have family support for higher secondary education might become more employable, but still, there was the expectation that marriage and children had priority, and not all families were supportive of further education. Employment had obstacles as well, though professionally trained women were employed in many situations. Improving the position of women, especially by providing more opportunities for the education of girls and employment of women, would certainly make it possible for some families to take the risk of not circumcising. In looking at the conditions for change, my perspective found that women's options—for education, employment, or social alternatives to early marriage and being a mother to large numbers of children –would need to change in order for families to take the risk of not circumcising, focusing on how change of this practice would need to be embedded in other changes of women's and girls' social situations.

Accelerating activism in the 1980s and 1990s—human rights, laws, and migration

Global attention to FGC accelerated in the 1980s and 1990s with academic publications (e.g., Boddy, 1982, 1989; El Dareer, 1982; Gruenbaum, 1982; Toubia, 1985), popular media exposure (a powerful excerpt from El Saadawi's (1980b) autobiography appeared in *Ms. Magazine* ca. 1982), calls for action (Toubia, 1993), and international organizations' follow-ups to the Khartoum Seminar. In the Global South, the multi-country IAC (the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children) was formed in 1984 with committees in each of the African countries known for practicing FGC, including the Sudan National Committee on [Harmful] Traditional Practices. The IAC

used discussion-based methods and health education lectures with plastic models, as well as developing horrifying posters and publications with stories to shock people into seeing how harmful the practices could be. At Ahfad University in Sudan, the Babikr Badri Scientific Association for Women Studies was formed in the early 1980s, developing an anti- FGC agenda that used students and community activists to spread the word using posters, publications, and community service.

Organizations were still fairly small initiatives that struggled for funding and effectiveness. They were nevertheless very important for their engagement with the global awareness then escalating in the Global North about the practices and putting international pressure on UN organizations and giving South legitimacy to movements opposing FGC. The developing NGOs began to find sponsorships from embassies and international organizations that allowed local activists to travel and interact with activists elsewhere, refining their goals and strategies and learning how to attract funds to do their work. Some of the responses were more punitive and escalated the rhetoric. Hosken urged the wealthy countries to cut off aid and development assistance to any country that did not promptly ban the practices. Both international and local groups began to push for more effective laws. The term "eradicate," which had been used by some of the speakers at the Khartoum Seminar, was widely embraced, thereafter, making FGM into a disease to be attacked, rather than a social practice to be altered. The term "female circumcision" came to be disparaged as apologetic, as if it were suggesting FGC is no more serious than male "circumcision,"[1] which many people considered benign; and female genital "mutilation" became the firmly established term.[2] And yet, the Egyptian physician/feminist Nawal El Saadawi warned Global North feminists that they should cede leadership to those whose culture it was, who would understand the process of change better, and avoid the "'them' helping 'us'" arrogance that she had observed (1980b).

In short, in the Global North, the attention to female circumcision and FGM was heavily targeted toward the Global South. In the North, it was rare enough

[1] In the United States prior to the 1970s, male circumcision was a fairly common practice, such that doctors sometimes neglected to even ask parents for permission before it was done to their newborns. It was thought of by popular opinion and medical opinion alike as prudent for preventing infections, adhesions, and accumulation of odor-causing smegma under the foreskin, and as conveying other sorts of health benefits. Historically, there were many other reasons, including religious, cultural conformity, mistaken ideas about prevention of masturbation, etc. But in any case, it had become so well established as to be almost universal, unlike the situation of previous generations in the U.S. or the patterns in Europe, where more boys were left uncircumcised.

[2] The term "Male Genital Mutilation," or MGM, did not come into use until much later.

for people to know of the existence of such practices, but if they did, it was about the "them" of the South, unaware of the little-known FGC practices of the past in the North. As awareness spread about immigrant populations from the South who were living with circumcision in the Global North, concern rapidly developed from how to care for them in medical settings to how to prevent them from continuing the practices in their new homelands.

In the early 1990s, in the run-up to the Fourth World Conference on Women in Beijing, workshops were held in many countries, including Sudan, to generate opinion on the development of the Platform for Action. When I, along with fellow U.S. anthropologist of Sudan, Sondra Hale, attended the NGO Forum at the Fourth World Conference on Women in Beijing in 1995, we found that interest in FGC was high, with scores of panels focusing on "Female Genital Mutilation." Dozens of Sudanese women were there, too, although their agendas were broader: they hoped to address the civil war and political and economic situations facing women in the country, too. But they also were clear that the time had come to address FGC, and the Platform for Action that was under debate called on signatories to end "harmful traditional practices." Sudanese women were well represented in the program for women's rights and anti-FGM work, and there were also some apologists for the Islamic regime that had come to power in 1989, who praised women's roles in the militias of the civil war then in full force, intimidating the Sudanese dissidents in attendance. In addition, there were Sudanese contingents from leftist parties, Ahfad-based organizations, and southern groups, the latter focusing on issues of the civil war with the government and the Southern People's Liberation Movement/Army. The feminist Global North now had FGM clearly in its sights, and the countries of the Global South, despite their many other concerns, saw that they could use this attention to mobilize resources.

As a strategy for ending FGC, the health awareness approach was slow, but the global discourse was in a hurry. After all, the Beijing Conference was not the first Conference on Women to bring up the topic—there had been harsh words in Nairobi in 1985 as the attendees reviewed the failures of meeting the goals of the first WCW in 1975. In 1985, Fran Hosken had reportedly made blistering attacks on female genital mutilation practices and the lack of progress in stopping them, and there was a Global South backlash when African women, defended their right to decide about their own cultures. Nevertheless, the 1985 conference debates were followed by the U.N. CEDAW Committee's "General Recommendation

Number 14: Female Circumcision" in 1990 that called upon the CEDAW countries to "take appropriate and effective measures with a view to eradicating the practice of female circumcision" (UN CEDAW, 1990). This was followed in 1993 by the U.N.'s Declaration on the Elimination of Violence Against Women, in which "female genital mutilation" was listed among the types of "physical, sexual, and psychological violence occurring in the family" that needed to be eliminated. U.N. Secretary-General Boutros Boutros-Ghali commented then that the struggle for women's rights was essential and that "the cause of women is the cause of all humanity" (1993). Then, in 1995 at the Beijing Conference, we heard Hillary Clinton echo the important feminist movement view that "Human rights are women's rights, and women's rights are human rights."

Already in the run-up to the 1995 conference, the idea of a "right to bodily integrity" had been shaping, and in 1994 in the U.S., Nahid Toubia and a group of African immigrants founded the Research Action and Information Network for the Bodily Integrity of Women (RAINBO). The Beijing Conference pushed human rights to center stage, calling for clearer human rights agreements to be ratified by member states and pushing for specific laws to ban all forms of violence against women. UNICEF adopted FGM elimination as a major goal of the "Child Protection" mission in affected countries and embraced the use of human rights arguments as a major tactic. To observers, it seemed that the "human rights" argument was supplanting the too-slow "health risks" argument, in hopes that it would be more persuasive to governments and policy makers.

After 2000 to "Now": Sudan and the Global South

En route to Sudan for research in 2004, I stopped to see Nahid Toubia in London at the RAINBO offices. Her team of well-educated young women from several African countries were using creative tools of global influence—magazines, online resources, organizing cultural events, training programs—from a Global North hub, to a broad feminist agenda with a solid human rights foundation. Nahid Toubia is a formidable leader and her organization attracted much support and attention, as well as visitors including me and Aud Talle, the Norwegian anthropologist who dropped by one day while I was there. To assist with my research, Nahid provided a list of contacts in Khartoum who were members of a Network of organizations against FGM. She also gave me a challenge: to find better social sciences theories to guide social change. Indeed, understanding how

change happens and how to influence it is vital for the future of our work in FGC, and increasingly projects must specify their "Theory of Change." Since then, my research has largely focused on activism, large organizations' policies, prevention strategies, and the process of change. I was several times affiliated with Ahfad University to offer workshops or short courses, and I participated in multi-country projects, including five weeks of research in Sierra Leone and a multi-country evaluation project.

In Sudan in 2004, I found the organizations working against FGC had adopted the framework of Violence Against Women and used human rights arguments, both of which helped them garner support from the international funders for whom they were competing (Gruenbaum, 2005, 2011). During that year, I not only revisited my two long-term rural research sites, but I also interviewed activists, worked with Women Gender and Development students at Ahfad University, conducted a project with PLAN Sudan, and carried out research for UNICEF Sudan on a project in four rural communities.

UNICEF was strongly committed to using the human rights approach, and the rural research enabled me to see how this worked in practice. In one community in western Kordofan, a Sudanese NGO contracted by UNICEF offered a class for girls and women to learn about CEDAW and develop literacy and other skills. UNICEF's commitment to the human rights perspective for child protection could not be effective if people did not have the same understanding of rights as does the international community, so that became part of their outreach programs that we were going to observe. The enthusiastic recitations of memorized clauses were an amazing example of the power of rote learning! Whether they would be able to utilize the CEDAW principles was another matter, but still, it was an encouraging example that reminded me of something I had seen at the Beijing women's conference. There, Nepali activists had demonstrated their successful song strategy for spreading awareness among girls and women of their rights to education, etc. I had also recently read about the Arabic rhyming couplets that anthropologist Lila Abu-Lughod's Egyptian Bedouin research participants used in their dealings with life, and that summer on Sudanese TV, an Islamist group had aired ads to promote prayer that used appealing images and rhyming couplets. Such messages were not only memorable—allowing them to be spread easily as they were sung or told—but they had the potential to provoke responses and interaction, opening

up the ideas to be reinforced by or discussed among peers within the cultural context.

After the fieldwork, I discussed the idea of using social marketing to work against FGC with anthropologist Samira Amin Ahmed from the Child Protection Unit in UNICEF Sudan, who had worked with me to develop the research plan that summer. We discussed how we might use the youthful energy of the Sudanese rote recitation learning styles, paired with culturally-rooted Arabic literary forms such as rhyming couplets, to make self-perpetuating human rights messages. Could children's games be a source of inspiration and their energy a force for change? Could girls' school achievements be celebrated in place of circumcisions? Could the bright colors in my photos of women's groups be useful in imagery for a social marketing campaign?

In the early 2000's, as was the case for decades, many of the social change messages and posters relied on scaring people, or telling horror stories of what girls and women suffered from their circumcisions. They spoke of pain and suffering, "harmful traditional practices" and "eradication" and "mutilation." I knew, however, that for many women, the pain of an initial circumcision experience was either forgotten or accepted, post-birth reinfibulation was desired, and they went on with their lives, enjoying love, sex, and children. As a result, the horror stories did not ring true. Positive, inspiring messages and images might do more to convince families who were considering abandoning circumcision to actually take the risk than shaming them for wanting to follow a tradition they thought honorable and beautiful.

In our UNICEF report Samira and I recommended using positive imagery and "success stories" of families who abandoned FGC rather than horror stories and posters depicting scary midwives, bleeding, and dire consequences of cutting. Together with the human rights theme, positive messages could offer a value system that could support change without denouncing culture or religion or vilifying midwives and grandmothers. Since the practices required community support to embolden change, we advocated developing social marketing messages that could be delivered more widely and could offer a new norm and provoke the discussions needed for social change.

The recommendations we put forward in the report were encouraged within the UNICEF Sudan office, and, two years later (in 2006), Samira convened a

group of religious leaders, artists, poets, journalists, activists, and others in Khartoum, to critique the existing posters, images, and language used for FGM/C work. Because the existing terms for uncircumcised girls all had negative connotations (e.g., not purified, uncircumcised, *ghalfa* (roughly, "slut"), etc.) the group selected a new term for the uncircumcised state—*saleema*—an Arabic word for healthy and whole that could be used as a noun, adjective, or name.

Subsequently, Samira worked with communications and media experts to build a positive-message program against cutting girls. The project uses TV ads, billboards, a song on a video, a colorful fabric pattern, and a host of celebrities and religious leaders who have become "Saleema Ambassadors" and advocate for not cutting girls. And yes, a rhyming couplet was part of it. "Every girl is born Saleema, Let her grow up saleema."

During my research in 2015 and 2016, I found that the language of "saleema" as a positive and pleasant term for an uncircumcised girl had spread. In 2015, I attended a folkloric performance in Omdurman, Sudan, where a male and female traditional singing group from the Kordofan area performed an original song that used the heavy rhythms, rhyming, and repeated verses characteristic of that region. This style offered a great way to let people learn it for use as a self-perpetuating cultural form—and for visiting anthropologists to write it down! The lyrics were striking evidence of internal dialogue, suggesting the saleema discussions were leading to ownership of abandonment of the practices, not because the *Khawajat* [white people, foreigners] pushed it:[1]

> Healthy, O Saleema, because you give birth to Saleema,
> Listen to what the people say, leave the old customs,
> It's not sunna [i.e., expected by Islam]; it's not our culture. That's the truth.
> It's not because the White People said it …
> Healthy, O Saleema [my translation]

Multiple groups have picked up the saleema design and images—which UNICEF made freely available with design and color standards—and the project was being

[1] *Salmah ya Saleema, Ashan teldi al Saleema*
Asma kalam al nas, Khali al adil gadeema.
La Sunna, La adatna, Da kalam hagiga,
Ma ashan galu Khawajat ….
Salmah ya Saleema

ramped up since 2016 to expand to each of the states, utilizing community dialogues based on the saleema messages. Also amazing to me during my 2015 and 2016 visits to the Gezira community where I had worked in the 1970s, was the fact that the term "saleema" had been adopted for uncircumcised girls and women, even though the activities of the "Saleema Initiative" had not been carried out there. This was the hoped-for cultural spread of language and ideas.

Even more exciting was my interview with the trained midwife Besaina in the same Gezira community. Over the course of her long career, which I was able to witness at intervals from 1977 to 2017, she first moved from enthusiastic advocate of infibulation, to serious contemplation of the religious issues, to an intention to change to the "*sunna*" form when her clients would accept that. By the early 2000s her practice of FGC had indeed changed to clitoridectomy without infibulation, which had become the general pattern for the community. But as she continued to learn more through public information and Ministry of Health workshops (during the same period as the community started viewing saleema as a positive idea), she eventually decided to stop doing them completely, and took the oath that the Ministry was asking midwives to take, never to do FGM of any sort again. The families holding out against the abandonment trend resorted to bringing in a different midwife under cover of darkness to do the last few girls in 2011, but when the medical assistant at the clinic found out, he threatened to report her to the Ministry of Health if she ever came back. Since then, the community has not had any further circumcisions of girls and people seem quite supportive of abandonment. Two of the girls who were part of that last group to be circumcised told me that they did not blame their mothers for following the old ways, but that they would never circumcise their own future daughters.

The Global South contexts are so varied, that the experience of Sudan or any other country cannot be exactly replicated. Concerned international organizations, especially UNICEF, WHO, and UNFPA, have replicated ideas from one place to another and promoted training and discussions among change leaders from various countries. Organizations have developed theories of change, published "what works" comparative studies, and sometimes copied techniques—such as TOSTAN's public declarations—in situations where they do not work as effectively. Of great value has been the expansion of data gathering and publishing MICS and DHS results on FGC, which has begun to enable useful comparisons by country, region, ethnicity, and other variables over time. Evaluation research

on effectiveness of FGC behavior change projects and programs is taking place in many countries. Today, it is recognized that both the human rights arguments and the health education approaches are useful and should be offered together, along with methods that are tailored for the sociocultural context. In some places there must be engagement with religious leaders, in others alternative rituals might be appropriate. In some countries, the opposition from women's organizations could be strong, while in others, women's rights organizations may be taking the lead. Laws are not uniformly useful, but could be a tool. In some countries, safe houses have been tried for girls to run away from cutting, while in other places that would be shameful. In short, change efforts are becoming more sophisticated and countries are taking ownership. All have at their core a challenge to cultural/traditional values and norms of behavior as it has been—requiring a shift in norms, a change in social conventions, a reinterpretation of doctrines, a rethinking of identity, and all of this embedded in community and family as well as larger bodies of ethnic group, region, nation, sect, and faith tradition. A key element is to bridge from the valued norms to the new ones without a complete rift, mobilizing support or neutralizing disapproval of new choices. Messages based on enduring values but that take advantage of tensions in society and allow conversation on the areas of tension, are the most ethically sound and potentially effective. People must be able to so envision adopting new or modified social norms knowing that others are supporting the change.

Rapid change and "zero tolerance for FGM" approaches risk being perceived as externally motivated and condemnatory. It is difficult for activists and change agents in the Global South when they are labeled as "Western" or "un-Islamic." The Global North has been heavily implicated in the movement to end FGC, as the line of the song above shows, and Global South leadership on strategies is vital.

"Now"

In the 1970s, my Sudanese academic friends were convinced female circumcision would die out of its own accord (Gruenbaum, 1982a). The Global North's attention to it, it seemed, was a distraction from the more pressing social injustices that with which Sudan and other African countries were contending. They faced colonial and neo-colonial plunder, resource extractions, exploitation of labor, debt, and other injustices that were holding back development. The people I interviewed in my fieldwork had a long agenda for improving their lives—clean water,

schools, employment opportunities, clinics—and ending FGC was not the most urgent concern. So why has FGC been so high on the list of problems when the Global North looked at African countries? Were they throwing up a distracting smokescreen, blaming the problems of "Third World" poverty on "backward cultures" and "harmful traditions" rather than the political economic realities?

The potential for misuse of the issue persists today, as the "female circumcision controversy" and the smokescreen (Gruenbaum, 2015) take new forms and extend to the Global North with increased immigration. At base, anti-immigration attitudes are fueled by racism and other struggles receiving countries face in trying to understand why the middle-class dream is elusive. When anti-immigrant sentiments are encouraged by right-wing political groups, the specter of "FGM" is often raised, and false rumors are easily spread about "circumcisers being flown in to hold circumcision parties" or suggesting that FGM is frequent, even when there is no evidence (Public Policy Advisory Network, 2012). In a swirl of anti-immigrant hysteria in the U.S. state of Georgia, for example, an Ethiopian father was convicted of circumcising his daughter on flimsy evidence and under accusations from his estranged South African wife (Steffen, 2011). The U.S. government denied visas to witnesses who could have attested that his family no longer practiced FGC. (He served 10 years in prison and then was deported to Ethiopia.)

On the other hand, we also see immigrants able to utilize fear of FGM in their home countries to gain individual asylum in the Global North. As such cases have become more frequent, receiving countries are becoming skeptical, questioning the legitimacy of asylum seekers' claims. In 2016, recognizing that better guidelines were needed, the European Asylum Support Organization met in Malta to consider how to develop such guidelines on the claims of asylum-seekers from various countries and regions. In short, there is a growing need for those of us with FGC expertise to engage in the global dialogues, not merely to contribute to ending the practices, but also to work to prevent the injustices and international hysteria that is turning "FGM" into a tool of fear or hatred or misplaced pity toward Africans and Muslims.

Even when anti-FGM work is pursued in a benign way, the misunderstandings in the "mutilation" discourse contribute to harmful effects. We hear about immigrant girls suffering psychological damage in Europe as they are told their bodies are mutilated and their futures are dismal, as when they hear, "You will

never be able to enjoy sex," or "You'll never have an Italian boyfriend," as Lucrezia Catania's clients have reported. This can lead young women to fear intimacy or seek surgeries to create the appearance of a clitoris when in fact they may need only information or counseling to realize their sexuality, as Jasmine Abdulcadir has discussed. In the Global North, enforcement of anti-FGM laws "to keep girls safe" has at times resulted in family separations, examination of girls' genitals without parental knowledge, and denial of freedom to travel. In Michigan, practitioners of the minimal Dawoodi Bohra pricking were arrested, separated from their families, and required to pay high bail before their trials, in a case that was eventually thrown out. In Australia, two Dawoodi Bohra men were sentenced to prison for their roles and two women to house arrest.

In light of these cases, it is ironic that Global North physicians in several countries are building lucrative cosmetic genital surgery careers, removing labia tissue and sculpting designer vulvas for middle class women seeking a "Barbie" or a "clean slit" aesthetic (Boddy, 2016; MacDougall, 2013). European, North American, Australian, Brazilian and many other middle class women are the main clients who are seeking to have their genitalia surgically modified to suit their aesthetic tastes. The concept of "designer vaginas" (Ahmadu, 2007) includes things like labiaplasty (to make labia minora less visible and reduce the normal protrusion of tissue now given unsavory label "camel toe"), mound sculpting, and other enhancements. They can view "before and after" photos on clinic websites, read about patients' experiences, listen to doctors' descriptions of satisfied patients' experiences, and compare with pornographic photos. MacDougall's research found clients are seeking to inscribe on their bodies a new cultural ideal they have come to believe is beautiful, normal, and attractive to sexual partners (2013). These major procedures are legal, while the prepuce prick is not.

It seems illogical to permit and facilitate such major changes to the genitalia, while at the same time prohibiting African immigrant women from having their infibulations repaired after childbirth, as is illegal in some countries. In the Global North, it is reported that girls under the age of eighteen are getting genital cosmetic surgeries, yet any African genital cutting to girls under eighteen is considered a serious crime. The idea seems to be that for Western (white, middle class?) women and girls, it is their choice; for African women and girls, it must be that they are victims. Janice Boddy calls this "the hypocritical narrative of African barbarity that persists in the righteous West" (2016, p. 64). It is surely time to challenge the

focus on ills of the Global South and turn attention to the ethnocentric and discriminatory practices of the Global North, where preoccupation with its "civilizing mission" has made us blind to the double standard of genital cutting practices. White women's genital cosmetic surgeries would not be so popular were it not for the efforts to undermine women's and girls' body self-image to create demand for beauty products and surgeries to alter genitalia. Surely this is as much about the power of societal norms to command conformity as are "African traditional purification" practices.

Anthropologists have long discouraged viewing "culture" in a reified way as something that does not change, pointing instead to its dynamism, its contested and contingent character. The "harmful cultural practices" discourse often echoes the "civilizing mission" one of colonial politics of the past centuries, awaiting international saviors. Henrietta L. Moore points out that

> … the West's ongoing effort to present itself as having transcended culture has long been recognized as the absent core of liberal politics. Claims to transcendence being little more than claims for the universality of a particular set of historical specificities. The West, it turns out, has culture just like everyone else. What falls out from this critique … is that culture is never simply culture, it is also always politics [2007, p. 311].

I encourage us to turn our attention to how we can enhance this dynamism in culture, and let our research go toward being helpful. For example, scholars in the Global North who work with immigrant populations know well that immigrants from circumcising countries have struggled to find appropriate health care for their altered genitalia. Global North governments have legislated against cutting, and evidently most immigrants have successfully adopted the new social convention in their adopted lands within a few years of migration, not only because of laws, but also because of an opportunity to shift to a new norm (e.g., Wahlberg, 2017).

I count myself among those who are working toward abandonment of all forms of child genital cutting as unnecessary, yet I recognize a range of priorities—some forms are more harmful than others and some situations are more open to change than others. Also, I believe that pushing for "zero tolerance" to "all forms" (including pricking and labia stretching) in all contexts is not likely to succeed in the short term. There are those, such as anthropologist Fuambai Ahmadu, who calmly defend the right of Sierra Leonean women to practice the Bondo secret

society initiation ritual that includes genital cutting—with appropriate precautions for hygiene and consent—based on the rite's important role in women's identity and the right of women to make decisions about their culture. Similarly, observant Jews consider boys' *brit milah* to be a religious rite that they should be allowed to continue freely.

In my own short-term research in Sierra Leone (with UNICEF research assistants) in 2007-08, it was evident that the Bondo initiation practices were strongly supported and unlikely to change anytime soon. We met numerous health providers who either avoided stating opinions on "women's business" or were accepting of the fact that it took place, even providing tetanus injections and hygienic surgical equipment to help reduce risk to the girls, thereby providing harm reduction. Not all ethnic groups practiced Bondo, but people from many different faiths (Islam, Catholic Christianity, etc.) were members of Bondo or men's Poro. And yet, change is slowly happening due to the work of activists, including initiated no-longer-involved Bondo members and also members of Evangelical and Pentecostal Churches.

If unconsenting young girls can be protected from abduction and forced initiation and if cutting can be made safer and minimal, it is difficult to argue that this is any worse than the widely accepted practices on boys.[1] Similarly, in the case of the Dawoodi Bohra, their understanding of their religious faith requires both boys and girls to receive genital cutting—a foreskin circumcision for boys and a prepuce nick for girls. If the children assent, can religious freedom and cultural self-determination be extended to these situations? Or must the "zero tolerance" approach be enforced for girls, but not for boys?[2] And if a whole generation of Somali immigrants—whose parents demanded infibulations a generation ago – decides that a prick is enough once they have moved to Sweden (Wahlberg, 2017), shouldn't we see that as progress, likely on the way to future complete abandonment? Proposals in the Global North to promote a pricking alternative have been harshly attacked—and prevented from being tried—in Seattle, Washington, and Florence, Italy, and elsewhere—so we don't have evidence of its long-term consequences.

---

[1] It is also ironic that Male Genital Cutting is ordinarily tolerated in law and discourse, despite sometimes quite serious damage (The Brussels Collaboration on Bodily Integrity, 2019).

[2] The questions of age and consent are sticking points for both female prepuce-pricking and infant male prepuce removal.

What is next?

Social scientists are continuing to make key contributions to the movements for ending female genital cutting. UNICEF and other organizations adopted our perspective that the practices are inherently dependent on culture, social norms, and behavioral expectations that are reinforced by the society and community. Organizations now engage with community dynamics to challenge old norms and embolden families to accept new patterns, in addition to offering medical advice, laws, or even human rights education.[1] Instead, educational outreach on health issues, facilitating religious leaders' discussions, group discussions and decision-making, pledges to enable others to trust that their children will find marital partners if they join the change, alternate rituals, and well-publicized public declarations (as Tostan in Senegal has long utilized) are all used to gain traction. Eventually, these are expected to result in a situation where the changing norms are so wide-spread that there is momentum for change in practice. This theory of change via norm shifts posits that eventually there will be a dramatic behavioral shift when the new norm is widely accepted and those following the old norm find themselves in the minority. This is the theorized Tipping Point, when change is rapid and irreversible.

This "tipping point" idea, like global warming and melting polar ice caps, posits accelerating change that becomes irreversible. If we take recent statistics on changes in female genital cutting prevalence rates by age group in the countries reported in MICS and DHS studies (see UNICEF, 2013), a comparison of prevalence of FGM/C reported for girls aged 15 to 19 compared with women aged 45-49 can be used as a rough assessment of how practices have changed in the past 30 years. UNICEF found that the practices are becoming less common in more than half of the 29 countries reported in *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change* (2013) and noted, "The decline is particularly striking in some moderately low to very low prevalence countries." In other words, where the rates are already low (such as Kenya), abandonment seems to gather momentum. In contrast, countries with high rates (such as Egypt and Sudan) show slower rates of change. This theory of change still leaves unanswered the question of how to mobilize individuals to abandon FGC at high enough rates

[1] Susan Chebet, a Kenyan anthropologist and public figure actively involved in promoting abandonment of cutting while still preserving respect for Kalenjin cultural values and rites of passage, once said to me that there is such a thing as overemphasizing one message. Some of her community said, "We are tired of hearing about human rights."

to achieve a tipping point. But organizations (UNICEF, UNFPA, and WHO) and publications (*Innocenti Insight*) have worked hard to share best practices and new ideas, hoping that the "tipping point" for FGM/C will be achieved soon, with rapid, widespread abandonment of all forms of FGM/C (e.g., UNICEF, 2010). No doubt some practices will not entirely disappear—perhaps the defenders of Bondo or Dawoodi Bohra pricking will find ways to adapt to their legal environments—but wherever cultures can embrace the change in a positive way, it may be able to quickly fade.

Many different approaches are needed, simultaneously, serially, and variously in different contexts. Strategies and messages should be deployed at the right time in the appropriate context. There is no "one-size-fits-all." Because there are so many players and contexts in every situation—from aging grandmas to snapchatting schoolgirls, from politicians guarding Islamist reputations to academic feminists, from rural isolation to urban cosmopolitan life—strategic deployment of different methods is warranted.

Perhaps it sounds like a crazy assertion to pursue many avenues that have been tried before, when you consider that the prevalence rate for Sudan has barely budged in the last few decades (still 88% on the UNICEF 2013 map, 87% for 2016). But regional/ethnic/urban variation in all of the countries underscores the need to better understand the tensions that drive the process of change, to make sense of the acceptance and resistance. It is well understood among leaders and organizations working on the issue that an integrated strategy is needed to address the social complexity of changing norms and practices around FGM/C, because it is very risky and difficult for individual families to abandon the practices. As the Joint Programme of UNICEF/UNFPA has phrased it, "the social cost of not conforming is higher for the individual and possibly also for his/her family than the perceived harm. It is necessary to collectively coordinate the change of a social norm within the appropriate social network(s)" (personal notes, EASO presentation, 2016).

This calls for pairing of the best quantitative and big data measures with the most fine-grained, organic ethnography. Making sense of the complexity of the processes involved in changes—such as the fact that there needs to be coordination of change in complex social groups, affecting families, honor, and marriageability, and that there are elusive processes of religious re-interpretation among various

sects—means that we cannot make straightforward prescriptions. Nor can we necessarily identify specific effects of specific interventions, since combinations of factors apparently work together to result in change.

Lasting change can take a long time, but some changes also can happen rapidly when the conditions are ripe. We are now in the midst of dramatic change of FGC globally, fueled by a combination of educational efforts, creative approaches to activism and programs, expansion of communication abilities, migrations of people and the ways immigrants maintain social links and influence with their families wherever they are located, intercultural and global discourse, and life course experiences shared inter-generationally. Cultural anthropologists argue culture is contested, always in tension, and pregnant with change. When seeded with potent inputs designed from cultural insights, the results cannot be precisely predicted, but changes for which there is an inherent potential—as is the case with abandonment of severe genital cutting practices on children—can be catalyzed and accelerated.

References

Abdalla, R. (1982) *Sisters in affliction: Circumcision and infibulation of women in Africa*. London: Zed Press.

Abusharaf, R. (Ed.). (2006). *Female circumcision: Multicultural perspectives.* Philadelphia: University of Pennsylvania Press.

Ahmadu, F. (2007). "Ain't I a woman too?" In B. Shell-Duncan, Y. Hernlund (Eds.), *Transcultural bodies: Female genital cutting in global context* (pp. 278–310). New Brunswick, NJ: Rutgers University Press.

Assaad, M.B. (1980). Female circumcision in Egypt: Social implications, current research, and prospects for change. *Studies in Family Planning*, *11*, 1, 3-16.

Boddy, J. (1982). Womb as oasis: The symbolic context of pharaonic circumcision in rural northern Sudan. *American Ethnologist*, *9*, 682–698.

Boddy, J. (1989). *Wombs and alien spirits: Women, men and the Zar cult in northern Sudan*. Madison: University of Wisconsin Press.

Boddy, J. (2007). *Civilizing women: British crusades in colonial Sudan.* Princeton: Princeton University Press.

Boddy, J. (2016). The normal and the aberrant in female genital cutting: Shifting paradigms. *HAU: Journal of Ethnographic Theory, 6*, 2, 41–69.

Boutros-Ghali, B. (1993). Secretary-General's international women's day message. Retrieved from www.un.org/womenwatch/feature/iwd/1993/

El Dareer, A. (1982). *Woman, why do you weep? Circumcision and its consequences.* London: Zed Press.

El Saadawi, N. (1980a). *The hidden face of Eve: Women in the Arab world*. London: Zed Press.

El Saadawi, N. (1980b). Creative women in changing societies: A personal reflection. *Race and Class, 22*, 2, 159–82.

Gruenbaum, E. (1982a). The movement against clitoridectomy and infibulation in Sudan: Public health policy and the women's movement. *Medical Anthropology Newsletter*, *13*, 2, 4–12.

Gruenbaum, E. (1982b). *Health services, health, and development in Sudan: The impact of the Gezira Irrigated Scheme*. Doctoral Dissertation, Department of Anthropology, University of Connecticut.

Gruenbaum, E. (2001). *The female circumcision controversy: An anthropological perspective.* Philadelphia: University of Pennsylvania Press.

Gruenbaum, E. (2005). Feminist activism for the abolition of female genital cutting in Sudan. *Journal of Middle East Women's Studies, 1*, 2, 92–112.

Gruenbaum, E. (2011). Competing globalizing influences on local Muslim women's reproductive health and human rights in Sudan: Women's rights, international feminism, and Islamism. In C. Browner, C. Sargent (Eds.), *Reproduction, globalization, and the state* (pp. 98–110). Durham, NC: Duke University Press.

Gruenbaum, E. (2015). Epilogue: Harm and well-being: Cultural practices and harmful global practices. In C. Longman, T. Bradley (Eds.), *Interrogating harmful cultural practices: Gender, culture and coercion* (pp. 193–205). Farnham: Ashgate.

Hosken, F. (1978). The epidemiology of female genital mutilation. *Tropical Doctor*, *8*, 150–56.

Hosken, F. (1979). *The Hosken report: Genital and sexual mutilation of females*. Lexington, MA: Women's International Network News.

Hosken, F. (1980). *Female sexual mutilations: The facts and proposals for action*. Lexington, MA: Women's International Network News.

Johnsdotter, S. (2002). *Created by God: How Somalis in Swedish exile reassess the practice of female circumcision*. Doctoral thesis, Department of Social Anthropology, Lund University.

Kameir, W. (1977). Personal communication, University of Khartoum, Khartoum, Sudan.

Kenyatta, J. (1938). *Facing Mount Kenya*. London: Secker and Warburg.

McDougall, L.J. (2013). Towards a clean slit: How medicine and notions of normality are shaping female genital aesthetics. *Culture, Health, and Sexuality, 15*, 7, 774–87.

Ngugi wa Thiong'o. (1965). *The river between*. London: Heinemann.
O'Brien, J. (1974). *Imperialism by proxy*. M.A. thesis, Department of Anthropology, University of Connecticut.
Public Policy Advisory Network on Female Genital Surgeries in Africa. (2012). Seven things to know about female genital surgeries in Africa. *Hastings Center Report*, *42*, 6, 19–27.
Rahman, A. & Toubia, N. (2000). *Female genital mutilation: A guide to laws and policies worldwide*. London: Zed Books.
Sanderson, L.P. (1981). *Against the mutilation of women*. London: Ithaca Press.
Steffen, C. (2011). *Mutilating Khalid: The symbolic politics of female genital cutting*. Trenton, NJ: Red Sea Press.
The Brussels Collaboration on Bodily Integrity (2019). Medically unnecessary genital cutting and the rights of the child: Moving toward consensus. *The American Journal of Bioethics, 19*, 10, 17–28.
Toubia, N. (1985). The social and political implications of female circumcision. In E. Fernea (Ed.), *Women and the family in the Middle East* (pp. 148–59). Austin, TX: University of Texas Press.
Toubia, N. (1993). *Female genital mutilation: A call for global action*. New York: Women, Ink.
Toubia, N. (1996). Dr. Nahid Toubia Discusses Female Genital Mutilation. Radio interview by Terry Gross on *Fresh Air*, WHYY, March 27. Freshairarchive.org.
UN CEDAW (1990). A/45/38. CEDAW General Recommendation No. 14: Female Circumcision. Retrieved from www.refworld.org/docid/453882a30.html
UNICEF. (2010). *The dynamics of social change: Towards the abandonment of female genital mutilation/cutting in five African countries*. Florence, IT: Innocenti Research Center.
UNICEF. (2013). *Female genital mutilation/cutting: A statistical overview and exploration of the dynamics of change*. New York: UNICEF.
Wahlberg, A. (2017). *Continuity or change? Improved understanding of attitudes towards female genital cutting after migration from Somalia to Sweden*. Doctoral thesis, Department of Women's and Children's Health, Uppsala University.
Watson, M.A. (2005). Female circumcision from Africa to the Americas: Slavery to the present. *The Social Science Journal*, *42*, 3, 421–437.
WHO, World Health Organization, Regional Office for the Eastern Mediterranean. (1979). *Seminar on traditional practices affecting the health of women and children, Khartoum, 10-15 February 1979*. WHO: EM/MCH/137, EM/MENT/91, EM/SEM.TR.PR.AFF. HTH.WM/44, March.

Lisen Dellenborg

The Significance of Engagement — Challenges for Ethnographers and Healthcare Givers in Understanding Human Vulnerability[1]

Introduction

Confronted with human vulnerability, healthcare staff and ethnographers face similar challenges in understanding other people's circumstances and lived experience. Ethnographers and care professionals both have to try to put themselves into the shoes of others on the basis of their own experience and life story. The will and the courage to be engaged and emotionally moved are crucial for the creation of knowledge within both ethnography and healthcare. Empathy and compassion in turn, are interwoven with knowledge, context and understanding. This means that compassion can just as easily lead us astray by revealing more about ourselves than it does about those we try to understand. That is, "the shoes may be our size, but we cannot assume that they will fit" (Savage, 2000, p. 324). Having done ethnographic research on initiation rituals in West Africa and now conducting hospital ethnography (van der Geest & Finkler, 2004) in Sweden has made me reflect on similarities in ambitions and concerns among healthcare professionals and ethnographers. Within both healthcare and ethnography, others' lived experience needs to be translated into words, in ethnographic texts and

[1] This is an updated and revised version of a text that has been published in Swedish in *Människan i vården, Etnografi, vård och drama*, by Carola Skott, Lisen Dellenborg, Margret Lepp and Kristina Nässén. Stockholm: Carlssons förlag, 2013. Thanks are extended to The Centre for Person-Centred Care (GPCC: http://gpcc.gu.se) at the University of Gothenburg, Sweden for funding.

teaching, in documentation, round reports and turn-overs—and into the practices of caring and creating ethnographic knowledge respectively. As the experiencing researcher and healthcare provider is a person with memories and a history, this constant process of translation needs to be reflected on. Caring relations are fundamental for human relations and strongly connected to ethics. The French philosopher Paul Ricoeur (1994, p. 172) defines his ethical intention as "*aiming at the 'good life' with and for others, in just institutions*." In other words, this means to strive for reciprocity, care and equality, which demands self-knowledge on the part of the personal care giver, dialog, and an understanding for the unique person in their cultural context (Skott, 2013a, p. 8). To realize this ethic in practice, healthcare givers need to be supported by a methodology. Ethnography essentially is about creating inner understanding for other people in a hermeneutical strife of making the unknown familiar, and in the end to say something about what it is to be human. Its' methodology implies reflexivity and relativism in connection with empathic involvement in others' life worlds, clarification of the process of interpretation and awareness of one's pre-understanding (Scott-Jones & Watt, 2010).

In the following, I describe this methodology in practice and illustrate how ethnographic knowledge is created by describing what actually happens when an ethnographer learns by allowing themselves to be moved by what is happening to people whose situation and life world they try to understand. In order to do this, I shall present an ethnographic description from an emotionally disturbing episode during my fieldwork in Senegal, West Africa and show how an ethnographic methodology and hermeneutical approach helped me reach a deeper understanding of both adults' and children's experiences of the practice of female genital cutting. The episode also brought to light the limitations of my understanding, as researcher, for the experience of "others". The story is about an ablution ceremony that is commonly carried out one week after a girl has been circumcised. The text will go back and forth between discussions on challenges in ethnography and healthcare, and proposes ethnography and hermeneutics as methodological approaches that may enrichen professional caring.

The importance of being affected

The ethnographer's active engagement and concerns about conducting fieldwork nowadays are regarded as fundamental to the production of knowledge (Borneman & Hamoudi, 2009). However, the ideal of objectivity that is upheld in the

positivist tradition held sway for a long time in the social sciences and began to be criticized in the 1970s and 1980s. The production of knowledge was then subjected to critical scrutiny, the influence and power of the researcher over their results was hotly debated and the notion of the ethnographer being an independent observer was called into question. Ethnographic fieldwork and participant observation became understood as considerably more complex than "strategic methods" for gathering, classifying and analyzing social facts (Collins & Gallinat, 2010), and fieldwork meaning far more than simply having "been there". Ethnography now began to be seen as something that arose out of the personal meeting between an ethnographer and the people they met in the field (Clifford & Marcus, 1986) and ethnographic knowledge thought to require empathy for others (Kleinman & Benson, 2006). In our day, ethnography is recognized as an activity in which we not only allow ourselves to be removed from our familiar environment and worldview, but also to be emotionally affected (Stevenson, 2009; Malmström, 2019).

A short description of the practice of female genital cutting in Casamance

My doctoral thesis deals with the cultural significance of female genital cutting in West Africa and it is based on 21 months of ethnographic fieldwork in a number of villages in Casamance, southern Senegal between 1994 and 1995, 1997 and 1999 (Dellenborg, 2007). In Casamance, clitoridectomy is performed on girls between the ages of four and eight years. Locally the practice is termed *circoncision* and also *excision* in French, which is the official language in Senegal, and *sunay* in the local languages of Manding and Jola.[1] Boys are circumcised at the same age as girls, often by healthcare professionals, and the procedure implies the removal of the penile prepuce. Boys' circumcision is referred to as *circoncision*. Female circumcision is prohibited according to Senegalese law and is not performed in hospitals or clinic, but is nevertheless practiced in the country.[2] The practice of circumcision has different social, cultural and religious meanings to people depending on ethnic belonging and region. In Casamance, female and male circumcision is practiced as part of important initiation rituals often celebrated several years

[1] I will here use the terms female circumcision to stay close to the local interpretation of the practice and the more neutral female genital cutting. The etic term female genital mutilation will only be used when referring to a juridical context.

[2] An estimated number of 24% of the Senegalese women and girls are circumcised, depending on ethnic identity, religious belonging and also where in Senegal you live (Agence Nationale de la Statistique et de la Demographie, 2018; Dellenborg, 2007).

after the actual cutting. They are also connected to Islam, although the meaning of female circumcision as a Muslim practice is challenged and internally debated in Casamance and Senegal. The majority population in Senegal, Wolof, are Muslims and do not practice female circumcision while there are Christian groups in Senegal that do. In Casamance, female genital cutting, in contrast to male circumcision, is carried out in the home of the "circumciser", locally referred to as *l'exciseuse* and *ánaman*, who is an older, respected woman who has learnt her art from another knowledgeable woman through many years of apprenticeship (Dellenborg, 2004, 2007, and 2009; see also Dellenborg & Malmström, in this book).

Engagement in practice

Female circumcision—the ethnographer, the children and their mothers

Having grown up in a country in which female genital cutting, or mutilation as it is commonly called in an Euro-American context, is considered a serious breach of human rights and to then conduct fieldwork among people who defend the practice was a major challenge for me. I found myself constantly tossed back and forth between my role as researcher and my personal feelings of frustration and distress. My dilemma was made all the worse by the respect and warmth that I came to feel for many of those parents, grandparents and families I got to know and who so generously shared their time and thoughts with me, opening their homes and inviting me into their lives. It became obvious to me how much they loved their children and that their decision to have them circumcised was made with the best of intentions. It was with this insight that I tried to understand why this practice was so important that parents were prepared to put their children through pain and danger in order to have it performed. Circumcision and initiation of both boys and girls is a risky business and the initiates are particularly vulnerable. A good circumciser should not only be skilled with the knife, but also in protecting the children from attacks from witches and malevolent spirits.

At the time of the ceremony I shall be describing here I had been in Senegal for about a year. I had acquired a reasonable understanding of the complex social, cultural and historical features of circumcision and I had discovered how hotly it was debated even among those who practiced it. I could not accept this kind of intervention on children's bodies but slowly I had learned to accept the situation. My realization that the best thing I could do was to do my job as an anthropologist

well, helped me to come to terms with my role in the field; creating good ethnographic knowledge about the meaning the practice holds may provide the basis for change.

The neighbor of my host family was the village circumciser, Siré. I had interviewed her several times and she was possibly prepared to permit me to attend a circumcision ceremony. Awareness of this came to influence my experience of the ceremony described here in specific ways. The invitation to this actual ceremony came suddenly. My assistant, Marie, a French-speaking woman from the region, and I were asleep when Siré came and woke us up early one morning. She was preparing an ablution ceremony for newly circumcised girls and she told us we were welcome to attend. We threw on our clothes and hurried after her. Siré's husband met us at the door and showed us through the house. The windows of their house were closed so it was dark inside. We passed a room in which some women were helping a couple of girls get dressed. The women greeted us warmly and we responded. Marie whispered to me that she recognized them from the neighboring village. We were ushered out into the enclosure where the ablution would take place and the man disappeared into the house again. Every family has a similarly concealed place behind the house where household members can wash each day out in the open air. We were shown to a bench that was standing along one wall.

A raffia mat lay rolled out at our feet and at the other end of it were four large urns full of water. Siré's co-wives, who were busy preparing for the ablutions, greeted us with smiles. My eyes fell upon a small knife with a black handle that was lying at one side of the raffia mat. The blade was curved from having been sharpened so many times. It was the kind of knife that women usually use for harvesting rice and that I had learned played an important symbolic role in circumcision (these days each girl is circumcised with a new razor blade). Marie saw the knife as well. Our eyes met and we whispered uneasily to one another: what exactly was going on? Had we really been invited to a circumcision ceremony? I felt a spasm of fear grip me. I was psychologically unprepared for actually witnessing the operation. But if I really wanted to understand circumcision as fully as possible how could I refuse an offer to observe one? What right did I have to protect myself from the reality that these girls were about to experience? What would it mean if I left? And what would it mean if I stayed? A jumble of feelings and thoughts churned inside me as Marie and I sat there staring at one another.

Then suddenly the children came out of the room, carefully guided by some of their female relatives, maybe mothers or aunts. The girls were around five or six years old. They youngest was maybe only four. Each had a piece of cloth wrapped around her small body. They looked anxiously around at all of us who were gathered there: the circumciser Siré, her co-wives, Marie and myself, the white woman who must have appeared so out of place. I read in their wide-open eyes and fluttering gazes, their tense bodies and slow, hesitant steps that they were afraid. They crowded together and pressed themselves against their mothers. One of the girls looked directly at me and held my gaze. She looked fearful and bemused. The agonizing realization that whatever happened now, I had no right to intervene made me look away in shame.

The women were also silent and their body language was restrained. They carefully pushed the girls ahead of them towards the urns, where Siré and her co-wives stood side by side waiting for them. Siré signaled to Marie and myself to come closer so that we could see what she was about to do. She took a cake of soap and used it to write a cross on each girl's head from forehead to the nape of the neck and from ear to ear. Then she and her co-wives began washing the girls from top to toe with large sponges that frothed with soap. Marie nudged me and brought my attention to the fact that the youngest girl had something white between her inner labia, where her clitoris would have been. Perhaps it was a piece of cotton or shea butter, which is commonly used to encourage healing. Marie concluded that the circumcision must have already taken place and that the little girl's wound had not yet healed. Now that I realized I would not have to witness the cutting of these children's bodies a wave of relief swept through me. It was distressing enough just to know that they had been through the experience and to see how afraid they were from what I now understood was the memory of the circumcision itself from a week earlier.

The smallest girl cried throughout the washing procedure. All four of them looked terrified but she was the only one who cried. The other three didn't let out a sound. I ached for the little one and wished someone would comfort her. I didn't dare move from where I sat since I was a guest and was unsure of what I was allowed to do. A moral struggle was brewing inside me. When the oldest of Siré's co-wives, Ndey, took over the washing the little girl began to scream. Ndey was holding the knife in one hand and it had evidently frightened the life out of the little girl. I could see how she was backing away from it, pulling her arms hard

towards her. I couldn't bear it anymore and so I asked Marie to ask Ndey to put the knife down. Marie did so and the old woman stopped washing the child and looked towards me, then at Marie, then at the knife and finally at the little girl in front of her, who was now sobbing ferociously. To my astonishment, she then put the knife right under the child's nose and said threateningly, "See this knife?" I understood enough Jola not to require Marie's translation. The little girl went rigid and immediately stopped crying. Ndey continued to wash her, apparently indifferent to her fear and still with the knife in her hand. Her rough behavior left me utterly bewildered. The horrific thought that I may have exacerbated the situation for the little girl made me sit motionless and silent throughout the rest of the ceremony.

Once the girls had all been washed the cloths were wrapped around them again and they were told to sit down on the raffia mat. They crept close together on their knees with their foreheads on the floor and one hand on each side of their heads. I had had it explained to me earlier that this is how the girls should greet the circumciser. The littlest one had begun sobbing again but very quietly now. The circumciser dipped a knife into a bowl of milk and one of her co-wives called to the first girl to come forwards. With the point of the knife dripping with milk, Siré drew a cross on the girl's hands, forehead, chest, feet and lower back without scratching the skin. Then the girl was given a sip of milk from the bowl and told to go back to her place on the mat. She lay down with her forehead on the ground again and then it was the next girl's turn. At last came the youngest girl's turn. She was still trembling, but her sobs had almost stopped.

When all four of the girls had been marked and drunk milk from the bowl the atmosphere changed. The tension and seriousness dissolved and another of Siré's co-wives, Mabintou, began to dance in front of the girls who now got up and stood with their mothers. Mabintou sang that everything was over now and the girls could eat whatever they wanted again. I later found out that during the week following their circumcision the girls had had to avoid certain foods that were considered to slow healing. The women clapped in time with the song and Mabintou finished her dance by flinging her headscarf to the ground. Then she told the other women to do the same while the girls stood there, watchful and quiet.

Deepening understanding

Participating in this ceremony gave me a rude awakening from the calmness I had been lulled into while doing fieldwork until then. Now, for the first time, I was forced to engage directly with the girls' vulnerability. There was nothing protecting me from these girls' suffering; I sensed their fear in my own body and it evoked powerful feelings of empathy. I felt that I identified with their situation—what it must feel like to find yourself at the mercy of others and unable to decide over your own body. What had these girls actually experienced during the operation and how much fear and pain had they experienced during the week after it? Pain is a deeply personal and subjective experience and we cannot experience another person's pain. It can be difficult even to recall our own experiences of pain in the past (Smith, 2006); we remember *that* we were in pain, but the concrete sensation is hard to revive. Still, because pain is also collective in the meaning that in language there are words and metaphors for pain and we in some sense may share the experience and imagine another person's pain, there is a potential for understanding (Skott, 2013c). The uneasiness that the ablution ceremony evoked in me forced me to confront questions that I would otherwise have been unable to ask but which were important for understanding the broader meaning of circumcision. The anthropologist Paul Stoller (1989) notes that ethnography based upon the senses help us pose new questions that arise out of bodily experience. For instance, the shame that I felt made me aware of the children's perspective as different from the adults that I was constantly talking with. Why did the little girl look at me like that? Was it because she wanted me to help them? Was it because she did not know what was going to happen? Or was it because I was white and stood out from the others? Why did the circumciser's assistant frighten the little girl with the knife? What do mothers and the female kin actually experience? Why were they so quiet? And why did the women throw off their headscarves at the girls' feet? Marie, who had been circumcised when she was young but had not allowed her own daughters to be circumcised, was as disturbed as I was by the ceremony. In other words, it was not simply my foreignness that made it upsetting for me. I later understood that the initiation ritual that is held sometimes years after the genital cutting was associated with joy even for the girls themselves while the circumcision itself was experienced as an arduous ordeal by all who underwent it and for those witnessing it.

New aspects of what adults had told me about the importance of preparing children for a tough adult life with multiple births and demanding physical work in the everyday life, in the rice fields, in co-operating with co-wives and obeying husband and his kin became evident to me. I had learned that stoicism is essential for presenting oneself as a moral person and this is revealed in many facets of daily life. During my total of 21 months in the field, I never saw an adult woman or man cry. My own expressions of sadness, such as in relation to death, were viewed negatively. To reveal that one is or has been in pain was thought to be a sign of weakness. Suffering is considered a part of life, a good teacher and a source of strength. With time I could see that the adults were using circumcision and the subsequent initiation ritual to teach the children how to manage physical and mental trials and thereby be better equipped for a hard life. Ndey's threatening wave of the knife exemplified this: "pull yourself together because neither fear nor tears will help you in this life". When I later analyzed the event I felt that I gained a deeper understanding of, on the one hand, adult ideals about child raising and about what is best for children and, on the other, the children's own experiences of fear and insecurity as to what will happen next. The children know from young age that they are going to be circumcised: "*pitampi!*" (Manding, "*I will circumcise you!*") is a threat that adults commonly throw at disobedient children, but the children don't know how and when this will take place and they are not prepared when the time comes for the operation. The adults say that they don't want to worry their children by telling them; it would only create more suffering, so the parents say. Instead, they tell the children they are going to a grandmother and eat bananas or white bread, which is considered a luxury. I presume that these girls therefore had no idea what was going to happen when they were taken to the circumciser a week before I saw them. And maybe they thought it was going to happen again, now during the ablution ceremony? What does this well-meaning effort to save children from "suffering twice" do to children's faith in adults (cf. Crapanzano, 1992)?

Throwing one's headscarf onto the ground, as Mabintou and the women did before the girls, is a gesture of deep respect and reverence. I had also seen women do this when they wanted to make a profound apology. I was surprised to see the women do this during the ablution ceremony. This is a society with a strict age hierarchy. The young must always show respect for the older and children must obey adults without question. Now, these children were receiving a show of respect from adult women that I had never observed before. Perhaps it was because they

had been obedient and perhaps also because they had suffered. I was comforted by what I witnessed and began to understand that this is hard for the mothers as well. In previous discussions with parents, both women and men, about their concerns for their children when they were to be circumcised, I had received comments such as "that's life" or "it's alright if it's painful". They dismissed my questions with jokes and laughter. I didn't understand at first what their laughter and curt responses were about. I thought they seemed quite indifferent to their children's pain. But when I followed up on what I had seen with my own eyes at the ceremony the circumciser told me that mothers—who, together with their mothers-in-law are responsible for making sure the circumcision is performed—often delay the operation because everyone knows it is painful and risky. Hearing this gave me an awareness of another aspect of the mothers' attitude. I was only now beginning to understand the mothers' anxieties and this made it easier for me to imagine their situation and anguish. Perhaps it also made me more open to actually be able to hear these aspects in their narratives, and, so to say, "read between the lines"?

By participating in the ablution ceremony, I had been forced to examine my own feelings of powerlessness and shame, which were so strong that I felt I had to look away. The fact that I was then part of an adult world that was inflicting all this upon these children put me into a ghastly quandary. The children's fear and the thought of what they had been through made me nauseous. I imagined how terror-stricken I would feel if a part of my own body was going to be cut away while I was powerless against the adults who decided over me and the fear that they would hurt me again. Faced with their fear and crying I was unable to hide behind cultural explanations. The children's experience was something I had not been able to access earlier since the local rules banned me from attending the circumcision ceremony; only circumcised women are allowed to take part. Furthermore, my ethical responsibilities prohibited me from speaking to children about circumcision as I did not know what reactions it might have raised in them.

Does the fact that I had empathized with the children's fear and their mothers' ambivalence mean that I understood how the children actually experienced the operation? Does it mean that I understand what it implies for them to live with this memory? Were my feelings during the ceremony comparable to theirs? There is a risk here of confusing my experience with theirs. My shame was based in my conviction that circumcision is fundamentally a breach of the human rights of

children. However, in discussions with parents and other adults during the fieldwork it became clear to me that while they knew it was a painful and dangerous procedure, it was morally defensible. They were doing this because they cared about their children.

In order to better understand how the children may experience the cutting, I believe we should compare it to practices in our own society that involve pain and fear but are nonetheless done for the best of our children. I do not believe it is helpful to compare these children's experience of circumcision with children who are abused or beaten, which is common in the activist discourse of "mutilation", "child abuse" and "torture". Instead, I suggest we compare their experience with that of children in Sweden who have to deal with pain and fear in relation to operations in hospital or at the dentist. The cultural meaning of the pain afflicted a person matters; pain is never a purely physical experience (Kleinman et al.,1992). Anthropologists have suggested that culturally meaningful pain may be easier to bear than accidental pain (Jackson, 1994; Sachs, 1987). Johansen (2002, p. 331) remains skeptical and points out that "[t]o some extent … cultural meaning may function as a 'filter' that can soften painful experiences. But … [s]ometimes the pain is simply too extreme … and the meaning of the painful experience is itself questioned. Even in situations where pain is experienced as a necessary or acceptable price, personal experiences may still be overwhelming and traumatic…" Importantly, medical research indicates that the body "remembers" pain—it becomes embodied—and new situations involving physical pain "reactivate and amplify embodied pain experiences" (Johansen, 2002, p. 314). This shows the complexity of pain, body, mind and meaning, which, I argue, is equally valid in the case of a Senegalese child going through circumcision as a Swedish child going through a painful medical procedure.

Engagement and professionalism in healthcare

Above, I have described the significance of engagement and reflexivity in order to create ethnographic knowledge and understanding for human vulnerability in a certain context. In this section, we will look into the meaning of feelings and engagement within healthcare for the understanding of patients' suffering. We will then return to the importance of reflexivity and self-knowledge on the part of the care professional to understand the unique person in their particular health situation and context. Healthcare professionals are used to and must deal with ethical

dilemmas when confronted with human suffering in their profession. While engagement and presence are considered essential features of professional care (Skott, 2001), overly personal involvement commonly is deemed unprofessional (Schuster, 2006). However, what is deemed "overly personal involvement" remains unclear and causes tension within and among healthcare professionals. Although the relation between biomedicine with is general focus on cure and nursing with its focus on care is one of complement and they are overlapping practices, the relation is also one of hierarchy where medicine generally is deemed the prioritized knowledge (Bishop & Scudder, 1985; Kleinman, 1995; Mol, 2011; Wolf et al., 2012; Wallström & Ekman, 2018). This implies that the positivistic approach and ideal of objectivity exists as a tension within healthcare, further stressed by "the current trends toward evidence-based practice, with its emphasis, for example, on the measurable, on empirical evidence" (Savage, 2000, p. 331; Skott, 2001). The care scientist Marja Schuster (2006) has written about the ambivalence nurses experience in how they should relate to the private, the personal and the professional in their meetings with patients suffering from cancer. She notes that the nursing profession is characterized by a profound belief in methods that are supposed to help care givers to manage this balance. In her discussions with nursing staff she found that physical contact and listening were cited as *methods* that care givers use to enhance trust in their dealings with patients without establishing too close a relationship with the patient and without involving the nurse in a personal way. Schuster explains that nurses according to these methods use their own bodies as instruments with which to reduce both their own and the patient's bodies to objects. Patients are usually quick to note a failure by a care giver to allow themselves to be moved by their patient's vulnerability and listening and touching is then felt to be simply mechanical. Skott in her ethnographic study of illness narratives at an oncological ward, demonstrates how the biomedical context creates distance through this objectification and the firm roles appointed to care professionals and patients:

> Medical problems are prioritized … In spite of good intentions and awareness of the need of support, the patient is often abandoned since coming too close—to share experience—may be felt as exposing oneself to the disease [Skott, 2013d, p. 151, my translation].

Schuster stresses the importance of the care giver's willingness and courage to meet a vulnerable person using their own life experience as a sounding board. A professional manner, she argues, is not achieved by closing off to the personal but requires that the care giver allows themselves to be moved while remaining aware of their own reactions:

> Being professional is about … leaving one's private space and entering a professional space while still leaving a door open to the personal. Affirmation of personal space in the professional encounter allows for a mutuality between nurse and patient that reduces the asymmetry of the relationship and enables professional self-awareness as well as awareness of the other and this is expressed in an engaged form of care [Schuster, 2006, p. 150, my translation].

Schuster's reasoning finds immediate parallels with the way in which the anthropologist Unni Wikan (1992) describes the concept *resonance.* Like the anthropologist Michael Jackson (1989), Wikan is interested in lived experience in which people recognize themselves in one another and discover similarities despite cultural distance. To achieve this requires more than distancing observations; it demands active and compassionate participation in the lives of others. In physics, the word resonance denotes so-called sympathetic vibration. This means that when a vibrating object comes into contact with another object, the latter begins to vibrate at the same frequency. Unni Wikan uses the concept of resonance metaphorically to describe what happens when people recognize themselves in others; we tune in to one another's emotional frequency. The reasons that certain feelings arise may differ according to cultural context but the feeling itself—of vulnerability, joy, grief, loneliness, pain—is nonetheless recognizable; such as me recognizing the fear the girls in the ablution ceremony experienced and the tension in the mothers. This recognition or resonance, Wikan proposes, occurs because of our own life experience. To understand what is being conveyed "beyond words", it is not sufficient to simply *think* oneself into another person's shoes. Again, besides active listening, personal engagement is needed on the part of the researcher, or care giver to achieve this resonance. Using their own past experience as a frame of reference, the researcher permits themselves to feel—to understand with both thought and feeling, with what Wikan calls *feeling-thought.* This requires that we are able to "dip into the wellsprings of ourselves for something to use as a bridge to others" (1992, p. 471). When our own body begins to quiver with feelings about a

particular incident, present or past, then the encounter may allow us to become the 'sound box' in which recognition and resonance is created. We don't have to have experienced what the other person has experienced; it isn't necessary for the care giver to have had cancer or for the anthropologist to have undergone circumcision in order to be able to find common ground for understanding.

Reflections on the lived body

How could we indeed participate in other people's lives and achieve an understanding without referring to our own life experience? It is, I argue with Wikan, in the interpersonal interaction of an encounter that resonance can evolve; through *thinking-feeling* in close contact with another person recognition occurs. The Cartesian model of embodiment that is at the heart of modern medicine views the body as purely mechanistic, it divides body and soul, which creates problems such as depersonalization (Leder, 1984). Marja Schuster and also Unni Wikan attempt to surmount this model. We learn and understand not only with our "minds" and through thinking but with all our senses, feelings and memories; with our whole body (Skinner, 2010). The concept of the lived body was created by the French philosopher Maurice Merleau-Ponty who revolted against the mechanistic perception of the body as an object for the mind. He argued the contrary: it is through the body that the mind takes shape; body and soul is a functioning *bodyandsoul-unity* that cannot be separated. We *are* our body and it is with our body that we meet the world and the world meets us. Merleau-Ponty advanced the phenomenological concept of intersubjectivity by emphasing that relations are created between *embodied* subjects, in what he termed *intercorporealité*. Through this intercorporealité we can understand something about the other intuitively; this communication often occurs without us being aware of it. Intercorporealité may thus enable a spontaneous understanding between people (Merleau-Ponty, 2004).

Inspired by Merleau-Ponty's phenomenology of "the lived body", Jackson (1989) claims that resonance with other people's experience occurs in the meeting between our bodies' experiences and we may learn about others by using our own body to imitate their behaviour. Working, carrying, sitting, walking, sleeping, eating and dancing as they do enables us, through this intercorporealité, to gain special insights about our common humanity. Carola Skott (2013b) suggests that it is in reflecting on this spontaneous understanding, that we can study implicit embodied knowledge. However, to come to such understanding demands knowledge

of the cultural context and pre-eminently, the researcher's ability to reflect on their own pre-understanding as it is awakened by the particular situation. Wikan's and Jackson's phenomenological approaches present the challenge of knowing if the way in which the ethnographer experiences the situation actually captures how people in the particular fieldsite are experiencing and interpreting it.

When one's own feelings get in the way

We now turn to the importance of reflexivity and awareness of one's own pre-understanding, as there is, of course, an acute risk of unreflectively taking one's own feelings to be the other's. Savage (2000, p. 333) emphasizes that the body of the researcher is "not a tabula rasa on which the experiences of others could be drawn, unsullied by those of the researcher" and that to assume "that the sheer fact of embodiment allows one to inhabit the world of the Other, is to reduce cultural body to biological organism" (ibid., p. 332). Savage (2000) warns against a naive understanding of Jackson's *radical empiricism* (as he calls his approach), but is convinced of engagement and participative observation as valuable methodologies to translate others' lived experience and learn about embodied, tacit knowledge—if the researcher reflects on the limits and conditions for this understanding. Significantly, we are always interpreting our experiences in relation to our own cultural, social and historical context. This is the reason, why I, for instance, cannot take for granted that the girls in the ablution ceremony—besides the fear that I could recognize—experienced, i.e. interpreted the situation exactly as I did, as my profound pre-understanding is that what is cut (the clitoris) should not be cut. In emotional situations, if we open up for the feelings they awaken, our own life experience can mislead us into confusing our experience with that of the other. Instead of resonance, *misresonance* (Wikan, 1992, p. 479) may result; the ethnographer may find similarities where there are none. In the same way, contact with a patient's suffering may lead to *misguided care* (in Swedish, *urartad omsorg*) if the care giver's own pain gains priority (Schuster, 2006). Engagement in suffering requires courage and will power. When we expose ourselves to the suffering of others we allow ourselves to be moved, and to experience grief, pain and suffering ourselves. Schuster (2006) claims that the care giver has an existential duty to open up for these feelings, yet remain critically aware of them. *Misresonance* and *misguided care* leave no space for the other's experience. When this happens, that the ethnographer or care giver unreflectingly interpret their own feelings as though they were

those of the other person, they consequently learn neither about the other nor about themselves.

Cultivating an ethnographic gaze to counter misguided care

In today's culturally, religiously and socially heterogeneous Sweden, care givers encounter people with widely varying ways of understanding the body, health and care. Female genital cutting is one example of this kind of variation. Women who have gone through a genital cutting have many experiences of, what we can call *misguided care*—in spite of carers' good intention: healthcare givers' general lack of knowledge on the practice, and providers' own emotions and interpretations of the same, and lack of technical skills to provide quality care for these women (Berggren, Bergström, & Edberg, 2006; Johansen, 2006; Jordal & Wahlberg, 2018). To hinder *misresonance*, Wikan stresses the importance of trying one's interpretations out with those one is trying to understand, and of "giving people the opportunity to point out that you are totally wrong" (1992, p. 479, footnote 19). The general lack of dialog within healthcare and the failure of not leaving room for the patient to formulate their own explanatory models and needs are well-documented (Ekman, 2011; McCormack & McCance, 2010; Wolf, Ekman, & Dellenborg, 2012). Both ethnographer and care giver need to remain open to the person in front of themselves, prepare time and place for the person's own narrative and listen attentively, while remaining aware of how their own pre-understandings are activated as they listen. Although it is not possible for healthcare professionals to do ethnographic fieldwork in each patient's own life context, they may be helped in their care practice by cultivating what I here have called an ethnographic gaze.

Arthur Kleinman (1988), an American medical anthropologist and psychiatrist, has developed a guide to open-ended questions that aims at facilitating cross-cultural communication by assisting care givers in reconstructing the patient's narrative ethnographically—a sort of "mini-ethnography" (see also Kleinman & Benson, 2006). In a complement to the medical focus, Kleinman's mini-ethnography concentrates on the patient's (and, when relevant, the family's) own explanatory model. The aim is to create an open dialog in which different cultural understandings of health and illness may be revealed as well as socio-economic factors interfering with the patient's possibilities of, for instance, following ordination. With this knowledge as starting point, the care giver, in dialog with the patient and, when relevant, their relatives, uses their medical and care expertise to plan for the

care of the patient. However, to develop an ethnographic gaze, dialog is not enough. Without a methodology that supports the care giver's awareness of their own spontaneous interpretations, care might become inappropriate.

Conclusion: An ethic in practice

In the narrative above, of the ablution ceremony, I describe how I used the methodology of ethnography—an ethnographic gaze—in a striving to understand what is going on "on the ground", what is actually happening to these children and their mothers, and what it means to them. Cultivating an "ethnographic gaze" among healthcare providers, I suggest is central for the development of a person-centred care, that is, a care ethic that urges healthcare professionals to change the focus from the disease within the person to the person with the disease (Ekman et al., 2011; McCormack & McCance, 2010; Zhao et al., 2016), and in which relationality is seen as fundamental (Edvardsson et al., 2020). Turning back to the French philosopher Paul Ricoeur's (1994, p. 172) ethical intention: "*aiming at the 'good life' with and for others, in just institutions*"—in the current era of corporate managerialism and economic steering that focus on efficacy as the prime objective for care, the cultivation of the ethnographic gaze significantly needs to be embraced by politicians and healthcare management leaders in order to develop healthcare organizations into just institutions that support and make it possible for healthcare professionals to counteract misresonance and misguided care in their daily care practice.

References

Agence Nationale de la Statistique et de la Démographie (2018). *Enquête Démographique et de la Santé Continue (EDS-Continue) 2017*, Dakar.

Berggren, V., Bergström, S. & Edberg, A.K. (2006). Being different and vulnerable: experiences of immigrant African women who have been circumcised and sought maternity care in Sweden. *Journal of Transcultural Nursing, 17*, 1, 50–57.

Bishop, A. H., & Scudder, J.R, Jr. (Eds.). (1985). *Caring, curing, coping. Nurse, physician, patient relationships*. Tuscaloosa: The University of Alabama Press.

Borneman, J., & Hammoudi, A. (2009). The fieldwork encounter, experience and the making of truth. In A. Hammoudi, J. Borneman (Eds.). *Being there: The fieldwork encounter and the making of truth*. Berkeley: University of California Press.

Clifford, J., & Marcus, G.E. (1986). *Writing culture: the poetics and politics of ethnography. A School of American Research advanced seminar*. Berkeley: University of California Press.

Collins, P., & Gallinat, A. (2010): *The ethnographic self as resource: Writing memory and experience into ethnography*. New York: Berghahn Books.

Crapanzano, V. (1992). *Hermes' dilemma and Hamlet's desire: On the epistemology of interpretation*. Cambridge: Harvard University Press.

Dellenborg, L. (2004). A reflection on the cultural meanings of female circumcision. Experiences from fieldwork in Casamance, southern Senegal. In S. Arnfred (Ed.), *Rethinking African Sexualities* (pp. 79–97). Uppsala: Nordic Africa Institute.

Dellenborg, L. (2007). *Multiple meanings of female initiation: Female "circumcision" among Jola women in Casamance, southern Senegal*. Doctoral dissertation. School of Global Studies, Department of Social Anthropology, University of Gothenburg.

Dellenborg, L. (2009). From pain to virtue—clitoridectomy and other ordeals in the creation of a female person. In A. Schlyter (Ed.) *Body politics and women citizens—African experiences* (pp. 93–101). Stockholm: Sida.

Edvardsson, D., Baxter, R., Birkett, P., & Dunlop, A. (2020). Supporting lives lived whilst protecting lives saved during COVID-19: The relational invariant in person-centred care. *Nordic Journal of Nursing Research*, *40*, 2, 61–63.

Ekman, I., Swedberg, K., Taft, C., Lindseth, A., Norberg, A., Brink, E., et al. (2011). Person-centered care: Ready for prime time. *European Journal of Cardiovascular Nursing*, *10*, 4, 248–251.

Jackson, M. (1989). *Paths toward a clearing. Radical empiricism and ethnographic inquiry*. Bloomington: Indiana University Press.

Jackson, J. (1994). Chronic pain and the tension between the body as subject and object. In T.J. Csordas (Ed.), *Embodiment and experience: The existential ground of culture and self*. Cambridge: Cambridge University Press.

Johansen, R.E.B. (2002). Pain as a counterpoint to culture: Toward an analysis of pain associated with infibulation among Somali immigrants in Norway. *Medical Anthropology Quarterly, 16*, 3, 312–340.

Johansen, R.E.B. (2006). Care for infibulated women giving birth in Norway: An anthropological analysis of health workers' management of a medically and culturally unfamiliar issue. *Medical Anthropology Quarterly*, *20*, 4, 516–544.

Jordal, M., & Wahlberg, A. (2018). Challenges in providing quality care for women with female genital cutting in Sweden—A literature review. *Sexual and Reproductive Health Care, 17*, 91–96.

Kleinman, A. (1988). *The illness narratives: Suffering, healing, and the human condition*. New York: Basic Books.

Kleinman, A. (1995). *Writing at the margin. Discourse between anthropology and medicine*. Berkley: University of California Press.

Kleinman, A., & Benson, P. (2006). Anthropology in the clinic: The problem of cultural competency and how to fix it. *PLoS Medicine*, *3*, 10, 1673–1676.

Kleinman, A., Del Vecchio Good, M.-J., Brodwin, P.E., & Good, B.J. (1992). Pain as human experience: Introduction. In M.-J. Del Vecchio Good, B.J. Good, P.E. Brodwin, A. Kleinman (Eds.), *Pain as human experience: An anthropological perspective* (pp. 1–28). Berkeley: University of California Press.

Leder, D. (1984). Medicine and paradigms of embodiment. *The Journal of Medicine and Philosophy*, *9*, 1, 29–43.

Malmström, M.F. (2019). *The streets are talking to me. Affective fragments in Sisi's Egypt*. Oakland, California: University of California Press.

McCormack, B., & McCance, T. (2010). *Person-centred nursing: Theory and practice*. Chichester: Blackwell Pub.

Merleu-Ponty, M. (2004 [1962]). *Phenomenology of perception*. London: Routledge & Kegan Paul.

Mol, A. (2011). *Omsorgens logik. Aktiva patienter och valfrihetens gränser* [The logic of care. Health and the problem of patient choice]. Lund: Arkiv förlag.

Ricoeur, P. (1994). *Oneself as another*. Chicago: Chicago University Press.

Sachs, L. 1987. *Medicinsk antropologi* [Medical anthropology]. Stockholm: Liber.

Savage, J. (2000). Participative observation: Standing in the shoes of others? *Qualitative Health Research*, *10*, 3, 324–339.

Schuster, M. (2006). *Profession och existens. En hermeneutisk studie av asymmetri och ömsesidighet i sjuksköterskors möten med svårt sjuka patienter* [Profession and existence. A hermeneutic study of asymmetry and reciprocity in nurses' encounters with severely ill patients]. Göteborg: Daidalos AB.

Scott-Jones, J., & Watt, S. (Eds.). (2010). *Ethnography in social science practice*. London Routledge.

Skinner, J. (2010). Leading questions and body memories. In P. Collins, A. Gallinat (Eds.), *The ethnographic self as resource: Writing memory and experience into ethnography*. New York: Berghahn Books.

Skott, C. (2001). Caring narratives and the strategy of presence: Narrative communication in nursing practice and research. *Nursing Science Quarterly*, *14*, 3, 249–254.

Skott, C. (2013a). Etnografins uppdrag i vård och drama [Ethnography's assignment in care and drama]. In C. Skott, L. Dellenborg, M. Lepp, K. Nässén (Eds.) *Människan i vården. Etnografi, vård och drama* [People in healthcare: ethnography, care and drama]. Stockholm: Carlssons.

Skott, C. (2013b). Beskriva, tolka och förstå—etnografins metodologi [Description, interpretation and understanding—the methodology of ethnography]. In C. Skott, L. Dellenborg, M. Lepp, K. Nässén (Eds.) *Människan i vården. Etnografi, vård och drama* [People in healthcare: ethnography, care and drama]. Stockholm: Carlssons.

Skott, C. (2013c). Symptomets sammanhang: en etnografisk undersökning [The symptom's bearing—an ethnographic enquiry]. In C. Skott, L. Dellenborg, M. Lepp, K. Nässén (Eds.) *Människan i vården. Etnografi, vård och drama* [People in healthcare: ethnography, care and drama]. Stockholm: Carlssons.

Skott, C. (2013d) Berättelser på en vårdavdelning [Narratives in a hospital ward]. In C. Skott, L. Dellenborg, M. Lepp, K. Nässén (Eds.) *Människan i vården. Etnografi, vård och drama* [People in healthcare: ethnography, care and drama]. Stockholm: Carlssons.

Smith, E.I. (2006). "The body in pain": An interview with Elaine Scarry. *Concentric: Literary and Cultural Studies, 32*, 2, 223–237.

Stevenson, L. (2009). The suicidal wound and fieldwork among Canadian Inuit. In J. Borneman, A. Hammoudi (Eds.), *Being there: The fieldwork encounter and the making of truth* (pp. 55–76). Berkeley: University of California Press.

Stoller, P. (1989). *The taste of ethnographic things: The senses in anthropology*. Philadelphia: University of Pennsylvania Press.

van der Geest, S., & Finkler, K. (2004). Hospital ethnography: Introduction. *Social Science & Medicine*, *59*, 10, 1995–2001.

Wallström, S., & Ekman, I. (2018). Person-centred care in clinical assessment. *European Journal of Cardiovascular Nursing, 17*, 7, 576–579.

Wikan, U. (1992). Beyond the words: The power of resonance. *American Ethnologist, 19*, 3, 460–482.

Wolf, A., Ekman, I., & Dellenborg, L. (2012). Everyday practices at the medical ward: a 16-month ethnographic field study. *BMC Health Services Research*, 12: 184.

Young, K. (1997). *Presence in the flesh: The body in medicine*. Cambridge: Harvard University Press.

Zhao, J., Gao, S., Wang, J., Liu, X., & Hao, Y. (2016). Differentiation between two healthcare concepts: Person-centred and patient-centred care. *International Journal of Nursing Sciences*, *3*, 398–402.

Emmaleena Käkelä

Rethinking Female Genital Cutting: From a Culturalist to a Structuralist Framework for Challenging Violence Against Women

Introduction

Since the beginning of the international campaign against it, not only Female Genital Cutting (FGC) but also the way these practices should be challenged has been subject to considerable debate. This chapter contributes to this debate by arguing for the need to move beyond culturalist explanations of FGC as they overlook the sociological complexity of violence against women. This chapter discusses the findings of qualitative research which has interrogated the continuation of FGC in Scotland from a migration perspective. By tracing FGC-affected women's trajectories of violence through their journeys from the Global South to the Global North, the findings illustrate the shared global failures in recognizing how FGC is rooted in and sanctioned by the systematic, intersectional discrimination of women. In an effort to challenge simplistic representations of migrant women's journeys from the patriarchal South to the emancipatory West, this chapter traces the societal conditions which perpetuate violence and trauma in the lives of displaced women. In doing so, the chapter demonstrates the possibilities that adopting a structural inequality perspective can provide for challenging both FGC-practices and the colonial representations of the anti-FGC discourse.

Tensions in constructing FGC

Since the 1970s, Western feminists have not only taken the lead in challenging Female Genital Cutting (FGC), but also in largely defining the terms in which the practice has and continues to be condemned. Early feminist activism framed FGC in terms of patriarchal hegemony and sexual politics and, still today, the practice is considered to be an extreme form of discrimination against women (Obiora, 1997; WHO, 2018). Western feminist opposition was marked by a commitment to global sisterhood, which has been critiqued for conveying "a sense of entitlement to define African women's interests, intervene on their account and dismiss their resistance" (Wade, 2011, p. 39). Western feminists assumed the duty to speak for their "mutilated sisters" (Daly, 1978, p. 101), constructing a simple binary between male perpetrators and female victims whom they perceived as being "mentally castrated" (Daly, 1978, p. 106) and as prisoners of ritual (Lightfoot-Klein, 1989). In doing so, feminists produced an image of a woman who for reasons of her gender is sexually constrained and, as being from the "Third World," is traditional, poor, and "still-not-conscious-of-her-rights" (Mohanty, 1984, p. 352). The influence of these feminist constructions of FGC-affected women can still be seen in the legislation of many Western countries, which set widely different standards for genital modifications depending on women's ethnicity (Johnsdotter & Essén, 2010).

It has been argued that "campaigns against FGM, which have relied heavily on demonization, have picked up where European colonial missionaries left off" (Mutua, 2001, p. 226). By culturalizing violence, radical feminists turned FGC into a symbol of the savagery and backwardness of Third World cultures (Volpp, 2001). These representations live on in modern public discourse, where accounts describing FGC in terms of barbarity and torture have become more the rule than the exception. By disproportionately emphasizing the most extreme manifestations of FGC, the popular discourse evokes images of African barbarism which Western audiences have consumed since the time of the Empire. In doing so, the international campaign against FGC has partaken in the neo-colonial project to reinforce inequalities between the Global North and the Global South. The global community began addressing FGC as a health issue, assuming that the practice would end when affected communities were made aware of its health consequences (Shell-Duncan, 2008). Blaming the continuation of FGC on blind adherence to tradition bears uncomfortable resemblance to the colonial stereotyping of backward Africa.

The prevailing human rights approach has the same undertones; the discourse on universal human rights has enforced the notions of FGC as inhumane and of practicing communities as lacking humanity, whilst remaining largely uncritical of the lack of meaningful participation from non-Western countries in the creation of the global human rights corpus (Mutua, 2001).

Western feminists argued that "beyond racism is sisterhood, naming the crimes against women without paying mindless respect to the 'social fabric' of the various androcratic societies" (Daly, 1978, p. 111). In contrast, Black feminists have called for contextual analysis of women's subjugation, arguing that for Black women, "beyond sisterhood there is still racism, colonialism and imperialism" (Mohanty, 1984, p. 348). Religio-cultural explanations of FGC have been criticized for concealing the structural forces which play part in shaping gender-based violence (McKerl, 2007):

> To fight against genital mutilation . . . without questioning the structures and social relations which perpetuate this situation is like 'refusing to see the sun in the middle of the day.' [Association of African Women for Research and Development in Lewis, 1995, pp. 32–33].

Black feminists have located gender subjugation in the context of wider societal conditions and global interconnections, calling for intersectional analysis of women's vulnerability (Abu-Lughod, 2002; Abusharaf, 2000; Crenshaw, 1991). Black feminists have argued that violence against women is shaped not only by gender but also other axes of difference, including race and class (Abusharaf, 1995, 2000; Crenshaw, 1991; Mohanty, 1984). Rather than placing FGC at the pinnacle of the hierarchy of oppressions, Black feminism has reconfigured FGC as a "symptom rather than a cause of women's troubles in a society" (Abusharaf, 2000, p. 156). It has been argued that women will not openly resist FGC, if doing so compromises their own material security (Abusharaf, 1995). Therefore, rather than to begin with women's sexual liberation, which played a prominent part in Western second-wave feminist agenda, African feminists have approached FGC by strengthening women's social, economic, and political standing in society in order to give women themselves the weapons to fight FGC (El Amin in Abusharaf, 2000, p. 158). This call for a structural analysis of FGC is not new; since the beginning of the global movement Black scholars have asserted that FGC should be treated not as an isolated phenomenon, but should be located in the context of women's

wider welfare needs, including access to resources, control over food production and financial independence (Women's Caucus of African Studies Association, 1983). Regardless, although programs such as Tostan have adopted a more holistic approach to address FGC as part of women's overall empowerment, the role of women's wider socio-economic subjugation, or Western complacency in this has rarely been recognized in the public discourse.

Anthropologists have also called for a structural analysis of FGC, arguing that women's participation needs to be analyzed in terms of women's social and economic vulnerability (Gruenbaum, 1982). Research has tied FGC to women's socio-economic survival by illustrating women's dependency in marriage for long-term security (Gruenbaum, 2001). It has also been framed as a strategy for accessing social capital, as uncut women face bullying, restricted access to resources, and exclusion from attending and participating in social functions (Bettina Shell-Duncan, Wander, Hernlund, & Moreau, 2011). Contexts of poverty and underdevelopment make people heavily reliant on social networks, thus making FGC a matter of survival also in a very different sense than the anti-FGC imagery often suggests (Gruenbaum, 1982; Bettina Shell-Duncan et al., 2011). Social researchers have argued for the need to reframe FGC-affected communities as active cultural agents who have the potential to not only reaffirm but also negotiate practices and values (Gruenbaum, 1996; Hernlund & Shell-Duncan, 2007; Johnsdotter, Moussa, Carlbom, Aregai, & Essén, 2009). Reconceptualizing FGC from deviance to strategy resists the dominant representations of affected women by recognizing the agency women exercise within patriarchal structures, as "mothers choosing female circumcision for their daughters in a specific situation are doing this to optimise their daughters' future prospects" (Johnsdotter & Essen, 2016, p. 20).

Although Black feminists and anthropologists have been participating in this debate since the start of the global anti-FGC campaign, these perspectives are regularly overlooked in favor of a more sensationalist narrative. The public debate continues to construct practicing communities as "bearers of tradition," conveying an imagery of a hidden, pervasive practice (Johnsdotter et al., 2009, p. 130). Research suggests, however, that the process of cultural change in relation to FGC is underway both in Africa and among diasporic communities (Gele, Johansen, & Sundby, 2012; Gruenbaum, 1996; Johnsdotter et al., 2009).

FGC in Scotland

Along with many European countries, Scotland lacks reliable estimates for the prevalence of FGC. The national anti-FGC campaign has been informed by research that estimates there to be around 24,000 "potentially affected" men, women, and children who had been born in FGC-practicing countries, living in Scotland (Baillot, Murray, Connelly, & Howard, 2014). As the authors themselves note, however, whilst this estimate can guide prevention work, the inclusion of men, and the inability to control for factors such as ethnicity and the influence of migration mean that the estimate has to be interpreted with caution (Baillot et al., 2014). There has been limited research on FGC in Scotland, and existing studies have primarily focused on health consequences, attitudes, and experiences of FGC (Mhoja, Azong, & Lawson, 2010; O'Brien, Baldeh, Hassan, & Baillie, 2017). To date, there has been no FGC prosecutions in Scotland. Furthermore, between April 2013 and September 2016, there were 52 referrals or child welfare concerns made to the police regarding FGC, but investigations revealed cutting had not occurred in any of the cases (Scottish Government, 2019). Regardless of lack of evidence and prosecutions, there has been a growing narrative of FGC being on the rise in Scotland. This trend is encompassed by newspaper headlines such as "Female Genital Mutilation 'rising in soft-touch Scotland'" (Adams, 2013), "Scotland has to wake up to reality of FGM abuse" (Scotsman, 2017) and "Glasgow midwife sees 150 FGM cases a year" (*The Times*, 2017). A closer scrutiny of these headlines, however, shows that they rely on anecdotal evidence and, in the case of the last headline, the increase in the number of migrant women who have undergone FGC before their arrival to Scotland. Regardless, the hypervisibility which has been afforded to FGC has built considerable political pressure and public outrage to prosecute perceived perpetrators of the practice. Much like in the Scandinavian discourse on FGC (Johnsdotter, 2019), the lack of prosecutions in Scotland has often been attributed to the hidden nature of the practice and the complacency of statutory services, rather than to cultural change among migrant communities.

Researching FGC through a structural inequality framework

This chapter discusses a PhD study which examined FGC and cultural change in Scotland from a migration perspective. The research built on the limited evidence on FGC in Scotland by interrogating how migration and resettlement conditions

shape women's vulnerability and experiences of violence. The violent experiences which the research captured are not limited to FGC and other forms of inter-personal harm; this chapter further describes women's interlinked experiences of structural violence, that is state facilitated forms of violence that prevent women from meeting their basic needs (Canning, 2017; Galtung, 1969). Following Johan Galtung's definition, for the purposes of this research structural violence is defined as "the cause of the difference between the potential and actual, between what could have been and what is" (1969, p. 168). The conceptual framework of the research has been informed by anthropological and Black feminist conceptualizations of FGC as a strategy and the affected communities as cultural actors whose behaviors respond to the wider social conditions and institutional settings. The analysis has drawn from Kimberlé Crenshaw's work on structural intersectionality (1991) and Liz Kelly's conceptualization of conducive contexts (2007). These have been particularly useful for conceptualizing how FGC-affected women's positions at the crossroads of race, class, culture, and immigration status can place them simultaneously at a greater risk of violence and at a further disadvantage in seeking help for their situations. Rather than to dismiss culture as unimportant in the continuation of FGC, these analytical concepts have informed the analysis in moving beyond community attitudes to exploring the social, economic, and political conditions which facilitate women's exploitation and violence against women.

The findings presented in this chapter were derived from a sub-sample of FGC-affected adult women who participated in individual and focus group discussions during the spring of 2018 in Glasgow, Scotland. The nine women originated from Sudan (n=2), Nigeria (n=3), Malawi (n=3) and The Gambia (n=1), and their stay in Scotland ranged from three to fifteen years. The limited previous research on FGC in Scotland led to a selection of a culturally diverse sample over focusing on one national group. Rather than to undermine the cultural intricacies which are often overlooked in discourses about "Africa," the diverse sampling proved fruitful in facilitating detailed reflections on women's vulnerability, as the participants readily compared differences between cultures and women's positions in different countries. In addition to the interviews with FGC-affected women, this chapter draws from two of the nine key informant interviews which were conducted as part of the study. The interviewed key informants worked in women's support organizations that engaged in FGC-awareness raising and support work with women who had experienced gender-based violence.

All interviewed women disclosed that they had been subject to either some degree of cutting or elongation/stretching of the labia. The inclusion of elongation under the umbrella of "FGM/C" has been debated; it has been argued that elongation does not constitute mutilation and thus should not be targeted through human rights legislation as a form of violence against women and children (Bagnol & Mariano, 2008). The decision to include elongation in this chapter is two-fold; first, all the interviewed women who had experienced elongation viewed themselves as victims of "FGM." Second, as the next sections highlight, the research identified considerable similarities in both the reasons that underpin the continuation of cutting and elongation, and the wider conditions which sustained women's vulnerability to these practices. I argue that disregarding elongation on the basis of lesser health consequences inadvertently reaffirms the discourse of barbarity that authors including Bagnol and Mariano (2008) strive to challenge; using the yardstick of "mutilation" as an inclusion criterion conveys a hierarchical construction of gender-based violence whereby FGC manifests an extreme form of violence against women. This approach dismisses women's intersectional vulnerability and continuums of violence (Kelly, 1987). Rather than constructing violence as a single episode, this chapter locates different forms of FGC on a continuum of control over women's bodies and livelihoods (Kelly, 1987). It has also been argued that women's decision to participate in both cutting and elongation can manifest their agency and sexual determination (Bagnol & Mariano, 2008; Njambi, 2011). Rather than to dismiss these diverse meanings, this chapter advocates a conceptualization of women's agency that goes beyond the binaries between empowerment and oppression to accommodate the role cutting and elongation play in women's negotiations of patriarchal values and structures.

Before commencing the data collection, the research was granted ethical approval from the University of Strathclyde Ethics Committee. All participants gave written informed consent to be interviewed by the researcher. As part of this consent process, all participants were informed about the law on FGC in Scotland and the researcher's ethical responsibility to report any disclosures of imminent risk of FGC or other forms of violence. Although the interview questions framed FGC as a cultural practice rather than as a form of violence against women, these steps made it unlikely for participants to express favorable opinions about FGC. During the data collection FGC was introduced as a topic of interest following the increased media and policy attention towards these practices in Scotland. Questions

on FGC broadly focused on community attitudes and women's perceptions of what factors influenced these attitudes in different contexts. The interviews and focus groups focused on women's experiences of migration and resettlement and the participants were asked to reflect on the changing role of culture in their lives and how moving to Scotland had influenced family relationships, gender roles, and cultural practices such as FGC. This comparative focus on women's lives before and after migration encouraged the participants to locate FGC in the wider context of women's rights, opportunities, and position within family and society. Further, as illustrated in the next sections, the wider research focus on changing culture and relationships directed many of the participants to discuss FGC in the context of other forms of gender-based violence and abuse. Additionally, the key informant interviews focused on participants' perspectives on the cultural and resettlement challenges affecting African migrant communities in Scotland. FGC was discussed as part of this, in the context of asylum applications, changing gender roles, and community attitudes.

The key informant interviews were semi-structured and were held at the participants' places of work. The interviews with migrant women were also semi-structured, in order to give the participants an opportunity to direct the discussion to the topics which they perceived had crucially influenced their experiences. This flexibility afforded the participants more control over how, and at what stage, they chose to reflect on their personal experiences of violence, displacement, and loss, resulting in a more cathartic approach to addressing deeply personal and difficult experiences. The interviews were conducted in English and held in a third-party location the women attended regularly in order to provide a safe space for disclosure. This third-party provider had previously organized FGC-awareness workshops which all the women had attended. This meant that the interviewed women had already formulated a negative opinion about FGC, as the awareness-raising work had heavily informed their conceptualizations of FGC as gender-based violence. However, as these workshops had mainly focused on cultural attitudes and health complications arising from FGC, it is nevertheless likely that the participants' emphasis on locating FGC in the wider social, economic, and political contexts was informed by their own experiences rather than these workshops. Crucially, addressing FGC with women who already had prior knowledge of these practices meant that the women had had the opportunity to begin to make sense of their own experience of FGC. As discussed later in this chapter, realization

about the different meanings attached to FGC can be traumatizing to women who are suddenly faced with the task of recrafting their identity in relation to gender and culture. Overall, whilst this sampling procedure influenced the data, it crucially enabled me as an "outsider" to gain insight into personal experiences, which many previous studies have explored by using community interviewers.

By reflecting migrant women's trajectories of violence from the Global South to the Global North, this chapter will illustrate the ways women's experiences of FGC are shaped by intersecting inequalities before and after migration. The following sections will illustrate the complex ways institutionalized and normalized gendered inequalities perpetuate violence and trauma in the lives of FGC-affected women. The first part of the chapter reflects women's accounts of violence and vulnerability before migration, problematizing the usefulness of addressing FGC solely through a culturalist framework. The second part illuminates how Western structures can also be complicit in perpetuating harm in the lives of FGC-affected women. By reflecting women's experiences at the aftermath of violence, the chapter begins to untangle what structural perspective can offer for developing our understanding of FGC in migration contexts.

Structural causes of violence against women

In the focus group discussions, gender-based violence and gendered inequalities were central in women's narratives about their pasts. All women discussed their experience of FGC in relation to other forms of gender-based violence that had contributed to their subordination within their families and community. Other forms of violence, including child and forced marriage, domestic abuse, and rape had preceded, accompanied, and directly followed their experiences of FGC. Therefore, whilst I do not intend to conflate FGC with other forms of gender-based violence as their dynamics are distinct, throughout this chapter I will draw parallels across the conditions which maintain women's vulnerability to these different forms of violence.

In line with existing research, women discussed how normative constructions of womanhood and female sexuality came to legitimize FGC. In different communities, FGC was associated with beauty, cleanliness, respect, and longevity of marriage. Regardless of the type, resistance to FGC mandated bullying, social exclusion, and harassment. The pressure to undergo FGC was experienced from multiple directions within and outwith the family, including from female peers who

constructed FGC, marriage, and childbirth as transition points which demarcated boundaries of friendship groups. In the case of FGC, and particularly elongation, being excluded from friendship groups contributed to the pressure for girls to start stretching their labia. Although women had done this to themselves, they had been instructed and pressured to elongate their labia by older women at a young age. Whilst the different FGC practices were said to make women marriageable for different reasons through impacting premarital and marital relationships, participants described elongation and cutting in similar terms. First, both practices were said to enforce restrictive gender roles; cutting was said to curb premarital relations by constraining sexual desire and preventing access, whereas elongation formed part of initiation rituals which informed girls in assuming their culturally prescribed roles as submissive wife and caregiver. Second, cutting was said to make women marriageable by ensuring virginity, whereas elongation was described as a strategy for ensuring lasting marriage through heightened male sexual satisfaction. Crucially, these restrictive gender roles and the cultural and socio-economic significance of marriage also underpinned women's sustained vulnerability to other forms of violence. The gendered cultural and material restrictions which women experienced within the family and society acted as a justification for other forms of violence, as women's conformity to marital rape and domestic violence was constructed as a "normal" part of woman's role as a wife.

Crucially, the cultural values underpinning FGC were not discussed in isolation, but all women situated FGC and other forms of violence against women in the context of women's wider socio-economic dependency. Women's focus on reflecting on FGC in the context of gendered inequalities was likely informed by their experience of the asylum process. As further discussed in the next section, most of the women had made derivative asylum claims to protect their daughters from FGC, which had required them to provide evidence of the barriers to mobility, protection, and independence they would face if returned to their countries of origin:

> They [UK Home Office] say I can go back home and go stay in another city or in another area, where I can't get in contact with my partner's family. But I say to them, in Malawi, you need family, family we help each other, nobody else can help you. (Star, Malawian woman)

Having undergone FGC after being married into a practicing family at the age of fourteen, Star endured prolonged abuse by her husband and his sisters until she fled from Malawi to the UK. In discussing her on-going asylum application, Star illustrates the ways social and economic conditions converge, leaving women vulnerable to culturally normative forms of violence; in contexts of limited welfare provision and pronounced gendered labor market inequalities, resistance to FGC can be exercised only at the expense of women's socio-economic survival. Situating FGC in the context of wider socio-economic injustices allows us to see women's compliance with violence as a choice, but not of their own choosing (Kelly, 2007). The limited opportunities for women to gain financial independence maintain women's dependency in the family unit and, thus, the forms of violence marking established age-based and gendered hierarchies. This financial dependency also constrained women's help-seeking opportunities:

> Living in the other city is difficult, it's not like moving from Edinburgh to Glasgow and I'll be okay. If I want to move, I have to go meet the owner of that land and tell them why I am there. But it doesn't matter, that man will say, if you want to live with us, you must pay and then we will give you this land to stay. But even then, I won't be safe. (Joyce, Malawian woman)

As Joyce argues, the wider disregard for gender-based violence, together with lack of established safe havens, forces women to pay for their own protection, creating further barriers to help-seeking. This was also discussed in relation to other financial transfers, including bride price, which was described as a barrier to family support. Women related how, in patrilocal contexts, the custom of bride price could become both a "ticket for abuse" for the husband, and a symbol of departure from the paternal family, leading them to turn away daughters who are fleeing from domestic violence. This happened to Star, whose family told her to return to her husband when she first tried to flee abuse. In her case, the cultural stigma surrounding divorce and women's financial dependency converged to sustain her inability to survive independently from her husband's family, which had perpetuated FGC and continued to abuse her.

In addition to economic dependency, the participants also described the prevailing political conditions that undermine women's abilities to challenge FGC in either private or public spheres. The women argued that the lack of national (and

in the case of Malawi, international) recognition of the existence of FGC limited women's abilities to resist the practice:

> In Malawi, they don't accept that FGM is being practiced. But it is being practiced in the villages where we come from. The police will tell you no, it's not done here, but it's happening. (Star, Malawian woman)

In countries such as Nigeria, where FGC has been outlawed, women argued that the wider disregard for "women's issues" had sustained the continuation of FGC by shifting the practice underground. The participants argued that the exclusion of FGC and other forms of gender-based violence from the political priorities not only undermine national efforts to end violence against women, but further limits women's help-seeking opportunities in the private sphere:

> If you are a rich person you can do FGM on your child… if you're a wife of a rich man and the husband wants you to do the FGM, but you are not going to do it and you are going to call the police, then even the police will leave it, or you may be in prison at the end of the day. You may be victimised. It's lawless. (Chibundu, Nigerian woman)

Chibundu described widespread corruption as a barrier to state protection. This was compounded by prevailing perceptions about gender-based violence as a private matter which meant that women not only had little to gain in seeking help from the authorities, but by doing so could in fact expose themselves to further violence, imprisonment, and victimization. This suggests that the silence surrounding FGC is not only a cultural issue but is maintained through the normalization of gender-based violence, which represses women's calls for action. Women's accounts locate FGC in the context of "multi-layered and routinised forms of domination that often converge in women's lives, hindering women's ability to create alternatives to the abusive relationships" (Crenshaw, 1991, p. 1245). Focus on women's wider subordination explains why some women continue conforming with FGC or at least will not openly resist the practice if doing so endangers them further. This highlights the need for more nuanced conceptualizations of women's agency and participation, as their actions do not exist in a vacuum, but are instead exercised both in relation to and as a response to specific conditions.

Reflecting FGC-affected women's experiences through an intersectional lens casts light on the social, political, and economic structures that make the position

of women at the crossroads of gender, class, and culture one of vulnerability and multi-dimensional subordination. As argued by Rogaia Abusharaf, "women are not merely subordinated because their genitals have been excised, in other words not because of the practice itself, but because of the values, ideologies, and the politics attached to the practice" (1995, p. 53). The participants' accounts of barriers to help-seeking demonstrate how women's inferiority is deeply ingrained in the economic and political spheres, legitimizing and naturalizing violence against women. Women's accounts illuminate the way corruption, police violence, poverty, and women's financial dependency create a conducive context (Kelly, 2016) for violence against women, including FGC. This suggests that challenging FGC necessitates moving beyond community education and awareness-raising to dismantling the social, political, and economic barriers women face in challenging their own situations.

Structural violence in the asylum system

For the participants, relocation to the UK offered critical distance to the peer and family pressures maintaining FGC and other forms of violence against women. Although some women had heard anecdotal accounts of FGC continuing in other parts of the UK, or children being taken to be cut in their countries of origin, none of the women considered their own daughters to be at risk in Scotland. Nevertheless, women's experiences of resettling to Scotland challenge the assumption of their migration trajectories from Global South to Global North as journeys from oppression to emancipation. Rather, seeking asylum in the West became characterized as the lesser of two evils:

> I would sacrifice anything, I don't mind Home Office taking me to detention, but I prefer that than my children to be cut. And I am ready for that. Even the Home Office would take me to jail for life, I am fine with that, but my children will not experience that, no. (Isatou, Gambian woman)

Although women had relocated to a context which was no longer conducive to particular cultural manifestations of violence, their new context afforded them fewer resources to deal with the aftermath of the violence (Kelly, 2016). In crossing borders, the control over women's lives shifted from their communities to the UK asylum system. The women's lives became tightly controlled by a system which restricted their income, employment, places of residence, and living conditions.

These restrictions illustrate how the continuum of structural violence characterizes women's lives even after migration. When discussing their resettlement experiences, the participants' descriptions of torture shifted from physical violence to being tortured by a system that imprisoned them in a state of uncertainty. Women described how the "fear of the brown letters" characterized their long wait for the decisions on their asylum claims:

> You are even scared to open your own door, because you don't know what letter is behind that door… because they might be like, you're supposed to be going back home. (Joyce, Malawian woman).

Many of the interviewed women had been waiting years for their asylum decision. The asylum system was "trapping women in limbo" (key informant 1), where both the asylum restrictions and fears of being deported stood in the way of women's ability to settle and find closure after violence. As emphasized by another key informant, "it's very difficult to recover from something if you don't know whether it's over" (key informant 2).

Many of the women had conflicted feelings about engaging with communities from their own countries due to their experiences of violence. Regardless, women considered community support and meeting people essential in integrating into Scottish society. The asylum system limits women's access to social capital, leading to emotional and material disadvantages. The participants felt that the asylum process was consuming all their energy and resources, leading them to deny themselves new romantic relationships. Women also felt that having no right to remain was damaging their relations within their own community, because they were seen either as a "burden" or a "threat." Settled migrants were said to fear that helping those without status would compromise their own resources, welfare entitlements, or immigration status. The extended family support and sense of community that had previously characterized women's cultures had come to an end, as heightened fears within communities contributed to "breaking down families and friendship from the BME [Black and Minority Ethnic] communities" (Vera, Malawian woman). These fears reflect UK's hardened approach to immigration. The profound sense of isolation, lack of resources, and resulting mental health difficulties all stood in the way of women's ability to build their lives in Scotland.

By failing to address the migrant women's aspirations beyond their mere everyday survival, the asylum system has become a barrier to the women's reclaiming their lives and sense of self in the aftermath of violence:

> Having been through the issue of domestic abuse, which was a very terrible situation that I went through, it really affected my overall well-being. This situation now adds, it makes it worse for me to do anything, except when I come out of this, that is when I can really move forward, you know. But when you keep someone's hands tied, you tie the person's hands and legs and then you ask the person to jump and to walk, how possible is it? It's just impossible. (Chibundu, Nigerian woman)

Chibundu's story was one of violence; she was cut at the age of eight in Nigeria and, years later, became a victim of domestic abuse and controlling behavior by her partner in the UK. Chibundu was further traumatized upon giving birth to her daughter when she came to discover that FGC was not a norm in the UK. She found the medical professionals' shocked reactions deeply unsettling, as she was given little information about FGC at the time. Her experience of the aftermath of all this violence reflects the struggles and structural violence faced by women who are forced to depend on the restrictive system. Although Chibundu was able to separate from her abusive partner, she continued to experience the effects of interpersonal violence as the long wait for her asylum decision exacerbated her feelings of anxiety and depression. By restricting her abilities to provide for her daughter and pursue her own employment aspirations, she felt that the system kept her "hands and legs tied," whilst expecting her to "jump and to walk," that is, to move on and find closure to her experiences of violence. For Chibundu, the asylum restrictions inhibited her from regaining control over her life, which had long been denied by her abusers. This illustrates how the asylum regime normalizes social and economic inequalities, enforcing the continuation of loss of control triggered by interpersonal violence.

Culture of disbelief

Although the limited recognition of FGC as grounds for asylum has been criticized (Beety, 2007), less attention has been given to the lived experiences of FGC-affected women who are negotiating the asylum process. The participants who had sought asylum in order to protect their daughters from FGC said that the Home Office had questioned why they had not relocated elsewhere in their countries of

origin. When it comes to FGC, a successful asylum claim requires women to prove that they cannot relocate or seek protection for themselves or their daughters from the local authorities (European Institute for Gender Equality, 2015). In pushing women to relocate, the Home Office failed to recognize the ways oppressive gender norms are institutionalized in political and economic structures, thus limiting women's abilities to resist and evade patriarchal practices:

> They say this country goes against FGM, but if somebody then has a case of FGM, they refuse to believe the person is going through that process. Because they will tell you, we know they are doing FGM in your country, but you can say no to it. But we don't have the power to stop the tradition... So, in other words we try to escape to a country that goes against it, and that same country will tell us no… (Olufunke, Nigerian woman).

This failure to recognize how women's lives are marked by intersecting social, economic, and political inequalities in their countries of origin meant that much like their own communities, the Home Office framed gender-based violence as a private matter. The emphasis on FGC as violence inflicted by communities and "culture" masks the way FGC and other forms of gender-based violence are condoned by state institutions and state actors. Yet, FGC-affected women struggle to provide evidence for the barriers to internal relocation, including how poverty, corruption, and gendered inequalities maintain women's vulnerability to violence. This was the case for women fleeing countries such as Malawi where women's place in the public sphere is limited but not explicitly restricted by law, but also countries such as Nigeria where FGC is outlawed but the law is not effectively enforced.

Participants described how Home Office interviewers had accused them of lying about their circumstances. Interviewers had questioned forced marriage as the basis of Joyce's asylum claim because she was in her thirties. In discussing this, Joyce contrasted the self-determination which Western cultures afford women entering adulthood with African respect for parental authority; for her, the latter would continue to place her at risk of forced marriage regardless of her age, whilst the Home Office's failure to question the universality of the former stood in the way of her right to be granted protection. This demonstrates a failure to recognize the effect overlapping gendered and age-based hierarchies have on African women's vulnerability to violence. The dominant representations of forced marriage and FGC affecting younger girls mask a diverse set of practices, contributing

to the failure to recognize the varied profile of victims of cultural manifestations of gender-based violence.

The culture of disbelief is nothing new; researchers and campaigners have been critiquing the performance of immigration law for operating from a presumption of guilty until proven innocent (Anderson, Hollaus, Lindsay, & Williamson, 2014; Souter, 2011). The lengths to which the Home Office has gone to question FGC-affected women's circumstances manifests the growing pressures to reduce and restrict immigration to the UK. After giving birth to a daughter in the UK, Star began receiving letters from her husband's family urging her to return to Malawi to have her daughter cut. Firstly, the Home Office disputed her own experience of undergoing FGC, arguing that her medical certificate sounded like she had dictated her story to the doctor without undergoing a medical examination. Then, the Home Office interviewers not only pushed her to relocate elsewhere in Malawi to protect her daughter, but also constructed Star as a deviant mother in attempting to refute her inability to do so:

> When I said, if you send me home, my daughter is going go through FGM and my husband is going to do this [domestic abuse], they [Home Office] were like:
> 'Does your husband know you are here?'
> I said I don't know, because I left in 2005. If he knows I don't know, but I never told him. Even my kids don't know that I'm here. But if I go home, I would want to see my kids. And they asked:
> 'Why would you want to see your kids?'
> (Star, Malawian woman)

The treatment of gender-based violence as grounds for asylum has been criticized for requiring women to conform to essentialist representations of a powerless woman, making women complicit in the reproduction of their own victimization (Kea & Roberts-Holmes, 2013). Prevailing gender expectations mean that women who are forced to leave their children behind to escape abuse do not fit the representation of a deserving asylum seeker. The imagery of an oppressed woman works against women who experience a persistent failure by the authorities to recognize seeking asylum as a means for women to exercise their agency. Isatou, a Gambian woman had also sought asylum in the UK in order to protect her daughter whom she had left behind. In her case, she continued to receive pressure from her family to return to the Gambia so her daughter could be circumcised. The community required the mother to be present for the cutting in order to care for the child

afterwards, so by staying away, Isatou was protecting her daughter. Her story resists the dominant interpretations of a deserving asylum seeker, powerless victim of FGC, as well as the common narrative regarding how FGC is practiced, making it even harder for her to navigate the narrow state interpretation of a genuine asylum seeker.

The increased public pressures to safeguard girls and prosecute perpetrators of FGC in the UK have led the asylum regime to frame FGC-affected women simultaneously as victims and as a threat. The requirement to prove well-founded fear of persecution means a woman's own experience of undergoing FGC is not sufficient grounds for asylum. However, disclosing (and more controversially, proving) their experience of violence may carry weight in convincing the Home Office of their need to protect their daughters from violence. Yet, by disclosing their own trauma, women open themselves up for scrutiny as potential perpetrators of the practice. As described by key informants, particularly for new arrivals with little exposure to the differing cultural norms, women's disclosure of undergoing FGC in asylum screening interviews can lead to multi-agency safeguarding procedures regardless of whether the perceived risk for the child is imminent. Key informants described how, even for women who had declared they would not continue FGC in the UK, responses which conveyed the normality of FGC in their home countries had led to urgent police and social work interventions. Key informants argued that rushed safeguarding procedures could lead to hostility towards statutory agencies among communities. Emergency responses were described as retraumatizing for women, particularly if women had migrated from contexts where police regularly abused its power by perpetuating violence. Such unmerited emergency responses are fundamentally insensitive to the confusion, exhaustion, and instabilities experienced by women who have been affected by interpersonal violence, displacement, and multi-layered loss. The interviewed key informants emphasized the need to address FGC in ways that enable women to adjust to their new context, allowing them to "re-evaluate what is normal… … and to provide the space and the scope to evaluate what has been done to them" (key informant 1).

Concluding remarks

By interrogating women's simultaneous vulnerability to physical and structural violence, I have made a case for rethinking the common approaches to challenging

culturally normative forms of violence against women. In illustrating the interconnections between interpersonal and structural violence, I have argued that, whilst FGC is a cultural practice, our understanding of it should not be limited to cultural terms. The participants' experiences suggest that the established imagery of FGC as a cultural issue has done few favors for women whose experiences of interpersonal violence are intrinsically intertwined with structural violence they face on the account of their gender, race, and class. As the women's experiences highlight, social orders and economic and political conditions can not only give license to violence against women, but also directly facilitate further interpersonal violence. Too often women's inability to challenge FGC has been framed as characteristic of the affected women, rather than as reflective of the spaces they occupy. Supporting women in bringing down the barriers to changing their situations requires going beyond the focus on community values to challenging the ways cultural constructions of womanhood become normalized in wider social orders and economic and political systems. The way FGC and other forms of violence connect with wider economic and political inequalities suggests that eradication efforts focusing on choice and attitudinal change may not lead to lasting social change if the measures do not extend to challenging the ways oppressive gendered expectations become institutionalized to limit women's wider opportunities in the society. Since the early feminist activism, the global community has recognized the ways FGC enforces gender discrimination but given less attention to the ways gendered inequalities contribute to the continuation of FGC. Rather than to seize aid to apply pressure to end FGC as was suggested by Fran Hosken (Women's Caucus of African Studies Association, 1983), wider societal inequalities ought to be addressed as a means of facilitating women's resistance.

Although women's reflections suggest that the continuation of FGC may not be a widespread issue in Scotland, increasing migration from affected areas warrants further attention to women's experiences in the aftermath of violence. Women's journeys of migration illustrate that even though they may no longer be as vulnerable to culturally normative forms of gender-based violence after migration to the West, Western societies may nevertheless operate in violent ways. This demonstrates the need to conceptualize FGC as a process rather than a one-off event, as women's experience of FGC is continuously shaped in response to their surroundings. In a new context, women's subordination at the intersection of gender, class, and culture becomes reconfigured to a position of multiple disadvantage

on the account of their gender, race, and immigration status. The participants' experiences of the asylum system suggest that even when women relocate to contexts where the violence against them is no longer culturally sanctioned, structural violence comes to sustain their vulnerability to the ongoing effects of trauma. The very system which was built to allow women to seek safety inflicts harms which prevent relocation from violence from becoming actualized in women's lives.

Participants' accounts suggest that there is a need to be vigilant of the ways colonial constructions of affected women blind us to women's efforts to exercise their agency to protect themselves and their daughters by means of seeking asylum. Women's struggles to make their case on the grounds of FGC, forced marriage, and/or domestic abuse illustrate the failure to recognize the ways gender-based violence is rooted in, and sanctioned by, wider systematic discrimination of women. Participants' experiences of the Home Office's hostility embody the ongoing conflict that characterizes women's struggles to seek protection from FGC and other forms of gender-based violence; increasing international migration and a growing fortress mentality in the UK have contributed to public pressures to condemn FGC, but also to the state-level reluctance to consider the practice as grounds for asylum. Although the increasing pressures to end culturally normative forms of violence in Scotland have led to more aggressive measures to prosecute perpetrators of FGC, such demands should not bypass affected women's needs to make sense of their experiences of violence.

References

Abu-Lughod, L. (2002). Do Muslim women really need saving? Anthropological reflections on cultural relativism and its Others. *American Anthropologist*, *104*, 3, 783–790.

Abusharaf, R.M. (1995). Rethinking feminist discourses on female genital mutilation: The case of the Sudan. *Canadian Women's Studies*, *15*, 2, 52–54.

Abusharaf, R.M. (2000). Revisiting feminist discourses on infibulation: Responses from Sudanese feminists. In B. Shell-Duncan & Y. Hernlund (Eds.), *Female "circumcision" in Africa: culture, controversy, and change* (pp. 151–166). Boulder: Lynne Rienner Publishers Inc.

Adams, L. Female genital mutilation "rising in soft-touch Scotland." *BBC News*. 15 November 2013. Retrieved from https://www.bbc.co.uk/news/uk-scotland-24915967

Anderson, J., Hollaus, J., Lindsay, A., & Williamson, C. (2014). *The culture of disbelief: An ethnographic approach to understanding an under-theorised concept in the UK asylum system* (No. 102). Oxford: Refugee Studies Centre, University of Oxford.

Bagnol, B., & Mariano, E. (2008). Elongation of the labia minora and use of vaginal products to enhance eroticism: Can these practices be considered FGM? *Finnish Journal of Ethnicity and Migration*, *3*, 2, 42–53.

Baillot, H., Murray, N., Connelly, E., & Howard, N. (2014). *Tackling female genital mutilation in Scotland: A Scottish model of intervention*. Glasgow: Scottish Refugee Council.

Beety, V.E. (2007). Reframing asylum standards for mutilated women. *The Journal of Gender, Race & Justice*, *11*, 239–270.

Canning, V. (2017). *Gendered harm and structural violence in the British asylum system.* Oxon: Routledge.

Crenshaw, K.W. (1991). Mapping the margins: Identity politics, intersectionality, and violence against women. *Stanford Law Review*, *43*, 6, 1241–1299.

Daly, M. (1978). *Gyn/ecology: The metaethics of radical feminism*. Boston: Beacon Press.

European Institute for Gender Equality (2015). *Clear guidelines on whether FGM justifies asylum*. Retrieved from https://eige.europa.eu/gender-based-violence/good-practices/united-kingdom/clear-guidelines-whether-fgm-justifies-asylum

Galtung, J. (1969). Violence, peace, and peace research. *Journal of Peace Research*, *6*, 3, 167–191. https://doi.org/https://doi.org/10.1177%2F002234336900600301

Gele, A.A., Johansen, E.B., & Sundby, J. (2012). When female circumcision comes to the West: Attitudes toward the practice among Somali immigrants in Oslo. *BMC Public Health*, 12:697, 1–10. doi.org/10.1186/1471-2458-12-697

Gruenbaum, E. (1982). The movement against clitoridectomy and infibulation in Sudan: Public health policy and the women's movement. *Medical Anthropology Quarterly*, 13, 2, 4–12.

Gruenbaum, E. (1996). The cultural debate over female circumcision: The Sudanese are arguing this one out for themselves. *Medical Anthropology Quarterly*, *10*, 4, 455–475.

Gruenbaum, E. (2001). *The female circumcision controversy: An anthropological perspective*. Philadelphia: University of Pennsylvania Press.

Hernlund, Y., & Shell-Duncan, B. (2007). Contingency, context, and change: Negotiating female genital cutting in The Gambia and Senegal. *Africa Today*, *53*, 4, 43–57.

Johnsdotter, S. (2019). Meaning well while doing harm: Compulsory genital examinations in Swedish African girls. *Sexual and Reproductive Health Matters*, *27*, 2, 87–99.

Johnsdotter, S., & Essén, B. (2010). Genitals and ethnicity: The politics of genital modifications. *Reproductive Health Matters*, *18*, 35, 29–37.

Johnsdotter, S., & Essen, B. (2016). Cultural change after migration: Circumcision of girls in Western migrant communities. *Best Practice & Research Clinical Obstetrics & Gynaecology*, *32*, 15–25.

Johnsdotter, S., Moussa, K., Carlbom, A., Aregai, R., & Essén, B. (2009). "Never my daughters": A qualitative study regarding attitude change toward female genital cutting among Ethiopian and Eritrean families in Sweden. *Health Care for Women International*, *30*, 1–2, 114–133.

Kea, P.J., & Roberts-Holmes, G. (2013). Producing victim identities: Female genital mutilation and the politics of asylum claims in the United Kingdom. *Identities*, *20*, 1, 96–113.

Kelly, L. (1987). The continuum of sexual violence. In J. Hanmer, M. Maynard (Eds.), *Women, violence and social control. Explorations in sociology* (pp. 46-60). London: Palgrave MacMillan.

Kelly, L. (2007). A conducive context: Trafficking of persons in Central Asia. In M. Lee (Ed.), *Human Trafficking* (pp. 85-103). Collumpton: Willan Publishing.

Kelly, L. (2016). The conducive context of violence against women and girls. *Discover Society*. Retrieved from https://discoversociety.org/2016/03/01/theorising-violence-against-women-and-girls/

Lewis, H. (1995). Between *Irua* and "female genital mutilation": Feminist human rights discourse and the cultural divide. *Harvard Human Rights Journal*, *8*, 1–56.

Lightfoot-Klein, H. (1989). *Prisoners of ritual: An odyssey into female genital circumcision in Africa.* New York: Haworth Press.

McKerl, M. (2007). Multiculturalism, gender and violence: Multiculturalism—is it bad for women? *Culture and Religion*, *8*, 2, 187–217.

Mhoja, M.E., Azong, J., & Lawson, A.M. (2010). *Baseline survey in Glasgow and Edinburgh on the beliefs, views and experiences of FGM*. Edinburgh: Dignity Alert Forum.

Mohanty, C. T. (1984). Under Western eyes: Feminist scholarship and colonial discourses. *Boundary 2*, *13*, 1, 333–358.

Mutua, M. (2001). Savages, victims, and saviors: The metaphor of human rights. *Harvard International Law Journal*, *42*, 1, 201–245.

Njambi, W.N. (2011). Irua ria atumia and anticolonial struggles among the Gĩkũyũ of Kenya: A counternarrative on "female genital mutilation." In O. Oyěwùmí (Ed.), *Gender epistemologies in Africa* (pp. 179–197). New York: Palgrave MacMillan US.

O'Brien, O., Baldeh, F., Hassan, J., & Baillie, M. (2017). *My voice 2: Women and female genital mutilation (FGM) in Scotland: A participatory action research project.* Edinburgh: Queen Margaret University.

Obiora, L.A. (1997). The little foxes that spoil the vine: Revisiting the feminist critique of female circumcision. *Canadian Journal of Women and the Law*, *9*, 1, 46–73.

Scottish Government (2019). *Female genital mutilation (protection and guidance) (Scotland) Bill Policy Memorandum*. SP Bill 47-PM Session 5. Retrieved from Scottish Government website: https://www.gov.scot/publications/national-guidance-child-protection-scotland/

Shell-Duncan, B. (2008). From health to human rights: Female genital cutting and the politics of intervention. *American Anthropologist*, *110*, 2, 225–236.

Shell-Duncan, B., Wander, K., Hernlund, Y., & Moreau, A. (2011). Dynamics of change in the practice of female genital cutting in Senegambia: Testing predictions of social convention theory. *Social Science & Medicine*, *73*, 8, 1275–1283.

Souter, J. (2011). A culture of disbelief or denial? Critiquing refugee status determination in the United Kingdom. *Oxford Monitor of Forced Migration*, *1*, 1, 48–59.

Volpp, L. (2001). Feminism versus multiculturalism. *Columbia Law Review*, *101*, 1181–1218.

Wade, L. (2011). Learning from "female genital mutilation": Lessons from 30 years of academic discourse. *Ethnicities*, *12*, 1, 26–49.

WHO, World Health Organization (2016). *Female genital mutilation (FGM): Prevalence of FGM*. Retrieved from www.who.int/reproductivehealth/topics/fgm/prevalence/en/

WHO, World Health Organization (2018). *Female genital mutilation: Fact sheet.* Retrieved from www.who.int/mediacentre/factsheets/fs241/en/

Women's Caucus of African Studies Association. (1983). Position paper on clitoridectomy and infibulation. In M.J. Stanley, C. Robertson (Eds.), *Genital cutting and transnational sisterhood: Disputing U.S. polemics* (pp. 1–4). Illinois: University of Illinois Press.

Maria Väkiparta

Young Men Against FGM/C in Somaliland: Discursively Negotiating Violence, Gender Norms, and Gender Order

Introduction

This chapter is based on my thesis (Väkiparta, 2019) which examines how young men engaged in FGM/C[1] prevention in Somaliland discursively negotiate violence against women, gender norms, and gender order,[2] and whether these negotiations are consistent with deconstructing the patriarchal gender regime and with locally prevailing masculinities. My analysis is informed by the perspective that FGM/C is a patriarchal practice upheld by and upholding other patriarchal practices and thereby women's subordination. Such practices are often legitimated by patriarchal interpretations of ideologies such as religion and culture/tradition. These interpretations are discursively mediated via institutions such as family and education, often through normalized or hidden discursive practices.

[1] In Somaliland, the acronym FGM (female genital mutilation) often refers to infibulation (referred to as *pharaonic cutting* locally), thereby excluding a range of less severe practices (see, for example, Lunde, 2012). To emphasize that I refer to all types of cutting practices, I avoided the acronym FGM during my fieldwork, instead employing the term female genital cutting (and acronym FGC). In the text here, I use the hybrid term FGM/C, unless when directly quoting texts or speech that employ different terms.
[2] Aligned with Walby (2009, 2011), I use the term "gender regime" interchangeably with the term "patriarchy." Whilst the term "gender order" has replaced "gender system" in, for instance, cultural studies (see Julkunen, 2010, p. 19), in this text a patriarchal gender order refers more narrowly to the purported superiority of men and the inferiority of women (drawing on Hirdman's [1990] concept of "hierarchical gender order").

Background: Men and FGM/C

FGM/C prevention efforts have extensively considered and addressed women's perceptions associated with the practice. Increasingly, academic research also addresses how men position themselves on FGM/C (see, for example, Abdalla, Omer, & Elmusharaf, 2012; Gage & Van Rossem, 2006; Kaplan et al., 2013; Sagna, 2014; Sakeah, Beke, Doctor, & Hodgson, 2006; Varol et al., 2015). Simultaneously, policy specialists and researchers call for more men to be engaged in efforts to end FGM/C (see, for example, Gele, Bø, & Sundby, 2013; Lunde & Sagbakken, 2014; Mölsä, 2008; Newell–Jones, 2016, 2017; Shell-Duncan, Naik, & Feldman–Jacobs, 2016; UNICEF, 2013).

Despite some geographical variation, men seldom directly participate in the decision-making surrounding and the execution of FGM/C (Kaplan et al., 2013). As a practice, mothers, grandmothers, or other elderly community women perform FGM/C (see, for example, Ahmadu, 2000; Mackie & LeJeune, 2009; UNICEF, 2010). Thus, FGM/C represents a form of gender-based violence in which women comprise both the primary victims and main perpetrators. Whilst women appear to stand at the forefront of perpetuating FGM/C, men also play a significant role in its continuation, as fathers, husbands, and community and religious leaders (Varol et al., 2015). Correspondingly, women who decide that their daughters will not undergo FGM/C often face both peer pressure and helplessness, particularly when they are not actively supported by their husbands or influential male leaders from their communities (Kaplan et al., 2013). The belief that men support FGM/C alone can represent an important motivating factor influencing women's behavior vis-à-vis cutting their daughters (UNICEF, 2013).

Varol and colleagues' (2015) systematic review of studies exploring men's attitudes, beliefs, and behaviors concerning FGM/C in fifteen countries, as well as a UNICEF (2013) study conducted in sixteen countries, revealed the ambiguity in men's views regarding the continuation of FGM/C. In most countries analyzed by UNICEF, both women and men expressed similar levels of support for FGM/C. In some countries, more men than women want to end FGM/C, whilst in other countries more women than men would like the practice to stop. Varol et al. (2015) claimed that notions of social obligation, religion, education, ethnicity, urban living, migration, and an understanding of the negative consequences of the practice influenced men's support for abandoning FGM/C. They found that higher education level most strongly influenced support for ending FGM/C. The reasons

men cite for abandoning the practice of FGM/C stem from an understanding that religion does not mandate it and that it may negatively impact sexual relationships, whilst few men conceptualize FGM/C as an act of violence or as an infringement of women's rights (UNICEF, 2010, 2013).

As I argue in my thesis (Väkiparta, 2019), FGM/C is a form of patriarchal violence, upheld by and upholding other patriarchal practices in the fields of housework, paid work, state, cultural institutions, and sexuality (cf. Walby, 1990). Thus, research on men and FGM/C should extend from men's attitudes regarding FGM/C to men's attitudes and practices reproducing and challenging other patriarchal practices, such as rigid gender norms, control of women's sexuality, women's economic subordination, and their exclusion from positions of power.

In this chapter, I first set the scene for exploring FGM/C and gender in Somaliland. I then discuss FGM/C as patriarchal violence in light of theoretical constructions of patriarchy and gender-based violence. After presenting my methodology and data, I present the four discourses that emerged in my thesis data. The discourses construct the meaning, religious status, and health consequences of different FGM/C practices, as well as knowledge and beliefs about gender ideals, gender roles, and gender equality.

Context: FGM/C and gender in Somaliland

The formerly British Somaliland Protectorate achieved full independence from the United Kingdom in 1960. A few days later, Somaliland united with Somalia, establishing the Somali Republic. In 1988, the Siad Barre regime in Somalia launched a crackdown against the Somali National Movement based in Hargeisa, Somaliland, part of a set of events leading to the civil war (Metz, 1993). Following the collapse of Barre's government, local authorities in Somaliland declared independence from Somalia in 1991, and reinstated the borders of the former independent State of Somaliland (Lewis & Sundström, 2014, pp. 80–83). Since then, the territory has been governed by a democratically elected government that seeks international recognition as the Government of the Republic of Somaliland (Constitution of the Republic of Somaliland [English], 2001).

With few exceptions, Somalis in Somaliland and elsewhere are Muslims, the majority of whom belong to the Sunni branch of Islam (Abdullahi, 2001, p. 1). Islam is the state religion in Somaliland, and no laws may violate the principles of sharia (Constitution of the Republic of Somaliland [English], 2001). The Somali

population is divided into a few large clan families. In Somaliland, the major clan families are the Isaaq, the Darood/Harti and the Dir (Luedke, 2015, p. 11). Below the clan family level, there is the clan itself, the primary lineage group, and the Dia (Arabic)/Mag (Somali) (Bradbury et al., 2005). All male members of society are defined by belonging to the Dia/Mag group which has a collective obligation to pay and get blood compensation, based on acknowledged rules or a contract known as Xeer, customary law in Somaliland (Gundel, 2006). Luedke (2015) claims that outside of politics, however, clan structures appear to become weaker and more scattered, especially in urban areas, where the initial responsibility of clan elders in resolving conflicts between pastoralists has reduced.

Gender represents a fundamental structuring principle that influences almost all spheres of Somali society: the family, the household, politics, and the economy (Hansen, 2008). According to the Academy for Peace and Development (APD, 2002), the position of women within an Islamic society is determined by the Qur'an, the tradition of the Prophet Mohammed, and the interpretations of Islamic law and traditions. These interpretations, in turn, are influenced by social customs and practices. Luedke (2018, p. 10) maintains that the significance of the clan system represents a primary reason for the continued subordination of women in Somaliland. She argues that that a woman's loyalty to the clan is weaker than a man's clan allegiance because a woman's clan alliance often transfers following marriage. Thus, women are excluded from decision-making and clan-based forums.

Luedke (2015, p. 9) wrote that the absence of men during conflict times made women acquire new importance as merchants, traders and heads of house. The resolution of conflict and peace and reconciliation in Somaliland, however, relegated women back to the status of passive agents, she argues. "As the modern state structures of the Barre regime collapsed, traditional modes of social organization, in which men define and occupy the 'public' sphere, took over" (Luedke, 2015, p. 9). Furthermore, radical versions of political Islam have gained ground since the civil war and precipitated a shift towards stricter interpretations of gender roles (Luedke, 2018, pp. 11–12). Women are denied inheritance under customary law, and have limited access to financial assistance such as micro-credit (Luedke, 2018, pp. 9–11), and women continue to be excluded from most public and political activities, including open councils (shir) where adult men debate and make deci-

sions (El-Bushra & Gardner, 2016). Women are never considered the most respected, senior "elders" of the society, and in cases involving conflicts between women and men, male elders often protect the interests of men over those of the women (SIHA, 2013).

Regarding the locally prevailing masculinities, I draw upon Arat and Hasan's (2018) findings on the salient character traits conveyed in the Qur'an, and El-Bushra and Gardner's (2016) feminist analysis of Somali men's masculinities and gender relations. Arat and Hasan outline five overlapping yet contradictory salient Muslim character traits that may be taken as prescriptions of Muslim masculinities. Submissiveness, taken as the opposite of domination and defiance, is the most exalted trait of the believer, since Islam means surrendering or submitting to God. The most frequent expression in the Qur'an of the second trait, altruism, is the duty of a charitable act. One of the five pillars (basic acts) of Islam, zakat, requires all adult Muslims to annually give about 2.5% of their wealth to those in need. The third trait, righteousness, is defined as morally correct behavior and thinking, transecting all other desirable character traits and offering the most uniform characterization of ideal masculine traits. The righteous husband tends to his wife's needs with care and commitment, and righteous parents guide their children towards good and virtuous lives, preventing them from committing sin. Commitment to the faith characterizes the principle expression of the fourth trait, steadfastness, which also prescribes a man's devotion to his wife by refraining from adulterous relationships and sinful desires. Some verses encourage believers to fight, although combat, the fifth trait, only legitimizes fighting when defending the faith against those "who disbelieve in the signs of Allah," and only with restraint. I suggest that these five salient character traits are largely compatible with the core ideals of "Somali manhood"—responsibility, self-discipline, courage, humanity, and generosity (El-Bushra & Gardner, 2016). These ideals are (partly) reflected in the concept of "raganimo," the local notion of a "real man," characterized as being tough and brave, but also helpful and generous, as well as oratorically skilled, capable of speaking eloquently and loudly (Hansen, 2008).

Turning to FGM/C in Somaliland, two recent studies show that the practice is nearly universal. Based on a community survey, key informant interviews, and focus group discussions with 2,060 community members (of whom 1,128 were women) and 209 opinion leaders (of whom 46 were women) in 25 communities, Newell-Jones (2016) concludes that the prevalence rate stands at 99% in urban

and 100% in rural communities. Data in Ismail and colleagues' (2016) study stem from two surveys conducted amongst women who attended the prenatal clinic at the Edna Adan Hospital in Hargeisa. The first cohort participated in the research between 2002 and 2006, and the second between 2006 and 2013. In the second cohort, data were drawn from a sample population (n=6,108 of 6,172 participants), the results of which rely on physical examinations of participating women receiving antenatal care. That survey revealed that 98.4% (or 6,011 women) of the second cohort had undergone FGM/C. A mere 1.6% (n=97) of participants bore no signs of FGM/C. Despite the consistently high prevalence rate, evidence (see Ismail et al., 2016; Newell-Jones, 2016) points towards a change in the type of cutting, whereby an increasing proportion of girls in the younger age cohorts undergo intermediate cutting (WHO type II) and sunnah cutting (WHO type I) instead of infibulation (WHO type III).

Johnsdotter (2002) argues that some Somalis consider sunnah circumcision a religiously recommended act. This stems from the meaning of the word "sunnah" in Arabic as "recommended." Furthermore, the same understanding of the term falls within one of the five categories to which all human actions can be classified according to Islamic law: 1) required/commanded; 2) recommended; 3) permitted; 4) disapproved; and 5) forbidden (Johnsdotter, 2002, p. 54; referring to Lewis, 1994, p. 5). Accordingly, Crawford and Ali (2015) claim that the term "sunnah" can refer to any type of FGM/C that Somali people believe is required or sanctioned by Islam, and can thus refer to WHO type I, II, or even III. They recognized the increasing use of the intermediate type of FGM/C that involves less stitching than the pharaonic practice and has likely emerged in response to government interventions to eliminate pharaonic cutting. To increase its acceptability in comparison to the pharaonic practice, this intermediate type is sometimes called "sunnah" or "sunnah 2" (Newell–Jones, 2016, p. 12). However, sunnah cutting may in reality be close or equivalent to pharaonic cutting because traditional cutters are often unaware of the differences between specific practices (Akar & Tiilikainen, 2009; Lunde, 2012; Vestbøstad & Blystad, 2014).

The strongest reason that participants in Newell-Jones' (2016, p. 26) survey gave for supporting the continuation of FGM/C in Somaliland was that FGM/C remains a traditional practice. Purification was the second most-cited reason associated with reducing the sexual desire of girls, which again is thought to protect girls from premarital sex and the associated loss of virginity. Marriageability was

listed by 20% of survey participants, and 22% cited religious reasons for supporting FGM/C. In the Ismail et al. (2016) study in Somaliland, 72% of female respondents who could pick only one option, reported that they would have their daughters cut for reasons stemming from tradition and 28% for religious reasons. These results reflect Boddy's (1986) notion that religion, tradition, and culture are often interconnected and mutually reinforcing—that is, valued traditions and cultural beliefs are incorrectly ascribed as mandated by religious doctrine.

Somalia initiated awareness-building campaigns to prevent FGM/C as early as the 1970s (Bruchhaus, 2013). Such campaigns collapsed with the fall of the Barre regime in 1991. In 1997, UNICEF relaunched anti-FGM/C activities in Somaliland, establishing a national committee and regional task forces to formalize policies. FGM/C was included in the national gender policy, categorized as a form of gender-based violence under the subheading "harmful traditional practices" (Lunde & Sagbakken, 2014). However, FGM/C was not seen as a priority in the 1990s since there were many more pressing needs (Lunde, 2012, p. 61). FGM/C is now quite openly discussed in urban areas (Bruchhaus, 2013), but there is still no ban criminalizing it, and the key ministries disagree on which types of FGM/C should be covered by the ban (Newell-Jones, 2016). Reflecting this debate, a religious fatwa was issued by the Ministry of Religious Affairs in February 2018. According to the fatwa, "[i]t's forbidden to perform any circumcision that is contrary to the religion which involves cutting and sewing up, like pharaoh [pharaonic] circumcision" (Ahmed et al., 2018). Local civil society organizations advocating for a zero tolerance of all types of FGM/C required rephrasing of the fatwa, which they accused of legitimizing sunnah cutting. Strategic Initiative for Women in the Horn of Africa (SIHA, 2018) interpreted that the fatwa is problematic also because it frames FGM/C as a religious matter.

Theoretical constructions of patriarchy and gender-based violence

Mackie and LeJeune (2009, p. 5) have argued that patriarchy as the cause of FGM/C is insufficient, "because most, if not all, communities that do not practice FGM/C are also patriarchal." Walby (1990, p. 16) argues that theories of patriarchy that utilize "a simple base–superstructure model of causal relations" do not aid in understanding variation and change. In Walby's theorizing, the private and the public comprise the primary forms of patriarchy. The private patriarchy is

based upon housework as the main site of women's oppression, and the expropriation of women's labor takes place primarily by individual patriarchs within the household. Public patriarchy, by contrast, is based upon employment and the state, where the expropriation of women represents a more collective appropriation (Walby, 1990, p. 24). Furthermore, in the domestic form, the processes of power are primarily exclusionary—thereby excluding women from locations of power and influence; in the public form, these processes are segregationary—that is, segregating women in the public sphere into positions of lesser power and influence (Walby, 2011, p. 105).

In the core of Walby's (1990) theorizing are six primary structures (also referred to as "fields" or "sites") from which patriarchal relations emerge and which form patriarchy. These six structures consist of paid work, housework, sexuality, cultural institutions, violence, and the state. Each structure carries causal effects upon the others, by both reinforcing and blocking them, and the interrelationships between structures create different forms of patriarchy (Walby, 1990, pp. 16, 20). In each of the six structures, patriarchal practices vary and develop separately.

Referring to Puleo (1995) and De Miguel (2015), Kaplan et al. (2017, p. 152) claim that every patriarchal system relies on coercion and consent, where the coercive model sanctions what is allowed and what is forbidden to women, whilst the consent-based model "builds inequality through binary narratives that leverage gender roles in a rigid way." With regards to the latter model, patriarchy is often associated with a patriarchal ideology that justifies male dominance and attributes it to inherent natural differences between men and women. Drawing from Gramsci (1971), Lazar (2007) argues that gender ideology is hegemonic in that it often does not appear as domination at all. Instead, she points out, it is often embedded and hidden in everyday routines and interactions and appears as largely consensual and acceptable to most within a community. Gaining consent and perpetuating dominance are thus largely accomplished through discursive means. According to Lerner (1986, p. 240), sexism defines the ideology of male supremacy, superiority, and beliefs that sustain it. In her view, sexism consists of prejudice, stereotyping, and discrimination based on gender, and "stands in the same relation to paternalism as racism does to slavery." Connell (2005) points out that there exist ideologies that justify men's supremacy on grounds of religion, biology, cultural tradition, or organizational mission such as that used in the military.

According to Hirdman's (1990) theorizing, a patriarchal gender system emphasizes a strict separation of the sexes, their hierarchical order, and heteronormativity. In her conception, separation of (or simply difference between) sexes entails both defining feminine and masculine as dichotomous and in opposition to one another, as well as a gendered division of private life and work. Hierarchy, in turn, entails the superiority of the masculine, portraying man as the human norm, and concentrating the material, cultural, and symbolic power in the hands of men. I borrow from Hirdman (1990) and Connell (2005) and suggest that the patriarchal gender regime is upheld by patriarchal interpretations of ideologies such as religion, biology, cultural tradition, or organizational mission. These interpretations provide the "content" of gender stereotypes and norms that justify a strict separation of the sexes, and their hierarchical order. Such interpretations are reproduced and mediated via cultural institutions such as family, education, church, and media, and through materialist and discursive practices, which, in turn, can be either coercive or non-coercive (consensual), materialist and discursive (Hearn, 2004, 2014; Whitehead, 2002).

I now turn to violence against women, one of Walby's (1990) primary patriarchal structures. Labelling something as violent entails separating legitimate violence (for example, by police for "due" course) from illegitimate violence, and results from cultural, historical, and social negotiations, which justify and account for certain forms of violence (Ronkainen, 2017). Gender represents one factor impacting the cultural and social meaning-making of violence, and both gender and violence are connected to power in various ways, Ronkainen argues. "Violence against women" (VAW), "gender-based violence" (GBV), and "gendered violence" are often used interchangeably. Anderson (2009), however, points out that when one assumes that VAW equals GBV without analyzing the relation to theories of gender, one fails to analyze the gender–violence nexus.

Bumiller (2010) calls for a focus on the meaning and purpose of violent acts and their relation to the performance of gender. Ronkainen (2017) notes that research on GBV should focus on resources enabling violence, how violence is justified to oneself and others, and the kind of gendered agency attached to it. Stark (2010, p. 209) argues that investigations of the violence/gender nexus should "identify how violence functions in relationships to preserve and extend gender inequalities," rather than asking who uses violence. Hunnicutt (2009) emphasizes

that the principal characteristic of GBV lies in that it occurs against women precisely because of their gender. She posits that the concept of patriarchy maintains the theoretical focus on dominance, gender, and power, and anchors violence against women within social conditions rather than against individual attributes. hooks (2000), in turn, proposed using the term "patriarchal violence" as a label for the abuse and violence that happens at home due to patriarchal structures, beliefs, and values, since the term "domestic violence" does not maintain the connection between violence and structures.

By considering FGM/C as a gendered practice, it is important to note that communities that practice it do not view it as violence, but as a means of guaranteeing prevailing notions of what is best for girls (see Mackie & LeJeune, 2009). Yet, I argue, FGM/C is a violent act which occurs against women precisely because of their gender (see Hunnicutt, 2009). Illiteracy and weak employment opportunities uphold the patriarchal order assigning women the role of giving birth and carrying out domestic duties, whilst men are assigned the role of providing for their family (Wilson, 2002). Marriage is thus often the (only) way for women to earn a living and status, Wilson argues, whilst virginity and chastity exist as prerequisites to marriage, symbolizing the honor of the girl's family. Under these circumstances, FGM/C is carried out to preserve the girls' virginity, chastity, marriageability and family honor (Gruenbaum, 2006). Furthermore, FGM/C often occurs in circumstances where social norms grant women little voice so they are unable to publicly challenge harmful practices (Mackie & LeJeune, 2009).

Building upon Wilson's (2002) and Mackie and LeJeune's (2009) views on patriarchy as a supporting condition of FGM/C, as well as on Walby's (1990) understanding of the six fields of patriarchy (paid work, housework, sexuality, cultural institutions, violence, and the state), I argue that FGM/C comprises patriarchal violence that sustains and is sustained by other patriarchal structures and practices. Crosscutting the fields of sexuality and cultural institutions, FGM/C represents a valued tradition often assumed to be mandated by a religious doctrine and linked to understandings of honor, thereby justifying the use of violence to control women's virginity and fidelity. In the fields of paid work and housework, women's socio-economic subordination upholds their dependency on marriage and, therefore, FGM/C as a prerequisite to marriage in some practicing communities. Health problems and child marriages, which often follow FGM/C, further disadvantage women's possibilities of gaining an education and participating in

paid work. In the field of the state, some countries where FGM/C is widely practiced have managed to enact legislation and related policies against the practice (UNFPA, 2013). In other countries with high prevalence (including my study context Somaliland), criminalization of FGM/C is hampered by, for instance, contradictory religious interpretations, fear of "outsiders" trying to alter the culture and customs, and/or unanimous support for the practice among the electorate.

Research methods and data

I gained access to the field with the help of an international non-governmental organization that supports local civil society organizations (CSO) in Somaliland in their efforts to end FGM/C. I also recruited a local research assistant to contact potential interviewees, schedule interviews, translate during the interviews, and conduct transcription of the interviews from the digital voice-recordings. The data collection took place in Hargeisa, the capital of Somaliland, in September-October 2016. I interviewed 19 university students (15 men, 4 women) who had recently participated in an anti-FGM/C training organized by a local CSO. The average age of participants was 23 years (range, 21 to 27 years). None of them was married or had children. Nine were born in Hargeisa, seven in other urban areas, and three in rural areas. Only one participant had lived abroad for a brief period of time during childhood. In total, 13 participants reported that some of their female family members were cut, three that all of their female family members were cut, and two that none of their female family members were cut (one did not know or chose not to answer). The student interviews were supplemented by interviews with employees of local CSOs (alone or in pairs). Thus, the final data consist of 24 interviews with 26 individuals, comprising nearly 24 hours of speech transcribed verbatim into text.

Interviews with the students were carried out at a meeting room at the hotel where I was staying. Because I did not expect to gather exceptionally rich accounts given the sensitivity of the topic, I used a semi-structured interview scheme with open-ended questions. I began the interview with a "warm-up" topic (practical questions about their anti-FGM/C training) and proceeded to topics that specifically addressed FGM/C practices, FGM/C prevention strategies, gendered roles and ideals, and gender equality. The interviews lasted on average one hour, ranging from 30 to 75 minutes. I encouraged the interviewees to rely upon the research assistant for translation assistance, but most of them chose to speak English.

Hence, the richness of the accounts correlated with the English-language skills of the participants.

My methodological framework is inspired by Fairclough's (1992, 1995, 2001) discourse analytical approach, which emphasizes the interrelation between discourse and social change. My analysis is also inspired by Lazar's (2007) feminist critical discourse analysis, which aims to understand the complex working of power and ideology in discourse that sustains (hierarchically) gendered social arrangements. According to Lazar, many social practices, far from being neutral, are gendered, as well as embedded and hidden in everyday routines and interactions.

To first examine how violence against women is (re)negotiated and (de)legitimated, I analyzed how the meanings and consequences of different FGM/C practices, as well as the subject positions in perpetuating and preventing the practice are negotiated in the data. Second, I examined how masculinities and gender order are negotiated. I investigated notions of men's and women's "natural" characteristics and roles, notions of gendered rights and responsibilities, as well as understandings of gender equality in Somaliland and the concept of "gender equality" itself. Throughout the analysis, I paid attention to the assumptions made, causalities suggested, as well as to the systems of knowledge and belief from which participants drew. I paid special attention to the taken-for-granted ideas and justifications granted to, for instance, the current state of gender (in)equality, as well as to the identification of the "root causes" of some harmful practices. I also explored whose stance was taken and whose was forgotten, and whose interests were promoted or ignored.

In the next two sections, I introduce the four discourses that emerged from the data. Due to the limited space, I provide only a few direct quotes from the data. To improve the readability, I have corrected any major grammatical or lexical errors in the quotes. Brackets indicate missing words that I filled in to render the quotes more readable. Brackets with three dots […] indicate sentences or words that were extracted to shorten the quotes. If the quote is based on the research assistant's English translation from Somali, it is indicated at the end of the quote. All the quotes in this text are from the male students (and not from female students or CSO employees), who are referred to with pseudonyms.

Discursively negotiating FGM/C practices

I next turn to presenting the two interlinked discourses—the righteousness discourse and the health discourse—through which my interviewees construct the meaning, religious status, and health consequences of different FGM/C practices, as well as the subject positions in perpetuating and preventing the practice. In both discourses, a clear distinction is made between pharaonic cutting as a harmful cultural practice—and, thus, the primary "target" of anti-FGM/C activism—and sunnah cutting as a "harmless" practice with some religious grounds.

The righteousness discourse

Through the righteousness discourse, my interviewees negotiate the religious status of the main types of FGM/C in Somaliland, on the one hand, and genital cutting as a means to prove women's religious purity (that is, virginity and abstinence from premarital sex), on the other. Sunnah cutting primarily emerges as not required by Islam, but also contradictory views emerge, as in Farah's quote:

> Farah: My idea is based on the religion, what the religion mentions. So, Sunna is acceptable, and I believe Sunna is perfect. But a woman with nothing [uncut] is a problem. So, women must undergo Sunna.

This tension reflects the disagreement amongst local religious scholars regarding how to advise communities on sunnah cutting, with a majority considering sunnah cutting as "honorable" (that is, recommended). Even those student interviewees who construct sunnah cutting as not required by Islam appear to consider it as permitted by Islam and, hence, remain indifferent to it. They construct sunnah cutting as "not a big problem"—neither bringing any benefit, nor causing health problems.

> Najib: They [religious leaders] are taking a Qur'anic verse which says: "Human being is created into its best form" as evidence. So, the two forms of FGM, the pharaonic type is totally forbidden, and the Sunna type is mildly invasive, so it is not a big problem if it is done or left. So, if the woman is exposed to something that is not allowed in the religion that means her right is violated.

Accepting what is understood as "just pricking" or "a mild invasion" undermines women's rights to bodily integrity. In light of my data, it remains unclear whether

ignoring the sunnah cutting results from a lack of information on the varying sunnah procedures and related health consequences or due to the understanding that sunnah cutting cannot be harmful because it is not specifically disapproved or forbidden in Islam.

The righteousness discourse is firmly attached to and reproduces the righteousness ideal, the most uniform characterization of the salient Muslim character traits which addresses both men and women (see Arat & Hasan, 2018). Whilst renegotiating women's righteousness by challenging the dominant religious interpretations regarding sunnah cutting as "honorable," religious purity (that is, virginity and abstinence from premarital sex) remains a central norm that specifically addresses women.

> Muuse: She [preferred bride] must be zero tolerant [uncut] or at least she must be Sunna, not pharaonic you know. That is the first point. The next thing is that she must be educated, at least [have] a degree level or secondary education. […] The third thing is that she must cover her body because she, you know, if she covers her body, she has been protecting herself for [a] long time.

Traditionally, pharaonic cutting was carried out to symbolize virginity in Somali society (Talle, 1993). In my data, virginity and abstinence from premarital sex are detached from all types of FGM/C and attached to chastity—covering one's body, behaving "modestly," and keeping away from men. The continued emphasis on safeguarding a woman's premarital virginity, however, risks perpetuating FGM/C, since many people in Somaliland still consider FGM/C a culturally approved and efficient means of guaranteeing it.

The health discourse

The health discourse represents pharaonic cutting (but not sunnah cutting) as a harmful cultural practice that causes women various health problems in both the short- and long-term.

> Mahad: When they become married, women with FGM [pharaonic cutting] experience more complications, for example, fistula or other related diseases, but a woman with Sunna cannot acquire any diseases related to FGM [pharaonic cutting].

Yet, pharaonic cutting is not framed as violence (that is, representing a violent act or act of force), but rather as a violation of women's rights to health. This is problematic, first, since talk about violence does not just represent norms: "it is (a creation of) reality in its own right" (Hearn, 2014, p. 9). Labelling and not labelling something as violence entails separating legitimate violence from illegitimate violence (Ronkainen, 2017). Second, a health approach to violence against women frames violence as a contributor to women's poor health, whereas feminist approaches frame violence against women as a symptom of gender inequality and oppression (Flood, 2015). Furthermore, most interviewees represented pharaonic cutting as a threat only to women's physical health, bypassing the long-term psychological and social effects that maintain women's subordination.

In the health discourse, students represented themselves as competent and legitimate. Female activists were viewed as advantaged, because a majority of people see FGM/C as a "women's issue," which is both inappropriate for men to intervene in and a taboo topic for discussions between men and women.

> Abas: Maybe they [people listening to the student activists] will ask you, "Aren't you a man? Why are you talking about FGM?" In the Somali context, they believe only women can talk about FGM because they say it's a special issue associated with women. […] Mothers are more sensitive than fathers [to men talking about FGM/C], I think.

Furthermore, female activists are assumed to have subjective experiences with FGM/C, which grants them legitimacy. Such accounts renegotiate women's public agency and their role in preventing FGM/C instead of being viewed as victims of FGM/C alone. Yet, because positions of power are currently held by men, it appears "rational" to engage men in anti-FGM/C efforts, thus reproducing men's domination.

In the health discourse, pharaonic cutting was also represented as a violation against women's "right to marry." Such understanding is problematic as it does not challenge women's socio-economic subordination and dependency on marriage. The emerging—yet weak—emphasis on a woman's right to bodily integrity, in turn, opens the possibility for opposition to all types of FGM/C, since it is less focused on the severity of the health consequences.

> Abdulle: They [girls and women] should not face a risk, so the right they have is to keep their body, all its parts, the 360 organs, you know, of their body, so they have that fundamental right. And women should be given consent about FGM, you know, the thing

> is that when Mum and Dad or those who are performing FGM, they do not [ask for] consent.

This emerging rights discourse on FGM/C also challenges the relativist view, in which communities that practice FGM/C do not see it as violation of the body or girls' dignity. Instead, this weak human rights discourse supports Donnelly's (2007) notion that "[n]o culture or comprehensive doctrine is 'by nature', or in any given or fixed way, either compatible or incompatible with human rights." The interviewees, however, highlighted the difficulty in invoking human rights arguments, particularly amongst the uneducated "ordinary people" and religious leaders.

In addition to the effects on women's health, "right to marry," and right to bodily integrity, the health discourse included accounts of how pharaonic cutting complicates marital sex, particularly for men who were represented as the primary "performers" of intercourse. Uncut or sunnah cut women were portrayed as more "sensitive" and thus more willing to engage in marital sex.

> Abdi: I think they are much better, women or girls who had no FGM compared to those who have undergone FGM. Simply from the side of sensation or feeling sensation, I think, when the women's clitoris is cut, they may not feel sensation, or their sensation is reduced.

This relates to idealized womanhood renegotiated through the righteousness discourse. The thin—yet gleaming—sexuality discourse together with the nascent human rights discourse illuminates how discursive "codes and elements" can be combined in new ways (see Fairclough, 1992, pp. 96–97).

Discursively negotiating gender norms and gender order

I next turn to presenting the hierarchical difference discourse and the masculine responsibility discourse, through which my interviewees construct gendered stereotypes, roles, norms, and ideals, as well as gender power relations. In these discourses, young men assume a "heroic position" (Wetherell & Edley, 1999) towards religiously and culturally idealized masculinities.

The hierarchical difference discourse

The hierarchical difference discourse locates women and men in strictly separate "roles" and spheres: women in the private and men in the public sphere, a separation justified through Islam, "natural" differences between men and women, and "balanced" gendered rights and responsibilities as understood to be prescribed by Islam.

> Guled: Because we are a Muslim community, there are different roles for women and men. As such, the primary role for women is to maintain everything related to the home and raising children and taking them to the school and all that is related to the house. Also, nowadays, many women participate in community issues.

As in Guled's quote, interviewees claimed that changes have occurred, particularly regarding women's expanding economic roles. Some of the young men accepted the change, explaining that women are now more educated and thus capable of and even "entitled" to enter new roles, and since women's participation in the income generation strengthens family resilience.

> Muuse: In my opinion, it [women's expanding role outside home] is somehow good, somehow not good. It is good when women learn something and when they come outside. It is good for the family, the fathers or the husbands of all Somali families. Most of them [families], their daily income is increased by women, because she works outside [the home]. So, at that part, it is good. And regarding learning, it is good. But when it comes to leadership, it is not good for a woman to lead the nation.

As in Muuse's quote, women's education and economic roles were sometimes supported only as "good for the husband and the family." Such an understanding risks reproducing women's traditional roles in the private sphere and, therefore, dependence on marriage. Yet, employing such instrumental arguments can be interpreted to imply that men attempt to comply with the righteousness ideal, and thus use religiously acceptable arguments when supporting women's extended rights and roles. Others. Like Guled, were hesitant about the change in gender roles, appealing to the roles prescribed by Islam:

> Guled: Women's life is not like in the past. They are entering into community life. Earlier, all [women's] roles concerned the home, but now they are in public. And, as Muslims, we do not support this culture.

Strict gender segregation was also justified by representing gender equality as a "zero-sum game." In these accounts, improvements in women's labor market status appear to discriminate against men.

> Muuse: The job has qualifications and conditions. These qualifications include knowledge level, experience, and similar things. Finally, they said you know, women are especially encouraged to apply. So, that means, if the job needs one person and, in the end, there remain two persons—a man and a woman—it is common that the woman will succeed, because she is already mentioned. So, in that way, there is gender inequality.

In the hierarchical difference discourse, Somaliland is presented as a gender equal society, given the "equal" rights and responsibilities prescribed by Islam. Women also appear as powerful change agents "behind the scenes," which downplays the need to promote women's formal decision-making power. In some accounts, women are blamed for disrupting the "gender balance" through claiming rights or roles which are not understood to be prescribed to them by Islam.

> Liban: There is not that much inequality in Somaliland. Everybody has a role and inequality happens when men assume the role of women and women assume the role of men. And if there is inequality, it is the women who take over some of the roles of men. For example, women moving from their role in the house and going to work leads to slight inequality [translated].

On the other hand, women are also blamed for marginalizing themselves and "preferring to stay at home" instead of pursuing work outside the home. In general, women's discrimination in education and paid work is, however, attributed to "ignorant" parents and husbands instead of structures and practices that favor men.

The masculine responsibility discourse

The embeddedness of the "gender contract" (see Hirdman, 1990) and "gender ideology" in religion makes them particularly stable in Somaliland, concentrating the power to interpret and renegotiate in the hands of those who possess religious authority—that is, primarily men. Viewing men's domination as divinely ordained provides men with "invisible power," which is more potent as deeply internalized

rather than explicit power (El-Bushra & Gardner, 2016). Therefore, the masculine responsibility ideal at best produces masculinist protection instead of supporting women's increasing decision-making power over their own bodies, and over private, nonetheless public affairs. This emerged in the other discourse that constructs gender norms and gender order in my data, the masculine responsibility discourse, whereby men's superiority was justified through men's wider responsibilities towards their nation and family—especially the masculinist protection and economic support that men (are expected to) offer women.

In the masculine responsibility discourse, the interviewed men represented their anti-FGM/C activism as fulfilling their responsibility—as men and as professionals—thereby strongly aligning with the idealized "Somali manhood" which emphasizes responsibility, protection, and care for one's family and country (see El-Bushra & Gardner, 2016). Men emphasize the "leverage" that nubile men possess in anti-FGM/C work through their impact on marriageability criteria. They thus represent themselves as in a unique role with special responsibility in preventing FGM/C.

> Mahad: Before we attended the [anti-FGM/C] training, we used to date some girls who had undergone FGM. But since we now understand the problems of FGM and we learned new information about FGM, we no longer date women who have undergone FGM.

Utilizing this leverage of rejecting cut women, however, entails the risk of double victimizing (pharaonically) cut women if they are left unmarried and thus socially ostracized because of the very procedure aimed at securing their marriageability and social status. Furthermore, to change only the content of women's marriageability prerequisites does not challenge women's socio-economic subordination and dependency on marriage.

In the masculine responsibility discourse, "other" men with power and legitimacy (often older men) were characterized as not fulfilling their responsibility to challenge FGM/C. In complying with the responsibility ideal that for my interviewees implies challenging a practice valued by many older men, young men renegotiate the submissiveness ideal that guides young Somali men to accept the authority of older men (El-Bushra & Gardner, 2016). The men I interviewed also identified a controversy between their "responsibility" to prevent FGM/C and the community that questions their motives.

> Guled: Many people believe that there is an under the table purpose to eradicating FGM. […] like this project is from the West or this project has another purpose like supporting women to move away from religion.

Another controversy facing men engaged in FGM/C prevention appears to lie between the religious righteousness ideal (Arat & Hasan, 2018), which guides men to follow religious prescriptions—or religious scholars' interpretations of them – and the responsibility ideal (El-Bushra & Gardner, 2016), which guides men to protect women and children. In my data, young men seemed to handle the dissonance by categorically labelling any practice understood as required or not specifically disapproved/forbidden by religion (such as sunnah cutting) as not harmful, as I showed in the righteousness discourse. There is also a controversy in that men's domination is discursively reproduced by people aiming to prevent FGM/C, a practice maintained by hegemonic power relations. I argue that this is due to the understanding of Somaliland as a gender equal society with "well-balanced" gender roles and responsibilities, and framing of FGM/C as primarily a health issue—not a gender equality issue or an issue related to gendered violence. Furthermore, young people's agency in negotiating gender norms and power relations remains quite restricted in Somaliland.

Discussion

My research interest was to gain a deeper understanding and problematizing of the engagement of young men in the prevention of FGM/C. Focusing on discursive practices, I examined how young men engaged in preventing FGM/C in Somaliland discursively negotiate violence against women, gender norms, and the gender order. Secondly, I examined whether these negotiations are consistent with the goals related to deconstructing the patriarchal gender regime, on the one hand, and with prevailing masculinities, on the other. The four interlinked discourses that the interviewees employed—the righteousness discourse, the health discourse, the hierarchical difference discourse, and the masculine responsibility discourse—challenge some forms of violence against women, while legitimating others. They (re)produce prevailing masculinities and hierarchical gender order in many ways, but there are also discursive elements that renegotiate prevailing gender norms, particularly idealized womanhood.

In terms of violence against women, the interviewees construct sunnah cutting as "just pricking" or a "mild invasion," which undermines women's rights to bodily integrity. The health approach to pharaonic cutting, in turn, frames violence as a contributor to women's poor health, but not as a symptom of gender inequality. Furthermore, not framing pharaonic cutting as violence but as a violation of women's (right to) health remains problematic, because not labelling something as violence is a way of legitimating it. "Ignorant" mothers are presented as the primary perpetrators of pharaonic cutting, which downplays fathers' responsibilities in the continuation of FGM/C and ignores how the cultural understanding of gendered responsibilities assigns women the role of preparing daughters for adulthood and marriage.

The nascent emphasis on women's rights to bodily integrity, however, opens the possibility of emphasizing women's individual rights, enabling opposition to all FGM/C practices regardless of the health problems they do or do not cause. Furthermore, decoupling women's religious purity (that is, virginity and abstinence from premarital sex) from all types of FGM/C and coupling it instead to covering the body, behaving "modestly," and keeping away from men serves as a justification for efforts against FGM/C. On the other hand, the persistent emphasis on women's virginity and chastity risks upholding FGM/C, a traditional means of safeguarding these virtues.

In terms of the consequences of the identified discourses on the rigid gender norms and prevailing masculinities in Somaliland, the "heroic position" (Wetherell & Edley, 1999) to the religious righteousness ideal upholds a strict gender segregation. In addition, a strict gender segregation is presented as natural and fair by paralleling it with a "balance" between gendered rights and responsibilities, and by emphasizing "natural" gender difference—defining feminine and masculine as dichotomous and in opposition to one another. Emphasizing men's primary role as the family breadwinners and constructing men as "natural leaders" also reproduces the responsibility ideal central to "Somali manhood" (El-Bushra & Gardner, 2016). Compliance with the responsibility ideal—together with awareness of the health risks related to pharaonic cutting—entails that men feel "obliged" to protect women from the practice. They handle the discrepancy between the responsibility and righteousness ideals regarding the unclear religious status of sunnah cutting by categorically labelling sunnah cutting as not harmful even if, in reality, sunnah cutting can approximate or mirror pharaonic cutting.

By openly criticizing older men's "irresponsibility" regarding efforts to prevent pharaonic cutting, the young men renegotiate the submissiveness norm that guides young Somali men to accept the authority of older men.

Challenging the dominant religious interpretations of sunnah cutting as "honorable" renegotiates women's righteousness. The heavily gendered norm of religious purity (that is, virginity and abstinence from premarital sex) is reproduced, whereas the means to achieve it are renegotiated. Religious purity is decoupled from all types of FGM/C and attached to chastity—modest behavior and clothing, "veiling" oneself physically and figuratively. In other words, women appear capable of controlling their sexuality and refraining from premarital relationships without undergoing FGM/C, which expands their agency over their bodies. Furthermore, being not pharaonically cut, and, hence being sexually willing and "sensitive" after marriage, represent components of idealized womanhood. Education, too, emerges as part of idealized womanhood, but it mostly carries an instrumental ("good for the family and the husband") rather than intrinsic value. Women's primary role is designated in the private sphere, even when she engages in paid labor.

The discursive constructions above, which (re)produce or challenge rigid gender norms also negotiate the hierarchical gender order. Women's inferiority is also reproduced by constructing pharaonic cutting as a violation against women's "right to marry," without challenging women's socio-economic subordination and their dependency on marriage. Similarly, "protecting" women from FGM/C by affecting the marriageability criteria—the unique power that young men assign themselves—does not challenge women's dependency on marriage. Furthermore, being "responsible" by not marrying pharaonically cut women risks double-victimizing them—resulting in their ostracism because of the very procedure presumed to guarantee their marriageability and socio-economic status. Connecting women's FGM/C-related health problems to challenges in marital sex, in turn, allows for the transformation of FGM/C from a women's issue to an issue affecting everyone. However, if recognition of FGM/C-related marital sex problems mainly focuses on men's psychosexual problems, it risks attributing women's sexual health and pleasure primarily an instrumental value, that is, representing the wife as an investment whose "payback" FGM/C endangers.

Emphasizing women's traditional roles in the private sphere (as well as promoting women's education and economic role as "good for the family"), whilst

describing men as primary breadwinners and "natural leaders" maintain women's economic subordination. The opposition to women's entry into higher (political) positions—justified through Islam—signifies (partial) transfer from private to public patriarchy, and men's concern for losing their privilege. Representing men's superiority as "divinely ordained" renders it particularly stable, especially since the attached rigid gender segregation concentrates the power to renegotiate the gender norms and gender order in the hands of male religious scholars.

Describing Somaliland as gender equal and blaming women for "choosing to stay at home" and, thus, marginalizing themselves implies a denial and, hence, maintains structural factors restricting women's access to paid labor. Moreover, characterizing women as powerful change agents who work "behind the scenes" also downplays the need to promote women's formal decision-making power. Recognizing that women have strong legitimacy as anti-FGM/C campaigners due to their subjective experiences, however, renegotiates women's public agency. Yet, women are also characterized as the weaker sex requiring men's protection, which serves to justify men's superiority and domination.

References

Abdalla, M., Omer, A., & Elmusharaf, K. (2012). Female genital mutilation (FGM) in Sudan: What do men think? *Contraception*, *85*, 3, 317. doi: 10.1016/j.contraception.2011. 11.022.

Abdullahi, M.D. (2001). *Culture and customs of Somalia*. Westport, Conn.: Greenwood Press.

Ahmadu, F. (2000). Rites and wrongs: An insider/outsider reflects on power and excision. In B. Shell-Duncan, Y. Hernlund (Eds.), *Female "circumcision" in Africa: Culture, controversy and change* (pp. 283–312). Boulder: Lynne Rienner.

Ahmed, S.A., Maruf, H., & Hassan, S.M. Somaliland Fatwa Forbids FGM. *Voice of America*. 6 February 2018. Retrieved from https://www.voanews.com/a/somaliland-fatwa-forbids-fgm/4241641.html

Akar, S., & Tiilikainen, M. (2009). Katsaus islamilaiseen maailmaan. Naiset, perhe ja seksuaaliterveys [An overview of the Islamic world. Women, family and sexual health]. In *Väestötietosarja* [Population data series]. Retrieved from https://www.vaestoliitto.fi/ @Bin/373235/Islam09_LR.pdf

Anderson, K.L. (2009). Gendering coercive control. *Violence Against Women*, *15*, 1444–1457.

APD, Academy for Peace and Development (2002). *Women's rights in Islam and Somali culture*. Hargeysa: United Nations Children's Fund (UNICEF). Retrieved from https://www. unicef.org/somalia/SOM_WomenInIslam.pdf

Arat, Z.F.K., & Hasan, A. (2018). Muslim masculinities: What is the prescription of the Qur'an? *Journal of Gender Studies*, *27*, 7, 788–801.

Boddy, J. (1986). Body politics: Continuing the anticircumcision crusade. *Medical Anthropology Quarterly*, *5*, 1, 15–17.

Bradbury, M., Abokor, Y.A., & Yusuf, H.A. (2005). Somaliland: Choosing politics over violence. *Review of African Political Economy*, *30*, 97, 455–478.

Bruchhaus, E.-M. (2013). *Report on the situation of FGM/C in Somaliland*. Network against FGM/C in Somaliland (NAFIS).

Bumiller, K. (2010). The nexus of domestic violence reform and social science: From instrument of social change to institutionalized surveillance. *Annual Review of Law and Social Science*, *6*, 173–193.

Connell, R. (2005). Change among the gatekeepers: Men, masculinities, and gender equality in the global arena. *Signs: Journal of Women in Culture and Society*, *30*, 3, 1801–1825.

Constitution of the Republic of Somaliland [English] (2001). Retrieved from http://somalilandgov.com/new/wp-content/uploads/2012/06/Somaliland-Constitution-Text-only-Eng-IJ.pdf

Crawford, S., & Ali, S. (2015). *Situational Analysis of FGM/C stakeholders and interventions in Somalia*. UNFPA, UNICEF. Retrieved from http://orchidproject.org/wp-content/uploads/2015/02/Situational-Analysis-of-FGMC-Stakeholders-and-Interventions-in-Somalia1.pdf

De Miguel, A. (2015). *Neoliberalismo sexual* [Sexual neoliberalism]. Madrid: Cátedra.

Donnelly, J. (2007). The relative universality of human rights. *Human Rights Quarterly*, *29*, 2, 281–306.

El-Bushra, J., & Gardner, J. (2016). The impact of war on Somali men: Feminist analysis of masculinities and gender relations in a fragile context. *Gender & Development*, *24*, 3, 443–458.

Fairclough, N. (1992). *Discourse and social change*. Cambridge: Polity Press.

Fairclough, N. (1995). *Critical discourse analysis: The critical study of language*. Harlow: Longman.

Fairclough, N. (2001). *Language and power*. Harlow: Longman.

Flood, M. (2015). Work with men to end violence against women: A critical stocktake. *Culture, Health & Sexuality*, *17* (sup2), 159–176.

Gage, A.J., & Van Rossem, R. (2006). Attitudes toward the discontinuation of female genital cutting among men and women in Guinea. *International Journal of Gynecology and Obstetric*, *92*, 1, 92–96.

Gele, A.A., Bø, B.P., & Sundby, J. (2013). Have we made progress in Somalia after 30 years of interventions? Attitudes toward female circumcision among people in the Hargeisa district. *BMC Research Notes*, *6*, 122.

Gramsci, A. (1971). *Selections from prison notebooks*. Ed. and transl. by Q. Hoare, G. Nowell Smith. London: Lawrence and Wishart.

Gruenbaum, E. (2006). Sexuality issues in the movement to abolish female genital cutting in Sudan. *Medical Anthropology Quarterly*, *20*, 1, 121–138.

Gundel, J. (2006). *The predicament of the 'Oday': The role of traditional structures in security, rights, law and development in Somalia*. Nairobi: Danish Refugee Council & Novib/Oxfam.

Hansen, P. (2008). Circumcising migration: Gendering return migration among Somalilanders. *Journal of Ethnic and Migration Studies*, *34*, 7, 1109–1125.

Hearn, J. (2004). From hegemonic masculinity to the hegemony of men. *Feminist Theory*, *5*, 1, 49–72.

Hearn, J. (2014). Men, masculinities and the material(-)discursive. *NORMA*, *9*, 1, 5–17.

Hirdman, Y. (1990). The gender system. Theoretical reflections on the social subordination of women. In *The study of power and democracy in Sweden, English Series.* Report nr. 40. Uppsala: Maktutredningen.

Hooks, B. (2000). *Feminist theory: From margin to center*. Cambridge, Mass.: South End Press.

Hunnicutt, G. (2009). Varieties of patriarchy and violence against women: Resurrecting "patriarchy" as a theoretical tool. *Violence Against Women*, *15*, 5, 553–573.

Ismail, E.A., Ali, A.A., Mohamed, A.S., Kraemer, T., & Winfield, S. (2016). *Female genital mutilation survey in Somaliland. Second cohort*. Hargeisa: Edna Adan University Hospital. Retrieved from https://www.orchidproject.org/wp-content/uploads/2019/08/fgm-survey-in-somaliland-edna-adan-hospital-1.pdf

Johnsdotter, S. (2002). *Created by God: How Somalis in Swedish exile reassess the practice of female circumcision.* Doctoral thesis, Department of Social Anthropology, Lund University.

Julkunen, R. (2010). *Sukupuolen järjestykset ja tasa-arvon paradoksit* [The gender order and gender equality paradoxes]. Tampere: Vastapaino.

Kaplan, A., Cham, B., Njie, L.A., Seixas, A., Blanco, S., & Utzet, M. (2013). Female genital mutilation/cutting: The secret world of women as seen by men. *Obstetrics and Gynecology International*, article ID 643780. doi:10.1155/2013/643780

Kaplan, A., Nuño Gómez, L., Thill, M., & Vitale, V. (2017). *Multisectoral academic training guide on female genital mutilation/cutting*. Multisectoral academic programme to prevent and combat female genital mutilation/cutting (MAP-FGM). Retrieved from https://www.researchgate.net/publication/316667620_Multisectoral_Academic_Training_Guide_on _Female_Genital_MutilationCutting

Lazar, M.M. (2007). Feminist critical discourse analysis: Articulating a feminist discourse praxis. *Critical Discourse Studies*, *4*, 2, 141–164.

Lerner, G. (1986). *The creation of patriarchy*. New York: Oxford University Press.

Lewis, B. (1994). Legal and historical reflections on the position of Muslim populations under non-Muslim rule. In B. Lewis, D. Schnapper (Eds.), *Muslims in Europe* (pp. 1–18). London: Pinter Publishers.

Lewis, I.M., & Sundström, L. (2014). *Somalia ja Somalimaa. Kulttuuri, historia ja yhteiskunta* [Somalia and Somaliland. Culture, history and society]. Tallinn: Gaudeamus.

Luedke, A. (2015). The other war. Gang rape in Somaliland. Hargeisa: Strategic Initiative for women in the Horn of Africa (SIHA). Retrieved from https://sihanet.org/wp-content/uploads/2018/02/The-Other-War-Gangrape-in-Somalialand-SIHA-Network.pdf

Luedke, A. (2018). *Women do not belong under the acacia tree. The conditions experienced by women street vendors in Somaliland*. Strategic Initiative for women in the Horn of Africa nc(SIHA). Retrieved from https://sihanet.org/wp-content/uploads/2019/09/women-do-not-belong-under-acacia-trees.pdf

Lunde, I.B. (2012). *Eradicating female genital cutting: Understanding reality conceptions. A study on perceptions of female genital cutting in Hargeisa, Somaliland (Somalia)*. Master's thesis, Department of Community Health, The Faculty of Medicine, University of Oslo.

Lunde, I.B., & Sagbakken, M. (2014). Female genital cutting in Hargeisa, Somaliland: Is there a move towards less severe forms? *Reproductive Health Matters*, *22*, 43, 169–177.

Mackie, G., & LeJeune, J. (2009). *Social dynamics of abandonment of harmful practices: A new look at the theory*. Innocenti Working Paper No. 2009-06. Florence: UNICEF Innocenti Research Centre.

Metz, H.C. (1993). *Somalia: A country study*. Washington, D.C.: Federal Research Division, Library of Congress. Retrieved from https://www.loc.gov/item/93016246/

Mölsä, M. (2008). Tyttöjen ja naisten ympärileikkausperinne [The tradition of circumcision for girls and women]. In T.P. Brusila (Ed.), *Seksuaalisuus eri kulttuureissa* [Sexuality in different cultures] (pp. 116–133). Helsinki: Duodecim.

Newell-Jones, K. (2016). *Empowering communities to collectively abandon FGM/C in Somaliland: Baseline research report*. London: ActionAid.

Newell-Jones, K. (2017). *Female genital cutting in Somaliland: Baseline assessment*. Population Council.

Puleo, A. (1995). Patriarcado [Patriarchy]. In C. Amorós (Ed.), *Diez palabras clave sobre mujer* [Ten keywords about women] (pp. 21–54). Estella, Navarra: Verbo Divino.

Ronkainen, S. (2017). Mitä väkivalta on? Erontekojen tärkeydestä, yhteyksien näkemisestä [What is violence? About the importance of differences, seeing connections]. In J. Niemi, H. Kainulainen, P. Honkatukia (Eds.), *Sukupuolistunut väkivalta: Oikeudellinen ja sosiaalinen ongelma* [Gender-based violence: a legal and social problem] (pp. 19–35). Tampere: Vastapaino.

Sagna, M. L. (2014). Gender differences in support for the discontinuation of female genital cutting in Sierra Leone. *Culture, Health & Sexuality*, *16*, 6, 603–619.

Sakeah, E., Beke, A., Doctor, H.V., & Hodgson, A.V. (2006). Males' preference for circumcised women in northern Ghana. *African Journal of Reproductive Health*, *10*, 2, 37–47.

Shell-Duncan, B., Naik, R., & Feldman-Jacobs, C. (2016). *A state-of-the-art synthesis on female genital mutilation/cutting. What do we know now?* Population Council.

SIHA, Strategic Initiative for Women in the Horn of Africa (2013). *Towards developing a methodology to work with men against violence of women in the Horn of Africa*. Kampala. SIHA. Retrieved from http://sihanet.org/sites/default/files/resource-download/Workshop Report_Men Against VAW.pdf

SIHA, Strategic Initiative for Women in the Horn of Africa (2018). *Somaliland Religious Affairs Fatwa on Female Genital Mutilation/ Cutting—NOT TO BE MISLED* [press release]. http://www.sihanet.org/news/press-statement-somaliland-religious-affairs-fatwa-on-female-genital-mutilation-cutting-not-to-be-misled/

Stark, E. (2010). Do violent acts equal abuse? Resolving the gender parity/asymmetry dilemma. *Sex Roles*, *62*, 3–4, 201–211.

Talle, A. (1993). Transforming women into "pure" agnates: Aspects of female infibulation in Somalia. In V. Broch-Due, I. Rudie, T. Bleie (Eds.), *Carved flesh cast selves. Gendered symbols and social practices* (pp. 83–106). Oxford: Berg.

UNFPA, United Nations Population Fund (2013). *Driving forces in outlawing the practice of female genital mutilation/cutting in Kenya, Uganda and Guinea-Bissau*. New York: UNFPA.

UNICEF, United Nations Children's Fund (2010). *The dynamics of social change. Towards the abandonment of female genital mutilation/cutting in five African countries*. Florence: UNICEF.

UNICEF, United Nations Children's Fund (2013). *Female genital mutilation/cutting: A statistical overview and exploration of the dynamics of change*. New York: UNICEF.

Väkiparta, M. (2019). *Young men against FGM/C in Somaliland: Discursively negotiating violence, gender norms and gender order.* Doctoral thesis, Faculty of Arts, University of Helsinki.

Varol, N., Turkmani, S., Black, K., Hall, J., & Dawson, A. (2015). The role of men in abandonment of female genital mutilation: a systematic review. *BMC Public Health*, 15:1034. doi: 10.1186/s12889-015-2373-2.

Vestbøstad, E., & Blystad, A. (2014). Reflections on female circumcision discourse in Hargeysa, Somaliland: purified or mutilated? *African Journal of Reproductive Health*, *18*, 2, 22–35.

Walby, S. (1990). *Theorizing patriarchy*. Oxford: Basil Blackwell.

Walby, S. (2009). *Globalization and inequalities: Complexity and contested modernities*. Los Angeles, CA: Sage Publications.

Walby, S. (2011). *The future of feminism*. Cambridge: Polity Press.

Wetherell, M., & Edley, N. (1999). Negotiating hegemonic masculinity: Imaginary positions and psycho-discursive practices. *Feminism & Psychology*, *9*, 3, 335–356.

Whitehead, S. (2002). *Men and masculinities: Key themes and new directions*. Malden, MA: Polity.

Wilson, T. D. (2002). Pharaonic circumcision under patriarchy and breast augmentation under phallocentric capitalism: Similarities and differences. *Violence Against Women*, *8*, 4, 495–521.

Inger-Lise Lien

Is the Ritual of Female Genital Mutilation/Cutting a Traumatic Event?
Cases from The Gambia, Somalia, and Eritrea

Introduction

Female genital mutilation/cutting (FGM/C) is mostly done in Africa but, due to migration, the phenomenon is known in European countries and elsewhere. It has many negative health consequences, such as immediate complications and common experiences of pain, excessive bleeding, and problems with wound healing, as well as sudden death (Dirie & Lindmark, 1992; Rozi, 2010). The World Health Organization (WHO, 2001) has divided female genital mutilation (FGM) into four types: (1) Clitoridectomy, which involves partial or total removal of the clitoris and/or the prepuce; (2) excision involving partial or total removal of the labia minora and/or the labia majora; (3) infibulation which involves narrowing the vaginal opening by creating a covering seal with or without removal of the clitoris; (4) others, a category that includes all harmful procedures to the female genitalia for non-medical purposes.

The purpose of this article is to examine whether the cutting event is a traumatic event as defined by manuals of the American Psychiatric Association and the International Classification of Diseases of WHO. Through analyzing the cutting rituals through different professional perspectives, traumatology and anthropology, we will be provided with a fuller understanding of what is happening during the cutting ritual itself and see whether the structuring of the ritual can contribute to the protection of children by the way it is set up in different countries.

A study from Senegal with women that had types 1 and 2 FGM/C (Beherendt & Moritz, 2005) argues that disturbances found in women subjected to FGM/C could be classified as "a psychological trauma according to DSM-IV and a potential cause of post-traumatic stress disorder. "Several other studies indicate that women with FGC were more likely to experience psychological disturbances and suffer from anxiety, somatization, phobias, and low self-esteem, and to have a psychiatric diagnosis. Only one study on children is known, a case-controlled study of Kurdish girls in Iraq (Kizilhan, 2011). It found that cut girls showed a higher prevalence of post-traumatic stress disorder (PTSD), depression disorder, anxiety disorder, and somatic disturbance. All cut participants remembered the day of their cutting as extremely frightening and traumatizing, and 74 % were suffering from intrusive re-experiences.

Berg, Denison, and Frethem (2010) did a review to answer the question: What are the psychological, social, and sexual consequences of FGM/C? They included and summarized results from seventeen comparative studies with a total of 12,755 participants from communities in nine countries, mostly African, where cutting is practiced. All studies compared cut with uncut women. The researchers concluded that the evidence was insufficient to draw conclusions about the psychological and social consequences of the cutting while their results showed a higher risk of pain and reduction in sexual satisfaction and desire as consequences of the procedures.

In spite of the fact that the psychological consequences of FGM/C have been difficult to validate, there has long been a too ready perception that FGM/C in general is a traumatic experience that is a risk for getting PTSD symptoms (Köbach et al, 2018, p 7). Vloeberghs et al. (2012) in the Netherlands showed that one out of six of their African female informants had indications of PTSD and that one third of the cut sixty-six informants showed symptoms of depression and anxiety as well as chronical psychosocial problems. They concluded that these symptoms were linked to the early cutting experience in the childhood of these adult women now living in the Netherland.

However, the procedures of cutting are in most countries done within a context that includes a ritual ceremony. In this article, it will be discussed whether rituals of female genital cutting as practiced in three countries could be viewed as traumatic events, as defined by authoritative manuals. The descriptions of the rit-

uals are based on interviews with Gambian, Somali, and Eritrean women in Norway who retrospectively described their childhood experience when the cutting took place in their home countries. In order to assess whether the cutting event is traumatic in general, it is necessary to look more closely into 1) the definition of a traumatic event; 2) the structure of the event of the cutting ritual in three different countries; 3) the pain experience; 4) a description of the stages in the cutting ritual, and then try to: 5) identify if cutting is a traumatic event within the context of the rituals in three countries.

I am not going to identify any symptoms of traumatic stress among the informants, but solely try to look at the Events described by them in order to see if the events fall within the definition of a Traumatic Event as defined within the DSM-lV and DSM-5 manuals (APA, 1994, 2013).

Definition of a traumatic event

A traumatic event is a necessary precondition to be identified, before one is able to diagnose a post-traumatic stress disorder (PTSD). Many of those researchers already mentioned who have found symptoms of post-traumatic stress among women who have been cut during childhood have not tried to establish if the cutting episodes they link the symptoms to have been truly traumatic events. Only if individuals have experienced a qualifying traumatic event can a post-traumatic stress disorder be diagnosed (Anders et al., 2011). According to Pai et al. (2017), this diagnostic category is distinctive among psychiatric disorders in the requirement of an exposure to a stressful event as a precondition. North et al. (2009, p. 927) posed the following questions: "Without exposure to trauma, what is post-traumatic about the ensuing syndrome?" He thereby pointed to the fact that irrespective of symptoms indicating a post-traumatic disorder, this condition cannot actually by diagnosed if there prior to symptoms not has been a qualifying event that caused it. This is the reason why we have to look at the cutting procedure itself, first of all, to see if it fulfills the criteria that lie within the definition of a traumatic event in the manuals.

There have been four consecutive diagnostic manuals that have tried to define the traumatic event which is the necessary pre-condition for assessing a PTSD diagnosis. In the first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) (APA, 1952), the category "gross stress reaction" was introduced

and the event was defined as a stressor: "an extreme stressor that would be traumatic for almost anyone." In the DSM-IV (APA, 1994), in the definition of a traumatic event, the A1 criterion reads: "the person experienced, witnessed, or was confronted with an event or events that involved actual or *threatened death or serious injury*, or a *threat to the physical integrity* of self or others." The A2 criteria reads: "the person's response involved intense fear, helplessness, or horror." The event (A1) is thereby defined by the fact that it is *threatening* the person's life and physical health, and (A2) that the reactions are fear, horror and helplessness. In the ICD10 manual (The International Classification of Diseases) of the WHO (2015), the threat connected to an event followed by post-traumatic stress reactions is also clarified: (PTSD): "….arises as a delayed or protracted response to a stressful event or situation (of either brief or long duration) of *an exceptionally threatening* or catastrophic nature, which is likely to cause pervasive distress in almost anyone" (F43.1).

In 2013, a revised diagnostic manual, DSM-5 (APA, 2013), was introduced in which a traumatic event was defined somewhat differently from that in the DSM-IV, but here as well the idea of the threat was carried further. The disorder was reclassified from an anxiety disorder into a new category called "Trauma and Stressor-related Disorders," linking it more tightly to the classified event. The A criterion in DSM-5 now reads as follows: "Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: 1) directly experiencing the traumatic event(s); 2) witnessing the event as it occurred to others; 3) learning that close members or friends have experienced it, and 4) experiencing repeated or extreme exposure to details of the traumatic event." The A2 criterion from DSM-IV on the person's response with fear and horror, was dropped. The DSM-5 definition of a traumatic event has maintained the fact that *the event is experienced as threatening to life (threatening death)*. Stressful events such as divorce or job loss and terminal cancer are not considered as trauma according to this definition (Pai et al., 2017, p. 2). "Waking up during surgery" is mentioned as a potential traumatic event, but debilitating medical conditions and life-threatening illness are not (APA, 2013, p. 274).

Traumatic events, usually listed in trauma questionnaires, include rape, torture, combat, violence, and environmental catastrophes such as a tsunami, earthquake, fire, and events such as shooting, mugging, burglary, physical or sexual assault, bullying, and war. Some events are accidental and not planned, but other

events are intentional, organized, and planned by perpetrators, though not foreseen by the victims. A systematic review of 2,570 articles on traumatic stress events (Luz et al., 2011) found that the most frequently reported traumatic events are war-related traumas, motor vehicle accidents, and child abuse. A very small percentage of articles record terrorism, but the number of these events has increased in recent years. Violent crime accounts for 5.5% according to the review, and sexual trauma 4%. Most of the articles (93.6%) deal with adults only.

When it comes to FGM/C, however, the cutting event is not similar to a burglary, a car accident, or an earthquake, where everyone can agree upon the interpretation that the event is catastrophic and/or traumatic. Cutting is an event that usually and traditionally has taken place within a meaningful context of a ritual ceremony that is generally positively appreciated by the members of the community. Where FGM/C is practiced, it is often seen as necessary for the life of the child and not as a threat to it. The surrounding context is important for people's interpretation of what kind of event it is. Therefore, the context around FGM/C is necessary to grasp in order to understand whether or not the ritual of FGM/C is a traumatic event, within the different contexts. This context varies in different countries so that the event must be analyzed within its particular frame to see whether it is a truly traumatic event within its specific context; an event that might lead to a high risk of getting a traumatic stress reaction in the aftermath.

Ritual contexts of the cutting

The ritual ceremony of cutting has a structure where activities are orchestrated, and in which participants have different roles to enact in different arenas and within a timeframe. In the classical anthropology literature on rituals, boys' circumcision has had a central focus, and knowledge built from analyses of boys' ritual can be transferred to understand cutting rituals of girls, as they are usually built with the same structure.

A circumcision ritual is a rite of passage with a general pattern of three stages: separation, liminality, and incorporation (Turner, 1977; van Gennep, 1960). Van Gennep (1960) claims that "interest lies not in the particular rites, but in their essential significance and their relative positions within ceremonial wholes, that is, their order." According to Gluckman (1962), the sequence within the ritual is used to alter peoples' social relationships. Firth (1936) argues that rituals are an "excel-

lent means of classification," implying that rituals are used to declassify and reclassify the individual and give him/her a new position in the society. Turner (1977) argues that through a process of circumcision, a neophyte/child/adolescent in the liminal stage is in a state of *betwixt and between,* and that the person must demonstrate a passive and humble behavior and accept arbitrary punishment without complaint. This means that there may be a push built into the structure of the ritual to make the child accept pain when it arrives, and to be proud of having gone through it, when it ends. This movement in time and space can make the ritual meaningful for the person, in spite of the humiliation, suffering, and pain that it caused to the person in the liminal stage. It seems as if the humiliation and pain are a prerequisite for the change of the social status of the child when he or she is reintegrated back into the community.

Morinis (1985) has pointed to the fact that in most earlier studies on rites of passage almost all attention was focused on symbols and the social function of the rites, with very little focus on the painful ordeals as part of the process of entering adulthood. A circumcision ritual for boys deals with painful sacrifice and mutilation. Through the pain experience, the boy is asked to submit himself to the group; but he also alters his self-awareness. Living through a painful ordeal, according to Morinis' argument, can produce a peak experience, a heightened sense of self, a self that, if it becomes too strong, can become a problem for the community. The person can become "high" on him/herself. Thus, it becomes important to let society win over the individual. The rising self-awareness must be tamed, and the pain experience demanded by society is built into the ritual as a forced expectation. The child cannot escape, even though some do try to run away. They must submit to social pressure and what is expected from them. By sacrificing a piece of flesh in agony and pain, the boy or girl earns group membership and a new and enforced identity, not only through submission but also through the mark on the body. In this way, society "wins" over the individual. Clasters (1974) argues that an initiation ceremony among Guayaki Indian men in Paraguay, is like torture and cites them: "None of you is less than us, none of you is more than us. And you will never be able to forget it. You will not cease to remember the same marks that we have left on your bodies … the law written on the body is an unforgettable memory."

In Morinis' view (1985), there is not only a change of social status, or a mark on the body, but also a fundamental transformation within the mind of the person

who has gone through a circumcision ritual. This change in self-awareness and identity will adapt the individual for lifelong membership in the group.

Aronson and Mills (1959) conducted an experiment to test the hypothesis that persons who undergo an unpleasant initiation ritual to become members of a group increase their liking for the group. The results from the study support the hypothesis. Gerard and Mathewson (1966), in another study, also found evidence for the "suffering-leading-to-liking hypothesis." This means that a painful experience required to become member of a group can strengthen the liking of the group. Knowledge about such effects of pain may have motivated circumcision rituals, so that an ordeal is built into the kind of structure that Turner has described, a liminal phase where pain and humiliation is an important part in order to create motivation and loyalty as members of the community. It can lead to the contradiction that the endured pain itself becomes symbol of identity, pride, morality, and solidarity in the community, all of which will make a change in attitudes to FGM/C difficult.

Method

Twenty Gambian women, twenty Somalian, and fifteen Eritrean women were interviewed in Norway in 2018. The average age of the Gambian women was 41, the Eritreans 46, and the Somalis 43. The youngest informant was a Gambian 22 years of age, and the oldest a Somali woman of 68.

The interviews lasted for more or less two hours each, but when issues needed a fuller description, a second and third interview would take place. Because negative attitudes to audio-taping was encountered, it was decided not to audiotape the interviews, but to take notes.

The lead researcher, a social anthropologist, has been in touch with both the Gambian and the Somali communities since 2008 because of earlier research projects on FGM/C in Norway (Lien & Schultz, 2013, 2014; Schultz & Lien, 2013, 2014). One of the Gambian women, an activist and member of this project's user group panel, took part in the project as a gate opener and conducted some interviews herself. In some of the interviews, the anthropologist sat in, and in others, the Gambian woman performed interviews alone. A Somali midwife in her fifties was willing to assist in recruiting and interviewing Somali informants, making use of her huge network. Some interviews she did alone, and others were done by the anthropologist. The Somali interviewer found that several of the Somali women

were reluctant and needed strong persuasion. We assumed that this reserve was due to the attention the media has given the Somali diaspora through the years when it comes to FGM/C. We also encountered secrecy and silence in the Eritrean group. In Norway, there has been very little attention paid to the Eritrean diaspora in research in general. We found midwives and activists who were highly respected in the Eritrean community willing to assist in interviews and developed a network of informants who were willing to talk freely about FGM/C.

Methodologically, a snowball method was used (Goodman, 1961), as well as a kind of "targeted sampling" (Watters et al., 1989). Persons within the network that surrounded the Gambian, Somali, and Eritrean assistants were contacted and interviewed. Using contacts through acquaintances and key informants is a qualitative method commonly used by social anthropologists, and it implies borrowing the trust that the assistants have in the community. The interviews focused on the women's experience of the cutting ritual and their reactions. However, we wanted to pay attention to the number of traumatic experiences, as well, that the women had experienced during their lives, to see if they assessed FGM/C to be among these events. A list of potential traumatic events was made, based on the event list from the Harvard Trauma Questionnaire (Mollica et al., 1992; Jakobsen et al., 2007) and women were asked to mention how many events they had experienced.

Potential traumatic events from the list were: "lack of food," "military combat," "rape and sexual abuse," "murder of families and friends," "forced isolation," "kidnapping," "close to being killed," "serious physical injury," "violence" and, "being almost killed" and FGM/C. When adding FGM/C to the list, it was 24 events.

The project got ethical clearance from the Norwegian Regional Committees for Medical and Health Research Ethics on the 12th of September 2017.

FGM/C as a traumatic event

During the qualitative interviews with the Gambian, Somali, and Eritrean women, we showed them the list of twenty-four events, and asked them to tell us which they had experienced, and which one was the scariest. All of the women had been cut. Most of the Gambian women, eighteen out of twenty, mentioned that cutting was the worst event they had experienced in their life. On average, the Gambian women mentioned 1.7 scary events from the list that they had experienced themselves. They did not have any war experiences to report. However, four out of

twenty said that they had been raped. Out of the twenty-four events listed, the Somali women marked on average more than eight events. The most frightening events were related to warfare and seeing family members and others being killed, going into hiding, or having family members kidnapped. Three Somalis out of twenty mentioned cutting as the scariest event.

The Eritrean women marked on average 4.8 events that they had experienced in their life, mainly related to warfare, but none of them mentioned cutting as the scariest event. One reason for this may be that they could not remember this event, although they were all cut as infants. For both the Somalis and the Eritreans, war experiences were the most terrifying. When it comes to the Somalis, it may be that other more recent events in their life have been experienced as scarier than cutting, or that more recent events have overshadowed the cutting episode that happened a long time ago. Some Somali women complained that, due to migration, they had problems in their life that were more difficult and more important to deal with than FGM/C. But when asked to describe their cutting experience, they all remembered it as very painful.

However, the reason why there are differences in the way that these three groups report their reactions to the cutting procedure, may also be linked to the way that the cutting ritual is organized in the different countries.

Three types of cutting rituals

The informants were asked to describe the cutting rituals within the ethnic group they belong to. The Gambians belonged to the Mandinka tribe, the Somalis to several clans. Most of the Eritrean women belonged to the Tigrigna ethnic group. Most of the Gambians were married, and some of them lived in polygamous marriages, as the husband had taken a second or third wife in The Gambia. Most of twenty Somalis were divorced and lived as single mothers, and half of the Eritrean women interviewed were divorced. We discussed descriptions of the rituals with the informants during interviews and received three main ritual sequences that were quite different from each other in the way they were structured.

The cutting ritual in The Gambia

Half of the Gambian women in this study were cut between the age of five and thirteen, and the other half were cut when they were under five years of age. Only one woman was cut before she was one year old.

Within the Mandinka community in The Gambia, the ritual usually takes place in the woods over a period of weeks, but in the larger villages and the small cities, the bathroom is usually the place where the cutting is done. The cutting is supposed to be a secret, and the girls are often told they are going for a party. In the party, there is drumming and dancing. Before the child is taken to another place for cutting, she is blindfolded and not supposed to know the identity of the circumciser, or what is going to happen. Because of secrecy, many girls have said they had been tricked into cutting. Sometimes they can hear other girls cry, which scares them, because they do not know why.

After the cutting, the girls are taken to another place and put on a mat side by side with other girls, and the healing process starts. The girls are given a mentor, and they receive care from family members. The adult women also educate the girls about the way to relate to men and other family members, to avoid early sex, and information about how to behave as a woman in general. They learn songs and poems. The girls are informed that they must hold this ritual a secret. The time spent healing can last up to a month. They are given justification for the cutting and told about the necessity of the act of cutting, and the danger that will happen to them if they are not cut. The following cases show experiences and reveal variations within the ritual ceremony:

Case 1:

I visited my Grandmother. Then we went to the woods. Ladies were sitting there, playing and singing. Suddenly somebody came and took me, and I was blindfolded. I got scared, cried and wanted to go to my mother. I remember that somebody held my legs. You hear that somebody cries in the vicinity. You become very scared. I cannot remember the pain or the cutting. The pain came as a surprise. After this I was afraid of leaving my parents. I did not any more want to go to my grandmother. I have heard that other children get nightmares after happenings like this. (Gambian woman, 40)

Case 2

It happened when I was only four years old, with other girls in our community. We were all excited, our bodies prepared one by one with jujus sewn in our hair together with beads and seashells and washed with holy water by our mothers. We were told we were going to a party of some sort. We were taken to the bush, there were many of us, I cannot count but we were more than ten of different ages. At the bush I was allocated a place and when it was my turn I was taken in, my hands held by one woman and another held my legs and

I was cut, the process went on for ages before I was taken back to my mat. (Gambian woman, 42)

Case 3

I was circumcised with nine other girls at the age of nine. We all knew each other because we used to play together. We were excited, and we talked at length how lucky we were, going to a party. Of course, this was before we knew the horror that was to dawn on our innocent and tender genitals. We went in as ten girls but came out one less. One of our playmates died and we were told to never talk about it. I remember her laughter, her tears as she bled to death and no one could save her.

I do not know what the other girls went through, but I can tell you mine was extremely brutal … I screamed for help. I was forced down by women I trusted, and brutally violated with a razor blade that took away an organ I never knew even existed. I screamed, I cried for days and refused food or water as it was excruciating to go to the toilet to urinate or to poo.

My sex life is destroyed, and I have been told I should be thankful for this ritual. My friend died. I was told I should thank God that I survived. (Gambian woman, 36)

In these cases, the ritual followed a sequence: first, a party with dancing and drumming, then cutting, and then healing, care and education. As the cutting is kept a secret, the girls are psychologically unprepared for the cutting event within the ritual, and cutting comes as a shock. However, some women have said that they heard somebody scream, and then started to feel unsafe. Being blindfolded, they also felt insecure and this made them expect something terrible to happen. A couple of women told that they had been informed in advance that they would be cut, but they were not prepared for the fact that cutting would be painful. Others told that they had a feeling that something bad would happen. That implies that many felt threatened by the circumstances. Interviews with Gambian women show that most of them felt tricked into cutting. They also said they felt numbed, shocked, powerless, and forced, in addition to a terrible pain. It could be that they felt that their life and body were threatened. They obviously reacted with horror. Both the A1 and the A2 criteria related to the event within the DSM-IV definition of traumatic events seem to have been satisfied. Their experiences could also fall within the DSM-5 definition of traumatic event as "a threatened death, an actual or serious injury. "Some of them had started to fear that there was a threatening situation already in the sitting room, when there were drums and singing, as they could hear children screaming in the background. For others the fear came together with the

pain. As the children were not prepared in advance, they could not protect themselves during the cutting episode. However, after cutting, which was described as the most terrible experience in their life, some said that they had never been loved so much as during the healing period. Other women said that they felt proud and happy afterwards, as they now could do things they could not do before, such as eating burnt rice from the rice pot, which protects against evil magic.

The cutting ritual in Somalia

Somali girls are usually cut (type 3) when they are between four to fourteen years, with most (79%) when they are between five and nine years (UNICEF, 2006). The age of cutting among the Somali informants of this study was mostly seven to eight years. In our material. two girls were eleven and one girl thirteen when they were cut. The Somali cutting ritual, as described by Somali women living in Norway, follows a two-day pattern, with a fourteen-day healing phase afterwards. The day before cutting, guests are invited for coffee. Mothers and girls who have already been cut in particular, are invited. Their task is to harass the girls present, who are going to be cut, for not being cut. In addition the girls have usually been harassed for many months before the ritual takes place.

On the next day, the girl to be cut takes a bath and her body is anointed with sesame oil. Often the girls are instructed not to cry or raise their voices, but to be brave. The next step is to place the girl on the table; four women hold her arms and legs. The circumciser cuts the girl and stiches her labia. Then her legs will be tied together, and she will be put on a mat where she will stay for fourteen days, together with other girls, while they heal.

In the days following the cutting, families, neighbors, and friends arrive when they have the opportunity, bringing presents to the cut girls, crediting them for having been brave. After seven days, the circumciser usually inspects the girls to see if the healing process goes according to plan. There are no further celebrations related to the cutting procedure during the healing period, or after the wounds have healed.

However, there are variations in the way the ritual is performed, depending on where the cutting is taking place, and on other factors such as: whether it is done at home, at somebody else's place, or at the hospital; at which time of the day; the age of the girl; the number of girls cut together; the use of sedatives; the

role of parents and other visiting family members; the girl's behavior during cutting, girls running away; infections occurring afterwards so that the girl has to be removed from the group healing together. There can also be unexpected events, as in one of our cases when a relative sat on the girl's hip. Below, Somali informants describe their own participation within the cutting ritual.

Case 4

I was cut when I was 6 and I looked forward to it. All children look forward to it, but when they came and took me, I got scared. I was afraid of the pain. All girls have seen all other girls having pain, but in some ways, they have not taken it in. They may have thought that they should deal with it in a much better way than the others. Then it becomes terribly painful… Afterwards, when the wounds have healed, they become proud of what they have gone through. Most women experience this trauma when they are under six years of age. It is a trauma that sits there, and it is a new trauma when they get married, and a new trauma when they are going to have their first child. (Somali woman, 45)

Case 5

I myself did not have a feeling of being maltreated by my parents. Because I looked forward to it. I was begging my mother to cut me, and even made a deal with the circumciser. I said to the circumciser that she had to come to our house because my mother wanted to talk to her. I was eight years of age and impatient. (Somali woman, 41)

Case 6

I was cut when I was six years. I got sedatives so it was not very bad the first hour. I used to think that this is good, that this is something I am proud of. The girls compared their cutting, and I could see that mine was smaller than the other girls' cutting. I complained to my mother that my cutting looked awful, and that I had to do it again. My mother said I had the best cutting. It was precisely like the cutting of the prophet's daughter, and I would go to Paradise because I had such a nice cutting. (Somali woman, 40)

Case 7

I was cut at home together with three other girls. I was given a bath, and then I was taken in with the girls. I was lying with my head in my mother's lap. And my mother told me: You have to show me that you are my best girl. Your voice must not come out through the wall. You must not give me shame. You must be my good girl. She put her hand in my mouth and said I must not scream, and if it was painful I should bite her hand… It was terribly painful when I was cut. I did not bite my mother's hand. My labia were so small and the circumciser was holding them with her sharp nails. I could feel the nails through

my flesh. Then she was stitching and every needlestick was painful. I can remember everything as extremely painful. (Somali woman, 60)

Case 8

I wanted to be cut. When it was my sister's turn, I begged my mother to cut me as well. I did not want anybody to harass me and say I was unclean. I wanted to become like the other grown-up girls. But it was very painful. I knew that it would be painful, but I did not know how painful it would be. (Somali woman, 52)

Case 9

I was eleven when I was cut… it was very painful. I cried because of pain. I was forced and my aunt sat on my hip. I have cried a lot in my life because my hip was hurt … and I did not understand why. I have lots of problems because of the cutting… The same pain every day the rest of my life—today as well. It makes me unhappy. The medical doctor here in Norway thinks the pain in the hip is due to overweight, but it is because of the cutting. (Somali woman, 48)

Case 10

I will never forget. It sits in your heart. If I could decide, it would never have happened… Sometimes they take many girls together, but it was only me that day. I do not like to talk about it. They cut you. You bleed, and it is extremely painful. You also have to be cut when you get married, and when you give birth. (Somali woman, 68)

The harassment during the first day of the cutting ritual, and even long before, accelerates motivation to endure the shock of the pain that will come later. It is a psychological preparation for the cutting, but it can also lead to fear of the pain. Two women in this study tried to run away. One ran away before the cutting procedure because she was scared, and was forced to do it later. Another ran away after she had been put on the mat for healing. When she moved while leaving, it opened up the sealing. After some months, she herself as a small girl took the initiative, went to the circumciser's house and asked her to come and cut her again, paying her money she had stolen from her mother. We see from these examples that there is an awareness about the pain. Some of the girls are so afraid of the pain experience that they run away. Nonetheless, no informant has mentioned that she was afraid of dying, or that the cutting would injure her health. Rather, the opposite seems to be the case. Cutting is supposed to improve the health of the woman and girl. The clitoris is perceived to be a destructive tissue that needs to

be removed. It has also been said during interviews that a clitoris can harm the husband's health, as well, if he comes into contact with it. Therefore, removing this particular tissue and stitching the labia is a way to save the health of girls and women, improve their status, and provide a better chance to get married and give birth. Their moral and physical integrity is upgraded as seen from their own cultural perspective. But pain can be intolerable, so much so, that it is difficult to talk about it and also difficult to describe it later. Often the women interviewed would not go into details about the pain. It seems like women have been given instructions about ways of dealing with pain, as described in case 7. Some of the girls had begged for the cutting to be done, like in case 5 and 8, and two girls had themselves elected to go through the procedure a second time, on their own initiative.

To feel threatened is a subjective feeling. Subjectively the girls do not in general feel that their life is threatened, or that they are going to be injured. They are eager to go through the pain experience in order to achieve a better social position. From their point of view, their moral integrity, their marriage options, their social life, and physical health will be improved as a result of the cutting episode. However, from an objective professional "western" perspective, that does not take the girls' interpretation into account, the cutting could be described as an event that is a threat to the health and a "serious injury" (APA, 2013), and a "threat to the physical integrity of self or other" (APA, 1994). Yet, this conception is not part of the cultural understanding of the procedure in the community of which the girls are a part. Even though the girls are being prepared, the pain can come as a shock and be intolerable, more intolerable than they are prepared for, as Johansen (2002) has described in her analysis. What stands out in the women's descriptions of their childhood experiences is the fear of pain, and the fact that the intensity of the pain can come as a shock. So, there is an ambivalence here that they feel: a fear of pain and strong reactions to it, but a happy feeling afterwards that they went through the procedure to obtain a better social, moral, and physical health condition.

After the cutting, family members care for the girl, bringing her food, new clothes, and other presents. Healing together with other girls, getting support and rewards from family members and friends, the showing of respect by bringing gifts, can function as protective factors against the potential trauma symptoms that can follow. Most Somali informants say that they were proud of having undergone the ritual. Girls often use a mirror to compare their scars and admire the beauty of the cutting and share how well the cutting procedure went. They also boast about

being brave for not crying loudly. Even though the experience was painful, they had been prepared and motivated beforehand so that they did not feel that the cutting was a threat to their health and life. Thereby it can be doubted that the event should be understood as a traumatic event based on their own cultural and subjective interpretations.

The cutting ritual in Eritrea

Among the Tigrigna in Eritrea, a newborn girl is cut (type 1) (WHO, 2001) when she is seven days old—or at least before she is one year old. All the women interviewed reported they were cut when they were below the age of one. The ritual happens at home in the morning and there is no public ceremony with invited guests, neither before nor after the cutting. Women living in Norway, but born in Eritrea, who had witnessed a sister's cutting or somebody else's cutting, say that the baby screams agonizingly and cries for days because of the pain.

The cutting of babies in Eritrea is a ritual even though it has a different structure than in The Gambia and Somalia. It is arranged beforehand by the mother who prepares and invites helpers and circumcisers to come and do their job. The cutting procedure is usually done in the morning and takes only a few seconds. The infants' reaction to the inflicted pain, is screaming and crying that takes a long time of soothing and comforting by the mother who gives the baby the breast. The baby cries a great deal for several days, according to the women interviewed, especially when urinating; and the mother gives it milk and holds it whenever it cries. We can call this post cutting stage for a "healing stage" as well as an incorporation stage. The baby is redefined from being uncut, to being cut, and incorporated in society with a new social status and membership. Later when the baby girl grows up, she will not remember or know that she has been cut, unless she is told about it. The baby will not be able to interpret the incident one way or the other. Exactly what subjective mental processes that takes place behind the baby's reactions, is difficult to establish. It is obvious that the baby feels the pain, but if there is also a feeling of threat and danger to life, is difficult to assess.

The nature of the pain

Johansen (2002) is among the few researchers who have focused on pain related to FGM/C. In the study of Somali women's pain during cutting, she distinguishes

between "accidental pain" and "ritual pain," categorizing pain, it seems, according to several aspects, such as meaning-making based on culture, and the intensity of the pain as another. Johansen links "accidental pain" to war, famine, and catastrophes, which have no cultural underpinning, while "ritual pain" that is felt within a rite of passage, has a cultural meaning. Johansen finds that the Somali women in Norway who have been infibulated describe their pain as so intense that it exceeds cultural meaning and, therefore, she prefers to call it "accidental pain" rather than "ritual pain," even though the pain occurs within a ritual. It is the intensity of the pain that makes her describe it as "accidental," placing the experience outside culture.

However, as already shown, the pain that follows cutting, irrespective of its unbearable intensity, comes to the girl-child at a moment when she is in a stage within a ritual order. Pain is put in the middle of the ritual structure. It is intentional and planned by the adults. For the parents and circumcisers, there is culture all around, all the time, while for the child, the pain experience can be so intense that everything—culture as well—becomes irrelevant at the moment she is engulfed in the pain. "When pain is intense, body dominates consciousness," Scarry (1985) argues, as referred by Good (1994). At exactly this moment, the child's experience is "a counterpoint to culture" (Johansen, 2002). Intolerable pain would possibly set aside all kinds of thoughts for a moment for most people, but then gradually persons will get back to their senses and be able to reflect on the cultural significant of the pain experience.

Nietzsche's perspective on pain is that memory is created by the infliction of pain (Das, 1995). Clastres (1974) and Durkheim (1976) claim that "the pain that the individual learns to bear in initiation rituals becomes not only a witness to his moral life, but also, through the mediation of the body, a means of remembering, an effective obstacle to any forgetfulness by the individual of his membership of his moral community" (Das, 1995).

The cutting ritual in Eritrea is different from the other rituals in The Gambia and Somalia, as it takes place before the child is one year old. The baby girl has no opportunity to understand why she suddenly experiences overwhelming pain. Seen from the perspective of the baby, the event cannot be explained in cultural terms: there is no cultural meaning-making for the baby, even though it is a ritual and has a depth of cultural meaning for the adults around. The infant cannot prepare for the pain, reduce the fear and the threat of the pain or take in cultural

instructions beforehand, nor follow the justification for the act of cutting later. Pain comes as a shock when it arrives, and may be experienced as a threat, even though the baby has no concept for the experience of being threatened.

According to Craig et al. (2002), all sensory and affective qualities are present in newborns, but the infant's ability to understand the meaning of a pain experience is inadequate. For the child, crying, body language, and facial expressions are ways of communicating pain in its purest form. Taddio et al. (1997) found that boys at age four to six months, who had been circumcised, reacted with a greater behavioral pain response during an immunization at six months of age than those in a control group who were uncircumcised. This suggests that the pain experienced by the infant can have long-term consequences, and be remembered by the body, even if it is not remembered by the mind later. Von Baeyer et al. (2004) argue that behavioral changes due to pain can create lower tolerance for pain and cause emotional distress later in life. They also claim that sensitization may occur with more pain, and especially with a strong painful event like circumcision/cutting.

In the DSM-5, the definition of a traumatic event for children under six years of age is equal to the definition for adults, but there is some modification of other criteria that deal with reactions after the traumatic event. However, pain as a criterion is absent within the manuals, both when it comes to children and when it comes to adults. Thereby there must be other factors present such as threat to life, serious injury, or sexual violence that must be identified in order for cutting of the infant to be classified as a traumatic event (ASA, 2013).

The subjective and objective understanding of the event

Within the definition of a traumatic event in the DSM-IV, we find "the person" concept present: "The person experienced…". In the DSM-5, the person concept is removed and substituted by a verbalized formulation: "Exposure to actual or threatened death…" In addition, the person's reaction is removed from the definition. What implication can this way of formulating the definition of the event have for the understanding of FGM/C as a traumatic event? Should a subjective interpretation of the event be listened to at all? Should the power of definition lie solely in the hands of the medical experts, even though threat to life and injury are denied by the person or the community that practices cutting? Based on facts, the medical experts would be able to conclude that there is a serious injury that has

taken place, as tissue has been removed. A conflict between the subjective and objective understanding of a Traumatic Event becomes a challenge for the interpretation of cutting as a traumatic event. A person's own positive interpretations of the experience may contribute to protection against trauma at the moment of being cut, thereby cutting will not qualify as a Traumatic Event. The experience is not seen as a threat but as a necessity. On the other hand, an objective medical perspective that takes the power of definition away from the persons affected, or from the community that practices cutting, may with extrapolation of the worst case scenario conclude that FGM/C is truly a standardized traumatic event, as tissues are removed which could lead to serious injury and be life threatening. This conclusion may be drawn in spite of the subjective understanding of the Event as a Good Event, but painful. Medical experts may also be inclined to think that cutting must be traumatic because it is so very painful, even though pain alone is not part of the definition of a traumatic event. It seems like the DSM-5 to a higher degree than previous manuals can lead medical experts to ignore the subjective interpretation of the cutting event, when defining cutting as a Traumatic Event.

Three stages in a rite the passage—a conclusion

The ritual of cutting/circumcision has been described by anthropologists as a rite of passage with three stages: the separation stage, the liminal stage, and the incorporation stage. The anthropological focus has been on the way the ritual moves the child from one status to the other through the ritual, in order for the child to be reintegrated as a full member in society, after being separated from it. The painful ordeal has not been the central focus among most anthropologists, which has been on the symbols and movement of the child towards the increased status, and the symbolic and cultural factors within the ritual.

However, if we analyze the ritual from another angle, and put at the center of the analyses the experience of the ordeal for the child, then the first stage of the ritual could be described as a motivation and preparation stage for the painful ordeal in the second stage. The last stage would represent a healing and justification stage that has the job of healing the child both physically and mentally after the painful ordeal. Schultz and Lien (2014) have described the healing factors at work in the Gambian ritual at this last stage, based on Hobfall's five elements of community resilience (Hobfoll et al., 2007): to promote safety, calmness, efficacy, hope, and connectedness. In The Gambia, these elements were found during the

last stage of the ritual (Schultz & Lien, 2014). We can imagine that these factors are at work in Somalia as well, though the last stage is not so long lasting, and not as organized as in The Gambia. One may also argue that breast-feeding in Eritrea has the potential to reduce the shock reactions of an infant.

Table 1. The stages in anthropological and traumatological perspectives

Anthropological description	Stage 1 Separation	Stage 2 Liminality	Stage 3 Incorporation
	Separated from community	Betwixt and between Painful Ordeal	Membership in Society Increased social status
Traumatological description		Traumatic Event Immediate reactions	Symptoms Treatment and care

A traumatological analysis would put the main focus on stage 2, on the painful ordeal, to see if it is a traumatic event that can have a harmful consequence for the mental health of the child.

As we have seen in this article, there are variations between countries in the way that the ritual is organized, so that cutting can be more of a traumatic event in one country than in another. There is unclarity about the seriousness of cutting as an injury to health, as threatening death, and also unclarity about the role of a subjective understanding in relation to a professional medical understanding when identifying a Traumatic Event. We cannot presume in all cases that cutting would be a Traumatic Event that could possibly be linked to later PTSD symptoms. We can also not take for granted that a cutting ritual will not be a traumatic event that would not lead to PTSD symptoms in the aftermath. There are several risks to the health and well-being for those who have been cut. But we need to investigate the events themselves before mechanically, for all cases, drawing conclusions about cutting as a Traumatic Event triggering PTSD symptoms shortly after, or later in life.

The combination of the two perspectives, anthropology and traumatology, can be fruitful for the overall understanding of the effect of the ritual process for the child's mental health, and for the child's social status and membership in the community. In Table 1, I have tried to visualize the two perspectives and show where they would put their main focus. The anthropological perspective would in most cases be processual with a focus on the cultural context and the changes of social status, while we can imagine that a traumatological perspective would try to identify a traumatic event and then investigate the person's reactions and symptoms in the aftermath in order to know if it is necessary to provide professional treatment, or if community treatment exists and is sufficient.

In Table 2 I have tried to visualize a standardized description of the ritual in three countries. The degree of importance that is put on the different stages in the different countries shows the balance between preparation/motivation, pain and treatment/justification.

Table 2. The presence of elements of the ritual stages in The Gambia, Somalia, and Eritrea

Standardized description from countries	Stage 1 Preparation and motivation	Stage 2 Painful ordeal Cutting/circumcision	Stage 3 Healing, communal treatment and care/ Justification
The Gambia		X	XX
Somalia	X	X	X
Eritrea		X	

In The Gambia, the first stage does not, in general, prepare and motivate the child to go through the second stage, which is the cutting. Instructions in the first stage are not given about ways of behaving in the Gambian ritual, as it is a secret. Instead the child has been misled to think that she is going to have a nice party, and

she is blindfolded before entering the second cutting stage, where pain often comes as a shock.

However, the healing process, in stage 3, is important within the Gambian ritual, and has been assigned a double weight compared to the Somalian healing stage, visualized with two x's compared to one. The three weeks or the month that the Gambian girls stay together with family and friends who care and give support to the cut girls, may reduce the damage that may have been inflicted to psychological health in the second stage. I will argue that the lack of preparation in the first stage can have the effect that the Gambian ordeal in stage 2 is more likely to be categorized as a Traumatic Event based on the fear and the threat that is felt. However, the care in stage 3 may mitigate or protect against negative psychological effects of the cutting, including PTSD. However, we cannot rule out that there are risks involved in developing PTSD reactions in the aftermath, in spite of the protection given.

In Somalia, there is another, more equal balance between the first, second, and third stage. The harassment in stage 1, as well as harassment endured a long time before, gives motivation to go through the pain of stage 2, without feeling that life or health is at stake. Pain is known to happen, and seen as a necessity, and is feared by the children. Thereby there is an ambivalence within the ritual. Girls are looking forward to undergoing the ritual in order to get the status reward, but they fear the pain. Pain can also be shocking in its intensity. Pain, or the intensity of the pain, is not mentioned in the DSM manuals. A subjective feeling of the threat to life and health is not necessarily something the girls think about at all; rather the opposite, they think of cutting as a benefit. Instead, they feel threatened by an expected intolerable pain, being afraid they cannot deal with the pain, the way it is expected. From a professional medical perspective, however, the cutting event can be interpreted as a traumatic event as it includes a removal of tissues. It is an injury of the genital organs, seen from a medical perspective. But the girls and parents do not necessarily think that there has been an injury to the health. Rather the opposite, they see the cutting as something that the girls will benefit from healthwise as well as socially. The subjective point of view, as well as the cultural point of view will thereby not match the criteria of a traumatic event.

However, there will always be variations in the way each individual goes through the ritual process, and interprets the pain experience, and the perceived threat to health and life. Incidents can happen, as well, that makes the painful

ordeal very traumatic from a subjective point of view. One Somali woman described the fact that her aunt sat on her hip and damaged it as the most terrible thing that happened during the ritual. A Gambian woman told that when her blindfold was removed, she saw a shining razorblade in the hand of the circumciser that affected her eyes so much that her eyesight got blurred for many years thereafter, without a medical reason. Other women told that they were bleeding so much that they had to be taken out of the healing stage and taken to the hospital or home, which would remove them from cultural protective factors.

It is only within the Eritrean ritual that the pain stands out as unexplained for the child. There has been no motivational stage in the ritual. There is also no last justification stage present, but a healing stage. A child before the age of one, would not have enough language comprehension to take in cultural meaning making and justifications. For the child, the event is a painful cutting. According to Hernlund (2000), a cutting process where ritual functions are reduced and privatized would best be described as a "cutting without a ritual." However, for the grown up's, it is a ritual performed on most newborn girl children, even though there is no celebration ceremony or justification stage involved. Unfortunately, pain and its intensity have not received sufficient attention in the manuals used to identify Traumatic Events, which may be a weakness of the definition in the manuals.

According to professional interpretation following the diagnostic criteria in DSM-5, when cutting an infant is performed in a way that is life threatening, even though the infant would have no comprehension about the threat, would justify defining cutting within the ritual as a traumatic event. Unfortunately, there is a tendency in many countries to perform cutting at a lower age, and to reduce the content within the ritual, particularly reducing the last stage (Hernlund, 2000; Shell-Duncan et al., 2011). Changing the ritual in this way may put more children in the world at risk of experiencing the cutting as a traumatic event. However, it is difficult to know how small newborn children experience and understand pain, and how they memorize it. Thereby it is necessary to investigate the effect of pain on traumatic events and to assess what role pain can have within the definition of Traumatic Events, especially when pain is involved within a ritual that is interpreted culturally as something very positive and necessary.

References

Anders SL, Frazier PA, Frankfurt SB. (2011) Variations in Criterion A and PTSD rates in a community sample of women. *Journal of Anxiety Disorder*, *25*, 2176–84.

APA, American Psychiatric Association (1952). *Diagnostic and statistical manual of mental disorders.* Washington, DC: APA.

APA, American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders*. 4th ed. Washington, DC: APA; pp. 209-211.

APA, American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders*. 5th ed. Washington, DC: APA; pp. 271–289.

Aronson, E., & Mills J. (1959). The effect of severity of initiation on liking for a group. *Journal of Abnormal and Social Psychology, 59*, 2, 177–181.

Beherendt, A., & Moritz, S. (2005). Posttraumatic stress disorder and memory problems after female genital mutilation. *American Journal of Psychiatry, 162*, 5, 1000–1002.

Berg, R.C., Denison, E., & Fretheim, A. (2010). *Psychological, social and sexual consequences of female genital mutilation.* Report 2010(13). Oslo: Norwegian Knowledge Centre for the Health Services.

Clastres, P. (1974). *Society against the state*. Boston, MA: Zone books.

Craig, K.D., Korol, C.T., & Pillai, R.R. (2002). Challenges of judging pain in vulnerable infants. *Clinics in Perinatology, 29*, 3, 445–457.

Das, V. (1995). *Critical events: An Anthropological Perspective on Contemporary India.* Oxford: Oxford University Press.

Dirie, M., & Lindmark, G. (1992). The risk of medical complications after female circumcision. *East African Medical Journal* 69 (9): 479–482.

Durkheim, E. (1976). *The Elementary Form of Religious Life.* Abingdon: Routledge.

Firth, R. (1936). *We the Tikopia.* New York, NY: Routledge.

Gerard, H.B., & Mathewson, G.C. (1966). The effects of severity of initiation on liking for a group: A replication. *Journal of Experimental Social Psychology, 2*, 3, 278–287.

Gluckman, M. (1962). *Essays on the ritual of social relations.* Manchester: Manchester University Press.

Good, B. J. (1994). A body in pain—the making of a world of chronic pain. In M.-J. Delvecchio Good, P.E Brodwin, B.J. Good, A. Kleinman (Eds), *Pain as human experience: An anthropological perspective* (pp. 29–49). Berkeley, CA: University of California Press.

Goodman, L.A. (1961). Snowball sampling. *The Annals of Mathematical Statistics, 32*, 148–170.

Hernlund, Y. (2000). Cutting without ritual and ritual without cutting: female "circumcision" and the re-ritualization of initiation in The Gambia. In B. Shell-Duncan, Y. Hernlund (Eds.), *Female "circumcision" in Africa: Culture, controversy, and change* (pp. 235–252). Boulder, CO: Lynne Rienner Publishers.

Hobfoll, S.E., Watson, P., Bell, C.C., Bryant, R.A., Brymer, M.J., Friedman, M.J., et al. (2007). Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence. *Psychiatry, 70*, 4, 283–315.

Jakobsen, M., Sveaass, N., Johansen, L.E., & Skogøy E. (2007). *Psykisk helse i mottak: Utprøving av instrumenter for kartlegging av psykisk helse for nyankomne asylsøkere* [Mental health in reception: Testing of instruments for mapping mental health for newly arrived asylum seekers]. Oslo: Nasjonalt kunnskapssenter om vold og traumatisk stress [Norwegian Centre for Violence and Traumatic Stress Studies].

Johansen, R.E.B. (2002). Pain as counterpoint to culture: Toward an analysis of pain associated with infibulation among Somali immigrants in Norway. *Medical Anthropology Quarterly, 16*, 3, 312–340.

Kizilhan, J.I. (2011). Impact of psychological disorders after female genital mutilation among Kurdish girls in Northern Iraq. *The European Journal of Psychiatry, 25*, 2, 92–100.

Köbach, A., Ruf-Leuschner, M., & Elbert, T. (2018). Psychopathological sequelae of female genital mutilation and their neuroendocrinological associations. *BMC Psychiatry, 18*, 1, 187.

Lien, I.L., & Schultz, J.H. (2013). Internalizing knowledge and changing attitudes to female genital cutting/mutilation. *Obstetric Gynecology International,* 1–10. doi:10.1155/2013/467028

Lien, I. L., & Schultz, J. H. (2014). Interpreting signs of female genital mutilation within a risky legal framework. *International Journal of Law, Policy and the Family* 28(2): 194–211.

Luz, M.P., Mendlowicz, M., Marques-Portella, C., Gleiser, S., Berger, W., Neylan, T.C., Coutinho, E.S., & Figueira, I. (2011). PTSD criterion A1 events: A literature-based categorization. *Journal of Traumatic Stress, 24*, 3, 243–251.

Mollica, R.F., Caspi-Yavin, Y., Bollini, P., Truong, T., Tor, S., & Lavelle, J. (1992). The Harvard Trauma questionnaire: Validating a cross-cultural instrument for measuring torture, trauma and posttraumatic stress disorder in Indochinese refugees. *The Journal of Nervous and Mental Disease, 180*, 2, 111–116.

Morinis, A. (1985). The ritual experience: Pain and the transformation of consciousness in ordeals of initiations. *Ethos, 13*, 2, 150–174.

North, C.S., Suris, A.M., Davis, M., & Smith, R.P. (2009). Toward validation of the diagnosis of posttraumatic stress disorder. *American Journal of Psychiatry, 166*, 1, 34–41.

Pai, A., Suris, A.M., & North, C.S. (2017). Posttraumatic stress disorder in the DSM-5: Controversy, change, and conceptual considerations. *Behavioral Sciences, 7*, 1. doi: 10.3390/bs7010007

Rouzi, A.A. (2010). Epidermal clitoral inclusion cysts: Not a rare complication of female genital mutilation. *Human Reproduction, 25*, 7, 1672–1674.

Scarry, E. (1985). *The body in pain: The making and unmaking of the world.* New York: Oxford University Press.

Schultz, J.H., & Lien, I.L. (2013). Meaning-making of female genital cutting: Children's perception and acquired knowledge of the ritual. *International Journal of Women's Health, 5*, 165–175.

Schultz, J.H., & Lien, I.L. (2014). Cultural protection against traumatic stress: traditional support of children exposed to the ritual of female genital cutting. *International Journal of Women's Health, 6*, 207–219.

Shell-Duncan, B., Wander, K., Hernlund, Y., & Moreau, A. (2011). Dynamics of change in the practice of female genital cutting in Senegambia: Testing predictions of social convention theory. *Social Science & Medicine, 73*, 8, 1275–1283.

Taddio, A., Katz, J., Ilersich, A.L., & Koren, G. (1997). Effect of neonatal circumcision on pain response during subsequent routine vaccination. *Lancet, 349*, 9052, 599–603.

Turner, V. (1977). *The ritual process: Structure and anti-structure.* Chicago, IL: Aldine Publishing.

UNICEF, United Nations Children's Fund (2006). *Multiple indicator cluster surveys (MICS) Somalia.* [Internet]. Retrieved from http://microdata.worldbank.org/index.php/catalog/51

Van Gennep, A. (1960). *The rites of passage.* Chicago, IL: University of Chicago.

Vloeberghs, E., van der Kwaak, A., Knipscheer, J., & van den Muijsenbergh, M. (2012). Coping and chronic psychosocial consequences of female genital mutilation in the Netherlands. *Ethnicity & Health, 17*, 6, 677–695.

Von Baeyer, C.L, Marche, T.A., Rocha, E.M., & Salmon, K. (2004). Children's memory for pain: Overview and implications for practice. *Pain, 5*, 5, 241–249.

Waddell, G., Newton, M., Henderson, I., Somerville, D., & Main, C.J. (1993). A Fear-Avoidance Beliefs Questionnaire (FABQ) and the role of fear-avoidance beliefs in chronic low back pain and disability. *Pain, 52*, 2, 157–168.

Watters, J.K., & Biernacki, P. (1989). Targeted sampling: Options for the study of hidden populations. *Social Problems*, *36*, 4, 416–430.

WHO, World Health Organization (2001). Female Genital Mutilation. The prevention and the management of the health complications. *Policy guidelines for nurses and midwives*. Geneva: WHO.

WHO, World Health Organization (2015). ICD-10 Manual. Retrieved from https://icd.who.int/ browse10/2015/en#/F43.1

Lisen Dellenborg & Maria Frederika Malmström

Female Circumcision/Genital Mutilation and Human Rights: Ownership of Personal Change[1]

Introduction

In recent decades, female genital mutilation has come to be regarded as a major breach of human rights. International anti-FGM agencies such as WHO, UNICEF and The Red Cross/Red Crescent have drawn up strongly worded documents designed to protect women and children from this procedure. Nonetheless, it continues to be practised, in keeping with prevalent power relations and local cultural values (cf. Cowan, Dembour, & Wilson, 2001). International resolutions and national legislation alone are inadequate for putting a stop to well-established social patterns. The question therefore is how sustainable social change may be brought about among people who support a particular practice that is considered by others to be an offense.

Our chapter is based on ethnographic fieldwork conducted in Cairo, Egypt, and Casamance, Senegal, where female genital cutting is widely referred to by those who practise it as "circumcision" (*tahâra* in Egypt and *sunay* or *circoncision* in Senegal). We argue that efforts to stop circumcision must be based upon 1) knowledge of what the practice means to those who use it, 2) an understanding of the heterogeneity of the group and 3) the active participation of those that it con-

[1] This is an updated, with major revisions, version of a text that has been published in Swedish in Internationella relationer: könskritiska perspektiv, P. de los Reyes, M. Eduards & F. Sundevall (Eds., 2013).

cerns. Circumcision must be understood in the dynamic cultural and political context in which it takes place—a context that includes internal contestation that interplays with global shifts in a variety of ways.

Various actors in Egypt and Senegal, such as national level decision makers, international organizations, and local activists, are all working to stop female genital mutilation within the framework of equality and human rights. Although local activists may use different approaches, there are often problems in their communication with the practicing people, due to factors such as class and education differentials. The question is whether the practice of female genital mutilation/circumcision needs to be seen as a controversy between "African women" and "western feminists" (Moore, 2007). Our research has shown that women who have undergone the procedure and who do not belong to the elite or any activist organizations are often silenced in public space. At the same time, it seems that it is precisely this group that holds the key to change; if these women are not active participants, then campaigns against the practice will be fruitless. Female circumcision is a *contemporary* phenomenon, and its meaning is being actively negotiated in relation to social factors such as power structures, religion, and moral notions. Efforts to stop female genital mutilation therefore meet various obstacles, depending upon time and place.

This chapter describes how different meanings relating to gender identity and morality are ascribed to same type of procedure, that is, clitoridectomy[1] (Type II according to the WHO definition) in Cairo and in Casamance. We argue that human rights interventions therefore need to be designed differently for each case.

Choice of concepts

Female genital mutilation has long been the standard term used in the international anti-FGM campaigns. It was coined in the 1970s by the American feminist and journalist Fran Hosken in order to evoke opinion. Many Western and African feminists agreed that "circumcision" was a mitigating term that tended to equate the practice with male circumcision and conceal the gender-based sexual violence against women. However, anthropologists (e.g., Hernlund & Shell-Duncan, 2000) note that using the term genital mutilation tends to counteract efforts to change

[1] Clitoridectomy means that the external part of the clitoris is removed. For basic facts, see the WHO's information available at https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation (31-01-2018).

practices since both women and men take offense at the idea that they would mutilate their children. We have not met any non-activists in the local populations who use the term mutilation. The conceptualization of female circumcision as a form of genital mutilation is culturally constructed. Like sexuality, ideas surrounding circumcision are shaped by norms, history, and context. The idea that the circumcised female body is mutilated and frigid is the product of interventionist notions that are inculcated through global hegemonic structures (Malmström, 2013). Activists at various levels are increasingly choosing to use the more neutral, less offending term female genital cutting (FGC). Since we are dealing with local people's understanding, in the rest of this chapter we choose to use the local term circumcision as well as genital cutting instead of mutilation, except when referring to an activist- or law context.

Fieldwork and the role of the researcher

The aim of ethnographic fieldwork is to understand how people in a particular group or place understand a phenomenon such as circumcision in its broader social, cultural, political, and historical context. Fieldwork gives the researcher an opportunity to meet people in their own environment, and to observe and participate in their activities (Dellenborg, 2013). To be invited into people's lives, the researcher needs to first spend time building up relationships and earning people's trust. Several methods may be used. Interviews enable the researcher to gather people's narratives. However, the most important method is participant observation since it enables the researcher to create an understanding of people's everyday lives in relation to the broader context in which they are framed. This method helps the researcher become aware of inconsistencies between what people say that they do and what they actually do. Analysis of these differences can reveal what is considered permissible to say, to whom and under what circumstances, and it may shed light on things that are embodied or are difficult to express in words. Participant observation is an ongoing reflexive process in which the researcher's understanding is always evolving while shifting between engagement in people's everyday worlds and adopting an analytical distance when writing up (Nässén, 2013). Ethnographic fieldwork is a source of knowledge that changes what we know not only about the "other" but also about ourselves. The researcher's self-image and insight into their own society is altered in this process (Borneman & Hammoudi, 2009).

Ethnographic methods entail that the researcher themself is the primary tool. The results depend on the interaction between them and the people with whom they establish contact in the field. The researcher's interest may be found disturbing or irrelevant for those involved. For instance, many of the women we met had lost several children. With some irritation, they might blurt out things like: "There is so much greater suffering in our lives than circumcision! Don't you want to hear about that?" The stories that form the basis of the research are a result of the interplay between the researcher's presence, questions and reflections and their interlocutors. Interpreters and research assistants constitute a third voice that also contributes to the shaping of narratives. It is important to stress and problematize the fact that however carefully various voices are presented, the researcher has ultimate control over the form the final narrative is given.

Fieldwork focusing on this practice was carried out by Maria Malmström in Egypt for one year between 2002 and 2003 in the suburbs and some central areas of Cairo. Malmström has since returned to Cairo almost every year to conduct new research focusing on political bodies. The first area she worked in is located in the city center, which is characterized by classical Islamic architecture. The second area was in the suburbs of Cairo, where there are newer buildings. For ethical reasons, the neighborhoods are not identified by name. The women Malmström spent time with lived in low-income areas of Cairo, but their lifestyles were not strictly associated with economic class or consumption. The group included Muslim women from various socio-economic and educational backgrounds and women of different generations, marital status, and sexual orientations.

In Senegal, fieldwork was conducted by Lisen Dellenborg for three months in 1994-1995 and seventeen months in 1997-1999. Some urban areas were included but most of the time was spent in the countryside in Casamance, in southern Senegal, among people who refer to themselves as *Jola*. They live off agriculture, petty trade, and seasonal labor migration; young and adult women migrate when they can to The Gambia and Dakar to work as house maids. When they marry, women leave their natal village and move to their husband's. However, they retain strong bonds to their natal villages, where they enjoy much authority as sisters. Being a wife is a less prestigious position, but motherhood is crucial for being considered an adult and moral woman. The highest family position a woman can acquire is that of widow in her oldest son's household. Although her son is still the head of his household, his mother commands considerable authority

in the family and local community. As in all societies, social status is important for a person's agency, but this inevitably intersects with individual personality and personal relationships such that any individual woman's authority may shift. When Dellenborg was conducting fieldwork, it was the elderly mother in her host family who took the newcomer under her wing and introduced her to the women in the surrounding villages. Dellenborg had not yet become a mother herself and so was considered a "girl" (although she was in her 30s) who could be taught about local cultural values and practices such as circumcision. Being seen as a "girl" or young woman meant that young men could address her as a peer, but holding the position also of outside researcher gave her the authority to talk to older men as well. However, the close association she had with the elderly woman made adolescent women hesitant to talk to her about genital cutting because they knew they were not supposed to think too much about it.

Both researchers lived near and mixed with a number of families who introduced them to others in the communities. We interviewed both older and younger women and men, activists, circumcisers, nurses, doctors and midwives, and religious and ritual leaders. For ethical reasons, we did not conduct interviews with children, even though circumcision primarily affects them.

The changes we have witnessed since being in the field are that the practice has become more medicalized in Egypt (Shell-Duncan & Kimani, 2018; Shell-Duncan, Moore & Njue, 2017). The debate has also intensified in Casamance with several campaigns against circumcision having been carried out. Despite this and the fact that female genital mutilation is forbidden by law in both countries, circumcision of both girls and boys has maintained its importance to local practitioners. (In this chapter we address female genital cutting only. Elsewhere Dellenborg [2007; 2009] has written on male circumcision in Casamance.)

A contemporary phenomenon

Although female genital cutting is forbidden by law, some 97 percent of women in Egypt and 24 percent in Senegal were circumcised in 2017. As noted, clitoridectomy is practised in both countries on girls, while boys have the foreskin removed with reference to Islam. The procedure is carried out on girls when they are aged between four and eight years. In Senegal, boys are circumcised at around this age, as well; whereas in Egypt they are circumcised as infants. In Senegal, the procedure is usually carried out without anaesthetic, except in the case of boys

who are circumcised in hospital. In Egypt, it is becoming increasingly common to use anaesthetic since the operation on boys is often performed by doctors. In Cairo and Casamance, both male and female circumcision are seen in much the same way; both are associated with values concerning gender identity and morality.

Particularly the older women we met in Egypt and Senegal considered female circumcision to be a normal and essential part of life. They saw it as an integral step in the process of transformation from childhood to adulthood and a crucial element in the creation of womanhood. In Egypt, the procedure was seen as a preparation for marriage whereas in Casamance it was related to motherhood, in particular. The girls learned early in life how they should behave and appear according to norms that were inculcated through various bodily and verbal practices. In Casamance, these norms were particularly exaggerated in the elaborated initiation ritual related to the circumcision (Dellenborg, 2004, 2007, 2009). The daily processes by which femininity and morality were maintained were replete with references to circumcision. Purity and gentleness were often mentioned as important qualities that a woman should demonstrate in social interaction, in relation to Islam, sexuality, and body modification. The Egyptian women, in particular, learned to understand themselves as feminine social beings through visual references, such as to soft, smooth and sweet food. Daily references to food and food preparation were used to teach girls how the ideal female body should look and be and what kind of moral behavior was expected of them (Malmström, 2004, 2015).

In both of our research fields, in Cairo and in Casamance, the women we met were fostered to manage the difficulties of motherhood and to obey and please their husband's family. A woman acquires merit if she bears her suffering patiently, and she is regarded as a moral being and a good Muslim. Both femininity and masculinity are closely associated with the ability to tolerate pain and suffering in both settings. Boys as well as girls are expected to accept the pain associated with circumcision. The purpose of suffering seemed similar in both fieldsites: to help children achieve a good life by learning early on how to endure hardships. The ability to manage under difficult conditions is what makes women and men into moral beings. However, the social form of suffering that children are prepared for differs between boys and girls and between Egypt and Senegal. That which appears similar on the surface is shown to differ considerably upon deeper analysis of the practice in its local context. At the end of this chapter, we return to the way

in which these differing social, cultural, historical, and political contexts are, in turn, of significance for how to design human rights interventions relating to female genital cutting.

Female circumcision in Egypt

An incident that took place during the UN population conference in Cairo 1994 had repercussions that affected ongoing efforts to prevent female circumcision the world over. The American TV channel CNN screened a documentary that showed girls being circumcised in an urban area in central Cairo. Just before the film was shown, President Hosni Mubarak had stressed that female circumcision did not take place in Egypt, but was an ancient practice that had died out long ago. The CNN screening was an embarrassment for the Egyptian government, and many among the country's population took offense (Abd el Salam, 1995). In Egypt, it stirred intense public debate between religious authorities, doctors, politicians, and activists (Tadros, 2000; Rahman & Toubia, 2000).

Older women's lives are filled with trials and ordeals. They have usually borne many children, and have experienced poverty, illness, and bereavement. They had also often been married at a very young age. For them, painful experiences are deemed part of a woman's lot, and they refer to three types of physical pain in particular: circumcision, defloration, and childbirth. As an outsider, it may be tempting to see the suffering that women undergo as avoidable and unnecessary, but this is not how they view it themselves. It is, they maintain, through suffering that they learn and develop the kind of femininity that is expected of them, and thus become respectable *Muslim* women. Endurance is virtuous. Stoicism and self-control are highly valued. By responding to these norms, women both demonstrate their own agency and also react against some prevailing ideals. For example, abortion and extra-marital sexual relations are forbidden in Egypt, and a woman is supposed to be a virgin when she marries. But this is not always the case. Some women undergo a hymen repair operation in order to qualify socially as a virgin again. Similarly, abortions are becoming more frequent, yet they are performed clandestinely (Foster, 2002; Malmström, 2017). As long as these things are not publicly acknowledged, they are quietly accepted.

Some of the young, unmarried Egyptian women were highly critical of circumcision, while others accepted it as necessary. Some claimed that it is one's

mother-in-law who decides over the children, in any case. Circumcision is therefore a question dealt with between older women while men generally have little knowledge of or responsibility for it. Some women viewed circumcision as a health issue and preferred doctors to perform it as, they were anxious errors being made. Many were ambivalent. The same person might say that circumcision was unnecessary and involved meaningless pain, and yet later say that it was good as long as it was carried out by professionals who used anaesthesia. This ambivalence relates to broader social change taking place. Pain has no place in ideas about the modern good life. For this reason, many young women are now electing to give birth by caesarean section. Campaigns against circumcision are also influential in young women's ambivalence. We will return to this at the end of the chapter. Meanwhile, regardless of age and attitude to circumcision, all the people Malmström spoke to—women, men, young and old—agreed that it was wrong of CNN to screen a film on TV showing the circumcision of a young girl (Malmström, 2016).

During Malmström's fieldwork, it was clear that everyday life was undergoing a process of Islamization.[1] In the poorer areas, the local mosques and Islamic charity organizations, many of which belong to the Muslim Brotherhood, were playing an increasingly important role filling the gaps in the state's incapacity to satisfy the people's needs for healthcare and education. These organizations offered cheap healthcare, religious education, and interest-free credit. Female circumcision became a tool in the struggle for power and political influence; the state opposed the practice as non-Islamic while the Islamic political actors affirmed that it was essential (Abd el Hadi, 2000; Hatem, 1994; Rahman & Toubia, 2000). According to Malmström (2016) and other researchers, these events may be seen as the political background against which people in Egypt interpreted international and national campaigns to stop circumcision (Abd-el Salam, 2003; Boyle, 2002). The effects that the Arab Spring may have upon female circumcision still remains to be seen. The people voted for political Islam, the Muslim Brotherhood, and the Salafists in the most recent parliamentary elections 2011-2012. Malmström and Van Raemdonck (2015), who began her fieldwork in 2013, have co-authored an

[1] The term Islamization refers to the way in which the political implications of Islam gain ground in people's everyday lives. The takeover of welfare functions by Islamic organizations affects people's attitudes to both politics and Islam.

article discussing findings from President Morsi's one year of rule (he was ousted in 2013).[1]

Over the course of ten years, the tone of the discourse opposing female circumcision has become more refined. In 2012–13, Van Raemdonck observed that the notion of harm remained central. The way that it became incorporated into local campaigns offers insights into which societal norms were being implicitly upheld. Training and education account for the bulk of activities organized by campaigners and these usually take the form of awareness-raising seminars held at local community level. The national media was broadcasting messages in 2003, but large-scale educational programs formed the backbone of the campaign. Women and men from different socio-economic strata and from both urban and rural areas were recruited by local civil society and larger NGOs, and were trained to provide information that would encourage families to stop practicing female circumcision. In Egypt, awareness-raising seminars have continued to be organized ever since the uprising of 25 January 2011, with support and monitoring by the UN and EU. Van Raemdonck's findings have enabled scrutinization of different levels of campaigning educational discourses (Malmström, 2016, pp. 204-205).

Categorizing circumcision as a harmful practice has a significant impact on the practicing society. In the early 2000s, the first campaigning initiatives against female genital mutilation affected some women's self-perception and resulted in their feeling sexually maimed (cf. Malmström, 2016). Local anti-FGM discourse has made inroads in Egypt and has become an important regulating normative discourse. It describes the risks of circumcision leading to marital sexual problems, and this focus on the effects on marriage has facilitated more open discussion in public and private fora about the practice and, in general, about sexuality between the spouses. On the other hand, characterizing female circumcision as a harmful cultural practice continues to leave some women feeling as though they have had their sexuality destroyed (Malmström & Van Raemdonck, 2015, p.134; cf. Malmström, 2013).

[1] Van Raemdonck's fieldwork research consisted of participant observation at a series of lectures and awareness-raising seminars held in Cairo in November and December 2013 by the Coalition of NGOs against FGM/C. It also relies on interviews and informal talks with trainers, other NGO personnel and seminar participants, and it includes a study of grey literature such as organization reports and training manuals.

To conclude, in the early 2000s, the health professionals and activists Malmström spoke with claimed that Egyptian men experienced potency problems because of the wives' frigidity, which, they said, was caused by female circumcision. Today's discourse also awards only women responsibility for failing to fulfil their marital duty, but also depicts them as deformed, mutilated, and frigid. This recalls post-Freudian Western understandings of sexuality and female circumcision (Malmström, 2016, p. 206). Ultimately, the question is whether circumcision will maintain its strong position as a political tool when power relations have again been altered; Egypt is once again under the military rule of President Sisi.

Female circumcision in Senegal

An estimated 24% of Senegalese women aged 15-49 have been subjected to female genital cutting, and in the Jola ethnic group, this figure is 59% (Agence Nationale de la Statistique et de la Demographie, 2018). Whether a woman is circumcised or not depends largely on her ethnic and religious identity, but also on various circumstances in a girl's life. For instance, Dellenborg's research assistant was raised in the ethnically diverse town of Ziguinchor in Lower Casamance by a Christian mother and a Muslim father, who had also been raised as Christian in his aunt's family. Dellenborg's assistant was circumcised as a young girl when they moved to a neighboring country, where female genital cutting is common. When she reached adulthood, she married a Muslim man from her father's native village. Her husband opposed the practice and forbade his mother and wife to circumcise the couple's daughters. The girls have remained un-circumcised. This example illustrates how Lower Casamance is affected by the movement of people and the broad diversity of ethnic, cultural, and religious ideas and practices throughout history. The meanings of female genital cutting and the associated initiation rites are many, contested and negotiated by various male and female social actors. Recent decades of global and national campaigns against "female genital mutilation," the Senegalese law forbidding the practice in 1999, religious revival, regional ethnic relations, and a political situation that often pits the Jola against the Senegalese state and the South against the North further affect local negotiations about the meanings of female "circumcision" and initiation. The CNN film referred to above was part of an intensified global campaign against female genital mutilation during the 1990s, which had repercussions in Senegal as well as in Egypt. Genital mutilation was now being framed as a form of violence against women and children

and as a breach of their human rights instead of, as previously from the 1970s and through the 1980s, a health problem (Hernlund & Shell-Duncan, 2007).

The demand for governments of countries in which girls undergo circumcision to legislate against it was strengthened by the UN World Conference on Women in Beijing (Beijing Declaration, 1995, paragraph 124i). In Senegal, a national law prohibiting female genital mutilation was adopted in 1999. The preparations for this law generated debate for several years. The majority population in Senegal is the *Wolof* ethnic group, which, unlike many other Senegalese ethnic groups, does not normally practice female circumcision. The Wolof are also tightly connected to political power, and this gave the question of legislation a political charge. The Jola mainly living in Lower Casamance is a minority and account for only around 500,000 of Senegal's nine million inhabitants. In Casamance, people described the law against female genital mutilation as part of a Wolofization, an encroachment upon local cultural rights and an expression of the Senegalese regime's weakness in the face of the imperialism of *l'occidentale* (the West) (Dellenborg, 2004). Since the country achieved independence in 1960, the relation between the Senegalese state and people in Casamance has been tense, escalating in the 1980s into armed conflict between the state and local separatist groups (Mark, 1992; Dellenborg, 2007). Outbreaks of violent clashes with government's forces have continued until today (Tomàs et al., 2018). Many people living in Casamance, and those of Jola ethnic identity in particular, have felt discriminated against. Adding to the national power relations, Muslim Jola people commonly are referred to by the Wolof and other Muslim ethnic groups in northern Senegal as heathens. Female circumcision and the associated initiation rites have often been cited by "northerners" as an illustration of Jola ignorance about Islam.

In Casamance, as in many other parts of West and Central Africa (but, significantly, not in the northern parts of Senegal) clitoridectomy is practised together with initiation into certain female initiation societies. In the literature, these are commonly referred to as "secret societies." Circumcision is considered the single most important ritual of these secret societies, and the genital cutting cannot be understood separately from the initiation context and vice versa.

Contemporary Jola society is marked by gender dissonance: men are considered superior to women in legal and political domains but, as initiated mothers, women also have considerable power inside and outside the family realm. This gender disjunction is reflected in the initiation rituals: on the one hand, the female

rites affirm the gender order, according to which women should be docile wives and self-sacrificing mothers. On the other hand, controversial as it may seem from a feminist and activist perspective, clitoridectomy in its wider cultural and social context actually provides individual women with self-esteem, cultural recognition as moral female persons, and space for agency (Ahmadu, 2000). Therefore, campaigns against female circumcision have met with strong resistance from women themselves (Bledsoe, 1984; Dellenborg, 2009; Hernlund, 2000). Importantly, in Casamance, the religious and cultural value of girls' circumcisions and initiation rites were negotiated and challenged in various ways by different actors. The greatest schism was along gender and age lines. During Dellenborg's time in the field, young and middle-aged men tended to question women's circumcision rituals while older women defended them. Older men generally supported the opinions of their wives and sisters. A recent study confirms that these circumstances have not changed (Tomàs et al., 2018). A survey of students conducted by Jordi et al. found that the majority of young people defended the practice as part of local culture, and this illustrates just how complex the picture is.

Women generally emphasized that circumcision is a crucial process of purification preparation for prayers. Men complained that women did not know enough about Islam, and that the idea of female circumcision being connected to religion was a misunderstanding. Men were also concerned about clitoridectomy having an impact on sexual pleasure, arguing that sex was more enjoyable with an uncircumcised woman. Another problem noted by men was the expense entailed in conducting the initiation rites and the fact that their wives would be absent from the home for several weeks while the rites took place. Chastity is not particularly highly valued in Jola society, and married women are permitted to take a lover (*asangor*) during the ritual, although this should be done with discretion and their husbands are rarely keen on it. Women explained the custom (*basangabou*) as linked to arranged marriages and a socially accepted way of meeting your 'high-school lover.'

Muslim leaders were divided in their opinions concerning female genital cutting. Some said this was an African tradition that should not be confused with Islam. Others claimed it had to do with purification in readiness for prayer. However, they all agreed that the initiation rites are not acceptable according to Islam, and they often spoke of this in their criticisms. The older women, supported by older men, listened to the religious leaders who were positive to circumcision and

said that men who cared more about sexual pleasure than about religion and the fostering of girls were simply "immature." Married men also expressed worries that circumcision may affect a woman's ability to give birth. Older women fiercely denied this, claiming on the contrary that circumcision and initiation strengthen a woman's reproductive powers through fertility rites that protect her from the risks of maternal and infant mortality. Importantly, the hardships of initiation, like those of everyday life, are mixed with joy. Even the girls look forward excitedly to the event. Female relatives and friends come together, dance, eat good food, married women meet lovers and get a rest from the labor of everyday village life. These aspects of the initiation are significant in a society in which women, when they marry, must leave their own family to join that of their husband and then have to ask permission to travel. No man can uphold his honor if he forbids his wife to participate in the initiation of the family's daughters. The initiation rites were described as a means of socializing girls into proper female behavior. The message to the girls was that "if you submit to the conditions of life and society, you will be rewarded with a good life." The initiation ritual is a condensation of the central gender values and practices that are bound together into this single strongly communitarian initiation experience. Boys normally undergo circumcision at the same age as girls, 4-8 years,[1] and go through a similar initiation ritual that involves both physical and mental ordeals. The ordeals are said to toughen up children in preparation for adult life and foster them into moral persons of a certain gender. Women and men are both expected to provide for their families and to work hard in the fields. Women must also be able to cooperate with co-wives and obey their mothers-in-law and husbands. Girls are fostered from an early age to become compliant, hard-working, patient, friendly, and obedient towards their elders. On a general cultural level, this was supported by everyone. Men and women, young and old gave the same response to the general and initial question of why they performed circumcision: "in order to be eligible for initiation."

Several moral discourses thus co-existed, some supporting and some critiquing the women's rituals. The resistance expressed by men is multifaceted and their criticism makes the women suspicious: are men opposed to the genital cutting itself

[1] In Muslim Jola society, there are two forms of initiation ritual for boys: the Mandinka ritual called Kuyamba, that is referred to here, and that is commonly celebrated in relation to a boy's circumcision (the excision of the penile prepuce), and a traditional Jola male initiation ritual called bukut, in which the initiands may be in their adolescence or even adult. Confusing for outsiders, both male rituals locally are referred to as "circoncision" (Dellenborg, 2007, p. 11).

or to the freedom women gain through their communal bonding in the initiation rite? More detailed analysis supported the women's view that men were uneasy about the independence women gained during the initiation ritual and, later, through their membership of the women's society. Some men expressed vehement opposition to the practice and had also taken action against it, such as by forbidding their wives and mothers to circumcise their daughters. Some had even participated in anti-excision campaigns. Most men, however, silently acquiesced to the practice, saw it as routine, or vacillated or claimed they were powerless to prevent their mothers from making decisions about circumcision of their daughters. At the same time, men generally valued the idea of patient wives and moral mothers that are supposed to be fostered through genital cutting and the initiation rites. To achieve this, the initiation ritual's culturally single most important act is enough: the genital cutting, which is performed discreetly in a secluded area years before the elaborate initiation rites (Dellenborg, 2007).

Possibilities and challenges

This brings us to the key question: How may a human rights perspective be applied in order to bring about change in the practice of female genital cutting? As Graamans with colleagues in a study on factors for change in the practice of female genital cutting in Kenya highlight:

> Repeatedly emphasising human rights and the possible health risks associated with FGM/C will have a limited effect if people still have other social concerns /…/ influencing their decisions, such as those related to marriageability, honour and shame [Graamans et al., 2019, p. 91].

Other scholars as well, such as Obiora (1997), have stressed the need for contextualized understandings of local meanings in their contribution to postcolonial critiques of the Western discourse of human rights in relation to the practice. Likewise, in our fields, we have seen that, in Egypt and Casamance, there are strong concerns supporting the upholding of the practice, such as marriageability, virginity, and proper womanhood in the first example, and moral motherhood and membership in women's "secret societies" that endow initiated and foremost elderly women with many privileges, in the second. We have also seen that there are many voices and understandings on female genital cutting in these two areas.

Within the human rights movement and international development work, great value ideally is attached to the concept of ownership. In other words, for change to be effected, it is important that the people involved own the problem. In this case, this means *the practitioners* of circumcision need to consider it to be a problem (see also Malmström, Sabir Zangana, & Barton, 2015).[1] The studies described here show that the key decision makers about circumcision are women of the older generation.[2] In Egypt, doctors also play an important role. Campaigners against genital mutilation, however, often target religious leaders. Our experience suggests that these are not the most important group, even though religious belief is important to the people and religious leaders and schools are indeed constantly discussing which practices should be permitted or forbidden (cf. Hjärpe, 2004). Importantly, "one-sided approaches do not work, whether they are alternative rites, awareness campaigns, legislation or economic incentives /…/ more contextually developed approaches and the design of holistic interventions are required" (Graamans et al., 2019:92; see also Ahmadu, 2000). If campaigns are to be successful, it is important to identify the key actors and see them in relation to the historical and cultural context.

Relativism as method

The principles of human rights are seen as universal, but if they are to be implemented, they must be interpreted (Freeman, 2002). Inevitably, people interpret their world according to the particular context that frames their lives. Even the notion of universality derives from and is shaped by specific power structures. The Sudanese-American lawyer and human rights activist Abdullahi Ahmed An-Na'im (1992, 2009, 2013) argues that dialogue and a good understanding of people's motivations for breaking the norms of human rights are essential for the implementation of such rights. This, we contend, demands the adoption of a relativist attitude. Cultural relativism has often been criticized for being value relativist, and thus for proposing that any practice should be tolerated if it is considered to uphold

[1] One example is the "UNFPA-UNICEF Joint Programme on Female Genital Mutilation-Cutting: Accelerating Change," which promotes inter-cultural dialogue, bringing local, national, and transnational actors together in Africa (Malmström et al., 2011). Another organization that works in a similar way is Senegalese Tostan (www.tostan.org).

[2] Efforts to engage elderly women as actors for change in relation to female genital cutting and other practices have recently been implemented in Senegal, see The Grandmother Project in Senegal uses intergenerational dialogue to foster community change: https://www.grandmotherproject.org/wp-content/uploads/2018/07/GMP.-LL-DOC-DHF.ENG_.pdf.

certain cultural values. We, however, argue that this is not a question of accepting but of understanding why a practice such as circumcision is so important to people that parents are willing to put their children through pain and risk in order to carry it out. Like An-Na'im, we use relativism as a method, not as an ethical point of departure for understanding another worldview. As a method, it means becoming more aware of one's own values and pre-understandings and, in so doing, becoming more open to alternative ways of experiencing the world. This in turn, generates the conditions for a dialogue in which cultural legitimacy may be created. An-Na'im posits that in order to make human rights culturally intelligible to people and give them a familiar form, they need cultural legitimacy. In this process, practitioners themselves, if they are made active participants in change, may come to understand genital cutting as something negative for which they may seek solutions. Creating this kind of cultural legitimacy for a human rights issue is a process, which, as An-Na'im notes, often takes place through cross-cultural dialogue. This may happen at the level of the UN and then filter down into local debate. In the process to create cultural legitimacy, the role of local human rights activists who act as "translators" in vernacularizing human rights discourses are especially important as they may develop hybrids that merge local structures with imported ideas (Merry, 2006). It is, we believe, when laws, debates, and local changes in attitude come together that enduring change becomes possible (cf. Carlsson, 2009).

When campaigning goes wrong

National and international campaigns against female genital mutilation can be counterproductive if they fail to work from the perspectives of the people involved, which is becoming discernible both in Cairo and in Senegal. Younger women in Cairo are questioning why suffering should be used to create femininity and the moral value attached to the three painful ordeals of circumcision, defloration, and childbirth (Malmström, 2009; Malmström & Van Raemdonck, 2015). However, a problem is that the young women's criticisms framed circumcision increasingly as a medical issue, leading them to question how circumcision is done rather than the operation itself. During fieldwork, it became apparent that younger women, unlike their mothers, also felt that they had been sexually mutilated. Many experienced this as a double trauma. This was of course not what aid donors had hoped to achieve.

In our research, we have found that while gender relations are central to the meaning ascribed to circumcision, when it comes to responsibility for the act it is primarily a question of the power relations between children and adults. It is adult women who have young girls circumcised and, conversely, adult men who have young boys circumcised. This means that it is not men controlling the genital cutting of girls. However, in the anti-excision campaign that Dellenborg followed in 1999, the activists did not involve women in the campaign but focused on local men's resistance to the practice. One may wonder if the activists had bought into the common Euro-American story of female genital mutilation as a patriarchal custom instigated and controlled by men and thereby missed women's agency. Or if they, paradoxically enough, were acting according to the local gender norms positioning men as household heads and simply tried to force women to end female genital cutting, which was women's understanding of the situation. Taken men's complaints over women's privileges during the ritual, such as spending high amounts of money on food and fine clothes as well as taking a lover, women's suspicion that men were opposing the elaborate initiation ritual with its emancipating aspects for women, rather than the cutting itself, was not taken out of the blue—and it made the anti-excision campaign politically charged. Eventually, the anti-excision organization together with the local men managed to draw up an agreement with the female ritual leaders to put an end to genital cutting. They held the public ceremony with much media attention. However, Jola women told Dellenborg that it was a "theatre" that the female leaders felt obliged to participate in. In phone calls some years later, her research assistant confirmed that the initiation ritual had not been held since, yet, they were still circumcising girls, though now in secret.

In her doctoral dissertation (2007), Dellenborg discussed the risk for an unfortunate development if anti-FGM campaigns continued to be misguided and failed to involve concerned women as active participants: the risk is simply that the practice will go underground and be performed in secret. She also argued that the initiation ritual that gives women certain privileges might disappear because of its association with genital cutting. In that case, the practice that activists wish to abolish would remain while the initiation rite with its empowering aspects might disappear. As early as 1999, it was clear that the initiation ritual was being celebrated less frequently than twenty years earlier but participant observation and

conversations with people in Casamance revealed that the practice of circumcision had become no less frequent.

Recent studies from Senegal (Shell-Duncan et al., 2013) and Casamance (Tomàs, Kaplan, & Le Charles, 2018) show that the law against female genital cutting has led to the practice being performed clandestinely. Concerning Casamance, Tomàs and colleagues (2018) describe a situation in which not even fathers are always aware that their daughters have been circumcised, and people refrain from taking girls to hospital if something goes wrong during the operation for fear of being reported. However, the initiation rite with its elaborate seclusion and aggregation ceremonies still takes place in public (Tomàs et al., 2018, pp. 168–169).

The ethnographic examples described here illustrate how a lack of understanding and respect for the cultural context and its power relations may mean that campaigns simply result in girls continuing to undergo circumcision but without the benefits that the initiation rites offer them as adults and also hinder people to seek care if needed (see also Malmström & Van Raemdonck, 2015).

Taking a look at ourselves

Sweden has one of the strictest laws against female genital mutilation. All forms of intervention that leave permanent changes to a woman's outer genitalia and are not performed for medical reasons are forbidden. However, cosmetic genital surgery is still legal in Sweden and elsewhere in the world and has indeed increased in prevalence since the 1990s.[1] Increasing numbers of women in Europe and North America are opting for labiaplasty operations, of various so-called aesthetics and sexual reasons, with hundreds of clinics now offering the surgery. When the UK passed legislation outlawing FGC, a clause was added to permit surgery on the grounds of "mental health", upholding its illegality for "custom or ritual" reasons (Boddy, 2016). Despite the investigation (if cosmetic genital surgery should be considered as FGC) carried out by the Swedish National Board of Health and Welfare in 2004,[2] cosmetic genital surgery (so-called "designer vagina" modifications) was deemed legal, and experts including anthropologist Sara Johnsdotter and obstetrician Birgitta Essén (2004) claim that: "[this] intervention is considered acceptable when it is performed for reasons relating to aesthetics and sexuality but

[1] Female circumcision was practised in the USA and the UK up until the 1940s by doctors as a means to cure hysteria and mental illness (Johannisson, 2005).

[2] "Intimkirurgi strider inte mot lagen", www.dagensmedicin.se (2004-04-15).

not when it has to do with tradition and religion" (see also 2010).[1] This means that in purely legal terms, there may be a greater number of Swedish women than African women who are breaking the law against female genital mutilation as it is formulated in Sweden. Another example that demonstrates the importance of reflecting upon our own norms is what happens when a baby is born with ambiguous genitalia—when the external organ is too small to qualify as a penis but too large to qualify as a clitoris (Fausto-Sterling, 2000), a so called intersex condition or disorder of sex development, DSD (Brömdal, 2008). Approximately 2,000 children per year in the USA (Fausto-Sterling, 2000) and between five and ten children per year in Sweden therefore undergo an operation to re-form their external genitalia, ostensibly for psychosocial reasons, so as to make them fit with prevailing notions of gender normality (Alm, 2006; Garland, 2016). If it were not for the strong cultural norm of two genders, two sexes only, these children would not need to be operated on; it is thus not a problem with the child's anatomy per se, but the narrow cultural understanding of a person as *either male or female* and the culturally based assumed importance of the look of the genitals as a manifestation of gender.

Thus, it would seem that there are cultural ideas in Sweden and the USA that support the cutting of children's genitalia just as there is cultural support in parts of Africa. The difference is that in the USA and Europe, the practice is legitimized by medical expertise and is consequently not regarded as a form of mutilation.[2] However, when the federal law against female genital mutilation was about to be passed in the USA in 1997, a number of American women sued the state, maintaining that they had been subjected to genital mutilation because their genitalia had not fitted into the norms governing how women and men are supposed to look. They said that they had suffered serious physical, psychological, and sexual injury as a result of what had been done to them (*New York Times*, 1997; *New Internationalist*, 1998). These examples show that even the lives of people in the North, who consider themselves to be "rational" and "modern," are shaped by cultural values and that these impact upon medical practice. The practice to operate on children with DSD is increasingly challenged by research from Human Rights Watch, the World Health Organization, and the United Nations Committee Against Torture, which has condemned medically unnecessary non-consensual surgeries on children on six occasions since 2011 (Human Rights Watch, 2017;

[1] Our translation from original.

[2] We do not discuss male circumcision, although it too is controversial even if widely accepted in Europe and the USA.

see also Alm, 2010). The Parliamentary Assembly of the Council of Europe passed a resolution on "children's right to bodily integrity." addressing female genital cutting (FGC) as well as "normalizing" surgeries for intersex children, and many western activists have during the last decade struggled for intersex children's right to decide their gender for themselves when adult (Ammaturo, 2016). Still, there is no consensus among experts, and surgeries are still recommended by physicians in wait for evidence of what is the best of the child (Garland, 2016). This example is meant to illustrate that from an inner perspective, cultural values seldom are understood as "cultural" but as self-evident and true. However, in a global dialogue on female genital cutting, the countries that correct these healthy children's outer sex organs in order to fit a narrow cultural two-sex understanding of human beings might have to reconsider this practice if an equal dialogue should take place. According to An-Na'im (1992, 2009, 2013), for a human right discourse to become culturally legitimate, the partners in dialogue needs to be equal.

Conclusions

We have argued for the importance of beginning by understanding practitioners' own perspectives when working with a human rights issue such as circumcision/genital cutting. We have used relativism as a method for gaining insight into what motivates people to uphold values and practices that are now deemed a breach of human rights. The critical reflection upon "ourselves" and the meeting with "the other" are central in the creation of such insight.

Making reference to human rights is a powerful way of generating debate and challenging accepted ways of thinking. However, the principles must be made familiar to those affected, and they must be woven into the context of local and global power relations and cultural values. Creating cultural legitimacy for new patterns of behavior—such as ceasing to perform circumcision—is a slow and conflict-filled process. We contend that those defined as "perpetrators" in the eyes of the international community should be given a chance to discuss, question, and take responsibility for bringing about their own social change. Ultimately, this has to do with the interplay between local, national and international power orders (Gruenbaum, 1996, pp. 455–475).

References

Abd el Hadi, A. (2000). Female genital mutilation in Egypt. In M. Turshen (Ed.), *African Women's Health* (pp. 145–167). New Jersey: Africa World Press.

Abd el Salam, S. (1995). *Female genital mutilation: Violation of human rights.* Cairo: Cairo Institute for Human Rights Studies.

Abd el Salam, S. (2003). *Genital mutilations. History, and suggestions for change*. Paper presented at The International Meeting on Preventing and Eliminating Female Genital Mutilation. Stockholm: The Swedish Parliament, Foreign Ministry, Ministry of Health and Social Affairs. Retrieved from http://www.norm-uk.org/page.html?action=showitem&item= 885

Agence Nationale de la Statistique et de la Démographie. (2018). *Enquête Démographique et de la Santé Continue* (EDS-Continue) 2017, Dakar.

Ahmadu, F. (2000). Rites and wrongs: An insider/outsider reflects on power and excision. In B. Shell-Duncan, Y. Hernlund (Eds.), *Female "circumcision" in Africa: Culture, controversy, and change* (pp. 283–312). London: Lynne Rienner Publishers.

Ahmadu, F. (2007) Ain't I a woman too?: Challenging myths of sexual dysfunction in circumcised women. In Y. Hernlund, B. Shell-Duncan, (Eds.), *Transcultural Bodies. Female Genital Cutting in Global Context* (pp. 278–310). New Jersey: Rutgers University Press.

Alm, E. (2006). "*Ett emballage för inälvor och emotioner": föreställningar om kroppen i statliga utredningar från 1960- & 1970-talen*. [A wrapping for intestines and emotions: Perceptions of the body in state investigations from the 1960's and the 1970's]. Doctoral dissertation, Department for History of Ideas and Theory of Science, University of Gothenburg.

Alm, E. (2010). Contextualising intersex: Ethical discourses on intersex in Sweden and the US. *Graduate Journal of Social Science, 7,* 2, 95–112.

Ammaturo, F.R. (2016). Intersexuality and the 'right to bodily integrity': Critical reflections on female genital cutting, circumcision, and intersex 'normalizing surgeries' in Europe. *Social & Legal Studies*, *25*, 5, 591–610.

An-Na'im, A.A. (1992). *Human rights in cross-cultural perspectives: A quest for consensus.* Philadelphia: University of Pennsylvania Press.

An-Na'im, A.A. (2009). Toward a cross-cultural approach to defining international standards of human rights: The meaning of cruel, inhuman, or degrading treatment or punishment. In M. Goodale (Ed.), *Human rights: An anthropological reader* (pp. 68–85). Massachusetts: Wiley-Blackwell.

An-Na'im, A.A. (2013). An inclusive approach to the mediation of competing human rights claims. *Constellations*, *20,* 1, 7–17.

Bejing Declaration and Platform for Action, Fourth World Conference on Women (1995). UNESCO. Retrieved from http://www.unesco.org/education/information/nfsunesco/pdf/BEIJIN_E.PDF

Bledsoe, C. (1984). The political use of Sande ideology and symbolism. *American Ethnologist*, *11,* 3, 455–472.

Boddy, J. (2016). The normal and the aberrant in female genital cutting. *HAU: Journal of Ethnographic Theory*, 6, 2, 41–69.

Borneman, J., & Hammoudi, A. (Eds.). (2009). *Being there: The fieldwork encounter and the making of truth*. Berkeley: University of California Press.

Boyle, H.E. (2002). *Female genital cutting: Cultural conflict in the global community*. Baltimore: The John Hopkins University Press.

Brömdal, A. (2008). *Intersex. A challenge for human rights and citizenship rights.* Saarbrucken: VDM Verlag Dr. Muller.

Carlsson, N. (2009). *Avslöjandets tid. Kvinnors bearbetning av sexuella övergrepp*. [A time for revealment: women working through sexual abuse]. Doctoral thesis, Department of Social Work, University of Gothenburg.

Cowan, J., Dembour, M.-B., & Wilson, R.A. (Eds.). (2001). *Culture and rights: Anthropological perspectives*. Cambridge: Cambridge University Press.

Dellenborg, L. (2004). A reflection on the cultural meanings of female circumcision: Experiences from fieldwork in Casamance, Southern Senegal. In S. Arnfred (Ed.), *Rethinking African sexualities* (pp. 79–97). Uppsala: Nordic Africa Institute.

Dellenborg, L. (2007). *Multiple meanings of female initiation: "Circumcision" among Jola Women in Lower Casamance, Senegal.* Doctoral dissertation, School of Global Studies, Department of Social Anthropology, University of Gothenburg.

Dellenborg, L. (2009). From pain to virtue—clitoridectomy and other ordeals in the creation of a female person. In A. Schlyter (Ed.), *Body politics and women citizens—African experiences* (pp. 93-101). Sida Studies, No. 24. Stockholm: Sida.

Dellenborg, L. (2013). Fältarbete [Fieldwork]. In C. Skott, L. Dellenborg, M. Lepp, K. Nässén (Eds.), *Människan i vården: Etnografi, vård och drama* [People in health care: ethnography, care and drama] (pp. 18–32). Carlssons förlag: Stockholm.

Fausto-Sterling, A. (2000). *Sexing the body: Gender politics and the construction of sexuality*. New York: Basic Books.

Foster, A. (2002). Young women's sexuality in Tunisia: The health consequences of misinformation among university students. In D.L. Bowen, E.A. Early (Eds.), *Everyday life in the Muslim Middle East* (pp. 98–111). Bloomington: Indiana University Press.

Freeman, M. (2002). *Human rights*. Cambridge: Polity.

Garland, J. (2016). *On science, law, and medicine: The case of gender-"normalizing" interventions on children who are diagnosed as different in sex development*. Doctoral dissertation, Department of Law, University of Uppsala.

Graamans, E., Ofware, P., Nguura, P., Smet, E., & ten Have, W. (2019). Understanding different positions on female genital cutting among Maasai and Samburu communities in Kenya: A cultural psychological perspective. *Culture, Health & Sexuality*, *21*, 1, 79–94.

Gruenbaum, E. (1996). The cultural debate over female circumcision: The Sudanese are arguing this one out for themselves. *Medical Anthropology Quarterly*, *10*, 4, 455–475.

Hatem, F. M. (1994). Privatisation and the demise of state feminism in Egypt in mortgaging women's lives. In P. Sparr (Ed.), *Mortgaging women's lives: Feminist critiques of structural adjustment* (pp. 40–61). London: Zed Books.

Hernlund, Y. (2000). Cutting without ritual and ritual without cutting: Female 'circumcision' and the re-ritualization of initiation in The Gambia. In B. Shell-Duncan, Y. Hernlund (Eds.), *Female "circumcision" in Africa: Culture, controversy, and change* (pp. 235–253). Boulder: Lynne Rienner Publishers.

Hernlund, Y., & Shell-Duncan, B. (2000). Female "circumcision" in Africa: Dimensions of the practice and debates. In B. Shell-Duncan, Y. Hernlund (Eds.), *Female "circumcision" in Africa: Culture, controversy, and change* (pp. 1–41). Boulder: Lynne Rienner Publishers.

Hernlund, Y., & Shell-Duncan, B. (2007). Transcultural positions: Negotiating rights and culture. In Y. Hernlund, B. Shell-Duncan (Eds.), *Transcultural bodies: Female genital cutting in a global context* (pp. 1–45). New Jersey: Rutgers University Press.

Hjärpe, J. (2004). *99 frågor om islam, och något färre svar* [99 questions on Islam, and somewhat fewer answers]. Stockholm: Leopard.

Human Rights Watch (2017). *"I want to be like nature made me": Medically unnecessary surgeries on intersex children in the US*. Retrieved from https://www.hrw.org/report/2017/07/25/i-want-be-nature-made-me/medically-unnecessary-surgeries-intersex-children-us

Johannisson, K. (2005). *Den mörka kontinenten: Kvinnan, medicinen och fin-de-siècle*. [The dark continent: the woman, medicine and fin-de-siècle]. Stockholm: Norstedt.

Johnsdotter, S. & Essén, B. (2004). Analys av lagstiftningen rörande ingrepp i kvinnliga genitalier. Estetiska och sexuella motiv godtas—men inte religiöst traditionella [Analysis of the legislation concerning modifications of the female genitalia. Esthetical and sexual motives being accepted but not religious or traditional ones]. *Läkartidningen* [The Swedish medical journal], *101*, 37, 2810–2812.

Johnsdotter, S., & Essén, B. (2010). Genitals and ethnicity: The politics of genital modifications. *Reproductive Health Matters, 18*, 35: 29–37.

Kirberger, E., Randolph, K., & Toubia, N. (1995). *Intersections between health and human rights: The case of female genital mutilation.* New York & London: RAINBO, Research, Action and Information Network for the Bodily Integrity of Women.

Malmström, M.F. (2004). "Omskärelse är sött": Mat, kropp, och kvinnlig omskärelse i Kairo. ["Female circumcision is sweet": food, body and female circumcision in Cairo]. *Socialmedicinsk tidskrift, 6*, 512–519.

Malmström, M.F. (2009). Bearing the pain: Changing views of the meaning and morality of suffering. In A. Schlyter, (Ed.) *Body politics and women citizens—African experiences* (pp. 104–115). Sida Studies, No. 24. Stockholm: Sida.

Malmström, M.F. (2013). The production of sexual mutilation among Muslim women in Cairo. *Global Discourse, 3*, 2, 1–16.

Malmström, M.F. (2015). The continuous making of pure womanhood among Muslim women in Cairo: Cooking, depilating, and circumcising. In G. Ozyegin (Ed.), *Gender and sexuality in Muslim cultures* (pp. 139–163). Surrey: Ashgate Press.

Malmström, M.F. (2016). *The politics of female circumcision in Egypt: Gender, sexuality and the construction of identity.* London: I.B. Tauris.

Malmström, M.F. (2017). The body as the locus of moral cultivation by the self and others: Secret acts, social virginity and the practice of female circumcision. An example from Cairo. In C. Fortier, S. Monqid. (Eds.), *Corps des femmes et espaces genrés arabo-musulmans* (pp. 183–190). Paris: Karthala.

Malmström, M.F. et al. (2011). *UNFPA-UNICEF Joint Programme on Female Genital Mutilation-Cutting: Accelerating Change.* New York: UNFPA-UNICEF. Retrieved from http://www. unfpa.org/gender/docs/2010_Annual_Report_2.pdf

Malmström. M.F., Goran A., Zangana S., & Barton, F. (2015). Conversation on Female Genital Cutting. In Ozyegin (Ed.), *Gender and sexuality in Muslim cultures* (pp. 167–181). Surrey: Ashgate Press.

Malmström, M.F., & Raemdonck. A.V. (2015). "The clitoris is in the head!" Female circumcision and the making of a harmful cultural practice in Egypt. In C. Longman, T. Bradley (Eds.), *Interrogating harmful cultural practices: Gender, culture and coercion* (pp. 121–138). Abingdon: Routledge.

Mark, P. (1992). *The wild bull and the sacred forest: Form, meaning, and change in Senegambian initiation masks*. Cambridge: Cambridge University Press.

Merry, S.E. (2006). Transnational human rights and local activism: Mapping the middle. *American Anthropologist, 108,* 1, 38–51.

Moore, H.L. (2007). The failure of pluralism? In Y. Hernlund, B. Shell-Duncan (Eds.), *Transcultural bodies: Female genital cutting in a global context* (pp. 311–331). New Jersey: Rutgers University Press.

New Internationalist. April 1998. Issue 300. Oxford, UK.

New York Times. May 13, 1997. New York, USA.

Nässén, K. (2013). Deltagande observation [Participant observation]. In C. Skott, L. Dellenborg, M. Lepp, K. Nässén (Eds.), *Människan i vården: Etnografi, vård och drama* [People in healthcare: ethnography, care and drama] (pp. 33–43). Stockholm: Carlssons förlag.

Obiora, L.A. (1997). Bridges and barricades: Rethinking polemics and intransigence in the campaign against female circumcision. *Case Western Reserve Law Review, 47*, 2, 275–378.

Rahman, A., & Toubia, N. (2000). *Female genital mutilation: A guide to laws and policies worldwide*. London: Zed Books.

Shell-Duncan, B., Hernlund, Y., Wander, K., & Moreau, A. (2013). Legislating change? Responses to criminalizing female genital cutting in Senegal. *Law & Society Review*, *47*, 4, 804–835.

Shell-Duncan, B., & Kimani, S. (2018). Medicalized female genital mutilation/cutting: Contentious practices and persistent debates. *Current Sexual Health Reports, 10,* 1, 25–34.

Shell-Duncan, B., Moore, Z., & Njue, C. (2017). The medicalization of female genital mutilation/cutting: What to the data reveal? *Evidence to end FGM/C*. New York: Population Council. Retrieved from https://www.popcouncil.org/uploads/pdfs/2017RH_ Medicalization FGMC.pdf

Tadros, M. (2000). Breaking the silence: An Egyptian experience. *Hadithi*, *2*, 1–35.

Tomàs, J., Kaplan, A., & Le Charles, M.-A. (2018). Female genital mutilation/cutting in Basse-Casamance (Senegal): Multiple voices from a plural South. *Journal of the Anthropological Society of Oxford, X*, 2, 157–179.

R. Elise B. Johansen, in collaboration with Amira Jama Mohammed Ibrahim, Naeema Saeed Sheekh Mohammed, Khadra Yasien Ahmed, Abdirizak Mohamud, Ibrahim Sheick Mohammed Ahmed, & Omar Nur Gaal

Methodological Reflections on the Engagement of Cultural Insiders:
A Study on Female Genital Cutting Among Somali Migrants in Norway

Introduction

The purpose of this chapter is to explore how the engagement of cultural insiders in a study of a sensitive topic among a migrant minority population might affect access, trust, and potentially study findings. We will also discuss some ethical implications on the use of insider positionality as a methodological tool. The empirical basis of the chapter is experiences from a study conducted in 2018 exploring personal opinions and social norms concerning female genital cutting (FGC) among ethnic Somali migrants in Norway (Johansen, 2019). In the study, six Somali research assistants (three women and three men) conducted the entirety of recruitment and data collection and took an equal part in study planning and the primary analysis of findings with the principal investigator (PI).

There is a common perception that cultural insiders may access back-stage information and thus produce more truthful findings. This is particularly so in situations where the topic of inquiry is illegal and morally condemned, as is the case of FGC in Norway. Adding to the picture is a sense of stigmatization of Somali

migrants in Norway, which could encourage a stronger desire to present an acceptable front-stage image to the majority population. We thus find it useful to employ Goffman's (1949) delineation of a distinction between back- and front-stage to understand discourses on exposure to potentially stigmatizing elements of Somali cultural practices and discourses.

One example of such a front- and back-stage divide was evident in the fall of 2000 when the Norwegian national TV channel produced a documentary on attitudes toward FGC in Norway. The program featured a young Somali woman in distress, seeking advice on whether to accept her parents' wish to have her circumcised (Bråten & Elgvin, 2014). A journalist in disguise, equipped with a hidden camera, captured religious leaders who advised her to obey her parents' wishes, even if that included FGC. Such statements contradicted former public statements of some of these very same religious leaders against the practice. The program was awarded a prize for Documentary of the Year, and the Somali journalist received several awards for her role, including from the Fritt ord Foundation (the Free Speech Foundation).

The documentary, which was broadcast in two segments in September 2000, caused an uproar among Somalis and Norwegians. Norwegian media and politicians portrayed the journalist as a hero for revealing back-stage support for this illegal practice. The program led to major political initiatives, and the first in a series of consecutive action plans targeting FGC emerged as a direct result. In this first action plan, a project targeting FGC with a subproject targeting migrants of Somali origin more broadly was included (the OK project) and was led by the PI of this study (Johansen, 2017). While some Somalis appreciated the program's outcome in terms of political will and engagement, many spoke of the journalist as a traitor whose contribution shamed and stigmatized the Somali community through the exposure of the double communication and partial support of the practice by some religious leaders. Later, other female anti-FGC activists had similar experiences of being judged as heroes by the Norwegian majority and as traitors within their ethnic communities (Lien & Schultz, 2013; Lunde et al., 2019).

A takeaway from the documentary and the following discussions is the revelation of a carefully guarded distinction between front- and back-stage, in this case, between a public rejection of the practice and private acceptance. The weight of this distinction is sharpened by the contradiction between the positive traditional Somali values and meaning of FGC and the moral and legal condemnation of the

practice in Norway. This discrepancy may lead to a sharpening of the distinction and careful guarding of the boundaries between the front- and back-stages.

Conducting research in such a setting, one could expect that a cultural insider will be able to access back-stage discourses and thus produce more truthful study findings. Given such a fundamental divide, one could expect a stronger social desirability bias, which could produce almost opposite findings, depending on the researcher's positioning as a cultural insider or outsider.

The significance of the positioning of the researcher as a cultural insider or outsider relates to the concept of social desirability bias in research; that is, how study participants' perception of the positioning of the researcher can affect the direction and strength of bias toward the perceived expectations or attitudes of the researcher. The sensitivity of this study's topic can be expected to lead to an even stronger bias than what could be expected in studies of less controversial topics.

By positionality, we refer to the position of the researcher as a person vis-a-vis the study participants. Positionality can thus include various personal elements, such as gender, age, ethnicity, migration status, and education. In recent years, the potential significance of researcher positionality for access, trust, and study findings has become a standard part of method reflexivity in qualitative studies. In studies of migrants and minority communities, the researcher's position, in terms of being a cultural insider or outsider, has commonly been given the most attention (Ahmadu, 2000; Carling et al., 2014; Ganguly, 2016; Kusow, 2003).

In this chapter, I will explore the experiences of cultural insiders in a study of FGC among Somali migrants in Norway. I will build on two contrasting perceptions concerning researcher positioning. On the one hand, cultural insiders are expected to conduct higher-quality studies because they are better at building the necessary rapport and trust. This view seems have a relative stronghold in the field of migration research. On the other hand, a cultural outsider's position has been perceived as more open to detail and system, and especially cultural practices that are taken for granted and naturalized in the study community. Social and cultural anthropologists have most strongly supported this view. Regarding interventions against FGC, the dominant view is that such work could and should be conducted only by cultural insiders for both ethical and quality reasons.

My aim in this chapter is to further explore these pre-understandings within the context of studying FGC among migrants. This discussion aims to explore the insider/outsider debate, particularly concerning three factors that have been less

explored previously, namely, whether positioning affects the quality of the study, its ethical implications, and, finally, the trustworthiness with which the findings are interpreted.

The discussion will build on experiences from a study specifically built on the engagement of cultural insiders in all parts of the project, comparing the experience to other studies, and on the PIs experiences of conducting similar studies as a cultural outsider in the same setting and on the same topic.

Study setting: Female genital cutting among Somali migrants in Norway

We selected Somali migrants as our study population because they constitute more than half of the 17,300 girls and women in Norway estimated to have undergone FGC prior to immigration (Ziyada et al., 2016). Here, we refer to Somali as an ethnic group sharing geographical, linguistic, and cultural traditions, as well as a sense of shared identity, independent of countries of origin (Somalia, Djibouti, Ethiopia, and Kenya). Clan and lineage form a fundamental structure for subdivisions among Somalis and constitute an important factor in social organization. It is further interrelated with geographical origin and social status. Clan has further played a significant role in recent years' civil war and strife, thus adding to a certain sensitivity to the issue (Fangen, 2008). However, we did not ask about clan or its importance in this study, neither among the research assistants nor participants.

FGC is almost universal among Somalis, with a prevalence of between 94 and 99% across the different regions. Ethnic Somalis also traditionally practice the most extensive form of FGC, infibulation, defined as the cutting and apposition of labia to create a seal of skin covering most of the vulva with a small opening left at the lower end for the passage of urine and menstrual blood (Abdalla, 1982; World Health Organization, 2008).

Somali immigrants constitute the largest FGC-practicing group in Norway. Due to their number and the severity of FGC commonly practiced, Somalis have been a major target group for both studies and interventions (Bråten & Elgvin, 2014). Simultaneously, Somali migrants have been subjected to much negative media focus, both due to their tradition of FGC and other social factors (Horst et al., 2013). They thus experience a strong degree of stigmatization from the Norwegian majority population, which includes policies and services (Hervik et al., 1999; Fangen, 2008). The political discourses that led to the passing of a specific law against FGC in Norway in 1995 seem to have been set in motion by the influx of

Somali refugees and migrants following the civil war in Somalia. Additionally, later political initiatives against FGC have, to a large extent, been pushed by the media focus on Somali FGC practices, including the previously mentioned and later TV documentaries (Bråten & Elgvin, 2014; Johansen, 2017). On the other hand, Somali immigrants have been actively involved in volunteer engagement to improve community members situations, including numerous interventions targeting FGC (Ibrahim et al., 2011).

The REPLACE approach

The qualitative study on readiness to abandon FGC on which this chapter builds was conducted among Somali migrants living in or close to a medium-sized Norwegian town of approximately 100,000 inhabitants, including approximately 1,000 Somalis. The study followed the outline of an action-research framework for FGC in the diaspora, the REPLACE approach (Barrett et al., 2015). REPLACE stands for the replacement of inefficient with efficient interventions targeting FGC and was developed by a research team based at Coventry University in the UK. The approach has been piloted and implemented in several settings and formulated in a set of guidelines (Barrett et al., 2015). Central to the approach is the engagement of "community-based researchers" (CBR) in all study phases. We refer to these as research assistants for reasons described in the Methods section and concentrate our discussion on their positioning as "cultural insiders."

The REPLACE approach includes three major phases: an initial qualitative study to assess community attitudes and readiness to change, an intervention phase that builds on the findings from the qualitative study, and a qualitative and quantitative evaluation of the effect of the intervention (Barrett et al., 2020). The CBRs are expected to take part in all phases of the study. The study is based on a framework of participatory action research (PAR), in which a central aim is "securing community ownership to the project" (Barrett et al., 2020). This is linked to a dominant ideal in intervention research that those who are experiencing a problem are best suited to both identify and solve their problem. This builds on a goal of community empowerment expected to enhance the sustainability of interventions. The engagement of CBRs is thus expected to improve both the quality, effectiveness and sustainability of interventions. Furthermore, community empowerment is considered a more ethically sound approach than outside interference.

The main argument for the engagement of CBRs in the REPLACE guidelines was their expected effect on the intervention. However, we were so far able to conduct only the first phase of the REPLACE approach due to lack of funding and hence will build our discussion on this. Hence, our main aim is to explore the significance of engaging cultural insiders for the research part of the intervention research. Nevertheless, as the REPLACE approach has been designed as participatory action research, we will also discuss some potential consequences of the findings for future interventions.

Theoretical perspectives

As indicated, migration research and social anthropological studies can be contrasted in terms of their overall view of researchers' cultural positioning. Although this is an oversimplification, many migration researchers emphasize the benefits of a position as a cultural insider for building the rapport and trust necessary for a good study (Carling et al., 2014). Furthermore, their cultural competence is expected to enable the formulation of better-informed research and interview questions as well as analysis. Anthropologists, in contrast, have often emphasized the methodological benefit of being a cultural outsider. Not knowing the culture is expected to cause a "cultural shock" that increases the researcher's attention to detail and overall structures, especially by unraveling and questioning silent and doxic cultural structures (Bourdieu, 1977; Hastrup, 1996). Furthermore, the outsider may take on the position of an ignorant child, which can spur community members to take it upon themselves to educate the researcher. A cultural insider, in contrast, would be expected to possess the necessary cultural insight and thus risks being considered rude or stupid if asking basic questions.

This simplistic outline has been nuanced over the last decades, particularly as part of a renewed focus on qualitative data as coproduced between researchers and participants and, as such, the importance of positionality (Carling et al., 2014; Ganguly, 2016; Kusow, 2003). Researchers have explored the significance of a wide variety of personal, relational, and contextual factors that interlace with cultural positionality. Personal factors could include migration experience and time of residence, linguistic skills, gender, age, education, religion, and social status. Relational and contextual factors could include perceived and real differences in power, relative social status, minority/majority, and legal framework (Carling et al., 2014; Ganguly, 2016). For example, research participants sharing insider information on

potentially illegal acts could be hampered by knowing the duty to report cases of child abuse, including plans for conducting FGC.

However, this chapter aims to move beyond the discussion of how positioning affects access and data collection to explore ways in which it might affect the study findings and quality. I will also explore some ethical aspects of insider positionality and some reflections on how the researcher's positioning might also affect the trustworthiness of the results, that is, how the reader receives it.

Method and materials

This chapter is based on our experiences from a study constituting the first phase of the REPLACE approach conducted in 2018, including planning, recruiting six Somali research assistants, training, data collection, analysis, and community feedback. This is complemented by data from interviews with five of the research assistants in the spring of 2020.

The six Somali research assistants (three men and three women) participated in all study phases, except in the initial planning and writing of scientific articles. However, the recruitment procedure and positioning of the research assistants deviated from the REPLACE approach guidelines in several ways. These guidelines described the CBR as trusted community members selected by their community and identified through local ethnic or national nongovernment organizations (NGOs) (Barrett et al., 2015). In our setting, however, there was no local Somali NGO from which to recruit CBRs. Thus, the PI contacted a few (3) Somali men and women who lived in or near the study site, asking them to help recruit potential research assistants. As they proved to be unable to assist in recruitment, the PI turned to broader networks beyond the local town. The post was thus advertised internally at regional universities in a Somali student network and through various informal networks. The post asked for a preferred minimum of a bachelor's degree, preferably in social sciences, and bilingual competency of Somali and Norwegian or English.

Thus, the six research assistants were not recruited from or selected by the local community, as outlined in the REPLACE approach. Nevertheless, they shared ethnic, linguistic, and cultural backgrounds with the study community and lived in a nearby town (40 minutes by train). None of the research assistants lived in the study area, but one had formerly lived there, and several had social networks with

residents. Due to these divergences between our recruitment procedures and positioning of our research assistants and those indicated in the REPLACE approach, we have chosen to refer to them as research assistants rather than community-based researchers (CBRs).

All the research assistants held a bachelor's degree, and two were simultaneously studying for their master's degree. All were born in Somalia and had come to Norway at different ages: two as young children, one as a youth, and three as adults. They were between twenty-four and thirty-three years of age. All spoke Norwegian and fluent Somali, as well as varying levels of Arabic. None of the research assistants had previously worked or participated in research or interventions targeting FGC.

The research assistants completed approximately forty-five hours of training over a few weeks for their tasks. Training included building rapport and trust with study participants, conducting qualitative interviews and focus groups in a flexible and nonleading manner, and ensuring confidentiality. Practical training on recording, transcription, and safe data storage was also included. After the completion of data collection, new training on qualitative data analyses was conducted.

Most of the training on data collection was provided by an external consultant, a researcher specializing in communication pedagogy and social sciences. She is a native Norwegian, but her experience from conducting similar training in prewar Somalia helped build rapport and trust. I, PI and author of this chapter, am also a native Norwegian, a medical anthropologist by training, with over 20 years of experience working with FGC and particularly Somali migrants in Norway. In general, I have experienced that my many years in the field, numerous visits to many FGC practicing countries, including Somalia, and my former marriage to a man of Tanzanian origin with whom I have three daughters facilitates access, trust, and rapport by reducing outsider positionality.

The extended research team, including the PI, research assistants, and the external consultant, met regularly during data collection to discuss experiences and progress. Research assistants were provided with office space to strengthen data safety during transcription and analysis and facilitate collaboration. The external consultant and the PI were available for any questions beyond the formally organized meetings, and the research assistants arranged their internal meetings when needed.

To approach the study community, the research team (the research assistants and the PI) arranged three informational meetings. The first meeting was held at

the local mosque and included both male and female participants of various ages. This was done because we expected staff at the mosque to be gatekeepers for the recruitment of community members. The next two information meetings were divided by gender and held at a more "neutral" locality, a Red Cross office known to arrange local events for refugees and migrants easily accessible by public transport. This locality was also used for all focus groups and most of the personal interviews.

The research assistants used networks from the abovementioned informational meetings and their personal and professional networks to recruit the final seventy-two study participants. The participants were almost equally distributed between women and men, youth and adults (Johansen, 2019). All data collection was paired with gender, with interviews conducted individually and in focus groups in pairs of two. The only exception to this was the informational meeting and the feedback seminar for men, in which the PI, who is a female, was also present. All data collection, except in informational meetings and feedback meetings, was tape-recorded, and the research assistants subsequently transcribed and translated them into Norwegian.

Data were analyzed collectively in the following way: Each data transcript was read and thematically analyzed individually by two research assistants and the PI, after which they met to compare and come to an agreement of key factors. Basic findings for each entity (in-depth interview and focus group discussion) were then summarized in a table, highlighting commonalities and differences. These individual sheets were read by all, and the findings were discussed to identify commonalities and differences within and between subgroups as defined by age and gender.

Based on the analysis, the PI drafted a presentation to explore community members' recognition of key findings and further discuss unclear items through two validation seminars. The research assistants recruited participants for two such seminars, one for young women and one for adult men. During these seminars, the PI and one research assistant presented the main findings for discussion. Another motive for these seminars was to provide feedback to the study community. The feedback from the participants was then used to fine-tune the final analysis of our study findings. Subsequently, the PI wrote a scientific article in English (Johansen, 2019). Although an early manuscript was shared with all research assistants, they were unable to contribute as co-authors due to other commitments and the end of funding. The noninclusion of research assistants in papers based on studies to which

they contributed so significantly, as in the REPLACE approach, is a dilemma to be further explored.

Then, in the spring of 2020, five of the six research assistants were interviewed about their reflections and experiences from the previous work. Due to the coronavirus situation, these interviews were conducted over the phone. For these interviews, oral consent was provided, and notes were taken on the spot rather than recorded.

The study followed the required ethical requirements and was approved by the Norwegian Centre for Research Data (NSD). All research assistants have been presented with the text in this chapter for approval, as they are not granted anonymity. However, to ensure confidentiality, some information is deliberately vague, and direct quotes are avoided.

Positioning as a cultural insider

In the following, I will share some of the research assistants' experiences of their positioning during the study. First, I will explore the role of shared language and cultural identification. I will then explore how research assistants experienced the effect of their positioning on rapport and trust through the following factors: confidentiality, reciprocity, and representation. Finally, I will explore the ways in which these methodological factors might have affected the study in terms of quality of data, ethical implications, and trustworthiness.

Shared language

Mastery of a common language, particularly a shared mother-tongue, can be expected to improve both trust and quality of data. It can ease communication flow, make people feel at ease, and reduce the risk of misunderstandings. In Norway, where two-thirds of people of Somali origin are first-generation migrants, and few second-generation migrants have reached adulthood, the research assistant's mastery of the Somali language was expected to be a major asset.

All the research assistants were Somali-born and overall experienced their fluency in the Somali language as an important asset for their work, both in terms of formulating and understanding the interview questions and as a vehicle for creating a good atmosphere through jokes and playing with language and dialects. There

were, however, differences in language fluency and preference between both research assistants and study participants, mainly due to migration stories and lengths of stay in Norway. One of the two research assistants who had come to Norway as a young child (preschool age) felt more comfortable speaking Norwegian than Somali, and the two who had lived in Norway more than half their lives felt equally comfortable in both languages. Many of the young study participants who had come to Norway at a young age and the few born in the country felt more comfortable being interviewed in Norwegian. Due to the variation in linguistic preference and fluency in both groups, it was possible to accommodate this by pairing research assistants and study participants according to linguistic fluency and preference.

In most interview settings (both individual interviews and focus groups), however, more than one language was used, including Somali, Norwegian, Arabic, and English. We have not systematically analyzed the use of language, but a general impression was a preference for Somali when talking about Somali tradition and culture, Norwegian for specific Norwegian experiences and practices, Arabic when discussing religious practices and perspectives, and English when referring to transnational discourses.

Furthermore, while Somali is defined as one language, there are substantial dialectic variations. Such dialectical differences could have affected the study because it can hamper mutual understanding and because dialectical variation, to some extent, covaries with political lines of division between regions and clans. The PI had firsthand experience with challenges caused by such experiences from previous work and studies (Johansen, 2004). During a study tour to Somali regions with a former colleague of Somali origin in 2003, we encountered several incidences indicating clan significance. The colleague's southern Somali dialect gave her easy access and trust among other southerners, both those living in the south and the north, reduced mutual understanding in a Somali region in Ethiopia, and caused suspicion and resistance among northern Somalis. During our visit to Somaliland, for example, a man we encountered was able to identify her as belonging to the clan of the former president, Siyad Barre. As Barre's history of dictatorship and warfare against northern Somalia/Somaliland has made him and his clan little appreciated in the region, this created a tense atmosphere. Furthermore, dialects can be linked to cultural identification and knowledge. The most well-known example is the common designation of Kenyan Somalis as *sijui*, Swahili for "I don't know," a term indicating both linguistic and cultural ignorance (Scharrer, 2018).

However, the research assistants did not consider their dialect or place of origin (their origin covered all of Somalia, north, south, and middle) to affect their rapport with the study participants. Rather, they experienced variations in dialect, especially in terms of various denotations for FGC, as a useful departure for exploring similarities and differences, leading to interesting data and discussions rather than affecting positioning.

A major surprise to our research assistants was the different understandings and definitions of a term they originally (i.e., before training and data collection) had considered mutual and shared among Somalis, namely, sunna circumcision. There seemed to be a sense of agreement in the Somali community concerning both its meaning and physical extent and consequences, which proved to be only superficial. That is, while sunna circumcision was generally assumed to be a minor, harmless procedure and people seemed to assume there to be a common agreement of its physical extent, probing proved this to be far from the case. These variations could easily have been missed if the research assistants had entered the study with only their emic, i.e., cultural insider, understanding of the practice. We experienced that both the training on this and the exploration of each person's perception of the term during the study were vital to ensuring data accuracy.

These experiences also shed light on the important interplay between linguistic and cultural competency, including the cultural competency of cultural insiders.

Cultural competency

Describing our research assistants as cultural insiders built on a perceived advantage of shared knowledge between researcher and study participants in terms of facilitating common understandings, which again can improve the quality and depth of questions explored and interpretation of answers. As suggested in the above discussion of sunna circumcision, being a cultural insider can also contribute to blind spots or superficial agreements. This is a major concern in social anthropological warnings of not "going native" but keeping an ethical outsider perspective.

Cultural competency in the Somali setting includes an understanding of the significance of clans. Clan constitutes an important social organizing principle among Somalis and a major aspect of identity and belonging. This could cause bias in recruitment, as some of the research assistants expressed how personal networks led to a dominance of participants belonging to the same clan. However, this bias

was balanced out through the other forms of recruitment, mainly snowballing and contacts made during the informational meetings.

A further complicating factor is that the clan tends to be considered a sensitive topic. One contributing factor is a sense of hierarchy between clans, with majority clans at the top and minority clans at the bottom. Traditionally, clans are further interlinked with residence patterns, which commonly follow family, lineage, and clan lines. This, again, is further linked to some aspects of FGC practices. While almost all clans practice FGC, there are some differences, particularly concerning the performance of FGC, type of FGC practice, and procedures for defibulation. The performance of FGC has traditionally been conducted by women from a minority clan with a low social status (commonly referred to as *goboroye* in the north and *midgan* in the south) (Abdalla, 1982). This clan is often positioned in a sort of patron-client relationship to the other clans, in which various services of manual labor are also included. Furthermore, while infibulation historically has been the dominant type of FGC in Somalia and sunna circumcision can be considered a new term and practice, certain clans have also historically practiced less extensive types (Crawford & Ali, 2014; Powell et al., 2020; Talle, 2010). Finally, is there a major divide mainly following a north-south distinction in how traditional defibulation at marriage has been conducted (Johansen, 2017). All these differences, together with the role of clan in the ongoing conflicts in Somalia, have contributed to both strengthening the importance of clan and making it a sensitive topic. This is even more so in the Norwegian context, where the majority associates clans with the civil unrest in Somalia, which seems to contribute to the general stigmatization of Somali migrants (Horst et al. 2013). Consequently, to avoid stirring any potential conflicts or a sense of superiority or subordination, we followed the outline of the REPLACE approach which did not target clan as a topic.

Nevertheless, we found clan to play a significant role in two factors explored in the study: procedures of defibulation and matrimonial strategies. There is a major difference between traditional procedures for marital defibulation between the southern and northern Somali regions, affecting medical help-seeking and social relations. In northern Somali regions, the infibulated seal is traditionally cut open by a circumciser at marriage. In the south, in contrast, men are generally expected to open the infibulation by their penis, a process commonly associated with perceptions of virility (Johansen, 2016, 2017). It is a general impression that the offer of medical defibulation is perceived as more culturally acceptable by women familiar

with the northern tradition likely because surgical defibulation at marriage is more similar to their traditional practices than it would be for women with a tradition of penile opening at marriage.

The southern Somalia tradition of the husband being expected to tear open the seal of his wife's infibulation with his penis in the days following the wedding was differently perceived by participants according to their regional origin. Whereas most southern women saw this as evidence of virginity and virtue for the women and virility and strength for the man, northerners perceived it as cruel and inhuman. The northern tradition of defibulation by a circumciser shortly after the wedding, sometimes after an inspection by the groom's mother, was perceived as a more humane method by northerners. On the other hand, southerners perceived it as a modern adaptation, shameful, or as a sign of lack of virility. These different interpretations were rarely expressed in plain words but more commonly in the forms of jokes and indirect comments, which one might need a cultural insider's background to understand. One example is how some participants joked about regional diet preferences, implying that certain foodstuffs reduced male virility.

Building rapport and trust

Without a minimum of trust, people would refuse to take part in a study. Without rapport, they would not share information, particularly not experiences they perceived as sensitive or private. This is important for recruitment and access to rich and truthful data (Guillemin & Heggen, 2009). It is common to distinguish between formal and informal ways of building rapport and trust. The formal ways include regulated procedures to secure informed consent, whereas the informal ways include a wide variety of factors, including positionality. In this section, we will focus on three interrelated aspects of building rapport: confidentiality and acceptance, reciprocity, and representation.

Confidentiality and acceptance

A major requirement in research ethics and a measure to build trust is the assurance of confidentiality. Thus, the information provided to potential study participants followed an outline provided by the ethics board (NSD) and included information about the study's purpose, the reason they were approached, responsible institution, and names of the PI and all research assistants. It also included information

on the rights of the study participants and the duties of the researcher. The study participant's rights include the right to voluntary participation and withdrawal at any time without a need for explanation and without any repercussions. The researcher's duties include the measures taken to ensure confidentiality, including data storage, access, anonymization, and routines for deleting data at the end of the study. This project information was provided to potential study participants in the form of information sheets available in Norwegian and Somali and was explained to potential and actual study participants.

This information was experienced as vital for establishing trust. Some research assistants reported that emphasizing the risk that breaking confidentiality held for them was fundamental to gaining study participants' trust. The importance of the formal rules of confidentiality in this setting is interesting. First, based on the idea that common cultural background and belonging are beneficial for rapport and trust, one could expect formal regulations to carry less weight. Even more so, in former research projects on FGC among Somali migrants in Norway, I rarely experienced this as vital for trust. Quite the contrary was my experience that personal factors that could be said to bring me closer to an insider (marriage to a husband of African origin with whom I have three daughters) appeared to be the most significant factor in gaining study participants' trust (Johansen, 2006). This could indicate that a cultural insider could be perceived as posing a risk for exposure to gossip in case of breaking their duty of confidentiality. In contrast, a cultural outsider would not be expected to socialize much with cultural insiders and thus be less temped and pose a smaller risk of breaking confidentiality and may thus be perceived as more trustworthy. This was substantiated by the research assistants' feeling that the social distance inherent in their residence outside the local community increased participants' openness and willingness to participate. This, however, contradicts the REPLACE approach's emphasis on the local recruitment of community-based researchers.

Another aspect of positionality is the perceived opinion of the researcher. In qualitative research, the researcher is expected to be as objective as possible, making efforts not to ask leading questions. As indicated, this was one of the major learning outcomes experienced by the research assistants, who otherwise were socially and politically engaged and opinionated. Furthermore, as the research assistants were not a part of the local community and were not previously engaged in

activities relating to FGC, their views on the topic were unknown to the study participants. This situation seems to differ from the outline of the REPLACE approach, with its emphasis on recruiting locally known people engaged in NGO activities, where opinions about many social and political issues, including FGC, would already be known to the study participants. Knowing the researcher's opinion could counter the idea of their neutrality and contribute to a social desirability bias in the responses. At the same time, not knowing and having to guess can make the study participant insecure and uncomfortable in the situation. However, given that the study was conducted in a country where FGC is forbidden and morally condemned, and a native Norwegian PI led the study, one would expect that the study participants had it in the back of their minds that they were being interviewed for a study with a negative attitude toward FGC as a baseline. Study participants did not seem to be aware of the PI's former engagement in a national program against FGC (Lien, 2005) or my infrequent public presentations on the topic. Furthermore, in the informational meetings prior to the study, plans for a future intervention against the practice were presented, thus providing insight into the project's intention to work toward FGC abandonment.

The significance of the research assistants' positions was probably less important in focus group discussions, where the other participants can be considered more important referents than the research assistants. Additionally, while encouraged not to share information from the discussion, the other participants were not bound by formal confidentiality regulations. Thus, focus group discussions might be a more natural social setting when the participants belong to the same local community, as was the case in this study. In this context, one would expect that the social desirability bias would be more in the direction of expressing conformity to local community norms than to the research assistants' expectations.

The findings gave some indications that the perception of social norms within the community differed from the participants' individual opinions or perceptions that they shared with the researchers. Some of the study participants took part in both individual interviews and focus group discussions as well as a feedback seminar. In some cases, the researcher could observe divergences between the statements and claims made in the two settings. These divergences could be interpreted as an indication of the local community's perceived social norms (Johansen, 2019).

There were, however, certain limitations in the form of social desirability bias in all settings. Neither the research assistants nor the study participants expected

that if anyone had a positive perception of infibulation, they would be willing to share this in any setting. This could be one reason why several study participants expressed doubt about certain other community members' public statements against the practice. These social norms regarding what can and cannot be said can indicate that the social norm has turned fully against infibulation or that the fear of legal prosecution is so strong as to scare anyone from stating eventual adherence.

The position of the research assistants as leaders and guides in discourses was occasionally experienced as challenging. One of the main challenges reported from the focus group discussions was a tendency for one or more participants to take a dominant role, monopolizing and steering the discussion and opinions. This had been anticipated due to experiences from earlier studies, and different ways to handle it had been explored prior to data collection. However, in focus group discussions with adult participants, it occasionally seemed that the relatively younger age of the research assistants made it more difficult to implement, as it challenged traditional respect for older individuals. Issues of age and seniority also affected discussions between group members. For example, for a feedback seminar aimed at young men, only one young man arrived, but numerous adults. During the discussions, which were led by one of the male research assistants in collaboration with the PI, the young man remained completely silent, whereas the participating adult and older men and religious leaders dominated the discussion.

Additionally, the content of the discussion could be influenced by the group age composition. For example, one could expect young participants to show reticence in addressing topics and experiences perceived as adult matters, such as sexuality and childbirth. Comparing the research assistants' experience and that of the PI (who has worked in the field since her early thirties) suggests that both the relative age and personal marital and childbearing experience of the researcher may influence access and depth of data. For example, during my Ph.D. work on FGC and childbirth among Somali women in Norway, my experience was that the shared experience of childbirth constituted an important bridge to study participants and their sharing of personal childbearing experiences. Over the years, I have felt that this shared female experience of motherhood may have been an important factor in installing trust and rapport. Most of the research assistants, in contrast, did not have children. This may be one of the reasons why female research participants experienced some challenges in building rapport with adult, married mothers. The

potential significance of shared cultural background and experience is relevant in the context of our next topic, namely, the value of reciprocity in human relations.

Reciprocity

Interviews and focus group discussions differ from everyday conversations in that there is a sense of one-way communication that contradicts the everyday importance of reciprocity. In the following, we will discuss two forms of reciprocity: mutual sharing of personal information and mutual help and support.

A major part of the research assistants' training was to ask nonleading questions to increase objectivity and decrease the risk of social desirability bias. This form of one-way communication implies that the researcher accesses private information about the research participant without sharing any of their own. This differs substantially from everyday forms of communication, which commonly include the mutual exchange of experiences, views, and perspectives and could create a form of distance and unbalanced power relations. This can, again, reduce the foundation on which rapport and trust can be built. Reflecting on this, some of the research assistants suggested that they probably could have accessed more personal, deep-felt, and truthful information in informal conversations with close friends due to trust based on mutual sharing of personal information. On the other hand, they expected that this lack of reciprocity in the exchange of information in research to some extent, could be balanced out by their position as a researcher. Furthermore, in particular, the female research assistants expressed an impression of the participating women truly appreciating the opportunity to share private experiences and perceptions in such a setting. For some research participants, the research assistants felt they were oversharing, going far beyond the study's questions and purpose.

At the same time, the research assistants did consider a certain minimum of personal sharing as an absolute necessity for data collection. Research assistants were frequently asked to identify and position themselves within the Somali community, particularly in terms of kinship and family, such as the name of parents, place of origin, and current residence. Most of the time, they experienced this as unproblematic and unavoidable. However, the female research assistants were also asked about their FGC status. Sometimes this was presented in the form of implicit expectations of shared experiences, such as "you know," "I suppose you remember when..." Although the research assistants occasionally found direct questions and

allusions slightly unpleasant, this had been expected, and they had in advance reflected on and discussed how to deal with it. They chose not to reveal their FGC status and preferred to answer in vague and nonconclusive manners.

Research assistants were also exposed to requests for emotional and practical support from some of the study participants. These requests were experienced as motivated by a variety of factors: as an expectation to get something back from their participation in the study, as a part of cultural expectations of mutual assistance, or due to a perception that the knowledge and network of the research assistants could be useful to solve some problems. Study participants were offered a voucher of 300 Norwegian kroner (approximately thirty English pounds) for their participation, and food and drinks were served during all group meetings to show appreciation for their participation. This was also because these encounters would occur when many participants just had left their jobs and studies and thus would likely be both hungry and thirsty. Furthermore, other studies and projects have found that providing food helps relax and ease the atmosphere and thus may be beneficial for conversational flow.

The help and support requested varied, including assistance in following up contacts with public services, such as children's schools, after-school activities, and social services, help to fill out different forms, finding a place to stay, work, or study and accessing medical help. In most cases, the research assistants welcomed such requests for assistance as an opportunity to build trust and reciprocate study participation. However, in a couple of cases, they faced requests that included ethical dilemmas or were experienced as overwhelming or scary. This included cases where the requests were incessant, involving large numbers of telephone calls and requests for help with difficult mental health or domestic issues without accepting help from existing service providers. As the PI had never experienced such a situation, the requests' strength and intensity were most likely related to the research assistants' position as cultural insiders.

In a couple of instances, the research assistants also felt vulnerable. This included situations where, for practical reason, interviews were conducted in the research participant's home or where the study participants experienced suffering from mental health troubles. In other interviews, the home situation was experienced as a difficult setting for interviews. This was particularly the case when the study participant was clearly older than the research assistants. The latter felt that their role as younger guests challenged their position as researchers, placing the

study participants in full control of the situation. In some cases, they perceived this to make it more challenging to ask questions that could be considered impolite or challenging.

These research assistants' experiences contrast sharply with my experiences from previous individual studies, where I was left with the impression of home visits as the most relaxed settings providing the richest data. I expect that being a guest in the interviewee's home reduced the potential power difference between the researcher and member of the host society, and the interviewee and migrant. Thus, whether home interviews will improve or reduce access to rich data is likely to vary with the researcher's and participant's relative positions, as different constellations of age/maturity, education, ethnicity, and minority/majority status can affect the setting in various ways.

In this study, cultural insiders were research assistants. Thus, study participants were informed that the information would be shared with the PI, who is a cultural outsider. They had also been informed that while their anonymity was granted, the overall study findings would be formulated into a scientific paper and were meant to form the basis for an intervention study. This implies that in addition to establishing personal rapport and trust during data collection, willingness to share information is likely to be affected by perceptions of data sharing and use. In the following, we will explore how individuals' participation in studies might also be affected by concerns about how the final presentation may represent the group with which they identify.

Representation

As indicated, Somali migrants in Norway commonly experience a sense of stigmatization from the host society. Many participants expressed such concern, and many referred to the TV documentary in the introduction as an example of media exposure and stigmatization. Many also claimed that the young Somali journalist in the program was commonly referred to as a traitor. They saw her exposure to FGC, including some religious leaders' acceptance of the practice as causing public shame to all Somalis living in Norway. Thus, when asked to participate in a study of FGC, Somalis might be concerned not only with personal anonymity and confidentiality but also with how the study findings could potentially affect the whole community.

During the introductory informational meetings, many potential study participants expressed skepticism about the study. Two main arguments were used: that the topic was irrelevant for Somalis in Norway because the practice has been abandoned and because of a concern that renewed focus on the topic could add to the already stigmatized status of Somalis there. Nevertheless, many did agree to participate in the study. Furthermore, the research assistants experienced most participants as eager to share personal experiences and thoughts. For example, although we did not raise questions concerning personal FGC experiences, both women and men shared numerous personal stories, reflections, and concerns. Thus, there seemed to be a major gap between strong personal experiences and concerns and a perception of the practice as irrelevant or something that should be concealed.

We suggest that a major aspect of this gap between concern over FGC and resistance to the public discourse of the topic can be analyzed in terms of back- and front-stage. The back-stage would here refer to significant personal experiences, traditional cultural values, and social norms. Most study participants knew that FGC was still the common norm in Somalia and expected most girls and women who had migrated after the common age of FGC to have undergone the practice. Thus, the practice constituted a part of most participants' everyday life, either as a procedure on their own body or that of people close to them, such as mother, daughter, sister, and wife. The front stage, on the other hand, refers to the image most of the participants seemed to want to present vis-a-vis the Norwegian host community, namely, that of a practice long abandoned. This was mainly motivated by a desire to reduce the risk of stigma and moral condemnation. This distinction between back- and front-stage is probably sharpened and shaped by a public debate on FGC and its focus on the risk that young Norwegian-Somali girls may be subjected to FGC. In contrast, the need for health care for those already subjected to FGC that could be a less stigmatizing approach has largely been absent in media, despite its place in policies, interventions, and research (Bråten & Elgvin, 2014; Johansen, 2017; Ziyada et al., 2020).

We thus see that a concern for the public image can reduce access to certain groups and topics. One of the methodological concerns is whether research participants expect cultural insider researchers to share their concerns over public image and filter potentially compromising information (Kusow, 2003). In such cases, insider researchers can experience ethical dilemmas, such as a sense of betraying in-

siders' confidence if sharing and publishing such data, versus dishonesty if they experience a need to censor study findings. A couple of research assistants reported such dilemmas. Fortunately, the potentially sensitive information in these cases was not related to the study topic and was thus not relevant for the analysis. However, we consider it important to reflect upon the risk that cultural insiders experience ethical challenges if provided with back-stage information that could contribute to the stigmatization of the study group if published.

Another option for dealing with potentially stigmatizing data is to express views and experiences by carefully maneuvering different frames of reference and understanding. The way in which sunna circumcision is framed may be an example of how different understandings of the terms make it possible to present front- and back-stages to different groups simultaneously. If a Somali girl claims to have not experienced FGC, a native Norwegian will most likely think she has not undergone any form of FGC, whereas a fellow Somali might interpret it as a sign that she has undergone "only" sunna circumcision but not infibulation. If she were to claim sunna circumcision, the cultural outsider might think it is a minor and harmless procedure. In contrast, a cultural insider might consider it a procedure that fulfills what some see as a religious obligation and that others believe reduces sexual urges (and thus promotes virtue) and can include a significant amount of tissue removal, including some extent of closure. Thus, both claims of non-FGC and acceptance of sunna circumcision can accommodate cultural outsiders and cultural insiders alike, both back- and front-stage.

The suggestion that representation and audience can affect study findings has been systematically explored in several FGC studies. In a study on FGC in Kenya, study participants were presented with different information regarding the audience of the study: One group was told that the information would be used by local NGOs to develop local initiatives targeting FGC, whereas the other group was informed that the ultimate audience was international organizations. The findings differed significantly between the two groups, with the first group presenting more FGC support than the other (De Cao & Lutz, 2018). Thus, the results suggest that social desirability bias may be geared not only toward the researcher but also the audience for the findings. It is possible to interpret this as an expression of concern over group image rather than over anonymity and trust vis-a-vis the person collecting the data.

Several studies have explored various forms of indirect questioning to reduce such social desirability bias. One such method is a form of list experiment and item count technique that has been used in a study of FGC perceptions in Ethiopia. Here, the researchers used focus group discussions to identify a set of items or qualities considered important in hypothetical daughters and daughters-in-law (Gibson et al., 2018). Five items were selected for the experiment: one popular (going to college), one unpopular (early marriage), two that were incompatible (living in the city or living close to home), and FGC. One informant group was asked how many of the first four elements they wanted for a hypothetical daughter and a hypothetical daughter-in-law. A second group was asked the same question with all five items. A third group was shown all items and asked about their opinion on each specific item. By comparing the findings from the three groups, the researchers found that participants expressed higher support for FGC in indirect listing than when directly asked to assess the item (Gibson et al., 2018). This and other studies using such indirect methods to measure attitude tend to yield data expressing higher support for FGC than what is captured through more direct questions, confirming a social desirability bias against FGC (De Cao & Lutz, 2018; Gibson et al., 2018; Vogt et al., 2017). To our knowledge, such methods have not been used in the diaspora but could be useful also in that context. Thus, it could be useful to consider using such indirect methods in further studies in the diaspora.

In the next section, we will explore what influence these varied positions and considerations might have on the findings, including the data's content and quality.

Findings, trustworthiness, and credibility

In this section, I explore experienced and possible consequences of positioning as a cultural insider for study findings and data quality, as well as for trustworthiness in terms of reader assessment.

To explore possible differences in data quality dependent on the researcher's positioning as a cultural insider versus outsider, I will compare findings from our REPLACE study conducted by cultural insiders with findings in former studies conducted by the PI and other cultural outsiders. This comparison is only tentative, as it cannot take into account all relevant factors, including the study questions and selection of study participants. I will highlight three areas where I found a difference that might be related to the researcher's insider/outsider positioning: the extent of

support for and acceptance of sunna circumcision, the significance of clan for marital preferences, and the perception of risk of forced FGC.

Support for or acceptance of sunna circumcision has been found in several studies by cultural outsiders in both countries of origin and countries of migration (Johansen, 2016; Lunde & Sagbakken, 2014; Wahlberg et al., 2017). However, in these studies, support for sunna circumcision was rare. In contrast, a study conducted by a cultural insider among Somali migrants in Oslo found that approximately 30% supported the practice (Gele et al., 2012). Whether this indicates a social desirability bias to conform to a perceived acceptance of sunna circumcision in Somali networks or a reflection of trust, causing participants to be more honest of their opinion is difficult to discern. Another possible reason for differences in sunna support expressed to cultural insiders and outsiders may be biased in recruitment. The REPLACE projects' initial contact with the local mosque may have led to a bias toward a religiously conservative sample. An indication of this was that all female research participants adhered to a strict religious dress code, which contrasts significantly with a much more varied dress code in female research participants in all my former studies. This religious adherence was also reflected in many of the responses and statements, in which religion was more commonly referred to than in former studies by the PI. However, expressions of religious adherence might also have been related to a social desirability bias and expectation of the researcher's knowledge of religious texts and interpretations. Alternatively, it may be an expression of an overall more deeply religious local community.

The two other findings that differ from those of the PI's former studies, a preference for clan endogamy and concern of risk of forced FGC if spending time with family elders in the country of origin might be related to cultural insider status as well as the age of the researchers and study participants. The REPLACE study included many young participants, which contrasted with former studies conducted by the PI that tended to include mainly adult and married participants. This age difference has partly been related to a thematic focus on sexuality and childbirth on many of the PIs former studies, topics that young women are not supposed to have insight into. Additionally, the PI was already married and had children when embarking on FGC research, whereas most of the research assistants in this study were young and single. Thus, their young age may have facilitated their access to and ability to build rapport with youth. Several young participants, mainly women,

expressed an expectation to marry within their clan. In contrast, adults often insisted on clan not being an issue, laughingly noting that most of them had married within their clan. This preference for clan endogamy came as a surprise to the researchers. As we did not ask about the clan or its significance, the responses on clan endogamy came as a reaction to a question about perceptions of cross-cultural marriages, that is, marriage between a Somali and a native Norwegian or a migrant from another country of origin. Thus, without this question, it could have escaped our attention. In contrast, the risk of forced FGC was specifically targeted, as this has been a major concern for FGC policies in Norway. Additionally, on this topic, it was almost only youth, and mainly young women, who expressed a fear that longer stays with relatives in the country of origin could pose a real risk of forced FGC, irrespective of their parents' wishes. In contrast, such a risk was generally rejected by adult men as well as many of the adult women. Thus, the extent to which eventual divergences in findings between studies conducted by cultural outsiders and insiders are related to the differences in their cultural positioning or other aspects of their positionality, such as age and marital status, is difficult to discern.

Another potential factor that may contribute to different findings in studies conducted by cultural insiders versus cultural outsiders is how study participants and researchers balance personal concerns and public image. Expectations of clan endogamy and the risk of forced FGC during travel home could be perceived as potentially stigmatizing information vis-a-vis the host community. Fear of stigmatization of the community may lead study participants to want to withhold potentially stigmatizing information. This could also lead to distrust in studying sensitive topics, particularly when conducted by cultural insiders that could be feared to be biased in the direction of image control.

On the other hand, findings from studies conducted by cultural insiders may be perceived as more credible. As cultural insiders, researchers may be trusted to have access to back-stage and deep cultural insight. We recall how the TV documentary presented in the introduction led the Norwegian public to believe the information provided by a cultural insider to be truer and more honest than public statements made by religious leaders. Cultural insiders can be perceived as people accessing back-stage insight, and thus their findings are more trustworthy. This has also been the case in research. One example is the reception of the writings of social anthropologist Fuambai Ahmadu, whose scientific articles over the years have expressed an increasingly positive attitude toward FGC. She has questioned reported

health complications and dismissed reports of negative sexual consequences as being based on a Western cultural bias rather than on the experiences of women who have undergone FGC (Ahmadu & Shweder, 2009). Her writings have been taken to heart by many social anthropologists and rewarded with prizes and individual interviews (Sulkin 2016). In her case, her origin from an FGC practicing country and personal experience with the procedure add a different kind of legitimacy to her findings than to those of a cultural outsider.

Discussion and concluding remarks

Discourses on researchers' cultural positioning have elaborated on its significance for access and trust but have been less concrete regarding how it might affect study quality and outcome. Comparing the experience of the PI conducting studies as a cultural outsider with the cultural insider researchers in REPLACE suggests that cultural positionality may affect study findings, though probably to a limited extent. This is particularly interesting given the sensitive topic at hand and the Somali experiences of stigmatization in Norway. Of course, the comparison is hampered because the studies compared differ in both research question and recruitment. For example, the REPLACE study recruited people in geographical and social proximity, thus possibly increasing the similarities between participants, and internal social desirability bias might have been as important as that of the researcher. Another major difference is, as mentioned, a high number of young participants.

Furthermore, the fact that the PI was a cultural outsider might, to some extent, have balanced out the potentially increased trust created by the research assistants' position as cultural insiders. The study participants were informed that the PI would access the findings. They were also informed that the findings would be presented in a scientific paper, thus being shared with a broad audience of cultural insiders and outsiders. Thus, even though a cultural insider might increase trust and rapport, concern over cultural representation, and stigmatization from the host society might counteract this.

Moreover, some of the study participants had shared intimate and vulnerable information after the interview was officially over, and the tape recorder turned off. This could put the research assistants in a difficult position, as they had the insight that could not be used directly in the analysis. In studies where the researcher collecting data is the same as the one writing up the results, insights gained beyond the formal interview can be used indirectly in interpretation and analysis. However,

this is more challenging both ethically and technically when data collection and final analysis are not performed by the same person. Consequently, some of the potential extra insight gained through the use of cultural insiders as data collectors might be lost in the analysis and writing process. Hence, research assistants' involvement in the analysis and writing process is likely to improve its quality.

Additionally, divergences between statements presented during interviews versus after interviews can put the research assistant in an ethical dilemma of sharing this with co-researchers and the PI. This brings us back to the positioning of the researchers. The REPLACE approach's guidance documents describe "community-based researchers" (CBRs) recruited through local NGOs and selected by the study community. This would suggest that the study community already has a perception of their role and position and potentially also their attitude toward FGC. Their position is described even more clearly in a paper evaluating the method, where their position has been changed to "peer group champions" and "change agents," reflecting their role in the intervention phase. This points to a challenge that might be inherent in intervention research: If cultural insider researchers and their position toward the practice in question are known in advance, social desirability bias could lead to the intervention's intended outcome. If CBRs are also gatekeepers for access to resources, as could be the case if they are engaged in local NGOs, this could further increase such bias. This points further to the potential effect of the researchers' position within the community on the study findings.

We observed how the research assistants' position as cultural insiders required differences in maneuvering between closeness and distance and managing higher reciprocity expectations. They experienced expectations in terms of personal information and practical assistance that went far beyond the PI's former experiences.

A final ethical challenge lies in the fundamental basis for participatory action research, focusing on community empowerment, which has guided the design of the REPLACE approach. One of its aspects is to assess "readiness for change" on a scale from 1 (ignorance or rejection of problem) to 9 (engagement and responsibility). In our REPLACE study, we graded our study participants in three to five in different aspects. To score full marks, in contrast, the community in question not only had to have abandoned all forms of FGC within their families but also actively engage in efforts for its abandonment in the community at large. That is, it builds on an expectation that "the community" should take full responsibility for FGC abandonment at the group level. This could be considered a major responsibility

not expected of other groups subjected to social change efforts. This perception of community responsibility also brings to the fore the question of how and who delineates a community. For example, could a goal of intervention in the diaspora be more geared toward engaging participants to engage against the practice by trying to discourage relatives in the country of origin from conducting FGC? This is because our study findings indicated that family and clan members in other countries might be perceived as more important community members than ethnic Somalis living in the local area in the diaspora. Thus, it would be useful to explore the expectation of community delineation, identification, and responsibility when designing FGC interventions. This would be particularly important in a diaspora setting, where the community's delineation might be more challenging, and where FGC for most is a practice associated with the country of origin rather than country of migration.

References

Abdalla, R. (1982). *Sisters in affliction: Circumcision and infibulation of women in Africa*. London, Zed Press.

Ahmadu, F. (2000). Rites and wrongs: An insider/outsider reflects on power and excision. In Shell-Duncan, B., Hernlund, Y. (Eds.), *Female "circumcision" in Africa: Culture, controversy, and change* (pp. 283–312). London: Lynne Rienner Publishers.

Ahmadu, F.S., & Shweder, R.A. (2009). Disputing the myth of the sexual dysfunction of circumcised women: An interview with Fuambai S. Ahmadu by Richard A. Shweder. *Anthropology Today, 25*, 6, 14–17.

Barrett, H., Brown, K., Alhassan, Y.N., & Beecham, D. (2015). *The REPLACE approach: Supporting communities to end FGM in the EU. Community handbook*. Coventry: Coventry University.

Barrett, H.R., Brown, K., Alhassan, Y., & Leye, E. (2020). Transforming social norms to end FGM in the EU: An evaluation of the REPLACE Approach. *Reproductive Health, 17*, 1, 1–16.

Bourdieu, P. (1977). *Outline of a theory of practice.* Cambridge: Cambridge University Press.

Bråten, B., & Elgvin, O. (2014). *Forskningsbasert politikk? En gjennomgang av forskningen på tvangsekteskap, kjønnslemlestelse og alvorlige begrensninger av unges frihet, og av de politiske tiltakene*

på feltet [Research-based policy? A review of research on forced marriage, female genital mutilation and serious restrictions on young people's freedom, and on policy measures in the field]. Oslo: FAFO.

Carling, J., Erdal, M.B., & Ezzati, R. (2014). Beyond the insider–outsider divide in migration research. *Migration Studies, 2*, 1, 36–54.

Crawford, S., & Ali, S. (2014). *Situational analysis of FGM/C stakeholders and interventions in Somalia*. London: HEART, UK Aid. Retrieved from http://www.heart-resources.org/wp-content/uploads/2015/11/Situational-analysis-if-FGM-stakholders-and-interventions-somalia-UN.pdf

De Cao, E., & Lutz, C. (2018). Sensitive survey questions: Measuring attitudes regarding female genital cutting through a list experiment. *Oxford Bulletin of Economics and Statistics, 80*, 5, 871–892.

Fangen, K. (2008). Identitet og praksis: etnisitet, klasse og kjønn blant somaliere i Norge [Identity and practice: Ethnicity, class and gender among Somalis in Norway]. Oslo: Gyldendal akademisk.

Ganguly, T. (2016). The politics of location: Being a native anthropologist among Western interlocutors in India. *Sites: A Journal of Social Anthropology and Cultural Studies, 13*, 2, 210–231.

Gele, A.A., Johansen, R.E.B., & Sundby J. (2012). *When female circumcision comes to the West: Attitudes toward the practice among Somali Immigrants in Oslo.* BMC Public Health. **12**(1): p. 697.

Gibson, M.A., Gurmu, E., Cobo, B., Rueda, M.M., & Scott, I.M. (2018). Indirect questioning method reveals hidden support for female genital cutting in South Central Ethiopia. *PloS One* 13, 5. doi: 10.1371/journal.pone.0193985

Goffman, E. (1949). Presentation of self in everyday life. *American Journal of Sociology, 55*, 6–7.

Guillemin, M. & Heggen, K. (2009). Rapport and respect: Negotiating ethical relations between researcher and participant. *Medicine, Health Care and Philosophy, 12*, 3, 291–299.

Hastrup, K. (1996). Det antropologiske project [The anthropological project]. In A. Gustavsson (Ed.), *Kunskapsmål, teori, empiri* [Knowledge objectives, theory, empirics] (pp. 143–158). Uppsala: Etnologiska institutionen [Department of Ethnology].

Hervik, P., Vestergaard, G., & Fadel, U. (1999). De "besværlige" somaliere [The "troublesome" Somalis]. In Hervik, P. (Ed.), *Den generende forskellighed: Danske svar på den stigende multikulturalisme* [The embarrassing diversity: Danish responses to the increasing multiculturalism] (pp. 133–170). Copenhagen: Hans Reitzels Forlag.

Horst, C., Ibrahim, F.K., Baumbach, B., Hussein, M., Muuse, H., & Osman, S. (2013). *Somalis in Oslo, Somalis in European Cities*. New York: Open Society Foundations. Retrieved from https://www.prio.org/Publications/Publication/?x=7068

Ibrahim, A., Rasch, V., Pukkala, E., & Aro, A.R. (2011). Cervical cancer risk factors and feasibility of visual inspection with acetic acid screening in Sudan. *International Journal of Women's Health, 3*, 117–122.

Johansen, R.E.B. (2004). *Endring innenfra. Sluttrapport for OK-prosjektet 2001-2004* [Change from within. Final report of the OK Project 2001-2004]. Oslo.

Johansen, R.E.B. (2006). *Experiences and perceptions of pain, sexuality and childbirth. A study of female genital cutting among Somalis in Norwegian exile, and their health care providers.* Doctoral thesis, Section for Medical Anthropology, Institute of General Practice and Medicine, Faculty of Medicine, University of Oslo.

Johansen, R.E.B. (2016). Undoing female genital cutting: Perceptions and experiences of infibulation, defibulation and virginity among Somali and Sudanese migrants in Norway. *Culture, Health & Sexuality*, *19*, 4, 1–15.

Johansen, R. (2017). *Kjønnslemlestelse: Forebygging og informasjon om helsehjelp til flyktninger, asylsøkere og bosatte i Norge* [Genital mutilation: Prevention and information about health care for refugees, asylum seekers and migrants in Norway]. Oslo: NKVTS, Norwegian Centre for Violence and Traumatic Stress Studies.

Johansen, R.E.B. (2017). Virility, pleasure and female genital cutting. Perceptions and experiences of medicalized defibulation among Somali and Sudanese migrants in Norway. *Reproductive Health, 14,* 25. doi: 10.1186/s12978-017-0287-4

Johansen, R.E.B. (2019). Blurred transitions of female genital cutting in a Norwegian Somali community. *PloS One*, *14*, 8. doi: 10.1371/journal.pone.0220985

Kusow, A.M. (2003). Beyond indigenous authenticity: Reflections on the insider/outsider debate in immigration research. *Symbolic Interaction, 26*, 4, 591–599.

Lien, I.L., (2005) *Tiltak mot kjønnslemlestelse. Evaluering av OK-prosjektet*. Report. Oslo: NIBR.

Lien, I.L., & Schultz, J.H. (2013). Internalizing knowledge and changing attitudes to female genital cutting/mutilation. *Obstetric Gynecology International,* 1–10. doi:10.1155/2013/467028

Lunde, I.B., & Sagbakken, M. (2014). Female genital cutting in Hargeisa, Somaliland: Is there a move towards less severe forms? *Reproductive Health Matters, 22*, 43, 169–177.

Lunde, I.B., Sagbakken, M., & Johansen, R.E.B. (2019). Negotiating female genital cutting as a difficult characteristic in Kurdish national identity. *Nordic Journal of Migration Research, 9*, 3, 363–381.

Powell, R.A., Yussuf, M., Shell-Duncan, B., & Kabiru, C.W. (2020). *Exploring the nature and extent of normative change in FGM/C in Somaliland.* Evidence to End FGM/C: Research to help girls and women thrive. New York: Population Council.

Scharrer, T. (2018). "Ambiguous citizens": Kenyan Somalis and the question of belonging. *Journal of Eastern African Studies, 12*, 3, 494–513.

Sulkin, L.C.D. (2016). Fuambai's strength. *HAU: Journal of Ethnographic Theory*, 6(3): p. 107-133.

Talle, A. (2010). Getting the ethnography "right". On female circumcision in exile. In Melhuus, M., Mitchell, J.P., & Wulff, H. (Eds.), *Ethnographic practice in the present* (pp. 107–120). Oxford: Berghahn Books.

Vogt, S., Efferson, C., & Fehr, E. (2017). The risk of female genital cutting in Europe: Comparing immigrant attitudes toward uncut girls with attitudes in a practicing country. *SSM—Population Health*, *3*, 283–293.

Wahlberg, A., Johnsdotter, S., Selling, K.E., Källestål, C., & Essén, B. (2017). Factors associated with the support of pricking (female genital cutting type IV) among Somali immigrants–a cross-sectional study in Sweden. *Reproductive Health*, *14*, 92. doi: 10.1186/ s12978-017-0351-0

World Health Organization (2008). *Eliminating female genital mutilation: An interagency statement*—OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO, WHO. Geneva WHO.

Ziyada, M.M., Lien, I.-L., & R.E.B. Johansen (2020). Sexual norms and the intention to use healthcare services related to female genital cutting: A qualitative study among Somali and Sudanese women in Norway. *PloS One*, *15*, 5. doi: 10.1371/journal.pone. 0233440

Ziyada, M.M., Norberg-Schulz, M. & Johansen R.E.B. (2016). Estimating the magnitude of female genital mutilation/cutting in Norway: an extrapolation model. *BMC Public Health 16*, 110. doi: 10.1186/s12889-016-2794-6

Mimmi Koukkula, Natalia Skogberg, Hannamaria Kuusio, Satu Jokela, Eero Lilja, & Reija Klemetti

Improving Data Collection on Female Genital Mutilation/ Cutting (FGM/C) in Finland

Introduction

As elsewhere, FGM/C is also a concern in Finland and more efforts are needed to eliminate the tradition. Improved care and stronger support is required for girls and women who have undergone FGM/C to improve their life and well-being. It is important to understand the extent of the FGM/C phenomenon in order to target the preventive measures and to direct health care activities properly.

The size of the migrant population in Finland has increased from 1% of the total population to 8% during the last decades. Even though FGM/C is a common practice in some countries of origin of the largest migrant groups, until recently, data on the prevalence of FGM/C in Finland have been restricted to two cross-sectional population-based studies, *Migrant health and wellbeing study* (The Maamu study) (Castaneda, Rask, Koponen, Mölsä, & Koskinen, 2012) and *Survey on work and well-being among people of foreign origin* (The UTH Survey) (Nieminen, Sutela, & Hannula, 2015).

The Finnish Institute for Health and Welfare (THL), which is a research and development institute subordinate to the Ministry of Social Affairs and Health has been raising awareness and constructing measures to eliminate FGM/C in Finland. THL maintains most of the Finnish health care registers including the Finnish Medical Birth Register and the Care Register for Health Care and conducts most of the population-based surveys in Finland. THL aims to collect systematic data on FGM/C in Finland.

The Medical Birth Register, established in 1987, collects data on all pregnancies resulting in the birth of live and stillborn infants with a gestational age of ≥22 weeks or with a birth weight of ≥500 g. The registry data are collected via a structured form filled in by healthcare professionals by the time the infant is discharged from the delivery hospital or is seven days old, whichever occurs first. The Care Register for Health Care collects data on the activities of health centers, hospitals, and other institutions providing inpatient care and on the clients treated in them, as well as on home-nursing clients, for the purposes of statistics, research, and planning.

When studying a sensitive and marginal topic such as FGM/C, it is important to use all available data collection methods. Therefore information on diagnosis and operations related to FGM/C have been included in the Finnish Medical Birth Register and the Care Register for Health Care. Furthermore, a question on FGM/C has also been included in several population-based surveys conducted by THL.

Background

In 2019, the largest migrant groups in Finland were of Russian, Estonian, Iraqi, and Somali origin (Official Statistics of Finland [OSF], 2019). The first study examining the prevalence of FGM/C, the *Migrant health and wellbeing study* (Maamu 2010–2012, from now referred to as the Maamu study) was conducted by THL in collaboration with the Finnish Ministry of Social Affairs and Health, the Finnish Institute of Occupational Health and the cities where data collection took place. The second study, the *Survey on work and well-being among people of foreign origin* (UTH 2014–2015) was conducted by Statistics Finland, THL, and the Finnish Institute of Occupational Health (Castaneda et al., 2012; Nieminen et al., 2015).

The Maamu study

The Maamu study is a comprehensive cross-sectional health interview and examination survey which collected data on the health, well-being and use of services of working-aged migrants of Russian, Somali, and Kurdish origin. A sample of 1,000 people from each migrant group (N=3,000) living in six cities in Finland hosting the substantial majority of people of migrant origin was randomly selected from the National Population Registry. The selection criteria included: age (18–

64 years), a minimum period of residence in Finland of one year, country of birth (Russia/former Soviet Union, Somalia, and Iraq/Iran) and mother tongue (Russian/Finnish for the Russian-origin group and the Sorani dialect of Kurdish for the Kurdish origin group, except for Somalis who were identified only by the country of birth).

The Maamu study consisted of a health examination and a structured face-to-face interview. Data were collected by trained fieldwork staff. A brief questionnaire was offered to those who declined the interview. During the face-to-face interviews, among other reproductive health issues, women of Somali and Kurdish origin were asked about their FGM/C status. The interview also included questions concerning problems during pregnancy or delivery as a result of FGM/C (yes, no), reluctance to give birth because of difficult delivery (yes, no), infections because of FGM/C (yes, no); pain as a result of FGM/C (yes, no); difficulties in marital life as a result of FGM/C (yes, no); other health problems (not specified) related to FGM/C (yes, no). All the responses related to reproductive health issues are based on self-reporting and women's subjective experiences (Koponen & Mölsä, 2012). The study has been described in more detail elsewhere (Castaneda et al., 2012).

The participation rate in the face-to-face interviews in the Maamu Study was 54% for the Kurdish women and 36% for the Somali women respectively. In the study, FGM/C was more common than previously estimated: 69% of women of Somali origin (N=165) and 32% of women of Kurdish origin (N=224) reported having had FGM/C (Koukkula et al., 2016). Problems during pregnancy and delivery were reported by 20% of the women with FGM/C.

The UTH Survey

The UTH Survey collected information among people of foreign origin about employment and working conditions, ability to work and function, physical and mental health, experiences of discrimination, and need for services. The questions of the survey were gathered from large-scale national population studies conducted in Finland (Labour Force Survey, Regional Health and Well-being Study, Health 2011, Work and Health), which allows comparison of the results with the population living in Finland.

In the UTH Survey, a random sample of 5,449 people aged 15 to 64 years living in Finland, whose both parents (or the only known parent) had been born

outside Finland, was drawn from the Statistics Finland's database. The participation rate was 66%. The study has been described in more detail elsewhere (Nieminen et al., 2015). The survey data were collected in 2014 in face-to-face and phone interviews, and a question on FGM/C and health problems related to FGM/C was included and asked from women with origin in a country of high FGM/C prevalence (list of 30 countries, UNICEF). In the survey, 19% of the women with origin in high prevalence country reported having FGM/C, most at the age of 6–15 years, and 24% of them reported health problems related to FGM/C (Koponen, Jokela, Skogberg, Castaneda, Suvisaari, Laatikainen, & Koskinen, 2015).

Estimation of the number of girls at risk of FGM in Finland

Although two cross-sectional, population-based studies including questions on FGM/C have thus been carried out in Finland, the exact number of girls and women in Finland who have undergone FGM/C is not known. While the subject has from time to time received extensive attention in the media, and the previous action plan was published six years ago, the practice of FGM/C remains relatively poorly known, for example among social welfare and healthcare professionals. THL has, however, made estimates of the prevalence of FGM/C using register information on the number of migrants from each country residing in Finland and the most recent data on the prevalence of the practice in the countries of origin among different migrant groups in Finland.

Based on national statistics (Statistics Finland, 2017; Finnish Immigration Service, 2018), we calculated that there are approximately 38,000 girls and women living in Finland originating from countries where FGM/C is practiced. We calculated the estimates for the prevalence of FGM/C and the number of girls at risk of FGM/C (European Institute for Gender Equality [EIGE], 2015) using EIGE guidelines (*Estimation of girls at risk of female genital mutilation in the European Union: Step-by-step guide*). This estimate is based on the most recently available data on the prevalence of FGM/C in countries practicing this tradition, the typical age at which FGM/C takes place in each country, and information on the countries of origin of first and second-generation members of communities originating from countries where FGM/C is practiced and on asylum seekers' countries of origin. Thus a theoretical maximum number of girls at risk was obtained. It should be noted, however, that this high-risk scenario assumes the risk of FGM/C for a girl living in a new country to be as high as in the country of origin, not taking into

account the impacts of migration, acculturation, legislation, and preventive work against FGM/C in Finland.

In practice, the effects of migration, acculturation, legislation, as well as preventive work on attitudes and behavior regarding FGM/C should be taken into account in the risk assessment. These are accounted for in the low-risk scenario. In this scenario, the risk was calculated by factoring in the impacts of migration and acculturation on changing attitudes and customs related to FGM/C as the EIGE (2015) guidelines instruct. For second-generation girls originating from countries where FGM/C is practiced, the risk is lower or close to non-existent. For this reason, second-generation girls from countries practicing the tradition are excluded from the estimates. According to these estimates, roughly 10,000 girls and women living in Finland could have undergone FGM/C, and approximately 650–3,080 could be at risk of FGM/C, depending on how acculturation affects the tradition (Koukkula & Klemetti, 2019a).

Data sets and methods for improving data collection on FGM/C in Finland

The Finnish Institute for Health and Welfare has carried out several population-based studies including data collection on FGM/C in 2018 to 2019; *Survey on well-being among foreign born population* (the FinMonik Survey), *The asylum seekers health and wellbeing survey* (the TERTTU study) and *The school health promotion study* (the SHP study). Questions concerning FGM/C have been added into recurring data collections as well as into national patient registers: *The Finnish Medical Birth Register* and *The Care Register for Health Care*.

Survey data

FinMonik—Survey on well-being among foreign born population

The survey on well-being among foreign born population (FinMonik) is a comprehensive cross-sectional population-based survey that collected information about well-being and health, ability to work, discrimination, functional capacity, and service use of the foreign-born population in Finland. The data collection was conducted by THL in 2018–2019. The study was funded by the Ministry of Economic Affairs and Employment, municipalities, and the EU's Asylum, Migration and Integration Fund (AMIF).

The stratified random sample of the FinMonik Survey consisted of 12,877 adults aged 18 to 64 years living in Finland. The participation rate was 53%. Women constituted 55% of all participants. The study population was categorized into seven regional groups; Russia and the former Soviet Union, Estonia, Middle East and North Africa, Other Africa, Asia, EU, EFTA and North America and Latin America, Former Yugoslavia and Other countries.

In order to reduce non-response bias and to take the unequal sampling probabilities into account, analysis weights were constructed based on register information. The stratified sampling was accounted for in the calculation of the confidence intervals, and finite population correction was applied due to a significant amount of the total population being included in the sample (Lehtonen & Pahkinen, 2004).

Data were collected with a self-administered questionnaire available in the seventeen most commonly spoken languages in Finland (Finnish, Albanian, Arabic, Chinese, Dar, English, Estonian, Farsi, Polish, Russian, Somali, Soran, Spanish, Swedish, Thai, Turkish, Vietnamese and French). First, a letter containing a link to the online survey with all language options was sent to all included in the sample. After two reminders, a paper-based questionnaire was sent twice to the non-respondents. Finally, supplementary phone interviews were carried out by multilingual interviewers.

The issue of FGM/C was addressed with the following questions: *"In some countries, girls may be circumcised, and this might have effects on the person's health. Have you been circumcised?"* and *"If yes, what age were you when the circumcision was performed on you?" "If you either do not know or cannot remember the exact age, an estimate will be enough."*

TERTTU—The asylum seekers health and wellbeing survey

The asylum seekers health and wellbeing survey (TERTTU) is a population based prospective study with a total population sample of newly arrived asylum seekers to Finland, both adults and children. The study was carried out by the Finnish Institute for Health and Welfare in collaboration with the Finnish Immigration Service and the reception centers where the study was conducted. The TERTTU survey was carried out as part of a national-level project aimed at developing the health examination protocol for newly arrived asylum seekers (2017–2019), funded by the Asylum, Migration, and Integration Fund (EUSA/AMIF). A more

detailed description of the survey protocol has been provided elsewhere (Skogberg et al., 2019).

In the TERTTU survey, the baseline data collection was carried out in reception centers in 2018 and consisted of a face-to-face interview, self-administered questionnaire (provided as an interview if the participant was illiterate or otherwise needed help with answering the questions or if the translation of the questions was not available in the language spoken by the participant), and a health examination following a standardized protocol. The data collection was implemented by eight trained multilingual fieldwork personnel. In addition to having a good command of Finnish, languages spoken by the fieldwork personnel included English, Arabic, Somali, Persian, Dari, Sorani dialect of Kurdish, Urdu, Russian, Portuguese, and French. If the study participant spoke another language than the ones spoken by the fieldwork personnel, a professional interpreter was used.

The total sample of the TERTTU survey constituted of 1,433 adults and children. The participation rate was 76% both among men and women. Women constituted 41% of all participants. Altogether 311 adult women, 27 adolescent girls (13–17 years), 41 primary school aged girls (7–12 years) and 70 under school aged girls (0–6 years) participated in the survey. *The guardian replied to the interview questions of 0–12-year-old survey participants. Guardians of 0–12-year-old participants were also asked whether the mother of the child had been circumcised. Adolescents (13-17 year-olds) answered the questions themselves and without the presence of other family members.* The study population was categorized into four groups: those from Russia and the former Soviet Union, the Middle East and North Africa, Other Africa and Other regions. The data collection was mainly carried out at the reception centers in Helsinki, Turku, Joutseno, and Oulu.

Two types of methods were used to collect information on FGM/C. These were face-to-face interviews by THL's multilingual field work personnel and a self-administered questionnaire. The issue of FGM/C was addressed with the following questions: *"Female circumcisions are practiced in some countries, and they may affect health. Have you been circumcised?"* and *"If yes, how old were you when you were circumcised?"*

The school health promotion study

The school health promotion study (SHP) monitors wellbeing, health, and schoolwork of Finnish children and adolescents and is conducted by the Finnish Institute for Health and Welfare. The aim of the SHP study is to strengthen the planning

and evaluation of health promotion activities at school, municipal, and national levels. The SHP study provides information about the health of 120,000–140,000 school children and young adolescents and has been conducted nationwide biannually since 1996. The sample consists of 1st and 2nd graders from upper secondary school and 1st and 2nd graders from vocational school. The results were analyzed using the female student's birth country and the birth country of her parents or the only living parent. The data collection of the School Health Promotion Study was carried out in March–April 2019 in an anonymous and voluntary classroom-administered online questionnaire. A question regarding whether the participant was circumcised or not was asked from the 1st and 2nd graders from upper secondary school and 1st and 2nd graders from vocational school aged between 15 and 21 years. The issue of FGM/C was addressed with the following description: "*Female or male circumcisions are practiced in some countries, and they may affect health. Female circumcision is a procedure where female external genital organs are partially or completely removed or harmed in another way based on cultural or other non-medical reasons.*"

The prevalence of FGM/C was calculated for all the female respondents (n= 26,241 in secondary schools and n= 9,363 in vocational schools) in the study group and for the females with a foreign background in the study group.

Register data

The Finnish Medical Birth Register

Almost all expectant mothers in Finland have a health examination at a prenatal clinic before the end of the fourth month of pregnancy, and more than 99% of mothers give birth in a hospital (Ministry of Social Affairs and Health, 2013). Pregnant women receive a maternity card from the prenatal clinic containing data on the mothers' health, pregnancy, birth, and postnatal period. It is used for passing on information between the maternity clinic at the health center and the delivery hospital. The card is also used as a source of information collected for the Finnish Medical Birth Register. Since 2017, pregnant women's FGM/C status has been recorded on the maternity card.

The Finnish Medical Birth Register contains data on all mothers, deliveries, and new-born infants up until the age of seven days. In the register, statistical data are collected for the purposes of conducting research; developing maternity care, deliveries, and the care of new-born infants; and offering services. Since 2017, the form used to collect data for the Medical Birth Register has contained information

on FGM/C and deinfibulation (re-opening the vaginal introitus) during delivery. At the moment of writing this article, the data concerning maternity hospitals in the Hospital District of Helsinki and Uusimaa (capital area) were not yet available.

The prevalence of FGM/C was calculated for all the female respondents in the study group. The prevalence was also calculated for the females with a foreign background and from backgrounds with FGM/C traditions. In addition, due to restrictions in the data collection, information about the origin of women who have migrated to Finland after 2014 was not available.

The Care Register for Health Care

Reporting FGM/C, deinfibulation, and problems, complications and operations associated with FGM/C to the Care Register has been possible and mandated since 2017.

Results

FGM/C

Of all female asylum seekers included in the TERTTU Survey (n=282) 10.6% reported having undergone FGM/C (Table 1.). Among the female foreign-born population in Finland (FinMonik survey, (n= 3,442)) the prevalence was lower, at 2.4%. Female school-age students in upper secondary school and vocational school reported FGM/C less frequently (Table 1.). When the analysis was restricted to female students born abroad, the prevalence was 1.1% and when restricted to the female students whose parents or the only known parent was born abroad it was 0.6%.

In the 2017–2018 period, 97,427 women gave birth in Finland. Of them 0.4% were reported to have undergone FGM/C (Table 2). After including only women from countries practicing FGM/C, the prevalence was 14.7%. One third of the women with FGM/C were giving birth for the first time. In 2017–2018 there were twenty-six registered deinfibulations.

FGM/C by age

Among asylum seekers (in the TERTTU survey) FGM/C was most common in the youngest age group of adults while among the foreign-born population living in Finland (in the FinMonik survey) FGM/C was more common in the older age

groups (Table 2). None of the asylum seekers reported that their daughters, aged 0–12 years, had undergone FGM/C and only a few teenagers reported having undergone FGM/C. In the Medical Birth Register the 18–29-year-old parturients (women having recently given birth) had most commonly undergone FGM/C and two thirds of the women with FGM/C were under thirty years old.

Table 1. Prevalence of FGM/C in the different data sets in 2017-2019 in Finland

Study	Number of female participants in the study group	Prevalence of FGM/C, % (95% CI)
TERTTU Survey, asylum seekers (n=1,433) (18– years)	282	10.6 (7.5–14.8)
FinMonik Survey, foreign born population in Finland (n=12,877) (18–64 years)	3,442	2.4 (1.5–3.7)
School health promotion survey Female students in upper secondary schools (n=26,241) Female students in vocational schools (n=9,363) (15–21 years)	35,543 Born abroad 1,698 Born in Finland 33,148 Born abroad or in Finland and parents or the only known parent born abroad 4,037 Born in Finland and parents or the only living parent born in Finland 30,749 Born in Somalia 41	0.2 1.1 0.2 0.6 0.1 19.5
Medical Birth Register in 2017–2018 (n=97,427) (15–56 years)	65,092 Foreign background with FGM/C tradition 886	0.4 14.7

CI= Confidence interval. (The interval in which the value is at 95% certainty)

The average age at which female asylum seekers had undergone FGM/C was five years. The majority underwent FGM/C between the ages of 0 to 1 year, whereas

some reported having undergone FGM/C at school age or later. Among the foreign-born population living in Finland, the average of having FGM/C performed was 7.0 years (CI 5.6–8.5) which was also the most common age for FGM/C.

Table 2. FGM/C among women by age-group in TERTTU and FinMonik Surveys in 2018-2019

Study (total sample size in the study)	18–29 years % (95% CI)	30–39 years % (95% CI)	40 years + % (95% CI)	Total % (95% CI)
TERTTU survey, asylum seekers (n=1,433)	n=84 14.3 (8.3–23.5)	n=127 7.9 (4.3–14.0)	n=71 11.3 (5.7–21,0)	n=282 10,6 (7.5–14.8)
FinMonik Survey, foreign born population (n=12,877)	n=668 1.5 (0.8–2.6)	n=1067 2.1 (1.1–4.2)	n=1707 3.0 (1.3–6.1)	n=3442 2.4 (1.5–3.7)

CI= Confidence interval. (The interval in which the value is at 95% certainty)

FGM/C and the country of origin

The prevalence of FGM/C was highest among women of Other African origin both among asylum seekers (34%) and the foreign-born population living in Finland (18%) (Table 3). FGM/C was also reported by women of Middle Eastern and North African origin (10% and 8%). Of the upper secondary school and vocational school foreign born female students, FGM/C was most common among adolescents born in Somalia (20%). Women of Somali origin also had the highest prevalence of FGM/C among women who had given birth (58%) according to the Medical Birth Register. Additionally, women from Afghanistan, Myanmar, the Dominican Republic, Ethiopia, Eritrea, Iran, Iraq, Morocco, Nigeria, Sudan, Turkey and Egypt were reported to have undergone FGM/C.

In 2017-2019 totally 63 women were registered to have deinfibulation in the Finnish health care registers: 42 in the Medical Birth Register and additionally 21 in the Care Register for Health Care.

Table 3. FGM/C among women by region of origin in 2017-2019 in Finland

Study	Russia and the former Soviet Union % (95% CI)	Middle East and North Africa % (95% CI)	Other Africa % (95% CI)	Other area % (95% CI)
TERTTU Survey, asylum seekers (n=1,433)	NA[1]	n=126 10.3 (6.1–17.0)	n=50 34.0 (22.3–48.1)	NA[1]
FinMonik Survey, foreign born population (n=12,877)	NA[1]	n=321 8.0 (4.3–14.6)	n=115 18.3 (9.7–31.8)	n=1851 0.4
Medical Birth Register[2] (n=97,427)	NA[1]	n=536 2.1	n=284 40.8	n=65 4.6

CI= Confidence interval. (The interval in which the value is at 95% certainty)
[1]NA= Not possible to count, group size <30 or cell size <5.
[2]=Information about the origin not available for 150 women.

Discussion

Work aiming to prevent FGM/C on a national level has been carried out in Finland since the 1990s when the first migrants from countries practicing FGM/C started to arrive in the country. However, the first national action plan was launched in 2012 (Ministry of Social Affairs and Health, 2012). The *Action Plan for the Prevention of Circumcision of Girls and Women 2012–2016* was based on the implementation of the Internal Security Programme 2008−2011 and produced on the initiative of the Ministry of Social Affairs and Health. The action plan was in-

tended as a guideline and recommendation on preventing FGM/C, and its objective was to establish effective and permanent national and regional structures in Finland to prevent the practice. The action plan was also a response to Finland's international obligations to promote women's and girls' human rights and to prevent violence against women. THL coordinated its implementation by producing brochures, guidelines, and information for websites, by training professionals, through information activities, and by cooperation with the communities from FGM/C practising countries.

After the expiry of the first action plan, preventing FGM/C was included in the *National Action Plan on Sexual and Reproductive Health for 2014–2020* under the theme of violence (Klemetti & Raussi-Lehto, 2013). In this action plan, however, the topic was not addressed extensively enough to cover FGM/C prevention as set out in the *Action Plan for the Prevention of Circumcision of Girls and Women*. NGOs have also played an important role in the work to prevent FGM/C in Finland. There is a network on FGM/C prevention working on a national level, including members from different ministries, immigration services, and NGOs, among others. In recent years, several local projects related to migrants' health and welfare have been launched in the country, in which FGM/C has also been addressed.

The prevalence of FGM/C was unknown in Finland until the first survey among migrants in 2010–2012 (Castaneda et al., 2012). Since then it has been clear that we need information on the prevalence of FGM/C, estimations of girls at risk of FGM/C and of girls and women living with FGM/C in Finland.

THL's estimations on girls at risk of FGM/C and living with FGM/C are based on the EIGE's guidelines, but they might be overestimation. Studies conducted in Europe indicate that second-generation girls from countries where FGM/C is practised and who have been born in Europe are rarely cut, compared with girls living in the countries of origin. However, there is a report by Fenix Helsinki association on four girls living in Finland who had been taken abroad for a FGM/C procedure, and also the results of the SHP Study indicate that there are at least some girls born in Finland who have undergone FGM/C (Ahmed & Ylispangar, 2017; Koukkula et al., 2020). The reasons for the decreasing trend in FGM/C prevalence after migration could include that the social pressure to follow the tradition experienced by families is absent or weaker, and that the families'

attitudes towards the tradition change in a new country (AIDOS, 2016; Gele, Johansen, & Sundby, 2012; Johnsdotter, 2002; Johnsdotter & Essén, 2016; O'Neill et al., 2017).

New data collection methods, both survey- and register-based, were and are needed in order to obtain more accurate information on sensitive areas of women's health, such as FGM/C. Sensitive survey protocols need to be developed to reduce reporting bias, since the usefulness of a survey depends on cultural issues, as well as the data collection methods used (Jokela et al., 2018; Jones & Kost, 2007).

For example, under-reporting of induced abortions has been associated with socio-demographic characters, experiences in life (e.g. reproductive history) and the women's own and general attitudes on abortions, as well as the context of the survey, such as the sex and training of interviewer (e.g., Bumpass, 1997; Jagannathan, 2001; Jones & Kost, 2007; Rossier, 2003; Udry et al., 1996). In a previous Finnish study (Jokela et al., 2018) survey-based and register-based information were compared to examine the level of agreement between the data sets. In this study, substantial differences in the proportions of induced abortions between the two data sources were observed. Especially Somali-origin women under-reported their previous induced abortions (1% vs 18%.). Somali origin women might under-report induced abortions because termination of pregnancy is not culturally acceptable and there is a high level of related social stigma (Jones & Kost, 2007). It is also possible that respondents can misinterpret or confuse induced abortion and spontaneous abortion.

In the Maamu study (Castaneda et al., 2012), the aim was that the questions on women's reproductive health would be asked by female interviewers of the same origin as the respondent whenever possible. It was assumed that sensitive questions (such as FGM/C, contraceptive use, births, miscarriages, and abortions) were more culturally acceptable when asked by a same-sex interviewer. Unfortunately, e.g. due to lack of multilingual interviewers, these questions were on a few occasions asked by male interviewers. Interviewers should be well trained to ask sensitive questions. In ideal situation, the interviewers are healthcare professionals.

The low level of agreement between survey and register data on induced abortions among Somali-origin women might be partly due to problems in the data collection process. Discussions with the interviewers revealed that a few interviewers had skipped the questions as they thought that it was inappropriate to ask questions about the induced abortions and births when the interviewer was

male, younger than the interviewee, or if the woman was unmarried. However, it is likely that abortions are underreported because they are not socially approved. We suggest that attention should be given to the training of survey interviewers, and that there is a need for same-sex interviewers as well as for developing other methods to improve culturally sensitive survey protocols.

The subject of FGM/C is highly sensitive. Talking about the issue may be difficult for women and girls from countries with a tradition of FGM/C, especially when living in a foreign country where legislation and public opinion are against the tradition. It is known that the self-reporting of different forms of FGM/C is unreliable and that under-reporting is common. Often women and girls themselves do not know what type of procedure they have been subjected to and therefore do not always consider the operation to be FGM/C (Elmusharaf et al., 2006; Reisel & Creighton, 2014). In some societies, women might claim they have undergone FGM/C because of the high social pressure and the risk of social ostracism so also over-reporting in the studies has been documented (Yasin, Al-Tawil, Shabila, & Al-Hadithi, 2013). This should be taken into account when evaluating and putting the results of the studies into practice. While FGM/C-status was not examined, only asked about, under-reporting is more likely, as is recall bias, as not all those interviewed would be able or willing to talk about their FGM/C situation in an interview. Respondents may know that FGM/C is illegal in Finland, which might have meant that a social acceptability bias led to underreporting of FGM/C.

A population-based survey is a good tool for estimating the prevalence of FGM/C, and it also enables the study of other outcomes and their associations with FGM/C. Studying migrants as a target population is known to be difficult because migrants do not tend to take part in demographic surveys, with language and culture often preventing their participation (Font & Méndez, 2013). The moderate response rates (Maamu 54%/ 36%, UTH 66%, FinMonik 53%, TERTTU 76%) in the studies included in this article can therefore be considered reasonable for a migrant survey. Communication with participants in their mother tongue and the interviewer being of the same sex as the participants can ease the interview.

Special attention should be paid to the quality of the data collection. Research personnel should receive comprehensive training, including lectures and training on interview techniques, as well as on the conduct of standardized interviews and

health examinations. The questionnaires should be translated into as many languages as needed and special attention should be paid to the quality of the translations. Answering in the persons' native language can make it easier for the participants and can increase the response activity. Furthermore, answers given in a native language are more reliable (Font & Méndez, 2013).

The Medical Birth Register data are based on the information contained in the maternity card and hospital records, and FGM/C is noted during examination during pregnancy or delivery, so the data on FGM/C are more reliable than that obtained in interviews. However, the Finnish figures are not yet reliable because the biggest hospital district, the capital area including one third of the deliveries and the highest proportion of migrant birthing women in Finland, is not yet able to provide data on FGM/C due to problems in their electronic reporting system. The problem will be solved after 2019 and then information on FGM/C among birthing women will be more comprehensive (the Medical Birth Register, 2018). In the Care Register for Health Care there have been registered only a few deinfibulations so far. There is always a cap when a new measure is included in the register and it takes time before the professionals learn to fill in all the required data fields. In the future, the Care Register for Health Care can be used to follow up the prevalence of deinfibulation.

FGM/C was common among girls and women from African countries in all data sets. However, the prevalence of FGM/C was not as high as expected based on the previous surveys (Koponen & Mölsä, 2012; Koponen et al., 2015) conducted in Finland. Surveys based on a representative random sample of persons of foreign origin (such as UTH, FinMonik and TERTTU) require broad groupings by region of origin to make the analyses feasible. This may dilute the findings compared with those when grouping of participants is made by country of origin. Furthermore, the method of administration of the questions (self-administered questionnaire or interview) may also influence reporting. Regarding FGM/C, the prevalence should be possible to calculate based on the countries of origin where FGM/C is still a practice and not grouped, for example, as African countries in one and some other countries in another group. However, the grouping has been made for other purpose than just for calculating the prevalence of FGM/C. Of course it may be that FGM/C practices have declined, but it may also be due to the small numbers of women in each group, the way of reporting, and the small number of asylum seekers and immigrants from countries with a tradition of

FGM/C practices having led to lower numbers of FGM/C in the data. The total prevalences were most probably underestimated because of the grouping.

This was the first time we received information on FGM/C concerning adolescents; asylum seekers and upper comprehensive and vocational students. The numbers on adolescent asylum seekers and especially those with FGM/C was so low that no firm conclusions can be drawn based on the data. However, the question on FGM/C will be asked in the initial health assessment for asylum seekers in the reception centers in Finland, which holds some potential for assessing the prevalence of FGM/C among asylum seekers using the patient registry of the reception centers.

As migrants, adolescents are also a challenging group as survey participants (Ikonen & Helakorpi, 2019; Malin & Raisamo, 2011). International studies have identified that a small percentage of adolescents give unlikely or inconsistent responses in surveys. In the SHP study, these unlikely responses are routinely identified by going the data through carefully. The unlikely responses are mostly related to sexuality and cultural background. In the 2019 data, 413 female students' responses were removed from the data based on unlikely response options, corresponding to 1.2 percent of the data.

In the SHP study, 0.2% of upper secondary school girls and 0.8% of vocational schoolgirls did not know whether they had had FGM/C. On the other hand, 0.2% (n=40) of female students who were born in Finland and whose both or the only known parent was also born in Finland reported FGM/C. Because the data in the SHP study were collected without identifiable information, it was not possible to verify the gender, country of birth, or parents' country of birth indicated by the respondent. It might be that some of the respondents have never heard of FGM/C. On the other hand, those who have undergone FGM/C might not know it. Furthermore, it is possible but very unlikely that the forty female students with Finnish-born parents have been cut, because in Finland we have had immigrants from FGM/C-practising countries only since the 1990's. Inaccuracies in the figures can be in both directions: under- or over-reporting.

Thus the reliability of the results is difficult to estimate. It may be that the reported FGM/C among girls of Somali origin can be considered more reliable. The prevalence was somewhat lower than that of migrants from other African countries in the FinMonik study and half of that of birthing women of Somali origin reported in the Medical Birth Register. This is consistent with a previous

study (Koukkula et al., 2016) in which the prevalence of FGM/C among women increased with age.

The age of undergoing FGM/C was lower among the asylum seekers compared to the general foreign-born population and previous research knowledge on the topic. This might be because the countries of origin differ in the studies and the average age of undergoing FGM/C differs vastly in the practising countries.

Due to a lack of knowledge and the small size of the target group, the subject of FGM/C has often received little attention in social welfare and healthcare, as well as in the education and research sectors. Bringing up the topic has usually been considered awkward as it is sensitive and culture-bound, and professionals encountering girls and women who have undergone FGM/C have not necessarily known enough about the practice to start a conversation about the issue. To be able to get a holistic picture of FGM/C in Finland we need even more information about the practice via our national statistics, registers, or reports. Therefore it is important that different professionals discuss the issue with their clients and systematically write down the results of the conversations. In addition, qualitative research is needed in order to gain a more profound understanding on FGM/C and its prevalence in Finland.

For newly arrived migrants, information sessions or courses on Finnish society as well as primary health examinations are a good opportunity to share information on the disadvantages of FGM/C and its illegality (Koukkula & Klemetti, 2019b). The whole population, including asylum seekers, should be offered access to psychological support and support and guidance for sexual and reproductive health. Professionals in health care and social welfare, the police, early childhood education, schools, and in the reception system should be educated on the risk of FGM/C and they should know their role in acting against FGM/C. In Finland the risk of a girl being subjected to the practice should be reported to child welfare services and the police. The threat of FGM/C can be a reason to seek asylum, so the prevalence of FGM/C in the country of origin, as well as information about FGM/C that has already occurred, or the threat of FGM/C, are important. All girls and women who need deinfibulation, should be offered the opportunity for it. Asylum seekers should also be given the information that in Finland, if necessary, deinfibulation can be done at the latest during childbirth.

To tackle these problems, Finland launched its second national action plan for preventing FGM/C in 2019 (Koukkula & Klemetti, 2019a). The principal purpose of the new action plan is to prevent FGM/C in Finland, to make sure girls living in the country are not taken abroad for FGM/C, and to improve the well-being and quality of life of girls and women who have undergone FGM/C. In addition, the target is to carry out research associated with FGM/C and disseminate research evidence both at national and international level.

When studying a sensitive and marginal topic such as FGM/C, it is important to use both surveys and register data to combine all the possible data that are available. However, none of the studies can give a complete picture of the prevalence of the phenomenon, as it is not possible to reach all the girls in risk or all the women who have undergone FGM/C. In the future, we aim to collect data systematically on FGM/C in Finland. With systematic, reliable data collection we can better estimate how the practise declines and how well the preventive work affects. Based on the results from our new, improved data collection it seems to be that FGM/C might not be as common as was previously thought. However, we already have thousands of girls and women in Finland who have undergone FGM/C and our challenge is to offer them all the support and available treatment possible to improve their life and well-being.

References

AIDOS (2016). *Female genital mutilation/cutting (FGM/C). A quick guide for media*. Rome: AIDOS. Retrieved from https://aidos.it/female-genital-mutilationcutting-fgmc-a-quick-guide-for-media/

Bumpass, L.L. (1997). The measurement of public opinion on abortion: the effects of survey design. *Family Planning Perspectives*, *29*, 4,177–80.

Care Register for Health Care. THL. https://thl.fi/fi/tilastot-ja-data/aineistot-ja-palvelut/rekisterien-tietosuojailmoitukset/terveydenhuollon-hoitoilmoitukset

Castaneda, A.E., Rask, S., Koponen, P., Mölsä, M., & Koskinen, S. (Eds.). (2012). *Migrant health and wellbeing: A study on persons of Russian, Somali and Kurdish origin in Finland*. Report no. 61 (report in Finnish with English summary). Helsinki: National Institute for Health and Welfare (THL).

EIGE, European Institute for Gender Equality (2015). *Estimation of girls at risk of female genital mutilation in the European Union—Step-by-step guide.* Vilnius, Lithuania. Retrieved

from https://eige.europa.eu/publications/estimation-girls-risk-female-genital-mutilation-european-union-step-step-guide-2nd-edition

EMN, European Migration Network (2019). *Key figures on immigration 2018*. European Migration Network & Finnish Immigration Service. Retrieved from http://www.emn.fi/ files/1965/Maahanmuuton_tunusluvut_2018_EN_SCREEN.pdf

Finnish Medical Birth Register. THL. https://thl.fi/en/web/thlfi-en/statistics/information-on-statistics/register-descriptions/newborns

Font, J., & Méndez, M. (Eds.). (2013). *Surveying ethnic minorities and immigrant populations: Methodological challenges and research strategies*. Amsterdam: Amsterdam University Press.

Gele, A.A., Johansen, E.B., & Sundby, J. (2012). When female circumcision comes to the West: Attitudes toward the practice among Somali immigrants in Oslo. *BMC Public Health*, 12:697, 1–10. doi.org/10.1186/1471-2458-12-697

Ikonen, R., & Helakorpi, S. (2019). *Lasten ja nuorten hyvinvointi: Kouluterveyskysely 2019* [Welfare of children and young people: School Health Survey 2019]. Statistical report 33/2019. Helsinki: Finnish Institute for Health and Welfare.

Jagannathan, R. (2001). Relying on surveys to understand abortion behavior: Some cautionary evidence. *The American Journal of Public Health*, *91*, 11, 1825–1831.

Johnsdotter, S. (2002). *Created by God: How Somalis in Swedish exile reassess the practice of female circumcision.* Doctoral dissertation, Department of Social Anthropology, Lund University.

Johnsdotter, S., & Essén, B. (2016). Cultural change after migration: Circumcision of girls in Western migrant communities. *Best Practice & Research Clinical Obstetrics & Gynaecology*, *32*, 15–25.

Jokela, S., Lilja, E., Kinnunen, T.I., Gissler, M., Castaneda, A.E., & Koponen, P. (2018). Births and induced abortions among women of Russian, Somali and Kurdish origin, and the general population in Finland—comparison of self-reported and register data. *BMC Pregnancy and Childbirth*, *18*, 296. doi: 10.1186/s12884-018-1931-x.

Jones, R.K., & Kost, K. (2007). Underreporting of induced and spontaneous abortion in the United States: Analysis of the 2002 National Survey of family growth. *Studies in Family Planning*, *38*, 3, 187–197.

Klemetti, R., & Raussi-Lehto, E. (Eds.) (2013). *Promote, prevent, influence. The action programme for the promotion of sexual and reproductive health in 2014–2020.* Discussion paper 14/2018. Helsinki: National Institute for Health and Welfare.

Koponen, P., Jokela, S., Skogberg, N., Castaneda, A.E., Suvisaari, J., Laatikainen, T., & Koskinen, S. (2015). Terveys. Ulkomaalaistaustaiset kokevat terveytensä hyväksi, mutta terveysongelmien yleisyydessä on suuria eroja [Health. Foreigners feel good

about their health, but there are big differences in the prevalence of health problems]. In T. Nieminen, H. Sutela, U. Hannula (Eds.), *Ulkomaista syntyperää olevien työ ja hyvinvointi Suomessa* [Survey on work and well-being among people of foreign origin] (pp. 151–162). Helsinki: Statistics Finland.

Koponen, P., & Mölsä, M. (2012). Naisten ympärileikkaus [Female circumcision]. In A.E. Castaneda, S. Rask, P. Koponen, M. Mölsä, S. Koskinen (Eds.), *Maahanmuuttajien terveys ja hyvinvointi. Tutkimus venäläis-, somalialais- ja kurditaustaisista Suomessa*. [Migrant health and wellbeing. A study on persons of Russian, Somali and Kurdish Origin in Finland] (pp.141–144). Tampere: Juvenes Print.

Koukkula, M., Gissler, M., Ikonen, R., & Klemetti, R. (2020). *Tyttöjen ja naisten ympärileikkaus: Esiintyvyys Kouluterveyskyselyssä ja syntyneiden lasten rekisterissä*. [Female circumcision: Prevalence in The School Health Promotion Study and in The Finnish Medical Birth Register]. Statistical report 11/2020. Helsinki: Terveyden ja hyvinvoinnin laitos [Finnish Institute for Health and Welfare].

Koukkula, M., Keskimäki, I., Koponen, P., Mölsä, M., & Klemetti, R. (2016). Female genital mutilation/cutting among women of Somali and Kurdish origin in Finland. *Birth*, *43*, 3, 240–246.

Koukkula, M., & Klemetti, R. (2019a). *Action plan for the prevention of female genital mutilation (FGM)*. Helsinki: Ministry of Social Affairs and Health.

Koukkula, M., & Klemetti, R. (2019b). Sukuelinten silpominen ja ympärileikkaukset. [Female genital mutilation and circumcision] In N. Skogberg, K.-L. Mustonen, P. Koponen, P. Tiittala, E. Lilja, A. Haji Omar, O. Snellman, A.E. Castaneda (Eds.), *Turvapaikanhakijoiden terveys ja hyvinvointi. Tutkimus Suomeen vuonna 2018 tulleista turvapaikanhakijoista*. [The asylum seekers health and wellbeing. A survey among newly arrived asylum seekers to Finland in 2018.] Report 12/2019. Helsinki: National Institute for Health and Welfare (THL).

Koukkula, M., & Klemetti, R. (2020). Naisten sukuelinten silpominen ja miesten ympärileikkaus. [Female genital mutilation and male circumcision] In H. Kuusio, A. Seppänen, S. Jokela, L. Somersalo, E. Lilja (Eds.), *Ulkomaalaistaustaisten terveys ja hyvinvointi Suomessa. FinMonik-tutkimus 2018– 2019* [Health and well-being of people with a foreign background in Finland. FinMonik study 2018–2019]. Report 1/2020. Helsinki: Terveyden ja hyvinvoinnin laitos [Finnish Institute for Health and Welfare].

Kuusio, H., Seppänen, A., Jokela, S., Somersalo, L., & Lilja, E. (Eds.). (2020). *Ulkomaalaistaustaisten terveys ja hyvinvointi Suomessa : FinMonik-tutkimus 2018-2019*. [Survey on well-being among foreign born population: FinMonik survey 2018–2019.] Report 1/2020. Helsinki: National Institute for Health and Welfare (THL).

Lehtonen, R., & Pahkinen, E. (2004). *Practical methods for design and analysis of complex surveys*. Chichester: John Wiley & Sons.

Malin, M., & Raisamo, S. (2011). Maahanmuuttajien elinolojen ja terveyden selvittämiseksi on tehtävä erillisiä tutkimuksia. Maahanmuuttajien hyvinvointisurveyt 1/2 [Separate studies are needed to determine the living conditions and health of immigrants]. *Hyvinvointikatsaus* [Welfare Review], *4*, 66–70.

Ministry of Social Affairs and Health (2012). *Action plan on the prevention of circumcision of girls and women 2012–2016 (FGM)*. Helsinki: Ministry of Social Affairs and Health.

Ministry of Social Affairs and Health (2013). *Child and family policy in Finland*. Brochures 9eng, 2013. Retrieved from http://julkaisut.valtioneuvosto.fi/bitstream/handle/10024 /69916/URN_ISBN_978-952-00-3378-1.pdf

Nieminen, T., Sutela, H., & Hannula, U. (Eds.). (2015). *Ulkomaista syntyperää olevien työ ja hyvinvointi Suomessa* [Survey on work and well-being among people of foreign origin]. Helsinki: Statistics Finland.

Official Statistics of Finland (OSF) (2018). *Population structure*. Annual Review 2018. Helsinki: Statistics Finland. Retrieved from http://www.stat.fi/til/vaerak/2018/02 /vaerak_2018_02_2019-06-19_tie_001_ en.html

O'Neill, S., Dubourg, D., Florquin, S., Bos, M., Zewolde, S., & Richard, F. (2017). "*Men have a role to play but they don't play it": A mixed methods study exploring men's involvement in female genital mutilation in Belgium, the Netherlands and the United Kingdom: Full Report*. Brussels: Men Speak Out Project.

Rossier, C. (2003). Estimating induced abortion rates: A review. *Studies in Family Planning*, *34*, 2, 87–102.

Skogberg, N., Koponen, P., Tiittala, P., Lilja, E., Ahmed Haji Omar, A., Snellman, O., & Castaneda, A.E. (Eds.). (2019). Asylum seekers health and wellbeing (TERTTU) survey: study protocol for a prospective total population health examination survey on the health and service needs of newly arrived asylum seekers in Finland. *BMJ Open, 9*, 4. doi:10.1136/ bmjopen-2018-027917.

Udry, JR., Gaughan, M., Schwingl, PJ., & Van den Berg, B. J. (1996). A medical record linkage analysis of abortion underreporting. *Family Planning Perspectives*, *28*, 228–231.

UNICEF. 2016. *Female genital mutilation/cutting: A global concern*. New York: UNICEF. Retrieved from https://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf

Yasin, B., Al-Tawil, N., Shabila, N., & Al-Hadithi, T. 2013. Female genital mutilation among Iraqi Kurdish women: a cross-sectional study from Erbil city. *BMC Public Health*, *13*, 809. doi: 10.1186/1471-2458-13-809

Sara Johnsdotter

The Bike Accident and the Canon Portrayal of FGM

Introduction: Differently situated

A winter day some twenty years ago, I was on a visit to a Somali family in southern Sweden as part of the study for my doctoral thesis (Johnsdotter, 2002). The mother of the family was concerned because something had happened earlier that day: her children had been playing wildly, running around in the apartment, and her five-year-old daughter had fallen astride the headboard of a bed. There had been blood in the genital area and the girl had been in some pain. Her mother told me that she would have preferred to have it checked by a doctor or nurse, but that she did not dare: "They will suspect that we have had her circumcised." I made a quick call to Birgitta Essén, gynecologist and co-worker of mine, who performed a consultation with the mother over the phone. The bit I remember this many years later, was that the most important thing was to check that the incident had not led to swelling, which could potentially have serious consequences. She made sure that there was no problem for the girl to urinate and asked the mother to check that regularly for a day or so.

I was reminded of this situation a couple of years later, when something similar happened to my own daughter, Tea. She was seven years old at that point, and they called from school and told me that she had injured her genital area. She had climbed a tree, slid down the trunk and been hurt by something protruding from the tree stem. There was bleeding from her labia. I kept an eye on her for a day or two, making sure that she could urinate without problem. This incident made me compare the situations, and I realized that I would not have hesitated for a moment to take Tea to a health center had I deemed it necessary.

The crucial point here is that the Somali mother has her background in a country where circumcision of girls is practiced, while I do not. On the one hand, Sweden has legislation banning the circumcision of girls and women *(Act (1982: 316) Prohibiting Female Genital Mutilation)* and mandatory reporting for healthcare staff of any suspicion that harm is inflicted on a child to the child protective services, who in turn should report any suspected crime committed against a child to the police. On the other hand, everyone in our society should have equal access to good healthcare *(Health and Medical Services Act (2017:30))*. The current situation—that ethnic background determines who in our country dare to take their daughters to medical checkup when the genitalia are involved, and risk being suspected of having performed "FGM" if they do—hints at there being some kind of discrimination built in here.

In this chapter, I will discuss this conflicting situation by describing one of the cases from my archive of criminal investigations of suspected FGM cases in Sweden. I will report the case in quite some detail in the hope that a detailed description can give readers a sense of the circumstances, an understanding of the actions undertaken by the authorities, and how these may have affected the girl and her family. A kind of trade-off takes place between the political will and legal obligation to identify illegal cases of "FGM," and the political will and legal obligation not only to give all citizens equal access to good care but, in more general terms, treat them as equal subjects before the law.

Terminology and focal concept

Various terms will be used in this chapter. I prefer "circumcision" when discussing the procedure as a cultural practice. "FGM" will be used in referring to the legislation or the general discourse, especially since I want to highlight the existence and ramifications of the so-called "standard tale of FGM" (Leonard, 2000) and "the FGM fantasy" (Rogers, 2013). The American sociologist Lori Leonard used the term "standard tale" in an article about a study in which she struggled with empirical data that contradicted what most people know about these practices:

> What is cut, how much is cut, at what age it's cut, with what implement, and by whom; these are all elements of the standard tale. So is the litany of consequences: hemorrhage, shock, infection, infertility, sexual dysfunction, problems in childbirth, death, and so on. The standard tale tells us that female circumcision is old. It is a "traditional practice," an "ancient rite," a "cultural relic," something practiced "since time immemorial". It is

> deeply rooted in local practice—"entrenched" and "embedded" are common descriptors. Girls are "prisoners of ritual". They are "victims of outdated customs, attitudes, and male prejudice". These statements have been repeated so often that they have become real. They have become fact [Leonard, 2000, pp. 213–214; the original is full of references, which have been omitted here].

The Australian criminologist and trauma expert (within a psychoanalytic framework) Juliet Rogers describes the fantasy of FGM thus:

> The fantasy of female genital mutilation, and the demand for an accompanying law, is the result of the production of an image. Every law comes with an image and the image comes with a story—a symbolic frame to which the tropes and emblems, the icons and gestures of that image, can be attached. The image of the practices of female circumcision, as the violently opposed crime 'female genital mutilation', is a product of an industry; an industry which accompanies the image of a little girl held down. [...] it involves the suppression of other stories which may contradict or compete with the child held down [Rogers, 2013, p. 22].

Leonard's and Rogers' approaches have some similarities, but differ in some regards. In my interpretation of how these authors use their concepts, they can be related. Leonard primarily refers to a kind of canon, a set of packaged "knowledge" that is expected to be presented in an introductory lecture or (activism-oriented) text. This package of knowledge carries with it a fundamental tone, which guides the listener or reader toward a specific perspective, which is inherently negative, condemning, and—arguably, neo-colonialist. In contrast, Rogers intends to capture a psychological phenomenon: the creation of an image (the girl held down, the coercion, the violence) which is symbolically loaded with negative associations and which inevitably awakens strong negative emotions in the listener/reader.

Both Leonard's "standard tale" and Rogers' "fantasy of FGM" occupy the mind of the recipient of the discourse, permeate and direct their interpretations, and crowd out other facts, stories, and experiences. The emblematic example of how the two concepts can merge is the description of female circumcision, or FGM, in Waris Dirie and co-authors' book *Desert Flower* (Miller et al., 1998). It is a story in line with the standard tale as it is described by Leonard, and this impression is strengthened by the afterword which is full of "facts" about genital mutilation of girls. The FGM story itself is a personification of Rogers' FGM fantasy, as the vivid description of Waris Dirie's own circumcision evokes the image of the

child held down; the violence, pain, and coercion. It has a strong potential to plant itself in the mind of the reader in a way that blocks all other experiences or stories that do not present themselves in accordance with this image. Through all the translations, new editions, and a film based on the book, it has had an enormous impact on the spread of the standard tale or FGM fantasy among the public in Western countries (Earp & Johnsdotter, 2020; Johnsdotter, 2019, preprint; Palm et al., 2019). I believe that the two concepts, "the standard tale" and "the fantasy of FGM," could be merged into one—a single phenomenon which has several aspects. I will call this *the canon portrayal of FGM*.

Arguably, this canon portrayal of FGM is what guides authorities in Western countries when they encounter girls and families from areas where circumcision of girls is practiced (Johnsdotter & Rogers, 2020, ms). In reality, few real cases—at least illegal FGM, cases which have been presented at criminal courts in Europe—are in line with the canon portrayal. After an analysis (at the request of the European Commission) of such cases in Europe, Johnsdotter and Mestre i Mestre (2015) make a distinction between "typical" and "atypical cases," among which those that are in line with the canon portrayal can be said to be "typical" but these are far fewer than "atypical" cases (see also Mestre i Mestre & Johnsdotter, 2019).

The case described in this chapter is taken from an archive of Swedish police reports and investigations. The archive, and how it was compiled, is described in detail in Johnsdotter (2019). The first file is dated 1996, and it is the first known police investigation in Sweden regarding suspected FGM after the legal ban was introduced in 1982. The number of acquired files today is 170, and I am confident that I have collected almost all of the (closed) police reports and investigations. The case described below was chosen because it illustrates how the canon portrayal of FGM may have triggered a series of incidents that led to a less than optimal outcome for a Swedish Somali girl and her family.

The case: Zahra's bike accident and its aftermath

2010

When Zahra was six years old, she had an accident with her bike. Her father took her to the doctor, and it is stated in the medical record:

> According to the patient, she put on the brake suddenly and slipped backward and was hurt in her genital area. According to the father, she arrived home sad and with blood on her clothes. After that they went to the emergency ward.

It is said in the record that she was an "unperturbed girl who is compliant and rather willingly accepts a careful examination." The doctor summarized his general assessment thus:

> Young girl who after a fall from a bike has an injury in the genital area. No one else was present during the incident and the anamnesis [the clinical case history of a patient] is rather brief regarding the course of events. After consultation with pediatrician and primary physician on-call, it was decided that the patient be admitted for observation and assessment of whether further inquiry is needed. The girl's father stays with her. Due to the fact that the injury has originated during unclear circumstances, a report is sent to the social authorities [child protection], for their assessment of the situation. The patient is transferred to the children's ward.

Another medical record shows that Zahra and her father stayed in the ward awaiting the multi-sectorial consultation summoned by the social authorities. In that meeting it was decided that a social welfare officer should have a meeting with the father and the girl in order to try to clarify what had happened and whether there were circumstances indicating that a crime had been committed. Since the girl had not been thoroughly examined, a decision was taken to carry through a pediatric examination at the Barnahus.[1] It was performed by a pediatrician, a pediatric neurologist, and a urotherapist, with the father present. The girl's status was reported in the medical record:

> Good. Unperturbed. Walks unhampered from the hospital to the Barnahus. The girl is calm and seems to feel safe and secure and takes part willingly. Adequate interaction with the father. Relates spontaneously that it hurts "there" (points toward the genital area) and that she "fell from her bike." Chats with nurse NN during examination.

[1] Barnahus, literally "house of children", described in an EU document: "The innovation is called the Barnahus. In the Nordics, this multi-disciplinary and interagency service model forms an integral part of the welfare and judicial system. It provides support to child victims and witnesses to violence, giving them access to justice, avoiding re-victimisation and ensuring recovery." (The website *Launching the European Barnahus Movement*, at https://cor.europa.eu/et/events/Pages/Launching-the-European-Barnahus-Movement.aspx). The Barnahus were organized in Sweden in order to avoid situations in which children would have to relate the background repeatedly to professionals in various authorities (The Swedish Board of Health and Welfare, 2014).

No measures were indicated from a medical standpoint. The father was encouraged to contact the clinic in case the girl would have problems urinating. After the examination, the father and the girl had a meeting with the social welfare officer for an assessment of the situation and to decide whether further inquiry was needed. The girl was discharged from the children's ward after this meeting.

From the records we learn that Zahra's father was doing work for the municipality and that his fluency in Swedish was very good. When the meeting with the child protection unit was over, ending in the conclusion that no circumcision of the girl had occurred, he asked the social authorities for a document attesting to the closing of the case of suspected FGM.[1]

2015

Five years later, in mid-May, Zahra returned to the doctor's clinic with her father because a flap of genital tissue had grown after the bike accident. The doctor examined her and wrote in the medical record:

> The patient lacks outer labia, the inner labia remain. There seems to be corpus cavernosum in the clitoral area. Above ["cranially to"] the clitoris, there is flap ca 4 cm with a diameter of 3-4 mm at its base and somewhat larger further down. Most likely, this is the remainder of the outer labia. At palpation, there seems to be no tissue in the flap that might be corpus cavernosum.

Corpus cavernosum is erectile clitoral tissue. The trauma to Zahra's genitalia had resulted in some rearrangement of the parts, and the physician concluded that the flap that had grown above the clitoris consisted of labial tissue and not clitoral tissue. He scheduled her for surgery after summer:

> Considering that this is probably a remainder of the outer labia and it does not seem to contain any corpus cavernosum, it should be possible, if done very carefully, to extirpate it without causing any damage to what is left of the clitoris. Thus the patient is scheduled for polyclinic extirpation of the skin lesion.

[1] In a later police interrogation, in 2015, he recalled this. From the minutes: "Because he had been a suspect, he wanted a paper which stated that the case was closed, and he received it the subsequent day."

During the summer the family made a trip to Somalia to visit relatives. In August, they showed up for the surgery on Zahra's skin flap. It was noted in the medical record:

> The patient has told a story about a bike accident early in life to explain the skin flap she wants to have removed in the genital area. The reliability of that story is difficult to assess, but as the patient herself has described the incident vividly and with many details, we have decided to comply with the patient's wishes without any other action.

The surgery was performed on 21 August after yet another examination of Zahra's genitalia:

> We can see that the patient has rests of a labium to the left, which are adhered anteriorly, but to the right, the labium is completely missing. There is no visible clitoris, so the accident must have been grave. However, through palpation we can perceive that the corpus cavernosum of the clitoris is still there. [After the surgery:] Cosmetically, the look is acceptable. We probe the area around the clitoris with forceps and do not find any visible clitoris but a well-defined palpable representation of corpus cavernosum.

Now, a nurse present at the surgery learned that the family had been to Somalia, and started to suspect that the girl had been subjected to FGM. She reported the suspicion to the police three days after the surgery. It was noted in the police report:

> During the operation, it was established that Zahra was genitally mutilated. Zahra said that she had been to Somalia to see her family last summer.

Now the child protection officers at the Barnahus, where Zahra and her father had been investigated five years earlier, again summoned a multisectoral child protection consultation which took place on 31 August. Present were officials from the social authorities, the police, the prosecution, the pediatric clinic, the Barnahus, and the child psychiatric care unit. The meeting ended with a decision to open a criminal investigation, to ask the court to appoint a Special Representative for a Child,[1] and to open a child protection investigation. A date was set for police interrogation: four days later.

[1] *Act (1999:997) regarding Special Representative for a Child*. This law enables the special representative for a child to make decisions, for example about a forensic examination, without the knowledge of or against the wishes of its legal guardians.

Two days after the multisectoral consultation, a special representative was appointed for Zahra. On the same day, the pediatric surgeon who had removed the flap was interrogated by the police as was the nurse who had made the report to the police. From the police minutes: [Surgeon:] "There was nothing in her story that was questionable or made him wary. Even if there is always room for speculation, there is nothing in the girl's story that is contradicted by the look of the injury." [Nurse:] "The girl's father was present before the surgery and all the time until she was anaesthetized. The girl was cheerful and nice. Her attitude was unreserved, and she was not at all anxious." The nurse also said that they had discussed the possibility of FGM during the surgery, as they could not find any visible clitoris in the girl. She said that she wanted to report it because the girl had sisters who might need protection from FGM.

The police brought in Zahra for an interrogation on the subsequent day, 3 September, on the same day that Zahra's father and mother were arrested. The excerpt[1] below is from a 40-minute conversation with Zahra at which a police officer took minutes. At the beginning of the interrogation, Zahra was asked how she felt about being there. She responded that she was a little anxious, but fine. The first questions seem to have been very general, about school and everyday life. Zahra said that the following day would be her 11th birthday, and that they were going to sing for her in the classroom. She was asked about the trip to Somalia and her story was summarized thus:

> *They went to Somalia to see the family and help out. They celebrated Eid, after the fast, on the first day you are allowed to eat. After the fast, which is called Ramadan, Eid is celebrated. That is fun. First they went to grandmother and then they were together with aunts and uncles.*

Zahra was asked about hospitals in the area where they had spent time in Somalia, and she responded that she had not been to one but that they "looked nice." She was asked to tell what happened when she had her bike accident. She told the story with many details, and after that she was asked, according to the minutes: "AA [interrogating police officer] wonders whether someone has told her about her accident." The phrasing is vague and could possibly be translated into "has

[1] The same excerpt is discussed in a submitted manuscript (Johnsdotter & Rogers 2020, ms).

told her how to tell the story about the accident."[1] Zahra answered that she remembered everything about the bike accident and that she had told her father about it. Later in the interrogation, there is a section with insistent questions about Zahra's genitalia:

> AA [police officer] asks whether someone did something to Zahra's genitals between the accident and the trip to Somalia.
> Zahra says that nobody has done something. It was the accident that caused the injury.
> AA says that she has talked to the doctor NN, who says that Zahra lacks her outer labia. AA asks how it can be that Zahra does not have any.
> Zahra says that she doesn't know.
> AA says that all girls have them when they are born.
> Zahra says that she doesn't know.
> AA says that she knows that her outer labia where still there when she fell from the bike. AA asks how they disappeared.
> Zahra says that she doesn't know, but maybe they disappeared afterwards. She doesn't know, she hasn't felt anything [any pain].
> AA asks when she realized that they were missing.
> Zahra says that she doesn't really know. She didn't feel anything after the bike accident.
> AA says that we girls and women take showers and wash ourselves. She asks if Zahra has noticed when they were not there any longer?
> Zahra says that she doesn't know because she has not seen any picture of them. She hasn't felt anything. Before the bike accident and after she didn't feel anything.
> AA says that before the operation that NN performed, they were no longer there, so something must have happened.
> Zahra says that after the bike accident, they [healthcare professionals] had a look and then she went to sleep and they made sure there would be no more bleeding. They said that she would be fine.
> AA says that it must have hurt when they disappeared.
> Zahra says that she has not been in pain.
> AA says that she had them after the accident but not at the operation.
> Zahra says that she had them.
> AA asks whether someone has done something to her, taken away the labia. AA says that she must tell if someone removed hers.
> Zahra says that she doesn't know why she doesn't have any.
> AA asks whether her sisters have their labia intact.
> Zahra says that she has not seen them.
> AA asks whether they have talked about this at home.
> Zahra says "no." Zahra starts crying and says "I don't know why."

[1] In Swedish: "AA undrar om någon sagt till henne och berättat om olyckan för henne."

AA asks "What are you thinking about?"
[Zahra:] I didn't do anything after the bike accident.
AA informs that it is never the child's fault, the adults always have the responsibility.
Zahra says that all she knows is about the bike accident and that she was hurt by the saddle. She went home, they had dinner, and then they went to the hospital. Dad went to the police station and the doctor wrote about the accident. The documents about the accident are at home.
AA says "It is a good thing to tell another adult if something has happened."
(Zahra weeps.)

In a specific document,[1] Zahra's emotional breakdown was recorded: she was too distraught to leave the room after the hearing. She sat in silence, weeping. From the minutes written by the police officer: "I asked her how she felt but got no response. I asked her what she was thinking about, but she remained silent, crying." Her weeping came in waves, and it took quite a while before Zahra was calm enough to leave the room. Later, child protection officers who drove Zahra back home after the interrogation, stated that she seemed to be "well given the circumstances" but that she had been asking questions about why her parents were still with the police. They had explained to her that it had nothing to do with things Zahra had said, but that the police wanted to have further talks with them.

Zahra's both parents, now in detention, were interrogated twice each. Both denied the charges. Zahra's mother was interrogated with a seven-month-old baby on her lap the first time. When she was taken to the jail cell, the baby was taken by child protection officers who would take her to her sister-in-law for care. She said she is an opponent of the practice, that circumcision of girls was something that had ceased to be done in her family, and that nothing [bad] happens if one does not practice it. She said none of her daughters would undergo circumcision.

Zahra's father was asked about the rationale for circumcision of girls, and he responded that "it's a good question why it is done." According to the minutes, "he says he can't give an explanation but argues that it is a deranged [practice], irrespective of whether there is a rationale or not." As a Muslim believer he could say that it has nothing to do with religion. He said he lives with a circumcised woman and thus knows how horrible it is. He related that nothing can have happened to Zahra, since she hadn't slept over with someone else, nor had anyone taken care of their children in their home. The record of the interrogation ends

[1] Police PM: Observations after hearing with injured party, 3 September 2015.

with the words: "NN says that he trusts Zahra and what she will say when she is interrogated, even though he has no knowledge of her statements."

Zahra's parents were released after three days in detention. The prosecutor wrote in her directive to the police: "It remains unclear why the court reached the conclusion that there was no probable cause [for prolonged detention]." She instructed the police officers to keep interviewing the physicians, to ask the child protection unit what had happened to Zahra now that she was back with her parents ("that has an impact on whether or not we should interrogate her again"), and to have new interrogations with Zahra's parents, "now that they are released and can coordinate their stories." She also raised the issue of contacting an expert who could advise them on FGM in Somalia, on whether it is performed in Sweden, and how FGM is usually done in this area.

A week later, the police contacted Zahra's father to tell him that they wanted to perform a forensic examination of Zahra—"not the other children, that would be on the initiative of the child protection unit."[1] He responded that they were welcome to do so, and that there was no problem at all. The lawyer who had been appointed Zahra's special representative wrote in an email to the police on 16 September that "given that Zahra's parents consent to the examination, I allow it to be performed. It must take place with utmost care and preferably be done by a female forensic physician." It was decided that the examination would take place at the Barnahus and without anesthesia.

The final forensic examination was performed on 21 September. The examination of Zahra's whole body was carried out by two forensic physicians, and a specialist in pediatrics. The genital examination was carried out by two gynecologists and one of the forensic physicians. Zahra's mother was present during all the moments of the examination. Before she wrote the final affidavit, the head forensic physician had accessed pictures and a film from the healthcare visit after the accident in 2010. A week after the forensic examination, she contacted the police, saying that "the outer genitalia had practically the same appearance at that point [in 2010] compared with what they look like today. The outer labia were

[1] In police notes about a phone call from the child protection unit, it is stated that "Child protection officers have had a meeting with the parents, and when they said that they wanted all six children to be [genitally] examined, the parents responded that they thought it would be a good idea and they hoped it would happen as soon as possible. When they were told that also the police would be interested in knowing the results, they said that was a good thing" (Police notes, 11 September 2015).

not very prominent also in 2010." She said that she wanted one of the gynecologists who had been present during the examination to have a look at the filmed material. The prosecutor told the police officers to hold back any activities until the matter could be solved. On 5 October, the head physician contacted the police again. The gynecologist, the head forensic physician said, wanted the surgeon who made the operation in 2015 to watch the film "so that he can describe exactly what he removed." A meeting with several of the physicians involved was arranged.

The prosecutor probed for the final conclusions of the forensic examination on 20 November: "We were in contact about this more than a month ago and even though the assessment is tricky, some conclusions must have been made. For the sake of the family, this case must move on a.s.a.p." On 27 November, the final affidavit was sent to the police.

The head forensic physician concluded in the affidavit, first, that the size of the girl's labia was normal and consistent with photographic documentation from the year of the bike accident, and, second, that the state of the girl's genitals was a result of the bike accident in combination with the Swedish physician's surgical removal of clitoral tissue by mistake. The "missing clitoris," according to this assessment, had been located, as a result of the bike accident, in the skin flap that was removed years later. In effect, if a "mutilation" of clitoral tissue had been performed, it seems to have been performed by a surgeon within the Swedish healthcare system (although with no intention to do so).

In mid-December, the prosecutor made the decision to close the criminal investigation.

Taking the family's point of view

6-year-old Zahra has been out playing and been hurt in a bike accident. She gets home, her parents take care of her, and her father takes her to a doctor. She is cared for in the clinic, but it is also clear to her father that the localization of the wound arouses suspicions about FGM. He cooperates in the investigation, and when it is finalized, he asks for a document that states that the investigation ended with the conclusion that no FGM had been performed. He seems to be aware that there is a more general climate of suspicion regarding the Somali group in Sweden and, with this document, he wants to protect himself from future allegations.

When Zahra five years later says that the skin flap that has grown disturbs her, her father takes her again to a doctor. They decide to have the flap surgically

removed after the summer holiday. Zahra travels with her mother and siblings to Somalia that summer and seems to have had a good time. In August, she undergoes the surgery and possibly thinks it is over.

About two weeks later, Zahra is collected in school.[1] She is accompanied by a "safety person"[2] and taken to a video-filmed interrogation at the police station. She is interrogated for forty minutes, with her safety person in an adjacent room. She seems happy to start with and answers the first questions with ease. Then comes insistent questioning regarding her bike accident, the state of her genitalia, and the assumption that someone has deliberately hurt her. We can only speculate here, but it could be expected to be a negative experience when an authoritative person like a police officer keeps saying over and over again that something is wrong with one's genitalia. In addition, Zahra must ensure repeatedly that the only moment of pain has been at the bike accident, that it happened the way she describes it, and that nobody has done anything to harm her. Something in this situation breaks her; whether it is the persistent message that something is wrong with her body, or that she is not believed when she says what she knows about the bike accident and the trip to Somalia, or whether it is a combination of all aspects of the situation. She has an emotional collapse. On her way back home with the child protection officers, she worries about her parents who are still with the police.

Her parents are in detention for three days. During the interrogations, Zahra's mother seems to reply to all the questions: regarding the bike accident, the trip to Somalia, the status of her own genitalia, and what she thinks about circumcision of girls. She asks the police officer if she is suspected of any other crime and is told that she is not. There is an incident described in detail when she is taken to the cell after the first interrogation: the two (female) police officers require that she take off her veil, which she refuses to do. The heated discussion goes on, with the help of an interpreter, for more than twenty minutes. She spits at one of the officers and the spit hits the arm of the police officer. The police officer, the notes say, takes one step closer, stares her in the eyes, waves her finger and yells at her that her behavior is unacceptable. Zahra's mother yells ("in Swedish!") that Sweden is a stupid country with stupid Christians, that she hates everything here

[1] It is not clear from the criminal investigation protocol who collected her. In many other cases, it has been the Special Representative for a Child, accompanied by police officers (Johnsdotter 2019).

[2] In Swedish: "trygghetsperson." It is a person, often from the pre-school or school staff, who accompanies the child to make him or her feel safe during a police intervention.

and especially the Swedish laws. "Since I [the police officer] was really upset, I told her that if this is the way she feels, she does not have to live here, but could leave Sweden and go back to Somalia." They seem to have argued for a while before Zahra's mother resigned and took off her clothes, including the veil.

Zahra's father also seems to respond patiently to all questions. He is obviously bewildered when the police keep telling him that Zahra had labia in 2010 but that she lacks them now—he can't understand how that can be and has no explanation.

After their release, both parents cooperate well with the police. For example, it is reported that Zahra's father politely thanks the police for reaching out, when the police ask them about their consent for a forensic examination. Zahra's parents are willing to let the authorities check not only Zahra's genitalia but her sisters' as well.

From the family's point of view, the months in 2015, from the first days in September when they were taken to the police station to mid-December when the investigation was closed, must have been turbulent and upsetting. For Zahra's part, we can only guess what the harsh interrogation did to her view of herself, her genitalia and body—and also to her trust in authorities and society at large.

Taking the authorities' point of view

For many years, claims have been made in public that circumcision of girls, or FGM, is going on at a large scale in the Swedish society. This is often claimed despite the fact that only two cases of illegal FGM (cases in which both girls were resident in Sweden and circumcised abroad) have been taken to court and led to sentences. Both these cases went to court in 2006.

The current leader of the Liberal Party, Nyamko Sabuni, asserted in 2006 that the procedure takes place often in Sweden, and "first and foremost we need to reach consensus that genital mutilation occurs. Every week Swedish girls are mutilated."[1] As a member of parliament she promised she would work for a "zero tolerance" approach. For several decades, this assumption—that large-scale FGM activities secretly are going on among certain migrant communities—has been widespread not only in Sweden but in other European countries as well (Johnsdotter & Mestre i Mestre, 2017). Browsing a newspaper database to see examples

[1] "Lättare att rapportera könsstympning" [Easier to report genital mutilation]. *Sydsvenskan*, 1 Oct 2006.

of the public discourse in 2015 gives mixed results. But here an example of the discourse that can be found regularly in the media:

> **FEW CASES OF GENITAL MUTILATION REPORTED**
> **Genital mutilation is not legal in Sweden. Yet many children's and young girls' genitalia are being forever destroyed.**
> Yesterday about 50 employees from the social authorities, the healthcare sector, and the legal sector attended a one-day-course about female genital mutilation, which is prevalent in many places in the world. Sweden makes no exception, even though many people go back to their countries of origin to have the genital mutilation performed.
> One of the speakers at the conference was prosecutor NN, who talked about the legal aspects of genital mutilation.
> - Very few cases are reported. I think it was six cases in the whole country last year, and we want to make more people report it, says NN.[1]

So this is an important ingredient in the sociopolitical climate in 2015, when Zahra's case was handled by the authorities. The prevalent assumption is that the scarcity of reported cases can be explained by failure to report, because the widespread belief is that this is a practice upheld by many African immigrants in Sweden.

We can understand why the nurse becomes suspicious: here is a girl from a Somali family, who has recently been to Somalia, and whose genitalia are damaged. It is in a situation like this that the canon portrayal of FGM kicks in. It is not difficult to imagine that the story about the bike accident is an invented story to cover up a crime. She states in her report to the police: "Zahra had a surgery 2015-08-21 and then we saw that she had been mutilated. Zahra arrived in Sweden when she was six months old. She travelled with her family to her home country [sic] in the summer of 2014. In the family there are many children and [the nurse] is worried that also her siblings might be genitally mutilated."[2] The activation of a canon portrayal of FGM can be seen in how the nurse describes the situation: she admits that "the girl and her father had a good relationship. The father did not express any aggression or something like that."

What is worth noting in the report—beside the fact that both Zahra's parents are named as suspects—is that the estimated time of crime is set to be "later than August 2010 at which point the damage in Zahra had not yet emerged." The

[1] "Få fall av könsstymning anmäls" [Few cases of genital mutilation reported]. *Vestmanlands Läns Tidning*, 6 March 2015.
[2] Report to the police regarding suspected crime against a child, 1 Sept 2015.

police were thus informed by a health expert that something—illegal—had taken place *after* the bike accident, and this will guide their handling of the case throughout the entire process.

The subsequent day, they interviewed the surgeon and the anesthesia nurse. The surgeon who performed the 2015 operation said that when he met the girl and her father in May 2015, "there was nothing in her story that he had reason to question." He said that nothing in her account contradicted the look of her genital area. He had not raised the issue of possible FGM, because then the family maybe would not have come back to the clinic. He thought it was important for the girl to get her problem fixed, and then other potential issues could be handled after that.

The police also talked with the physician who cared for Zahra in 2010. Here is an important detail, which may explain why the police perceived that the evidence was growing stronger: this doctor says that Zahra's injuries after the bike accident were "minor":

> Is asked about whether the extent of the injuries on 11 August 2010 can have resulted in removal of the clitoris.
> NN responds "no."
> Is asked whether the outer labia can grow back after a blow in that area.
> "No, absolutely not." Labia can't disappear in any other way than through violence/operation. If the bike accident had resulted in destruction of the labia and clitoris, that would have inferred a very serious accident and it would have required surgery to stitch already at the time of the accident; then it would have been major damage and this (in 2010) was about minor injuries.[1]

In retrospect, it is obvious that we see variation in how individual physicians assessed the state of Zahra's genitalia. The doctor in 2010 might have had his reasons to downplay Zahra's injuries—if they had been more serious, he possibly should have scheduled surgery for her already then, in 2010. His description could be a way to defend his choice of care level. The nurse claimed that during the surgery in 2015, the surgeon had said during the procedure that "he didn't think that the injuries looked like ones caused by a bike accident. If the girl had been in such a serious bike accident, [...] she should have been stitched."

[1] Police interrogation, 4 Sept 2015.

One can see this chain of statements from the point of view of the police: the 2010 doctor described mild injuries that do not require stitching, while the 2015 health providers describe the injuries as serious and refer to a *missing clitoris* and *missing labia*. And the girl had recently visited Somalia. (The police did not yet have access to the final affidavit in which experts had assessed all the records, pictures and films—comparing Zahra's genitalia in 2010 and 2015, ending in the conclusion that the look of Zahra's genitalia could be explained by the bike accident and the 2015 surgery of the skin flap.)

The evidence thus appears strong on 3 September 2015, when Zahra is collected for interrogation and her parents are arrested. For the prosecutor and the police, it becomes a matter of making Zahra, her father, or her mother admit that FGM has been performed. Such a scenario would be completely in line with the canon portrayal of FGM. It would also be a contribution to the societal mission of identifying illegal FGM in Sweden, and to finding a case that could be taken to court.

Concluding remarks

One might object that I in my analysis overemphasize the impact of the canon portrayal on how the authorities handled the case of suspected FGM in Zahra. But I have tried to find a reason for why the prosecutor and police did not pay attention to the requirement in law that also circumstances that may benefit the suspect must be heeded during a criminal investigation: in the Code of Judicial Procedure, it is established that during a criminal investigation not only circumstances that seem to incriminate the suspect, but also those that seem to prove his innocence, should be taken into account.[1] In the investigation concerning Zarah, there is no trace that the investigators ever considered the possibility that Zahra had not undergone FGM—or, if she had, that someone else beside her parents could be responsible for it. Thus, it is reasonable to assume that a scenario in line with the canon portrayal—"in Somalia and some other countries, this is what parents do to their daughters because it is their culture"—has been what motivated their actions during the investigation phase. The scenario was backed by a sociopolitical

[1] RB 23 kap. 4 §: "Vid förundersökningen skola ej blott de omständigheter, som tala emot den misstänkte, utan även de som äro gynnsamma för honom beaktas och bevis, som är till hans förmån, tillvaratagas."

climate characterized by frustration that so few cases of illegal FGM—"which we know happens all the time"—are taken to court.

How can similar situations be avoided in the future? Swedish Somalis and other families with origin in areas where circumcision of girls is practiced, should ideally have the same access to healthcare as other residents in Sweden, without the fear of triggering child protection and police interventions if they turn to healthcare clinics with an injured girl child.

The case seems to bring out the importance of *expertise*.[1] What made the prosecutor and police so sure that they had evidence of a committed crime was the statements from physicians, who obviously varied in their conclusions about the state of Zahra's genitalia at different times. Consequently, early involvement of medical experts, preferably a group of experts with various specialties (see chapter by Essén in this volume), would be valuable. Also the mere knowledge among the police about inter-individual assessment variation would be helpful: medical experts reach different conclusions when they are presented with the same data or evidence. If the police were better aware of that, it would possibly lead to investigations that, to a higher extent than today, were open to the possibility of various scenarios. In this case, the prosecutor and the police could possibly have led the investigation with a second scenario in place: one in which they considered the possibility that Zahra in reality had had a bike accident and that no FGM had been performed during or after that incident, and that divergent assessments from physicians about the magnitude of injury are common. That possibly would have brought about smoother interventions into this family's life, and a more open-minded and less intrusive interrogation with Zahra.

Operating with various scenarios during investigations would also benefit from better access to cultural expertise (Mestre i Mestre et al., forthcoming). If the prosecutor and police contacted anthropologists and other experts with knowledge about these practices, they would be better equipped to make assumptions about what might have happened in a specific case, and which factors or circumstances

[1] Expertise in the legal context may be even more important when the involved parties are migrants, and the cultural backgrounds differ markedly between the migrants and the actors in the legal systems of host countries. These issues are increasingly discussed under the umbrella term *cultural expertise*. For an introduction to this research field, see Livia Holden's work (e.g., 2019a, 2019b). For a discussion about cultural expertise in Sweden, see Annika Rabo's paper (2019). For an example of how lack of cultural expertise in court can result in an unfortunate outcome of an FGM criminal court case, see Johnsdotter (2008).

might support or contradict the suspicion that a girl has undergone an illegal procedure. It is probably safe to assume that the current law on FGM is there to protect girls at risk, and it should be a pertinent issue for society to ensure that the implementation of this law does not cause more harm than good for the girls it intends to protect.

References

Earp, B., & Johnsdotter, S. (2020). Current critiques of the WHO policy on female genital mutilation. *IJIR*, in press. Available online ahead of print at https://www.academia.edu/42281793

Holden, L. (2019a). Cultural expertise and socio-legal studies: Introduction. *Studies in Law, Politics, and Society*, *78*, pp. 1–9.

Holden, L. (2019b). Beyond anthropological expert witnessing: Toward an integrated definition of cultural expertise. *Studies in Law, Politics, and Society*, *78*, 181–202.

Johnsdotter, S. (2002). *Created by God: How Somalis in Swedish exile reassess the practice of female circumcision*. Doctoral dissertation, Department of Social Anthropology, Lund University.

Johnsdotter, S. (2008). Popular notions of FGC in Sweden: The case of Ali Elmi. *Finnish Journal of Ethnicity and Migration*, *3*, 2, 74–82.

Johnsdotter, S. (2019). Meaning well while doing harm: compulsory genital examinations in Swedish African girls. *Sexual and Reproductive Health Matters, 27*, 2, 87–99.

Johnsdotter, S. (2019, preprint): The growing demand in Europe for reconstructive clitoral surgery after female genital cutting: A looping effect of the dominant discourse? Forthcoming in *Droit et Cultures* 2020, *79*, 1, 93–118.

Johnsdotter, S., & Mestre i Mestre, R. (2015). *Female genital mutilation in Europe: An analysis of court cases*. Brussels: European Commission, The Directorate-General for Justice.

Johnsdotter, S., & Mestre i Mestre, R. (2017). "Female genital mutilation" in Europe: Public discourse versus empirical evidence. *International Journal of Law, Crime and Justice, 51*, 14–23.

Johnsdotter, S., & Rogers, J. (2020, ms). The trauma of female genital mutilation discourse: Interrogating the impacts of the standard tale of 'female genital mutilation' in Sweden and Australia. Submitted manuscript.

Leonard, L. (2000). "We did it for pleasure only": Hearing alternative tales of female circumcision. *Qualitative Inquiry, 6*, 2, 212–228.

Mestre i Mestre, R., & Johnsdotter, S. (2019). Court cases, cultural expertise, and "female genital mutilation" in Europe. Special issue: Cultural Expertise and Socio-Legal Studies. *Studies in Law, Politics, and Society, 78*, 95–113.

Mestre i Mestre, R., Wendel, L., & Johnsdotter, S. (forthcoming). Cultural expertise and female genital mutilation/cutting. In L. Holden (Ed.), *Cultural expertise, law and rights: A comprehensive guide*. London: Routledge.

Miller, K., Dirie, W., & James, C. (1998). *Desert flower: The extraordinary journey of a desert nomad*. New York: Virago.

Palm, C., Essén, B., & Johnsdotter, S. (2019). Sexual health counselling targeting girls and young women with female genital cutting in Sweden: Mind–body dualism affecting social and health care professionals' perspectives. *Sexual and Reproductive Health Matters, 27*, 1, 192–202.

Rabo, A. (2019). Cultural expertise in Sweden: A history of its use. *Laws*, *8*, 3, 22. doi: 10.3390/laws8030022

Rogers, J. (2013). *Law's Cut on the Body of Human Rights: Female Circumcision, Torture and Sacred Flesh.* London: Routledge.

The Swedish Board of Health and Welfare (2014). *Barn som far illa eller riskerar att fara illa: En vägledning för hälso- och sjukvården samt tandvården gällande anmälningsskyldighet och ansvar* [Children who are maltreated or neglected, or at risk thereof: a protocol for the healthcare system and the dental-care system regarding mandatory reporting and responsibility]. Stockholm: Socialstyrelsen [The Swedish Board of Health and Welfare].

Birgitta Essén

One Genital, Two Judgments:
Why do "expert witnesses" draw different conclusions in suspected cases of illegal cutting of girls' genitals?

Introduction

In this chapter, I seek to understand why different experts draw different conclusions despite examining the genitals of the same girl. How do these experts reach their conclusions? Two different approaches can be easily identified in court cases regarding suspected "female genital mutilation": one in which a more confident and convinced expert with no previous research or clinical experience operates in an uncritical manner, resulting in misguided diagnoses and prognoses; and another one, in which the expert assumes a more critical stance with opinions anchored in proven theoretical and practical knowledge in a multidisciplinary context. The latter approach offers diagnoses and prognoses based in science and proven experience, supporting one of the most important principles of justice: *in dubio pro reo*—the benefit of doubt, or "innocent until proven guilty." Below I will discuss my concern that individuals without the proper experience and expertise are allowed to act as "expert" witnesses. In conclusion, I offer some practical recommendations from the so-called Uppsala Model to consider before taking on the role as expert witness—all in the interest of acting in the best interest of the child, which includes not contributing to sending innocent parents to jail.

The questions that will be discussed here are: What is an expert? How do prosecutors and lawyers recruit experts? How best to safeguard professional examinations of the genitals in children and young women and the legal procedures, when professional practice in examinations gives different classifications on the

same individual? Comparative data from examinations by practitioners of gynecology, forensic medicine, and pediatrics will be presented. Further, a legal court case will be discussed, illustrating the conflicting culture of science versus the culture of unshakeable confidence in court. I will present a structured model with clinical recommendations, based on the Uppsala Model best practices of caring for migrant women, including safeguarding of best practices for genital examinations (Essén & Johnsdotter, 2006). The Uppsala Model rests on three legs. The first is evidence-based knowledge from trans-disciplinary research collaboration in reproductive health. Clinical medicine and theoretical knowledge of anthropology of reproductive phenomena such as female genital cutting are explored and the results of the analyses are applied in health promotions or in reproductive, maternity, and youth care including care of circumcised individuals. The second leg is the condensation of practical experiences from different professionals. The third is an approach that builds on collaboration between stakeholders of the Somali community in Sweden on the one hand, and me and other academic scholars on the other; an approach that focuses on culture-sensitive care, meeting the needs of circumcised women and girls.

Background

Over the last fifty years, WHO has served experts with guidelines on attributed health consequences as well as a classification of what they think should be included in the practice of circumcision/genital cutting (FGC) or, according to WHO's terminology, "female genital mutilation" (FGM). The typology has been reconsidered, reformulated, and changed several times, most recently in 2020 (WHO, 2020).

Generally, we are accustomed to WHO guidelines being well supported, but when it comes to FGC, researchers have criticized WHO for taking far too uncritical an approach in terms of causes and consequences (Public Policy Advisory Network on Female Genital Surgeries in Africa, 2012). Furthermore, these guidelines have been issued without the usual concern for randomized studies (Balogun, Hirayama, Wariki, Koyanagi, & Mori, 2013). I argue that misleading conclusions have led to WHO consensus statements around FGC that are now taken for granted and widely used despite being based in skewed or insufficient data. In this paper I ask: What effect might WHO's premature consensus statements have on legal proceedings when relied upon by expert witnesses in individual cases?

Since the 1980s, refugees have been coming to Europe and North America from the Horn of Africa, where the majority of women traditionally have undergone some type of FGC. As a consequence of this migration, many countries have now instituted legislation banning female circumcision, but few cases have been tried. Most EU governments have put considerable effort into prevention and management by means of written guidelines and professional training activities for best practices in treating women and children (EIGE, 2015). With all these initiatives, one would assume that the medical, social welfare, and legislative efforts would have resulted in a smooth operation for safeguarding and protecting children. However, studies from the UK and Sweden indicate that the opposite is true (Johnsdotter, 2019; Karlsen, Carver, Mogilnicka, & Pantazis, 2019), and we have seen troublesome indications that professionals assessing small girls' genitalia, when there are suspicions about illegal FGC, reach divergent conclusions (Mestre i Mestre & Johnsdotter, 2019, p. 102). How come?

The WHO typology and guidelines are used as the golden standard reference when presenting evidence in court cases. However, it is well known that there are inter- as well as intra-individual differences between physicians' opinions and judgments after performing medical assessments including genital examinations. In criminal court cases regarding FGC, I have identified a pattern of a range of variations of expert conclusions, such as: Dr. A does not see a clitoris, but Dr. B does. Dr. C identifies scars, but Dr. B sees physiological skin folds. Dr. D describes normal anatomy, but at the same time concludes that "it is most likely mutilation." Dr. E sees asymmetric labia minora and judges it as cut labia, but Dr. B assesses it as part of normal variations of anatomy. Dr. F prognosticates the healthy young girl to have complications if she gives birth in the future, while another doctor is doubtful (Essén, 2020).

I intend to here discuss how and why an examination of one genital results in different judgments. I will relate this to the principles of, on the one hand, the scientific approach and, on the other, the legal principle of *in dubio pro reo*—the benefit of doubt or "innocent until proven guilty." There have been approximately fifty court cases relating to FGC in Europe, most of them in France in the early 1980s (Johnsdotter & Mestre in Mestre, 2017), as well as occasional cases in Denmark (Mestre i Mestre & Johnsdotter, 2019), Australia (Jabour, 2015) and recently in the US (Baldas, 2020; Stempel, 2018), the UK (Summers & Ratcliffe, 2019), and Ireland (*The Irish Times*, 2020).

My discussion primarily builds on in-depth analysis of one court case involving two Danish girls who went on holiday to Kenya with their Somali-born parents in 2015; a case in which I acted as expert in the late stage when an appeal was planned. So, am I qualified to be an expert? I have a solid background as a clinical gynecologist caring for circumcised patients both in the diaspora and in Africa, and since the 1990s I have headed research projects, published extensively, and continuously educated students and professionals on the subject. All in all, this should make me qualified as an expert of FGC.

In addition, I speak from the experience of acting as an expert witness in other investigations and trials concerning FGC; but as they are ongoing, I cannot refer here to any specifics of these cases. In 2012, I was called as an expert in a preliminary investigation by the Swedish Police. A mother originally from The Gambia was suspected of having had her two little girls circumcised during a visit to The Gambia. A pediatrician with expertise in child abuse did the first examination and concluded that the girls were mutilated. However, the preliminary investigation was discontinued after our multi-professional expert examination concluded normal genitalia, using the Uppsala Model (Essén, 2020). I have also testified in US v. Nagarwala (Kiertzner, 2017), in which three healthcare providers in 2017 were accused of "illegal FGM of 12 girls, transportation with intent to engage in criminal sexual activity, and conspiracy." When the case went to a Child Protective Services trial held in Detroit's State Court of Michigan in 2018, I acted as an expert witness. I testified in court (in person, twice) about my findings as to each and every girl and her genitals. The judge and jury agreed with the defense lawyers' arguments and evidence. None of the parents lost custody of their children, and all parents were allowed immediately to move back home with their daughters.[1] Another case that I am currently involved in concerns a married couple in Ireland and their daughter of one and a half years. In November 2019, an Irish jury found the parents guilty of "aided and abetted, counselled or procured FGC," allegedly performed in Dublin (*The Irish Times*, 2020). The father and mother were both born in Somalia but permanently live in Ireland since many years. In September 2016, the father brought his daughter to the hospital emergently after a falling accident at home, which caused bleeding from her genitals. A couple of

[1] In November 2018, the district judge of the Eastern District of Michigan found the Female Genital Mutilation statute to be unconstitutional and dismissed the charges of FGM and conspiracy to commit FGM. In May 2020, a federal judge dismissed the most serious remaining charge against the doctors (Dyer, 2018), but the juridical process is still ongoing.

pediatrician experts argued in court that the trauma was not consistent with an accident but rather with the practice of FGC. The father was sentenced to five and a half years in prison for the FGC charge, the mother to four years and nine months; both despite their denials of guilt. An appeal is currently under preparation.

In my discussion of why expert opinions vary, even about one and the same genital, I will consider the prerequisites for an expert making optimal judgements: knowledge of the context of FGC practices and processes of cultural change as well as of scientific risk assessments when it comes to correlation or causality. The experts' scientific and practical experience, their clinical experience of patients with FGC, and their use of WHO consensus guidelines, will be evaluated. A question that arose during this analysis was whether courts and jurists might have trouble grasping basic knowledge in anatomy and physiology in cases that concern an issue as politicized and sensitive as FGC (Public Policy Advisory Network on Female Genital Surgeries in Africa, 2012).

The Danish case

The case study I use in the discussion below is based on a case referred to the Danish Supreme Court, decided in May 2018, regarding two Somalis parents of seven children. They were accused of having allowed FGC to be performed on two of their daughters during a vacation trip to Kenya in 2015; however, both parents vehemently denied the charges. The girls were at that time eight and fifteen years old and they, as well, denied that the circumcision had taken place. The parents were sent to jail for one and a half years each. They were convicted of having "participated in FGM" and having committed "breach of duty of care of their children." It was assumed that the cutting procedure had been done at a hospital by medical staff and under local anesthesia. No specific evidence was presented in court of when or where the alleged crime had been committed, or by whom. It was the youngest girl's teacher, knowing about the trip, who had raised the suspicion of "summer vacation mutilation" when the girls did not appear in time for the start of school. According to the parents, the return trip had been delayed due to illness of their sons. In court the parents stated, as part of their defense, that they had never left the girls alone during the Kenya stay, that as parents they had never discussed the issue of genital mutilation, and that they fully understood the law against FGM.

The girls were examined in December 2015 by a pediatrician with expertise in child abuse. She admitted that she had never before examined a child with FGC and did not consider herself an FGC expert. Her conclusions after the genital examination were confirmed by a doctor specializing in forensic medicine. He did not examine the girls himself, however, but gave his opinion after having taken part of the video examinations. He, as well, confirmed that he had never before examined a child with FGC. The mother had the girls examined by two gynecologists, on separate occasions, and each of them concluded normal uncut genitals, confirmed by photos in 2016. One of the gynecologists became a bit doubtful when he learned about the ongoing court case. In the last stage at the Supreme Court in 2018, he changed his mind and supported some of the conclusions of the pediatrician and the forensic doctor.

The final conclusion, however, by the Medical Examiner's Council in the Supreme Court, was that both girls had undergone FGC, type 2b according to the WHO classification. Some millimeter of tissue of the labia minora had allegedly been cut and the prepuce of the clitoris seemed to be "shortened and compressed along the edges." The *clitorial glandula* was not seen; hence, they concluded that it had to have been cut. Further, as the doctors could not see any scars "or adhesion of tissue," it was assumed that the procedure of FGC had been done by professionals in a hospital under sanitary conditions, rather than by a traditional rural circumciser. The defense lawyers did not call any medical expert witness on the District Court level, but an anthropologist (Johnsdotter) testified. She stated that, according to research findings, it is highly unlikely that Somalis living in Scandinavia continue with the practice. Also, she mentioned that no confirmed cases of circumcision had been performed on Scandinavian soil. In court, however, this fact was used as supporting evidence for an illegal "summer vacation mutilation."

As a mitigating circumstance, the Supreme Court emphasized that circumcision must have had been performed in a hospital and in a way that there had been a complete recovery without visible scar tissue—that the procedure had been performed in a clinical setting by trained medical professionals was offered as an explanation for why the girls experienced no symptoms or complications after the alleged operation. Yet, it was assumed by the court that the girls in the future would suffer from long-term physical and mental complications, which led to stiffer penalties for the parents.

In 2018, I was contacted by representatives of the Somali community and asked to serve as a medical expert in the appeal of the case. I examined the girls, three years after their trip to Kenya, now aged eleven and eighteen. My examination and video documentation concluded that both girls presented normal genitals with no evidence of asymmetric anatomy or scarring of any part of their external genitalia. The external clitoris was visible and easy to palpate on both girls. They did not present any signs of physical or mental illness. In September 2019, when the father was in custody and the mother on her way,[1] the defense lawyer presented this new evidence to the Danish Special Instance for Appeals and Complaints (*Den Saerlige Klageret*). Serious, medically based doubt was now raised about the correctness of the Medical Examiner's Council's earlier statements in the case. The defense lawyer argued that the first examination was not performed by an expert of the practice or anyone with experience examining patients with FGC. The parents' lawyers argued that the Medical Examiner's Council's earlier statements were brief and did not contain any element of justification or argumentation. The lawyers wrote in their demand for a court review: "their opinion is less reliable than the opinion of the senior expert in the field of FGC and gynecology, with long-term clinical practices both in Europe and in Africa and highly acknowledged by researchers in the field of FGC."

The Instance for Appeals and Complaints, however, found that "no new information has been provided that could lead to the case being reopened, nor are there any special circumstances that make it overwhelmingly probable that the evidence has not been correctly assessed" (The Danish Instance for Appeals and Complaints, 5 September 2019, G-118-119). The demand for a court review was rejected as the jury did not see any reason for changing the first verdict of FGC type 2b. Moreover, they did not provide any guarantee of reopening the case for appeal.

Discussion

So, how could one genital be judged in two completely different ways? The following discussion investigates possible explanations, organized into four areas:

[1] As the court did not want the seven children to be placed in a foster home, the judge decided in 2018 to send first the father to prison for 1.5 years, then in late 2019 the mother was to be incarcerated.

1) Some selected experts have limited knowledge of the specific anatomy of the genitals, both in terms of theory and practice.
2) Experts proceed from two diametrically opposed hypotheses about culture; either the one presuming cultural continuity or the one focusing on change in the practice of FGC after migration. This situation calls for multi-disciplinary teams of experts.
3) Experts interpret data on FGC-related complications differently. Those who are unaccustomed to critical reading will be prone to drawing faulty conclusions.
4) Judgments in court might confuse presentations of unshakeable confidence with accuracy.

1) Limited knowledge and clinical experience

The first issue I would like to explore is whether many experts have limited knowledge of the specific anatomy of the genitals, both in terms of theory and practice; and, if so, how this might impact their judgment. None of the doctors who performed the primary examination had previously encountered patients with FGC. Not one of them had ever done research or teaching in the area. For example, in both the Danish and US cases, the prosecutor's expert declared not having any previous experience with patients having undergone FGC:

> [Denmark] It is the first examination of female circumcision that I have performed. It is, in general, my first case ever in relation to female mutilation.

> [US] I hadn't seen it on a child that I personally evaluated. I had seen it in photos and cases of other people, but not hands-on or in a clinical evaluation at my clinic.

In my own expert opinion, I testified that I could both see and palpate the clitoris and labia minora of the girls. So why did the others not come to the same conclusion? The anatomy and findings of the normal genitalia in newborn, prepubertal, and adolescent girls are by nature a dynamic process of developmental changes. Generally accepted knowledge is that when examined, the cutaneous folds, *labia majora* (outer labia) with the pudendal cleft, are relatively dominant in childhood compared to in puberty. From plastic surgery studies we know that the *labia minora* (inner labia) constitute a part of the body that is very individualized, both in terms of size and symmetries. The labia minora, the clitoris and the clitoral hood are anatomically distinct structures and have separate embryological origins (Akbiyik

& Kutlu, 2010; Brodie et al., 2016). When it comes to the external part of the glans clitoris, *one might not always be able to see* it in uncut girls (Cold & Taylor, 1999). The inter- and intra-individual variability of the visible morphological changes that a child undergoes is remarkable (Akbiyik & Kutlu, 2010; Brodie et al., 2016); hence, a professional who is not familiar with the vast array of possibilities in the genital morphology of a child will be a poor judge of what can be considered "normal."

Simply put, when skin cells are injured, the wound heals with persistent scar tissue while injured mucosa membrane heals without scarring. These facts need to be recognized and acknowledged when one takes on the role of an expert witness. The clitoral hood anatomy has several shapes. The pediatric hood could for example look like a horseshoe, a trumpet, a coffee bean, or a tent (Brodie et al., 2016). In the fetus and in childhood, the inner part of the foreskin (hood/prepuce) is adherent to the glans clitoris, by *synechies*, and these adhesions could persist into puberty. This makes the glans clitoris concealed and less visible on inspection. *Phimosis* in boys (e.g., Cold & Taylor, 1999; Shahid, 2011) is a state that is due to naturally occurring adhesions between prepuce and glans and to narrow skin of prepuce and short frenulum. At birth boys are noticed to have a nonretractile foreskin and this separates over time. This is anatomically similar to the physiology of girls' genitals. As noted by Cold and Taylor (1999): "The glans clitoris can be partially or completely covered by the prepuce; this merely represents anatomical variation" (Cold & Taylor, 1999, p. 41). The authors stress that most medical doctors are not sufficiently trained to identify these normalities. If one cannot directly observe the glans clitoris, often there is a presence of smegma between the foreskin and glans clitoris (Akbiyik & Kutlu, 2010). This is desquamated "dead" mucosa epithelial cells and is also a normal feature of the infant genital anatomy.

The expert on pediatric sexual abuse diagnosed the children as having FGC Type 2b and claimed that "some millimeter of tissue of the upper part of labia minora had been cut" and that "the prepuce of the clitoris was shortened and compressed along the edges." I did not diagnose FGC, however. One reason for our different judgments may be that we practiced different examination procedures. When examining children for child abuse, the standard methods are supine labial separation or supine labial traction techniques—both are two-hand grips (Boyle & Miyamoto, 2008). These tractions actually shorten, compress, and deviate structures such as the hood, and the hands of the examinator cannot be used for palpation. Hence, the examination procedure may give an illusion of damage,

with an incorrect diagnosis as the result. If instead the inspection is executed with a technique which leaves one of the hands free for palpation, the structures can easily be observed and palpated at the same time while they remain in their natural shapes and positions.

Further, the forensic doctor admitted in court to his lack of expertise in gynecology and to never having performed previous examinations in cases of FGC, yet he did not entertain any doubt of his findings that both girls had had their clitorises cut.

> *Forensic doctor:* There is no risk whatsoever for misinterpretation. We looked at the girls during the examination. I cannot answer why doctors came out with different conclusions, that circumcision has not been performed. However, it does not change my position and I am completely sure that both girls have been circumcised.
> [Minutes from court proceedings]

However, in his role of educating the court, he recognized the variation of anatomy by age, and thereby somewhat contradicted himself:

> With regard to the examination of the youngest girl, it may here be difficult to see [the clitoris]. It requires knowledge of how the normal conditions are, to be able to see if something is different. The clitoris will typically be bigger in older girls. In younger girls you can see only the foreskin and not the clitoris itself. It will vary from woman to woman, if you can see the clitoris, but one can typically not see it before the woman has reached puberty. Therefore, it is easier to see that circumcision has taken place among the oldest girls.
> [Minutes from court proceedings]

This forensic doctor was not an expert on FGC and had no experience of assessing FGC in women and girls, and this can explain our completely different judgments. He did not apply his theoretical knowledge when judging the anatomy of the genitals in practice. In contrast, my use of theoretical knowledge led to a different conclusion. Being skilled in anatomical variation from long-time experience of examining patients with FGC, I gave the following judgment after having examined the girls:

> My findings show, for age, completely normal variations of the external genitalia, that there are no signs of external trauma or damage to skin surface, mucous or glandular

> tissue, that nothing emerged in the investigation that corresponds to the previous conclusions in judgments. In light of my gynecological competence and very significant experience examining circumcised individuals, I find it absolutely medically unjustifiable to base an assessment on information provided by another doctor who lacks gynecological expertise or experience working with circumcised girls or women.[1]

I argued that the parents would not have been charged and jailed had the Supreme Court been presented with evidence from a knowledgeable expert witness. In a study where we scrutinized teaching materials and best practices for examination procedures of suspected sexual assault of children, we did notice the absence of routines and standard procedures regarding how and whether the glans clitoris should be evaluated (Grönvall, 2020). Hence, even among expert assessors of genitals in sexually abused children, there might be a lack of experience as regards assessment of the clitoris (Creighton & Hodes, 2016). Again, in my judgment, if the gland clitoris is not visible, this does *not* mean that it has been cut. The clitoris can be compared to a sponge, which means that its size is dynamic, varying not only with age, but also with blood infusion, and nerve or hormonal stimulation. This is generally accepted knowledge which I took into consideration when judging the size of the clitoris. To conclude, this situation may explain why experts arrive at different judgments of the same genital.

I further argue that another explanation for why the same genital is judged in different ways, is that some summoned experts disregard common knowledge and generally accepted facts about scarring. In the scientific community, it is well accepted that basically all types of surgical procedures heal with some form of scars (skin) or adhesion (mucosa). So, I argued, if there is no scar on the foreskin or underneath, the most probable conclusion is that *no* cut has been performed. Contrary to this inference, the prosecutor's expert in the Danish case declared that "the absence of scarring does not exclude the possibility of mutilation." This quote illustrates what I have also come across in cases in other countries: the prosecutor's experts conclude that the absence of scar tissue is indirect evidence of the girls having been cut by a professional at a hospital facility under proper hygienic circumstances:

> Circumcision was most likely performed in a hospital. That conclusion is drawn as scar

[1] The Danish Instance for Appeals and Complaints, 5 September 2019, G-118-119.

> tissue cannot be seen. Conversely [if the procedure had been performed under unhygienic circumstances], one would have expected scar tissue, that it healed asymmetrically or [that one would find] remnants of an infection.
> [Minutes from court proceedings]

Needless to say, this reasoning is a fallacy—a result of a faulty starting point. These so-called expert witnesses, who themselves report that they are not experts in the field, presented their conclusions using what seems to be a pre-conceived hypothesis, in line with "regardless of whether or not scarring is detectable, the cause is most likely genital mutilation." In my judgment, if I do not see or feel any scar tissue, it is far more probable that no surgery has been performed than that the opposite would be the case. Thus, in the Danish case, my judgment was that a negative finding speaks more to there not having been any circumcision—neither by a traditional circumciser, nor in a hospital. I assumed, based on basic surgical knowledge, that surgery, even under the most sterile conditions, leads to some scarring. The flawed reasoning that presupposes "mutilation" whether or not there is scarring, jeopardizes important principles of justice, such as the one stating that one is innocent until proven guilty. As a result of the experts' judgments in this case, the Danish prosecutor needed not to present any evidence whatsoever for who would have performed the alleged crime nor tie the presumed act to a crime scene. It was not deemed necessary, when it had already been concluded that—scarring found or not—it had to be genital mutilation.

The Swedish National Centre for Knowledge on Men's Violence Against Women[1] (NCK) has recommended, in cases involving the specific and very complex area of FGC, to work in a multi-professional (practitioner) team (NCK, 2011). Such teams should include experts with diverse professional backgrounds such as obstetrics and gynecology with a focus on FGC, along with pediatrics with a focus on sexual abuse, urology/surgery, and forensic medicine. In medicine, we have basically two tracks or specialties: surgery or internal medicine. Ob Gyn is part of the surgery "family" and pediatrics of the internal medicine family. Sub-specialties in surgery are pediatric surgery and pediatric urology; that is, doctors in the surgery family who are skilled in tissue, trauma, and injury, but in infants. When it

[1] The Swedish Government commissioned NCK in 2010 to produce a knowledge review and guidelines for healthcare staff on the support and care for girls and young women affected by FGC. Sara Johnsdotter and Birgitta Essén were the expert authors.

comes to examining female genitalia, gynecologists are the experts, mainly due to their daily applied work with genital tissue. But when it comes to young children, pediatric surgeon/urologists are the experts on the tissue and anatomy of the young child, compared to a general pediatrician who rarely examines genitals in routine consultation and who never performs surgery. Pediatric urologists rarely routinely work with FGC and very seldom, compared to general pediatricians, see "ordinary" patients. Some pediatricians are sub-specialists in examinations of victims of abuse. Doctors of forensic medicine are experts in trauma and external injuries, but they never have clinical consultations. They are fewer in number and often located at university and central hospitals, and they are seldom involved in examinations of sexual abuse or of genital trauma in general (Thiblin & Michard, 2014, p. 19).

Therefore, I argue that a multi-professional team, including assessments from each expert, will enrich the trial process and be in the best interest of the child and her family (Essén, 2020). In short, limited knowledge, contradictory arguments, and single-professional teams lead to faulty conclusions in court, which in turn leads to inequality before the law. In order to keep a highest standard of medical and legal practice, such genital examinations must be performed only by recognized expert teams with specific knowledge in combination with proven experience.

2) Opposed hypotheses about prevalence of FGC after migration

The second explanation for why experts have different judgments of the same genitals could be that they proceed from two diametrically opposed hypotheses about whether there is continuity or change in the practice of FGC after migration. The hypothesis of continuation of a harmful practice such as FGC, is that the practice is so "deeply rooted" in culture that it is not likely to change even after migration from a country with a high prevalence into a non-practicing context. The hypothesis has poor support in empirical data (Isman et al., 2013; Johansen, 2016; Johnsdotter & Mestre i Mestre, 2017) and is basically ideology-driven. In guidelines for health care practitioners, WHO argues in a similar way: "Whatever the reason provided, FGM reflects deep-rooted inequality between the sexes. This aspect, and the fact that FGM is an embedded sociocultural practice, has made its complete elimination extremely challenging" (WHO, 2016). On the other hand, there is the hypothesis of cultural change as regards FGC after migration. It is

grounded in theories about cultural change that results in convention shifts (e.g., Mackie, 1996) or social norm changes (e.g., Shell-Duncan et al., 2018). It suggests that the convention to circumcise daughters shifts, for several reasons, when families move to non-practicing communities—thus the practice of FGC is hypothesized to be generally abandoned under certain circumstances (Johnsdotter, 2002; Mackie, 1996). The hypothesis is supported by several empirical data sets from Israel (Belmaker, 2012) and Scandinavia (Gele et al., 2012; Johnsdotter & Essén, 2016; Johnsdotter et al., 2009; Wahlberg et al., 2017a; Wahlberg et al., 2019). Moreover, studies that review court cases in which the process of culture change is revealed (Bader, 2018; Johnsdotter, 2018; Johnsdotter, 2019; Johnsdotter & Mestre i Mestre, 2017), research with insights into migrant communities' response to harsh anti-FGM policies (Karlsen et al., 2019), and reports about cases of suspected FGC by pediatric units in the UK (Ali et al., 2020; Hodes et al., 2020) strongly give further evidence for the hypothesis of cultural change. In our Danish case, the father shared his views around the FGC issue:

> The last time I saw the girls' genitals was when I changed diapers when they were little. I do not know what their genitals look like. It is not customary for a Muslim man to see the genitals of his daughters. Before this case arose, we had never talked about circumcision. The girls simply did not know the word (for circumcision) and did not know what it consisted of. The girls are Danish!
> [Minutes from court proceedings]

Acknowledging these changes in the practice of FGC does not equal a call for stopping prevention efforts; rather, it is an opportunity to understand dynamics of culture and what changes are happening. This wider context ought to be incorporated into the expert's judgment. In the Irish case, as well, the parents claimed to be innocent and were distancing themselves from the practice. They felt they were being judged based on their ethnic background and presumed culture, for being of Somali origin (*The Irish Times*, 2020).

> In one exchange in court, the mother told the police she believed she was charged with allowing FGM to happen "because I am Muslim, I am black, and in my country, they do that." She added that she did not think she would have been charged if she had been a Christian. The father, when giving evidence, said the presumption that he carried out

> FGM was "based on preconceived ideas because I'm a Muslim from Somalia."[1]
>
> The pediatric FGC expert in court, in contrast, emphasized the importance of (Somali) "culture": "FGM is a cultural phenomenon that goes back many thousands of years" [*The Irish Times*, 2020].

I would say that here would have been a golden opportunity for the medical experts to use context-specific data and reject the hypothesis of general, large-scale continuation. In my final judgment, I used findings from multidisciplinary research sources and highlighted that, due to processes of cultural change, many individuals are opposed to the practice. Thus, it is possible and even probable that they are trustworthy when they say that they would not subject their daughters to it. For example, in regard to the scenario and motivations, the parents seemed to be well-integrated into Danish society, all their seven children were born in Denmark, and they expressed having negative attitudes towards the practice of FGC.

> In one exchange in court, the mother said she is still in shock over the accusation of circumcision. She declared that she and her husband always make important decisions about the children, together. So, if the girls were to be circumcised, then they would both be involved in making that decision. But they had never talked about it [circumcision]! FGC is forbidden in Somalia since 21 years, and there are many anti-FGM campaigns running in the country.
> [Minutes from court proceedings]
>
> The mother explains, in court, that she is aware of the Danish FGM law. She herself was circumcised as a child and remembers it as "torture." Why would she expose her children to torture?
> [Minutes from court proceedings]

In addition, the family was not in contact with people performing such practices, and the children had never been to Africa before the trip to Kenya. During the visit, the family stayed together at all times and the only hospital visits were in relation to their sons' illness. That corroborated the perspective of the parents, that they demonstrated parental caring and were trustworthy when they avowed that the girls had not undergone FGC during the visit in Kenya. I argue that in the Danish and Irish cases, the outcome would have been different if a panel of

[1] https://www.shiftingsands.org.uk/worrying-questions-about-expert-evidence-at-fgm-trials/#more-3804

multidisciplinary experts had been contacted before the legal process started, since experts knowledgeable of cultural processes among migrant communities would have been better suited to evaluate the claims made by the accused parties. Thus, incorporating experts in anthropology (with special expertise in theories of social and cultural norms and traditions) would provide important benefits for the final judgment of the cases. A general conclusion is that the expert witness who uses a weak and poorly substantiated hypothesis—such as the one about general continuation of FGC in diaspora settings—will *not* offer evidence-based opinions in the court of law. Indeed, their contribution to the legal process will be the opposite of the intended purpose.

3) Different interpretations of FGC-related data and uncritical approaches to scientific literature

As a third explanation, I argue that experts interpret data on FGC-related complications differently, with the risk of premature conclusions on the part of some expert witnesses. In all the cases in which I have been involved, the prosecution established the fact that the girls did not have any current complications. Nonetheless, they insisted that the girls will suffer from long-term physical, mental, and sexual health problems in adulthood. An example from the Danish case (which arguably would warrant a stiffer sentence):

> There has been a nice healing without visible scars. There is a small loss of tissue corresponding to the inner labia. There is no change of the vaginal entrance or vagina. The outer part of the clitoris is missing. There is no immediate physical concrete significant discomfort or pain. As the outer part of the clitoris and a small part of the inner labia are missing, this may lead to decreased desire or decreased enjoyment or satisfaction during intercourse. *It cannot be denied that there may be inconvenience in future childbirth due to scar tissue, although scar tissue cannot be ascertained.*
> [Minutes from court proceedings, my emphasis]

> There may be mental problems in the form of anxiety re-experiencing the intervention, or depression. Psychological or social difficulties can potentially arise, depending on the woman's future partner's cultural affiliation and thus understanding or acceptance of the procedure performed.
> [Minutes from court proceedings]

I would contend that on an individual level, future health-related complications cannot be prognosticated in childhood, and this is what I have communicated

during the preparation of the planned petition for a new trial. I base my opinion on proven experience and science. Systematic reviews show that studies claiming an association between the exposure of FGC in childhood and the adult woman's perceived ill health in fact often lack appropriate study design and do not provide biological causal explanations (Berg et al., 2014; Obermeyer, 2005; WHO, 2016). Most results are inconclusive due to lack of a representative sample of girls and women, missing anatomical description, recall bias from women (Elmusharaf, Elhadi, & Almroth, 2006), observation and misclassification bias from examiners, lack of significant association, and/or lack of longitudinal studies to determine causal and effect relationship (Berg et al., 2014). When future obstetrical problems for the girl are anticipated, the reference used is the WHO consensus guidelines on FGC and the multicenter study (WHO study group et al., 2006). However, these findings have been criticized (Hodžić, 2013; Public Policy Advisory Network on Female Genital Surgeries in Africa, 2012; Rodriguez et al., 2017) and have not been reproduced in high-resource settings (WHO Regional Office for Europe, 2018). While the WHO study group concluded that FGC poses a risk to women and newborns during childbirth, there are seemingly other contributing factors, which are being neglected while our attention is turned towards FGC only (Esscher et al., 2014; Essén et al., 2002a; Essén et al., 2002b; Essén et al., 2005). A systematic review finds "the quality of the evidence for all outcomes as being too low to warrant conclusions about a causal relationship between FGC and obstetric complications," and points out that "inconsistencies in results and estimate imprecisions contribute to this conclusion" (Berg & Underland, 2013).

WHO includes FGM type 4 (pricking, nicking, piercing, with no tissue removed) in their classification and relates such practices to health complications, despite the fact that the empirical association between pricking and health complication has not been established (Isa et al., 1999; Merli, 2012; Newland, 2006; Obiora, 1997; Wahlberg et al., 2017b). In fact, the opposite prevails, as it is generally accepted knowledge in medicine that a nicking of the skin (no tissue cut), regardless of where on the body it is performed, will not lead to long-term health consequences—the relationship is not even biologically plausible. It is not rare for scientific facts to be intertwined with values, and there is reason to contemplate how significant the personal values of the expert are when applied to criminal court cases regarding FGC. This is what may be happening when expert witnesses claim in court that tissue with no trace of damage or scarring is associated with

future health complications.[1] I argue that it would benefit the process of judgements to better refine these fact- versus value-based aspects, without thereby diminishing the perspective that FGC can harm the child.

Hence, to truly be an expert on FGC in court, one needs to understand the complexity of the practices, have insights into methodological limitations, and use common sense. Moreover, insights from a wide range of scientific disciplines—such as obstetrics and gynecology, pediatrics, sexology, epidemiology, psychology, sociology, and anthropology—cannot be expected from one single expert witness. Lack of these insights might be one of the explanations why we in court experience and see different judgments of one genital, with expert statements in some cases bordering on perjury.

4) Different approaches of presentations in court

The fourth and my final argument is related to how evidence is presented and interpreted in the court: different experts reach different conclusions, and whoever assumes the position of absolute certainty tends to be judged as more "credible" than the one expressing scientifically based doubts (Thiblin & Michard, 2014, pp. 72–74). Medical science is, however, not black and white; and the correct answer is rarely a simple yes or no. Cross-examination in a court of law, on the other hand, does rest on questions that are expected to be answered with a simple yes or no.

In the Danish case, the expert team selected by the prosecutor and police was comprised of two forensic doctors and one pediatrician, all of whom declared having no clinical experience with patients with FGC, nor expertise regarding the practice. Only the pediatric expert examined the girls, but in the courtroom one of the forensic doctors testified. In court, he told the jury that he was convinced, beyond a doubt, that the findings were absolutely equal to FGC type 2. The

[1] For a discussion of a criminal court case regarding type 4 (with no traces of any tissue damage) in Australia, see Rogers (2016). In 2015, the mother of two girls—aged six or seven at the times of the rituals—and a nurse were charged with breaching the ban on FGM in New South Wales, and a Dawoodi Bohra community leader was charged with being an accessory. They were all found guilty and sentenced to fifteen months in jail. In 2016, the charges were quashed in Court of Appeal when it was proven that there was no damage to the genitals of either girl (a colposcopic examination "could find no evidence of any incision, cut or injury at all" [Rogers, 2016, p. 235])—hence, no "mutilation." Eventually, the High Court found the defendants guilty in a divided ruling (Byrne, 2019). The High Court judgment repeatedly referred to the WHO classification, in which type 4 is categorized as "mutilation" (The Queen v A2 [2019] HCA 35; retrieved from http://eresources.hcourt.gov.au/showCase/2019/HCA/35).

mother, however, had taken the girls for examinations with two different gynecologists, for additional opinions. Their conclusions were that the girls had not been cut. The clitoris and intact labia minora were presented in both of the girls with photo documentation. One of the gynecologists, clinically familiar with FGC patients, confirmed the findings in court, stating that:

> The parents would not have come to me if the girls were circumcised because it would have been too risky.
> [Minutes from court proceedings]

During the final cross-examination in the Supreme Court, however, he became a bit insecure about whether the girls were uncut, but he was sure about the visible clitoris. He felt he was no longer able to confirm with a hundred percent certainty that the younger girl's labia minora were completely intact:

> It might be possible that one of the inner labia has been cut, but I am sure that no cut has been performed regarding the clitoris.
> [Minutes from court proceedings]

The forensic medicine expert, however, did not entertain any doubt despite never having encountered a person with any type of FGC and not having personally examined the girls:

> There is no risk of misinterpretation. I cannot explain why two doctors disagree on whether or not circumcision has taken place. However, it does not change my position, I am absolutely sure that the girls are circumcised.
> [Minutes from court proceedings]

This example shows that an expert who assumes a more reasoned position may find it more challenging to get through to the court with a final conclusion. In contrast, the expert who maintains a strong position, who is driven by conviction and expresses unshakable confidence without any apprehension about the existing possibilities, will present the winning concept in court. But is this approach in the best interest of the child? The Danish court decisions were in line with the "confident expert's opinion" despite the fact that the court was aware that this "expert" had no clinical experience with circumcised patients and did not conduct clinical examinations. To me, it was obvious that the girls had not been circumcised. My

assessments were made after I had rejected the hypothesis that "if one cannot see the clitoris it must be mutilation," through examination and taking into account the circumstances of the individual case. I also presented high quality photos and videos of the girls' clitorises, typically considered stronger evidence than is mere opinion. Although I was the expert with the most proven skills, scientific publications, and long-time clinical experience with FGC, my judgments did not succeed in making the Instance for Appeals and Complaints reconsider previous court judgments of FGM type 2.

In general, expert witnesses are expected to use references for educative purposes in court. NGO activists who work with values-based campaigns are sometimes called to act as experts. Publications from NGOs or text from social media sources are not peer-reviewed according to scientific principles but based in ideology rather than science. If the prosecutors or lawyers use such materials and do not recognize their limitations, preconception bias will be introduced into trials. Thus, if this kind of information is promoted in court, the jury may interpret the statement as the one and only truth or fact.

Conclusions

Professionalism and practice: Safeguarding of best practices for genital examinations and equality before the law

In conclusion, I judged the genitalia to be uncut in the Danish case because I could show evidence of intact clitoris and labia minora anatomy of girls with no clinical signs of complications. In addition, I recognized parents who had undergone the process of cultural change as regards the practice of FGC. The original judgments opposing this conclusion were made by non-qualified physicians who acted without experience and had poor knowledge and took a pseudoscientific approach. They seem to have disregarded the principles of science and were thus unable or unwilling to question faulty claims in WHO reports. It led to incorrect conclusions—a more critical and analytical approach for the examination of the same genital arrives at another conclusion. It is apparent which position most benefits the justice system and ultimately the welfare of the child. My view is that erroneous conclusions about FGC have led to premature consensus. If, then, the WHO's consensus documents are used uncritically in court, it will lead to innocent people being convicted of crimes they did not commit.

According to my thirty years of experience in the field of FGC, the dialogue between academic scholarship and policy makers of WHO have several times been closed down, censored, or compromised. If we continue to accept that the ideology-based zero-tolerance discourse weighs heavier than a science-based approach, we risk incarcerating innocent parents and separating children from their families on ideological rather than scientific grounds. This can certainly not be in the best interest of the child (Macklin, 2006).

Practical recommendations by the Uppsala Model

Over the years in Uppsala, we have developed a model for best practices of caring for circumcised women and children. This model includes recommendations regarding how to assess whether or not genitalia have been cut (Essén & Johnsdotter, 2006; Essén & Mosselmans, 2020). I have found the conceptual framework of "factfulness" by Rosling and colleagues (2018) useful, as they propose the stress-reducing habit of only carrying opinions for which one has strong supporting facts. The Roslings introduce a number of "instincts" we have that make us misinterpret facts in the area of global health matters, where we tend to see them as more dramatic than they are. He offers rules of thumb to control "the drama-intake attention filter" by making it a habit to always question dramatic stories that trigger one's fear instinct (Rosling, Rosling, & Roennlund, 2018, p. 104). The concept is very applicable to reproductive health in general and FGC in particular. In line with this refreshingly critical stance, I have developed practical recommendations for judging genitals. Below, I provide some guiding principles to help expert witnesses act in a fact-based manner in future judgements of allegedly mutilated genitals.

• Act as an expert only in the specific field in which you have proven experience, such as the multidimensional practice of FGC. Rosling and colleagues emphasize that "experts are experts only in their specific field" (2018, p. 187). However, they incline to believe that their special skills make them generally the best in judging, which is not the case.

• Before acting as an expert, recognize your "destiny instinct"[1] by updating your knowledge of the context and processes of cultural change. The "standard tale of FGM" (Leonard, 2000; see also Johnsdotter about "the canon portrayal of FGM" in this volume)—the idea that "the practice of FGC is so deeply rooted in culture so it never changes"[2] —may make you misinterpret facts and neglect manifestations of change of attitudes in individuals after migration from affected communities (Hodes et al., 2020).

• To enrich the process of judgment and reduce the "single perspective instinct," work within a multi-professional team. The team should offer multiple tools from different expert specialists: the gynecologist (expertise in genitals, tissue, and experience with cut patients), pediatric surgeon/urologist (expertise in child genitals and tissue), pediatrician with training in child abuse (expertise in child inquiries), and a specialist in forensic medicine (expertise in trauma, external injury, and legal aspects).

• FGC is not a uniform standardized intervention, rather it is about context-specific practices with a variety of motives as to when, where, and by whom the procedure takes place, and the amount of tissue cut. Be aware of your "generalization instincts" by judging through a multidisciplinary team including anthropologist and other social scientists (expertise in culture, norms, religion, the politics of the practice, and ethnography).

• FGC is typically controlled and managed by women. The instinct of blaming men for controlling women's sexuality by genital mutilation is not substantiated by facts (Earp & Johnsdotter, 2020; Public Policy Advisory Network on Female Genital Surgeries in Africa, 2012). The rule of thumb is to resist the urge of "pointing the finger" at the father when assessing a case.

---

[1] Regarding what they call the "destiny instinct," Rosling and colleagues (2018) advise people to heed change, also slow one. "Some knowledge goes out of date quickly. Technology, countries, societies, cultures, and religions are constantly changing" as it is formulated on the website *gapminder.com* about factfulness.

[2] See Johnsdotter (2002) on culturalist ideas in relation to unreflected expectations that FGC practices are maintained on a large scale among migrant communities. See also Palm et al. (2019) for a discussion about ramifications of the support for "the standard tale of FGM."

• Use common sense when evaluating health consequences related to FGC. Is the perceived risk identified out of dread or does it reflect a solid medical inference? Evaluation of the risk of complications should not rest on assumptions. Control your "fear instinct" by separating risk calculation made on group level from individual level and by separating facts from values. Any attempt at prognosticating—during childhood—long-term physical, mental, or sexual complications in adulthood, should be avoided.

• In general, WHO guidelines enjoy a high level of credibility (Earp & Johnsdotter, 2020). The widely publicized medical long-term complications attributed to FGC are, however, rather infrequent and many of them lack causal explanations. The rule of thumb before judging a case is to keep in mind the accurate proportions and probabilities as well as using a critical approach when reviewing literature.

• In general, activists turn to exaggerating the facts (Rosling et al., 2018, pp. 188–189). Distinguish between testimonies emerging from migrant communities and statements from NGO activists who work with ideology-driven campaigns. An activist of Somali background is not, per se, representative of the Somali community in the court room.

• Information about bad events is more likely to reach us than is good news. This gives us systematically too-negative expectations according to Rosling and colleagues (2018). If you feel that you may carry such a "negativity instinct" in relation to the practice of FGC, remember that evidence shows that there is large-scale change in the practice among the Somali diaspora (Johnsdotter & Essén, 2016).

• Finally, contemplate your role in the court proceedings if the court case has been reported in the mass media and gained publicity among the general public. The expectations of certain trial outcomes created by media reporting and public discussions can be overwhelming (Hayes & Luther, 2018; Otto, Penrod & Dexter, 1994). Your role as an expert is not to accommodate such expectations and give in to social pressure—it is to maintain scientific principles and act in a way that protects the integrity of the legal system, and by so doing safeguard the best interests of the child.

References

Akbiyik, F., & Kutlu, A.O. (2010). External genital proportions in prepubertal girls: A morphometric reference for female genitoplasty. *The Journal of Urology, 184*, 4, 1476–1481.

Ali, S., Patel, R., Armitage, A.J., Learner, H.I., Creighton, S.M., & Hodes, D. (2020). Female genital mutilation (FGM) in UK children: A review of a dedicated paediatric service for FGM. *Archives of Disease in Childhood, 105,* 11, 1075–1078.

Bader, D. (2018). *Gender, race, and nation. Femonationalism and the problematisation of female circumcision and genital cosmetic surgery in the Swiss public sphere.* Doctoral dissertation, Institute of Social Sciences, University of Lausanne.

Baldas, T. (2020, April 22). Feds give up on female genital mutilation law, say it's too weak. *Detroit Free Press* [Internet]. Retrieved from https://eu.freep.com/story/news/local/michigan/detroit/2019/04/12/female-genital-mutilation-law/3445289002/

Balogun, O.O., Hirayama, F., Wariki, W.M., Koyanagi, A., & Mori, R. (2013). Interventions for improving outcomes for pregnant women who have experienced genital cutting. *The Cochrane Database of Systematic Reviews*. doi: 10.1002/14651858.cd009872.pub2.

Belmaker, R.H. (2012). Successful cultural change: The example of female circumcision among Israeli Bedouins and Israeli Jews from Ethiopia. *The Israeli Journal of Psychiatry and Related Sciences, 49*, 3, 178–183.

Berg, R.C., & Underland, V. (2013). The obstetric consequences of female genital mutilation/cutting: A systematic review and meta-analysis. *Obstetrics and Gynecology International*. doi: 10.1155/2013/496564

Berg, R.C., Underland, V., Odgaard-Jensen, J., Fretheim, A., & Vist, G.E. (2014). Effects of female genital cutting on physical health outcomes: A systematic review and meta-analysis. *BMJ Open, 4*, 11, 1–12. doi:10.1136/bmjopen-2014-006316

Boyle, C & Miyamoto, S. (2008). Comparison of examination methods used in the evaluation of prepubertal and pubertal female genitalia: A descriptive study. *Child Abuse & Neglect, 32,* 2, 229–43.

Brodie, K.E., Grantham, E.C., Huguelet, P.S., Caldwell, B.T., Westfall, N.J., & Wilcox, D.T. (2016). Study of clitoral hood anatomy in the pediatric population. *Journal of Pediatric Urology, 12*, 3, 177. doi: 10.1016/j.jpurol.2015.12.006

Byrne, E. (2019, Oct 16). High Court rules female genital mutilation illegal in all forms, NSW court erred in quashing convictions. *ABC News.* Retrieved from https://www.abc.net.au/news/2019-10-16/high-court-rules-female-genital-mutilation-illegal-in-all-forms/11606396

Cold, C.J., &. Taylor, J.R. (1999). The Prepuce. *British Journal of Urology, 83*, Suppl. 1, 34–44.

Creighton, S.M., & Hodes, D. (2016). Female genital mutilation: What every paediatrician should know. *Archives of Disease in Childhood 101*, 267–271.

Dyer, O. (2018). US judge drops FGM charges against two doctors, saying law is unconstitutional. *BMJ: British Medical Journal (Online), 363*. doi: 10.1136/bmj.k5002

Earp, B.D., & Johnsdotter, S. (2020). Current critiques of the WHO policy on female genital mutilation. *International Journal of Impotence Research*, advance online publication. doi:10.1038/s41443-020-0302-0.

EIGE, European Institute for Gender Equality. (2015). *Estimation of girls at risk of female genital mutilation in the European Union: Report*. Vilnius: European Institute for Gender Equality.

Elmusharaf, S., Elhadi, N., & Almroth, L. (2006). Reliability of self reported form of female genital mutilation and WHO classification: cross sectional study. *BMJ: British Medical Journal, 333,* 124. doi: 10.1136/bmj.38873.649074.55

Esscher, A., Binder-Finnema, P., Bødker, B., Högberg, U., Mulic-Lutvica, A., & Essén, B. (2014). Suboptimal care and maternal mortality among foreign-born women in Sweden: maternal death audit with application of the 'migration three delays' model. *BMC Pregnancy Childbirth, 14*, 1, 141. doi: 10.1186/1471-2393-14-141

Essén, B. (2020). Professionalism & practice: Safeguarding of best practices of genital examinations and equality before the law. *Journal of Obstetrics and Gynaecology Canada, 42,* 2, e20-e21. doi: 10.1016/j.jogc.2019.11.038

Essén, B., Bödker, B., Sjöberg, N.O., Gudmundsson, S., Östergren, P.O., & Langhoff-Roos, J. (2002a). Is there an association between female circumcision and perinatal death? *Bulletin of the World Health Organization, 80*, 8, 629–632.

Essén, B., Bödker, B., Sjöberg, N.O., Langhoff-Roos, J., Greisen, G., Gudmundsson, S., & Östergren, P.O. (2002b). Are some perinatal deaths in immigrant groups linked to suboptimal perinatal care services? *International Journal of Obstetrics and Gynaecology, 109*, 6, 677–682.

Essén, B., & Johnsdotter, S. (2006). Nyvunnen kunskap i klinisk praxis: Kultursensitiv specialistmottagning erbjuds inom kvinnosjukvården. [New knowledge in clinical practice: A culture-sensitive clinic available in Women's Health]. *Socialmedicinsk Tidskrift, 3,* 193–199.

Essén, B., & Mosselmans, L. (2020). *How to ensure policies and interventions rely on strong supporting facts to improve women's health: The case of Female Genital Cutting, using Rosling's Factfulness approach*. Unpublished manuscript.

Essén, B., Sjöberg, N.O., Gudmundsson, S., Östergren, P.O., & Lindqvist, P.G. (2005). No association between female circumcision and prolonged labour: a case control study of immigrant women giving birth in Sweden. *European Journal of Obstetrics, Gynecology, and Reproductive Biology, 121*, 2, 182–185.

Gele, A.A., Johansen, E.B., & Sundby, J. (2012). When female circumcision comes to the West: Attitudes toward the practice among Somali Immigrants in Oslo. *BMC Public Health, 12*, 1, 697. doi: doi.org/10.1186/1471-2458-12-697

Grönvall, K. (2020). *Clinical praxis in police investigations concerning suspected illegal female genital mutilation/cutting*. Master's thesis, Faculty of Medicine, Lund University.

Hayes, R.M., & Luther, K. (2018). CSI effect: How media impacts the criminal legal system. In R.M. Hayes, K. Luther (Eds.). *Crime: Social media, crime, and the criminal legal system*, pp. 43–78. Cham: Palgrave Macmillan.

Hodes, D., Ayadi O'Donnell, N., Pall, K., Leoni, M., Lok, W., Debelle, G., Armitage, A.J., Creighton, S.M., & Lynn, R.M. (2020). Epidemiological surveillance study of female genital mutilation in the UK. *Archives of Disease in Childhood,* published online first. doi: 10.1136/archdischild-2020-319569

Hodžić, S. (2013). Ascertaining deadly harms: Aesthetics and politics of global evidence. *Cultural Anthropology, 28*, 1, 86–109.

Isa, A.R., Shuib, R., & Othman, M.S. (1999). The practice of female circumcision among Muslims in Kelantan, Malaysia. *Reproductive Health Matters, 7*, 13, 137–144.

Isman, E., Ekéus, C., & Berggren, V. (2013). Perceptions and experiences of female genital mutilation after immigration to Sweden: An explorative study. *Sexual & Reproductive Healthcare, 4*, 3, 93–98.

Jabour, B. (2015, Nov 13). Australia's first female genital mutilation trial: How a bright young girl convinced a jury. *The Guardian* [Internet]. Retrieved from www.theguardian.com/society/2015/nov/13/female-genital-mutilation-trial-young-girl-convinced-jury-australia

Johansen, R.E.B. (2016). Undoing female genital cutting: Perceptions and experiences of infibulation, defibulation and virginity among Somali and Sudanese migrants in Norway. *Culture, Health & Sexuality, 19*, 4, 528–542.

Johnsdotter, S. (2002). *Created by God: How Somalis in Swedish exile reassess the practice of female circumcision.* Doctoral thesis, Lund, Lund University.

Johnsdotter, S. (2009). *Discrimination of certain ethnical groups? Ethical aspects of implementing FGC legislation in Sweden*. Malmö: Faculty of Health and Society, Malmö University.

Johnsdotter, S. (2018). The impact of migration on attitudes to female genital cutting and experiences of sexual dysfunction among migrant women with FGC. *Current Sexual Health Reports, 10*, 18–24.

Johnsdotter, S. (2019). Meaning well while doing harm: Compulsory genital examinations in Swedish African girls. *Sexual and Reproductive Health Matters, 27*, 2, 87–99.

Johnsdotter, S., & Essén, B. (2016). Cultural change after migration: Circumcision of girls in Western migrant communities. *Best Practice & Research Clinical Obstetrics & Gynaecology, 32*, 15–25.

Johnsdotter, S., & Mestre i Mestre, R.M. (2017). "Female genital mutilation" in Europe: Public discourse versus empirical evidence. *International Journal of Law, Crime and Justice, 51*, 14–23.

Karlsen, S., Carver, N., Mogilnicka, M., & Pantazis, C. (2019). *When safeguarding becomes stigmatising: A report on the impact of FGC-safeguarding procedures on people with a Somali heritage living in Bristol*. Bristol: University of Bristol.

Kiertzner, K. (2017, May 17). CPS investigator says daughter of Detroit doctor, wife had FGC procedure. *WXYZ abc.com Detroit News* [Internet]. Retrieved from www.wxyz.com/news/cps-investigator-says-daughter-of-doctor-wife-had-FGC-procedure

Leonard, L. (2000). "We did it for pleasure only." Hearing alternative tales of female circumcision. *Qualitative Inquiry*, *6*, 2, 212–28.

Mackie, G. (1996). Ending footbinding and infibulation: A convention account. *American Sociological Review, 61*, 6, 999–1017.

Macklin, A. (2006). The double-edged sword: Using the criminal law against female genital mutilation in Canada. In R. Abusharaf (Ed.), *Female circumcision: Multicultural perspectives*, pp. 207–223. Philadelphia: University of Pennsylvania Press.

Merli, C. (2012). Negotiating female genital cutting (sunat) in Southern Thailand. In C. Raghavan, J.P. Levine. (Eds.), *Self-Determination and Women's Rights in Muslim Societies*, pp. 169–190. Waltham: Brandeis University Press.

Mestre i Mestre, R.M., & Johnsdotter, S. (2019). Court cases, cultural expertise, and 'female genital mutilation' in Europe. Special Issue: Cultural Expertise and Socio-Legal Studies. *Studies in Law, Politics, and Society 78*, 95–113.

NCK, Nationellt Centrum för Kvinnofrid [The national centre for knowledge on men's violence against women] (2011). *Kvinnlig omskärelse/könsstympning i Sverige: En kunskaps- och forskningsöversikt* [Female circumcision/genital mutilation in Sweden: An overview of knowledge and research]. Uppsala: Uppsala University.

Newland, L. (2006). Female circumcision: Muslim identities and zero tolerance policies in rural West Java. *Women's Studies International Forum, 29*, 4, 394–404.

Obermeyer, C.M. (2005). The consequences of female circumcision for health and sexuality: An update on the evidence. *Culture, Health & Sexuality, 7*, 5, 443–461.

Obiora, L.A. (1997). Bridges and barricades: Rethinking polemics and intransigence in the campaign against female circumcision. *Case Western Reserve Law Review, 47,* 2, 275–379.

Otto, A.L., Penrod, S.D., & Dexter, H.R. (1994). The biasing impact of pretrial publicity on juror judgments. *Law and Human Behavior, 18*, 4, 453–469.

Palm, C., Essén, B., & Johnsdotter, S. (2019). Sexual health counselling targeting girls and young women with female genital cutting in Sweden: Mind-body dualism affecting social and health care professionals' perspectives. *Sexual and Reproductive Health Matters, 27*, 1, 192–202.

Public Policy Advisory Network on Female Genital Surgeries in Africa (2012). Seven things to know about female genital surgeries in Africa. *The Hastings Center report, 42*, 6, 19–27.

Rodriguez, M. I., Say, L., Abdulcadir, J., & Hindin, M. J. (2017). Clinical indications for cesarean delivery among women living with female genital mutilation. *International Journal of Gynaecology and Obstetrics*, *139*, 1, 21–27.

Rogers, J.B. (2016). The first case addressing female genital mutilation in Australia: Where is the harm? *Alternative Law Journal*, *41*, 4, 235–238.

Rosling, H., Rosling, O., Roennlund A. (2018). *Factfulness: Ten reasons we're wrong about the world – and why things are better than you think.* London: Hodder & Stoughton Ltd.

Shahid, S.K. (2012). Phimosis in children. *ISRN Urology,* Article ID 707329. doi: 10.5402/2012/707329

Shell-Duncan, B., Moreau, A., Wander, K., & Smith, S. (2018). The role of older women in contesting norms associated with female genital mutilation/cutting in Senegambia: A factorial focus group analysis. *PloS One, 13*, 7. doi: 10.1371/journal.pone. 0199217

Stempel, J. (2018, Nov 21) Judge voids U.S. female genital mutilation law. *Reuters* [Internet]. Retrieved from www.reuters.com/article/us-usa-crime-genital-mutilation-idUSKCN1NP2OR

Summers, H., & Ratcliffe, R. (2019, Feb 1). Mother of three-year-old is first person convicted of FGC in UK. *The Guardian* [Internet]. Retrieved from www.theguardian.com/society/2019/feb/01/FGC-mother-of-three-year-old-first-person-convicted-in-uk

The Irish Times (2010, Jan 27). Parents jailed over female genital mutilation of daughter'. *The Irish Times* [Internet]. Retrieved from www.irishtimes.com/news/crime-

and-law/courts/circuit-court/parents-jailed-over-female-genital-mutilation-of-daughter-1.4152765

Thiblin, I., & Michard, J.F. (2014). *Rättsmedicin i teori och praktik: En guide för läkare och jurister* [Forensic medicine in theory and practice: A guide for doctors and lawyers]. Lund: Studentlitteratur.

Wahlberg, A., Johnsdotter, S., Selling, K.E., Källestål, C., & Essén, B. (2017a). Baseline data from a planned RCT on attitudes to female genital cutting after migration: When are interventions justified? *BMJ Open, 7*, 8, e017506. doi: 10.1136/bmjopen-2017-017506

Wahlberg, A., Johnsdotter, S., Ekholm Selling, K., Källestål, C., & Essén, B. (2017b). Factors associated with the support of pricking (female genital cutting type IV) among Somali immigrants – a cross-sectional study in Sweden. *Reproductive Health, 14,* 92. doi: 10.1186/s12978-017-0351-0

Wahlberg, A., Johnsdotter, S., Selling, K.E., & Essén, B. (2019). Shifting perceptions of female genital cutting in a Swedish migration context. *PLoS One, 14*, 12. doi: 10.1371/journal.pone.0225629

WHO study group on female genital mutilation and obstetric outcome, Banks, E., Meirik, O., Farley, T., Akande, O., Bathija, H., & Ali, M. (2006). Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. *Lancet, 367*, 9525, 1835–1841.

World Health Organization (2016). *WHO Guidelines on the Management of Health Complications from Female Genital Mutilation*. [Internet]. Retrieved from: www.who.int/reproductivehealth/topics/fgm/management-health-complications-fgm/en/

World Health Organization (2020). *Female genital mutilation. Fact sheet 3*. [Internet]. Retrieved from www.who.int/news-room/fact-sheets/detail/female-genital-mutilation

WHO Regional Office for Europe (2018). *Improving the health care of pregnant refugee and migrant women and newborn children*. Technical guidance on refugee and migrant health. Copenhagen: WHO. [Internet]. Retrieved from www.euro.who.int/__data/assets/pdf_file/0003/388362/tc-mother-eng.pdf

About the Authors

Dellenborg, Lisen

Lisen Dellenborg is senior lecturer at the Sahlgrenska Academy, University of Gothenburg, and holds a PhD in Social Anthropology. Dellenborg has long-time experience doing ethnographic research in Senegal on female genital cutting and initiation rituals, and in Sweden, where she has specialized in hospital ethnography focusing on inter-professional relations, person-centered care and transcultural healthcare encounters. For many years, Dellenborg has been involved as a teacher in human rights, African studies and transcultural care and communication. She has also specialized in action research.

Her publications include "Transcultural encounters in a medical ward in Sweden: Experiences of health care practitioners" (Dellenborg, Skott, & Jakobsson, 2012) in *Journal of Transcultural Nursing*, "The development of ethnographic drama to support healthcare professionals" (Dellenborg & Lepp, 2018) in *Anthropology in Action*, and *Människan i vården. Etnografi, vård och drama* [People in healthcare: ethnography, care and drama] edited by Skott, Dellenborg, Lepp and Nässén (2013).

Essén, Birgitta

Birgitta Essén is Professor in International Maternal and Reproductive Health at the Department of Women's and Children's Health/IMCH at Uppsala University, Sweden. She is also a Senior Consultant in Obstetrics and Gynecology at the University Hospital of Uppsala, where she runs a clinic especially for circumcised girls and migrant women. For the last twenty years, she has participated in research collaborations with anthropologists, translating social and cultural theoretical aspects of reproductive phenomena and then making results applicable in health care. She has conducted both explorative and clinical studies in relation to FGC, the most recent on maternal near-miss events among cut women in Somaliland and a community-based study on cultural change as regards FGC among Swedish Somalis after migration. Currently she is the PI of a program granted by

the Swedish Research Council: *Migration and equity in sexual and reproductive health: The importance of dynamics in cultural and social values for improving practice through co-production.* She has acted as an expert witness in several court cases of suspected cases of illegal female genital cutting both in Sweden, Denmark, Ireland, and the US.

Her publications include (Palm, Essén, & Johnsdotter, 2019): "Sexual health counselling targeting girls and young women with female genital cutting in Sweden: Mind-body dualism affecting social and health care professionals' perspectives" in *Sexual Reproductive Health Matters*, and (Wahlberg, Johnsdotter, Selling, Källestål, & Essén, 2017): "Baseline data from a planned RCT on attitudes to female genital cutting after migration: when are interventions justified?" in *BMJ Open*.

Gruenbaum, Ellen

Ellen Gruenbaum is Professor Emerita of Anthropology at Purdue University and Visiting Scholar in Anthropology at the University of California, Riverside. Her research since the 1970s has focused on cultural practices related to women's health, particularly controversies and change efforts related to female genital cutting practices in Sudan and other countries. For five years during the 1970s, she taught at University of Khartoum and conducted research. Later she held faculty positions at the University of Wisconsin College in Manitowoc, the California State University in San Bernardino, and served as Dean of the College of Social Sciences at California State University, Fresno. She then served as Head and Professor of the Department of Anthropology at Purdue University from 2008 until 2019, when she returned to California. Gruenbaum has been a research consultant to UNICEF, conducted research in Sudan and Sierra Leone, held a Fulbright Lectureship at the University of Uppsala, Sweden, and a residency at the Rockefeller Center in Bellagio, Italy. She authored *The Female Circumcision Controversy: An Anthropological Perspective* (University of Pennsylvania Press, 2001) and many articles and chapters, including a commentary on "Debating deinfibulation: Why some women resist the WHO advice" (*Archives of Sexual Behavior*, April 2020). She is currently at work on a project entitled "Generation of Change," focusing on the leadership and processes through which people have been rethinking FGC.

Johansen, R. Elise B.

R. Elise B. Johansen has a PhD in Medical Anthropology from the Medical Faculty at the University of Oslo. She is currently a researcher and research leader at the Norwegian Centre for Violence and Traumatic Stress in Oslo. She has more than thirty years of research experience in the field of sexual and reproductive health and rights (SRHR). She has conducted studies in various African countries and among African migrants and locals in Norway. During the last twenty years, she has mainly engaged in research, policy development and interventions concerning Female Genital Mutilation/Cutting (FGM/C), particularly in Somali and Sudanese communities in Norway. Prior to her current position, she was a technical officer for seven years at the World Health Organization. She has also studied initiation rituals among a matrilineal migrant group in Tanzania, ethnicity and cultural policy in the Ivory Coast as well as the use of humor in discourses of sensitive topics such as sexuality among Norwegian youth.

Her publications include (Johansen, 2019) "Blurred transitions of female genital cutting in a Norwegian Somali community" in *PLOS One*, and (Johansen, 2016) "Undoing female genital cutting: Perceptions and experiences of infibulation, defibulation and virginity among Somali and Sudanese migrants in Norway" in *Culture, Health & Sexuality*.

Johnsdotter, Sara

Sara Johnsdotter is Professor in Medical Anthropology at the Faculty of Health and Society, Malmö University, Sweden. In 2002, she defended her doctoral dissertation (Lund University) about how Swedish Somalis have reassessed the practice of circumcision of girls: *Created by God*.

Her research has included various aspects of genital modifications with a special focus on circumcision of girls. Much of the research has been done in collaboration with Prof. Birgitta Essén, obstetrician and gynecologist, at Uppsala University. Johnsdotter has represented Sweden in five EU research projects. In 2014, she was the PI of a study about FGM court cases in Europe, at the request of the European Commission. Co-author of the report was the Spanish philosopher of law Prof. Ruth Mestre i Mestre (*Female genital mutilation in Europe: An analysis of court cases*. Brussels: European Commission, The Directorate-General for Justice, 2015). Currently, she is the PI in a project funded by the Swedish Research Council for

Health, Working Life and Welfare, collaborating with Lotta Wendel, PhD and lawyer: *Societal measures to check for suspected female genital mutilation in Sweden: An analysis of proportionality in the authorities' handling of suspected cases*. Regarding these matters, Johnsdotter recently published (2019) "Meaning well while doing harm: Compulsory genital examinations in Swedish African girls" in the journal *Sexual and Reproductive Health Matters*.

Jokela, Satu

Satu Jokela is a midwife, MHSc (Public Health), and a doctoral student at the University of Tampere (Faculty of Social Sciences). Jokela works as a development manager with expertise in equality and reproductive health at the Finnish Institute for Health and Welfare, Finland.

She has expertise in research and development projects aiming at promoting equality, security, fundamental and human rights, health and wellbeing among migrants, and sexual and reproductive health. Jokela was the first author of the article (Jokela, Lilja, Kinnunen, Gissler, Castaneda, & Koponen, 2018) of "Births and induced abortions among women of Russian, Somali and Kurdish origin, and the general population in Finland—comparison of self-reported and register data" in *BMC Pregnancy and Childbirth*.

Käkelä, Emmaleena

Emmaleena Käkelä, MSc, is a PhD researcher at the School of Social Work and Social Policy, University of Strathclyde, Scotland. Her Economic and Social Research Council-funded doctoral research examines women's vulnerability to FGC and other forms of gender-based violence in the context of changing cultural and structural conditions after migration. Emmaleena's thesis findings particularly address how FGC-affected women's position in relation to colliding European discourses on FGC and forced migration influence women's experiences of and abilities to engage in FGC prevention, protection and support provision. Her wider research interests are in the areas of forced migration and asylum, gendered and racial inequalities and the relationship between gender-based and structural forms of violence and harm. She has previously published her MSc research focusing on tensions in cross-cultural social work as an article titled "Narratives of power and

powerlessness: cultural competence in social work with asylum seekers and refugees" (*European Journal of Social Work, 23*, 3, 425–436). She has also worked on a number of research projects on areas of migration and belonging, gender-based violence in higher education, and historical abuse in care.

Klemetti, Reija

Reija Klemetti has a PhD degree in Epidemiology and is Associate Professor in Public Health. She is a research manager with expertise in sexual and reproductive health at the Finnish Institute for Health and Welfare, Finland. Klemetti is an expert on studies on sexual and reproductive health including FCM/C, infertility and infertility treatments, maternal health and health care, perinatal health, intentions of childbearing, fertility knowledge, and postponement of parenthood as well as child health and wellbeing. She is experienced in both survey and register-based studies. Also, she has experience of international collaboration, for example in studying and developing maternal care in rural China (CHIMACA project) and developing antenatal guidelines (including FGM/C, contraception and breastfeeding) for Somaliland (MIDA FINNSOM project).

Among her publications is (Koukkula, Keskimäki, Koponen, Mölsä, & Klemetti, 2016) "Female genital mutilation/cutting among women of Somali and Kurdish origin in Finland," published in *Birth*.

Koukkula, **Mimmi**

Mimmi Koukkula is midwife, has a MHSc degree in Public Health, and is an FGM/C expert. She has expertise in sexual and reproductive health at the Finnish Institute for Health and Welfare (THL), Finland.

Mimmi Koukkula work at the Unit for Children Adolescents and Families at THL, where she has expertise in sexual and reproductive health and in research on FGM/C. She has also coordinated FGM/C prevention work at the national level in Finland in recent years. Further, she has international experience of a developmental program (MIDA FINNSOM) in training of professionals of antenatal guidelines (including FGM/C) for Somaliland.

She is first author of (Koukkula & Klemetti, 2019) *Action plan for the prevention of female genital mutilation (FGM)*, Publications of the Ministry of Social Affairs and Health 2019:7.

Kuusio, Hannamaria

Hannamaria Kuusio, PhD in Public Health, is research manager at the Finnish Institute for Health and Welfare, Finland, where she is an expert on monitoring migrants' health, wellbeing and service use, as well as equality and inclusion of migrants. She was the first author of the report *Migrants' health and wellbeing: Fin-Monik-research 2018–2019* (Kuusio, Seppänen, Jokela, Somersalo, & Lilja (Eds.), Helsinki: National Institute for Health and Welfare (THL). Report 1/2020).

Lien, Inger-Lise

Inger-Lise Lien is a Research Professor at the Norwegian Center for Violence and Traumatic Stress Studies in Oslo, Norway. She has been researching widely on subjects related to migration such as integration, racism, gang formation, and female genital mutilation/cutting (FGM/C). She has been leading the Norwegian National Function on female genital mutilation for five years and has been writing on several aspects related to FGM/C.

Among her publications on the subject is (2017) "Prosecution of the offence of female genital mutilation/cutting in Norway" in *International Journal of Law, Policy and the Family*. In collaboration with Jon-Håkon Schultz she published "Internalizing knowledge and changing attitudes to female genital cutting/mutilation" (in *Obstetrics and Gynecology International*, 2013), and, in 2014, "Cultural protection against traumatic stress: Traditional support of children exposed to the ritual of female genital cutting" in *International Journal of Women's Health*.

Lilja, Eero

Eero Lilja has a MSc degree in Statistics and is statistical researcher at the Finnish Institute for Health and Welfare, Finland. He specializes in survey methodology and the analysis of complex surveys. Lilja works as a statistician in the field of migrant health statistics, and his expertise concerns sampling methods and survey methodology.

He co-authored the article "Births and induced abortions among women of Russian, Somali and Kurdish origin, and the general population in Finland—comparison of self-reported and register data" (Jokela, Lilja, Kinnunen, Gissler, Castaneda, & Koponen, published in *BMC Pregnancy and Childbirth* in 2018.

Malmström, Maria Frederika

Maria Frederika Malmström is Associate Professor at the Center for Middle Eastern Studies, Lund University, where she, in January 2017, started the collaborative research project *The materiality of suspicion and the ambiguity of the familiar: Nigerian and Egyptian cityscapes* together with Professor Mark LeVine, and Assistant Professors Ulrika Trovalla and Eric Trovalla. This five-year project is funded by the research council FORMAS. In January 2018, she started the research project *Making and unmaking masculinities and religious identities through the politics of the ear* in Egypt. This three-year research project is funded by the foundation RJ. She is currently Visiting Research Scholar in the Middle East and Middle Eastern American Center, Graduate Center, CUNY, New York City. Malmström is author of *The Streets Are Talking to Me: Affective Fragments in Sisi's Egypt* (2019).

Skogberg, Natalia

Natalia Skogberg has a PhD in Public Health. She is a research manager at the Finnish Institute for Health and Welfare, Finland. She is an expert on migrant health monitoring, noncommunicable diseases, equality and inclusion, and health promotion and works with research and development projects aimed at promoting equality, inclusion, health and wellbeing among migrants.

She was the first author of the report *Asylum seekers health and wellbeing. A survey among newly arrived asylum seekers to Finland in 2018* (Skogberg, Mustonen, Koponen, Tiittala, Lilja, Ahmed Haji Omar, Snellman, Castaneda. Helsinki: National Institute for Health and Welfare).

Väkiparta, Maria

Maria Väkiparta has a PhD in Gender Studies from University of Helsinki, Faculty of Arts. She defended her doctoral dissertation *Young men against female genital mutilation/cutting in Somaliland: Discursively negotiating violence, gender norms and gender order* in December 2019. She works as Advisor on Gender Equality at the International Solidarity Foundation, a Finnish non-governmental organization, which supports work in collaboration with local civil society organizations in Eastern Africa, including Somaliland. She focuses on planning, supporting, and monitoring projects that aim to eradicate FGM/C and other forms of harmful practices and violence against women and girls.

"It is the task of scholars working on the topic of female genital cutting not only to provide perspectives to reduce ethnocentrism, but also to offer ideas for generating acceptable changes for immigrants and their new countries, informed by reasonable approaches that do not rely on inflamed rhetoric or distorted science. The work of scholars, such as those writing in this volume, is essential to engaging in a more just and thoughtful future, where human cultural behaviors can change in positive directions that ameliorate the conditions of the lives of women and girls without unjust condemnations of different ways of living."

These words are from the keynote lecture at the 9th FOKO conference in Sweden, *Female Genital Cutting: The Global North & South*, which appears as a chapter in this anthology. This keynote was delivered by Professor Ellen Gruenbaum, an American anthropologist who has done research on this subject for more than four decades. The other chapters build on research papers presented at the conference, covering studies done in countries where circumcision of girls is widely practiced as well as those from European countries which host migrant communities that are affected by these practices. The collection covers a wide range of the issues that currently demand attention among Nordic researchers in the field of female genital cutting.

MALMÖ UNIVERSITY
CENTRE FOR SEXOLOGY AND SEXUALITY STUDIES