Experiences and perceptions of pain, sexuality and childbirth

A study of Female Genital Cutting among Somalis in Norwegian Exile, and their health care providers

By

R. Elise B. Johansen

Section for Medical Anthropology, Institute of General Practice and Medicine, Faculty of Medicine, University of Oslo

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Abstract

Background

With the large influx of Somalis into Norway since around 1990, following civil war and chaos in their home country, Female Genital Cutting (FGC) also became a problem in Norway. At first it was basically seen as a health care problem related to assisting infibulated women in delivery that is associated with medical, ethical and legal aspects. In spite of a specific law passed against the practice in 1995, many health workers remained insecure about how to handle it in practice. Another concern was how the affected women themselves felt about the moral and legal condemnation of a practice that had been 'carved into' their bodies.

Aim

The purpose of this study was to gain insight into at least three arenas. Firstly how women and men from societies practicing FGC experienced and considered the practice while living in Norwegian exile; secondly how infibulated women experienced health care, particularly during pregnancy and delivery, and thirdly the quality of the reproductive health care provided for infibulated women. An overall aim was that the knowledge gained could be used to the benefit of women affected by FGC.

Materials and methods

It was a three years study (1997-2001), complemented by 4 years of work in the Norwegian national project to combat FGC (2001-2005). Fieldwork was mainly done in and around Oslo, the capital of Norway, as this was where more than half of the Somali population in Norway lived. The study was based on the use of qualitative methods, focusing on repeated in-depth interviews and participant observation and a multi-cited approach. Some studies of registers and of medical records were also conducted.

Data-collection was executed in two different study populations: the Somali community and the reproductive health service providers: Within the Somali community repeated in-depth interviews were carried out with about 45 women and 25 men. Many of these were followed over several years. Informants for formal

interviews were recruited by the snowball method, with various starting points. This included national organizations and informal networks, and a few were also recruited through the health sector for case findings. Participant observation included organizational work, seminars, parties and celebrations, home visits, holiday camps, and travels.

Within the reproductive health sector about 36 health workers, mainly midwives and gynecologists, were interviewed. These were mainly recruited through their working places, including three maternity wards and three mother and child clinics. Participant observation was done on a maternity ward and in a mother and child clinic. In addition information has been drawn from numerous other settings, including seminars, meetings, spontaneous group discussions and informal conversations.

Main findings

The main finding in the Somali community was a pre-occupation with three major aspects of how the practice was experienced: pain, sexuality and birth. All these concerns were formulated in a discourse on change, that is, the vast majority felt that it would be better to abandon FGC.

Pain: Women described their circumcision as overwhelmingly painful, in a way that affected them for life, both physically and mentally. The experience had led most women to question the tradition itself and its cultural legitimacy, at least at the time. Life in exile often seemed to reactivate the pain and revitalize doubts about the meaning and value of the practice. Hence the pain was a central driving force in women's desire for change.

Sexuality: Women and men were both concerned about the way FGC affected women's sexual drives and pleasures. They shared a sense of ambivalence between a continued emphasis on premarital virginity that was intimately linked with infibulation on the one hand, and an increasingly positive evaluation of female sexual enjoyment on the other. There was an increasing questioning of whether FGC was necessary to form an acceptable womanhood, and a growing concern that it may reduce women's sexual drive and pleasure. Thus there seemed to be a change in the perception of sexual lust from mainly being seen as a dangerous potential for

immorality and unfeminine behavior to increasingly being seen as a positive experience and force, both for the women themselves and for increased equity in the marital relationship, which was again linked to its stability.

Birth experience: Somali women often experienced deliveries as painful, lonely and frightening. The re-traumatization of their original infibulation, the fear of lack of knowledge among health workers and the fear of stigmatization all contributed to increased vulnerability during delivery.

Within the reproductive health sector, insecurity and a sense of discomfort in dealing with the issue prevailed. Many health workers experienced encounters with Somali women as emotionally, morally and legally challenging. In spite of their intention to offer good medical and culturally sensitive care, lack of knowledge and misconceptions often led to insecurity, avoidance and even care procedures that were neither in line with medical guidelines nor in line with the needs and desires of Somali women. Processes of stigmatization and culturalization have been analyzed as significant reasons for the misconceptions.

There were fundamental discrepancies between what Somali women wanted and expected, and what health workers assumed they wanted. My hypothesis is that the misconceptions following from this, may at times lead to sub-optimal care which may again explain part of the increased risk of birth problems among Somali women.

Attitudes: Most Somalis were ambivalent towards the practice and were in the process of reconsidering it. This reconsideration seemed to be inspired by life in exile, which increased the distance from the social pressure supporting the practice at home, and encounters with other groups that do not practice FGC in exile. People emphasized an experience of ambivalence between a wish to avoid the pain and dangers of the practice on the one hand, and a social pressure to keep up a tradition closely related to female morality and Somali identity on the other hand. A push towards a continuation of the practice was linked with a dream of returning to the home country, in which FGC is still close to universal and seen as a prerequisite for marriageability. Most people considered that the best available “solution” was either to refrain from genital cutting, at least unless returning home, or to resort to what they considered a milder form of FGC, so-called *sunna*. Most Somalis defined only

infibulation as circumcision, while excision/*sunna* was generally not seen as a type of FGC, but something else.

List of papers

Paper I

Johansen, R. Elise B. 2002

“Pain as a Counterpoint to Culture: Towards an Analysis of Pain Associated with Infibulation among Somali immigrants in Norway”.

Medical Anthropology Quarterly 2002; 16(3): 312-340

Paper II

Johansen, R. Elise B. (in press)

”Experiencing sex in exile – can genitals change their gender?”

A short version has been accepted for publication by Hernlund & Shell-Duncan (eds.) *Transcultural Bodies: Female Genital Cutting in Global Context*. Rutgers.

Paper III

R. Elise B. Johansen 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, 29(4): 516-544

Paper IV

Vangen, Siri; Johansen R. Elise B.; Træen, B. ; Sundby, J.; Stray-Pedersen, B. ; 2004

"Qualitative study of perinatal care experiences among Somali women and local health care professionals in Norway”.

Eur J. Obstet Gynecol Reprod Reprod Biol; 2004; 112, pp. 29-35

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Numerous people and institutions have contributed in one way or another through the process of research. The greatest thanks have to go to all the people involved - most of them women – whom I for reasons of anonymity cannot name. Without their enormous generosity, interest and openness, this study would not have been possible. They also deserve a major part of the credit for why I have experienced the study as such an enriching adventure, deeply moving, extremely interesting and frequently great fun.

My first entries into the circles of Somali women and men were through an NGO working at a local support center for immigrants (PMV). They generously allowed me to participate in their Somali-run activities and networks, which included discussion groups on women's health, FGC and religion. This gave my fieldwork a flying start. Thank you!

One of the women whom I can name is Barlin Ali Farah. We first met at PMV, and after four years she joined me as a colleague on the OK Project. Thank you for always being willing and open to discuss and ponder about almost any topic, at almost any time. Particularly I want to thank you for your contribution in making our rather strenuous study tour to Somali areas both very informative and a pleasant memory. I also want to thank Suad Farah, Asha Barre, Ahsan Hersi, Khalgacal Hassan, Sara Khasai, and many others for similar inspiring co-operation and discussion.

The idea, money, office and support of various kinds were also a prerequisite for the study. The study was financed by a three-year PhD scholarship from Norwegian Research Council (NFR). In addition the Ministry of Social Affairs financed a three-month pilot-study. Financial support was also granted by the Section of Medical Anthropology and my last place of work, the National Center of Competency for Minority Health (NAKMI). Thank you!

I want to thank my supervisor through all these years; Professor Johanne Sundby, who was the one who had the original idea of a study. You have been a great support, uniquely and generously sharing information, and contacts. The Section for Medical Anthropology headed by Benedicte Ingstad, at the University of Oslo, Faculty of Medicine, provided me with an office, and admitted me into their doctoral program. They have shown generous flexibility: first paying for my one-and a

half year long maternity leave in the middle of the study period, then allowing me to spend five months in Tanzania during the writing process, then in 2001 allowing me to leave the program just four months prior to its conclusion to take up the job at the OK project, and finally by receiving me back into the Institute again and releasing money for 2½ months to wind up my dissertation in 2005. I am also deeply indebted to the Institute of Social Anthropology, who admitted me to participate in PhD training courses, though I was enrolled in another faculty.

I would like to thank the Swedish School in Dar-es-Salaam, Tanzania, which generously allowed me to use their library as my study for five months during the winter 2001. Undisturbed by mails, telephones and meetings, this became my most productive period, during which all the papers found their basic form. I am also grateful for the opportunities offered through my work in the OK project, including study tours to Somali areas in Kenya, Somalia, Ethiopia, and Djibouti. A special thank to The Norwegian Church Aid and Norwegian Peoples Aid who helped my colleague and me around. In Somaliland a special thank to Edna Adan Ismail, now Minister of Foreign Affairs, who invited us to stay in her hospital.

Finding a much-needed anthropological co-supervisor was not easy. As a result, I ended up with a series of co-supervisors. I first requested Professor Aud Talle at the Institute of Social Anthropology who has done extensive work on FGC, also among Somalis both at home and in exile. Though she was not able to take on this role, she has read earlier versions of some of the papers in her role as a professor on some of the PhD courses I attended. Then, for a short period, postdoctoral student Sidsel Roalkvam took on the role. However, due to an uncooperative e-mail system we lost track with each other when she moved out of the country. During the last part of the writing process, Tordis Borchgrevink, at the Institute of Social Research, took up the baton, and has stayed with me to the end. Her insistence on reading my material to check out not only my scientific abilities but also my ethical approach prior to accepting the role as a co-supervisor, was refreshing. As a specialist in gender and immigration studies with significant theoretical knowledge as well as ethical concerns, her comments and contributions to our discussions have been of tremendous support and inspiration.

The introductory chapters have also been commented also by other people: philosopher Harald Grimen commented on my first attempt to formulate the introductory chapters, which anthropologist Ingrid Rudie also did at a later stage, and

Anne Leseth in the final spurt. Thank you for insightful comments and suggestions. Anne Leseth was also the one who informed me of the possibility of doing a study on FGC in the first place. In addition I have asked colleagues to read and comment on particular parts of the introduction; Jan Haakonsen (on clans and Somali history), Tord Larsen and Finn Sivert Nielsen (on ethical perspectives). I would also like to thank those who contributed in one way or another to each of the Papers.

Paper I: on pain

I must thank Professor Jorunn Solheim in particular for her insightful reading and comments. Her inspiring support contributed significantly to the quality of the analysis. Particularly, she gave me the courage to elevate the idea of pain as counterpoint to the culture, from a timid hypothesis at the end, to a major argument. I have benefited from comments and advice from readers of various versions of the paper from; Professor Thomas Chordas, Ronald Frankenberg, Benedicte Ingstad and Axel Sommerfelt, as well as fellow students at the Section of Medical Anthropology, and at the Institute of Social Anthropology. In addition editors and anonymous revisers in Medical Anthropology Quarterly provided insightful comments and suggestions.

Paper II: on sexuality

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Papers III and IV: on birth and birth care

I particularly want to thank Dr. Siri Vangen who responded so positively to my desperate yearning for statistical evidence on birth complications among Somalis. As no such statistics existed, she decided to include Somalis in her ongoing research on birth outcome among immigrants. Her research results, and our subsequent co-operation, have greatly improved the quality of the study. She also taught me how to read medical records and with Johanne Sundby provided valuable guides into the field of medicine in general, and reproductive health in special. Several health

workers with whom I discussed the findings also helped to throw additional light on their challenges. Especially I want to thank two midwifes who read and commented on Paper III: Synne Holan and Kirsten Liland.

For all the papers

I want to thank the vast group of researchers who have joined the Nordic Network of Research on FGC (FOKO), which I initiated along with Johanne Sundby in 2001. The idea of establishing this network grew out of a desperate need to talk scientifically about FGC with other people working on the same topic. This group provided me with a creative academic breathing space, free from the intense politization that tends to polarize and simplify discussions on the issue. Thanks to you all for enlightening papers, discussions, exchange of ideas both during our three workshops and informally through e-mail, phone and informal gatherings. All the papers in this volume have first been presented in some form or another in this forum. In addition to members already mentioned, I will direct special thanks to Lars Almroth, Vanja Berggren, Maria Malmstrøm, Nahid Toubia and Berit Thorbjørnsrud for inspiring discussions and sharing of knowledge.

My involvement in the OK project also brought me into innumerable discussions with colleagues and partners who have contributed to my knowledge. Thank you Chava E. Savosnick. Thanks also to the interpreters Guled Osman and Fatima Mader for inspiring discussions on terminology and translation. And to Ali Osman Egeh, for the first guided tour to Somali cafees in Oslo. And all the others who have contributed and helped in so many ways.

Writing in English has been another challenge, in which publishers and editors have provided valuable assistance. Librarian Nancy Frank at the Ethnographic museum in Oslo has proof-read two of the papers, and Elizabeth Sætre the two others, in addition to the introductory chapters. And thanks to Siv Lakou for advice on headings.

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Nevertheless, this thesis and the findings and opinions that are presented in it are my full responsibility. I know I divert at times from the opinions and experiences of many of the fruitful partners of discussions thanked above. But it is only through controversies, discourses and challenges, our understanding and management of any one issue, and particularly such controversial issues as FGC, can move forward.

Preface

My entry into the field of FGC was similar to that of many fellow anthropologists, through a general interest in women's life, particularly in relation to gender, sexuality and reproductive health. However, my work up till then (1996) had not been on the Somali or any other group practicing FGC. Rather than focusing on what I saw as harmful practices affecting women and children, I had wanted to focus on rituals that I believed to be empowering for women. As a result I had carried out research on female initiation rituals among a matrilineal group, in which women had a strong say, and where female sexual pleasure and fertility were positively evaluated (Johansen 1995, 1996 & 2000).

However, the growing migration of genitally cut women into my country aroused my interest. In 1996, a friend told me of a lecturer that had called for an anthropological study of FGC, with a focus on reproductive health care for infibulated women in Norway. I went to talk to Professor Johanne Sundby, who had made the request. She volunteered to be my supervisor and project leader, and arranged my affiliation as a PhD student to the Section for Medical Anthropology, Faculty of Medicine. Then, from the summer of 1997 until late 2005, I have worked with the issue of FGC, only interrupted by maternity leave for 1½ years when I gave birth to twin girls in 1998.

The study has introduced me to an empirical field that has been deeply moving, stimulating and at times painful. It has been a journey into the heart of lived life, to the compelling concerns of pain, sex and childbirth. All of these were strong personal experiences that automatically created resonance (Wikan 1992). I will illustrate this with the description of some of the situations that affected me in particular.

I vividly recall my first encounter with Jamila. We had agreed to meet discreetly in a hamburger-bar in a large shopping center. After an introductory exchange of greetings and my project presentation, she leant forward, fixed her eyes on mine, and started to tell her history - of how her initially painful sexual life had been transformed into a positive one after she had re-opened her originally infibulated vagina *(defibulation)*. Her story was deeply personal, extremely open and strongly moving. Her story also helped to confirm that I was on the right track in discerning the patterns of meaning. I also remember the sense of revelation I felt

when a group of Somali women played the game called *karbash*, in which the identification and punishment of a "thief" is the main content (presented in Paper I), and "truth or lie" giving insight into Somali discourses on sexual experiences and perceptions (in Paper II). Their choice of the two games was almost like a dejà-vu, as if they knew the results of my study, which up to then I had shared with no-one.

Fieldwork also took me into many emotional situations, with intense bodily sensations. Participant observation in a birth clinic was challenging. Not mainly to get past hospital routines and bureaucracy, but maybe more my own emotions and fear of experiencing childbirth with a bad outcome. Although I was lucky not to encounter such a situation, the fear was always there. My sensation of childbirth as a major wonder in life made me cry at the conclusion of every birth I attended. I tried to hide it from the mother though, fearing that she could misinterpret it as a sign that something was wrong with the child. I also vividly remember how the cloying smell of the amniotic fluid seemed to stick in my nose and body for several days after leaving the clinic. And I can recapture my bodily sensation upon looking at a newborn little girl, whose body was all stiff and thin due to lack of water in the womb. Only her eye movement revealed that she was alive.

When entering this study, I had a plan to give something back to the Somali community. Not only as knowledge, but in the form of improved medical care, understanding and respect from the Norwegian majority, as well as a contribution to the know-how on how best to work towards an abolition of FGC. Because, though I knew FGC was culturally meaningful, the women's stories also told me that it was a painful experience they would preferably be without. I felt I got this chance through my involvement in the OK Project. Here I could work in companionship with Somali women for a common goal, rather than only asking questions to achieve my academic degree.

Chapter 1

ENTERING THE FIELD

Female Genital Cutting (FGC) is a collective name for a number of traditional, surgical procedures in women's, or girls' genitalia, done to literally carve their bodies to fit the local cultural images of womanhood. It is practiced in several countries, its core areas constituting a belt across Sahel-Africa.

For the time being I will roughly distinguish between two major categories of FGC: *Excision* which comprises procedures that cut all or part of the clitoris and labia minora and *Infibulation*, which in addition creates an adhesion between the vaginal lips, so that it forms a seal of skin covering most of the vulva, with only a tiny orifice for the passage of urine and menstruation. Infibulation alters the female genitalia so extensively that new surgical procedures are necessary at later stages in life, particularly at marriage and childbirth. Among the Somalis infibulation is close to a universal practice (Worldbank & UNFPA 2004).

Since the civil war in Somalia, thousands have fled the country to seek refuge in the west. As a result Norway has experienced a vast influx of Somalis, rising from about a hundred around 1990 to more than 7,000 in 2001. By the time the last words in this dissertation were written in late 2005, their numbers had exceeded 17,000. As a result they are by far the most numerous immigrant group in Norway practicing FGC.[1]

In an effort to deal with the issue, the Norwegian government passed a law against Female Genital Mutilation (FGM) in 1995.[2] Evidently, however, a law can only solve some of the problems FGC can cause in the encounter between Somali immigrants and the Norwegian society. The Somali migration to Norway has forced both the affected women and their host communities to deal with what emerges as fundamentally diverging perceptions of the female body.

Due to their migration, Somali women have moved away from a society where FGC is the cultural norm to live in a country in which the practice that has been carved into their body is seen as abhorrent and immoral. This has given rise to the fear that legal and moral condemnation could promote further stigmatization of an already vulnerable immigrant group, and consequently place an additional burden on affected communities. In the host society, the most affected group are the maternity health care providers, as they have to deal directly with the infibulation itself when caring for Somali women during pregnancy and birth. For them the law raised as many medical, legal and ethical questions as it solved. A major dilemma was experienced between legal regulations forbidding FGC and directives to respect individual wishes and cultural and bodily integrity.

The intention of this study was to investigate some central aspects of this encounter between the Somali community and their medical caregivers in the host community. To achieve this, the research was designed to include fieldwork both in the Somali community and among maternal health care providers.

Problem formulation and reformulation

In this section I will describe my plans and expectations as they were formulated in my research proposal, and how these were adjusted to fit the evolving data material. This is to highlight the way in which the study evolved in a dynamic interplay between empirical findings, ethical concerns and methodological and analytical tools. This will also enhance the transparency of my analysis, and hence increase the possibility of critical reading and hopefully stimulate future studies.

When formulating research questions significant for the Somali community, my original approach was to get an insight into Somali reactions to their situation as

immigrants where infibulation had been transformed from a symbol of status to a social stigma. I was curious as to whether Somali ideals of femininity, body, beauty and identity were affected by their encounter with Norwegian perceptions.

My original focus within the health care sector concerned whether and how these diverging ideals of femininity could affect health care provided to circumcised women. I was particularly concerned with whether ignorance or stigmatization from the health care providers constituted an extra burden on the self-esteem and self-respect of Somali women. Hence I wanted to investigate how infibulated women experienced health care during pregnancy and delivery, as well as the knowledge and attitude among the health care providers.

The original research plan also included a component of action research and implementation of knowledge into health care. A major motivator for this component was an ethical concern that if I was to study such a sensitive topic, then I was obliged to give something useful back to the community. Due to pressure of time and lack of official support, this ambition had to be disregarded as a part of my PhD study. However my later work in the OK project, offered an opportunity to fulfill this obligation.

Although these ideas influenced the research plan, the study was designed in an open and flexible way so that I would be able to adjust to the concerns of my informants.

Study population

The original plan was to focus on the Somali population in Norway both because of their large number and because of the high prevalence of infibulation, which was the type of FGC that was mainly experienced as a health care problem. But, the study included informants from many other African countries as well. This was required by the *Regional Committee for Medical Research Ethics*, because they feared that a focus on Somalis alone could increase the risk of stigmatization of this group. In the end, though, the non-Somali data had to be withdrawn from the analysis, as it became clear to me that I could not pay due respect to their socio-cultural and historical diversities of a wide variety of ethnic groups. The dissertation is therefore based on the Somali material only.

Thematic reorientation

My initial concern that Somali women's self-perception might be affected by a sense of stigmatization and discrimination by the Norwegian society was not found to be a major issue for Somali women. On the contrary, they generally seemed relatively unconcerned or ignorant about how ordinary Norwegians saw them and the practice of FGC. Still, processes of stigmatization often featured as an underlying element in their exile situation, affecting their lives in both direct and indirect ways. Therefore this perspective constitutes part of the background in all the papers. Also, it was an issue of concern in encounters with health workers, and appeared to be an important aspect of the challenge health care providers experienced when caring for Somali women in childbirth.

The main concerns of Somali women were centered on bodily sensations of the practice: the pain of the circumcision itself and its effects on sexuality and on childbirth. These empirical findings were so distinctive that I felt compelled to use them as the organizing principle for the papers. Hence I have dedicated one paper to each of their main concerns. I have also placed them in the order of significance indicated by the women, which is also their general chronological order of occurrence.

On pain

Somali women's experience of pain in relation to FGC which is the focus of Paper I, was not included in my original research plans. I did not intend to ask Somali women about how they had experienced their circumcision. Partly, I feared that such questions could cause re-traumatization, or that I would trouble people with uncomfortable thoughts. Partly, I did not expect the pain of circumcision to be significant to women's experiences in exile. As most women would have been circumcised years prior to their arrival in Norway, I also expected the pain of infibulation to be long forgotten. I was wrong. Women wanted to talk about their original cutting. And in their stories, experiences of extreme pain were put to the forefront. I also saw that the experience of pain was a significant aspect of women's yearning for change, and that a focus on pain could therefore prove useful in contributing to this.

Following up the topic, I grew increasingly concerned with why anthropological literature on FGC had paid so little attention to the experience of pain that seemed so significant to my informants. Moreover, fellow anthropologists, such as reviewers and colleagues, often expressed doubts about my findings.[3] Many wondered whether the pain I found was not merely a reflection of what my eyes saw as an external westerner, projecting my presumed horror at the practice on to my informants (for a similar view, see Parker 1995). Another cause of doubt was the possibility that the informants told me these stories to satisfy what they expected to be *my* prejudices. Others again suggested that it was only their life in exile, which had made Somali women reconsider the experience of pain in an adjustment to western reactions.

Though I always find it important to be cautious about any predispositions on the part of the ethnographer, I really do feel that the stories women told me represented their experience of the practice. Their stories were too numerous and too emotional for any of these doubts to undermine their validity. It also correlated with findings from other researchers (Boddy 1998; Gruenbaum 2001; Chalmers & Hashi 2000; Talle 2001, 2003). Nor do I believe their experiences were formulated mainly to "give the researcher what she is looking for". I do however suggest that life in exile may both revitalize and strengthen the experience of pain (Johansen forthcoming b, Tiilikainen 2003; Talle 2003, forthcoming a, b). Still, this is no reason to undermine the validity of their experiences. Firstly, because women still living in Somalia told of similar experiences and perceptions. Secondly, because even if their experiences of pain were intensified in exile, this was the situation of my informants. Knowing that about two out of a total of around seven million Somalis live outside their area of origin, exile experiences affect also a considerable proportion of Somali women (Talle 2003).

I also find this tendency to disbelieve the authenticity of immigrant women questionable in itself. The view that immigrant women are in such a weak position that they immediately absorb their own stigmatization strongly contrasts with my impression of Somali women. Though forced to relate to the society in which they live and in which stigmatization and moral and legal condemnation of FGC are a basic trait, Somali women did not appear to me to be "products of culture", or subordinate head-nodders either to traditional Somali cultural norms or to Norwegian or western prejudices. Instead, they appeared to have a strong will and a reflective approach to

life, actively negotiating and reconsidering their personal experiences in relation to a complex set of knowledge and beliefs of both the home and the host culture.

Furthermore, as discussed in Paper I, numerous medical studies, my medical advisors' and my own personal experience have assured me that cutting tissue without pain relief or anesthesia is immeasurably painful, regardless of how motivated and intentional the procedure is. That is why doctors are never supposed to perform such procedures as a part of a medical practice without pain relief, also during the time of healing.

My impression is that some of the disbelief about pain is caused by a difficulty to comprehend the intrusive physical character of infibulation and to fully comprehend that such a procedure is culturally condoned (See also Boddy 1998). One example was when a Somali co-worker and I were interviewed by a journalist for a midwifery journal. The journalist revealed (in a whisper to me) that she had left out of her manuscript the fact that infibulated women had to be reopened to be able to have sexual intercourse, as she believed that what she had read about such practices was an untrue exaggeration. And I have observed how the audiences in lectures on FGC often tie up their legs, grimace and show signs of pain. Fellow scientists who have read my papers have told me about similar reactions, about feeling pain while reading, and at times having to skip certain passages.

My solution has been to present data that is true to the ways in which Somali women told me about their pain experiences, while trying to limit it to what readers find emotionally manageable and believable. Another consideration has been to avoid stories that could enhance stigmatization of the Somalis. Consequently, I have only included cases that represent widely shared experiences.

On sexuality

My Somali informants' experiences and considerations of the relationship between sexuality and FGC, which is the focus of Paper II, was neither a part of my original plans. On the contrary, I expected sexuality to be too sensitive and personal, also because of the exile and minority situation in which my informants found themselves. There again, I was mistaken. Both women and men talked about sex, asked about sex, sang about sex and played, joked and danced around sex. Sexuality proved to be the second topic in order of importance to Somali women, and the first in line for Somali men. So I followed up the theme.

In the process I discovered how little I knew about “European” or “Norwegian” sexuality. Hence I had to investigate this issue as well, reading literature on adult and child, male and female sexuality, i.e. sexology. And I started troubling friends and colleges on the same issue. I found Somali informants in many ways to be more open than my Norwegian acquaintances, an observation my Somali informants found highly amusing.

Still, sexuality was a highly sensitive subject. Somali women appeared to find it challenging to relate to the public emphasis that was put on female sexual pleasure in Norway and to the widespread belief, both among Norwegians and themselves, that FGC significantly reduces female sexual pleasure. Not to be, or believed to be, sexually satisfied can be experienced as a social disgrace in Norway.

Thus, in understanding the sexuality of Somali women, the Norwegian context was important. One aspect of this was a strange complexity in Norwegian attitudes to sexuality, which entailed both different expectations and norms attributed to Norwegians and Somalis, as well as contradictory perceptions of the Somalis themselves. Somalis were simultaneously perceived as sexually deprived and oppressed by their infibulation, and as representatives of a free and wild sexuality that is associated with western perceptions of Africans as the “noble savage”.

The focus on sexuality was an inspiration to methodological creativity. I have used methods I never learned about during my anthropological training, such as: producing genital models of play dough and cloth together with informants and using photographs and plastic models of female and male genitalia as a point of reference during discussions. This did not only help to clarify whether or not we were talking about the same body part; it also gave rise to significant discussions of both a humorous and a serious nature.

As in the studies of pain, I found a striking contrast between my informants’ emphasis on sexuality as an important aspect of FGC and anthropological tendencies to de-emphasize the subject. My search for possible underlying reasons for this discrepancy led me to the tendency of anthropologists to take on the role of protagonist of minority cultures, in which the dismissal of sexuality may have been seen as a way to counteract the polarized view of sexuality in Africa as “primitive”, whether by brutal oppression or by being unconstrained and free.

On birth care

The part of the study focusing on birthcare, which is the focus in Paper III and IV, very much went as planned. As mentioned above, the challenges to birth care brought about by infibulation, were the main reason why policymakers and caregivers in Norway wanted to initiate and fund a study on FGC.

The health care providers' general view was that the problems with Somali deliveries were caused by "their culture". Their major concern was to understand Somali resistance against c-sections. Also many health workers felt that the legal prohibition of "reconstruction" of the FGC that is; to close the infibulation again - *reinfibulation* - was in conflict with their responsibility to respond to the wishes of adult women. In addition there was a general insecurity in dealing with affected women. Health workers therefore wanted to gain knowledge that could improve their understanding of "the other". This, they hoped, would make them better equipped to provide culture-sensitive care, and also be in a better position to convince women of necessary infringements, such as defibulation and c-section.

In contrast, health care providers rarely reflected on the procedures of their own treatment, or the cultural bias of medical know-how. Understood as "evidence-based" scientifically developed procedures, they did not consider them to be of interest for the study. That is probably why the health workers I interviewed saw the interviews as attempts to increase my understanding of Somali women rather than seeing the significance of their own perceptions. When later presented with results that questioned many of their presumptions about Somali women, their surprise often led to new reflections and discussions. This made it increasingly clear that the roles and attitudes of the health workers were significant to understand the often uncomfortable experiences of healthcare encounters. It could possible also throw light on the increase risks in child-birth for Somali women in Norway (Vangen et al 2002). Consequently I focused most attention on the perceptions of the health care providers, in contrast to reflections of the concerns of Somali women.

Theoretical reorientation

The empirical data, and particularly the ways in which my informants answered my questions, also contributed to a theoretical reorientation. When asked about the cultural meanings of the practice, women preferred to tell me deeply personal stories

of their own experiences. This tendency was also striking in conversations with men. Even men whom I had searched out specifically in order to hear their opinions and concerns in relation to their public role, always gave me personal answers. One example was when I interviewed a religious leader on what he considered to be the Muslim stand on FGC, and the approach taken by the Mosque in which he worked. He could only answer in relation to personal experience, he said, that is the circumcision of his sisters and the difficult defibulation of his wife. He claimed that FGC was a private concern, and not an issue for religious regulation. And in these stories, Somali women and men often contrasted their personal experiences against their ideas about "Somali culture".

Consequently, my initial focus on Somalis' experiences of stigmatization and its consequences for their gendered cultural identity, was gradually replaced by a growing interest in personal and bodily experiences of the practice. To better grasp the dynamic relationship between personal experience and a multitude of cultural models that was apparent in the Somali stories, I employed Shore's theories on cultural models and personal experiences (1996 & 1998). He defines cultural models as culturally accepted ways of seeing, experiencing, interpreting and expressing personal experiences that to some extent are shared within a community. However, he also emphasizes that; "Important as culture is for humans, our experiences are never exhaustively accounted for by a cultural analysis (...) Not all experience is culturally modeled to the same degree" (1996: 46). His approach then highlights the importance to focus on the relationship between "the cultural" and the "personal", between culture-in-the-world and culture-in-the-mind, and between public and private. His approach offers tools to better grasp culture as dynamic, lived, and ever-changing, as will be discussed later (chapter 4).

Responding to the women's main perception of FGC as a bodily experience, I also had to change focus, from anthropological approaches to the body as symbolic and "good to think with", towards the "new" anthropological attention to embodiment (Shore 1996; Chordas 1990, 1994). This change of focus benefited particularly from theories developed in the field of medical anthropology, as discussed in chapter 4 and in Paper I and II.

Theories of stigmatization, particularly as developed by Goffman (1984), was useful both to grasp the situations in which the Somalis in exile live, and more importantly to disentangle the apparent contradiction between the well-intended and

knowledgeable Norwegian health workers, and their tendency to misunderstand and provide care procedures that were neither culturally nor medically appropriate, as discussed in Paper III.

Ethical and methodological re-orientation

Writing about FGC forces the researcher to constantly grapple with a whole range of ethical questions, which affect everything from the choice of terminology, the selection of informants and research questions, and to the focus in analysis and writing. Having been vigorously warned in advance of the difficulty of pursuing a study of FGC in general and in Norway in particular, I was relieved to find the fieldwork surprisingly easy going. Both women and men were generally much more open and flexible than expected. In fact, there was probably more shyness and reluctance on my part than on theirs. Thus the major ethical and methodological challenge was not to get people to talk.

More challenging was my efforts to find a position within the scientific debates. My original focus on identity and social stigmatization seems to have been inspired by the traditional anthropological focus on "vulnerable groups" and their struggle for self-identity and respect within a larger social world. In such situations, anthropologists have often taken on the role of "spokesman" for the "natives", immigrants or other minority groups. As discussed later, many anthropologists have defined their role as to present an *emic* understanding of FGC, that is; how it is understood from "the local point of view". Not only because this is what anthropologists are trained to do, but also to counteract the overwhelming negative presentation both of the practice and of the Somalis themselves that dominate media attention and political debates.

As pointed out, however, the main message of my Somali informants was not to convince me of the cultural meaning of the practice. On the contrary, they focused mostly on their negative personal experiences of the practice, and reflected on how these experiences made them question its cultural underpinnings. This brought me to focus on the ways in which most Somalis presented FGC; as *both* harmful *and* meaningful. Presenting this, I experienced a dilemma with regard to how I could provided an understanding of FGC as a personal experience, including the pain, doubt and sense of meaninglessness, while simultaneously showing respect for the

people and the culture of which it is a part. This dilemma point towards a tendency of polarization in FGC discourses, between those that emphasize the cultural meaning of the practice, and those that emphasize pain and harm (Lyons 1981). In this dissertation I highlight how this tendency of polarization affect both academic discourses and political debates on FGC. It appears to promote an either-or thinking, that portray women as marionettes of cultural models, whether "local" or "western", in ways that hide the ways in which personal experiences and perceptions are created in an interplay between personal experience and cultural models. Also important is how this either-or thinking permeating public discourse affect Somali women living in Norway.

Time and the ethnographic present

In social anthropology the presentation of the informants in time has been heatedly discussed. At some point the "ethnographic present", that is, the anthropologists' tradition of describing their field material in the present tense was harshly criticized. It was seen to imply a "static view of society", inattentive to the ways in which culture is always constantly changing (Fabian 1983; 81). In response to this, I have generally described my data in the past tense, in order to highlight that this is the data I found at the time and place the study was done. However, this is not meant to indicate that the situation is radically different now. Quite the contrary, it seems that most of the data found was still descriptive of the situation when the last corrections were made.

Mutilation, circumcision or cutting – choice of terminology

One aspect of the politization and polarization of the FGC debate is that the choice of terminology is highly value-laden, having both ethical and political implications. I therefore want to clarify my choice of terms.

In Norwegian there are two available terms; Female Circumcision (FC) (in Norwegian; *Kvinnelig omskjæring*) and Female Genital Mutilation (FGM) (in Norwegian; *kjønnslemlestelse*). Both terms have advantages and disadvantages. FC,

on the one hand, seems to be closest to the emic understanding in which FC is regarded as a necessary and culturally good way to change the girl child into a respectable woman. The practice is also often understood as a parallel to male circumcision. However, in medical terms the term may give the wrong associations, as almost all forms of FGC are significantly more physically infringing than male circumcision; Where as male circumcision usually cuts all or parts of the foreskin of the penis, most forms of FGC involve cutting (more or less off) the clitoris itself, as well as tissue from labia minora. In infibulation, tissue is also cut or scraped from the labia majora. When stitching or sealing is done to close the wound, it may later hamper free flow of body fluids as well as sexual intercourse and later childbirth.

The difference in types and amount of tissue removed in male and female circumcision is a major reason why most international agencies and NGOs have for a long period of time preferred the more "serious" term; Female Genital Mutilation. This is also the term used in most Norwegian official documents relating to laws and policy. In medical terms mutilation refers to the destruction or removal of healthy tissue. In daily vocabulary, however, it also tends to be understood as destructive and maiming. Some people also understand the term as an insinuation of evil intentions on the part of those who pursue the tradition (e.g. Johnsdotter 2002; Guering and Elmi 2001; Talle forthcoming, a; Schweder 2003).

Owing to the strong negative associations of the term FGM, many researchers and others, including most people from practicing communities, have been reluctant to adopt it (e.g. Bergjord 1991; Dellenborg 2001, 2004; Gruenbaum 2001; Johnsdotter 2002; Morison et al 1998; Obiora 1997; Talle 2001; Shell-Duncan & Hernlund 2000; Schweder 2003). In some cases, the term has been rejected as unfitting for the mildest of the procedures, in others because it is felt to be derogatory towards those for whom FGC is part and parcel of their tradition and culture.

Another problematic aspect of the term FGM was that my Somali informants generally understood it to mean infibulation only. *Excision (*in the local term of *sunna)*, on the other hand, was generally not understood as a type of FGM at all (see also Klepp 2002). Hence, if I had used FGM, there would have been an increased risk of misunderstanding due to our different understandings of what the term encompassed. In discussions with informants it has therefore been necessary to use a host of different terms, as well as anatomical drawings and detailed descriptions to facilitate mutual understanding of what we were talking about.

In English the term Female Genital Cutting (FGC) has gained in popularity in recent years, and several international agencies have converted to this term.[4] FGC is thought to be more morally neutral, as it simply refers to cutting without indicating either meaning or "harmlessness" (as "circumcision" may do) or destruction or even evil intentions (as "mutilation" may do).

My choice of terminology has changed during the research period, as is evident in the papers. I started off using Female Circumcision, mainly due to its resonance with emic terms. This was also the term almost universally used in Norwegian daily language. Even people who promoted the term FGM tended to employ the term circumcision when they became animated. Furthermore, the Norwegian term for FGM is a bit of a tongue twister. However, over time I have come to see Female Genital Cutting as the best alternative in English. In addition to the reasons mentioned above, I prefer its concrete reference to cutting (Johansen forthcoming a). In the dissertation I use various terms depending on the context of the discussion and the time of the writing. In the first two papers to be published, Papers I and IV, I generally use female circumcision. In the last two Papers, II and III, and the introduction, I employ FGC as the general term. In addition I use FGM when referring to documents and settings in which this term was used, and when referring to actual women who have undergone genital cutting, I use the term circumcised, as was preferred by most informants. In addition I use the terms referring the two major types, *infibulation* and *excision*, when specificity is possible or needed.

Different perspectives on FGC - Rites de passage or genital mutilation

I will now outline the major trends in analytical approach to FGC to throw light on the ways in which studies of, and discourses on, FGC tend to be politicized and polarized. My objective is then not to present a comprehensive analysis of all approaches used, but rather to try to understand why FGC tends to be presented *either* as an act of "Genital Mutilation" *or* as a "rite of passage".[5]

First it is pertinent, however, to point out how little first-hand research has actually been done on the topic in general, and among the Somali in particular. Until recently, FGC has been largely a topic of avoidance in social anthropology. Considering the immense importance of infibulation in the Somali community, it is striking that Lewis, a leading scholar of Somali culture only mentions the practice in a footnote (1961; 1962; 1994). Nor has the focus been prevalent in the Somali Studies International Association (SSIA) or the European Association of Somali Studies (EASS) congresses. The issue was for example not discussed in the conference in Copenhagen 2004. A parallel tendency is found in many other studies of societies in which FGC is widely practiced but barely mentioned (e.g. Wikan's study from Egypt 1980).

To my knowledge there is only two empirically based anthropological studies of FGC among Somalis, one by Aud Talle (Talle 1993), and one by van der Kwaak (Kwaak 1992). However, there are studies from other fields that also have contributed significant cultural insight, such as Abdalla (1982). Her in-depth investigation of both physical and psychological consequences, and cultural and religious underpinning as well as attitudes and gender relations constitute the first in-depth study from Somalia. I have also come across two PhD studies on the practice (Ali 2003; Irqhat 1999), but there may be more. Other studies of Somali society and culture also provide some insight, such as those of anthropologist Helander (e.g. 1987; 1988; 1991), the historian Kaptejins (1995), sociologist Ntiri (1991; 1993), biologist Gallo (e.g. 1986), (Gallo & Abdisamed 1985; Gallo & Boscolo 1985, 1988) and medical scientists Dire & Lindmark et al (eg 1991).

Even less research has been done on the practice in exile. The only other anthropological studies of Somalis and FGC in the context of exile I have found, is that of my FOKO colleague, Sara Johnsdotter, in Sweden (Johnsdotter 2002), and Aud Talle's ongoing research in London (Talle 2003, forthcoming a, b). Significantly more has been done within the context of health and health care (e.g. Catania & Hussen 2005; Chalmers & Hashi 2000; Essen 2001; Fjell et al 2003; Nath & Ismail 2000; Nienhuis 1997, 1998; Vangen et al. 2002; Widmark et al 2001, 2002; Wiklund 2000) and two studies on experiences and attitudes (Morison et al 1998; Bergjord 1991). FGC has also been discussed in biographies of Somali women in exile (Ali 1994; Barnes & Boddy 1994; D'Haem & Dirie 2002; Dirie & Miller 2001) and in a reportage book by the Somali novelist Nurudin Farah (2000).

Among the growing number of studies on Somalis in exile, few focus extensively on FGC (e.g. Aaretun 1998; El-Sohl 1993; Fangen 2005; Griffiths 1997; 2002; Gundersen 2001; Højdal 2001; McGown 1999; Meramitdjian 1995; Tiilikainen 2001, 2003). For some it has been a conscious choice not to focus on such a sensitive issue, particularly since the Somalis are in a vulnerable situation in exile, and because there are so few studies of Somali women at all (Tiilikainen, personal communication, Ahmed 1995). Many studies have rather been inspired or provoked by the negative focus on Somalis in western media, including on FGC (Fadel et al 2000; Fangen 2005; Figenshou 2000; Gylseth 2001; Johnsdotter 2002; Klepp 2002, 2004; Lamo 2002).

A review of existing studies on FGC reveals a clear (and logical) division of labor between social anthropology and medicine, with anthropologists focusing on the cultural meanings of the practice and medical research focusing on health hazards and care issues, that feed into the polarization in different ways.

Within anthropology, studies of FGC have often embarked on the subject as a part of the female initiation rituals of which FGC frequently constitutes a part. Consequently, the meaning of FGC has often been analyzed as an integral part of the ritual itself. Here it has often been analyzed in relation to its social function, specifically to transform a child into an adult and responsible member of society. FGC and rituals of initiation have thus been seen as a vehicle to install discipline and respect for social norms, as well as for its guardians, such as the elders and other community authorities. Consequently, theories of coming of age, discipline and social integration have been closely related, and have also been used to understand the infliction of pain through genital cutting (Ahmadu 2000; Girard 1977; Gosselin 2000; Moore 1996; Morrinis 1985; Shell-Duncan et al 2000; Walley 1997). In this perspective the pain involved in the cutting may thus be termed “ritual pain”. This can distinguish it from “accidental” pain, which can be used to designate pain that has no cultural underpinning. These perspectives may throw some light on FGC among Somalis because, although there is no ritual related to the circumcision, FGC is believed to be necessary to secure a successful transformation from girls into women.

Another major anthropological focus has been on the symbolic message of FGC. This has been especially elaborated in studies of infibulation, both among the Somali, as in Talle's analysis of the infibulated scar as a symbolic affirmation of

patrilineal clan affiliation (Talle 1993), the construction of a feminine body and identity as well as of virginity (Talle 1987), and in Sudan, in Boddy's emphasis on infibulation as a symbolic assertion of female fertility (Boddy 1989). This is again closely related to emic conceptualizations of social convention and marriageability (Johnsdotter 2002; Mackie 1996, 2000; Talle 2001, 2003).

FGC has also been interpreted as a trial, a symbolic price to entry into a secret society, womanhood or fertility in a variety of contexts (Ahmadu 2000; Dellenborg 2001, 2004; Hernlund 2000a, 2003; Leonard 2000; Skramstad 1990,1999; Talle 1994). When FGC and initiation rituals have been interpreted in relation to the cultural construction of gender, sex and fertility, emphasis was for a long time more on aspects of fertility and gender (e.g. Boddy 1989; Talle 1993, 1994) than on sexuality. Referring to van Gennep's claim that what part of the body is cut is irrelevant - it could just as well have been the nose – several anthropologists have expressesed a frustration of the anthropological tendency to de-emphasize sexuality and FGC; suggesting that "anthropologists are reluctant to admit that the genitals are not the nose" (Parker 1995; 517, from Lyons 1981; 508, again referring to Vizedom 1976, the translator of Van Gennep's *Rite of Passage*).[6] In the last decade we have seen an increased or renewed focus on gendering and sexuality as key concepts in understanding FGC (e.g. Ahmadu 2000; Hernlund 2003).

Discourses on FGC and gender have focused on its role to carve girls into "proper" women (e.g. Ahmadu 2000). It has been pointed out that, whereas gender in western cultures generally is determined on the basis of a child's genitals; female genitalia do not seem to be good enough for the cultural ideal of femininity among most FGC practicing societies. Instead, the genitals have to be culturally constructed by altering them physically. These perspectives can be used to understand both male and female circumcision (Rye 2000; Silbersmith 2004).

Less elaborate are the focuses on FGC as an ethnic marker, as it appear to play this role only in rare occasions (Boddy 1989; Dellenborg 2001, 2003). In some situations it has become a part of nationalistic or anti-colonial activity, such as in Kenya (e.g. Thomas 2000), and later as a part of post-colonial resistance such as in the Gambia (Sundby, personal communication.) Counter reactions, revitalization and diffusion of the practice has also been documented (Dellenborg 2001, 2003; Leonard 2000; Nypan 1991, Thomas 2000). One perspective here is the role the adoption of

FGC may play in social climbing, when practiced by higher social strata, which is also a significant aspect in Mackie's theory of social convention (1996, 2000).

In contrast to the common western, and frequent African, presentation of FGC as an "old barbaric tradition", practiced only in "remote areas" and likely to disappear when exposed to health education, studies show a much more diverse picture (Population and Reference Bureau 2001). In Somalia there is no evidence of change in the practice of FGC in Somali areas, neither over time, nor in relation to education and social status, or even towards less extensive forms of cutting (Worldbank/UNFPA 2004).

Medical research has mainly focused on the health effects of FGC, such as immediate complications, sexually transmitted diseases and birth problems. Also in this field research is limited, and many studies are based on cases and hospital records and as such are not representative in countries where few women have access to health facilities (see Obermeyer 1999 a, b).

There is a general agreement that FGC carries risks of hemorrhaging and infection and other complications on the short and long term, as will be described in the next chapter. These risks are further believed to be elevated due to the high percentage of genital cutting that is done by "traditional specialists", who have little or no training in anatomy and hygiene, and no equipment to take the necessary precautions. This is why some have discussed "medicalization" of the practice to secure "harm reduction" (Shell-Duncan et al 2000), which has also been a goal of some projects (see next chapter). However, most international organizations (such as the World health Organization (WHO) and the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC), warn against this, as it could provide additional legitimization of the practice as a "health promoting" procedure. An interesting parallel here could be the medicalization and legalization of male circumcision in the USA (Gollaher 2000). Also there is some indication that medicalization often entails more extenstive cutting. Clinical experience of doctors suggests that women who have been cut by medical doctors often have had more of their clitoris and labia removed. Another research focus has been on risks for genital infections and venereal diseases (Morison et al 2001), risk of birth complications (Banks et al 2006; Essen 2001; Vangen et al 2002), reinfibulation (Berggren 2005) and infertility (Almroth 2005).

This short presentation highlights a division of labor between medical research mainly interested in health hazards, and anthropologists mainly in cultural meaning. In the following, I will discuss how these different approaches are used in what Gruenbaum has labeled “The female circumcision controversy”, as it is played out in a polarized discourse between “anti-FGM activism” and “rite-de-passage studies”.

I am aware that to highlight the polarization is an undue simplification of the vast variety of studies. I refer however to the many insightful overviews of this variety of approaches by others (e.g. Gruenbaum 2001; Johnsdotter 2002 Shell-Duncan & Hernlund 2000). I also acknowledge the many insightful studies that grip both the meaning and the pain (e.g. Ahmadu 2000; Boddy 1998; Hernlund 2000b, Talle 2003, forthcoming a,b). However, for my contribution to stimulate new insight, I have found it useful to pinpoint the polarization, because all anthropologists working with FGC have to position themselves in relation to it. Furthermore, as most anthropologists argue against the tendencies to stigmatization and disrespect inherent in the FGM pole (e.g. Ahmadu 2000; Guering & Elmi 2003; Gruenbaum 2001; Johnsdotter 2002; Persson 2003; Moresy 1991; Shell-Duncan & Hernlund 2000; and also from other fields; Obiora 1997), I have chosen to turn the limelight the other way around. I will therefore take a critical look in the mirror, at anthropological emphasis on cultural meaning.

I have named the rite-de-passage pole after the frequent anthropological focus on FGC as a part of an initiation ritual. This perspective is mainly concerned in understanding FGC from “the local point of view”. As such, more attention has been given to publicly shared cultural models, than to the variety of personal experience. One part of this is the way in which the focus on pain has been mainly analyzed in terms of its “social function” to inscribe cultural values in the individual (see Paper I), rather than in relation to personal experiences that may diverge from this. Similarly have anthropological studies of sexuality and FGC had a higher emphasis on shared cultural models regarding this, than on personal experiences (e.g. Boddy 1989). The many studies that point at the flexibility and fluidity of personal experience and interpretation, point towards extensive variation, both between people and between situations (e.g. Hernlund 2003; Skramstad 1990). In general, I find many studies of FGC to see personal experience as more determined by publicly shared cultural models, than what I found to be the case with my Somali informants. As pointed out, I

also found most Somalis to be highly ambivalent in their perception of FGC, as simultaneously excruciatingly painful *and* deeply meaningful.

When anthropologists argue against the simplifications and exaggerations typical of the FGM-pole, they have often questioned presentations of FGC-related health hazards. A frequent argument has been to critique the way the anti-FGM pole tend to take health hazards caused by infibulation, to stand for all types of FGC (e.g. Ahmadu 2000; Shell-Duncan & Hernlund 2000; Guering & Elmi 2004). Another and more recent critique, is to question the cultural universality of the role of the clitoris for female sexual pleasure (e.g. Ahmadu 2000; Dopico forthcoming; Obermeyer 1999 a, b).

On the other side of the pole, the "mutilation approach" is mainly propagated by researchers and anti-FGM activists, who regard FGC both as physically harmful and as an extreme expression of male and patriarchal control over female sexuality and fertility.[7] This perspective is grounded in a perception of femininity as a universal biological entity, which is destroyed or disturbed by genital cutting. That is, all women are believed to experience femininity in the same way due to shared biology, and genital cutting is regarded as an infringement of this natural universal femininity, as discussed in Paper II. Research in this field is frequently related to anti-FGM campaigns and a request to "document" the need for change, with reference to harmful health effects or female oppression. In contrast, culture, especially cultural models that are used to legitimize FGC, is often described as "myths and misconceptions", and generally regarded as a sense of "false consciousness" created to cover up female oppression. In a sense then, FGC is seen first and foremost as a "maladaptive cultural pattern" or as a vehicle for patriarchal control and suppression (see discussion in Gruenbaum 2001).

To simplify the poles, we may state that the rite-de-passage mode relies on an idea of cultural determination, combined with a positive sense of culture. To this pole, FGC is first and foremost a culturally meaningful and socially important practice. On the other hand, the FGM pole is based on biological determinism, regarding the physical effects of FGC as the only relevant data on which the practice should be evaluated.

This polarization between FGC as either physically destructive or culturally meaningful tends to be mutually reinforcing. The "FGM pole" tends to emphasize the harmful effects of the most comprehensive type of FGC – infibulation – to prove the

need to eradicate any type of FGC. Consequently, the “rite-de-passage pole” criticize them for exaggerating the harmful effects and risks. They often also criticize the “FGM pole” for judging the practice by western ethnocentric and cultural imperialistic standards that are irrelevant for the practicing society. They emphasize rather the need to take emic perceptions into consideration. The “FGM pole” in return then tends to accuse the “rite-de-passage pole” of defending the practice. And so it goes on.

This dichotomization has a heavy impact on research and scientific discourses. And writing this dissertation, I have continuously had to maneuver and balance between the two, often antagonistic, poles. The polarized of the debate also strongly affects political and media discourses, and hence deeply affect the ways in which Somali women can negotiate FGC in exile. My main concern here is that this tendency towards polarization seems to divert a lot of attention from important scientific discussions. More significantly it may risk to mute the ambivalence of Somali women and men

I hope this dissertation is able to shed light on some of the ways in which Somali women and men balance and measure different perspectives and experiences, thus bridging these poles in real life. In this, I will not assume a priori that personal experiences are identical to cultural models, but rather explore where they differ. I also find it useful to take the physical aspects and personal experiences of genital cutting more into account than has generally been done in anthropological studies of the practice.

Presentation of the dissertation

The first five chapters form the framework of the dissertation, before the four papers are presented.

Chapter 2 outlines the empirical setting, the context in which the informants live, and in which research was carried out. It thus includes presentations of the Somali community at home and their migration to Norway and the practice of FGC in both Somali and Norwegian local and public discourses.

Chapter 3 presents the overall perspectives in method and data-collection within the two major fields of the Somali and the health worker communities. It also discusses some major methodological and ethical challenges.

Chapter 4 presents my overall analytical approach in the dissertation, also seen in relation to the different analytical tools used in each paper.

Chapter 5 deals with some major ethical challenges in the study. I want to position myself more clearly in the muddled water of polarization. Here I also take a closer look at some of the ethical dilemmas that arose regarding the position of the study in the intersection between social anthropology and medicine.

The main findings of the study are presented in the four papers, which are based on the main concerns of the Somali informants; pain, sexuality and two papers on birth.

Paper I:

On Pain

Johansen, R. Elise B. 2002
"Pain as a Counterpoint to Culture: Toward an Analysis of Pain Associated with Infibulation among Somali immigrants in Norway"

This paper explores how individual women experienced and reflected on female circumcision as a lived bodily experience within shifting social and cultural frameworks. It reveals that, in spite of the significant cultural meaning in which infibulation is embedded, women were deeply concerned about the pain itself. It was their main concern, and was given substantially more attention than the cultural meaning of the tradition.

Women described infibulation as the "three feminine sorrows" or pains, the pain of the original infibulation, the pain of defibulation at marriage and the pain during childbirth. They described the pain as intolerable, as beyond any other pain. At the time of their circumcision, the intensity of the pain had made them question the validity of the cultural models legitimizing the practice. They also described it as something they could never forget, like an embodied memory they always carried with them, or as "a shadow in the chest", as one informant put it.

However, both their feeling of pain and the subsequent questioning of the practice were largely muted in their home culture. Over time, most of them also said they felt they had come to terms with the experience as a necessary price for social acceptance. In a way then, the silence enveloping experiences of pain may have consequences for the persistence of the practice. In exile, however, the experience of pain was reconsidered, questioning and voiced. The burden of the pain itself also seemed to grow with the increasing questioning of the meaning and purpose of the tradition.

To understand women's experience, I investigated the relationship between pain and meaning, and between individual experiences and cultural models. Here I investigated the appropriateness of pain theories within "traditional anthropology", which has focused mainly on the "social function" of "ritual pain" as a vehicle to

inscribe cultural meaning into the individuals. As such, cultural meaning is expected to give form and meaning to personal experience of pain. It is often also presented as if it can reduce the sensation of pain itself. In contrast, I suggest that the overwhelming nature of the pain of infibulation challenges such modes of understanding. Here, I have found theories developed in medical anthropology to be more illuminating. Though they usually focus on “accidental pain”, such as sickness, accidents or even torture, rather than ritual pain, they seem better able to grasp the experience of pain as described by the Somali women. Studies of extreme pain and of chronic pain in particular have focused on the ways in which such overwhelming experiences tend to explode and challenge cultural meanings. Rather than seeing pain as a part of culture, it may be experienced as a counterpoint to culture.

Also, medical studies emphasize the complex psychosocial aspect of pain experience. It is further demonstrated how painful experiences bring about physical changes in the nervous system that increases later pain experiences. These perspectives throw light on how experience of pain is inscribed on human bodies. This inscription occurs on both the physical and the mental body; in other words, the pain becomes embodied.

The experience of intense and chronic pain also has a creative power, medical anthropology suggests. Disintegrating cultural models and the demands of everyday life compel the sufferer to search for new meaning. It appears that this creative power of pain is transferred from an effort to live with its consequences at home to a drive for change and abolition in the exile population.

Paper II:

On sexuality

Johansen, R. Elise B. (in press)
”Experiencing sex in exile – can genitals change their gender?”

Paper II explores how Somali women and men living in Norway experience and reflect about the relationship between FGC and female sexuality. This is analyzed in relation to the changes that constitute an inherent ingredient of life in exile, in which natal cultural models are juxtaposed with those of the host community.

Traditional Somali cultural models emphasize FGC as a natural and necessary operation that ”carves” the female body to fit local perceptions of femininity. In this context virginity is a core value, and seen as constructed and secured through infibulation. Sexual reticence is another central cultural value, which is thought to be enhanced by removing the clitoris, or parts of it, because the clitoris is perceived as a “male” and “aggressive” organ.

In Norway in contrast, virginity is hardly valued, and the clitoris is perceived as a key to female sexual pleasure and femininity. However, the Norwegian perceptions of African sexuality differ significantly from this. We can discern a polarized perception of Africans as “primitive savages”, who are attributed both with a positive perspective of free and uninhibited sexuality and with a negative perspective of female oppression, of which FGC is seen as the ultimate expression. This ambiguity complicates the ways in which the Norwegian society relates to African women and FGC in several arenas, including health care, media discourses and personal relations. Consequently Somali women and men are constantly confronted with these perceptions.

Somali perceptions of sexuality are also affected by the ways in which marital relationships tend to go through dramatic changes in exile. This is partly related to the ways in which traditional gender roles and relations adjust to the new situation. While maintaining their roles as mothers and wives, women gain greater and different forms of independence, including financial independence, due partly to increased education and work opportunities. Men, on the other hand, often expressed a sense

of loss of respect and influence, as their role as breadwinner and head of the household was reduced. This seemed to contribute to different types of marital strains and conflicts.

In many ways this increased men's vulnerability and reduced that of women. This was partly related to changes in the vulnerability of marital continuity and changing patters of divorce. While divorce in traditional Somali culture was mainly in the hands of men and to the bereavement of women, this situation was largely turned upside down in Norway. With social security benefits, women become less financially dependent on men and since child custody normally benefits the mother, many women felt that divorce offered more financial, as well as personal, independence.

These contrasts and changes stimulated Somalis to reconsider basic cultural values regarding sexuality and FGC, challenging the cultural model that necessitates FGC in order to control female sexuality. Intimacy and mutual pleasure became increasingly significant as a ”glue” to maintain the marriage. This was closely related to a increasing ideal of marital sexual life as reciprocal, and hence a fear that FGC could contribute to destabilizing marriage. Consequently female sexuality and its relationship to FGC were experienced as increasingly ambiguous. On the one hand, both women and men gave increasing emphasis to, and a positive evaluation of, female sexual pleasure. As such they regretted FGC, which was believed to reduce women's sexual pleasure and cause painful sexual intercourse. On the other hand, virginity and marital chastity were still highly valued and closely associated with infibulation.

In these ways exile seemed to change Somali concerns from a home culture, where FGC was seen as a condition for proper gender identity and “correct” sexual behavior, to the new culture with increasing emphasis on sexual pleasure and intimacy in the marital relationships in exile.

My analysis of sexual experience as something that is negotiated was inspired by theoretical perspectives in anthropology, which suggest that sexuality is such a private concern and strong experience that it is probably one of the human experiences in which personal experiences deviate most from cultural models. This perspective differs from those mostly employed in anthropological understanding of FGC, which generally suggest a much higher degree of determination by cultural models on personal experience. I further suggest that the discrepancy between

cultural models and personal experience is a key to cultural change, particularly the changing attitudes to FGC among Somali immigrants in Norway.

Paper III:

On health workers providing birth care

R. Elise B. Johansen forthcoming
"Care for infibulated women giving birth in Norway - An anthropological analysis of health workers management of a medically and culturally unfamiliar issue".

Paper III investigates the way Norwegian health workers experience and manage birth care of infibulated women. They experienced delivery care for infibulated women as challenging, and Somali deliveries as more "noisy and chaotic". Nonetheless, female circumcision was not recognized as an important maternity issue among health care professionals and it was not addressed ante-natally. The study revealed that Norwegian health workers, in spite of their well-educated status and their good intentions to be culture-sensitive in their care of Somali women, often provided care that was both counter to medical guidelines and to the wishes of Somali women.

An analysis of this apparent paradox suggests that cultural sensitivity often led to an over-interpretation of "culture", in the sense that they often regarded the women as cultural products, rather than as individual women with personal preferences and experiences. This became particularly acute, because it was partly based on a stereotyped view of African and Muslim traditions, which often differed from traditional Somali values.

A part of the misunderstandings this caused was based on an over-generalization in the literature on infibulation. Most writing on infibulation is based on data from Sudan, but is usually understood as representative for *every* society practicing infibulation, including the Somali. An example of this was health workers' universal belief that Somali women would wish to be reinfibulated, though this has never been a Somali tradition, nor did the majority of Somali women want it.

Hence both cultural sensitivity and generalization of both prejudices and knowledge led to a host of misconceptions. This was further emphasized by the challenge infibulated women pose to the dominant Norwegian philosophy of "natural birth", and the positive evaluation of everything natural. For, while African women in

general were often perceived positively as “natural” and “authentic” representatives of “the noble savage”, infibulation represents the negative aspect of “primitivism” as “barbarism”, as it is generally seen as one of the most barbaric forms of male oppression. I see this double and inherently contradictory perception of African women as a significant contribution to the widespread perception of FGC as a taboo subject, which health care professionals generally prefer to relate to through silence and avoidance. This silence, however, reduces their chances to give and receive relevant information, which again increases both parties’ feeling of insecurity in the situation.

To grasp the apparent contradiction between health workers’ intention to provide culture- sensitive care and the tendencies towards culturalization and avoidance, I employ Goffman’s theory of social stigmatization.

Paper IV:

Health workers and Somali women in birth

Vangen, Siri; Johansen R. Elise B.; Træen, Bente; Sundby, Johanne; Stray-Pedersen, Babill; 2004
"Qualitative study of perinatal care experiences among Somali women and local health care professionals in Norway".

This paper explores birth care for infibulated women, and the different perspectives of health workers and Somali women. It is based on the interviews with those of the Somali women who had given birth in Norway and who had presented information about it. It also includes data from interviews with 36 health workers.

The study showed that circumcision was not recognized as an important delivery issue among health care professionals, and generally the topic was not addressed. Most health care providers were unaware of any association between infibulation and increased risk of birth complications, and many felt insecure about how to discuss the issue of FGC with their patients. Therefore they kept quiet. The issue was rarely addressed in discussions with the women. Nor was relevant information such as FGC status or expected delivery care noted in medical records or otherwise shared between the different health services involved in women's reproductive health: antenatal clinics, birth clinics and perinatal care centers. This was partly related to a lack of agreement between outpatient clinics and hospitals about who was responsible for dealing with FGC. While antenatal clinics considered it to be the hospital's duty, the hospitals felt this should have been done as a part of antenatal care. The result was that nobody raised the issue.

Moreover, many health workers expressed limited technical knowledge and skill in making decisions about care procedures for infibulation. This led to a sense of insecurity and disempowerment. Many also reported emotional challenges in dealing with infibulation. Together these aspects led at times to misinterpretation of signs that could possibly lead to neglect in the care.

Somali women often experienced deliveries as painful, lonely and frightening. Women had not received information about different birth care procedures, such as pain relief, procedures for episiotomy or fetal monitoring. Some also experienced re-traumatization of their original infibulation. Many Somali women feared that health workers would lack experience, which could result in both sub-optimal treatment as well as stigmatization. There was also a widespread fear of unnecessary and frequent cesarean sections.

Somali women's fear and insecurity may enhance a sense of vulnerability and stress during delivery. Knowing that fear and stress are associated with increased birth complications, we further hypothesize that this may be another contributing factor to increased birth complications among Somali women in Norway. We also hypothesize that healthworkers misinterpretation and neglect of circumcision can lead to adverse birth outcomes, including unnecessary cesarean sections, prolonged second-stage labor and low Apgar scores.

Chapter 2

EMPIRICAL SETTING

This chapter presents the context in which the Somali informants lived. First I will give a brief presentation of the Somali, their culture and history and the political situation that has caused the present-day refugee situation, and their migration to Norway. Then I will move more directly to the issue of FGC, definition, typology and the role of the World Health Organization (WHO) and other international agencies in defining the practice. Thereafter I will discuss FGC as it is practiced among the Somali, before I describe the issue in the Norwegian context.

The Somali people

Somali-speaking people originate from the horn of Africa, in areas that are today divided into several countries: Northern and eastern Kenya (especially the regions of Mandera and Garissa), eastern part of Ethiopia (Ogaden region), Djibouti and Somalia. Somalia is in turn presently roughly divided into three separate “countries”. Northwest Somalia, called Somaliland and former British colony, declared its independence in 1991. Northeastern Somalia, called Puntland, claimed its autonomy in 1998. These two “states” have not gained international recognition, but have established some governmental agencies and infrastructure. The rest of Somalia, which together with Puntland constituted the former Italian colony including the

former national capital of Mogadishu, has had no effective central government since the departure of Siad Barre in 1991. Though a new government was established in 2004 and functions in exile in Nairobi, it has not been able to have much influence within Somalia (Haakonsen 2005).

Somali areas have been relatively homogenous from an ethnic perspective. Somalis generally speak of themselves as a united group with a common ancestry, political system, language and cultural heritage. Considering the wide area in which they live, there are obviously also significant cultural and linguistic variations. In addition there are variations related to clan and ethnic identity, as well as different life styles, such as urban and rural, farming or nomadic, education and class background.

The Somali written language was introduced and standardized in 1972, but spoken dialectical differences are still significant. In some instances mutual understanding is difficult, for example between people in Somaliland and people from the agricultural, interriverine areas of the South.

The traditional livelihood of the Somali is nomadic pastoralism with camels, cattle, sheep and goats. In the southern and more fertile regions, farming has been more common. Also trade, with live animals and hides and incense, has long traditions, as has work migration in trade and transport. At present, as much as a quarter of the total Somali population (about 2 million out of a total of about 7 or 8 million) may be living abroad, many as refugees in western countries (Talle 2003). The money they send home contributes significantly to the survival of the remaining population.

The Somali society is organized around clans, which are defined by descendancy from the same patrilineal line of descent, and constitute the basic political, social and economic unit. In everyday life this affects access to land, political rights and choice of marriage partners. In situations of conflict, the clan also functions as a legal unit.[8] Clans also played a significant role in the civil war and following conflicts. In the establishment of a new Somali government, clan representation is given considerable attention (Haakonsen 2005). These two aspects of Somali society, clan and conflict, have also been the major subjects of interest in Somali studies so far (e.g. Gardner & ElBushara 2004; Griffith 1997; Helander 1988; Lewis 1961, 1962, 1994; Lilius 1998; Mansur 1995; Menkhaus 2004.)

In this study, I have given little attention to clans. Normally I would ask people their region and country of origin, rather than clan identification. There was a general resistance among most informants to talk about clan, for various reasons. Some chose to keep their clan affiliation secret or "invisible" within the Somali community in order to avoid conflicts. In legal settings clan identities could also be used creatively to match up requirements for refugee status and residence permits (Gundersen 2001). Women also often claimed that clan was less important to their lives in Norway, and wanted to distance themselves from what they saw as male pre-occupation with clans and an inherent risk of conflicts (see also Johnsdotter 2002). Still it was obvious that clan played a significant role in several situations also in Norway. It was a basis for social networks, especially when in need of social and practical support. And in situations of cross-clan conflict, people appealed to common clan affiliation for support. Clan identity was also a major organizing principle for most Somali organizations in Norway.

The vast majority of the Somalis belong to one of the five major clan clusters: the *Darood*, *Isaaq*, *Hawiye, Digil* and *Rahanwiin*. Of these the three first are major nomadic clans commonly referred to as *Samaale*, while the last two are mainly agricultural clans dominating southern areas and are referred to as *Sab*.[9] The northerners regard themselves as somewhat superior to the southern *Sab*. In daily life the various levels of sub-clans are the most relevant units. In addition there are various minority groups. Three of these, the *Tumaal, Midgaan* and *Yibri,* though defined as Somali, are not regarded as part of the common Somali clan system and accorded a lower social status. They are traditionally affiliated to the majority clans through a sort of patron-client relationship, with the minority clans performing certain services for the majority clans (Hassan 2002).[10]

Other minority groups, such as the *Barawan* and *Reer Xamar* said to be of Arab origin, tend to be perceived more as a different ethnic group. These live mostly in the southern coastal regions and are involved in fishing and trade. The Somalized Bantus, commonly referred to as Bantu-Somalis, are another minority group. They work mostly as farmers or as servants and workers for the majority clans. The Bantu-Somalis are mainly descendants of slaves that were brought to the country about 200 years ago. The Italian colonial administrators abolished slavery during their reign, and later the independent Somali government passed anti-discriminatory decrees against minority groups. Bantu-Somalis retained a low status however, and became

particularly vulnerable during the civil war. This has led to a major international operation to rescue them from the country.[11]

The majority of my informants were, to my knowledge, from the majority clans. Within these, I made an effort to recruit informants from both the north and south of the country. This was partly done to avoid the risk of being drawn into inter-clan conflicts or accused of biased solidarity, and partly to get a wider picture of Somali cultural variation. For all practical purposes then, this dissertation deals with Somalis from the five majority clans.

Modern Somali history

After 1880, the northern part of Somalia was made a protectorate by Britain and called British Somaliland. The northern parts of Kenya, in which Somalis lived, became a part of British East-Africa. Italy colonized the north-eastern and southern part called Somalia Italiana. The eastern area, Ogaden, was annexed by Ethiopia, and the French colonized French Somaliland, which has been known as Djibouti since its independence in 1977. The colonial powers in Somali areas, whether British, Italian or French, never attempted to interfere with the practice of FGC, in contrast to countries such as Sudan and Kenya (Abdalla 1982).

After independence in 1960, British Somaliland and Italian Somalia merged into the Somali Republic through a union. Democracy was introduced with an elected president and a parliamentary system. However, internal differences led to increasing dissatisfaction with the government, and the chief of the army, Mohamed Siad Barre staged a coup in 1969. His ideals of “scientific socialism” included laws and regulations intended to improve women’s position. Included in this was an effort to fight FGC, that is, in the form of infibulation.

A vision to unite all Somalis in one state led to a military campaign into the Ogaden area of Ethiopia in 1977. The subsequent loss, and growing conflicts between the government army and clan-based organizations and the north-south divide, eventually led to the collapse of the regime in January 1991, after which Siad Barre fled the country. A significant contribution to the north-south divide that led to Somaliland’s declaration as an independent country, and my reason for including

people from both sides of the divide, was a government bombing raid on the northern major town of Hergeysa in 1988.

The civil conflicts in the 1980s and the civil war in the 1990s caused chaos and starvation that led to a mass exodus from Somalia. In an effort to find a solution, the UN intervened in 1992, but withdrew again in 1995. In spite of several peace negotiations and treaties, Somali has been ridden by civil war throughout the past decade. During this time southern Somalia has had no infrastructure, no government or other official authorities. Public institutions like schools and hospitals do not exist and health and school services, where they exist, are private or run by aid agencies and only function at the local level. The "independent states" of Somaliland and Puntland have been able to establish some degree of security and infrastructure.

Somali immigration to Norway

The civil war and the collapse of the state in Somalia is the major reason why Norway experienced the rather a sudden and vast influx of Somali refugees and immigrants around 1990. While only 1,733 Somalis arrived between 1980 and 1990, the number of arrivals between 1990 and 2002 was 12,000. As of 1 January 2005 16,765 Somalis lived in Norwegian exile. This includes both immigrants from Somalia and children born to two Somalia-born parents. About half of these live in Oslo, the capital of Norway, a city with about 500,000 inhabitants. 60% of the Somalis who were living in Norway in 2003 had been living in the country for less than five years, and hence they constituted one of the most recently arrived immigrant groups.[12] Moreover, 48% of the Somali population was at that time under 20 years of age (Engebrigtsen & Farstad 2004).

Though the majority of Somalis in Norway come from the area included in post-independence Somalia, quite a few also originate from or have lived for shorter or longer periods in Somali areas in neighboring countries or exile areas. Whatever their country of origin or residence prior to migration, most of them wanted to be registered as Somalis in Norway. This could be due to lack of citizenship in the country they came from, or a more practical approach to secure a residence permit in Norway. In general Somalis regard their ethnic Somali identity as more important than national identity, and also many are able to trace some clan affiliation to

somewhere within Somalia through the flexibility of the clan system in practice (Gundersen 2001; Helander 1988; Haakonsen 2005).

Somalis varied and complex background, and the encounter with Norwegian stereotypes of Somalis, can at times be challenging for both parties. The Somali values of pride, strength and generosity, and the background that many have from the better-off urban social strata, at times clash with their position as a refugee minority in Norway (Engebrigtsen & Farstad 2004; Klepp 2004). The Somalis themselves often expressed discomfort at being presented as "uneducated and ignorant people from a refugee camp". One example: During a conference a speaker on exile problems introduced her session with a slide showing a Somali refugee camp and a map of Norway to illustrate the route and change in the life of Somali women coming to Norway. Some of the Somali women in the audience were furious and criticized her harshly afterwards. They claimed that her presentation of them coming from a refugee camp was inappropriate. They were "good women", they said, "coming from good families, with good education, economy and social standing". To be presented as refugees, they regarded as shameful and degrading.

From the Norwegian perspective on the other hand, conflicts and confusion seem to arise when Somalis present themselves with pride and self-assertion, rather than as humble refugees (Fadel et al 2000; Klepp 2004). This becomes particularly noticeable in the case of Somali women, as they often do not fit into the Norwegian perception of oppressed Muslim women who are expected to be "extra" humble due to their genital cutting. Instead Somali women often spoke out clearly about what sort of care and assistance they wanted.[13] Norwegian care workers expressed a double attitude to Somali women: they found them difficult, as they did not "fit into the system", but at the same time they also expressed admiration for the strong Somali women (see also Klepp 2004).

Female Genital Cutting

I will here limit myself to a simplified description of the practice in relation to major discourses on typology, since I in the papers present physical and cultural aspects relevant to the subject of each. Female Genital Cutting is a common name for a

number of traditional surgical procedures on women's genitals (Sundby 2003). The World Health Organization defines the practice as comprising:

> *"all procedures that involve partial or total removal of the female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reasons.*

The WHO definition distinguishes between four major types, based on which parts of the genitals that are affected: Type I the clitoris, Type II labia minora and Type III labia majora. Type IV groups together all other genital practices.[14]

As described above, I have found it most relevant to distinguish between *excision* and *infibulation*. I define as *excision* all procedures that involve partial or total removal of the clitoris and/or labia minora (Type I and II in WHO's classification). In infibulation, excision is followed by scraping or cutting into the labia majora, after which the two sides are joined together (Type III in WHO's classification). The healing creates a seal of skin that covers most of the vaginal area, leaving only a small opening at the lower end for the passage of urine and menstrual blood.[15] Though the WHO definition describe a total removal of the clitoris and labia minora, recent clinical evidence indicates that a large proportion of Somali women have various amounts of clitoral tissue more or less intact under the infibulated seal (Austveg et al 1998). However, all typologies are standardized simplifications and cannot depict the large variation that exists in practice. To highlight the complexity of the procedures, and hence the various ways in which it may be experienced, I will therefore outline some variations.

Firstly: As the WHO typology is based mainly on the outline of the genitals, some practices are difficult to fit in. This includes the practice of removing only the labia minora, reported from Ethiopia (Rye 2002), Egypt and Tanzania (anecdotal information). It has also been questioned whether a seal formed by the labia minora should be defined as infibulation. This practice has been reported traditionally from some countries (such as Nigeria), and may also be what is commonly referred to as sealing in other west-African countries (such as the Gambia). Among Somalis and northern Sudanese, this is often described as a "new fashion", often referred to as "intermediate" or "*sunna*" circumcision. Excision (*sunna*) is gaining in popularity among people who oppose infibulation, as it is considered to be a less invasive

procedure (Almroth 2005; Bergjord 1991; Boddy 1989; Gruenbaum 2001; Guering & Elmi 2004; Ismail 1982; Kwaak 1992; Jaldesa et al 2005; Johnsdotter 2002; Osman 2002; Sanderson 1981; Talle 2003; Worldbank/UNFPA 2004). A couple of my informants also described two-layered infibulations, in which both the labia minora and majora were closed. It is not known whether this was intentional or a result of the healing of the wounds.

Secondly: There are personal variations. Since FGC is traditionally performed by women learning their skills from their mothers rather than in a standardized education, their practices vary. It appears that some of the creativity of naming that will be discussed later also refers to specific styles developed by individual circumcisers. The increased circumcision by medically trained staff (medicalization) imply further variations, apparently often in the form of more extensive cutting. For example, it turned out that some informants that had been cut by medical doctors, had got all of the clitoris and inner labia removed, in contrast to the clinical evidence that suggest this to be rare. Part of this may be related the use or non-use of painkillers, as the cutting may be affected by the extent to which a child reacts to the pain by kicking and moving. Another factor that may affect the outcome of the procedure is the physical state and age of the girl at the time of the operation.

Thirdly: Varying results may be caused by differences in the healing process. Complications such as hemorrhaging, infections and the scar formation may affect both the physical result of the operation and the personal experience of the procedure. A significant aspect of infibulation is a high incidence of a second, and at times even a third operation, if the resulting vaginal orifice is not regarded as small enough after the first. Though not given much attention in former studies, this was the case for more than half of my informants (see also Chalmers et al. 2000; Bergjord 1991). I lack information on any physical consequences of this, but women described this repeated infringement as a tremendous burden (see also Fjell et al 2003).

Fourthly: The life-long effects of FGC may vary. But in general, infibulation affects the women throughout life. From the period of a successfully healed infibulation until defibulation at marriage, menstruation can cause various problems - usually long and painful periods, and occasionally infections, as described by most of my informants. Urination can also cause problems - usually slow and painful passage of urine (Dirie 1985, 1991; Dirie & Lindmark 1991 b.; Ntiri 1993; Obermeyer & Reynolds 1999; Obermeyer 1999; WHO 2000). Often the urine will first be pressed

into the vagina before dripping through the vaginal orifice. Both Somali women and health care professions confirmed that urinary problems occasionally cause kidney problems, such as stones and infections.

Upon marriage, the infibulated scar has to be cut open – *defibulated* - to facilitate sexual intercourse. This causes painful wounds that take some weeks to heal. In Norway the procedure is often carried out in the hospital, where painkillers are used, and women are advised to refrain from intercourse until the wounds have healed. If defibulation is done in a traditional way (that is by the man's penis or the knife of a circumciser, see Papers I and II) repeated intercourse is necessary during the period of healing to prevent re-growth of the infibulation. Though most women told of a normal sexual life after their defibulation, some experienced sexual intercourse as painful for prolonged periods.

At birth, and especially before the first delivery, the infibulation has to be further opened to facilitate the passage of the baby. This may be necessary also at later deliveries if the mother has not been fully defibulated, or has been (partly or fully) closed again - *reinfibulated* - after her first delivery. Somalis in general have no tradition of full reinfibulation to the extent of re-creating virginity (Chalmers et al 2000; Momoh et al 1991; Talle 1993). At times spontaneous and partial reinfibulation may take place during the healing of the wound. Reinfibulation is however well known from Sudan (Berggren 2005). Familiarity with the Sudanese practice is probably one reason why reinfibulation has occasionally been performed in Norway, as is dealt with in Paper III. Birth complications are aggravated by infibulation, both in their countries of origin (Banks et al 2006) and in Norway (Vangen et al. 2002). At times reduced elasticity in the remaining tissue also causes a need for more extensive episiotomies, even after several deliveries. Infibulation is also associated with an increased rate of primary infertility (Almorth 2005).

Fifthly: The challenge involved in gaining exact knowledge of the type of circumcision and how it may affect women physically, is increased by a large discrepancy between stated type of FGC and medical status, which has been documented in communities practicing infibulation (Almroth 2005; Gallo & Abdisamed 1985; WHO Somaliland 2002; Worldbank/UNFPA 2004). It has been found that more than half of the women claiming to be cut in the *sunna type* were actually infibulated. The others had excision (WHO Type I and II).

It is significant to establish the type of FGC, as many of the medical sequelae vary significantly with the type. Generally infibulation is a much more invasive procedure with regard to both short and long-term consequences. In contrast to the various long-term effects described above, *excision* (Types I and II) is generally a one-time event. It involves acute pain and risk of complications, especially of hemorrhaging and infection, but there seems to be considerably less extensive and widespread. Some of the risks, such as cysts or excessive scar formation (keloid), are not universal. Nor does excision cause such widespread problems of obstructed urine and menstrual fluid, barriers to sexual intercourse and physical obstruction of labor as infibulation does, as these complications are directly related to the barrier created by the closure in infibulation (Banks et al 2006).

There are less than a handful of studies on the psychological consequences of FGC (Behrendt, & Moritz 2005; Gallo 1986 a; Gallo & Bosocolo 1985; Fjell et al 2003). Some indications can also be drawn from the few studies on pain as discussed in Paper I. It appears that infibulation is experienced as significantly more painful and traumatizing than less extensive forms of genital cutting (Hernlund 2000b). This may be related to the fact that infibulation is a significantly larger operation, taking about 15-20 minutes. Also the healing period needed is usually significantly longer, taking about 6-8 weeks. There is more risk of complications and more need for repeated surgery later in life (see Paper I). This is also evident from the strikingly higher focus on pain and complications in studies from infibulation-practicing societies (Boddy 1989, 1998; Gruenbaum 2001; Talle 2001, 2003). Studies in exile often also focus on the additional burden of stigmatization and increasing meaninglessness of the practice (Paper I, Johansen forthcoming b; Talle 2003, forthcoming b; Tiilikainen 2003). Furthermore, in studies on the sexual impacts of FGC, the effects are often also defined as partly psychological (Bur 2004; El-Deefrawi et al 2001). This significantly greater harm and risk associated with infibulation compared with excision, is a major reason for the widespread consideration of a transfer from *infibulation* to *excision* as an improvement.

FGC among the Somali

FGC is close to universal among the Somalis, where the majority has undergone infibulation (Dirie & Lindmark 1992; Worldbank/UNFPA 2004).[16] To get a

closer understanding of the practice and its local variations, I will first discuss some local terminology.

FGC is usually designated by the term *gudniinka*, which simply means to cut, and may be used to designate both male and female genital cutting. When used on women, it generally means infibulation (Abdalla 1982; Kwaak 1992). One expression of this was an informant who insisted that there was no female circumcision in Egypt, refusing to believe statistical evidence of its wide occurrence. This she grounded in her inability to trace a surgeon familiar with defibulation procedures, while she was living there for a period. Another example was a young male translator who stated that he had several friends who had married uncircumcised women. After some time of contemplation and further discussion he specified his message; “You know, when I said these wives were not circumcised, I meant that they were not infibulated. They have of course all had *sunna*”. And a third example was the translator in a conference, who systematically translated Scandinavian references to "circumcision" with the Somali term for infibulation (gudniinka pharaon).

The most commonly used term to specify infibulation is *pharaon (gudniinka fircooniga ah)*, a term related to the common belief that the tradition originates from the Pharaos in Egypt. Other terms refer to the enclosure through the act of sewing, such as *tool* and *quiduub*, which are linked with perception of kinship and clan identity (Talle 1993). To refer to excision, different terms are used. Often *gudniinka* is specified as *gudniinka sunna*. *Sunna* being a part of Islamic terminology referring to good deeds done in the name of religion, the term suggests a closer religious association in excision than in infibulation (Jaldesa et al 2005; Roald 2005). Another term, *Gudniinka Fadumo,* refers to a belief that the daughter of the Prophet Mohamed was circumcised in this way, though this public belief has no support in religious scriptures (Kristensen 2005; Talle 2003; World Bank/UNFPA 2004). *Fadumo* circumcision has been described alternatively as infibulation (Kristensen 2005) or excision (Talle 2003; Osman 2002). This term was however not used by any of my informants, who preferred the term *sunna*.

How should we understand the extent to which informants who resisted FGM, wanted to replace *infibulation* with *sunna*? (se also Talle 2003; Johnsdotter 2002 and forthcoming; Musse 2001; Worldbank/UNFPA 2004). Some defined this as an abolition of FGC, as *sunna* was generally not understood as a type of FGC, but as “something else”; “We have stopped FGM, we just do the *sunna*”, many said. Others

defined a change as a first step in a longer process towards abandonment of all types of FGC. But what is *sunna*, technically speaking?

Generally the informants described *sunna* as a minor and harmless cut into the genitals, for example: “Just a small cut in the clitoris”, or “Just a small pinch to draw some blood”. In literature it is frequently described as the removal of the clitoral prepuce (Talle 2003; see also Johnsdotter 2002). There were also variations between verbal expressions and their physical demonstration. For example, women who described *sunna* as just a pinch, when illustrating it on a play-dough model, they removed some tissue from the clitoris (se also Hassan 2002). This resemble Aud Talle’s observatioin of a *sunna* circumcision in Somalia, noting that they removed a visible amount of tissue, probably the clitoris and the labia minora (Talle 2003).

One indication of what appear to be different understandings of the practice can be deduced from Osman description of *sunna* circumcision as “What should be cut is just the minor foreskin with the medical term of clitoris” (Osman 2002). Several of my informants, both male and female, drew a parallel between the clitoris and the male foreskin. That is, they saw removal of the foreskin of the penis, to equal removal of the clitoris in women. The parallel is also linguistic, both being referred to as foreskin (*buryo*). For example does one of the derogatory terms for uncircumcised women (*gabar buruyoqap ah*) indicate a girl who has not had her foreskin removed (Talle 1993, 2003).

But the descriptions of *sunna* were even more varied. A common statement was that *sunna* designates all forms of genital cutting that are not defined as infibulation (Talle 2003; Johnsdotter forthcoming). Some described *sunna* as: “Just removing a small part, just the part which comes out,” and “You just sew a few stitches on top”. A circumciser in Somalia described her *sunna* procedure as follows: “You just remove the clitoris and part of the inner lips, and then, when you tie the legs together, they heal together. This makes a much softer seal, and is more easy to brake than infibulation. And sometimes the opening is also larger”. Another common distinction between infibulation and sunna was whether thread or thorns were used to close the wound, which would define the procedure as infibulation, or a traditional herbal mixture (*mal mal*), which was understood as *sunna*.[17]

This variety of classifications differed not only between people, but at times also by the same persons at the same time. In one case, for example, a mother described that both she herself and her daughters had a *sunna* FGC. But while her

sunna included an infibulation of the labia minora, that of her oldest daughter was described as "just removed the protruding stuff. We didn't sew or tie it together" and the youngest had "just a small tip of the clitoris" removed.

New terminology also seems to be created for local and historical variations, and also to designate variations in types.[18] In Somalia I encountered the terms; *sunna kabir* (large *sunna*), *sunna saghdir* (small *sunna*) and *cross.* As a type of FGC *cross* was described as a procedure that "remove the clitoris and the inner lips and sew two stitches just to stop the bleeding". The term draws associations between the hump of a camel (*cross*), and "animalistic" feature considered necessary to remove to beautify a woman (see also Talle 1993). Hence we see the complexity of the issue, and the way in which both terminology and definition is in a constant flux.

The large discrepancy between the many who claim *sunna* circumcision but were found to be infibulated, I suggest can be partly explained by the ways in which *sunna* fails to fulfill the central function of infibulation to create and preserve virginity.[19] Hence, while there is a strong political and religious motivation to do *sunna* rather than infibulation, people are not ready to "leave it all wide open", as many put it in Somalia. A group of medically trained anti-FGC workers in the Somaliland town of Boroma, told several stories of mothers who had come back with their daughters for infibulation after formerly agreed to limit the genital cutting to excision. It was too open, the mothers said. This group of anti-FGC activists, strongly recommended *excision* (in the form of *cross*) in place of infibulation and had declared their city an "infibulation free zone" at the gate of the town.

In practice, it can look as if the major difference between *sunna* and infibulation was rhetorical. In other words, that the term of *sunna* provided a new and more politically correct word for a variety of procedures, which in reality usually meant infibulation (Worldbank/ UNFPA 2004). In a way then, we can discern a change to more religiously flavored terms, such as *sunna* and *Fadumo*, which may also indicate an increased religious legitimization of FGC (see Opsal 2005; Roald 2005).

Type of FGC also vary with clan and ethnicity. Although information is scarce and uncertain, some patterns do emerge. Infibulation seems to be universal in the cluster of majority clans (*Darood*, *Isaaq*, *Hawiye*, *Digil* and *Rahanwiin*). The only possible exceptions are the *Rahanwiin* sub-clans, *Dabarre* and *Lisan* (Gallo & Abdisamed 1985), and an indications of less infibulation among the *Sab*-clans in

general, where it may have gained a foothold only recently as a way to maneuver towards the higher social status of the nomadic *Samaali* clans (Gallo & Viviani 1998).

Most informants believed that Somalis of Arab decent, particularly the *Reer Xamar* clan, performed *sunna* circumcision rather than infibulation, though it has not been possible to trace statistical evidence (Talle 2003; Johnsdotter 2002; Kwaak 1992). Nor is much known about genital practices among the *Bantu* Somalis. Many of my informants, however, believed that infibulation was less widespread among this group, and there are indications that at least one large group, the *Wazigua,* practices excision rather than infibulation (Declish personal communication, see also Johansen forthcoming a).

The *Midgaan* stand in a special position among the three Somali minority clans, as this is where the traditional circumcisers are drawn from (Osman 2002). Circumcisers in Somalia explained that the position of circumciser is traditionally passed down from mother to daughter. The daughters would first start to assist in the circumcision by holding the girls. Only when they had passed the age of fertility could they start doing the actual cutting themselves. This was related to fear that the act of cutting could endanger their own fertility. The *Midgaan* also had other specialized roles, particularly as midwifes (traditional birth attendants), and in treatment of infertility and some other medical care for mother and child (Osman 2002).[20]

In an attempt to reduce discrimination of these minority clans, the Somali government forbade the use of their names (Kwaak 1992). This may be one reason why so many informants seemed uncomfortable using the name. Though many informants knew some *Midgaan* in Norway, they refused to introduce me to them, because identifying them could be disrespectful. "*Midgaan* keep to themselves here, in an effort to avoid their stigmatized status", they said. It was rumored in some circles that the *Midgaan* did not practice infibulation themselves, but that infibulation was their form of revenge on the upper classes for their subordinate status. Whether these rumors contain any truth or not, they point to the Somalis' ambivalent and difficult relationship with the *Midgaan* and their role as circumcisers (Osman 2002; Talle 2003). Circumcisers are now said to be drawn from all clans and social strata, and is also now performed by women in childbearing age. This is partly due an increasing medicalization of the practice (Worldbank/UNFPA 2004).

All in all then, most evidence from Somali areas indicate that circumcision is still close to universal, with infibulation as the dominant type. The major change that

can be identified is the high increase in medicalization (WHO Somaliland 2002), and an increase in public debate. It is also said that resistance to the practice has increased. However, as widespread resistance was reported more than 20 years ago (more than 40%), it is difficult to estimate what type of change actually can be detected (Abdalla 1982; Ismail 1983).

International efforts to combat FGC

FGC was first described in the west through records from missionary accounts and colonial administration. A few efforts to prevent the practice are reported in the early 1900s, but they met with little success. In fact, these efforts often proved counterproductive, as local reactions to negative attitudes of colonial administrators often strengthened their adherence to the practice (e.g. Thomas 2000). After most African countries gained independence in the 1960s several of the new governments implemented their own measures.

International agencies, such as the UN, also have a variegated history. The UN Commission on the Status of Women discussed FGC at a meeting in 1952, and in 1958 they requested the World Health Organization to undertake a study. The WHO took the view that such social and cultural matters were outside their competence. Two years later African women speakers at a UN Conference in Addis Ababa asked the WHO for a study. Although endorsed by WHO in 1961 as a part of a wider study, this was never carried out. The issue was raised again at a UN conference in Togo in 1964, this time with an appeal also to African governments.

In accordance with the reluctance of several UN agencies, FGC was not addressed directly at the first world conference on women in 1975, but here the WHO urged governments to “foster useful traditions but to abolish harmful practices”. However, the issue was increasingly pushed to the front by a growing number of educated African women in influential positions. In 1976 the Director-General of WHO drew attention to the issue, and a review of literature on health complications was published. International efforts finally took off in February 1979 when the WHO sponsored a “Seminar on Traditional Practices affecting the Health of Women and

Children" in Khartoum, Sudan (Sanderson 1981). The next year, in 1980, a group of African women addressed the issue at the NGO Women's Forum in Copenhagen that was held simultaneously with the UN Decade for Women Conference. Here, also UNICEF declared its commitment to support the abolition of FGC (Sanderson 1981; Rahman &Toubia 2000; www.amnesty.org). Since 1989, major international organizations have targeted FGC. In 1993 the UN included FGC in its definition of violence against women. The practice has since been included in several UN declarations (1994, 1995). And in 1997 WHO/UNFPA/UNICEF made a joint declaration to support global, national and local efforts to abolish FGC (WHO 1997).

In 1984, the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) was established, with the abolition of FGC is a key objective. Now the IAC has member organizations in 26 African countries.

In the last decade, FGC has also been an issue in the west. The European Union has raised its voice against FGC, and contributes financial support to both research and outreach projects in Africa and exile countries. Several countries, including Sweden, Denmark and Norway, have established national plans of action and projects to work preventively. In other countries most of this work is done through NGOs, though with financial support from the government. Many of these countries also include efforts to combat FGC in Africa, particularly through foreign policy and development aid.

In western countries, FGC largely became a public concern as a result of increasing immigration from affected countries. In response, many countries passed specific laws against FGM: Sweden in 1982 and revised in 1998, England in 1985 and revised in 2004. Both revisions were made to remove the principle of double incrimination to ensure that FGC can also be prosecuted if carried out in another country with no legal regulations. The Norwegian law of 1995 was late in comparison. However, it had from the start a clause exempting the principle of double incrimination. Other nearby European countries, such as France and Denmark, decided not to pass a special law, but defined FGC as an act of crime and as child abuse (see Rahman & Toubia 2000).

Political management of FGC in Somalia

Of special relevance for the work in Somalia was "The Seventh Obstetrical and Gynecological Congress of the Sudan" which was held in Khartoum in 1977. Attending here was Edna Ismail, at the time Director of Training at the Ministry of Health in Somalia. Inspired and encouraged by the open and direct discussion and the existence of reliable data, she also raised the topic in her home country (Ismail 1983). She had been trained as a midwife and had work experience both in England and at home, and had been concerned about the amount of unnecessary suffering infibulation brought upon women (see Paper I).

On her return to Somalia Mdm. Ismail focused on FGC in an upcoming conference for the newly founded Somali Women's Democratic Organization (SWDO). The association, gathering more than 500 women from all over Somalia, responded with spontaneous support for modification or abolition of infibulation (Ismail 1983; Sanderson 1981). In 1978 a national commission, co-ordinated by the SWDO, developed a nationwide campaign for the elimination of FGC/infibulation. In the following years several activities were started, both studies (e.g. Abdalla 1982; Ismail 1982; Talle 1993) and campaigns directed at the community, including university health care students. Some major public hospitals were banned from or decided to refrain from performing infibulations. A couple of my informants had been involved in one way or another with the campaign.

One project joined medical doctors, religious leaders and Mother/Child/Health clinics (MCH) to develop a program to change attitudes and practice. Part of the project was to train circumcisers to perform *sunna* (here defined as removal of the prepuce). This was part of a program to teach Traditional Birth Attendants (TBA) more hygienic birth care and circumcision procedures, including the use of sterile razor blades etc. (Ismail 1983; Kwaak 1992). A similar strategy was adopted in Djibouti. Here it was later abandoned upon realizing that the circumcisers continued to perform infibulation as before (personal communication with the Ministry of Health in Djibouti).

In 1987 the Somali government arranged an international conference in Mogadishu, where both Somali religious leaders, politicians, circumcisers and ordinary women participated. What struck me most when watching a videotape from the conference, was that it hardly diverged from the numerous international

conferences against FGC I have attended, 20 years and more later. It included: declarations by religious leaders that infibulation was not a religious act, declarations from circumcisers that they would stop the practice, declarations from politicians that they would fight against it, and stories of the sufferings of ordinary women.

The increasing internal conflicts and finally the civil war, however, brought a halt to most of these governmental efforts within Somali proper. But in Somaliland and Puntland some steps have been taken to discourage FGC (Worldbank/UNFPA 2004). The Kenyan legal ban on FGC, also affects the large Somali population in the country, and prosecutions have occurred. So also does the Djibouti ban on FGC, although no prosecution has been carried out so far. There is also many projects run by international and local NGOs in all the Somali areas (Worldban/UNFPA 2004). Common to all activities, however, is that they have been almost uniquely addressing infibulation, while accepting or even promoting *sunna* (Musse 2001; Worldbank/UNFPA 2004). For example was there in 2005 described a project in a major hospital in the Mogadishu region, in which medical doctors perform *sunna,* described as a small cut in the prepuce, but with legs tied together (Hjort-Larsen 2005).

The history of FGC in Norway

The first recorded official concern about FGC in Norway was a circular letter distributed by the Ministry of Social Affairs and the Director of Health in 1980.[21] The purpose of the circular was to make clear that doctors in Norway could not perform FGC, and was partly caused by reports that some health workers had received requests for this. At that time, however, there were only about 300 women from countries practicing FGC in Norway.[22] Around the same time the Norwegian Agency for Development Cooperation (NORAD) also made a review of anti-FGC work in developing countries (Kramer 1983).

One of the first efforts after the sudden increase in infibulated women in the early 1990s was to write a manual for health workers. Though this work started in 1992, it was not finished until October 2000. The extended length of time was mainly

explained by the need to deal with the many ethical and legal dilemmas related to the issue.

During these first years of immigration from FGC practicing communities, the Ministry of Health did not consider it necessary to establish a special law against FGC, as existing laws were considered adequate. However various national and international NGOs, with feminist and human rights organizations in the forefront, pressured for a specific law. Ministerial work on the law started around 1993, with reference to the fact that existing laws could be unclear on certain situations: circumcision performed outside the country, circumcision with the consent of an adult woman, and reinfibulation after delivery. The Ministry of Health circulated a draft Bill for comments in February 1995, and in December the same year the Act was adopted.[23] In 2004, an additional provision was included to emphasize and clarify the duty of public servants to prevent FGC. This new provision was said to be necessary to ensure that non-infibulating practices were included in the regulations on crime prevention and child abuse. This time the circulation and the legal discussions were in the hands of the Ministry of Health.[24]

The Ministry of Health sent out a circular to inform all the hospitals about the new law, as discussed in Paper III. The reactions among health workers were mixed. Some saw it as an expression of distrust in their professional integrity, and hence as an insult. Existing laws were seen to be sufficient guidelines to discourage doctors from performing FGC. Some also felt that the ban on reinfibulation overruled their professional authority, as the decision whether to reinfibulate or not was one that should be taken on medical not legal grounds. Many were also concerned that the law was disrespectful to women's wishes, which may include reinfibulation: "Who are we to decide that she cannot leave the hospital the same way as she came in?" several doctors asked (see also Allotey et al 2001). A number of doctors told me that they had changed their opinion in hindsight, seeing the law both as an aid to their work and as an important signal to practicing communities, to prevent having genital cutting performed abroad.

As we can see, health care was the major consideration when the legal ban on FGC was introduced. Little attention was paid to the role of the law in preventing affected groups from, say, going abroad to have it done. This can be seen in the way FGC was first and foremost defined as a health problem, and therefore dealt with by the Ministry of Health and Social Affairs.

When the Bill was distributed for consideration by appropriate bodies, these did not include any national organization from affected communities. Only a couple of immigrant organizations were included, and most of their members came from societies in which FGC is unknown.[25] Later, the Act was not translated into languages spoken by the affected communities or communicated to them. Nor were there any plans for information work and attitude-changing campaigns - in spite of the fact that this was strongly recommended by several of the consultation bodies.

When I called round to various ministries during the planning and early stages of my study in 1996-1997, the prevailing attitude was that there was no reason for further focus on FGC. Both the Ministry of Children and Family Affairs and the ministry responsible for immigration defined it as a health issue, and thus not their responsibility. Besides, the law had clearly defined the practice as illegal and the problem was solved, they claimed. Many of them strongly advised me to stay away from the subject.

One reason for their preference for silence was a desire not to revive the tension between health authorities and the African population that had arisen just a few months earlier, when the so-called "African case" (Afrikanersaken) featured in the media headlines (e.g. Buntu 1996). In the summer of 1996 the Norwegian Board of Health had issued a warning against an increased risk of HIV/AIDS from having unprotected sex with men of African origin. African organizations and spokesmen reacted with fury to being pointed out as major carriers and spreaders of HIV. They arranged demonstrations, and made complaints both inside and outside the country, and even reported the Norwegian Health Authorities for contravening international laws on antiracism and human rights to the International Commission for the elimination of racism and discrimination. This was very uncomfortable for the health authorities, activists in the African-case argued, and may partly explain the apparent political desire to shun the issue of FGC.

The desire for silence was also spurred by the worry of stigmatization of the Somalis. At that time the Somali immigrant community was a recent arrival, and already the subject of negative stereotypes. Somalis were defined as "difficult", and both media attention and research focused heavily on social problems, such as criminality, unemployment, high reliance on social support, problems related to child care, high divorce rates, and housing problems (Fadel et al 2000; Klepp 2004;

Højdahl 2000). Their background in a lawless country, ridden by civil war, was a part of the picture.

However, I also got the impression that both the authorities and lay people expected FGC to stop automatically in Norway. Not only was the law expected to prevent FGC, there was also an expectation that affected groups, when encountering the modern Norwegian society, would be "enlightened" and realize the wrongs of such a practice, and consequently abandon it. One aspect of this was the extent to which care workers expected Somali women to be ashamed of their circumcision.

The media coverage of FGC generally coincided with the rhythm of political attention. It had featured from time to time since long, but generally as a distant custom, confined to the furthest corners of Africa.

FGC first appeared in the media as a relevant issue in Norway in the summer of 1993, when the municipal hospital in Bærum was accused of "re-constructing" (reinfibulating) circumcisions after delivery (Dommerud 1993 a,b; Osvold 1993; Skogsstrøm 1993, NTB 1993).[26] At that time Bærum Hospital received most of the newly arrived refugees and asylum seekers, due to its situation close to the main airport. The hospital admitted that they had done this formerly, when they were unfamiliar with the procedure, and when the newly arrived women panicked if they were not stitched. However, they denied that the practice was still going on (Smith 1994 b). "Now," the hospital said, "We only repair what we cut". However, they were aware that this could come close to reinfibulation:

> "(. . .) when we have to snip a circumcised woman during delivery, we cut into the old scars and in a different way than with Norwegian women. We have to suture what we cut, and this may therefore be called a reconstruction". (Dommerud 1993. My translation).

Their denial was thus based on the fact that they "do not sew them back to small tight openings" (op cit.). Such obscurities were also discussed by some of my health worker informations, for example by rhetorically asking; "How many stitches would count as reinfibulation? We have to sew some stitches, you know". This discourse is probably a major reason why the legal ban of FGC includes a specific clause against "reconstruction" of FGC.

In the weeks after the Bærum case, also some African women, mostly of Somali origin, were interviewed in the media. Their presentations focused mainly on the pain and suffering caused by the practice, combined with its socio-cultural significance in their country of origin (Harestad 1993; Smith 1994 a). Support for the tradition was also expressed, for example by the leader of the largest Somali association in Oslo (Smith 1995 b).

Also some women's and human rights organizations tried to get media attention, to support their argument for a law against FGC. They got limited attention, however. Of particular interest is the refusal of the daily newspapers to print a campaign advertisement for an NGO - the Norwegian Humanist Association, in 1995. The advertisement, featuring a naked white woman with the shadow of a razor blade covering her genitals and the caption "When she was five years old, they cut away her love", was regarded as discriminatory (Hansen 1995). After the year of 2000, however, both TV and newspapers have carried color photos of actual FGC operations, as in the "Kadra program" described further on (see also Olsen 2005).

Then followed several years, from about 1996 to the fall of 2000, in which FGC was hardly mentioned. This coincided roughly with the years in which I carried out the bulk of my fieldwork. During this period, some African women were working continuously to raise the issue and to work preventively, but were given little support and almost no public attention. They include Chiku Ali from Tanzania and Sarah Khasai from Eritrea, and later Somali women were affiliated with the project for immigrant women (PMV). Some of them found this frustrating, whereas others were happy to be able to work in peace within the communities.

Then, in October 2000, the issue of FGC again hit the headlines. This time the attention was triggered by a TV documentary focusing on FGC performed in Norway. Two subsequent documentaries in a series labeled "The state of the nation" (*Rikets tilstand*) were shown on the private TV2 channel. It was commonly referred to as "the Kadra case" after the young Somali woman who played a major role as an undercover journalist in the program. A major part of the program, and the part which got the most attention, features Kadra asking a series of Muslim religious leaders of Gambian and Somali origin whether she should obey her parents' desire to have her infibulated. The answers she got from four religious leaders, three Gambian and one Somali, varied. Whereas two, including the Somali one, expressed more or less support for the practice, two clearly defined FGC as a non-Islamic practice. However,

they too advised her to submit to the practice in order to obey her parents. The program also produced a list of 29 girls living in Norway said to have been taken out of the country for genital cutting. One of them was anonymously interviewed.[27]

The programs created a moral outrage in Norwegian society, which mainly targeted the religious leaders. Their failure to take a clear stand against the practice was regarded as a total failure in their role as religious advisors (e.g. Pedersen 2000; Viken 2000). Also the focus on risk of FGC for girls living in Norway appeared to come as a shock to many people. Several politicians stated that they had no idea that FGC was still practiced among affected groups in Norway (Bekkemellem-Orheim 2002; Jensen 2002).

Within a couple of months after the programs, the Norwegian Government had presented a National Plan of Action against FGC (BFD 2000). A major measure in the plan was to establish a national project to work on information and communication with the affected parties. This was the OK Project.[28] In 2003 the Ministry of Foreign Affairs launched an international plan of action against FGC (MFA 2003).

The Television programs and the subsequent debates and measures also had wide-ranging consequences for the Somali communities in Norway. One was to increase the sense of vulnerability and of being stigmatized that seems to affect men and young people in particular (Nath & Ismail 2000;Talle 2003, forthcoming a, b). However, health workers and others also reported more openness and requests for assistance from circumcised women. Also there has been a high increase in the number of women and men who are actively engaged in working against the practice. Some districts in Oslo, as well as some communes around the country, later developed specific guidelines on how to deal with FGC. The Directorate of Health also took an initiative to professionalize health care for infibulated women, building up regional competency. All in all, then, by breaking the silence surrounding FGC, the programs did contribute to a host of changes that also benefit Somali women.

Apart from all the projects and activities initiated, the study suggests that the mere act of moving into exile entails an increased resistance against FGC among the Somali. Most of my Somali informants reported a general resistance to FGC, particularly in the form of infibulation. Similar findings are found elsewhere in Norway. In a study of women's adjustment to life in Norwegian exile, Meramitdjan reports that women experience their resistance to FGC and focus on gender equality as their

major change in exile (1995, see also Klepp 2002). A similar pattern was identified in Bergjord's smaller study on attitudes to FGC (1991). The same tendency has been found in other exile countries (Talle 2003; Johnsdotter 2002; McGown 1999).

Many Somali women have also taken active measures to combat FGC. I personally know three Somali women in Norway who have made FGC a part of their studies: Asha Barre wrote about how nurses can "reduce pain and infection without humiliating women's self image" in her nursing thesis (Barre 1998), Marian M. Osman wrote a thesis on the legal and criminal aspects of FGC in Norway and Somalia as part of her bachelor's degree in criminology (Osman 2002), and Khalgacal Hassan wrote her midwifery thesis on care for infibulated women in childbirth (Hassan 2002).

I also know personally several women who have spent their holidays going to their home areas to spread information, usually without any financial support. The numerous organizations and conferences arranged in Norway and other western countries also bear witness to increased activity and an increasing number of women involved. This increased activity witnesses a change of attitude that is visible in all my papers.

As pointed out, some of my informants had been against the practice when they were still in Somalia, although most of them only in their minds. To explain the gap between a rather long-standing and widespread resistance against FGC, and the lack of factual change, Mackie and others have emphasized the importance of social pressure, and the importance of stimulating social change (Mackie 1996, 2000; Izett & Toubia 1999). As expressed by a Somali anti-FGC activist residing in Nairobi, the capital of Kenya; "I'm against it, but what can I do? If she was not circumcised, she would be ostracized" (see also Worldbank/UNFPA 2004). However, I share with Talle and Johnsdotter the impression that women in exile have a much higher chance turning their conviction into practical results. The increasing degrees to which even young unmarried girls arrange for defibulation, and often with the support of their parents, suggests that the significance of infibulation as a guarantee of virginity is diminishing. Though this is most clearly evident in exile countries (Kristensen 2005b; Vangen, personal communication), I also met women in Somali areas who had been defibulated independently of marriage.

Chapter 3

FIELD WORK METHODS AND INFORMANTS

In order to grasp FGC in the complexity of urban exile life, the fieldwork was "multi-cited" (Marcus 1995). This implied that I followed a theme as it appeared in various settings, rather than doing an in-depth study of a delineated community (Engebrigtsen 2002; Frøystad 2003; Hannerz 1980, 1996). In a sense, the anthropological aspiration towards a holistic approach is a prelude to this type of fieldwork, but urbanization and globalization increase the need to include settings that may be wide apart in both space and type. This meant also that participants could vary in the different arenas. Areas I searched out included such different arenas as for example, weddings in Oslo, a beauty saloon in Somalia, Somali web-discussions, childbirths, medical records and local, national and international conferences.

This multi-cited approach demanded the development of a variety of data-collection techniques suited for the different contexts. The complexity of the issue at hand also demanded method "triangulation". By this I refer to ways in which the same topic was targeted from different angles, in various social situations, combining oral information in interviews and discussion groups with observations, statistical material, medical records etc. I also made extensive use of visual techniques, such as pictures and anatomic models of female and male internal and external genitals, drawings and forming of clay, etc. Other sources of information included artistic expression, such as songs, poetry, theatre performances and jokes, as well as rituals and symbols.

The study is based on social anthropological methodology and fieldwork comprising mainly of repeated in-depth interviews and participant observation in various settings. Emphasis was put on keeping the interviews informal and flexible, partly in an effort to reduce the degree to which the researcher's pre-designed ideas could influence the choice of information gathered. It was also ethically necessary to make room for the many strong personal experiences informants wanted to share, even if these were not relevant to the study as such. To grasp the variety of cultural norms, as well as the interplay between personal experience and cultural models, comparing data collected in different contexts can provide new insights and a "thicker description" (Bernard 1995; Engebrigtsen 2002; Geertz 1973).

In my description of field and method, analytical approach and in the papers themselves, I distinguish between arenas in which Somalis, or health care workers are in the majority. To relate to the various groups of participants, different interview guides and check lists were designed: Somali women, Somali men and health care providers. [29] These were developed and tested out during the pilot study.

My ways of approaching the informants differed from group to group. Among the Somalis, where both informants and researchers alike were busy with many other activities, such as studies, work, bringing and fetching children in nurseries and schools, meant that there were little opportunity for participant observation as there would be in a village or in a "street corner society". Consequently most of the information had to be collected through agreed meetings. Access to informants and information thus required that informants were both interested in participating in the study and were confident that their participation would not lead to discomfort. Hence it was important to secure a relaxed and unofficial atmosphere with great flexibility in time spent together and themes discussed. Fieldwork among the health workers was more time-restricted, as it all had to take place within their working hours.

Field work within the Somali community

In describing the method of data gathering, I distinguish between information gathered through in-depth interviews, interviews with key persons and participant

observation, including informal conversations, meetings and seminars. Although it is necessary to organize the material in some way, in real life situations often overlap and the distinctions are less clear.

In-depth personal interviews within the Somali community

Informants

Informants who agreed to be interviewed included about 70 Somalis: 45 women and 25 men. In this number I include all the informants who were formally approached and requested to participate in the study, who went through in-depth interviews roughly following the outline of the interview guide, and for whom I have some basic biographical information. Most of these were recruited by "the snowball method", that is through somebody who knew somebody (Keesing 1981; Ellen 1984). Everyone I asked agreed to meet me, came on time and devoted their whole attention to the interview. Only one young girl never showed up for our appointed meeting. That was probably her way of refusing.

My objective was to include Somalis of various ages and social backgrounds in order to give a better description of diversity and contrasts. To build across the north-south divide of Somalia (Somalia and Somaliland), I made an effort to include informants with roots in both regions. I also wanted to cut across major clan divisions. To achieve this, I rolled the snowball from different starting points, such as women's groups and participants in their activities, other organizations, university students, and the health sector as well as friends and acquaintances. However, I also wanted to concentrate the selection of informants on a limited number of social networks to make it easier for me to follow discourses in the social circles. Thus the field was defined on the basis of both theme - FGC/Somali immigrants - and social network (Frøystad 2003).

I included any person who defined themselves as Somali. This means that I took Somali origin to designate self-proclaimed ethnic identity, rather than country of origin (Rapport & Dawson 1998; Haakonsen 2005; Gundersen 2001). The informants therefore came from various countries. More than half of my informants originated

from Somalia. Another large group originated from Somali areas in Kenya, Ethiopia and Djibouti. Another group of informants had grown up in exile communities elsewhere in Africa and Arabia, such as Yemen, Saudi-Arabia, Tanzania, Kenya and Dubai. Some of the informants had in addition lived for various periods in western countries.

Most of my informants had been living in Norway for a limited number of years (1-7); the average time of residence was between 3 and 5 years. A few had stayed longer, up to 18 years. Though most had come as a result of the civil war and chaos in Somalia, a few had come for studies or adventure.

The 45 female informants varied in age from 18 to 60, the majority being between 25 and 40 years of age. The focus on women of fertile age was at first a direct consequence of my entry point through birth experiences, and the ways in which the snowball methods strengthened this selection. Around 75% of the women were married. The remaining women were separated, divorced, widows or single (4, including two single mothers). This definition is based on the women's own statements, which may be at variance with their official status.[30] The number of children varied between none and nine, with an average of four. Most women were housewives, but a few were studying or working. From the women's statements, the large majority of their husbands were unemployed or underemployed. Some husbands also resided most of the time in another country.

The 25 male informants were aged between 25 and 60. With a few exceptions, they were not husbands or closely related to the female informants. This was partly a conscious choice to avoid being drawn into problems of loyalty and confidence, and partly because few informants invited me to include their partner. Most of the male informants were university students or held good jobs, while some were "artists" only partially employed or unemployed. Many of them were active in Somali organizations, and many had a relatively high social status and a large network within the Somali community.

The female informants did not seem to distinguish themselves systematically from the general Somali population in Norway. In contrast, the male informants were generally better off than the average male Somali immigrant as regards education and work, and hence probably also in a better financial position than the majority of Somali immigrants. For example, most of my male informants either had work or they studied, whereas the unemployment rate of Somalis is around 75% (Klepp 2004).

All informants were however less representative of the average population in Somalia. Due to patterns of migration, the informants generally had a higher education, were more urban, belonged to the higher social strata and had more cross-cultural experience than the general population in Somali areas. For example, only two of my informants had ever lived as nomads, which is the lifestyle of about half of the Somali population.[31]

Of the total number of 70 formally recruited informants, the number varies in the different papers. Paper I has fewer informants, as it was finalized before all interviews were done, while Paper IV only includes female informants who had given birth in Norway and who had supplied information about their experiences.

In-depth interviews

Potential informants were first presented with a written and an oral presentation of the study – a project presentation. This was developed in close co-operation with a Somali interpreter and key informant, and described the study as mainly concerned with ”reproductive health”. It made no direct reference to FGC, as Somali women had advised me not to. FGC was seen as an integral part of “reproductive health”, they said, hence no such direct reference would be necessary. It might rather be considered too direct and rude. I was also warned that a direct reference might scare husbands from allowing their wives to participate in the study. Due to the omission of the term FGC in the project presentation, I was careful at the beginning not to raise the issue myself, but only followed it up when it was raised by the women. But it always was, and they seemed so comfortable talking about FGC that I gradually approached the issue more directly. By that time also many women had been prepared by word of mouth that I was also interested in wider perspectives of FGC.

During interviews, the guides were mainly used as a tool for preparation and reflection afterwards, rather than as papers to go through with the informants. A few potential informants were provided with copies beforehand, as they wanted to know what questions I would ask before deciding whether to participate in the study. As such, the guide also acted as a door opener, as the questions apparently reduced skepticism and fear of participation.

Each interview lasted for two to three hours, and most informants were interviewed two or three times. About ten of the women and six of the men were continuous contacts that I met innumerable times over several years. Interviews were

carried out in a place chosen by the informants. This included: cafés, their or my home, their or my work place, or public health facilities. Mostly we were alone during the interview, though children were occasionally present when interviews were done in the woman's home. Some of the husbands were present at my first home visit, but after being introduced to the study and to me as the researcher, they left the house to allow their wife and myself to talk freely. Notes were taken on the spot and written out in detail immediately after. I did not ask to use a tape recorder with the Somalis, as I feared this might make the informants feel less free and easy about the situation. I also feared a tape could get into the wrong hands and break anonymity, or that the informants could be scared of this happening.

Interviews were generally carried out in a language that both the informant and I knew, which meant Norwegian (with informants with a long residence in Norway), English (with informants with long residence in Somaliland or Kenya, or with English education), Swahili (with informants with long residence in Kenya or Tanzania) or French (with informants from Djibouti). I never learnt any substantial Somali, though that was my original ambition (Ellen 1984). This was due to a combination of limited time, little access to study material, and my original inclusion of people with different ethnic and linguistic origins.

My original plans included an extensive use of a Somali interpreter, and one was offered all potential informants. However, only four women requested this. I also felt that the presence of an interpreter reduced the quality of the interviews. Having to talk through a third person, who as a professional translator could only repeat what both parties said, inhibited the flow and ease of the conversation. I also found it risky to use unprofessional interpreters, as they may be less familiar with official codes of silence.

The pros and cons of using interpreters and field assistants have long been discussed in social anthropology (Bernard 1995; Berrman 1982). Here I will highlight the risk of increased sensitivity in exile. My informants' resistance to using an interpreter, may be related to the extensive use of interpreters in other sensitive arenas, such as asylum cases and residence permit, family problems, criminal issues and problems involving social services and child protection services.

The non-use of an interpreter implied a certain selection of informants, as I could only interview people with whom I shared a common language. That may also have reduced my access to information, as the informants were rarely able speak in

their mother tongues. Insight into many linguistic nuances was also reduced. To increase mutual understanding under these conditions, I employed various probing techniques, repetition and different approaches. These included targeting the same topic from different angles in various social situations and comparing statements made in different contexts. The use of visual techniques, and other modes of communication such as body language, humor, games, dances, poetry and songs, was also motivated by this wish.

Interviews with key persons

Interviews were also performed with various key persons, in which the focus was less on their personal experiences and more on their findings, considerations of the community, or question in focus. In Norway I interviewed people working with Somali or immigration questions in general, in places such as national organizations, women's organizations, religious organizations, students' organizations and other interest groups. During my study tours to both European and Somali areas, I was also able to talk to a number of organizational leaders and activists in other exile countries, including participating in some of their FGC related activities.[32] Another important group of informants were researchers working with FGC, Somalis or other related fields.[33]

Participant observation in the Somali community

Participant observation was carried out in various social gatherings and organizational activities. I took regularly part in the activities of two Somali women's organization. This included conferences, meetings and discussion groups related to FGC. Hence I got an opportunity to participate in a setting in which Somali women themselves had already raised FGC as an issue. At times I was given a more active role, being invited to run the groups as a sort of focus group discussion. A similar situation was the setting for the discussion groups arranged through my appointment in the OK Project. This included a "brain-storming" seminar and two training courses for "out-reach workers", including more than 35 of Somali origin, who in turn arranged more than 40 discussions groups in their local areas (Savosnick & Johansen 2004; Johannsesen et al 2004).

I took part in two three-day summer camps with 20 and 30 women with their children and young girls to help them with child-care. On several occasions informants and other acquaintances also participated in study tours and conferences. This gave us broader contact, as they often introduced me to other friends and relatives, and occasionally we arranged trips or social activities together in the afternoon. I also participated in groups with other themes, such as religion, health, life in exile and other issues.

I also participated in less regular activities, such as festivals, conferences and meetings. This included Somali network meetings, and also male-dominated arenas such as national Somali organizations, cafés and local *khat*-rooms (place for chewing the narcotic leaves, see Opsal 2005). Included here was activities arranged through the local OK component, which was concerned with the general situation of Somalis in Oslo, such as religious festivals, a "Somali cultural day", and seminars on a diversity of subjects requested by Somali women and men.

More private social gatherings such as weddings and religious festivals were also opportunities for participation. In addition I visited women in their homes, either alone or in social gatherings, or we did things together, often with our children. Maternity visits in the hospital provided additional occasions for participant observation on the interplay between Somali women and health care workers, as did participant observation in childbirth, which is described later.

A number of national and international conferences where FGC and Somali questions were discussed, both in Europe and Africa, also gave access to new knowledge, perspectives and contacts.[34] Of special importance were two visits of altogether four weeks in Somali areas in Kenya, Somalia, Somaliland and Djibouti.[35] During these trips, I was also given the opportunity to arrange a couple of informal focus group discussions, and also informal interviews with "ordinary" women and men. The study tours gave an insight into the extent to which experiences in exile relate to the exile situation and the extent to which they express general Somali concerns. In the same way, impressions from other exile countries, including Sweden, Denmark, England and Australia, shed some light on what parts of the situation of Somali women in Norway are unique to Norway, and what may be more general exile experiences.

Participant observation also offered opportunities for numerous informal interviews and conversations with "ordinary" women and men.

Fieldwork within the reproductive health sector

Research within the health sector consisted of personal in-depth interviews, interviews with key persons, participant observation and a study of medical records.

In-depth interviews within the health sector

Interviews were performed with 39 health workers: 25 midwives, 11 medical doctors (nine gynecologists and three general practitioners) and three nurses. All but five were of Scandinavian origin, and four were from societies practicing FGC. Informants from the health sector were recruited from three different obstetric wards and three antenatal clinics in Oslo with a high proportion of immigrant patients. Here I first called a meeting to present the project and urged participants to volunteer as interview subjects. In other situations I sought out people who were known to have special experience and knowledge of the issue. As a result, the informants were probably more knowledgeable and experienced in dealing with genitally cut women than the average Norwegian health worker. Others were recruited through a poster urging health workers to call for an interview immediately after assisting in the childbirth of an infibulated woman, and some were recruited due to their involvement in the media debates on FGC.

Most of the health workers were interviewed once. About ten were interviewed twice. Each interview lasted from 30 to 90 minutes. They were carried out in the hospital location, in a spare room where we could talk without being interrupted. As the health workers only wanted to be interviewed during their working hours, the time-schedule was limited. To get the maximum time for the in-depth conversations, I therefore gave them a questionnaire beforehand for personal information.

All of the interviews were general and exploratory, and open in order to encourage the informants to freely express their main interests and concerns. Still they were more formal and structured than those with the Somalis. More direct use was made of the interview guides and most interviews were taped and transcribed. This was partly caused by a need to be more specific due to the time limit and less opportunity for repetition and more informal interviews. And partly I expected that formally trained health workers would be more familiar with such a formal approach.

About two thirds of the interviews were general, concentrating on the health workers' perceptions and experiences of circumcised women in perinatal care and

during delivery. The remaining third may be labeled case interviews, as they each focused on one specific case and took place as soon as possible after it took place. This was done to get fresh impressions of childbirths, as memories and emotions tend to fade over time. Case interviews were thought to compensate for the limited access to participant observation at actual deliveries. I also made an effort to interview others who had been involved in the delivery, in order to get a fuller picture of it and the differing perspectives of the involved parties (extended case method).

Interviews with key persons

Under this heading I include all interviews from what I may term "official Norway". They go beyond those working with reproductive health, and also include interviews and conversations with people in some way or another dealing with Somali immigrants.

Within the health sector I sought out people who had been involved in the Bærum case and discussion around the Act passed in 1995 and revised in 2004. This included government employees, such as lawyers and health administrators, at such places as; the Ministry and the Directorate dealing with health, the Ministry and municipal office dealing with children and family affairs, and the Ministry, Directorate and municipal office dealing with refugees and immigrants. Other public servants, such as a few teachers in schools and nurseries, social workers, workers of refugee housing and integration efforts were also interviewed either formally or informally.

Participant observation in the health sector

A few days of participant observation were spent in a maternal and child health clinic and in a maternity ward. In the maternal and child health clinic I followed antenatal classes. In the maternity ward, I observed the work of the midwives, including internal meetings, discussions in the break room and the deliveries to which they attended. When a woman arrived to give birth, the midwife in charge presented her with my study and asked if I could participate in the birth. I then participated as an "assistant" to the nurse, and generally watching the work of the midwife. This meant that I took part in deliveries of women with different ethnic and national background, as will be explained in Paper III.

Seminars, meetings and conferences were other important arenas, including when I first presented my study and later the results to the hospitals included in the

study. I also attended medical and midwifery conferences, both as a participant and as a lecturer, and taught both medical students and midwives doing further training. Of particular relevance were seminars and conferences at which Somali and Norwegians met together to discuss FGC as a health care issue.

Quantitative data and medical records

A study of medical records of twenty Somali women who had given birth in one hospital, covering a total of 32 deliveries, was also included. Moreover, I was given access to significant information from a register study of birth complications among Somali women, as I was able to persuade Siri Vangen, my fellow PhD student (she in medicine), to include Somalis in her ongoing study (Vangen et. al. 2002).

Securing anonymity

Anonymity has been necessary in order to avoid embarrassment and discomfort in view of the personal and intimate focus of the study. This was also required by the Regional Committee for Medical Research Ethics and by the Data Inspectorate.

To secure anonymity, all names have been altered and code names were used in both notes, records and contact lists. Taking into account the relatively small and transparent social circles of Somali immigrants, I have further had to alter recognizable biographical information. In some cases, I have also found it necessary to "split" some of the Somali informants by giving them different names in different cases. This was done to reduce risks of identification in situations where parts of the informants' stories were known, or could be recognized, within the community.

One disadvantage of this is that it has reduced the possibility of seeing the complexity of each person, which in turn could have given a wider perspective on the complexity of the issue (Vike 2001). I have had to leave out some data, for example from informants and contacts who have also been active in the public debate or lectures and are thus more easily identifiable. A particular loss here are the many situations where statements made in public differed in significant ways from information given in other contexts, which could have been used to thrown additional light on the social discourse.

Another loss is that I was not allowed by the ethical demands, to link information gained through in-depth interviews within the Somali community with information from the health sector. Hence I was unable to follow up the women whose deliveries I attended, or know the identity of women whose births were described in interviews with health workers. A couple of times I was able to recognize deliveries described by health workers and personal interviews, but to avoid discomfort for the implicated parties, I have not highlighted them.

Another measure to avoid identification was that Somali informants were not requested to sign their agreement to participate in the study. This is contrary to formal ethical requirements in medical research, but was accepted by the Regional Committee for Medical Research Ethics. Most of the health workers participating in the in-depth interviews signed written consents.

In some of the settings for participant observation, I did not have a chance to present my role as a researcher. Usually, however, my role was known through internal networks. Generally, I have made an effort only to quote private statements from informants who have agreed to this, either as formally recruited informants or by another form of request.

Access, trust and validity – the position of the anthropologist

In this section I will discuss some major methodological challenges that become particularly highlighted in studies of controversial subjects such as FGC. Emphasis will be on the role of the researcher in gaining access and trust, as this affect access both to informants and data, and should also be considered when estimating data validity. Tthe study's affiliation at the junction between anthropology and medicine also heightened my awareness of significant disciplinary differences in approach. This has confronted me with the tacit knowledge in my own field, and forced me to reflect on and specify things that are usually taken for granted (Bernard 1995; Leseth & Johansen 1998; Malterud 1998).

I have found it important to emphasise how fieldwork, analysis and writing are intertwined and circular processes. Data is not something I as a researcher "collect", but is rather created in an intimate interplay between researcher(s) and informants

(Briggs 1970; Hastrup 1989; Hastrup & Hervik 1994; Nielsen 1996; Powdermaker 1966; Rudie 1994; Wikan 1992). A deep involvement in the field includes attention to a variety of sensations, such as smell, tone of voice, shades of color and atmosphere as well as bodily sensations and experiences (Hammersley & Atkinson 1996; Hastrup 1989; Hastrup & Hervik 1994; Leseth 2004; Stoller 1989; Krogstad1989). But personal involvment in the field also demands a keen awareness of the position of the anthropologist within the society she is studying (Bell et al 1995; Haraway 1991; Heider 1988; Rugkåsa & Thorsen 2003). Therefore I will describe some key aspects of my position in the field. First, however, I will take up the theme of trust, which has to be understood in terms of personal positioning.

The role of trust

The participation of informants and their willingness to share information with us as researchers depends heavily on our ability to create an atmosphere of trust (Haraway 1992; Flikke 2003; Cohen 1992). Trust is also important when estimating the validity of our data, and we have to ask how our position may affect what informants tell us. "Informed consent", i.e. giving potential informants sufficient and understandable information to enable them to make an informed choice on whether to participate or not, is one way of securing trust, as well as of guaranteeing an ethical standard. In the field of anthropology this is usually obtained orally and informally, but the Committee for Medical Research Ethics also insisted on a written project presentation and a consent form (Nesh 1999; Smith 1998; Vike 2001).[36]

Fulfillment of the formal requirements, however, does not solve the ethical problem of whether the informants are able to grasp the full extent of what the researchers "are up to" (eg. Nielsen 1996). It is widely acknowledged that "informed consent" is based as much on trust as it is on information (Flikke 2003; Ofstad 1994; Vike 2001). In a sense the popular expression of "informed trust" may seem contradictory, because, as pointed out to me by Harald Grimen, the need of trust is based on insufficient information. The need to build trust among the informants points back to the significance of the personal aspects of the researcher and the relationship unfolding between her and the informants. Here, the researcher as a person is of significance,

including personal characteristics such as sex, age, and marital and reproductive status, as well as ethnic and national identity and class (e.g. Bell 2005).

The close relationship that may develop between the researcher and her, or some of her, informants, can at times also be ethically problematical. One reason is the way in which the distinction between the anthropologist's role as "friend" and role as "researcher" at times become blurred (Bell et al 1995; Nielsen 1996). As a consequence, I have been reluctant to use some information that I feel was given to me more as a friend than as a researcher. I also experienced that it was more uncomfortable to pose certain questions, especially the more sensitive ones, to people I came to regard as friends. Some informants were therefore redefined as friends only.

My position in the Somali field

I started research as an adult married woman with one child, a daughter who was then four years old. I was thus in a similar life situation as most of my female informants, which gave us several things in common on the personal level. Women often said that this shared experience made it easier for them to tell me about "adult matters" and "women's things", such as sexuality, marital relations, childbirth and child rearing. The women's trust, I felt, relied mainly on my role as a mother. In addition, the words of mouth from other women who already knew me were important door openers. Shared experiences with my informants increased when I got pregnant and gave birth to twin girls in the middle of my fieldwork (fall 1998). The experience of pregnancy and childbirth during our time of contact, as well as the increase in the number of my children, seemed beneficial for our contact.

Our shared role as mothers was also a part of participant observation, as we at times met with our children. Their eating and playing together created a more reciprocal atmosphere and at times gave rise to discussions with the mothers. One example was when my 4-year-old daughter and a Somali girl of about 11, while playing with their dolls, discussed the need for parental approval for the choice of a marital partner. Another when my daughter acted the tomboy when playing with the son of an informant. And another when a group of Somali children fled from the table when my daughter ate a bread spread containing pork.

Another significant personal feature was my long marriage to a Tanzanian husband. I often felt this information was a major key in easing the atmosphere,

particularly when meeting husbands of my female informants. “Oh, so you are a sister-in-law” many said. It seemed that my marriage to him was taken as a guarantee that I would be trustworthy and treat them with understanding and respect. The fact that some of them had also seen my husband, who was at the time performing with two Somali bands, was also a part of the picture. I am not sure whether my husband’s Bantu origin also affected our relationship. A general low regard of Bantu Africans could cause disrespect. Although neither I, nor my husband, ever sensed this, his Bantu identity may have made him, and hence me, less threatening. That is to say, his belonging to a social category usually looked down upon, may have counterbalanced my belonging to the majority society.

The fact that I had lived for many years in different African countries was also considered positive.[37] Another aspect of my African connections was my east African-accented English, West African-accented French, and knowledge of Kiswahili, which was used for both funny and serious conversations. Another aspect was our mutual love of music and dancing, and I have enjoyed many hours dancing with women at weddings, concerts and other celebrations. These, and probably some other aspects of my personality of which I am not aware, may have affected the study in various ways. Most important, however, was the positive interest and openness of the Somalis informants. They were sociable, informal and had a sense of humor I could relate to.

An informal atmosphere appeared to be of crucial importance (e.g. Chalmers & Hashi 2000; Hastrup 1994). Researchers who have tried a more formal approach in Somali studies, such as employing structured interviews in a hospital setting, appear to have experienced problems more often and often had to restructure their approach (Chalmers & Hashi 2000; Vangen, personal communication; Nour 2004; Nienhuis 1997, 1998).

I found the fact that the fieldwork was carried out in my hometown to be an advantage. I still live in the same neighborhood as many informants, a situation that demanded an increased sense of positioning. Many times when I have presented research results, informants and other contacts or acquaintances of informants have been among the audience (see Gulestad 2003). Also affecting my position is the dense social network and “café-radio” (oral spread of information and gossip), which makes it almost impossible to withdraw from the field. On several occasions I have

been confronted with things I have said or done in other towns or countries, when I encounter informants on the streets of Oslo during my daily errands.

My position in the health sector was different. Health workers were interviewed as professionals and at their workplace concerning their work, and our bonding was mainly through our common position as educated women/men, interested in reproductive health and infibulated women. Their professional role was also highlighted by the way most of them did not consider care procedures to be as relevant as "the culture" of Somali women, because that is where they identified "the problem". Health care procedures, on the other hand, were generally experienced as culturally neutral and "evidence-based scientific truth" (e.g. Martin 1990; Jordan 1993).

The power of resonance

In the wave of anthropological post-modernism, our common human ground was shaken by scientists who raised fundamental questions on whether cross-human and cross-cultural understanding is possible at all. Such questions become even more acute when dealing with experiences that are rarely expressed or easily observable. Studies of pain have for example emphasized how pain experience tends to avoid or even destroy language (see Paper I). How then is it possible to understand the pain of another person? And, as studies of sexuality discourage participant observation as well as encompassing intensive, deeply personal and intimate experiences that are rarely verbally expressed, how then do we know what other people do or feel with regard to sexuality?

One way, Wikan suggests, is do make conscious and systematic use of shared experiences and resonance (Wikan 1990, 1992). It is possible that one of the main reasons why I took Somali women's experiences of pain at face value and why I was interested in understanding pain also analytically was the way with they echoed my personal experiences of pain (including childbirth, a fistula, acute kidney stone and lumbago). Similar examples of how the personal experiences of the researcher affect the study have been discussed in anthropology (e.g. Flikke 2003). Resonance may be particularly crucial in understanding compelling concerns, such as birth and

death, sex and pain (Wikan 1990). A well-known example is Rosaldo's depiction of his understanding of headhunting among the Ilongot (Rosaldo 1983). It was only after experiencing his own rage at the death of his own wife, that he was able to take at face value what the informants had long been telling him: it was rage at death that led them to headhunt.

Some anthropologists have been worried that anthropologists' emotions may make us over-emphasize for example the pain inflicted during circumcision, due to our own cultural biases (e.g. Parker 1995). And maybe it was fear of my own emotions, increased by my own experience of vulnerability as a mother of three girls, that made me resist Somali women's efforts to expose me to pictures and films of actual circumcisions. "You have to see it for yourself, to really understand what we go through", many said, and on a few occasions I was compelled to do so. Aud Talle's description of her participation in a circumcision appears to have increased her focus on the pain and violence involved (2001, 2003, forthcoming a). It was also Somali women's personal experiences, and male experiences of the sufferings of their sisters, wives or daughters, that was their major motivator for change. The distressing experience of the circumcision of her son also appear as a significant reason why Shepher-Hughes expresses reluctance to deal with FGC (Shepher-Hughes 2001). A similar experience motivated another colleague to work against FGC.

Estimations of validity in the face of silence and multiple voices

In deciding how to estimate the validity of one's finding, one has to find a way to relate to the often contradictory findings and internal inconsistencies. Complexity of findings is not unique to the subject of FGC. Anyone who has interviewed a person more than once knows that each interview may give different answers (Berrman 1972; Heider 1988). That is why most anthropological studies include repeated interviews as well as informal conversations. Observance of practical behavior tend to give further divergencies, which is why anthropological studies so strongly emphasize the need for participant observation.

“Lies”, secrets, exaggerations and deceptive stories are a part of social life, and even necessary (Barnes 1994; Engebrigtsen 2002; Goffman 1969, 1971; Salamone 1977). Lies can also reflect the uncertainty of perception and memory, which is one reason why I chose to do case interviews immediately after a delivery. More precarious, however, are biases caused by “presentation of self “ (see Goffman) or more or less conscious attempts to mislead the researcher.

Such concerns have been taken into consideration especially in sexual research, as the private, intimate and strong moral evaluation of sex may reduce access to “the truth”, while public health concerns, such as the HIV/AIDS epidemic, have increasingly forged a need to know what people actually do in bed (Vance 1991). Hence several studies have approached the same subject with different methods, in order to be better able to take methodological biases and cross-cultural variations into account (e.g. Plummer et al 2004). For example, it has been pointed out that gendered double standards of morality may make men appear more promiscuous in larger social settings than in anonymous interviews, while the opposite more often appears to be the case with women. We also recall the many women who claimed to have had a *sunna* circumcision that were found to be infibulated. The following are some examples from my study where statements differed in different social contexts:

One young Somali woman told me that she was not circumcised, but that she had to claim to be so in her relationship with other Somalis, in order to avoid being ostracized. It is possible then that she told me the “truth” about her genital state, but had to hide it in the Somali context as it was against internal norms. But it could also be the other way around, that she was circumcised, but felt ashamed to tell me, as a representative of the majority Norwegian society.

In such cases, it is usual to compare the status with other knowledge of the person. My long contact with her and with her parents, as well as the background information, suggested that it was probably to me she told the truth. What may be most interesting, however, is the need to tell different stories in different contexts, as this may give useful insight into the art of social life and negotiation of experience and change, as argued by Simmel (Simmel 1964).

On another occasion, a woman working against FGC told me in private about the circumcision of her daughters. However in public, for example conferences against FGC, she publicly boasted that she had not circumcised her daughters. How

should we understand this? In a way, she told both of us the truth, because what had been done to her girls, *sunna* circumcision, was understood by me as FGC, but not by most Somalis, as discussed. We can also get glimpses into local codes of morality, by comparing the adult married women, who admitted during the game of "truth-or-lie" to having premarital boyfriends and even intimate contact, with the still unmarried women who hotly denied any close contact with men (Paper II).

I could also see how health workers' presentations of their own actions and considerations diverged from what I had observed in practice, or how they varied in different situations. This was especially noticeable in relation to legal aspects of FGC, as illustrated by the midwife who avoided me after realizing that the reinfibulation she had performed was in fact illegal.

These examples illustrate some of the ways in which stories told are adjusted to the social acceptability of the situation. This is common social behavior, but may be enhanced by the moral and legal condemnation of FGC, as a "wrong" presentation-of-self could result in moral degradation or even legal action. However, many times there may not be any final "truth". Especially when it comes to experiences, meaning, attitudes and knowledge, people may present different stories or opinions simply because they change their mind, or reconsider an experience, or want to test out social reactions, or forget certain details or elaborate or alter a story to make it sound better (Skramstad 1990; Hernlund 2003).

In addition to more or less "true" or "false" presentations, social life provides a host of other modes of communication in which compelling concerns can be discussed with varying degrees of social risk. For example, it has been noted that people often present "risky" personal information as if it were about someone else. In this way they can test out social reactions, or even get advice without revealing themselves. Several people told me stories that way the first time, but later revealed that it was actually their personal experience.

Another common method is the use of non-serious modes of communication, such as songs, poetry or jokes, where one may express personal considerations that are not socially acceptable. This is an important part of social life, and people often "know" when such "poetic" expressions reflect personal experiences or considerations. Abu-Lughood points to how the performance of standardized songs and poems is a socially acceptable way for women and men to express feelings and experiences that would have been seen as socially reprehensible if expressed in a

serious mode (Abu-Lughood 1986). Somalis seemed to have a similar relation to their rich poetry and song tradition (Adan 1996; Kapteijns & Ali 1999; Tiliikainen 2001, 2003).

I have therefore also included information from “extraordinary” and “non-serious” modes of discourse, particularly in relation to rituals and humor. Anthropologists have analyzed rituals as systematic forms of socialization, often seen as vehicles, which confirm social order and bring the individual into the line. Rituals often mark socially significant life-cycle events, such as birth, menarche, marriage, childbirth and death. Thus rituals can be seen as cultural elaborations of events that are significant for the individual and society (e.g. Morinis 1985; Turner 1967; Van Gennep 1960).

For the individual, rituals form standardized frameworks against which she or he can relate their personal experiences. Humor, in contrast, can be described as a creative mode of communication that allows expressions that are counter to the rules and regulations in the serious mode of communication of ordinary life (Apte 1985; Fine 1984). In this way, both rituals and humor are modes of communication set aside from everyday modes of serious discourse, while simultaneously being based on them, playing with them and breaking them. Thus humor and ritual often highlight and express basic cultural and personal concerns, including aspects that may be “muted” or “tabooed” in the everyday serious modes of social discourse.

In research, such data may be used in addition to the serious modes of in-depth interviews. Together they form a rather complex set of data, which tends to contain apparently incompatible and contradictory information. As regards the prudent self-presentation of the young girls in the game "truth-or-lie" described earlier, the women seemed to distrust its accuracy, though playing along and appreciating the young girls’ discretion. Their reaction suggests that apparent “lies” can be seen through. People often have a good sense of what is hidden behind the socially acceptable presentation, the joke or the song, but there is a mutual agreement of silence and discretion (See Johansen 1996).

Silence, jokes and transparent lies can be seen as a way to maneuver in an ethically and legally problematic setting, such as life in Norwegian exile, in which respectability in the two main ethnic groups, the Norwegian majority and the Somali minority, demands different approaches.

Chapter 4

ANALYTICAL APPROACHES

In this dissertation I argue that personal experiences of a strong and intimate character, such as pain, sexuality and childbirth, may to a higher degree than many other experiences diverge from cultural models. Furthermore, I will argue that a focus on discrepancies between "the personal" and "the cultural", and the ways in which they interact, offers a useful entry point to understanding how the FGC is experienced, lived, negotiated and is changing among the exile population.

In this chapter I will present my understanding of the relationship between the personal and the cultural that is highlighted in the works of Shore (1996, 1998). Another major field of inspiration for me has been the growing anthropological interest in embodiment as the existential ground of culture and self (Csordas 1994). Finally, I will present some key processes in Goffman's theory of social stigmatization to highlight specific aspects of circumcision in exile. I consider these three perspectives to be the major methodological, epistemological and analytical approaches that underlie the dissertation as a whole. They function as a base or framework within which the more theme-specific theories used in the papers should be understood.

This means that in order to understand the specific aspects of FGC focused on in each paper - pain, sexuality and childbirth – I have employed more theme-specific theoretical approaches. In Paper I, I discuss different analytical approaches to pain; in Paper II, I discuss different analytical perspectives on sexuality, and in Paper III and IV, different theories of how to understand "othering", in which

culture/nature and stigmatization are key concepts in understanding Norwegian birth care for infibulated women. As these are elaborately discussed in the papers, I will refer to them only fragmentarily in this chapter.

Personal experience and cultural models

As pointed out, my focus on the relationship between personal experience and cultural models grew out of Somali discourses on FGC as a mainly personal, bodily experience, which Somalis often contrasted with a variety of perceptions of "Somali" and "Norwegian" "culture".

Both "cultural models" and "personal experiences" have been the object of extensive anthropological reflection and renegotiation during the last decades. This renegotiation has led to a change in emphasis on "culture" from the perspective of "master narratives" to a focus on competing voices or discourses, including the political process whereby certain of these voices marginalize others as they achieve political and intellectual hegemony (Shore 1996; 8. See also Barth 1987; Keesing 1974, 1981, 1994; Moore 1999; Wagner 1975). As pointed out by Hastrup and Hervik this shift of interest "from structure to practice, or from pattern to process is a corollary also of the deconstruction of the image of "the others" as a generalized object for our professional curiosity" (1994: 3). This also entails increased attention to the ways in which culture is best conceived as "a very large and heterogeneous collection of models" (Shore 1996; 44). In this regard I have also been inspired by Barth's focus on culture as "systems of knowledge" (Barth 1990, 2002) and other critical writers (e.g. Moore 1999; Clifford 1986). With regard to FGC, increased attention to gender-specific and age-specific perceptions has been of special significance (e.g. Ardner 1975 and the Mead / Freeman controversy in Samoa referred to in Paper II).

What I term "personal experiences" are meant to include individual sensations and perceptions and the ways in which each person makes an effort to make sense of these, and produce "personal and idiosyncratic knowledge" (Shore 1996; 45).[38] In other words, the empiric findings made it important to find a conceptual couple that

can highlight the distinction between personal experiences and cultural models and account for the ways in which

> "our experiences are never exhaustively accounted for by culture. (. . .) Not all experience is culturally modeled to the same degree. And cultures differ in the extent to which certain classes of experiences are modeled for individuals" (Shore 1996; 45).

In this dissertation, I respond to Shore's appeal for an increased focus on the relationship between cultural models and personal experience (1996, 45). Such an approach seems particularly useful in this study, in order to grasp the ways in which life in exile stimulates greater reflection both on personal experience and its relation to cultural models. On the way this often leads the actors to question the legitimacy of the cultural models themselves.

For reasons of simplicity, I refer in my Papers mainly to the work of Shore (1996, 1998). However, he is only one of several anthropologists searching for more complex presentations of the relationship between the individual and society (e.g. Bruner 1986; Rudie 1994; Hastrup and Hervik 1994). Shore's approach is in line with Rudie's approach, which takes account of the "universal human effort of trying to bridge the gap between experience and representation" (Rudie 1994; 40). Other sources of inspiration include Unni Wikan's study from Bali (1999) and her discussion of the relationship between culture and lived experience, and Anthony Cohen's exploration of "the self" (1994).

My focus on personal experience is thus partly to avoid the risk of depicting individuals as "socially or culturally driven" (Cohen 1994: 7), which Cohen considers common in much western social science, including anthropology. My, and his, worry is that such an approach may reduce our attention to the diversities of lived experience. Comparing the relationship between society and the self as a dance, Cohen suggests that "Society created the illusion (which social science has perpetuated) that it ultimately controls the dance, for it provides the music and the stage" (p. 71). He suggests that the holistic ambition in the anthropological focus on "the need for society to impose itself over individuals and to imprint itself on their consciousness" (p. 15), is part of the reason for the bias towards cultural models in

anthropology. Again, I find it important to stress, along with Cohen that "societies do not determine the selves of their members" (p. 71). That is, while FGC can be seen as an example of the "most intimate and insistent impression of society on the individual's mind and body " (p. 58) that may certainly transform both body and self, *it may not always do so in the way the society supposes* (p. 65, see also Ahlberg 2001).

We can exemplify the issue by referring to Boddy's suggestion that the pain and trauma of infibulation inscribes in women's bodies, both physically, cognitively, and emotionally the framework for local *Hofriyati* female gender identity (Boddy 1996). The experience of traumatizing pain, accompanied by the cultural meaning underlying the tradition, and women's repudiation of their sexuality, is what gives women a sense of female identity, Boddy says (p. 57). In contrast, my Somali informants described how the traumatizing pain, and sexual worries concerning the effects of FGC, while inscribing culture in their bodies, also simultaneously provoked Somali women to question the meaning of the practice. As described in the papers: rather than uniquely inscribing a culture by literary carving it into their bodies, the experience of infibulation also appeared to inscribe in women a fundamental doubt about that culture. "Is it really necessary? What is it good for?" the women asked themselves and each other.

The distinction between "personal experience" and "cultural model" does not imply that these should be seen as a dualistic division, but rather as poles on a continuum, as suggested by Shore (1996). That is to say, while some "cultural models" may be incorporated and come to constitute a personal model, others may be felt to be at odds with personal experiences. Hence, identification with cultural models varies from one individual to another and from one situation to another. To use a different terminology, at some point cultural models are taken as self-evident realities (*doxa* in Bourdieu's term), whereas in other situations they become objects of reflection (*heterodoxy* and *opinion*) (Bourdieu 1977).

In this dissertation, I highlight two major aspects that contribute to discrepancies between personal experience and cultural models: the pain caused by FGC, and the private and intimate character of experiences of sex and pain. We can understand the pain of infibulation as the price women have to pay for cultural acceptance. Several researchers have pointed out how culture can in many ways be seen as "ways to distribute pain unequally in society" (Das 1995. See also Wikan

undated). This price increases the inclination to question its cultural legitimacy and make it an issue of heterodoxy and opinion, as discussed in Paper I:

> "(. . .) since cultural models can have significant psychic costs for individuals (and I will add physical costs as well,) it is reasonable to suppose that dominant cultural models are often accompanied by widely shared but not highly cognized or publicly symbolized alternative models" (Shore 1996; 49).

In Paper I, I show how shared experiences, such as the pain of infibulation, may be expressed in several ways and induce in women a sense of shared destiny that creates a bond of mutual understanding. The women were able to "read between the lines" in situations such as the game of *karbash*, plain statements of FGC as painful or something women could never forget, jokes, half sentences, grimaces and hints. In line with Wikan's observation from Bali that: "It is true that you should not cry in Bali when someone you care for dies. But most people do" (Wikan 1996; 27), Somali women also appreciate suffering that is not expressed or, if expressed, is dismissed.

The study suggests that experiences of FGC that did not "fit into" or had no meaning in terms of shared cultural models largely went unexpressed and unexplored at home. There was limited potential for sharing and verbalization of a desire for cultural change. But although questioning the meaning of infibulation appeared to be more outspoken and explicit in exile communities, it was in no way confined to situations of extensive cross-cultural contact. We recall how concerns of FGC since long have been raised as an issue also within Somalia. This I take as evidence of the way in which personal experience may be diverging from cultural models in a more fundamental way.

Life in exile and cultural change

Women expressed how a former, rather diffuse feeling about FGC ("I just sensed there was something wrong about it") was more often raised as a concern to be discussed after they had moved into in exile. This increase in reflection over both personal experiences and cultural models was, as discussed in the papers, promoted

by several characteristics of the exile situation. One important aspect of this was the encounter with people with a different cultural background, who were unfamiliar with practices of FGC, as expressed by Amina:

> "I could never know that I was black until I met someone white. I could never know about my culture until I met somebody who had another. When Norwegians ask me why we do it (FGC), I have to think, really think. It is like looking at oneself in a mirror, forcing a look from a distance. And I ask myself, why, really, do we cut the genitals of our girls. And I find no clear answer".

Being forced then to look for reasons that could explain FGC to Norwegians, she had to look beyond the standard answers, such as "tradition", "culture" and "religion", that no longer had legitimacy even for her, and she was left with no answer. She no longer believed in the tradition of FGC that she herself had gone through and had subjected her daughters to. In this way, the encounter with Norwegian cultural models, as well as those of other immigrants, particularly other Muslim communities, threw a new light on her own perception of FGC. Exile may thus provide a particular vantage point for internal cultural critique, as has also been suggested by Shore:

> "Long cross-cultural experience can profoundly alter individuals' consciousness and provide them with new insights. These transformations take place by giving people access to models for experience that were not represented or were underrepresented in their native culture" (Shore 1996; 69).

This dissertation suggests that life in exile may highlight and accentuate differences between personal experience and cultural models, as many taken-for-granted cultural and social norms become explicit and are questioned. In exile, FGC has moved from the doxic character of the practice in their home cultures to a hotly debated heterodoxy and opinion in exile.

As suggested, the verbalized discourses in exile focused extensively on the feeling women had that their personal experiences did not "fit in" with Somali cultural models. Most women said that the pain of infibulation simply didn't feel right, and that painful sex due to infibulation distorted rather than supported their sense of

femininity. However, it was only in exile that they were able to express and discuss these experiences, no longer as experiences to endure, but as reasons for cultural change. In this way their experiences of excessive pain are "talked into" a new form of meaningfulness in exile, as a legitimate reason for change. Shore (1996; 58) discusses the importance of telling and retelling personal experiences, particularly after "disturbing events", among which both FGC and migration seem to have special significance for my informants.

Focusing on these discourses also brings back into focus the multiplicity of cultural models, as these offer alternative models to individuals who are trying to make sense of their personal experiences. In exile this multiplicity increases, stimulating new discourses and reflection on the cultural models and personal experience of self and others, and consequently discovering new solutions. But while acknowledging the increased opportunity for reflection and critical distance offered by life in exile, I suggest that these discourses may also shed light on reflective processes among Somalis living at home, and the ways in which these are muted or expressed in a variety of ways.

I also find this focus on the relationship between personal experience and cultural models to be important for ethical and political reasons, to counterbalance the way in which emphasis on the cultural meaning of FGC may support tendencies of essentialized cultural understanding.[39] As discussed in Paper III, I see essentialization and culturalization as a major contribution to the many misunderstandings between Norwegian health workers and Somali women that may lead to reduced quality of health care.

I will now move to the way in Shore emphasis the need to "re-introduce the body" into our concept of culture. By emphasizing how "cultural models can take less palpable forms such as conventional styles of movement, speech, or social interaction", he connects with the increased focus on "embodiment" within anthropology.

Embodiment and embodied symbols

Perspectives on embodiment, in terms of the ways in which cultural models are not necessarily consciously expressed or formulated, but emerge in bodily tendencies and preferences, have also inspired the study (Shore 1996; Csordas 1994; Moore 1994; Solheim 1998). The concept of embodiment implies a focus on the body as "the existential ground of culture and self" (Csordas 1994; 4). It is significant here that both personal experiences and cultural models are regarded as embodied.

The overview of major trends in FGC analysis presented in Chapter 1 pointed to the different views of embodiment that have influenced FGC studies. Foucault's studies of the many ways in which society disciplines the body (Foucault 1978, 1979) and the perspectives of "body politics" as explored by Shepherd-Hughes and Lock (1987) are in line with studies that analyze FGC as a form of discipline and implementation of local structures of power.

Bourdieu's focus on bodily inclinations or "habitus" (Bourdieu 1977) has inspired an increased attention to the fundamental bodily character of "learning by doing". This may help us to understand how individuals in a society know how to act in culturally and socially accepted ways, even when acting unconsciously. Talle and others have described FGC in a similar ways, as something that is done rather than talked about (Talle 2003). Such perspectives have been used to highlight how FGC can continue unquestioned and without much need for legitimation (Mackie 1996, 2000. See also Talle 2003; Johnsdotter 2002).

As suggested in Chapter 1, focus on "body social" (Shepherd-Hughes & Lock 1987) or the "symbolic body" as analyzed in the works of Mary Douglas (1973) points to ways in which the body is used as a symbolic expression of social concerns as it is "good to think with". Such perspectives have been used extensively in the analysis of FGC (e.g. Boddy 1989; Talle 1987, 1993 & 1994). Though this perspective gives a useful insight into cultural models of FGC, I have felt the need for an approach that is better able to grasp this body symbolism as a lived and sensed personal experience. My main inspiration here has been Solheim (1998). Her conception of body symbolism as a body language that is immediate, sensory and experience-near calls upon researchers to "take body language at face value" to a greater extent than is done in much traditional anthropology. She suggests that our occasional trouble in understanding body language is not caused by its uncertainty but because it is too

direct and plain. Body language constitutes “nearsighted metaphors” (Skårderud & Isdahl 1998). In a sense her emphasis parallels the discussions of resonance in Chapter 4, in the sense that this perspective urges a more direct, humanistic approach. Such a perspective is becoming increasingly evident in FGC research (e.g. Talle 2003, forthcoming a, b).[40]

Theories of embodiment offer a broader focus on the study of FGC by their insistence on the embodiedness of life. We are in the world as bodies. We experience, sense and perceive as bodies. Pain, sexuality and childbirth are all basic bodily processes. The move into exile is also a bodily process. Talle describes the migration of Somali women to the west as a ”transnational flow of circumcised female bodies” (Talle 2003; 80). Coming to the west, their bodies are the most important instruments they have to position themselves and experience themselves as subjects and members in a global world. Talle’s words echo those of a young woman, describing her body as the only part of her self that could be used in the west: ”Coming here, my language, my knowledge, and all my experiences from home, I had to leave behind. I had no use for them in Norway. The only thing I have is my body. But here, my circumcision discredits even my body”. Her appeal gives us a glimpse into the tremendous effort of resituating oneself in exile, when faced with the social stigma of FGC in the west.

Othering, stigmatization and culturalization

Originating from ancient Greece, “stigma” was a physical mark, used to brand social outcasts. In modern, daily use, stigmatization usually refers to the actual process of negative attribution, irrespective of whether it is linked to a physical mark. In his book on social stigma, however, Goffman (1984) draws most of his examples from cases of bodily deformations. The physical mark is what the negative attribution is linked to, in ways that correspond closely with perceptions of FGC among the Norwegian public. Infibulation leaves a distinct, physical mark on the body and, though generally visible only to Norwegians in the role of reproductive health care workers, “everybody” knows about it and hence it affects social relations. And although infibulation is positively evaluated within the Somali culture, the Norwegian view of

FGC as abhorrent and cruel, also affects the Somalis both indirectly and directly in their relationship with Norwegian society.

In order to understand how stigmatization by the Norwegian majority affects the Somalis in Norway, it is important to note firstly how deeply discrediting the stigma is and how the stigmatized person is not given the social respect she would otherwise have been granted. Secondly, the stigma have a "polluting" effect. It is not only the stigma itself (the physical mark) but the whole person that is negatively attributed. Thirdly, when forced to deal directly with a stigma, avoidance and silence are more common strategies than outright harassment. This silence, though due partly to consideration for the stigmatized person, appears to produce an uncomfortable situation for both Norwegians and Somalis, a situation in which they are both acutely aware of what they are pretending not to notice.

Defining infibulation as a "stigma" is related to the symbolic messages that most Norwegians, including health workers, read into the physical scar, as discussed in Paper III. Referred to as "total circumcision" (totalomskjæring), infibulation is seen as the ultimate symbol and expression of female oppression, an archaic vehicle for controlling women's sexuality and fertility. It was also commonly understood as a Muslim and patriarchal tradition, and in turn associated with perceptions of African "primitivism" and "barbarism".

In Paper III, I describe how Norwegian perceptions of Somali women as "victims of culture" entailed viewing them as women who are determined by, and unconditionally accept, the subordinate position Norwegians attributed to their culture. Even frequent encounters with women who presented a different perspective of themselves and their culture did not lead to a redefinition of Norwegian perceptions of Somali culture. Rather, they were seen as the exceptions that proved the rule. On the other hand, Paper II and III also discusses how this negative view of Somali women as oppressed by culture is counteracted in an almost opposite perception of Africans as representatives of "the noble savage". Africans tend to be regarded as more natural than most Norwegians, as "children of nature" *(naturmennesker*). Many researchers have pointed out how the West often takes Africa, especially in matters of the body, to represent "ultimate nature" (Arnfred 2004; Boddy 1998; Butchart 1998; Caldwell et al 1989; Fadel et al 2000; Fjell 1998; Johansen forthcoming a). However, though this perception of Somali women as more "natural" and "authentic" was generally a positive attribution, since Norwegians tend

to appreciate everything “natural”, it can still be seen as a tendency to “other” Somali women. Whether perceived positively as more “natural” or negatively as more “barbaric”, the perceptions of the Somalis as "primitive" still defined them as “different”. My suggestion in Paper III is that this ambiguous perception lies at the heart of the health workers' problematic relation to Somali women.

Goffman outlines two alternative ways in which stigmatized parties may react to the experience of being stigmatized: They may accept or absorb the subordinate position attributed to them and feel ashamed of their stigma, or they may reject their definition as stigmatized, perceiving their own culture and society as a parallel moral structure, in which the moral evaluations from the majority culture are not applicable. To a large extent Somali women seemed to resort to this second solution, a solution that offered better opportunities for social prestige and dignity (see also Fangen 2005). On the other hand, there were situations in which Somali women expressed deep concern about social stigmatization, particularly in their relationship with health workers. Also young people appeared more vulnerable to processes of stigmatization (see also Anamoor & Weinberg 2000; Nath & Ismail 2000).

Chapter 5

CULTURAL RELATIVISM AND FGC

Female Genital Cutting has often posed a challenge to the anthropological ideal of cultural relativism (e.g. Gordon 1991; Lyons 1981; Talle forthcoming a). A central issue has been the possibility of distinguishing between cultural relativism as a methodological and analytical approach and cultural relativism as a moral and political stand. That is, can an emic analysis of FGC be distinguished from legitimization of the practice? The dilemma is caused by the centrality of cultural relativism in anthropological analysis, and the international definition of FGC as counter to human rights. My ambition in this chapter is to approach these general discussions with special regard to the Norwegian context.

I will take concrete ethical dilemmas encountered in my study as a starting point. One: Scientifically I have been worried that the polarized debate that tends to focus *either* on the cultural meaning of the practice (that most anthropologists emphasize) *or* on the pain and harmful consequences (as is mostly highlighted by health research and feminist writings) runs the risk of masking the deeply felt ambivalence of the Somalis in this study. Two: As studying FGC in Norwegian exile is a study of an illegal practice, the researcher's legal obligations may at times come into conflict with the anthropological methodological approach. Three: I will discuss ethical dilemmas related to my own change of role during the research period from a "pure" researcher to a combination of researcher and anti-FGC activist. These situations activate different aspects of cultural relativism, such as access and trust,

analysis and understanding, methodological approach, morality and politics, in ways that are difficult to disentangle analytically and are deeply intertwined in practice.

First, however, a few words to define cultural relativism as an anthropological approach. Cultural relativism is fundamental to anthropology, and can be seen as the anthropological way of securing objectivity in research by taking care that our own cultural inclinations do not influence our understanding of "the other". In an old essay, but of strikingly current interest, Tord Larsen likens the anthropological endeavor to the fairy tale of the ugly duckling (Larsen 1979). Upon encountering an apparently bizarre custom – an ugly duckling – the anthropologist looks for local perceptions as a way to understand the custom and so be able to "place the custom where it belongs". In this way, we may find that what may at first sight have appeared to be an ugly duckling can, once its proper context is uncovered, be redefined as a swan.

We perform this operation *both* with customs that appear to be meaningless *and* with customs that appear to be morally reprehensible, Larsen states. As morality is dependent on context, learning to understand another culture will often make the researcher see the original bizarre custom as both meaningful *and* morally acceptable. In this way Larsen highlights the intertwined character of morality and meaning.

The extent to which many anthropologists experience FGC as an ethical dilemma is evident in the number of articles wrestling with the issue. Actually it seems as if anthropologists have written more on ethical challenges related to FGC than they have provided in the way of emic analysis of the practice itself (e.g. Allotey et al 2001; Bashir 1997; Bell 2005; Boddy 1998; Cook et al 2002; Gordon 1991; Gruenbaum 1996, 2001; Guerin & Elmi 2001; Kluge 1993; Kwaak 1992; Lane & Rubinstein 1996; Lionnet 1992; Lyons 1981; Morsey 1991; Parker 1995; Persson 2003; Salmon 2001; Shepher-Hughes 1991; Talle 2001, 2003 and in press a; Walley 1997).

Two major concerns can be identified in these writings, which are mostly concerned with whether involvement in issues relating to FGC is yet another expression of neo-colonialism and ethnocentrism (e.g. Bell 2005; Cook et al 2002; Guerin & Elmi 2001; Lane & Rubinstein 1996; Lionnet 1992; Morsey 1991; Parker 1995; Persson 2003; Shepher Hughes 1991; Walley 1997) or whether they present FGC as *the* testing case for cultural relativism. As Gordon suggests: "Cultural relativism has its limits, and FGC is the one place where we ought to draw the line"

(Gordon 1991; 4. See also Kwaak 1992). A third position is more ambivalent, problematizing how to understand and analyze the practice, while still acknowledging the pain and suffering it brings upon girls and women (e.g. Bashir 1997; Boddy 1998; Gruenbaum1996, 2001; Talle 2001; 2003 and forthcoming a). This is also in line with my efforts.

These debates become more acute when linked to FGC in the Norwegian context. Norwegian anthropologists have engaged in a heated and politically sensitive? debate on how to handle various harmful or oppressive cultural practices with regard to the overall dilemma of cultural relativism raised here (e.g. Borchgrevink 2003; Eriksen 2003; Gullestad 2003; Larsen 1979, 2005; Sørheim 2003; Talle 2001, 2003, forthcoming a; Wikan 2002). Some have suggested that this debate is more intense in Norway than in many other countries due to the rather prominent role of some anthropologists in public life (Eriksen 2003; Gullestad 2003). In Norway, anthropologists are called upon to give lectures on FGC for health workers, social workers, women's groups, youth groups, NGOs, politicians and others. They present and are criticized for their opinions or presentations in the media, and are called upon to give input for policies and planning. They are also used as "cultural witnesses" in legal cases.[41] Hence in Norway, anthropological writings on FGC may have practical political consequences.

Borchgrevink and Eriksen (both 2003) define cultural relativism as a way to describe the conditions under which certain acts of the "others" are carried out, forcing the external reader to exclaim that "Given these conditions, I would have done the same" (Borchgrevink p. 264; Eriksen p. 308). As a "pure" description this may represent cultural relativism as an analytical approach. However, in daily life FGC as a cultural tradition encounters the Norwegian law prohibiting the practice, and as such the two moral systems, the Norwegian and the Somali, meet and have to be ranked in the legal system (Borchgrevink 2003). This brings us to the dilemma of cultural versus individual rights, which I will discuss a little bit more below.

Encounters with ethical dilemmas

I will now describe three major dilemmas from my study as outlined above, but in the opposite order. I will start by taking the last issue first, dealing with my position in the field, as this may be relevant for readers' estimation of the validity of the study, and hence of the further discussion.

The first dilemma: Re-positioning – from researcher to activist

Here, I am taking as a starting point the fact that cultural relativism as a method requires that the researcher's own opinion or understandings based on her own socio-cultural background be replaced with a scientific emic understanding. In a sense this is related to the "rite-de-passage" perspective. Conversely, FGM activism is often understood to be based on a western, ethnocentric, discriminatory and neo-colonial, outlook.

The irony of it is that I have found myself in the odd position of taking up an assignment to work for the abolition of the very same tradition that I had been studying. This is not a unique position, though. Many other anthropologists have also been more or less involved in, or given their intellectual support to, anti-FGC work (e.g. Sara Johnsdotter, Janice Boddy, Ylva Hernlund, Lars Almroth, Aud Talle).

How could I position my role in the field, first as a researcher and later as an activist? As a researcher I made an effort to employ cultural relativism as a method, and in this endeavor, my personal opinion was not relevant. However, during fieldwork I was open about my personal opinion. In contrast to some anthropologists who presented themselves as neutral when informants asked for their opinion (e.g. Hernlund 2003), I said I considered girls and women better off physically if not cut. I assumed most informants would expect me to have such a stance anyway, as they knew FGC was alien to my culture and forbidden in my country. I felt, moreover, that I would have been dishonest and "unclear" as a person if I had presented a false opinion.

When changing position and becoming a full-time activist against FGC, the change was thus not in my personal opinion, or my openness about it, but in my role - my role as a worker in the OK Project where the overall aim of all activities was to contribute to the abolition of FGC. Rather than seeking knowledge for knowledge's sake, I now had to seek knowledge with regard to how it could be employed to promote cultural change. In practice, this meant for example that at times I had to react when people expressed support for FGC. Such reactions could involve interrogating questions, counter arguments, or even refusal to employ people who did not have the "right" opinion.

What surprised me, however, was that the concerns and thoughts that were presented to me by Somali women and men did not seem to be affected in any substantial way by my change of position.[42] In contrast, I have experienced my position in scientific and political discourses as challenging. Still, I do not think my position either in the field or in the scientific discourses has been affected in any substantial way by my change of position. What I have experienced as most profoundly affecting my analysis is my growing empirical insight, and the struggle I have had deciding how to present this.[43]

When describing anthropological work as a way to "translate" from one culture to another in order to make "the other" understandable to someone else, it is important to ask who we are writing for (Altern & Holtedal 1995; Gullestad 2003). Our imagined readers affect all aspects of our studies and this is an important field of positioning that has not been much explored as pointed out by Gullestad (Gullestad 2003). Hence I will take a further look at the imagined audience of ethnographic writings on FGC.

With regard to the polarization outlined above, we may, to put it simply, define the positions of the two poles as follows: The major goal of the anti-FGM pole is to advocate abolition of FGC. Hence their imagined readers are those they want to encourage to change. They include, for example, women from practicing communities, political leaders, and international agencies. To convince this audience of the need for change, the anti-FGM pole emphasizes negative aspects of FGC, such as pain and health complications. The danger is that, if this line of argument is taken too far, it may lead both to counter reactions or defensive reactions within practicing societies, and as well stigmatization from external groups. On the other hand, the rite-de-passage pole wants to present an emic understanding of the

practice, often partly to counteract the negative image of "the other" presented by the FGM pole. Their public is therefore defined as those who need to be reassured that the extremist arguments from the FGM-pole should not be taken at face value. Their imagined readers then could include both fellow scientists, the general public and anti-FGM activists. To present a best possible image of the other, negative aspects are often given less attention.

In a sense then, the rite-de-passage focus take on the role Gullestad describes as "the brave knight who in a contradictory gesture both offers and defends the vulnerable princess" (Gullestad 2003; 245. My translation). Borchgrevink also draws attention to the tendency of anthropologists to favour "the weak party" (Borchgrevink 2003), referring I suppose partly to the anthropological tradition of often "studying down", such as studies of minorities who are exposed to brutal oppression and discrimination. With "cultures" as a focus, the "princess" or "the weak party" in need of studies and protection is more often the culture as a whole, rather than underprivileged or vulnerable groups within the group. The role of 'spokesman' here is highly legitimate, given the history of colonization and current discrimination that also affect the Somalis in Norway. However, I will argue that such a position also implies both ethical and analytical problems.

With regard to research, it may affect which aspects of our informants' concerns we choose to focus on. We recall how the main concern of my Somali informants centered on the pain and suffering brought about by genital cutting. Though most, but not all, of them disliked media attention on FGC, the majority insisted on the need to highlight the negative aspects of the practice both in anti-FGC work and scientific discussions, in order to alert people to these negative aspects. Hence the Somalis themselves were more concerned about making Norwegians understand their suffering than they were about presenting cultural explanations in a way that could reduce their stigmatization. At times during my work in the OK project, I discouraged Somali women who wanted to highlight their pain and suffering by strong visual means, such as live films or photographs of actual circumcisions. One reason for my resistance was a fear that such strong visual expressions could increase stigmatization. Nor did I consider such strong means necessary to convince Norwegians against FGC.[44] But I felt odd at times, as by so doing I might be seen to censor what Somali women wanted to express, and to conceal part of their experiences.

My way of coming to terms with the dilemma of how to express Somali emphasis on pain without the risk of causing increased stigmatization was to take their concerns seriously by making their pain and suffering the object of my study. That is to say, I have analyzed women's experience of pain, rather than just describing it as a side effect of the operation, which is the most common thing to do in anthropological writings. Secondly, I have made great efforts to try to promote improved health care for infibulated women, partly by drawing attention to obstacles in Norwegian society.

Second dilemma: Studying an illegal practice

When Somali women come to live in Norway or other western countries, the discrepancies between the minority and the majority cultures, where the majority culture has laws against a cultural tradition of the minority culture, give rise to problems of a scientific, political and cultural nature. In this section I will discuss this with regard to the legal status of FGC in Norway. I will illustrate this through two specific experiences, one concerning the demands of the *Regional Committee for Medical Research Ethics* (hereafter Ethical Committee) and the other concerning advice from fellow anthropologists.

What opened my eyes to the ethical problems in focus was my reaction to a phone call from the Ethical Committee. As mentioned, I had to apply to them for permission to carry out the study.[45] They said they wanted to discuss with me some difficulties concerning my professional confidentiality. My immediate interpretation was that they doubted my ability to be neutral on such a sensitive issue. I thought they feared I would be unable to be culturally relativistic. Though I was wrong about their concerns, some reflections on my immediate reaction can throw light on the issue.

First, however, I will look at the concerns of the Regional Committee. They insisted that, if I received any information about a planned FGC, I had an ethical duty to interfere and avert such plans. Furthermore they considered it most honest to inform potential informants about this duty, by describing it in the project presentation. In this way, they said, potential informants could be given a proper chance to keep any plans from me.[46]

While I accepted my obligation to prevent any planned FGC for both legal and ethical reasons, I found it impossible to comply with the suggestion that I include information about this duty in the project presentation. Such information could jeopardize the whole study, as I expected it to substantially reduce the willingness of informants to participate. Not necessarily because he or she had any plans of an illegal act, but because such a warning would have introduced a sense of distrust from the start. [47]

After several months of negotiations with the Ethical Committee, I finally achieved approval for an approach that did not mention FGC in the project presentation or my duty to avert potential plans. My view was that since the prevention of child abuse is a common civic duty, my informants would probably expect that of me, and hence be able to make an informed choice on what to reveal. Also, I thought that if a situation should occur and my obligation to take preventive action could jeopardize trust and hence the continuation of the study, it would be worth the price, if I had prevented a circumcision. As it happened, however, I never received any information that activated this duty.

What is most relevant here, however, is to investigate why I immediately anticipated that I was expected to have a cultural relativistic approach, especially when you remember that FGC is defined in Norway as illegal and contrary to ratified international conventions on human rights. I presume my immediate reaction was a direct result of my anthropological schooling, which both directly and indirectly had promoted cultural relativism. Also relevant here is the role of the anthropologist as a spokesman for minority groups. A part of this was probably related to the concerns I had encountered earlier, to avoid stigmatization of the Somalis, which had been expressed both by anthropological colleges, the ethical committee and political authorities. Hence, even in spite of my negative attitude to FGC, I took it as self-evident that I as a researcher ought to approach the issue in a cultural-relativistic fashion.

When I discussed the dilemma between respecting informant confidentiality and reporting illegal acts with fellow anthropologists, the most common advice I was given was to resort to silence (not to report) or avoidance (drop the study). One example was when I presented the challenge in general terms during the discussion in a seminar on ethical dilemmas in field work:[48] “During my research, I may get an insight into illegal activities, planned or performed by my informants, which the

authorities of the country of research require me to prevent or report." The unanimous response from fellow PhD students and professors alike was that I should either not report possible crimes to the authorities or drop the study altogether.

When I later specified that the issue in question was FGC and that the authorities concerned were Norwegian laws and ethical committees, this appeared to alter their views dramatically. Not telling the authorities was no longer an option. I suppose both because of greater respect for Norwegian authorities than for the imagined oppressive ones they may first have associated my question with and because FGC, particularly when performed within our own society. When FGC is transported to the west, it appears to be one of the cultural traditions that is less likely to be redefined as a swan, as Larsen suggested (1979). Instead, the commentators all strongly suggested that I drop the study altogether. It appears then that the transfer of FGC from "far away societies" into a western context makes a significant difference to the ways in which anthropologists feel obliged to relate to the issue, and make it less suitable for cultural relativism as an ethical stand (Borchgrevink 2003; Eriksen 2003).

To highlight this difference, I will discuss some methodological implications of studying FGC at home versus in exile. When FGC is studied in its country of origin, it appears to be regarded as ethically sound for an anthropologist to be present during the act of cutting (Parker 1995, see also Gruenbaum 1996; 2001; Boddy 1989, 1998). Recently, however, some anthropologists have discussed ethical challenges regarding the message their presence may send (e.g. Talle 2001, forthcoming a; Rye 2002). To my knowledge, Rye is the only anthropologist who, in the process of his fieldwork, decided to refrain from further presence for mainly ethical reasons. He realized that his presence was interpreted locally as support of the practice, in spite of his efforts to assure them otherwise.

I have never heard of any anthropologist being invited to an FGC operation in the west. However, I assume such a situation for participant observation would be ruled out for ethical as well as legal reasons. In a sense then, both the legal and the ethical balances appear to be different in exile than in the home of the practice. This may be partly due to the different ethical and legal systems. However, the increasing degree to which countries have committed themselves to international conventions of human rights, in which FGC is defined as an offence against children and women, presents a different situation also at home countries of FGC. Also important here are

the many FGC-practicing countries that have established national laws against FGC, countries such as Kenya and Djibouti.

Third dilemma: Can cultural relativism reduce our understanding of culture as a lived experience?

I will now turn to the last problem to be discussed here, the apparently contradictory question of whether cultural relativism may actually limit cultural understanding? As I have pointed out, a major purpose of the ideal of cultural relativism is to enable the researcher to understand a culture "in its own terms". We recall how the cultural context in which FGC appears and is given meaning and legitimacy (the flock of swans in Larsen's terminology) associates infibulation closely with a positive evaluation of virginity, purity, wholeness, femininity, beauty and morality. As such, infibulation gives meaning, pride, identity and a sense of social integration to Somali women. In this context, an uncircumcised woman would be the one considered immoral and reprehensible, an "ugly duckling" so to speak (Talle 2003).

But, as highlighted in this study, what constitutes "its own premises" or an emic perspective is a rather multiplex composition. We have to recall the increasing attention to the variety of cultural models and the subtle ways in which power unfolds and pain and privileges are unevenly distributed. We must also recall the ways in which individual women and men often understand their personal experiences as different from, and often in opposition to, cultural models.[49] If we want to take these diversities into account, it also implies a more complex understanding of cultural relativism. To put it bluntly, it may at times be difficult to be certain which model within a culture and whose personal experience one should be 'relativistic' to (Pollit 2002; Honig 2002).[50]

As already pointed out, a major concern for me has been whether the traditional anthropological focus on cultural models in combination with the anthropological sense of responsibility to prevent neocolonialism and stigmatization creates a bias towards studies of FGC that emphasize the powerful cultural models at the expense of the multiplicity of cultural models and personal experience. And this

bias, I argue, can easily come to highlight cultural meaning and under-communicate negative aspects (See also Gullestad 2003).

Having decided that my main ethical obligation is to be as true as possible to the major concerns of Somali women and men as they expressed them to me, I felt a responsibility to present their overall message of a deeply felt ambivalence to FGC as simultaneously culturally meaningful and excruciatingly painful and destructive. This ambivalence could easily be missed out, due to the polarization of the discourses on FGC as *either* culturally meaningful *or* as painful and harmful.

Cultural relativism and FGC in exile – a discussion

The dilemmas discussed above highlight some of the ways in which cultural relativism can be ethically problematical, with regard to the difficulties in distinguishing between cultural relativism as an analytical approach, and as an ethical stand. In practical life, even the most sober academic presentations may have political consequences that affect peoples' lives.

Challenges like the ones discussed above are probably an important reason why anthropologists have until recently shied away from studying FGC (Talle forthcoming a). This is obvious in the above-mentioned conspicuous absence of focus on FGC in studies of societies in which this is an important practice. Actually it appears that many of the most significant analyses of FGC have emerged as a bi-product of studies that originally had a different focus. This includes Boddy's study of spirit possession (1989) and Gruenbaum's study of health care (1996), both in Sudan. Other researchers have been more or less forced to deal with the issue, as it has constituted a significant part of the initiation rituals they wanted to study (eg. Moore 1996; van Gennep 1960). Yet others have felt compelled to respond to provocative questions from fellow students (e.g. Parker 1995). And, as pointed out, even my original interest in the subject was brought about by a request for a study rather than by my own initiative.

As we may sense, this avoidance does not only stem from ignorance or lack of interest in women's matters. Rather, FGC seems to have been seen as a taboo subject for anthropological investigation. Looking back at her first fieldwork in an

FGC-practicing group in Tanzania in the early 70s, Aud Talle recalls a sense of FGC as a non-subject. Hence, she left it out of her analysis in spite of its potential relevance to the issues at hand (Talle forthcoming a). Later, we have experienced more direct appeals not to investigate the issue, as in Shepher-Hughes' outburst:

> "Hands off! Enough is enough! (And two Rivers prize awards and one previous honorable mention for papers on this topic is *more* than enough). Let Egyptians and Sudanese women argue this one out for themselves." (Shepher-Hughes 1991; 26).

Her petition is even more striking when seen in relation to her general appeal for the opposite, arguing that scholarly research must be "ethically grounded" and that cultural relativism, if read as moral relativism, "is no longer appropriate to the world in which we live" (Shepher-Hughes 1995; 410).

One reason for Shepher-Hughes' appeal to anthropologists to keep their "hands off" FGC is that she sees it as just another part of western postcolonial anthropologists' attempt to re-colonize parts of the Third World, similar to that of many other anthropologists.[51] This makes her both wary of the motives and positioning of social anthropologists and fearful that western attention may do more harm than good by stimulating counter-reactions in practicing communities.

I will take a closer look at the apparent contradiction in Shepher-Hughes' emphasis on the need for "ethically grounded" research, while simultaneously suggesting the opposite in relation to FGC. A major difference is the difference in context. On the one hand, she requests avoidance in the context in which the ones who inflict the pain belong to the same culture and society as the "victims" and the act is emically meaningful.[52] On the other hand she preaches ethically grounded action when the pain is inflicted by external forces, that is by somebody external to the local culture.

This then could be read as an argument for cultural relativism as a moral approach, that is, as long as the aspect we study is meaningful within the culture in which it is practiced. If this is so, then we have to ask what lies behind the frequent equation between culturally meaningful and ethically sound. There appears to be a widespread, but rarely analyzed basis in anthropology that culture automatically legitimizes what it prescribes and, in a sense, that culture is necessarily good,

something that should be preserved or continued, as pointed out by Tordis Borchgrevink (2002; 150). Borchgrevink sees how in Norway uncomfortable cultural traits are often defined as "anti-culture" (*ukultur*). This resembles the way in which the arguments of the anti-FGM pole describe the cultural underpinnings of FGC as "myth and misconceptions".[53] Thus cultural relativism as a moral stand must then in a way be based on culture as inherently good for people.

This brings us back to challenges which are related to the ways in which the concept of culture is used in Norway. The lay use of the term "culture" when referring to immigrant communities is a much more essentializing concept than the complex understanding used by anthropologists. As pointed out by many people, when local anthropologists had finally succeeded in convincing Norwegian society of the need to acknowledge cultural differences, they lost control of the concept, which in non-anthropological circles achieved a much more essentialist and determinative meaning (Eriksen 2003; Gullestad 2002; Wikan 2002).

These different understandings of the same term can cause problems when anthropological writings are used as guidelines to understand "the other". We then have to ask whether this should have implications for the ways anthropologists write and, if so, how. As an anthropologist, I was seen as an expert on "the culture" of "the others" (Gullestad 2003). The need to understand "their culture" was the major reason why the requested study on FGC in Norway was to be an anthropological, not to mention medical, study. The health care system wanted to know "how the Somalis think", and "what Somali culture says about" such things as c-sections, divorce, premarital sex, etc. They wanted to know partly in order to be able to show due respect. And as the study will show, practical examples of this respect for culture included issues that did some seem to benefit Somali women (such as avoiding raising the issue, resisting defibulation and performances of re-infibulation).[54]

Internationally, arguments in favour of acceptance, and public health service offers of "mild" forms of FGC can be seen as the expression of an attenuated form of cultural relativism. A "minor or symbolic cut" (that must not be any more harmful or risky than the accepted forms of male circumcision) is suggested as a way to meet cultural demands "half way". This has been suggested not only in the home countries (e.g. Gallo et al undated; Hjort-Larsen 2005), but also in several European countries, such as Italy (Catania & Hussen 2005), Holland (Obioro 1997), USA (Schweder 2003) and generally (Schweder 2003; Gilman 2002). In most states in the US, FGC

would not be illegal if performed by adults (above 18 years of age), as it would then be defined along with other types of cosmetic surgery (Rahman & Toubia 2000). In Norway a “symbolic” cut, i.e. one that does not remove or harm any part of the genitalia is not considered illegal, as the law prohibits intervention that causes “lasting alterations” (The Norwegian Board of Health 2000).

In this thesis, I am particularly concerned with problems relating to how the Norwegian desire to show “respect for the culture of the other” is affected by the lay tendency to essentialize the culture of “the other”. This becomes even more problematic when realising the extent to which this “culture of the other” is an attribution of Norwegian misunderstandings or even invention of this culture. Essentialist concepts of culture can cause confusion, as is shown in the bewilderment many public servants expressed when they learn that a practice they have regarded as a form of patriarchal oppression of women, is in most cases propagated and continued by the women themselves. Another example is the midwife who appeared surprised when a Somali father hugged and kissed his newborn baby girl, as it contradicted her understanding that Somalis prefer boys.

Attempts by Norwegian health workers to “show respect” for the culture of “the others” can be read into a wider political discourse of multiculturalism. This is a political ideal that ethnic minorities should be given room to live according to their “culture” to a greater extent than most western states allow for today (e.g. Kymlicka 1995; Taylor 1994; Schweder 2003). However, at times the protection of ”group rights” comes into conflict with the protection of “individual rights” (Borchgrevink 2002; Okin 2002). If one wants to respect the group’s right to continue the cultural tradition of circumcision, then one cannot at the same time protect young girls from the profound and lasting bodily change that almost all forms of FGC entail.

This brings us back to the ethical dilemmas anthropologists appear to experience with regard to FGC and the way in which these dilemmas appear more acute when FGC comes to the west, that is when ethnic groups or “cultures” that accept, legitimize or practice forms of female oppression that is considered foreign and counter to Norwegian law and ideology (e.g. Borchgrevink 2002, 2003; Bredal 2004; Eriksen 2003; Larsen 1979, 2005).

However, it is difficult to see why this should pose a dilemma were it not for the idea that the ideal of cultural relativism was also considered a moral requirement. This has widespread consequences, because whatever their aspiration,

anthropologists are *expected to be* culturally relativistic by the Norwegian public. Hence, the very explanation of certain phenomena as emically meaningful, is read as a form of legitimization (e.g. Skartveit 2002; Storhaug 2002).

The issues discussed so far have mainly concerned the legal and practical implications of cultural relativism and FGC in exile. But FGC also poses a challenge to the Norwegian ideal of equality. For, while my impression is that most Norwegians condemn FGC as immoral and oppressive, we can also detect a widespread concern for an equal and respectful relationship between Norwegians and immigrants. And here we have to untie another knot. The major message of anthropology has been egalitarian, as Gullestad states: “The apparently strange customs of so-called primitive people can be sensible once they are interpreted from the local point of view” (Gullestad 2003; 236). In a way then cultural relativism is seen as an expression of, and promotion of equality between "Norwegians" and "immigrants". However, it appears that while you may present FGC as emically meaningful, most Norwegians still perceive it as the ultimate of barbaric practices. This, I suggest, is one reason why it is so difficult to deal with FGC in exile. In an effort to balance “intolerance of the practice with tolerance of the culture” (Bashir 1997, 11), Larsen suggests the most common solution is to historicize. In other words, by placing uncomfortable cultural traits in the past, we can create a bond of equality with the practitioners (Larsen 2005). This is also a common anthropological style of presentation (Fabian 1983).

In Norway this tendency to historicize FGC is evident in public expressions, particularly in media discourses. A popular Somali FGC lecturer in Norway routinely made active use of historization techniques; “We live in your past”, she said. She then drew parallels between FGC and cruel practices from Norwegian history, stating that: “We are like you were, not long ago”. In this way Norwegians are allowed to morally condemn FGC as a thing of “the past”, while maintaining a sense of equity with the immigrant groups practicing this tradition. The Norwegian audiences generally mumbled and smiled in support, seemingly comforted by her presentation:

> “Identity (we are all humans) or non-identity (they are our contrast) become united in: they are our past and will become like us through history. This is a move of a genius by evolutionary thinking (Larsen, forthcoming, manuscript page 7. My translation).

The other side of this coin is the way in which Somali girls who either oppose FGC or are considered to be at the risk of FGC, tend to be redefined as “Norwegian girls”, as one of “us” and “our” time, rather than as one of “the other” in media debates.

However, Larsen argues that this historical move still cannot solve the problem of “othering”, as this move also differentiates between “us” and “the other”. Suggesting that “We withdraw from “the other”, by saying that they exist in another time and in doing this, we invalidate anything but asymmetrical relations; “we study, colonize, isolate and idyllize /romanticize people we keep at a distance” (My translation. Larsen 2005; 169, inspired Fabian 1983). In a sense, then, both an essentialized sense of cultural relativism and an ethnocentric approach may be seen as processes of “othering”, which highlight differences and divide, rather than bridge, our common human nature.

These concerns create dilemmas that go beyond the scope of this dissertation. What I want to discuss is the implications these dilemmas have on the Norwegian debate that may throw more light on the tendencies of polarization, which I consider to be a major obstacle to scientifically sound discussions. As already pointed out, it is almost only within the FOKO network, with other researchers working in-depth on the same issue, that I have experienced sufficient academic freedom from this polarization to be able to think creatively and progressively about the practice

Larsen highlights how the act of placing “primitive” traditions in an historical past (even if still existing in the present) fits into the moral “grand narrative” of “the moral progress” which gives meaning to life, and has legitimized our/western behavior for the last 300 years“ (Larsen 2005; 167. My translation). This move can help to explain the incredible indignation and moral panic which seems to be provoked by the drawing of parallels between FGC and other bodily practices, such as those presently performed in the west.[55] Anthropologists who have dared to point to parallels between what in Norway are seen as “barbaric practices” of “the other”, and practices performed with the “blessing” of scientific medicine in our own community, such as cosmetic surgery on breasts or labia, thus making it comparable by placing it in the same “time”, have been harshly criticized (e.g. Skartveit 2002; Storhaug 2002). Such comparison seems to threaten fundamental cultural categories in the Norwegian society.

> "Since God performed the first classification by distinguishing heaven from earth, we (humans) have been unstoppably preoccupied with classification (…) We have clear perceptions of which regulations are applicable within a category, and not those outside. The borders between them are associated with holiness and taboo (as shown by Mary Douglas and Edmund Leach) and an enormous amount of ideological effort is invested in keeping the categories separate, *and forcing delinquents back into the fold*" (Larsen 1979; 120. My translation)

To sum up, I will go back to my definition of my main obligation, which is to be as true as possible to the main concerns of the Somali women. I am aware that this approach, given the results of my study, could risk increased negative attention to the Somalis, and consequently increased stigmatization. One reason why I have taken some risks in this regard is not only that the Norwegian health workers reacted with moral condemnation and panic with regard to FGC, but also that this view was partly counterbalanced by the quest to "show respect to culture". In order to promote better healthcare for infibulated women, I therefore consider it necessary to communicate the pain and worries expressed by Somali women. In this study, then, I have defined cultural relativism as an effort to understand FGC first and foremost as it is lived and experienced by the informants. In this regard, cultural models are not presented as "answers", but rather as a multiplicity of frames of reference to which informants relate in various ways.

If we focus on the reasons why FGC is done, it again draws our attention away from the price that has to be paid. McGown, for example, presents her obligation as a researcher to understand the perpetrators of FGC, as their intentions were good. Consequently she felt obliged as a researcher to understand the mothers and grandmothers (McGown 2003). While she insists that this does not condone the practice, it is a focus that again draws attention to the cultural groundedness that legitimizes the practice, as apart from the experience of the practice.

When discussing ethical concerns with regard to FGC, it is useful to distinguish between intentions and outcome in ethical considerations. Parents who expose their daughters to FGC have all the best intentions. Given that FGC is a socio-cultural requirement, they are doing their best to secure the life of their child, as pointed out by McGown (2003). However, all Somali informants were very clear

about the ambiguity of the outcome. They considered FGC to be *socially* good for a child, especially if growing up in Somalia, as it was regarded as a prerequisite for social acceptance. But they did not consider FGC to be good for the child's bodily experience or their physical health. They were all acutely aware that the procedure entailed pain and health risks and, as shown in the papers, they strongly regretted these. And this, again, was the major reason for my informants' widespread resistance to infibulation.

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NOTES

[1] In comparison the second largest immigrant group in Norway practicing FGM are from Ethiopia and Eritrea, constituting about 2,000 each.

[2] The Norwegian Law against FGM, Act no. 74 of 15 December 1995.

[3] I am aware that other anthropologists have almost contradictory worries than mine (e.g. Johnsdotter 2002)

[4] This includes organizations such as US Agency for International Development (USAID) and United Nations Population Fund (UNFPA). For a discussion see Boyle 2002. It is also increasingly used in literature on the subject, see for example Chekweko 1998; Cook et al 2002; Bell 2005; Hernlund & Shell-Duncan (eds.) forthcoming.

5 See for example Johnsdotter 2002; Hernlund & Shell-Duncan 2000 and Gruenbaum 2001

[6] Lyons paper analyze the historical background which led van Gennep and later anthropologists to de-emphasise sexuality, partly in an effort to counterbalance earlier writings that appeared to be based on little more than western perceptions of "primitive" sexuality.

7 Some French activists use "Sexual Mutilation" to emphasize the way in which FGC tend to cut mainly organs significant for women's sexual pleasure, e.g. CAMS (Comission pour l'Abolition des Mutilations Sexuelles).

[8] For more information about the Somali clan system, see Lewis (1961, 1998), Mansur (1995, 1995b) and Hicks (1993). For a description of how it works in everyday life, see Barnes Lee & Boddy (1994). Clan identity is also significant for marriage patterns, see for example Lewis 1993; 14 f, and Helander 1991; 23f)

[9] Sources diverge on both naming and definition of clans. Somalis often refer to the minority clans as "*sab*". Clans were often labeled "tribes" by my informants.

[10] This is probably why a Norwegian Somali specialist describes them as casts (Haakonsen 2005). Local traditions also often define minority clans as originating from elsewhere. Osman (2002) suggests for example that the minority clans are descendants of people from overseas who were shipwrecked on the Somali coast. The *Midgaan* are said to come from the untouchable casts in India, while the other two originated in Indonesia. This is only one of several different theories on non-Somali origin of minority clans. Osman describes the clan division of labor in which the Midgaan are responsible for FGC and maternal and child health issues, the *Tumaal* are blacksmiths, and the *Yibri* are hunters of wild animals.

[11] For more information, see www.culturalorientation.net/bantu/sbtoc.html

[12] Statistics Norway 2003

[13] In replying to the stereotype of Somali women as "double humble", Helander suggests rhetorically anyone with such an image, obviously have never met a Somali woman (Helander 1993 in Johnsdotter 2002, 41).

[14] WHO typology: Type I: Exision of the prepuce with or without excision of part or all of the clitoris. Type II: Excision of the prepuce and clitoris together with partial or total excision of the labia minora. Type III: Excision of part or all of the external genitalia and stiching/narrowing of the vaginal opening (infibulation). Type IV: Unclassified, includes pricking, piercing or incisions of clitoris and/or labia; stretching of clitoris and/or labia; cauterization by burning the clitoris and surrounding tissues; scraping (angurya cuts) of the vaginal orifice or cutting (gishiri cuts) of the vagina; introduction of corrosive substances into the vagina to cause bleeding or herbs to tighten or narrow the vagina; any other procedure which falls under the definition of FGM given above. (WHO: FGM information package)

[15] When performed by traditional circumcisers, healing is usually managed by fixing the two sides together with thorns or sutures or *mal mal,* to prevent infection and excessive bleeding (*mal mal* is a mixture of egg yolk, sugar and "kvae") . According to Osman, this is done by dipping a cloth in the *mal mal* which is then placed on the wound (2002). Then the girls' legs are usually tied from hips to feet to ensure healing. After 7 days the cloth may be removed. Meanwhile, the girls have to sleep on their sides. Without complications the girl may start walking with sticks after about 2-3 weeks, and women demonstrated how they would walk by moving their toes only. Full recovery takes about 2-3 months.

[16] Dirie & Lindmarks found in a study of 300 women from Mogadishu that 88% were infibulated (1991). Another study of 2092 women in 1981 showed that 93% had been cut, of which 75.7% had been infibulated. 23.6% were said to have "attenuated", which was not described (Gallo & Abdisamed 1985). Another survey published in 1983 showed significant differences between south and north, with less infibulation in Hergeysa (21 %), 99 % in a town a few miles away, and 70 % in Mogadishu (Obermeyer 1999). The report from Worldbank/UNFPA from 2004, compiling all evidence in the last years, show however an almost universal practice of infibulation, that does not appear to have change during the last 20 years.

[17] This may be related to the description of infibulation as "sewed", hence if closure is managed without stitching or thorns, then it would not quality as infibulation. Some circumcisers we talked to claimed that that health hazards of infibulation was only caused by the needles and sutures themselves, hence, again, if enclosure could be secured by other means, the health risks of infibulation would be reduced. However, lay women did not agree with this, many claiming that the herbal mixture of *mal mal* could cause extraordinary scar formation (keloid) and cysts, as well as increased risks of excessive enclosure.

[18] Osman (1992) refers to infibulation as *gudnin xaawo.* A study tour that appeared to visit the same areas as we did, but a year later, brought along yet another set of terms (Kristensen 2005). *Xalalays*, from Arabic, refers to cleansing, and is used both to describe various types of FGC and to describe one of the purposes of the operation (Talle 1993). From Sudan Gruenbaum describes a procedure named "sandwich", in which an infibulation is made over an intact clitoris and labia minora (2001).

[19] In Hergeysa and Boroma, 82.2 % of the women claimed to have been infibulated. Of the 11.1% who claimed to have "large *sunna*" more than 50% were found to be infibulated; the remainder had excision (types I and II). Among the 6.7 % that declared a "small sunna" were mainly types I and II, some type III (WHO Somaliland 2002). In a survey of 887 women from all regions in Somalia, 47% declared *sunna* and 52.6% infibulation. But in a register study in five major hospitals in different towns, 90% of incoming women were infibulated. In an interview at a major public hospital in Hergeysa, a medical doctor claimed to have seen one un-infibulated woman during his last three years of work. Hence there is a sharp contrast between an increasing claim of *sunna* and the findings of medical examinations, which are mainly infibulation.

[20] These data are mostly based on my interviews with circumcisers in Somalia.

[21] Circular 1-1030/80, from the Ministry of Social Affairs.

[22] Figures from Statistics Norway (SSB).

[23] Consultation memorandum on proposed law to prohibit female genital mutilation (circumcision of women), 2 February 1995. Letter 91/07555 Ha-2 JFR/-9 February 1995. Høringsnotat vedrørende forslag til lov om forbud mot kjønnslemlestelse (omskjæring av kvinner), 2 februar 1995. Brev 91/07555 Ha-2 JFR/- 09.02.95

[24] Proposition No. 21 to the Odelsting (2003/2004:8) On Act relating to amendments in Act No. 74 of 15 December 1995 relating to female genital mutilation. Ot.prp.nr. 21 (2003/2004:8): Om lov om endringar i lov 15. desember 1995, nr 74 om forbud mot kjønnslemlestelse.

[25] These were: 1) The MiRA Resource Centre for immigrant and refugee women, a women's organization open for all nationalities, but which have had a predominance of Pakistani and other Asian leaders and members. 2) The Contact Committee for Immigrants and the Authorities (KIM), where membership is supposed to mirror the pattern of immigration. FGM-practicing countries were still a minority and too recent an arrival to have a significant number of organizations to recruit representatives from).

[26] I also had access to some taped radio, and TV-debates, and interviews with some of the parties involved at the time.

[27] The program has already been heatedly debated from ethical and methodological points of view: Figenshou 2000; Gylseth 2001; Lamo 2002; Talle 2003, forthcoming. For a similar case in Sweden, see Johnsdotter 2002 and forthcoming.

[28] The Ministry of Children and Family Affairs, the Ministry of Foreign Affairs, the Directorate for Health and Social Affairs, the Ministry of Local and Regional Government, the Ministry of Education and Research, the Ministry of Justice and the Municipality of Oslo were all involved in drafting the National Plan of Action, financing it, and functioning as a steering group for government-supported work against FGC.

[29] I later developed a specific guide on sexuality, as the original guide did not include questions on the issue. A plan to do a special focus on young people, which was approved by the Regional Committee for Medical Research Ethics, had to be abandoned due to opposition from the parental generation. This was probably related the "Kadra-program, described in chapter 5. In general, as well as their vulnerable situation and my adult age.

[30] Muslim and traditional marriages were not always officially registered. The higher social support offered to single mothers stimulated a certain degree of discrepancy between an official status as single or divorced, and a social status as married.

[31] Kwaak 1998 states that 40% were living as nomads in the late 80'ies, but no reliable estimate exists.

[32] In the UK ; Forward; Rainbo; Black Women's Health Action Project (BWHAP); Bethnal Green. In Melbourne, Australia; Health Promotion and Nursing; African Australian Welfare Council; FARREP; Darebin City Council project for Somali youth; Southern Health Care Network (Springvale Community Health Centre), Working Women's Health; RANZCOG/ Royal Women's Hospital/Mercy Hospital/Key Centre for Women's Health, University of Melbourne. In Denmark; Foreningen mot Pigeomskæring; Somalian Mothers Community; Sundhedsstyrelsen.

[33] These included significant Somali researchers such as; social scientist Amina Mohamoud Warsame who has focused extensively on women's situation in Somalia, educationalist Abdi Muhamed Ali who did a study on FGC and education, Fatuma Abdi Muhamed who has been active in both research and anti-FGC activities, and Edna Ismail, who was the first to take up the issue in Somalia.

[34] This included three IAC conferences (Senegal 1997, Tanzania 2001, Ethiopia 2003); a conference in Gothenburg in 1997; a Somali women's conference on FGC in Aarhus, Denmark, 2003; International congress on Somali studies in Aarhus 2004; and two Somali conferences in Norway; the International Donors Working Group on FGM/C, Washington April 2004; Advancing Knowledge of Psycho-Sexual Effects of FGM/C: Assessing the Evidence Organized by the International Network to Analyse, Communicate and Transform

the Campaign Against FGM/C (INTACT & Population Council), Alexandria, 2004; three FOKO-conferences (Oslo 2001, Malmö 2003, Copenhagen 2005); "Review, Monitoring and Evaluation of anti-FGM Programs" by RAINBO and the London School of Hygiene & Tropical Medicine 2003.

[35] This included Norwegian Church Aid; Norwegian People's Aid; Beacon; National Focal Point; Habiba International; Women for Peace;; Edna Adan Hospital; WHO Somaliland; Somaliland state hospital; Mandera hospital; Academy for Peace and Development; Candlelight for Health; Nagaad; SIHA Somali-land Initiatives for Health Activities; Health Unlimited; Anna Lena FGM; Caritas Djibouti; Djibouti Ministry of Health.

[36] I also achieved; 1) Permission for interviewing people repeatedly and storing retraceable private information (phone number and code names) granted by The Data Inspectorate (Datatilsynet) 2) Ethical clearance for studying medical records in the hospitals from the Norwegian Board of Health (Statens Helsetilsyn) 3) and a code of silence was signed with the hospitals in which I did fieldwork.

[37] I have lived for a total of three years in Tanzania and 8 months in Cote d'Ivoire.

[38] My concept of "personal experience" appears to be similar to the "lived experience" discussed by Bruner 1985; Rudie 1984; Hastrup and Hervik 1994. By using the word "personal", however, I hope to highlight even more the extent to which experiences can vary interpersonally.

[39] The growing number of Somali women who seek defibulation, may be seen as a very concrete effort to undo the cultural carving of their bodies. In a sense, this is an extraordinary message of cultural critique from within, which deserves further study.

[40] Solheim's view of the female body as a primordial medium for experiences of borders suggests a promising new perspective of FGC (see Johansen forthcoming a).

[41] There have up to now been no court cases on FGC in Norway, but anthropologists have been summoned in other cases, such as forced marriages and honor killings. Also anthropologists, including myself, have been called in child-care cases.

[42] It may be that my position in the Somali community was related less to my formal position than to me as a person, as a sort of "betwixt and between" (Norwegian and African), which may have been strengthened by the continuity of many relations and networks (see also Sørheim 2003). An expression of this is the limited extent to which I felt Somalis strived to present a positive front-stage and to distance themselves from the negative media picture of Somalis, in contrast to what has been described by some other researchers (e.g. Fangen 2005).

[43] This is partly because my change of position took place only four months before my funding expired. At that time both fieldwork and analysis were finalized, and all the papers

had been drafted and presented in an earlier version in some scientific fora, and Paper I was already in press. As I see it, the main contribution of my work as an activist has been to strengthen and confirm the findings of the PhD study, as it provided me with numerous opportunities to test out and discuss the findings.

[44] I also considered it ethically wrong to film FGC, because it can both function as support of the on-going child-abuse, and increase the burden on the child.

[45] I also had to obtain: 1) Permission from the Norwegian Data Inspectorate to interview people repeatedly and store retraceable private information (phone number and code names) 2) Ethical clearance from the Norwegian Board of Health to study medical records in the hospitals 3) A code of silence signed with the hospitals in which I did fieldwork.

[46] This attitude highlights another dilemma, as an approach that emphasizes a right to hide illegal activities simultanously reduces the possibility of fulfilling the legal duty to protect the rights of the child.

[47] We see here how information could have jeopardized trust, as discussed chapter 5.

[48] Seminar arranged by the Institute of Social Anthropology, University of Oslo, April 1997

[49] We recall the gender differences, which also concerned who had the decision-making power. Somali women generally claimed that the men were to blame for FGC, as they demanded infibulated wives. Men on the other hand generally repudiated any responsibility for the practice, claiming this to be women's business. They often also claimed that FGC was performed both against their will and their knowledge.

[50] The different positions with regard to decision-making in FGC have been considered important in the design of anti-FGC programs. However, the systematically greater success of projects targeting ordinary women rather than "opinion leaders", suggest a need for further studies on change (Population Reference Bureau 2001; Rogers 1995).

[51] Another argument for Shepher-Hughes was that the medically condoned practice of male circumcision, which is widespread in the USA, places western anthropologists in the glasshouse with regards to FGC.

[52] The importance of this aspect is highlighted in the common term of "harmful *traditions*" to describe FGC in anti-FGM terminology.

[53] A similar assumption probably lies behind the horrific reactions I received from non-anthropological Norwegians, when I described infibulation as highly meaningful. Meaningful appeared to them as something good.

[54] One of the most extreme cultural-relativistic and "culturalist" standpoints I encountered was a child welfare worker who said he would never prevent FGC for the fear that this could cause the girl to be rejected by her parents, as he considered this to be more damaging to

the child than an infibulation. It is of special importance to note here that there is no indication that a parent would reject their child on such grounds.

[55] One journalist has describes parallels between western body practices and FGC as an insult to the sufferings of other people (Skartveit 2002). There are several contributions to the debate on comparisons between FGC and western cosmetic surgery, and also other traditional practices such as Chinese foot binding. This discourse goes beyond the scope of this dissertation, but needs to take into account differences not only in physical harm, but also in age and degree of coercion and pressure (see Johansen forthcoming a).

Paper I

Johansen, R. Elise B. (2002)

"Pain as a Counterpoint to Culture: Toward an Analysis of Pain Associated with Infibulation among Somali immigrants in Norway"

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R. ELISE B. JOHANSEN
Section for Medical Anthropology and International Health
University of Oslo

Pain as a Counterpoint to Culture: Toward an Analysis of Pain Associated with Infibulation among Somali Immigrants in Norway

This article focuses on how some Somali women experience and reflect on the pain of infibulation as a lived bodily experience within shifting social and cultural frameworks. Women interviewed for this study describe such pain as intolerable, as an experience that has made them question the cultural values in which the operation is embedded. Whereas this view has gone largely unvoiced in their natal communities, the Norwegian exile situation in which the present study's informants live has brought about dramatic changes. In Norway, where female circumcision is both condemned and illegal, most of the women have come to reconsider the practice—not merely as a theoretical topic or as a "cultural tradition" to be maintained or abolished but, rather, as part of their embodied and lived experience. [female circumcision, infibulation, pain, exile, Somali immigrants]

One of my first encounters with women affected by female circumcision was at a Somali theater performance in Norway in 1997.[1] I was keen to meet the subjects of my study and entered with my senses wide open. I found a room full of Somali women and men, mingling, smiling, talking, and laughing. The elegant women, the backs of their heads elongated by the head knots beneath their scarves, were swinging their hips in the dance, looking proud and happy. Yet I knew that beneath their colorful dresses, most of these women had had parts of their genitals cut off and parts sewn together. I also believed, based both on my review of the literature and my imagination, that this had been an extremely painful experience. What had the pain done to the women? How had they coped with it?

My intention in this article is to examine personal experiences of physical pain and women's reflections on these experiences, that is, how individual women experience and reflect on female circumcision (in this case, infibulation) as a lived bodily experience within shifting social and cultural frameworks. The women in this study live as refugees in Norway and therefore have left familiar surroundings in which female circumcision, although overwhelmingly painful, is regarded as in-

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trinsic to women's lives, as a part of being a woman, of growing up. In exile, however, they live as uprooted foreigners apart from most or all of their relatives, in a society and culture that both morally and legally condemn the operation they have gone through. This has provoked many of the women to reflect on female circumcision, not as a theoretical topic or a cultural tradition to be maintained or discontinued but, rather, in the sense of *feel-thinking* about it as a part of their bodies, their sexuality, and their lived experiences.[2] Was the procedure necessary? Was it worth it? Should they perpetuate the practice in Norway?

Most infibulated women stated that their circumcision had been the most painful experience in their lives, something they could never forget. "How can you not remember pain like that?" many women asked rhetorically, "They are cutting your flesh." When Halima, a lively and caring woman in her late thirties tried to depict what the pain had done to her, she said, "The pain of circumcision is like a heavy burden I always carry with me. It is like darkness in my life, in my chest. You can never forget it."[3] Many women expressed the lasting effect of their circumcision and the associated pain as a sense of loss in both body and soul.

Infibulation is often described as a practice with profound cultural meaning and importance related to basic cultural values attached, for example, to gender, sexuality, morals, beauty, lineage, and fertility. Nonetheless, most women who have experienced the operation associate it with extreme pain and health complications. Research on the practice, however, seldom considers both of these aspects but, rather, focuses on one or the other. Thus, in cultural anthropology, the focus of attention has been on cultural meanings, whereas medical and feminist research has focused on medical complications, with pain included on a "laundry list" of such sequelae (Shell-Duncan and Hernlund 2000:15). This article investigates the "empty space" left largely unexplored between bodily pain as nerve impulses, on the one hand, as is the approach in medical research, and symbolism, on the other hand, as tends to be the focus of anthropologists. Here, through a medical anthropological approach, I analyze pain as a complex web of physical, cultural/symbolic, and personal/emotional experiences.

Wondering if "meaningful" pain induced by culture is experienced differently from "accidental" pain caused by external forces, I searched for material that could give insight into the pain experience in different social and cultural settings. I found the literature surprisingly thin, especially considering the numerous anthropological studies of painful rituals. Even studies of female circumcision rarely explore the experience of pain. I agree with Lyons's and Parker's criticism that most anthropological studies offer too narrow a perspective on female circumcision when describing it as a "physiologically trivial, but socially important procedure mainly concerned with establishing clan membership and adult status"(Lyons 1981, quoted in Parker 1995:517). I miss a focus on the significance of pain as a personal experience, as well as a discussion of the relationship between personal experiences and cultural models.

My theoretical ambition is to grasp how people perceive their personal experiences and how they relate them to wider cultural models and social norms. In my approach to the particularistic, I have been inspired especially by the works of Moore (1994) and Shore (1996, 1998), particularly by Shore's concepts of "personal experience" and "cultural models." Cultural models are defined as culturally accepted ways of seeing, experiencing, interpreting, and expressing personal experi-

ences. I do not take this to mean that cultural models are consciously formulated. Rather, they may well be inculcated as bodily tendencies and preferences (see also Moore 1994). In this, I have been inspired by Csordas's concept of embodiment and the "new" focus on the body as an experiencing agent, as "the existential ground of culture and self" (1994:4). Thus, both the "personal" and the "cultural" are grounded in an embodied self. This perspective may also be applied to experiences of pain in female genital cutting: "It seems as if the pain of the original operation becomes fixed in the body and guides it in a certain direction—cultural models have become embodied" (Talle 2001:29, my translation).

My preference for the term *cultural models* focuses particularly on its pluralistic form, which emphasizes the existence of plural, even contradictory, cultural models within what anthropologists used to define as a culture. These models are continually constructed and negotiated within a social framework. Identification with cultural models varies between individuals and situations. At some points, cultural models are taken as self-evident realities (*doxa,* to borrow Bourdieu's term), whereas in other situations they become objects of reflection *(heterodoxy).*

The dynamic relationship between cultural models and personal experience may be particularly visible during periods of change. My exiled informants find themselves in a situation where many taken-for-granted cultural and social norms have become explicit and subject to question, thus calling forth a more articulated and conscious consideration of personal experience, cultural models, and the relationship between the two. As Amina said, when challenged on the limited resistance to the practice in her home country, "I could never know that I was black until I met someone white. I could never know about my culture until I met somebody who had another. Somebody who asked me and made me ask myself, 'But why do we do this?'" This process of articulation and reflection is interesting, particularly because it can give access to personal experience that has been muted in the women's natal environment and thus rendered beyond the reach of both emic reflection and anthropological investigation. Voicing such experiences opens the practice to investigation by both practitioners and anthropologists.

The Experience of Pain

My point of departure is the perception of the pain brought about by the operation constituting female circumcision. I use the term *perception* because pain cannot be limited to a study of nerve sensations. Rather, I draw on anthropologists and medical scientists who emphasize that pain is never a purely physical experience but, rather, has to be understood as an intensive and all-encompassing physical and mental experience: "However complicated to articulate and difficult to interpret, the patient's experience of pain is lived as a whole. Perception, experience, and coping run into each other and are lived as a unified experience" (Kleinmann et al. 1992:8). Or in Jackson's words, "pain is by definition simultaneously bodily experience and mental-emotional experience" (1994:209). Thus the "meaning" attached to pain constitutes a part of the pain experience. This lies behind some anthropological suggestions that culturally meaningful pain may be easier to bear than accidental pain (Jackson 1994; Sachs 1987).

The focus in this article, however, is not so much on the immediate experience of pain during women's circumcision, as most women in the study were cir-

cumcised years before coming to Norway. Rather, I focus on the memory of pain or, more precisely, on how the in-corpo-rated pain is experienced, reexperienced, and reinterpreted by women in their Norwegian exile. In this, I consider pain not only or necessarily as consciously "remembered" but, rather, as embodied. It constitutes a "body memory," as elaborated by Casey. Body memory is "memory that is intrinsic to the body, to its own way of remembering: How we remember in and by and through the body" (Casey 1987:147). Thus, body memory is something we *are* rather than *have*.

To regard pain as embodied is supported by medical research indicating that pain is inscribed mentally, emotionally, and physically. There are observable physical changes in the constitution of nerve cells transferring sensations of pain that ease and increase the transmission of pain messages (Knardal 1998). Thus, new pain stimuli or situations similar to earlier painful episodes reactivate and amplify embodied pain experiences.

The way women talked about their memory of the pain of infibulation supports the idea of pain as embodied, as does clinical experience.[4] Women generally talked about the pain as something they carried within their body and soul, as Halima said, "a heavy burden, a darkness in my life." Furthermore, the pain of infibulation is reactivated in several life situations, such as sexual debut and childbirth. Thus, the pain of infibulation continues to affect women's lives many years after the original operation—the whole of life, most women say.

Field and Method

Women of Somali origin were chosen as the basic unit of study. The main reason for this choice was the frequency of female circumcision in this group (approximately 98 percent prevalence), particularly of infibulation (80 percent) (Dirie and Lindmark 1991). Second, Somalis constitute the largest and most recent immigrant group to Norway from areas practicing female circumcision. By the year 2000, there were around 8,000 Somalis in Norway, almost all of whom had arrived during the ten years following the intensification of political unrest and civil war in 1988.

The study was carried out in and around Oslo, the capital of and largest city in Norway, where more than half of the Somali population has settled. Fieldwork was carried out during 12 months between 1997 and 2000. Participant-observation was undertaken in a Somali women's organization and a health group and in their varied subgroups and activities, as well as in a maternity ward.[5] Most of the information used in this article comes from conversations with approximately 30 Somali women, between 18 and 60 years of age.[6] Of these, about one-third were followed over time (from one to five years) through several interviews, casual communication, home visits, and joint activities. Fifteen Somali men aged 25–60 were also interviewed.[7] The informants did not distinguish themselves systematically from the general Somali immigrant population in Norway. They were not representative, however, of the general population in Somalia, in that they generally had more education and more often than not came from urban areas and from higher social strata. For example, only two of my informants had ever lived as nomads, which is the lifestyle of roughly 50 percent of the population in Somalia. Some of my informants had lived for many years outside of Somalia, mostly in other East African

or Arab countries. The informants in the study thus may have been more exposed to education and to other cultural impulses than the majority of the Somali population.

Life in Norwegian exile involves several dramatic changes that affect women's lives, and most women stated that they had changed their perception of infibulation due to their experiences in exile (see also Højdahl 2000; Johnsdotter 2000; Merametdjian 1995; Talle 2001). They usually attributed this to increased access to religious knowledge and confrontation with different cultural practices and perceptions, as well as to personal circumstances. A part of this picture is the Norwegian legislation prohibiting female genital mutilation that was enacted in 1995.[8]

As women were eager to relate their stories, I have given the fullest accounts possible while still ensuring anonymity. I hope that I have managed to depict these informants as the sensitive, warm, and openhearted women it has been my pleasure to be involved with.

Infibulation and Pain

When I asked Fardosa why she was opposed to infibulation, she said, "Because it is pain three times. It is the pain when the infibulation is done, the pain when it has to be opened again at marriage, and the pain when it has to be further opened when giving birth."[9] Infibulation thus seems always to involve pain, although the intensity, duration, frequency, and context vary among individuals. Below I describe the three main painful events related to the practice as described by Fardosa: infibulation, marriage, and childbirth.

Infibulation is the most extensive form of female circumcision and includes the partial or total removal of the clitoris, labia minora, and labia majora.[10] The labia majora are subsequently scraped or cut on the inside before the two sides are joined together by sutures or thorns. In this way, the vulva becomes closed by a seal of skin and scar tissue that covers the clitoral area, the urethra, and most of the vaginal opening. At the lower end, an orifice less than one centimeter in diameter is left for the passage of urine and menstrual blood. The procedure is estimated to take around 20 minutes and is typically performed at home by a traditional specialist, less often by trained medical personnel. A knife or a razor is the most frequent tool for cutting, and thorns or catgut are used for the sutures. Anesthetics are not in common use but may be used, depending on availability and the family economy. Very few of the women interviewed had received any analgesics, and of those who had, most felt they had had little or no effect.

After the operation, the girl's legs are tied together in order for the wound to heal. This tying is reduced little by little in the following days, gradually allowing the girl some movement. During the initial days, the legs are tied from hips to toes, and, subsequently the toes, feet, calves, knees, and eventually the thighs are relieved of the ropes. Women would often demonstrate how they had walked in this state by bending and stretching their toes, supported on wooden crutches. The healing process takes some weeks; most claimed that they were fully recovered after around seven weeks but that the worst pain was over after one to three weeks.

Infibulation is usually performed when girls are between five and eight years of age. Thus, most women have a vivid memory of the operation. They described both the operation and the healing period as overwhelmingly painful. Apart from

the operation itself, women particularly emphasized the pain associated with passing urine in the days following the procedure. Some women told of repeated infibulations when the scar reopened due to infections or movement. This had prolonged the healing process as well as the intensity and duration of pain.[11] Many women also reported indirect complications, for example, bedsores, that were mainly related to the tight tying and lack of movement.

In the period between the healing of the infibulation and marriage, many women reported painful menstruation, as the small orifice prevents the free flow of discharge, which may thus accumulate in the uterus. Lul, a woman in her mid-thirties, had such a tiny opening that the menstrual blood could not pass until the opening burst from the pressure. This was extremely painful and often resulted in infections: "Every two months I had to go to the hôspital because of infections." Some women had similar complaints concerning urination (see also Nath and Ismail 2000). Fatima said that she used to return from the bathroom having shed "more tears than urine" due to the pain and frustration arising when a full bladder had to be emptied drop by drop.

The second situation involving pain occurs at marriage, when the infibulation has to be partially reopened to make sexual intercourse possible. The procedures for defibulation differ, but all were described as extremely painful. Women reported that infections and pain were frequent and were regarded as a normal state of affairs for which they rarely sought medical care. Newlywed women were easily recognized by their walk, women stated, vividly demonstrating this gait with legs spread far apart and stiff, cautious movements.

The techniques used for defibulation vary according to local traditions (Abdalla 1982). In the north, surgical opening is common. A circumciser or another experienced woman usually performs this procedure, using the same tools employed in the circumcision itself. In the following days, the couple must have repeated penetrative intercourse to ensure that the vagina remains open. In describing their "honeymoons," women frequently referred to penetration through an open wound. The wound was expected to heal after two to three weeks, after which sexual intercourse was not supposed to be painful any more.

Women from the northern regions who had married in Norway invariably had defibulation performed in the hospital, after which they were instructed to forego sexual intercourse until the wound had healed, for approximately six weeks. The husbands of all but one of my informants respected this injunction. The single exception, who at the time had not yet immigrated to Norway, had insisted on his marital rights when Zainab, his wife, visited him in the Arab country where he lived. Although this was about three months after her defibulation, Zainab was still in pain due to complications and infections. Zainab experienced the sexual intercourse with her husband as rape and later divorced the man because of this experience. She saw this incident, together with complications after the defibulation surgery, as the cause of her present severe psychological problems.[12]

When defibulation is done in a Norwegian hospital, it is usually complete, which means that the seal is split to above the urethra or just below the clitoral area. In this case, there is no need for further defibulation when a woman subsequently gives birth. Thus, for most northern Somali women who marry in Norway, defibulation is done only once, except in cases of infections or regrowth (spontaneous reinfibulation), which a few women had experienced.

In the southern regions of Somalia, the cultural norm states that defibulation at marriage should be done through male penetration, preferably during the week-long marriage ceremony. All informants, however, men as well as women, conveyed that this procedure took longer, usually from two weeks to two months. Young men (in their early thirties) claimed that this was a frequent topic of discussion among friends sharing frustrations and fears, such reports contradicting references to male boasting and prestige frequently described in the literature (Lewis 1994; Talle 1987). When defibulation is performed through penetration, it causes wounds and tears around the vaginal opening, which is too small to allow sufficient expansion through stretching. Women told stories of those who had experienced so much pain during defibulation that they had to be forcibly held or tied to facilitate the process, and some recounted memories of hearing screams of other newlywed women.

Some women referred to oils that could be applied to reduce the pain (and to increase the man's strength), but such aids seemed not to be in common use. Men also described penetration at marriage as painful to themselves, and some reported wounds and scars on the penis (Almroth 2000; Dirie and Lindmark 1991). Many men also emphasized the trauma they experienced when causing pain to their wives (see also Abdalla 1982; Almroth 2000; Rye 2002; Talle 1987). Men often cited the pain of defibulation at marriage as their main grudge against the practice. Some couples did not manage to defibulate this way and thus did not have penetrative intercourse until after the delivery of their first child or even later, the women having gotten pregnant through the passage of semen only.

Typically, women described the pain of the operation itself and that of giving birth as their most traumatizing experiences, and they laughed at my presentation of men's main concerns: "Their only worry is how to get in, that is what they see for themselves."[13] Most couples depicted their sexual life as normal after a successful and healed defibulation at first marriage.[14] For some couples, however, sexual life continued to be painful. Such was the case in the first years of Jamila's marriage:

> I met my husband in Norway. We fell in love and decided to marry after getting the approval of our families. But I was circumcised, my vulva was closed, so to have sexual intercourse was impossible. It took two months before my husband had penetrated me properly. Two months of painful sex, while he was trying to break through. There would always be a wound paining me, small tears and chaps. It was very bad. I felt so much pain every time we had intercourse. Often I had to throw up and I cried from the pain. So sometimes we couldn't do it. It was just too much. But even after a while, when the opening was large enough and we had sex, it was still painful for me. . . . But I had to do it. I was my husband's wife, and I loved him. So I did it. But it was not pleasurable for me.

This problem lasted until she was surgically defibulated at the time of her second delivery. She was bitter that she had had to suffer from this pain for so many years.[15]

Delivery is the third situation in which infibulation causes pain. This is due in particular to the need for further defibulation and extensive episiotomy because of reduced elasticity in the scar tissue. It is also related to the memories evoked by the process, to the revitalization of embodied pain. The degree to which women consciously associated the pain of the original circumcision with the pain experience of delivery varied, but all who had delivered considered infibulation to increase

both pain and complications. Some women told of dreams and fears about delivery that brought the two experiences together, explicitly expressing fear of reexperiencing the trauma of infibulation during childbirth. Thus the combination of labor pain and complications related to the infibulation, including increased fear of pain, intensify the experience of pain (Johansen 2001b; Vangen et al. 2001).

We thus see how pain constitutes an inevitable part of infibulation. It is not pain once suffered and then gone but, quite the contrary, pain that accompanies important events later in life. The profound change in the body of the woman, together with the intensity of the pain and the recurrent experiences, probably all contribute to an incorporation of the pain. Consequently, pain becomes embodied, a part of lived and living experience.

Anthropological Inquiries into Pain and Their Application to the Analysis of Circumcision

In anthropology the most elaborate vocabulary and theories of pain have been developed to understand what we may term *accidental pain*, defined as pain caused by external forces such as war, famine, accidents, disease, or the like. This is a pain that is considered an infringement. Studies have usually focused on how victims of accidental pain try to come to terms with it by embedding it in meaning.[16] Another frequent topic is the resistance to language that seems to permeate extreme and chronic pain experience.[17] Within critical medical anthropology, the focus has been on the macropolitical and social processes causing pain, or "social suffering."[18]

The situation surrounding the pain that accompanies female circumcision, however, differs significantly from the above-mentioned causes of pain. This pain is intrinsic to a tradition that most regard as part and parcel of womanhood and morality.[19] It is also an experience shared by most women within the practicing communities. The cultural models and shared experience could thus give meaning and purpose to the individual experience, the cause of pain regarded as necessary or even good. Female circumcision is often understood as a transformative procedure that ensures or assists a successful transformation from girl to woman. The procedure of cutting may thus be seen to function as a "rite of passage," even when it is not embedded in an elaborated ritual, which is the case for most Somalis. The pain involved in the cutting may thus be termed *ritual pain*, to distinguish it from "accidental pain" that has no cultural underpinning.

The few anthropological contributions to the study of ritual pain tend to interpret it in a functionalist framework as maintaining or highlighting social structure. The way in which this is thought to be accomplished is debated, and there have been two main trends of inquiry, one focused on pain as a disciplinary device and one on pain as a symbolic message.

An analysis of pain as a disciplinary device requires a focus on power, wherein someone enforces discipline on somebody else. Hence, ritual pain can be regarded as something the power holders in a society—be they elders, men, ritual experts, religious leaders, or political authorities—inflict on individuals and groups as a means of control, usually defined as integration into society. Examples of this perspective include Wikan's (1995) depiction of female circumcision, Asad's (1983) study of pain in a religious cult, and Bloch's (1986) study of male

circumcision. The disciplinary approach has been utilized especially in analyses of male initiation rituals and recently also in relation to female rituals that include circumcision (Shell-Duncan and Hernlund, eds. 2000).

Analyses of the symbolic meaning of ritual pain have informed several studies of male as well as female circumcision (Girard 1977). In studies of infibulation, the symbolic focus has mostly been on the significance of the infibulated vulva rather than the pain associated with it. Examples of this focus include Talle's (1993) analysis of the infibulated scar as a symbolic affirmation of patrilineal clan affiliation, the construction of a feminine body and identity as well as of virginity (Talle 1987), and Boddy's (1989) emphasis on infibulation as a symbolic assertion of female fertility. Boddy does, however, discuss the meaning attributed to the pain involved. She describes how different body rituals in Sudan, including infibulation, are defined as *harr*, a term that refers to the "heat" and pain that is identified with various acts of female purification (Boddy 1989; see also Gruenbaum 1982). I have not found any similar associations among the Somali, either in literature or among my informants.[20]

Other studies of female initiation rituals that include circumcision relate the cutting to a cultural value placed on enduring pain. This is either seen as a sign of courage and stamina, as a preparation for later pain, or as a part of the transformative power of initiation (Ahmadu 2000; Gosselin 2000; Moore 1996; Shell-Duncan et al. 2000). Walley makes a parallel suggestion concerning the "function" of female initiation that includes excision (see Note 10): "pain is an intrinsic part of the ritual and is socially meaningful. . . . Within the context of Sub-Saharan African initiation rituals . . . pain may be viewed not simply as something to be avoided but as something to be endured that can result in the positive transformation of the individual" (1997:420).

These theories offer fruitful insights into the cultural meaning attributed to ritual pain. There are two shortcomings, however, in applying these theories to understanding the experience of pain in infibulation. First, although there may be a cultural evaluation of the pain in circumcision as something positive, this does not automatically account for the individual experience of this pain, which may vary considerably (Hernlund 1999; Johnson 2000). Second, all references to the pain as constituting a positive transformative power or test of endurance are described in relation to excision or less extensive forms of female genital cutting. In contrast, studies of infibulation univocally describe the pain involved as a matter of concern and worry for most women (Boddy 1989; Gruenbaum 1982; Ntiri 1993; Talle 1987, 2001).[21]

The symbolic and disciplinary perspectives on female circumcision correspond to the "body social" and "body politic," two of the three analytical focuses on the body explored by Scheper-Hughes and Lock (1987). The third of their perspectives, the individual body, understood in the phenomenological sense of experience, seems so far to be left out of most anthropological analyses.

Morinis's (1985) review of the literature on the infliction of pain in adolescent rituals was intended to throw light on its effect on the individual. His assumption was that the frequency of ordeals in initiation rituals must contribute to accomplishing the overall goal of the ritual, which is to transform (selfish) children into (socially responsible) adults. He saw the infliction of pain as a tool to intensify and personalize the function of the ritual itself. The intensive individual experience will, Morinis

claimed, induce in the individual a desire to pursue what is of benefit to society rather than selfish interests. To the victim, the pain may simply be "the price you have to pay for integration into the culture and society" (Das 1995). This is not a matter of individual choice, but an "entrance fee" to society that is individually experienced.

Whereas Morinis's emphasis on the personal intensity of the experience is convincing, there are shortcomings in applying his analysis to the understanding of pain in infibulation. In particular, I am skeptical of the deduction from assumed "result" to assumed "cause," which is problematized in functionalist interpretations (manifest versus latent functions).

In Somalia, female circumcision is not a part of a ritual and there is, to my knowledge, no explicit value attached to the endurance of the pain associated with it. There is reportedly a general value placed on women's endurance of the hardships of life, which, it has been suggested, may be made relevant for the individual management of pain (Adan 1996; Dirie 1998).[22] Somali women, however, univocally referred to the social pressure that rendered nonconformity impossible rather than to any value of the pain itself, when describing how they had come to terms with their experience. Infibulation was described as an "entrance fee" to society. As Halima put it, "It is like paying house rent. You don't like it, but you have to do it."

The idea that understanding the purpose or meaning of the event reduces the trauma or makes it more manageable for the individual is supported by studies of torture victims (Snaprud 1997). Although the context and purpose of female circumcision and of torture are dissimilar, some informants, such as Fatima, suggested a similarity in these pain experiences. Women who had experienced circumcision "out of context" tended to present their experience as a personal affliction rather than as a cultural positive or an "entrance fee" to society. This was the case for women who had lived in exile, in societies where female circumcision was not the norm, and for women who had been subjected to circumcision traditions of other ethnic groups that were more elaborate than those of their own traditions.

My argument is that the pain, once suffered, may be experienced differently by different individuals as well as by the same individual over time.[23] A Somali woman who moves from Somalia to Norway is confronted with an evaluation of the pain she has suffered that is opposite her own. Whereas, in her natal home, the pain involved was regarded as a necessary part off becoming a woman, in exile she is confronted with a society where pain is considered something that can and should be avoided (see also Gosselin 2000).[24] This may lead to a transformation of the pain experience from ritual to accidental, from necessary and meaningful to unnecessary and even destructive. This transformation may have dramatic consequences for the individual. If circumcision loses its meaning, so does the pain involved, and thus the management of the pain experience is challenged. Although the evidence seems convincing that pain experience is influenced by culture and meaning, does that imply that pain cannot be experienced outside of or counter to culture?

The Power of Pain—A Counterpoint to Culture

Scarry (1985) describes the management of extreme or chronic pain as "the making and unmaking of the world." "Unmaking" refers to the deconstruction of the world that such pain causes, whereas "making" refers to the sufferer's need to

reconstruct the world. There is thus a creativity inherent in pain that arises from a need to make sense of one's experience, to look for a meaning, a cause, as a way to cope with an experience that threatens the legitimacy of the everyday world. Thus we are back to the all-encompassing quality of pain, where sensation, meaning, and coping are experienced as a whole.

The "unmaking" of the world refers to the overwhelming character a pain experience can have. Both Jackson (1994), focusing on chronic pain, and Daniel (1991), studying torture, suggest that intense, acute pain is not affected by cultural models in its immediate experience. Rather, their and other research suggests that "intolerable" pain is a noncultural or even an anticultural experience, a "counterpoint to culture." Following this argument, I suggest that the pain involved in infibulation, although embedded in cultural meaning, experientially threatens to "explode" cultural universes. There seems to be a point at which pain becomes so overwhelming and all encompassing that it threatens the meaning of life itself. Various factors, such as intensity, duration, and meaninglessness, may contribute to this counterpoint experience.[25] It is this experience of pain as overwhelming, as unconditioned by culture, and the tendency of such experiences to force the individual to question basic cultural values, even life itself, that I want to capture in the description of pain as counterpoint to culture.[26] As Kleinman et al. note, "It is an experience that simply cannot be avoided, an experience that sets limits to the meaning given it by cultural beliefs, discourses, or practices. Something is at stake, frequently desperately so, in the lives of the pain patients. Pain can be a massive threat to the legitimacy of the everyday world" (1992:7).

To regard the pain of infibulation as a counterpoint to culture is supported by the stories Somali women tell. A vivid description is found in the biography of Waris Dirie, the Somali model and UN spokesperson against the practice:

> The next thing I felt was my flesh, my genitals, being cut away. I heard the sound of the dull blade sawing back and forth through my skin. . . . My legs were completely numb, but the pain between them was so intense that I wished I would die. I felt myself floating up, away from the ground, leaving my pain behind, and I hovered some feet above the scene looking down . . . watching this woman sew my body back together while my poor mother held me in her arms. . . . Since the moment . . . nothing could frighten me: I simply lay on the hard ground like a log, oblivious to fear, numb with pain, unconcerned whether I would live or die. [1998:45–47]

Dirie describes how, in the following days, when the wound became infected and she slept in a solitary cottage, she questioned the procedure: "Feverish, bored, and listless, I could do nothing but wonder: Why? What was it all for? At that age I didn't understand anything about sex. All I knew was that I had been butchered with my mother's permission, and I couldn't understand why" (1998:48). None of my informants was able or willing to give such an in-depth description of the pain experience as Dirie. When Halima told about the circumcision of her daughters, however, the counterpoint experience was evident. Halima and her husband had not wanted their daughters to be infibulated. As in several other cases, however, other family members took charge. One day when Halima came to pick her daughters up after a stay at her grandfather's place, she found them infibulated. She had to care for them during the healing process, which was long and hard, particularly

for her youngest daughter, who suffered from infections: "She cried all the time. She said terrible things. She just prayed to God that he should allow her to die. Why had we done this against her? Didn't we love her? 'I am just a small child, I have done nothing wrong,' she cried. It was terrible."

Her youngest daughter still feels bad about her infibulation and talks a lot about it, whereas the older one is silent on the topic, says Halima. The words of Halima's daughter, of Dirie, and of other women have a similar tone: of total resistance, of questioning basic qualities of life and parental love and culture (see also Talle 1987). Thus, however much many of the girls had anticipated the operation—thinking it was a necessary and good thing to do—the experience of the intolerable pain led many to question the practice, even if only to themselves.

With immigration to Norway, the relevance and meaning of the experience are again questioned, and through this comes a revitalization of the unconditioned questioning of the practice. These women's stories also demonstrate that however culturally elaborate and meaningful a practice may be, this is not automatically translated into individual meaning and significance.

Some of the significant processes of the pain experiences are illustrated by the story of Mariamu. Mariamu was infibulated at the age of eight, and the horror of the pain is still vivid in her memory. But at the time of the operation, she says she did not think it was a matter for discussion: "That is how it was. Everyone had to go through it," she said. She had known from early childhood that she was going to be circumcised and that it was going to be painful. She had never anticipated the intensity of the pain, however. Still, she claims that she never felt any bitterness toward the people who made the decision, including her mother. When she was married at the age of 18 and her infibulated vulva had to be penetrated by her husband, she recalls asking herself: "Why should I first be circumcised and closed, just to be opened again later?" The painful experience of opening something that it had been so painful to close, actually a partial reversal of the original operation, rendered infibulation meaningless to her. The cultural model that emphasizes the construction and proof of virginity was not sufficient to make it meaningful for Mariamu. These thoughts, she said, came to her through her own reasoning. But she considered it impossible to share her thoughts with anyone else. Her voice was muted. Only as an adult, divorced, and a mother of three, with years of residence outside Somalia, was she able to voice her critical thoughts. Today her main opposition to infibulation is still based on the uselessness of the pain involved in closing up something only to open it later.

There are three main points I want to draw from Mariamu's story: First, she was able to question the doxical tradition of infibulation. I interpret this to indicate the experience of pain as a counterpoint to culture. Second, she was not able to express either her experience of pain or her subsequent questioning of the practice. Her voice was muted. Third, she grounded her critical thoughts on an experience of meaninglessness: "Why should you close something only to open it later?" Her critical thought questioned established cultural meanings, because these failed to justify the pain involved. Thus, meaning appears to be a focal point. To function as a coping strategy, cultural models have to give personal meaning and relevance. Mariamu's consideration of infibulation as useless was raised in contrast to existing cultural models that defined it as highly meaningful.

When asked to describe the pain involved in the operation, women usually made sounds, shook their heads, and then nodded, "Oh, oh, it is painful, yes!" Trying to pursue the matter further, I sometimes asked them to compare it with the pain of delivery. The women always insisted strongly that the experiences were totally incomparable. The pain of circumcision was both hundreds of times more intense and of a totally different kind. When trying to describe the sensation of pain, many women referred to the cutting of meat, of flesh: "When they cut your body, your fresh flesh, you just know it is something wrong. The body tells you that. You know pain is the body's message to you that something is wrong. In most situations when you feel pain, you will try to remove the source of the pain. But in this situation you can't. You just have to endure it" (Amina, age 40, mother of six).[27] Dirie gives a similar description: "It is like cutting a leg or an arm, just that it is the most sensitive parts of your body" (see also Talle 1987, 2001). Having to endure something that it feels natural to run away from, which many women did or attempted to do, was often associated with a feeling of helplessness.

Many women described the cutting of flesh as "unnatural," in contrast to the "natural" forces of labor pain. Even Fatima, who had sufficient anesthetics and had felt no pain during the operation itself, and who at the time had felt happy that she was finally going to be like the older girls, recalls that she struggled and cried during the operation. The smell of her blood and the sound of her flesh being cut form important parts of the total memory. This memory is still haunting her, including the intense pain after the effect of the analgesics wore off. The sound of the knife cutting the flesh was mentioned by others as well. Lul repeatedly told how she had observed her blood splashing into the face of the circumciser when her clitoris was cut, "as if someone had put on a faucet," and how the circumciser had turned her face away from the spurting blood. She also vividly remembers her mother holding her tightly, while looking away. For some women, the memory of sisters or other relatives who were cut before or after their own operation also formed an important part of their experience. The memory of pain is thus a "thick" memory that includes the people present and various sounds, smells, and sensations.

The lasting effect of the operation was usually described by the women as a sense of loss, of having had something removed from them. Sahra, a beautiful woman in her late thirties, doubted stories I related to her of women who had suffered psychological problems because of their circumcisions. She did not think the experience alone could have such dramatic consequences. When asked, however, if the experience had affected her life, she firmly stated that it had. Trying to explain its effect, she said she felt a sense of loss. Something had been removed from her, from her body and her soul, she said, pointing to her chest. Even Fatima, who had not lost much of her physical body (her clitoris, as well as parts of the labia minora were intact under the infibulation tissue), and Sahra, who had been excised, emphasized a feeling of loss, of something missing. Zainab said she used to joke with her sister-in-law that one day they should go back to Somalia to look for the pieces that had been removed from them. She said this with a laugh, before continuing in a sad tone, "Of course that is not possible. They just threw it away. What has been cut away cannot be replaced. A part of my body is missing." Dirie (1998:49) describes how she actually went back to the site of her circumcision to look for the removed tissue.

What this feeling of loss was connected to varied and was often vaguely expressed. Often it was related to missing body parts, as Zainab's, Sahra's, and Dirie's descriptions suggest. For many, this was linked to reduced sexual pleasure. Another loss that is described in the literature on female circumcision is that of trust or childish innocence, also mentioned by Dirie. The literature on pain also refers to a sense of loss as a direct result of extreme pain experiences (Knardal 1998). Thus, what the sense of loss refers to may be complex. It seems, however, that this sense of loss may increase and be experienced more painfully in exile, as the result of encountering cultural models challenging the practice, as will be discussed below.

The clitoris, the body part that has been partially or fully removed (or just covered) during infibulation, is understood in completely different ways in Somalia and Norway. In their natal environment, Somali women understand the clitoris to be a "male" or "dirty" organ that must be removed in order for a girl to fully become a woman (Boddy 1989; Talle 1987, 1993). In Norway, in contrast, the clitoris is seen as the center of sexual pleasure and, consequently, of womanhood and self (Johansen 2001a).[28] A loss that may have been perceived as a cleansing or purification in their natal environment may be reinterpreted and understood by women in exile as an amputation or even mutilation. Thus, the contexts in which the pain is originally suffered and in which it is subsequently remembered affect the pain experience and its management.

Muted Experiences, Muted Practices

Despite the prevalence and documented cultural and social significance of infibulation, there is an almost overwhelming silence about the practice in both interpersonal discourse and cultural models. As has been described in Somalia (Talle 1993) and Sudan (Boddy 1989; Gruenbaum 1996), there are no ritual celebrations of the event and the practice is hardly mentioned in the elaborate poetry and songs of Somali culture.[29] Why is such a significant cultural practice and extreme personal experience muted?[30]

When Somali women were asked if they share their personal experience of circumcision and pain with each other, they invariably responded, "Why should we talk about it? Everyone has experienced the same thing," or "What is done is done. Talking cannot change that." Why do they not see any point in sharing experiences? I would think that this would make the pain experiences easier to bear. Women often exchange stories of their birth experiences, so why don't they share this? Is it simply too painful? Is it a reluctance to indulge in something one would rather forget? Or is the unspoken knowledge of shared experience comfort enough? Is something intrinsic to the pain itself muting the experience? Is there a feeling that words cannot encompass the experience? Or is it that cultural models and social norms discourage such expression? Before trying to answer these questions, I look at what studies of pain say about muting.

The difficulty in finding language that can account for the experience is a major topic in studies of pain, particularly intense or chronic pain. This constitutes a challenge to both the researcher and the one who has suffered pain. Even Dirie, who has given a very vivid description, complains that "There's no way in the world I can explain what it feels like" (1998:45). Research goes even further to suggest that pain does not simply avoid, but may actually destroy language (Daniel

1991; Kvalheim 1995; Scarry 1985).[31] "It occurs on that fundamental level of bodily experience which language encounters, attempts to express and then fails to encompass. Perhaps more than other somatic experiences, pain resists symbolization" (Kleinmann et al. 1992:7–8).

The emotional intensity of the experience probably forms an important part of its resistance to words and other modes of expression. Many women said that the memory itself was painful and that they had not been able to talk about their circumcision because it would revitalize the memory and make them cry. Some of my informants, who had sought psychological treatment for traumas that they primarily attributed to their circumcision, claimed that it took them a long time, from one to three years, before they were able to tell their psychologists about the experience. During my interviews, few were willing or able to go into any detail about the experience itself. They could describe the setting, what happened, the time, and who was present, and they described it as extremely painful. These presentations were often rendered in a matter-of-fact tone. This echoes the way victims of torture in Sri Lanka rendered their stories, listing what was done to them in a monotonous, low voice (Daniel 1991).

I never pushed women to dwell on the pain of their circumcision, mostly in deference to their emotional management. The only time I saw an emotional reaction during an interview was when Fardosa insisted on talking about the infibulation of her daughters, at which time she constantly struggled with tears. It seemed as if for many the reluctance to talk constituted part of the management of pain. A tendency to neglect and forget (a few women insisted that they had forgotten the experience) or to place it in the past, in the "there and then" ("done is done"), is described as a frequent technique for the management of traumatic experiences (Casey 1987). Such processes may be understood as an existential or experiential dimension of muting.

The difficulty others have in comprehending the pain may also contribute to the silence (Daniel 1991; Morris 1991; Scarry 1985). As pain can neither be measured nor seen, the listeners may try to understand it by comparing it to their own personal experiences. Listeners who have never experienced overwhelming pain seem often to doubt the extremity of the experience. This was the case for most men, who often insisted that the descriptions were exaggerated or untrue, or who avoided the theme of pain altogether.[32] Abdi said he used to believe the pain of infibulation was equivalent to his own circumcision. After our second interview, he had talked to his wife about her experiences for the first time. This made him change his ideas about the pain involved and the traumatic character of the experience. Suleyman, a Somali nurse, said that he had seen his sisters sitting with their legs tied and walking with sticks after the operation, and he did not consider it such an extreme experience: "They looked just normal to me" (see Note 31).

Fatima, who once had been persuaded by her teacher to tell her Norwegian classmates about her own experiences, said it left her with a hollow feeling. She had cried and they had cried, but it was too difficult an issue to continue to acknowledge in their relationship. Afterward, it became an ever present, but silent, issue.

This difficulty in communicating pain—its lack of social and linguistic basis, so to speak—can contribute, as Daniel suggests, to a situation in which pain loses some of its content and meaning. This "loss," he says, can intensify the experience of pain. This may again point back to Somali women's descriptions of their cir-

cumcision and pain entailing a sense of loss. Cultural models and social discourses that are available to the individual may support a muting of the experience. One element is the emphasis, mentioned above, on the value of "endurance."[33] In this regard, Dirie relates,

> The first night back at my family's hut, my father asked, How does it feel? I assume he was referring to my new state of womanhood, but all I could think about was the pain between my legs. Since I was all of five years old, I simply smiled and didn't say anything. What did I know about being a woman? Although I didn't realize it at the time, I knew a lot about being an African woman: I knew how to live quietly with suffering in the passive, helpless manner of a child. [1998:48]

In addition to the emphasis on endurance, many also referred to the lack of cultural or social support for questioning the practice. Several women and men said they had questioned the practice while still in Somalia but had not dared to raise their voices. One young, educated Somali man, Hassan, expressed this clearly in his story about his sisters' infibulations, which he had been asked to authorize: "You know that it is wrong. You just sense it. But there is nobody or nothing in the society supporting your bad conscience. It is not like murder. You know it is wrong, and everybody else tells you it is wrong. With infibulation you sort of feel it. But at the time it also seemed to be an easy solution to ensure my sisters' virginity and morals."

Hassan regretted his silent acceptance of his sisters' infibulations but insists that it was not really his responsibility or in his power to prevent it from happening. He admits, however, that his mother still blames him for his sisters' operations. He emphasized the significance of a lack of social and cultural support for his doubts about the practice. Social support for female circumcision is perceived to be immensely strong, so strong that few individuals dare to give voice to their critical thoughts. Even in exile, there is a strong tendency to mute discussions in public, and criticism, extending to threats against their lives, has been directed at women who have talked publicly about the practice, particularly in the media. However, this must also be interpreted in the context of fear of increased stigmatization in exile.

Symbolic Expressions of Muted Experiences

Studies of women's "muteness" have often identified symbolic or ritual niches where women's experiences can be expressed and reflected on, such as women's poetry in Somalia (Adan 1996), songs among the Bedouins (Abu-Lughod 1986), and female initiation rituals (Ardener 1975; Johansen 1996; Richards 1982). Such a niche for sharing the experience of infibulation does not seem to exist for Somali women. In their studies of the symbolism of infibulation, both Talle and Boddy state that it is exactly the muteness associated with the practice that forces them to resort to symbolic analysis. The pain of infibulation, however, seems to be absent in the symbolism. How do you symbolize pain?

In her analysis of anorectic youth, Solheim (1998) suggests that bodily experiences tend to express themselves symbolically in very concrete bodily processes. Thus, we have to look for concrete bodily actions, in other words, "let the body speak for itself." The possible presence of such concrete body symbolism struck

me when I was introduced to a Somali game. As it is a game, I see a danger in overinterpreting it. Nonetheless, I take the enthusiasm and excitement the women demonstrated while playing this game as an indication that it resonated with experiences I did not share.

The purpose of the game was to identify and punish a thief. It was played as follows: Participants were allotted different roles by drawing small pieces of folded paper naming the main roles of thief, police, witness, judge, and *karbash*—the one who carries out the punishment (also the name of the game). Each participant kept her paper and the assigned role secret. First, the police officer unfolded her paper to identify her role and then pointed out a suspected thief. Thereafter, the witness went through the same procedure. The thief then had to reveal herself, and if the guesses had been right, the thief was punished. If they were wrong, the police and the witness were punished. Then the judge had to decide on the sentence, consisting of up to five blows of variable intensity. The punishment was carried out by the karbash, who hit the victims' palms with a thin stick.

The women played the game over and over, for hours and days. They laughed, screamed, and jumped with excitement. Women who were weak in the face of pain or who were scared of being hit hard or repeatedly were teased as cowards, and the ones who hit hard were accused of cruelty and evilness. Nobody hit me very hard, and my own hitting was very soft, for which the women laughed at me. Whenever I left the room, I heard the roars of laughter increase, and when I reentered, women showed me the red inflammations on the palms of their hands resulting from extensive blows.

The game struck me as a bodily symbolic expression of pain. Of course, pain, including consciously inflicted pain, is present in many aspects of women's lives, such as marital relationships, legal procedures (Lewis 1994), and the raising of children (Dypdahl 1994). It seemed to me, though, that the game pointed toward female circumcision, particularly as it raised my consciousness with respect to the various roles involved in the practice. The pain of circumcision is not limited to each woman's physical suffering, which had been in the forefront of my mind up to that point. It is also the responsibility of women to oversee the circumcision of girls in their custody. They have to decide on the type of circumcision, as well as its context (i.e., in hospital or at home, with or without anesthetics).[34] They have to make arrangements with the circumciser, raise the money, call in relevant kin, and often help to hold their daughters while they undergo the operation. They then have to care for their daughters during their convalescence. The choices they make affect the girl's experience of pain, her risk of infection and other complications (including death), the long-term physical effects of the infibulated scar, and, subsequently, the girl's future status in society. In their roles as mothers or custodians, then, women are placed in the difficult situation of being responsible for inflicting tremendous pain on their daughters in order to make them socially acceptable. Thus, the karbash game may be interpreted as an occasion in which women are given a chance to symbolize, express, and "play with" the pain of circumcision as a bodily experience, acting out all of the different roles involved in the process. It was only after observing this game that I dared to ask a few women about their daughters' infibulations. The only two women who responded were women whose daughters had been infibulated against the mothers' will and in their absence. This I take to reflect the mothers' emotional difficulty with of the experience and per-

haps a sense of guilt now that their life in Norway has increasingly made them question the practice.

Voicing Muted Experiences—A Road to Change

Infibulation was publicly challenged in Somalia for the first time at the meeting of the Democratic Women's Association in 1977, by the Director of Women's Health in the Somali Government, Edna Adan Ismael. After concluding her studies in nursing and midwifery in England in 1961, followed by a period of work in that country, she returned to Somalia. There she had her first experiences delivering the children of infibulated women, experiences that made a big impact on her.[35]

> Up to then I had been proud of my circumcision. Now I saw so much useless suffering. I boiled inside, but said nothing. Now I am 60 years old. I was seven when I was circumcised. Still I can hear the sounds. Still I have nightmares. Sixteen years later, after my return to Somalia with a degree in midwifery, I became a director in the Ministry of Health in Somalia, as the first woman in such a position. I went to a conference in Sudan on obstetrics where female circumcision was talked about. This was the first time I heard the issue raised. People had data, overheads, pictures, and documents. I was shocked. They talked about clitoris, labia, and the vagina in a microphone! They said and documented what we saw every day. They had courage and intelligence.
>
> I was there with two male Somali colleagues. We never exchanged a word about it. But when we came back to Somalia, we had to present a report to the minister. This was in March 1977. That time there was to be a three-months training course for women from all over the country. A political thing, military, socialism, and all that. The ministers had to address the women. Since I was a health director, I had to do it. But what should I talk about? Something clicked in my head. If I could choose, then I wanted to talk about infibulation. It was even the first time I uttered that word to a man. He was shocked, said I must be crazy. To talk about that to 400 women!?

Her speech, in which women were presented with situations and experiences they could recognize from their own lives, touched and moved the audience, which, in unison expressed a desire to work against the tradition.

Voicing muted experiences, as happens among immigrants in Norway, removes the praxis from the doxic realm, making it possible to reflect on it. Many women said that however painful their circumcision had been, it was not until they traveled outside their home area and came to realize that this was not a universal practice that they really questioned it. Did this questioning affect the experience of their embodied pain? There are discourses suggesting that pain experience is affected by the context in which one lives. For example, I was observing a group of Somali women who had gathered to discuss female circumcision, when a young girl passed by. In a spontaneous role-playing exercise, the visiting girl took up the role of advocate for infibulation. She insisted that the practice was part of their culture and tradition and should therefore be continued. The group of women challenged her, particularly emphasizing the pain involved. The young woman replied, "Yes, it is painful now that you are here, but is it painful in Somalia, where you are all planning to go back? No, it isn't. So we can't stop because of that." The mature women laughed and nodded, replying, "That is true. But just you listen; you will remember our words when you marry. Just you wait and see." This incident seems

to support the earlier discussion of the pain of infibulation as embodied, lasting beyond the immediate sensation. Although these women were past most of the painful events related to the practice, their infibulation was still seen as "painful now that you are here."

The life story of Fatima illustrates how infibulation and the accompanying pain can be differently experienced and interpreted during various life stages and situations. Fatima had been infibulated at the age of seven while she was living with her mother in Somalia after the divorce of her parents. At that time, she said, she did not question the necessity of the practice but, rather, had looked forward to her change of status. When she was 12, she was brought to stay with her father, who had migrated to Norway several years earlier. In Norway, Fatima slowly came to realize that none of the other girls in her school had been circumcised. She was shocked and asked herself why she had gone through all that suffering if it was possible to do without. She felt bitter and awkward, different from all her friends and classmates: "I felt as if it was written on my forehead that I was different down there." The sense of difference affected her socialization with peers. For example, she avoided swimming and communal showers with her classmates after gym, as well as relationships with boys, however innocent. When she started menstruating she experienced excessive pain and became even more bitter when her doctor told her that her infibulated vulva was preventing the blood flow and causing her suffering.

She also came to think of her infibulation as something that could and should have been avoided, as accidental rather than ritual pain. An important part of this was the realization that it was her father who had sent the money and insisted that she be infibulated before she came to stay with him in Norway. She felt bitter that her father, who had lived for many years in Norway, had not understood that it was wrong and unnecessary to her life in Norway for her to be infibulated.[36] When she went for defibulation she was happy to find that her clitoris was intact under the infibulated seal. After years of psychological treatment, she also felt she had come to terms with her destiny. When she was pregnant with her first child, however, the memories came back in the form of nightmares in which her infibulation and expectant delivery were mixed. She feared that the experience of delivery would again revitalize the trauma of her circumcision.

The change, then, from living in a society where infibulation is considered both universal and unavoidable to a setting in which it is neither has been a great challenge to many women. This may particularly affect girls and young women, who identify more closely with Norwegian or other noncircumcised immigrant friends and schoolmates than with older Somalis, who often spend more time with family members and others of the same cultural background (Nath and Ismail 2000).

Concluding Remarks

My interest in the experience of the pain related to infibulation grew out of my conversations with the Somali women who participated in this study. This was not central to my initial interest in the subject, as the rhetoric of my introduction suggests. Rather, my reflections on the contrast between the warm and lively women and the traumatic experiences they had gone through grew during the course of the research. Similar astonishing contrasts have led many anthropologists to suggest

that culturally meaningful pain is less painful, as mentioned earlier. To some extent I think cultural meaning may function as a "filter" that can soften painful experiences. But not always. Sometimes the pain is simply too extreme, and sometimes 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, leaving women with permanent bodily and emotional wounds, "a loss, in their body and soul." The women I interviewed were deeply concerned with the pain involved in infibulation. In fact, it was their major concern.

I have argued here that intolerable pain, such as accompanies infibulation, is not affected by culture or meaning during the immediate experience. Rather, perceptions of pain are experienced as counterpoints to culture. The experience may change with maturation, time, and healing to yield a perception of the pain as a necessary experience, since it accompanies or accomplishes the transformation of the child to the woman. The healing process may be fueled by an urge to "remake the world," to give meaning and sense to the experience that threatened the legitimacy of the everyday world. This remaking can consist of finding meaning in and support for the practice and, thus, for its continuation, which seems to be usual in situations where the procedure is taken for granted and muted: "It was just how it was."

The new experiences that accompany the exile situation of these women have given rise to a more articulate and conscious consideration of their experiences. Through the dual process of voicing and confrontation, many women have come to question the cultural meaning of the practice. This questioning may change the experience from that of "ritual" to "accidental" pain. The women's concerns with pain seem to have been amplified in their exile situation, partly due to the confrontation with a society that both morally and legally condemns the practice. Research suggests, however, that the experience of pain is also a major concern among women in their natal environment. The main difference between the contexts of home and abroad seems to be the extent of voicing of and reflection on the experiences and, thus, on the practice itself.

To question the purpose and benefit of a traumatic experience may be painful in itself. For some, it is simply impossible, and the challenges may lead to a reinforcement of the tradition as a coping mechanism. Thus, contrary to the beliefs of many health workers and health policy makers in Norway, the exile situation does not guarantee that people will abandon traditions such as female circumcision to adjust to a Norwegian cultural standard of femininity that is strongly opposed to the practice.[37]

The significance of traumatic personal experiences in cultural continuity or resistance to change has been largely absent from anthropological research. In contrast, counseling literature tends to imply such significance (Adamson 1992). In the words of Toubia, one of the most vocal spokespersons against female circumcision: "the psychological effects are often subtle and buried in layers of denial, mixed with resignation and acceptance of social norms. Understanding the psychosocial balancing act which allows the child to overcome the trauma of circumcision, and the adult woman to live with its consequences, is important to helping women overcome their resistance to change" (1994:132). For most of my informants however, the pain involved was their major argument against the continuation of

this tradition. The pain made them wish to change and remake the world into one without infibulation.

NOTES

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Correspondence may be addressed to the author at Elisenbergveien 3, 0265 Oslo, Norway; e-mail: ejo@okprosjekt.no.

1. There is widespread, emotional debate on the most appropriate word to describe the various practices subsumed here under the term *female circumcision* (see Shell-Duncan and Hernlund 2000:3–7). I use two terms that have proven useful in communications with people who practice or are affected by this bodily infliction, namely, *female circumcision* and *female genital cutting*. Internationally, *female genital mutilation* has long been the most "politically correct" term, as it may better describe the effects of the operation. The main reason I do not employ this term is that it is rather contradictory to the various emic designations of the practice and therefore seems of little use in conveying the experiences of those personally affected. Also, as translated into Norwegian, the term sounds rather odd and is hard to pronounce, so it is rarely used.

2. The term *feel-think* is borrowed from Wikan (1990), who insists on the application of a word that covers both conscious thinking and the involved emotions, which she sees as inseparably entangled.

3. All names in this article are pseudonyms to assure informants of the anonymity promised them. All interviews were conducted by the author, in most cases in a shared language, usually Norwegian, English, French, or Kiswahili. Three women were interviewed with the help of a Somali interpreter. All interview excerpts were translated by the author.

4. Many health workers that were interviewed during the study reported that infibulated women felt extreme pain at the slightest touch to the vaginal area. Similar responses were reported by workers at a specialized clinic for infibulated women in England (McCaffrey 1995).

5. Ethical guidelines for medical research required that I identify myself as a student of medical anthropology and present all potential informants with a written and oral explanation of the project and its purpose. This seemed to assure participants of confidentiality and that their participation in the research could achieve something positive. What convinced most people to participate, however, was my marriage to an East African man and our three children together, as well as my long periods of residence in Africa. A pregnancy and maternity leave that interrupted my fieldwork for about 18 months meant that I lost contact with some informants, whereas I got the opportunity to follow others for a longer period of time. I knew Fatima, for example, from the time she was an infibulated youth, through defibulation, marriage, delivery, divorce, and her son's first birthday.

6. My female informants had been in Norway between one and 15 years, the majority between three and seven years. Around 75 percent of the women were married. The rest were separated or divorced, widows, or single, two of the latter being single mothers. The number of children varied from none to nine, with an average of four. (Marital status is difficult to ascertain, as many Somali women are separated rather than divorced. This may be due as much to economic as personal causes, in view of the economic support given to single

mothers in Norway.) Most of the informants' husbands, who, with two exceptions, were not included in the study, were un- or underemployed, which was consistent with the high unemployment rate among Somalis in Norway.

7. Most of the male informants were university students or held good jobs. They were thus not representative of the Somali male population in Norway. Many were very active in Somali organizations, had high status and large social networks, and were thus able to present a rather broad picture of men's concerns in various Somali communities in Norway.

8. The law (Law of 15th December, Nr. 74) also covers operations done outside the country and prohibits postnatal reinfibulation. The punishment for those performing circumcisions as well as those assisting in any way (i.e., arranging for the procedure to occur) is up to eight years in prison. The Norwegian law is thus relatively strong, both in scope and sentencing provisions.

9. I have found allusions to these "three pains" or "the three female pains" in literature from Somalia, which suggests that Fardosa's formulation represents a widely shared cultural model (Omer-Hashi and Silver 1994).

10. Most people practicing female circumcision (around 85 percent) do not perform infibulation but, rather, cutting of various amounts of tissue from the clitoris or the labia minora without narrowing the vagina. These types of genital cutting are often referred to as excision or clitoridectomy. In contrast to infibulation, most so-called milder forms of genital cutting take less time to carry out, often remove less tissue, and usually do not cause repeated painful events, such as at menstruation, sexual debut, and childbirth. These procedures may be seen as less painful. The difference in the removal of tissue may, however, be more a difference in kind than amount, as infibulated women may have retained all or part of the clitoris or labia minora under the infibulation scar (several experienced gynecologists in personal communication; Mc Caffrey 1995).

11. After the operation, various traditional medicines are used to heal the wound, particularly an herb named *mal mal* (see also Abdalla 1982:19; Talle 1993). Many of my informants described this as "glue" and identified it as the cause of many of the complications occurring in the painful aftermath of the infibulation, particularly contributing to the formation of keloid scars (vicious scars).

12. The complications consisted of excessive bleeding and infections. She said black blood was pouring out of her, flooding down her legs and into her shoes for almost a week. She thought she was going to die. The doctor concluded that it was accumulated menstrual blood that had been prevented from flowing due to the infibulation, an explanation Zainab doubted. For her, the experience was extremely traumatic and she had feared bleeding to death.

13. Aud Talle (personal communication) said that in Somalia women often presented defibulation at marriage as the most traumatic experience.

14. There is no evidence that Somalis practice reinfibulation to a premarital (virginal) vaginal size after delivery or divorce, as is frequently reported in Sudan. Somali women spoke with horror of this practice. There are rumors that certain clans may practice this, and Boddy (1988) cites one source who suggests that some Somalis do this only after their first delivery, whereas Talle (1993) reports reinfibulations after divorce in certain areas. It seems, however, that reinfibulations after delivery are, for the most part, only partial, and thus sexual life may be resumed without any repeated defibulation.

15. After her first delivery in Norway, she had been reinfibulated against her knowledge and will. At her second delivery, she therefore made a written request that defibulation be made permanent (Vangen et al. 2002).

16. See, for example, Das 1995, Good et al. 1992, Jackson 1994, and Scarry 1985.

17. Examples of this are studies of torture and violence (Daniel 1991; Scarry 1985), Kvalheim's (1995) study of fire victims, and Jackson's (1994) study of chronic pain patients.

18. Examples of this are studies of the politics of rape in India (Das 1995), international structures affecting HIV patients in Haiti (Farmer 1992), and the structural processes leading to a high child mortality rate in rural Brazil (Scheper-Hughes 1984).

19. See Leonard 2000 for an interesting description of a completely different situation in Chad, where female circumcision (excision type) is a newly adopted fashion among younger girls, performed against the will and without the support of the surrounding society and culture.

20. The Somali term for pain is *hanun*. Since most interviews in this study were done in languages other than Somali, there is no room here for a linguistic analysis of the terms used to describe the various painful experiences.

21. One partial exception occurs among the Pokot in Kenya, where the first stage of the circumcision, the cutting into the clitoral area, is performed in public and is regarded as a test and trial of stamina. Girls are subsequently infibulated privately, and endurance is not emphasized (Meyerhoff 1981).

22. Some women recall being told not to cry and to show stamina during the cutting. They did not, however, feel this was significant, as such stoicism was considered impossible due to the extremity of the pain. As described by my informants, pain is an unavoidable consequence of infibulation rather than a part of the procedure's purpose. The only evidence suggesting that the pain could have been seen to have a purpose was the stories of women who had been cut without anesthetics when these had in fact been available to the family. Some women talked with bitterness about the fact that their brothers had been circumcised in hospitals, whereas their own operations were done at home or even during travels to less developed parts of the country.

23. Some male informants told of similar changes in their perceptions of their own circumcisions. Whereas the pain in early years had made them critical of the practice, their conviction of its religious significance and perceived health benefits had later made them reevaluate it as "worth the price."

24. Childbirth is one of the few occasions in Norway where one may find a positive value attached to the endurance of pain. Certain experiences of self-inflicted pain in ecstatic cults or "new" traditions of piercing and tattooing are other occasions where pain sometimes is given a positive and transformative value.

25. Some authors suggest qualitative differences between chronic and acute pain. Both Scarry (1995) and Morris (1991) suggest that chronic pain is more destructive to language, whereas Casey (1987) suggests that acute pain is more destructive since it constitutes a profound break with the flow of everyday life and thus challenges it. This needs further research; however, the variation in context, intensity, and duration will probably discourage the establishment of generalizations.

26. My use of the term differs significantly from the way Daniel uses it, that is, to designate that extreme violence like that involved in the civil war in Sri Lanka has no cultural grounding and never could or should be inscribed in cultural terms. My use of the term is more similar to Daniels's (1991) concept of the "individual in terror."

27. Knardal (1998) describes how the sensations of pain, danger, and stress have the same neurological basis in the brain, suggesting a close association.

28. In the play *The Vagina Monologues* the clitoris is described by one character not simply as the center of "herself," but as actually constituting the self. In contrast, Gruenbaum (2001) describes how women in Sudan sometimes refer to their circumcision as their "self" *(nafsi)*.

29. The only exception to this is a ritual that marks the defibulation of a Somali woman at her first marriage (Talle 1993).

30. For an interesting discussion of differences between muted and silent experiences and their methodological consequences, see Skramstad 1999. Female circumcision, especially its relationship to pain and sexuality, seems also to have been relatively muted in an-

thropological studies. Whereas Parker (1995) relates both this and the simultaneous moral uproar to Western conceptualizations of sexuality, I suggest that the emotional and ethical conflicts generated in the anthropologist by the pain involved is as significant (Talle 2001). Several anthropologists who have written on the theme include passages on their own ethical and emotional difficulties with the subject. In fact, such difficulties seem to have received as much comment as the practice itself (Bashir 1997; Gordon 1991; Gruenbaum 1996, 2001; Lionnet 1992; Parker 1995; Talle 2001; Walley 1997).

31. The feeling that words fail to communicate the experience may be one of the reasons why many activists against female genital cutting frequently use pictures and videos in their campaigns. There seems to be great variation in how these cruel and authentic images are understood. Whereas some viewers turn their heads away in tears, others refuse to believe that the images have anything to do with the truth. The latter reaction was most common among my male informants, although I never exposed them to anything other than oral or written stories.

32. I gave Dirie's and Aman's books to informants and asked men especially to pay particular attention to the experience of pain.

33. A few men expressed frustration that migration had reduced women's willingness to endure. Such complaints were usually based on women's increased demand for male assistance with household and childcare chores and their increased willingness to seek divorce.

34. Infibulation, locally termed *faraon*, is the most frequent type of female circumcision practiced in Somalia. It is possible, however, to perform so-called *sunna*, although this is very rare. Sunna usually refers to any female circumcision that does not include extensive enclosure, usually the removal of clitoris and labia minora (see Note 10).

35. This description of the meeting is based on my interview with Edna Adan Ismail during the fourth regional conference/general assembly of the Inter-African Committee on traditional practices affecting the health of women and children, November 17–21, 1997, Dakar, Senegal.

36. Several informants reported infibulation, either their own or their daughters', as a part of the preparation to go to Norway.

37. The Norwegian view has often been that cultural practices seen by Norwegians as harmful and useless would automatically disappear on immigration to Norway.

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EXPERIENCING SEX IN EXILE: CAN GENITALS CHANGE THEIR GENDER?

- On conceptions and experiences related to Female Genital Cutting among Somalis in Norway

R. Elise B. Johansen

Introduction

During a meeting on female genital cutting (FGC) for immigrants in Norway, a Somali man proclaimed from the stage that his main grievance against the practice was that it leads to divorces, because it causes sexual frustration in both men and women. The women present were upset and furious: “How can he talk like that?” “Why do they remarry another circumcised virgin then, if it is so bad?” “How can women be satisfied in two minutes? Who will teach our two-minute-men how to treat women? “ “FGC does not affect sexuality, it just takes longer.” “I have no feeling in bed. I think it is because I was cut.” “An uncut woman will run after men and have sex with anyone.”

Some of these comments were stated loudly, others confided to the women close by. Some were expressed in fury, others as jokes, and yet others as intimate exchanges between friends. The comments point to the complexity and intensity of discussions about FGC and sexuality within the Somali community. The purpose of this chapter is to explore what statements such as these say about the way affected women and men perceive and discuss the relationship between FGC and personal sexual experience.

Sexuality was an important concern of my Somali informants when discussing FGC. Generally the practice was believed to reduce women’s sexuality in various ways, an effect that was regarded with ambivalence. On the one hand the informants saw FGC

as a positive way to “domesticate” female sexuality. On the other hand, they saw this “domestication” as negative, as they believed it reduced women’s sexual pleasure, which could in turn harm their marital relationship.

These concerns, and the often ambivalent worries, seemed to have intensified in the exile environment. In the informants' home countries, FGC was regarded as a natural and necessary ingredient in becoming a decent woman; it was tied up with basic cultural values relating to gender, sex, fertility, identity, morals, and beauty. In exile, they have been exposed to Western views of the practice as the destruction of genitals, sexuality, and even femininity itself. This has led to informants questioning some doxic cultural models of fundamental values regarding gender, genitals, and sexuality. Hence Somalis have had to ask whether circumcision carves women into complete, clean, and proper women – as it is understood in emic cultural models – or whether it deprives women of significant body parts, womanhood, and sexuality, as the Western view suggests. These questions were usually expressed as deeply *personal* concerns: How did *my* circumcision affect *my* sexual life? Would I have felt more had I not been circumcised? Would my marriage have been happier, or more difficult? Would my husband have loved me more or less? Would he have married me? Has my circumcision made me complete or destroyed me?

My informants, both men and women, focused mainly on three sexual “consequences” of FGC: the importance of virginity, the pain upon defibulation, and a reduction of sexual desire and pleasure. These concerns seemed to be at the root of a widespread ambivalence about FGC, as expressed by Hassan: “FGC is bad because it removes the feelings from a woman. But at that time (as a young boy), we did not know about clitoris and lips and all that. We did not know that women had genitals as such or any sexual feelings. We just felt it (circumcision) was a simple solution to preserve their chastity.” Though few juxtaposed this ambivalence as clearly as Hassan, the concerns were widespread, and hence form the basis and structure of this paper.

Culture and personal experience

In line with the emphasis placed on personal concerns and experiences by the informants, my approach to the relationship between FGC and sexuality focuses on how it is experienced *personally*. In contrast to many anthropological studies focusing on the "cultural construction of sexuality" in the form of commonly shared cultural models (but see also Ahmadu and Dopico, forthcoming), this chapter will look mainly at how cultural models are lived and experienced on a personal level, that is; how women and men expressed, considered, and reconsidered their personal sexual experiences and expectations.

The context of these deliberations is life in exile, and hence cultural models of both home and host cultures constitute a part of the multiplex background within which people try to make sense of their personal experiences. Also significant here are the personal histories and relationships in which the person is involved over time. I will also consider biological aspects, both how they have been described in medical literature and as they are perceived among the informants. My aim is thus to try to bring into the analysis the multitude of biological, experiential, and cultural factors which affect personal experience and social discussion of FGC.

My focus on the particularistic has been inspired especially by Shore's writings on the relationship between personal experience and cultural models (Shore 1996, 1998). On the level of cultural models, I am particularly inspired by his emphasis on their multiplicity. His model has systematized the new anthropological emphasis on the multiplicity of culture, that what was described in traditional anthropology as "a culture" in reality is made up of a multiplicity of cultural models that may both contradict and challenge each other and overlap and support each other. A familiar example in the field of sexual studies is the diverging presentations of sexual life in Samoa, where Mead's study described a cultural model of sexual license among the youth, whereas Freeman's study described a strict virginity cult. Allen Abrahamson suggests that the diverging descriptions represent contradicting cultural models that nonetheless coexist within the same culture. While the youth are allowed considerable sexual independence according to Mead, the elders represent a sexual ideology that is safeguarded by the power

structures as described by Freeman (Abrahamson 1987). The coexistence of such apparently contradictory cultural models also requires rules for how to deal with them both.

In contrast to many anthropological presentations that seem to take it as self-evident that cultural models coincide with personal experience, Shore has highlighted a much more complex relationship between the two. First, it is important to remember that "meaning – at least about any linguistic or cultural categories that matter to us – is always psychologically particular to the individual" (Chodrow 1995, 517). This has been discussed, for example, in relation to how ritual pain, such as circumcision, can function as a method to personalize cultural models and ideals into the individual body and psyche (see Johansen 2002). Here, however, I will focus mainly on the frequent discrepancies and gaps between personal experience and cultural models and the way in which individuals deal with these discrepancies. This may be particularly relevant in studies of sexuality, as sexual activity in most societies is performed in private and involves strong emotions that may lead to larger discrepancies between the "public" and the "private" than most other domains (Leavitt 1991; see also Tuzin 1991; Vance 1991). Thus, while "culture" may construct relatively shared understandings of body and sexuality in the public sphere, personal experiences may be at great variance with these. And these discrepancies may be significant to the individual in her effort to make sense of personal experiences and the cultural models. Furthermore, situations of change and exile may accentuate these gaps, as both personal experiences and cultural models become more multiple and questionable.

A second field of anthropological theorizing that has inspired this study is the increasing focus on culture as bodily experiences and "habitus" (Csordas 1994; Shore 1996; Solheim 1998). Culture is not only patterns of mental maps of meaning and symbolic significance; it is also embedded in bodily processes and experiences. This is particularly so in relation to sex and to FGC; hence it is vital to include personal bodily experiences in any analysis of sex and FGC. This means that the analysis should include both medical and emic understandings of the body.

Field and method

The material in this chapter is part of the larger study among African immigrants in Norway affected by FGC. The Somali were chosen as a main field of study since they are the most numerous immigrant group in Norway affected by FGC. This implies that most informants had experienced infibulation, as this practice is common among the Somali.

For the purpose of the present discussion, I will differentiate between two broad categories: excision and infibulation. Excision involves partial or total removal of the clitoris and/or labia minora (Types I and II in WHO's classification). In infibulation, excision is followed by scraping or cutting into the labia majora, after which the two sides are joined together to form a seal of skin covering most of the vulva. At the lower end a small orifice is left open to allow the flow of urine and menstruation (Type III in WHO's classification). However, recent clinical evidence suggests the presence of various amounts of clitoral tissue under the infibulated seal of many Somali women

Approaching such an intimate and private experience and practice as sexuality is bound to be challenging. The challenge is increased by several factors concerning FGC and the exile situation. First, the study looks at the relationship between sexuality and a practice that is both morally and legally condemned by the host society of which the researcher is a member. Second, FGC is practiced by members of a minority group who are relative newcomers to Norway, are highly stigmatized by the host society, and are themselves going through tremendous life changes. Third, the issue of FGC is highly politicized and a favorite subject for both political debates and stigmatization in media presentations.

One result of these challenges is that FGC is often regarded as a silent or taboo subject. This has had several implications for studies of FGC and sexuality. As cultural elaboration of a topic has often been taken to indicate that the theme at hand is of significance in society and culture, non-elaborated topics, as FGC and sexuality often are, tend to be seen as culturally and thus personally, insignificant. The suggestion by several anthropologists that sexuality is of subordinate significance in understanding FGC refers precisely to the silence of the informants. However, rather than take silence

as a sign of non-concern and lack of significance, it might be more fruitful to look into the causes of this silence (see Skramstad 1999). Studies of other silent themes suggest that silence may indicate the near opposite of insignificance, but rather the sense that the silent topic is so embedded and self-evident that it goes without saying.

The problem often presented in literature and by my informants that sexuality is a taboo topic in Somali culture proved to be the smallest challenge of all. “We Africans don’t talk about sex. It is taboo in our culture,” I was told repeatedly by my informants, after which they would talk, joke, recite poems, and sing songs about sex, and perform highly erotic dances, mimicry, and practical jokes. In searching for the taboo, I found that the cultural difference lay not so much in degree or amount of silence and disclosure as in diverging cultural guidelines as to where, when, how, and by whom sex could be discussed.

Another possible reason for the informants’ silence is the silence of the anthropologist. Though this has been less discussed, it is pertinent to ask to what extent the silence of the informants is caused by shyness, embarrassment, and insecurity on the part of the anthropologist (but see Ahmadu, Dopico, forthcoming). I suggest that this probably plays a much larger role in research results than is usually admitted. Furthermore, it may be that research on sexuality is particularly vulnerable to the personality and personal experiences of the researcher. The politicization of the issue, through which FGC in the West also has become highly politicized and mixed with concerns of minority/majority, power relations, gender inequalities, and so on, may increase the shyness of the anthropologist. For example, fearing to intimidate my informants and to appear ethnocentric, it took many months of negotiation with myself and with literature before I would ask about female orgasm.

The politicization also affects what can be written, and how it is read and used in debates. For example, while suggestions that FGC can reduce women’s sexual pleasure tend to provoke accusations of “ethnocentrism” and “racism,” the opposite suggestion, that FGC does not affect female sexuality, tends to provoke criticism for not acknowledging the seriousness of the operation and the negative effects it also has on women’s sexuality. I have been accused of both in my various presentations of this study. One example was when on our OK web page we urged parents not to

contemplate circumcising their daughters in order to ensure their virginity, arguing that it would be futile as "FGC does not diminish sexual desire, for desire is based in the head and in fantasy." That sentence caused an uproar. On the one hand I was criticized for diminishing the damage done through FGC, on three full pages, including the front page, in a major newspaper (Dagbladet 2002). The critique was expressed by a Somali woman, with the support of various medical doctors and sexologists. The critics demanded that I be removed from my job. Even senior government officials were asked to give their opinion. On the other hand, other Somali women embraced my replies on the personal variation of sexual experience and the need to show respect and allow dignity to all women, regardless of sexual pleasure and genital state.

A key element in the debates referred to above is a tendency to polarization between those whose main emphasis is on FGC as an intensively harmful and oppressive act, and those whose main emphasis is on the local cultural meaning of the practice (Bell 2005). This polarization is a challenge to anthropologists dealing with the issue.[1] This is partly because anthropologists are generally expected to, and often define it as their duty to, explain FGC through descriptions of emic meanings (e.g. Gruenbaum 1996, 2001; Talle 2003). Hence most anthropological writings on FGC aim at describing the practice from the local point of view. However, in the polarized and politicized climate of the FGC debate, their descriptions of emic perceptions are often *read* as if the researcher is legitimizing the practice. As a reaction against this, the other side (what I elsewhere have termed the Genital Mutilation approach), tends to dismiss cultural meanings as "superstition" or "myths." Hence, this pole rather emphasizes the harmful effects of the practice as well as its element of female oppression. As a reaction to this, anthropologists tend to counteract what they often see as attacks on the respect and dignity of practicing people by further elaborations on local cultural meanings, at times accompanied by questioning the extent of the harmful effects of the procedure. Hence the polarization tends to accelerate.

A problem with these polarizations is that they seem somehow to mute the ambivalence I encountered in most informants, who generally saw FGC as *both* physically destructive *and* culturally meaningful, and in sexual terms as simultaneously important for sexual morality and destructive to sexual pleasure. This ambivalence,

many informants said, had already been present in their minds prior to migration, though at the time they rarely voiced their doubts about the practice. It was within the realm of doxa.

The sensitivity and doxic character of the issues of sexuality and FGC may be a reason why social discourses on this subject often take indirect forms, such as rituals and humor. Both rituals and humor are modes of communication that are set aside from everyday modes of serious discourse while simultaneously being based on them, playing with them, and breaking them. In this way, humor and ritual often highlight and express basic cultural and personal concerns that may be muted or tabooed in the everyday serious modes of social discourse. Hence, though indirect or nonserious modes of communications, they may be a key to understanding central cultural and personal concerns.

Rituals are often described as systematic forms of socialization, and are generally described as vehicles to help the individual conform to social order and bring her into line. Rituals often mark socially significant lifecycle events, such as birth, menarche, marriage, childbirth, and death. Thus rituals can be seen as cultural elaborations of significant events for the individual and society. They are standardized, and thus form a relatively fixed framework against which individuals may relate their personal experiences. Humor, on the other hand, is described as a creative mode of communication that allows forms of expression that run counter to the rules and regulations in the serious mode of communication of ordinary life (Apte 1985).

Analytical approaches in studies of FGC and sexuality

FGC is a multiplex practice. It has a biological basis in that it consists of a physical operation on the genitals of each girl affected. It is performed to conform to cultural values held in the community and by those who have custody and power over the young girls. Each girl experiences genital cutting in a complex relationship between these and other significant aspects.

In anthropological studies of sexuality, the relative significance of biology and culture has changed historically, broadly speaking, from a focus on biological determinism to one of cultural constructionism (for a short summary see, for example, Löfstom 1992 and Vance 1991; also Foucault 2000; Ortner & Whitehead 1981). Earlier anthropological studies, such as those of Malinowski and Mead, were mainly carried out within a framework of sexuality as innate biological or psychological drives that were accepted or oppressed by culture and society in a certain culturally meaningful and functionally useful pattern (Malinowski 1927, 1939; Mead 1963, 1964). However, from about 1920, sexuality came increasingly to be seen as culturally constructed (Caplan 1987; Foucault 1980). In this way, sexuality has traveled the same route as gender, from being considered the "natural" expressions of "inborn female nature" to being seen as a cultural construction. Simultaneously we can detect a narrowing focus in sexual studies, which previously covered broad cultural aspects such as love magic, erotic tales, and incest regulations and now seem to be limited more to the sexual act per se. The new focus on "genital intimacy" is strongly related to recent needs for knowledge about the prevention of genitally transmitted diseases, in response both to the gay movement and to the HIV/AIDS epidemic that caused sexuality to reappear as a relevant focus of anthropological study in the 1980s (Vance 1991).

Parallel to these sexual studies, sexuality has been an integral part of many anthropological studies of initiation rituals. However, as sexuality has tended to be a byproduct in rite-de-passage studies, it has rarely been theorized as a thing in itself" but has rather been approached as the symbolic expression of other central issues, such as gender, fertility, and kinship: "Sexuality has more to do with procreation than with pleasure and more specifically with the continuation of the patrilineage" (Nelson 1987, 221). This emphasis on sexuality as a vehicle for and symbol of procreation and lineage brings FGC into the core of anthropological studies of kinship and ritual. However, we may find it frustrating that "in essay after essay, the erotica dissolves in questions of rank, and images of male and female bodies, sexual substances, and reproductive acts are peeled back to reveal an abiding concern for military honors, the pig herd, and the estate" (Ortner& Whitehead 1981, 24), a concern still troubling anthropologists working on sexuality in the nineties (Tuzin 1991; Leavitt 1991; Vance 1991).

As initiation rituals are also a common setting for FGC, a significant part of FGC studies is framed within studies of female initiation rituals, and hence many of the aspects mentioned on the bias in sexual studies are also frequent in anthropological studies dealing with FGC, including a tendency to *deemphasize sexuality*. In reference to van Gennep's claim that *what* part of the body is cut is irrelevant, that it could just as well have been the nose, Parker expresses her frustration of the anthropological tendency to disassociate sexuality and FGC by suggesting that "anthropologists are reluctant to admit that the genitals are not the nose" (Parker 1985. Originally in Lyons 1981).

One such central bias is the tendency to focus on the fertility side of the ritual's symbolic linkages between sex and fertility (Heald 1995). For example, Janice Boddy presents sex and fertility as opposites, with fertility taking the upper hand: "Pharaonic circumcision is a symbolic act which brings sharply into focus the fertility potential of women, by dramatically de-emphasizing their sexuality" (Boddy 1989, 55). Her emphasis on fertility explored symbolic linkages between the sealing of the womb in infibulation and other fertility-related symbols such as ostrich-shells, calabashes, and the enclosure of the house. In contrast, Abdalla's study on infibulation in Somalia suggests that FGC highlights sexuality: "The principal effect of the operation is to create in young girls an intense awareness of her sexuality and anxiety concerning its meaning, its social significance" (Abdalla 1982, 51). There may be several reasons why the two reach almost opposite conclusions regarding the relationship between sexuality and fertility in relation to FGC. Partly it may relate to differences in the empiric field of study, Sudan and Somalia respectively. It may also be related to the different scientific background of the two, in anthropology and medicine respectively, relating to the above-mentioned preference of anthropologists to focus on key concerns in their field, especially kinship and fertility.

But the difference may also relate to the different positions of the researchers themselves, Boddy being an external Westerner, Abdalla a Somali studying her own community. Boddy's approach follows what I see as a common tendency in anthropological writings on FGC to de-emphasize sexuality that may be related to a Western anthropological reluctance to focus on sexuality in Africa as a thing in itself. I

sense among many Western anthropologists a curious difference in the perspectives from which sexuality is viewed "at home" and "abroad." In contrast to Giddens' analysis which suggests that "everything" is seen as symbolizing sexuality in the West (Giddens 1992), the opposite seems frequently to be the case in analyzes of non-Western societies.

One example of this is Lena Gerholm's reflections on why she for several months failed to notice the groups of veiled women eagerly studying sexy underwear on the roadside, whom she passed every day on her way to do field work in Egypt, which she related to her bias of considering veiled Muslim women as disinterested in sex or sexy clothing (Gerholm 1998). Another example is my recurrent experiences of fellow researchers refuting that the mimicked sexual intercourse I have observed during the female initiation rituals in an earlier study had anything to do with sexuality. It was all about fertility, many said, accusing my sexual interpretation of the acts of being an expression of Western preoccupation with African sexuality.[2]

The magnitude of such tendencies to highlight everything but sexuality, has made me wonder whether anthropologists at times play the role of protagonist of non-Western cultures, trying to present them as more morally acceptable to Western notions (see also Narayan 1997). In contrast, I believe that while children and fertility are vital to any culture, community, family, and even to most individual women and men, so is sexuality. And this, I think, is not limited to Western culture, as suggested by Giddens and others. Quite the contrary, several recent studies support my research experiences in Africa and with Africans in Europe and show that sexuality is highly significant in itself in African cultures. It is often a cornerstone for moral concerns, in which personal, cultural, social, political, cosmological and religious concerns all focus and intertwine (see for example Ahmadu forthcoming; Ahlberg 1994; Caldwell and Caldwell 1987; Heald 1995; Hernlund 2003, for extensive later discourses see Arnfred 2004).

The scientific controversies concerning the relationship between FGC and sexuality pointed out here converge to a significant extent with mundane discourses that flavor everyday conversations, political decisions, and media presentations.[3] As such, they constitute a part of the context in which women in exile are working out their sexuality. That is, the perception most Norwegians have of African sexuality, affect the

way my informants are met by the host community and hence discourses among the Somalis. A key factor driving these controversies seems to be a tendency of polarization between the "sexual mutilation approach" and the "rites-de-passage approach." I will elaborate a little further on this, but to make my point clear I will simplify the arguments at the expense of showing due respect to the nuances and empirical variations in the various studies.

Those who take the "sexual mutilation approach" finds the most important aspects of Female Genital Mutilation (FGM), as they call it, to be the negative effects of the practice on women's health and human rights; they sees the practice as the most extreme example of male and patriarchal control over female sexuality.[4] This view is mainly held by anti-FGM activists, as well as by feminist oriented researchers. It generally attributes to FGC an almost total destruction of female sexual pleasure, grounded in a universal biological understanding of femininity and sexuality. A key factor here is the consideration of the clitoris as the main location of sexual pleasure; hence its removal is believed to remove the possibility of sexual enjoyment. With such a major emphasis on biological determination of gender and sexuality, local cultural meanings are generally presented as irrelevant, misconceptions, myths, vehicles of patriarchal power, or ignorance and lack of knowledge. Cultural constructions of femininity are seen as "false consciousness" that stands in sharp contrast to "real femininity" built on universal biological structures (see also Ahmadu, Boddy, Dopico, and Rogers, all forthcoming). One example of such a view is van der Kwaak' counterpositioning of cultural models against personal bodily experiences: "While infibulation is said to emphasize the feminine side of a woman (by removing hard, male parts, or by enclosing fertility) – the actual experience of femininity is destroyed, sexual pleasure is destroyed and the soft parts are no longer soft due to hard scar tissue" (van der Kwaak 1992, 782). Hence she here presents the culture (what infibulation *is said to do*), as an opposition to the personal experience, or *the real experience* of femininity, which is seen as based on biological constitution. Thus she sees femininity and sexuality as basically biologically determined rather than culturally construed. Her argument also indirectly criticizes the anthropological tendency to see personal experience and cultural models as coinciding.

The “rite-de-passage approach” considers descriptions and analyzes of local meaning and functions of genital cutting to be a key scientific obligation. This approach is pursued by most social anthropologists, and reflects how frequency the issue is dealt with mainly as an integral part of female initiation rituals (see e.g. Moore 1996). As the main focus of these studies generally has been the ritual as a whole, FGC is commonly understood as just one part of the ritual’s overall function and symbolism. This includes elements such as coming of age and maturity and the function of the ritual as a trial, a symbolic price to enter into a secret society, womanhood, or fertility (e.g. Ahmadu 2000; Dellenborg 2000, 2001; Hernlund 2000; Skramstad 1999). More recent studies have increasingly interpreted the practice in terms of gender and fertility (Leonard 2000; Talle 1994), and even later sexuality. As such, until recently, major emphasis tended to be placed the nonsexual aspects of both FGC and initiation rituals.

All studies have also had to ponder about the relative weight of biological and cultural structures in forming femininity, sex, gender, and sexuality. As suggested, the rite-de-passage approach mainly sees femininity and sexuality as culturally constructed (see for example Boddy 1989, 56), while generally deemphasizing or questioning the universal applicability of biological factors as described in sexology and medicine (see also Vance 1991, who strongly argues for a cultural constructionist perspective in studies of sexuality).

The discourse between the sexual mutilation approach and the rite-de-passage approach often appears as a polarization between an understanding of FGC as *either* physically destructive (the mutilation approach) *or* as culturally meaningful (the rite-de-passage approach) that tend to escalate. When those on the FGM side emphasize the harmful effects of FGC, in which often risks caused mainly by infibulation are described as harmful effects of all types of FGC affecting all women, this tends to stimulate counter-reactions from the rite-de-passage pole, emphasizing the need to take emic perceptions into consideration. In addition, many also question the reliability of the harmful effects as described by the FGM pole, especially the tendency to subsume any risk as a necessary resulting from all types of FGC. Many make the point, as well, that an emphasis on the harmful effects may have only limited effect in anti-FGM work, as most adherents to the tradition might neither recognize these harmful effects, nor would

it necessarily be sufficient reason to abolish what is for them a meaningful cultural practice. This again tends to provoke accusations of defending an oppressive practice by the FGM pole. When anthropologists in Norway have presented emic understandings of FGC, they have been portrayed in the mass media as a major danger to the human rights of young girls in Norway, as their studies of the cultural meaning of FGC are said to legitimize this as an oppressive cultural structure (VG 2002). This tendency of polarization increases the challenge of addressing the sexual effects of FGC. It proves the urgency of taking into account the physical changes involved, the cultural underpinnings of the practice, other cultural models on sexuality and FGC, and the relationships in which sexual activity unfolds.

The long-term physical effects of FGC vary with the type of cutting, the age at which it is done, and the healing process. Removal of tissue, especially the clitoris, and scar formation may cause reduced responsiveness to physical stimulation in the clitoral area and thereby affect achievement of orgasm. The significance of the clitoris in sexual sensitivity and orgasm has been elaborately discussed also by Ahmadu and Dopico in forthcoming (See also Ahmadu 2000; Bakri 1982; Gruenbaum 2001). One aspect of this debate focuses on the function of the shaft of the clitoris, which remains within the body, even if the whole outer part of the clitoris is cut.[5] There is also limited knowledge on the sexual function of surrounding tissue, as well as other erogenous zones and their ability to compensate for lost clitoral tissue.

Cutting may also lead to temporary or permanent oversensitivity and pain. The narrowing of the vaginal orifice in infibulation necessitates reopening (defibulation) to allow coitus. Most nonmedical methods of defibulation involve a lengthy and painful process that may affect sexual experience in both the short and the long term (see also Almroth et al. 2000; Dopico forthcoming; Johansen 2002; Talle 1993 and forthcoming).

Also affecting women's sexual experience are the cultural models of both FGC and sexuality. Emically, FGC is often considered to be a significant and constituent part of femininity and womanhood and a way to "domesticate" female sexuality. In very broad terms, cutting the clitoris is more often described as a means to reduce women's sexual desire in order to ensure virginity and fidelity, as seen in descriptions from Egypt (el-Sadawi 1980; Thorbjørnsrud 1999), Ethiopia (Rye 2002) and Somalia (Ali 2003; Hicks

1993; Talle 1993). At other times, it is described as a way to "open the woman," making her sexually accessible, as among the Masaai (Talle 1994) and in Ethiopia (Rye 2002). As seen in Simon Rye's study, apparently contradictory views may thus coexist. Other significant meanings are related to maturity, cleanliness (ritual and physical), endurance of pain, fertility, femininity, and religious and ethnic identity.

The closing of the vagina in infibulation is generally intimately linked with ideals and ideas of virginity. The infibulation seal inhibits coitus unless a partial reversal of the original operation is performed. Hence infibulation is believed both to prevent premarital sex and to function as proof of morality, as an intact infibulation on the wedding night is taken as the only legitimate proof of virginity. Other analyzes relate infibulation to fertility (Boddy 1989), clan affiliation (Boddy 1989; Talle 1993), purity (religious and hygienic), and beauty (Boddy 1989; Gruenbaum 1996; Talle 1993). [6]

The key dilemma and ambivalence towards infibulation among the Somalis, between the positive evaluation of FGC as a means to domesticate female sexuality and the negative evaluation of pain and reduced sexual pleasure, has probably been highlighted and inspired by the encounter with the Norwegian society.

The Norwegian encounter

Arriving in Norway, women and men from societies practicing FGC encounter Norwegian notions of gender, sexuality, and genitalia that differ significantly from those of their home societies. A central value in Norwegian culture is the praise of everything "natural." The opposite of natural is not "cultural," but rather "unnatural" and "fake" (Gullestad 1992) and, in terms of sexuality, "perverted" or "deviant." Sexuality is seen as inborn and natural and should be left to develop naturally. One expression of this is that, to the extent that Norwegians question sex education in school, it is less out of fear of moral degeneration than out of fear of systematizing and teaching something that ought to be left to develop on its own terms. These considerations may increase the

Norwegian perception of FGC as immoral, not only because it is considered destructive and oppressive, but also because it destroys "nature."

Present-day Norway may be characterized as having a comparatively liberal view of women's sexuality, with a strong emphasis on women's sexual pleasure, personal choice of both partners and activity, and little value attached to virginity and marriage. This liberal view of women's sexuality is closely related to a strong ideology of gender equity.

These ideologies are not automatically attributed to African women living in Norway, however. Norwegian views of the African "other" are ambiguous. On the one hand, Africa is viewed as the home of the "noble savage," whose culture and society have not been destroyed by modernization. In this context, African sexuality is seen as free and uninhibited, unconstrained by a Christian, particularly Lutheran, division of body and soul (Gotaas 1996, see also several articles in Arnfred 2004; Manderson 2004). This parallels anthropological studies of sexual life of the "noble savage" and the discourses on "African sexuality"... On the other hand, African women, especially Muslims, are envisioned as totally formed by their culture, a patriarchal society in which women are subordinated to men. [7] Veiling and FGC, both of which are practiced by Somali women, are seen as the most extreme symbols of women's oppression.[8] Somali women are easily recognizable; they visibly stand out among other immigrant groups in Norway. They are generally the only veiled Africans and are thus usually recognized by their appearance. I also frequently encountered Norwegians passing moral judgments on Somali women based on what the Norwegians perceived to be correct Somali or Muslim culture, rather than on Norwegian ideologies of gender equity and equality. There appeared to be a widespread concern among the Norwegian health care workers about a "moral degeneration" of the Somali in relation to practices such as divorces, extramarital pregnancies, abortion, contraceptives for single women and so on that were seen as less abhorrent when carried out by ethnic Norwegians. [9]

In Norway, FGC is both morally and legally condemned. Before the law was passed, there were extensive medical debates, presenting the practice as a health problem, a human rights problem, and a violation of the rights of children and women and of sexual and reproductive rights. Yet, at the time of my fieldwork and before, FGC

was generally considered to be a “strange and barbaric” practice carried out in remote areas of Africa, and few considered it to be relevant in a Norwegian context. An illustration of this was the outburst to me by a Norwegian pre-school teacher about a Somali female colleague: “No, no, she can’t have been circumcised. She’s so nice, and perfectly normal. I don’t think anything like that could ever have happened to her.” [10]

This public silence changed dramatically after a series of two documentary programs was shown on Norwegian television in the fall of 2000 (see also Johnsdotter and Talle, forthcoming). The first program, raising the issue and presenting a list of girls who were said to have been sent out of the country for circumcision, did not, however, give rise to any serious discussion or attention, neither among Norwegian nor Somalis. In contrast, the second program, which revealed that some Muslim leaders supported or accepted the practice, led to a national uproar in all corners of society.[11] The Norwegian authorities reacted immediately. First, knowing that the program was coming up, the National Guidance Book for health workers, which had been in process for several years, was finally published just prior to the program going on the air. Just two months after the program, a national plan of action was presented by the government. This is what led to the establishment of the OK Project. The media and “ordinary” Norwegians were upset and furious about the possibility that practices which they saw as abhorrent could be carried out by people living in Norway. Members of the Somali and Muslim communities were furious, as well. Their main concern was what they saw as a biased and wrong presentation of their communities, their religion, and their religious leaders.

Though the program was broadcast towards the end of my field work, and hence had limited effect on the data I gathered, I find it necessary to include some of the reactions it provoked, partly because it may point to possible changes in the field after this research, and partly as this incident illustrates the way many Somalis feel about public attention to FGC and the following stigmatization of them as a group.

The reactions among my Somali informants generally centered on the discomfort of raising such a sensitive issue in public and increased fear of stigmatization. Jamila said, “Such public attention makes people think of us as handicapped, as evil beings who want our children to suffer.” Many Somali women said they felt more vulnerable after the program (see also Johnson, forthcoming). One woman said she felt

Norwegians were “trying to see through my clothes.” Others reported having been asked very private and intimate questions about the effect of FGC on their sexual life by rather distant acquaintances. Many preferred to reject the problem or refuse to talk about it with Norwegians if they felt challenged. Amber, for example, who explained that she was against the tradition “with both head and heart,” exclaimed that if anyone criticized her culture she became very defensive. The tendency to become defensive was seen in many settings. One example of this was when a group of Somali women during a training session for anti-FGC work expressed surprise at their urge to defend their culture when talking to non-circumcised women from the majority population. Another example was a young girl who told us how she had tried to hide her circumcised status by assuming a “tough, modern” appearance. Men, too, seemed to be highly affected by the television program and still, years later, anger and fury at the media stigmatization were often the first reaction when FGC was brought up as a theme. It thus seems that such negatively experienced public attention increases women’s sense of vulnerability, exposure, and loss of privacy. However, in later years many Somali women and care workers alike said they felt that the program also had opened the issue for debate, and that Somali women more often came forward with questions and concerns on the issue after its broadcast

We see, then, how moving into exile has brought the Somalis into contact with various and contrasting cultural models: Norwegian ideas of sexuality and gender relations as well as Norwegian ideas of African and Muslim women and society. The Somalis have also experienced tremendous changes within their own communities and families, and in gender relations, sexual experiences, and considerations of FGC. Living in exile presents its own burdens. For some this includes fleeing from the war and leaving relatives and loved ones behind. In addition, many experience a tremendous decline in social status, from being among the better-off in their home communities to being members of a visible, stigmatized community in Norway. Somalis in Norway also experience many social and economic problems, which are often dramatically presented in the media. The rather negative public stereotypes of the Somali constitute a part of the environment of their life in exile.

In contrast to the negative media picture, the women in my study expressed a positive picture of, and pride in, their own culture. In particular, they praised the social ties and various cultural expressions, especially the weddings and marriage rituals. Furthermore, women generally seemed to manage the transition to Norway better than men. Many were able to make use of better opportunities for women for education, work, and economic independence. These changes seemed to be paralleled by a wish for increased gender equity, and an increased emphasis on sexual pleasure for women. This change did not seem to lessen the cultural emphasis on virginity and sexual chastity; however, for these were seen as significant aspects of women's identity as Somalis and Muslim (see also Aaretun 1998). One aspect of this, however, was women's frequent complaints about tight social controls (see also Johnsdotter, forthcoming). The problem was often described as a difficult balance on the right side of a moral dichotomization between "bad" and "good" girls. As Amina described it, "It is like balancing on a very narrow line; you are either right or wrong, and there is nothing in between." Young girls complained even more of strict social controls, which seemed to have increased in exile. They were simultaneously exposed to what they saw as the freedom of Norwegian girls, as well as of Somali boys.

The women's feeling of being under tighter social surveillance in exile may be related to an increased responsibility in women's role as moral custodians. While women in many, if not most societies, are carrying a large responsibility for the honor of their own family and clan, in exile this responsibility seems to extend to the whole ethnic group (El-Sohl 1993). Thus, Somali women were also expected to present a proper image of Somali female identity vis-à-vis the Norwegian majority. This was clearly evident in the strong negative reactions to fellow Somali women who had contributed to the public attention to FGC. Having "talked about private things in the open" and "exposed Somali culture," they were considered by many to have "betrayed" their own culture and society. However, similar sanctions also applied to women who had presented images of themselves that were evaluated positively by the Norwegian majority, for example, a woman whose child had been shown on television singing a Christmas song or a woman showing that she accepted her daughter's live-in, non-Somali boyfriend. Many Somali women complained to them and to each other about

them bringing “shame” on Somali culture, by showing such atypical and immoral behavior to the Norwegian society.

Many mothers also expressed a concern that exposure to Norwegian society increased the risk of moral failure among young girls, and there was a general fear that girls and women might become “too Norwegian”, and thus “bad” girls, and lose their “culture,” Muslim identity, and morality. For example, young girls wearing Western clothes described how they were addressed in the street by religious men and reprimanded for dressing indecently, and adult women who behaved in “non-Somali” ways often described social sanctions and criticism. A fear of losing cultural identity and sexual morals was often expressed in the emphasis on premarital virginity and intra-ethnic marriage (see also Aaretun 1998). A few informants suggested that some parents, after originally wanting to dispense with the practice, had circumcised their daughters at a late age as a last resort to preserve her Somali identity and moral character.

Traditionally, women said, rumors of “improper” behavior among unmarried girls in Somalia could be refuted by the presentation of an intact infibulation. In Norway, this presentation was said to no longer be practiced; it seems genitals and virginity had become a more private matter, no longer open for public inspection. I suggest that the former role of infibulation in proving moral conduct is in the process of being replaced by other symbols, especially of codes of dressing (see also Talle, forthcoming).

Life in exile also opens up new possibilities for maneuvering within the moral codes. Aspects such as living at a distance from powerful relatives, possibilities for increased anonymity in Norwegian towns, and ambiguous marital status allow for a more flexible practice of certain moral codes. For example the two parallel but distinct marital systems, the official Norwegian and the Muslim/traditional, seem to facilitate increased flexibility and freedom for women, since a woman can be simultaneously divorced or separated according to Norwegian law, while remaining married according to Islamic or customary Somali law. In this way women can more easily negotiate increased independence from their husbands, while simultaneously maintaining their respectability and fertility.[12] A disadvantage from the women’s point of view was that this

also enabled some men to maintain multiple wives and made it more difficult for women to demand money or services from their men.[13]

The differing expectations in the home and host cultures also contributed to widely different ways in which they presented themselves in various contexts. Some girls said they claimed another ethnic identity to avoid the stigma that arises when they are confronted about the issue of FGC by the host community. Some claimed to their non-Somali acquaintances to be uncircumcised, whereas within their own community they claimed they had been cut. For others, it was the other way round.[14]

Infibulation: questioning a painful door to virginity

Virginity and infibulation - Safeguarding open bodies

As mentioned above, premarital virginity was considered to be extremely important by the vast majority of my Somali informants. However, virginity was not considered an inborn quality, but had to be culturally constructed through infibulation (see also Boddy 1989; Talle 1993). An intact infibulation was believed to both ensure and prove virginity, as the infibulated seal has to be physically broken to allow coitus. In one study in a Somali area in Kenya, 79% of the informants claimed the protection of virginity as a major reason for FGC (Ali 2003). In that study, 86% of the men and 33 % of the women said they would question the morality of an uncut girl, fearing her to be “loose” and “oversexed.” My informants conveyed similar ideas, suggesting that an “open”, never-married girl would automatically be suspected of having engaged in premarital sex. The idea of a noninfibulated virgin seemed to present a puzzle to most Somalis. There appeared to be no way to differentiate between a woman who had never been infibulated and one who had been defibulated. Hence a non-infibulated unmarried girl would invariably be interpreted as already defibulated, and thus no longer a virgin and as such she would be socially stigmatized. [15]

Following from this, sexual activity was generally understood as synonymous with coitus. It was only coitus, and especially pregnancy, that could be proven and thus endanger a girl's reputation. Sexual acts that do not lead to defibulation, such as rubbing the penis between the legs or against the infibulated scar, and anal and oral sex were seen as less risky as they would normally not be detectable. Furthermore, such acts were generally not defined as sex at all. Shukri, who was still infibulated and considered herself a virgin, reported having several boyfriends. Though they had had intimate contact, she had never thought of these acts or experiences as sexual. This may be the reason why she feared never to be able to enjoy sex, in spite of having experienced intimate contact as pleasurable and exciting. She seemed puzzled and pleased at the reconsiderations brought about through our discussions about this.

Many also deemed infibulation necessary to avoid sexual activity. They found it difficult to believe that young women could manage to refrain from sexual intercourse if they were not physically closed. Some young women, such as Nima, used this as a reason for refusing or delaying their own defibulation: "I am infibulated still. I do not want to be defibulated. Why should I? Then people would think I was not a virgin. And I think virginity is important. I think my infibulation helps me to stay a virgin. I know it will be very painful to have sex, so it is easy for me to refrain. But of course the boys want it. I am a young modern girl. And my Norwegian boyfriends don't know that I am circumcised or what it means. So they don't understand that it [sex] is impossible for me."

Nima's resistance was thought provoking, as she was a very "progressive" girl, well educated, fashionably dressed, and socialized mainly with non-Somali friends. She had also made some efforts to fight FGC and had helped to rescue her younger sister from cutting. Nima's decision to remain infibulated demonstrates the emphasis that is put on infibulation as a physical reminder of moral standards (see also McGown 1999). Nima's attitude thus suggests that infibulation may function according to its intentions, by preventing premarital coitus.

Resistance against defibulating unmarried women was widespread, especially among teenage mothers. Similarly, some men, although opposed to infibulation on a general level, expressed doubts about the virginity and moral standards of an uncut

potential wife. Most Somalis, especially men, seemed to see defibulation as an open invitation to promiscuity, as expressed by one woman: “We are now doing a social experiment with our young girls that are not cut. Time will show whether they become more promiscuous.” As a consequence, most unmarried girls who wanted to be defibulated did so without parental knowledge or consent. One girl said she assumed her mother knew, but that they kept a mutual code of silence. In another case, the mother prevented the operation, since the hospital requested her approval of the operation, as her daughter was still a minor. [16] Physical hindrance thus seemed important or even necessary to prevent premarital sex, as sexual desire was described as easy to arouse and difficult to control mentally.

Virginity was intimately linked to morality in a significant way. The “danger” of an “open” woman seemed to be less a question of her missing her virginity than of premarital sex as evidence of moral failure. Women said that Somali men would often test the morality of a prospective bride by trying to pursue her to have sex. If she seemed willing, the man would consider her unreliable and break off the relationship. Many men made similar statements: “If she [any woman] agreed to go to bed with me, it means she could agree to go to bed with anyone. I could never trust such a woman,” Abdi said. However, men were only concerned about virginity when marrying a girl who had never been married. They expressed no objections to marrying a divorcee, and many had done so. Her sexual experience had happened within a marriage and thus did not endanger her moral reliability. Thus, premarital virginity seemed more important as a guarantee of a moral standard than of sexual innocence in itself. [17]

For infibulation to be seen as a proof and guarantee of virginity, it had to be performed prior to coitus. In Somalia, infibulation is mostly performed between the age of five and eight. There was a strong insistence that the operation should be done prior to menarche. One reason given was that the onset of menstruation was perceived to “open up” the woman’s body and make her able to have sex (coitus). Thus, if infibulation was done after menarche, it was also believed to leave her open to the risk of premarital sex. Another reason given was that menstrual blood, or a different skin texture after menarche, would prevent the infibulation from healing properly. However, research shows infibulation being performed with some frequency up to the age of fifteen in

Somalia and, among exile Somalis, even later (Aftenposten 1997; Morison et al. 1998). In addition, reinfibulation (sewing back the infibulation to recreate a "virginal" vaginal opening) can be done at any age, as is reported from Sudan (Almroth-Berggren 2001; Boddy 1989). However, among Somali women this was generally described as a very rare practice, as reinfibulation is not a Somali tradition. In rare cases, however, reinfibulation could be performed to cover up premarital sex or rape.

Male informants heatedly refuted the possibility of postmenarche infibulation. The possibility of postmenarche infibulation and reinfibulation seemed to create in them a sense of intense discomfort and disbelief, as it cast doubt on the possibility of proving virginity through infibulation. One Somali woman said she had been approached by a young man who feared that the request of his wife-to-be to visit her home country prior to marriage was based on a need to be reinfibulated. Thus he feared that her infibulated virginity was not "authentic," but a cover-up for illicit sex. These male concerns suggest that men perceive a closer link between infibulation and virginity than do women. This has also been suggested by Boddy (1989).

Parents emphasized the importance of infibulation in proving virginity as an assurance of their daughters' marriageability. This was the most commonly cited reason for the continuation of the practice and for resistance against premarital defibulation. This concern also indicates an implicit demand for ethnic endogamy, as it is basically only Somali men who could be expected to demand infibulation. In the case of exogamous marriage, infibulation is more likely to function as a discouragement. The possibility of cross-ethnic marriage was rarely discussed and, when it was discussed was generally feared and disapproved of. [18] I would therefore suggest that, in exile, infibulation has gained a new significance as an ethnic marker and incentive to ethnic endogamy.

But, although adult women seemed to fear the uncontrollability of a never-infibulated or defibulated vulva, they simultaneously claimed that there was no connection between infibulation and sexual conduct. "If a woman wants to have sex, the infibulation will not hinder her," many women said. This is supported by research, which gives no indication of significant differences in frequency of sexual activity (coitus) and FGC status (Morison et al 1998; Okonofu et al. 2002). Somali women's reflections on

this apparent contradiction between their understanding of infibulation as a guarantee of virginity and their simultaneous perception that infibulation provided no such guarantee in reality suggest an increasing reconsideration of the significance of infibulation to secure and prove moral standards.

This may be related to the general attitude of growing resistance to infibulation. It seemed to gradually be losing its significance, as indicated by the story of Amber:

> I had a very small hole, the smallest among my peers, and I felt very proud of it. I thought I was the best of all the girls because of this. Then I came to Norway, and realized that most of my classmates were not circumcised. My small hole, which caused me so much pain every time I had to pee, was nothing to be proud of. Instead I felt ashamed and different. But I could not think of being opened. I feared, I think, that if I did so, [Somali] people would lose respect for me. They would think I was a loose girl, a girl without morals. I was twenty-seven when I finally decided to be opened. I was not planning to marry, and I did not have a boyfriend. But the small hole had no meaning for me anymore. It was just a frustration.

The increased demand for defibulation, also from unmarried girls such as Amber, suggests that the overall significance of infibulation is diminishing among the exile population. Infibulation also seems to have become a more private matter. However, many associated values, such as premarital virginity, ethnic endogamy, and "proper Somali female identity" is still in demand, however, and these values may take different expressions.

Securing enclosure: from infibulation to veiling

I suggest that, in some ways, modes of dress are increasingly replacing infibulation as a locus for moral conduct and identity. The clothing habits of Somali women, particularly

veiling, have gone through significant changes in space and time (Akou 2004). Increased veiling has been a common trend in the period after the Somali civil war. Migration to Western countries seems to have further promoted this trend (Akou 2004; McGown 1999; Talle 2001 and forthcoming).

The dress codes of Somali women living in Norway can be divided into different "themes" depending on the context of everyday or celebration. In everyday and inter-ethnic contexts such as school, work, and walking in town, Somali women usually dress in one of the three following major styles: The first and most common style I call "decent mixed." It consists of a long skirt and a long jacket, with the hair covered by a scarf. This dress style was said to be practical in the cold Norwegian climate, while maintaining a Somali, Muslim, flavor. The second style, that I have labeled "Somali Muslim" or *hijab*, consists of a dress shaped as a long cloth from head to foot, said to be adopted from Saudi Arabia. My informants suggested that about half of the Somali women dress in this style, although my visual impression was that the number was much lower, although increasing during my years of working in the field. The third style was worn by a smaller but visible group of women and may be described as a more "modern European style," such as jeans, shorter skirts, and uncovered hair. Their enclosure could vary from "decent" according to a Somali standard, to the latest Norwegian fashion of bare navels, piercing, and tattoos. On a few occasions even miniskirts were observed, to the great dismay of elderly Somali women.

In purely Somali contexts, mostly celebrations of various kinds, women generally dressed more colorfully, with shiny materials, lace, embroideries, and beads, and were less covered. I could distinguish two major styles: the *dirac* and wedding dresses. *Dirac*, considered a traditional Somali dress, is made of a thin, transparent fabric that often renders a woman's skin and body shape visible beneath the cloth. A similarly thin shawl covers at least parts of the hair (*garbasaar*, literary shoulder cover). *Garbasaars* were found in three major sizes and with varying thickness, the smaller and thinner being more common in Norway. At weddings, which are large cultural events, most women dressed in almost skin-tight Western gowns with bare shoulders, covered by a shawl of lace (often the smallest size of garbasaar). The dresses were usually made of shiny materials that highlighted their body shapes, and their hair was never covered, but set in

elaborate hairdos. They also wore heavy make-up, including powder to make their skin look lighter. All weddings I attended were celebrated by men and women together, both at the tables and in the dancing.

Dress was a hot topic, often more so than FGC. The heat of the debate suggests that something important was at stake. The discussions often came to center on competitive claims as to what constituted "traditional" and "proper" or "real" Somali (female) dress. During these discussions, women often divided into two major groups, one claiming that full *hijab* was a traditional Somali dress, the other claiming that in pre-war Somalia dress included jeans, miniskirts, and creative and seductive uses of the transparent *diracs*. The discussions seemed to provide an arena for the negotiation of Somali, Muslim female identity, often in opposition to European values and styles (see also Akou 2004).

If we define veiling as dressing in ways that cover both skin and body shape, there seemed to be a systematic variance in its contextual use. The more the women were exposed to the Norwegian majority in public in mixed arenas, the more they veiled. Let me give two examples: An informant I had known for some time, who always used to be carefully covered in public, removed her scarf one day during my private visit, with a twinkle of her eye, joke, and comments that suggested that the disclosure was an act of increasing trust and intimacy in our relationship. In more African-dominated contexts, veiling was less extensive. One example is when I was attending a conference on FGC in Tanzania in which some of my Somali acquaintances from Norway also participated. As the conference proceeded through its five days, the women gradually reduced their veiling. By the last day, their head scarves had been reduced from framing their faces and covering their necks to small transparent scarves dangling from their ponytails. And on the last day, one of the women took a swim in a tiny bikini.

Women and children have also significantly increased the covering of their hair. Traditionally, the women said, women would start covering their hair after marriage, as could be seen in their photographs from home. The wedding ritual that is practiced in southern Somalia, *shaash saar*, literally means "covering head in scarves," which is the main content of the celebration. The practice of starting to veil upon marriage is interesting, as it means that bodily enclosure through veiling starts when their genital

“veil” (infibulation) is broken. In exile, as well as in postwar Somalia, veiling often starts at an earlier age. Many Somali girls in Norway start veiling at an earlier age, often at age six or seven, and at least when girls approach puberty.

Furthermore, the proportion of women who cover their hair seems to be increasing. Many women, who had never covered their hair in Somalia or in other exile countries, had started to do so a short time after settling in Norway. Social control was strong, they said. In Norway, also the occasions for veiling had changed, including increased veiling when talking about FGC. I often observed women throwing another shawl over their head and shoulders just as they entered a room where they were to talk about FGC. Conversely, women who gave presentations with “naked” hair or a slit in their skirt were frequently negatively characterized afterwards: “How can we listen to women dressed like that?” many complained.

As mentioned, the different dress styles in different arenas suggest that the most cited religious reason for veiling - that is, protection from male sexual lust – was less significant. Rather it was the presence of non-Somalis, rather than of Somali men, that influenced the code of dress.

We can see parallels to Boddy’s analysis of the different levels or layers of veiling: from infibulation, to dress, to enclosure in the house, to a symbolic linkage between protection from sexual penetration by a “foreign” man to ethnic penetration by exposure and intrusion of external groups (Boddy 1989). Hence the dress styles of Somali women in exile seem to communicate different messages externally and internally.

Externally, the increased veiling in interethnic contexts may be seen partly as an expression of a sense of vulnerability and a need for protection and distance from the host community and partly as a way to present a respectable ethnic identity. We may here draw links to the observation that increased veiling has been observed worldwide related to Islamization. In the exile context this has been seen as related to increased exposure to non-Muslim culture and society (McGown 1999).

Internally, however, increased veiling through dress may be seen as an alternative to veiling through infibulation. As already mentioned, the significance of infibulation appears to have decreased in the exile population. One reason for this is an

increasing opposition to the practice, along with an increased privatization of the genitals. For example, it was said that male relatives no longer wanted to inspect the infibulation of a bride, which was said to be a tradition in Somalia. The increased practice of premarital defibulation also reduces the significance of the practice. On the other hand, moral conduct seems to be more often evaluated on the basis of decent dress and behavior and in the choice of friends and social circles. This may be one of the reasons why everyone agreed that Somali girls were kept under stricter surveillance in exile than had been usual in the home countries. In this way, some central values may be maintained: the significance of enclosure, protection from intrusion from outside, and protection of moral and ethnic identity, while the veil is changed from skin to cloth, from the woman's physical body to the applied attire.

Opening the body

In order for a marriage to be consummated, the veil of infibulation has to be broken. This is an important event for both the girl and her family, because defibulation and marriage transform the girl from a closed virgin into an open, married, sexually active and potentially fertile woman. Also, through her marriage, an important link is established with another lineage, which is thereby given the rights over her sexuality and fertility. The significance of the event for the girl, her family, and the community is evident from the fact that defibulation is the only aspect of infibulation that is given significant ritual attention.

Traditionally defibulation was supposed to be performed during the first week of marriage, after which the marriage should be consumed. The ritual that marks the event is held immediately after the wedding ceremony. Two alternative rituals are performed depending on local customs: the *xeero* ritual in the north and the *shaash saar* ritual mentioned before, in the south. Here I will outline some significant aspects of the *xeero* ritual.

Xeero is the name of the figurine that plays a major role in the ritual. Several xeeros are made by female relatives of the bride, and consist of a particular type of jars

filled with a special dish of dried and fried camel meat in butter, covered by dough of dates, which are covered and formed into doll-like figurines. These are then covered with a white cloth and tied with ropes, before being dressed up in bridal attire, such as dress, headscarf, jewelry, shoes, and other ornaments. Much prestige and pride is put into both the preparation of the food and the intricacies of tying it tightly. The xeero ritual is a large celebration. Men from the groom's family are invited to untie the xeero and reveal its delicious contents, which are then eaten. The process of opening it is arranged as a competition or game, in which each man has his try, while being teased, hit, and prevented by the women. As the men fail to open the "doll," the women punish them by making them perform ridiculing acts.

As the untying of the xeero marks and coincides with the defibulation of the bride and the consummation of marriage, the ritual clearly symbolize the opening of the bride for sexual accessibility; and the inside food may symbolize her fertile potentials, which from now on belong to her husband's lineage. However, the ritual also symbolizes other aspects of defibulation and gender relations: it highlights female power, in the sense that it is they who tie up the bride that men have to struggle to untie, and during the ritual this is further marked by women hitting the men trying to achieve their goal. Hence it illustrates how men have to fight for access to a woman's (and her lineage's) sexuality and fertility. Through the beating women also inflict pain on men that may parallel the pain both women and men generally experience during defibulation. Both male and female informants described the ritual as hilarious, laughing as they talked about it.

In contrast, the actual defibulation was described quite differently. Defibulation requires that the infibulated scar has to be torn or cut open. This can be achieved either by the husband's penis (the ideal in southern Somalia) or by cutting (common in northern Somalia). To prevent reclosure of the wound and thus reinfibulation, coitus was said to be necessary during the healing period. This procedure, which often could take several days and even weeks, was described by both women and men as extremely painful, both physically and psychologically, and as a very negative start to married life (see also Dopico forthcoming; Johansen 2002; Talle 1993 and forthcoming). Resulting wounds and infections were regarded as a normal state of affairs for women and not infrequent for the men (see Almroth et al. 2001).

One may wonder why people use humor in a ritual that marks a significant, but painful life event for women. Ritualized humor is known to be frequently used in relationships and events that are simultaneously significant and problematic. This has been studied particularly in relation to African traditions of “joking relationships.” Jokes and laughter create a distance between oneself and the statement made, both emotionally and morally. Moreover, the xeero ritual is the main socially accepted channel through which women can express their experiences of this. In contrast, women said that personal complaints of pain were usually not accepted, as ”all women have to experience this.”[19]

Most couples who got married in Norway had their defibulation done in hospitals. This reduced pain to a minimum as it was performed under an anesthetic, with stitching on the sides to prevent regrowth, pain-reducing medication, and the advice to abstain from intercourse until the wound had healed (usually from two to eight weeks).

After a successful defibulation, most couples depicted their sexual life as unproblematic. For a few, however, coitus was painful for years and for others not possible at all. Jamila described her first four years of marriage as a series of painful intercourses. Although she married in exile, she and her husband resorted to defibulation through penile penetration both because it was their tradition and because of hospital waiting lists. During the first two months of their marriage, sexual intercourse was extremely painful because of open wounds and intense pressure as the husband tried to break through the vaginal seal. Jamila recalled how she often had to vomit and cry during intercourse, and she had constant wounds and pain in the vagina. After this initial period, the opening was sufficient for lovemaking in certain positions: “But we were young and in love and wanted to try different things, but then it was still very painful for me.”

Although most Somali women lamented painful defibulations, they generally described them as a normal part of a woman’s life, and there seemed to be little room to pity women who complained. Because defibulation and the accompanying pain mark an important change in women’s lives, one could expect the pain of defibulation to be experienced as part of womanhood, of femininity itself: this seemed not to be the case, however. Although there is some cultural approval associated with enduring pain,

particularly female hardship and pain describing it as a woman's lot, and sometimes even glory (Adan 1996), women did not seem to experience the pain of defibulation as relevant for their sensation of femininity – quite the contrary. One example is the story told by Jamila, who found all her sexual encounters with her husband to be painful, until she was finally defibulated after her second delivery. This, she said, changed her sexual life significantly:

> "It was fantastic. Finally I felt like a woman. I had been a woman all the time, but I didn't feel it. Not until now. Sex was not painful any more. And my husband was very happy. He said he loved me much more now. It was nice for him to see that I also enjoyed sex. Not to have any pain. It is a strange thing. I had to be an adult woman, and only after having two children was I to feel what it was like to be a real woman."

Jamila's story supports my suggestion that personal experience of womanhood does not necessarily correspond with cultural models. This might particularly be the case in exile, where both the infibulation itself and the pain associated with it are questioned, and women explore new roads to female gender identity, new roads that are affected by the Norwegian cultural models that see such painful experiences as degrading rather than glorifying. [20]

Thus, infibulation and defibulation are closely related to central cultural values of virginity, women's possibility for marriage, and honor. The personal experience, however, was flavored simultaneously by cultural models inspiring pride, by pain and by a sense of loss of meaning (see also Johansen 2002).

Reconsidering sexual pleasure: perceptions of the clitoris – is it changing gender?

In discussing the effect of FGC on sexuality, one needs to take into account the various understandings of genitals, sex, and gender. The practice of genital cutting itself

suggests that inborn genital differences are not considered sufficient to constitute proper women and men (Ahmadu 2000; Boddy 1989; Talle 1987, 1993). To make a girl a proper woman, her genitals have to be molded or carved to fit cultural standards. This means that a woman's body, her biology, not only her gender, is also perceived to be in need of cultural construction.[21] Among the Somali, the natural genitals are seen as ambiguous, consisting of both male and female elements. The clitoris (*kinter*) was described as unclean, a male element, a "penis" out of place, so to speak. As a masculine element, however, the clitoris has been regarded as something out of place that has to be removed to purify the female sex, gender, and sexuality (Ahmadu 2000; Boddy 1982 and 1989; Talle 1987 and 1993).[22] Grammatically, the word for it is also masculine. [23]

Somali women drew various parallels between the clitoris and the penis. First, there is the size. An uncut clitoris was believed to grow, like a penis, at puberty. Such an organ is considered aesthetically repulsive and counter to the idea of proper female genitals. Several Somali women described how they were teased by other girls prior to their circumcision, with references to the size of their clitoris. Jamila, for example, recalled how her classmates dragged her behind the school wall, threatening to remove her skirt to demonstrate her shame to the whole school: "You still have it. Let us see your big clitoris. It must be this big," they teased her. When I asked women to estimate the size of an uncut clitoris, they usually indicated large rounded shapes, mostly around three to four centimeters in diameter, occasionally larger, and sometimes elongated like a penis. To make for clearer estimations I made extensive use of visual aid. I gave Somali women play dough to form what they considered to be the size and shape of an uncut clitoris, or they would make drawings. When presented with various pictures and models of uncut clitorises, women always expressed surprise at their small sizes (see also Johnsdotter 2002). [24] As Idil mumbled: "If it is that small, what's the point in cutting it?"

Secondly, the clitoris is associated with strong sexual drives and could thus lead its owners to promiscuity if not cut. [25] Some informants used expressions such as "battery," "engine," and "the seat of sexual drive" when describing it. Women often claimed that if the clitoris was left intact and the woman kissed or hugged a man, her

sexual desire would be beyond control. There was a frequent equation between lack of circumcision and wanton behavior, sexual promiscuity, and uncontrollable sexual lust. [26] One expression of this was a widespread belief that Norwegian women experience almost constant sexual craving. The view that a strong sexual urge leads to sexual promiscuity was also common among male informants. One expression of this was a male Somali doctor living in Norway who, though he claimed to be against infibulation, was skeptical to anti-FGM work as he saw it as promoting sexual promiscuity, which again would inevitably lead to abortions. The male gender of the clitoris is associated with several male characteristics, such as growth, sexual urge, initiative, aggression, and promiscuity, all of which were seen as repulsive and ridiculous in women.

In exile, circumcised women are confronted with completely different ideas of the clitoris. Though some of the ideas of the clitoris are parallel, their cultural and moral evaluations often conflict. Whereas the "male-like" qualities of the clitoris were frowned upon in Somali culture, they seem to be seen as positive qualities in the West (see also Bell 2005). Though Western conceptualizations of the clitoris have varied through history, there presently seems to be fairly widespread agreement that the clitoris constitutes the main seat of women's physical sexual pleasure and achievement of orgasm (Hite 1976; Langfeldt 1993). [27] This is related to the clitoris being the organ with the highest concentration of nerve endings. In fact it is the only human organ with no known function other than pleasure (see also Dopico, forthcoming).

In Europe, the clitoris and associated female pleasure have become increasingly associated with femininity itself and with women's liberation (see also Rogers forthcoming). A recent example of this can be found in the world famous *Vagina Monologues*, a play based on interviews with American women (Ensler 2000). One of the characters explains how, upon "discovering" her clitoris and the associated sexual pleasure, she came to see her clitoris not only as central to herself but also as constituting her core identity as a woman. The play further contrasts the European "discovery of the clitoris" with its removal in operations of genital cutting. Hence FGC is seen as in need of eradication in order to achieve female liberation. At a performance of the play in Norway, the actors expressed a support for this, and presented plans of supporting the cause both economically and through plans to perform the play in

Somalia. To put it simply: whereas in Europe a “real” woman is a woman with an intact clitoris that gives her pleasure and orgasms, a “real” Somali woman should have no clitoris or “clitoral behaviors” that is to say she should express no sign of desire for sexual activity or pleasure.

Since most types of FGC are described as partial or total removal of the clitoris, the operation is generally believed in the West to reduce or even destroy women’s capability for sexual pleasure. This Western belief produces very uncomfortable situations for many circumcised women. Some informants report being questioned by Norwegian women about their sexual lives in derogatory and prejudicial ways. Thus, in some ways, the missing clitorises have become the most visible part of Somali women’s veiled bodies for the Norwegian majority.

Somali women may consider the clitoris as an out-of-place male element, as claimed in the cultural models from their home countries. Or they may consider it a core symbol of femininity, as professed in the society where they live in exile. Although the women’s stories and perceptions varied significantly, they often described their circumcision as a loss - a loss of body parts, of sexual pleasure, of nature - and particularly as an experience of extreme pain (see Johansen 2002). Earlier, I described how Amber gradually came to feel that her infibulation was a meaningless frustration, pushing her towards a decision to have a defibulation performed, as she describes here:

> “I was defibulated a few months ago. After the operation I asked the doctor what it looked like. My circumcision had been very radical, he said. There was nothing left. No traces of clitoris or inner lips. I was so disappointed. I just cried and cried for hours. Only then did I realize that all this time, ever since I was circumcised, I had always had a dream that there would be something, at least a little bit left underneath. But there was nothing. I felt sad and worried. “

Amber, after moving into exile, had come to see her genital cutting as a loss of significant body parts, rather than as cultural perfection or purification. This perception, she said, was caused by increasing knowledge of bodily functions that she had gained

through her health education. She had also, like many women, come to see “natural genitals” as more correct – morally, emotionally, and aesthetically.

Many Somali women in Norway have requested genital surgery to restore their genitals to their natural shape. Even Nima, who did not want to be defibulated, said that she would have wanted it if it had been possible to make her “look natural.” The desire to be operated “back to normality” is mostly expressed as a matter of aesthetics. The women want to “look natural.” This was the reason given by Suad who, desiring to “look natural” for her new, non-Somali husband, had a defibulation in her early forties. Gynecologists also said that women who requested defibulation often said they wanted to be made to look natural. Personnel at a hospital offering special services to infibulated women reported that all of the fifteen women who had approached them during their first months of operation had requested “to be made to look normal.” They wanted to be completely opened, including revealing the clitoral area. Other reasons women gave for a desire for defibulation were to remove pain and to increase sexual sensibility. This increased demand for “naturalization” could be a response to the Norwegian focus on “nature.” However, similar images are used as arguments against the practice in Africa, such as the argument that it is wrong to alter God’s creation.

In the following section I will discuss perceptions of how my informants believed FGC was affecting sexual pleasure. Before doing so, I want to make it clear that I see sex as much more than biology, nerve endings, and clitorises; I believe that to focus too narrowly on biology would present a limited view of sexuality (see also Dopico, forthcoming). Love, gentleness, caressing, and physical and emotional sensitivity and closeness may be as highly evaluated as clitoral sensations. As Fardosa explained, “I never liked sex, the coitus part, that is only a mess; but I like to feel close to a man, to hold and kiss each other.” The tendency to forget these aspects of sexuality when discussing the sexual life of “the other” suggests another challenge to this research. Sexual pleasure is not only a question of open or closed bodies, virginity and pain; it is also embedded in the relationship in which the sexual activity is a part. This was often emphasized by my female informants, as in the view that love-marriages would be more sexually enjoyable than arranged marriages. Also significant for a woman’s sexual pleasure is of course the relationship of which it is a part and the man’s “abilities,” as

was mentioned in the introduction: “How can we enjoy anything with our two-minute men?.” These aspects will be discussed later in the article. First, however, I will investigate Somali perceptions on sexual pleasure and how these relate to FGC.

Perceptions of sexual pleasure

Literature on the sexual experiences of infibulated women varies from suggestions that more than 90% of infibulated women experience orgasm (Lightfoot-Klein 1989) to claims that more than 90% have no pleasure in sex (El-Deefrawi et al. 2001; Hassan 2001). In a review of literature on FGC, Obermeyer concludes that the varying reports are sufficient to challenge the assumptions that capacity for sexual enjoyment is dependent on an intact clitoris and that orgasm is the principal measure of “healthy sexuality” (Obermeyer 1999).

Although the definition of what constitutes “healthy sexuality” or “sexual satisfaction” may vary significantly between persons and across cultures, a frequent measure is the extent to which women experience desire, pleasure, and orgasm. It is also fairly widely agreed within biomedical and sexology sciences that the clitoris plays a central role in this for most women. Hence it is probable that the sexual effect of genital cutting varies with physical factors, particularly the amount and type of tissue removed. Based on the known biological processes and functioning of the clitoris, its removal could significantly affect sexual sensitivity in the area, and probably the ability to experience orgasm. However, as many infibulated women are found to have significant parts of their clitorises intact under the infibulation scar, if the clitoris is a major factor in sexual satisfaction infibulation may be less harmful than excision to sexual sensitivity. Doctors performing defibulation in Norway report that women sometimes experience of intense sensitivity in the area after defibulation, one whispering happily to the doctor that she had finally experienced orgasm, a gynecologist told me.

Because of the development chronology of the nerve system, the age at which the operation is done may also be significant for sexual sensitivity. This also relates to

sexuality as a learnt behavior, in which good experiences become embodied, and pleasure can be more easily accessible over time. This may be why research has found women to enjoy higher sexual pleasure and reach easier orgasm as they age, even though sexual lust and desire may reduce. Once, during a party, a former informant, the wife of Abdi, came up to me with a huge grin on her face, drawing me aside, and reminding me of our conversations on sexual pleasure during the early days of her marriage. “It is so much better now,” she said, giggling shyly. “You know, at that time I didn’t know anything. You have to learn to do these things, you need experience. Now it is very nice.” A part of this picture may bee that a clitoris that has been hidden under a thick seal for many years may be less sensitive to stimulation until ”getting some practice”(Talle 2003).

Significant new contributions to the scientific discourse on sexuality and FGC express doubts about the importance of the clitoris for sexual sensitivity and orgasm in genitally cut women (for example Ahmadu 2000 and forthcoming; Bell 2005; Dopico forthcoming, and others previously mentioned). Others also suggest that some women may feel they have a healthy and satisfactory sexual life without experiencing orgasm (e.g. Obermeyer 1999; Vance 1991). My “measure” of sexual satisfaction is based on perceptions and experiences as the informants presented them to me.

My female informants were divided almost half and half in the way they considered that their genital cutting had affected their sexual life. The slightly larger group complained of reduced sexual feelings resulting from their genital cutting. They expressed this as a feeling of loss that they regretted, a feeling that they missed something, as Amina put it; “You know, circumcision affects your sexual life. I feel less. I feel I miss something. When I talk to my Norwegian friends and they tell me how they feel, I see that there is something I am missing.” Many women expressed similar views. Edna, for example, when I first met her during her labor with her first child, complained that the main complication of her circumcision was sexual deprivation. Her focus on sexual loss in the process of her first delivery suggests that it was important to her. Zainab also expressed a sense of loss, both of body parts and of the sexual feelings associated with them: “The bad thing about infibulation is that they remove something from your body, your sexual feeling. There is something missing. Sometimes I joke with

my sister-in-law that we should go back home and look for ‘our things,’ the things they cut away from us. But, of course, there is no way you can replace what has been removed.” This sense of loss of a significant body part was frequently expressed. As the clitoris was regarded as the most sexually responsive organ in the female body, most women regretted its removal through circumcision.

There was, however, a growing knowledge that many infibulated women actually may retain at least parts of the clitoris beneath the infibulated seal. Women’s wish for ”total defibulation,” to be opened ”all the way up,” was often done to expose the clitoris, and hence, many hoped, to experience increased sexual pleasure. Many were disappointed when they found that the clitoris had been totally removed. Amina had experienced this, as she had felt an itching bump at the site of the clitoris, recalling: “I was opened in the hospital . . . but they did not open all the way up. The clitoris was hidden . . . so I went back to be operated again, and I told them to open me all the way up. I was so disappointed when they found that there was no clitoris there. The bump I had felt and that had been itching was just a clot of blood. I felt sad.”

Most of the informants attributed their reduced sexual feelings to the absence of the clitoris. Others, however, were not so sure of this. Recall Jamila, who experienced a new sexual enjoyment when, after defibulation, she could indulge in sexual intercourse without pain. At first she did not consider that her missing clitoris made a difference. But then she wondered, “Maybe I would have felt more if I had it. But I can't know. I was always like this.” Many shared this expression of a vague sensation that there may be something missing but that it is impossible to know since they had only experienced sex after circumcision.

Those who claimed sexual pleasure had not been reduced through circumcision often suggested that rather than being reduced, sexual pleasure was “just different.” Fatouma Ali, a Somali psychiatrist, claims that “Somali women don’t have less sexual feelings, but different,” pointing to an increased sensitivity in other erogenous zones (Heller 2003). This view was shared by many of my Somali informants. Although they considered the clitoris the most sexually sensitive part in uncut women, they were also concerned with the fact that the whole body could be sexual: “If you are in love and young, just the touch of the fingertips can make you shake all over.” Several described

their breasts, abdomens, thighs, and buttocks as their most sensitive parts. A Somali healthcare worker said that she had been approached by women who worried about their need for stimulation of other body parts to be sexually aroused, for example by the man suckling her breasts or touching her abdomen and buttocks. They were afraid that such practices could constitute a health risk. In a study of sexual sensitivity in circumcised and non-circumcised women in Nigeria, the main difference was that circumcised women considered their breasts to be their most sexually sensitive parts, whereas non-circumcised women considered it to be their clitorises (Okonofu et al. 2002). Some informants also suggested that infibulated women may need a longer time to be aroused and satisfied.

Because little is known about the functioning of the remaining clitoral tissue in excised women, and because some infibulated women may have various amounts of clitoris intact under the infibulated seal, it is difficult to know to what extent this feeling of loss of sexual sensitivity is directly related to the removal of tissue. Even less is known about the body's ability to compensate less feeling in one area (such as a cut clitoris) with increased sensitivity in another (such as nipples or abdomen), or to "repair" of clitoral nerves.

Another general challenge to understanding female sexuality is the widespread discrepancy between women's sexual function and cultural models. For example, there is a cross-culturally widespread ideal that women should orgasm through coitus alone, while research show that few women do. Rather, most women need more varied physical stimulation. This gap between expectations and experience seems to constitute a central cause of much of women's (and men's) sexual frustrations in many places, including both Norway and Somalia. Hence cultural models on the "shoulds'" and "should-nots'" of sexual acts can affect women's access to, and knowledge of, other routes to sexual pleasure. We may recall here how Shukri, who had experienced sexual excitement and pleasure during noncoital sexual contact, still feared she would not experience sexual pleasure during coitus.

The inculcation of sexual prudence since childhood can also affect a woman's ability both to show and to experience sexual pleasure. The Somali women I interviewed generally emphasized cultural models of sexual prudence, including a demand not to

show sexual pleasure or desire, which had been taught since childhood, for example by punishing a girl child for touching her genitals. Reactions they said were much less restrictive for boys and men.

As words are our key to information about sexual satisfaction, we need to look into how such feelings are talked about and what words and cultural models are available to make sense of one's personal experiences. Hence local terminology is a useful tool for gaining insight into local cultural models. Therefore, I asked women and men about sexual terminology. When asking women about Somali words for sexual pleasure (Norwegian "*lyst*," which may also indicate desire), the women's first term was usually *dareen*, which is used to signify any feeling, and thus has to be specified. Other terms with a more direct connotation to sexual desire were *galmo, wasmo* (coitus), and most directly *kacsi* (erection/aroused). These terms apparently were seen as synonymous, suggesting no clear distinctions between desire, pleasure, and activity.

Women always talked about desire, pleasure, and orgasm as slow and continuous processes and never mentioned any specific and time-limited or repeated sensations that could clearly mark orgasms. Nor did their terminology refer to orgasm as such. Only when I asked a linguistically interested man was I told of specific terms for orgasm itself: *shahwabax* and *biyabax*. Both words denote ejaculation in some way; shahwabax refers univocally to ejaculation of sperm and could thus only be used about male orgasm, whereas biyabax simply indicates ejaculation of fluid or water and could therefore also be used about women, he said. These terms for orgasm were never volunteered by women, but when presented to them seemed to be well known.

When women talked about their physical sexual reactions, they usually described vaginal humidity, "getting wet," whether or not related to "orgasm." Both women and men drew a parallel between female discharge of fluid (literally "water") and male ejaculation. Some women also expressed a view that both fluids were equally important for conception, as when Leyla expressed a concern that her lack of sexual pleasure could prevent conception, and hence make her barren. However, women usually described the discharge of vaginal fluids as a slow and continuous flow, and as a sign of arousal and excitement, rather than a time-limited ejaculation like that associated with male orgasm. Thus it is possible that their concept of orgasm was closer to sexological

concepts of sexual arousal and pleasure than orgasm as such. However, this may need further investigation.

These linguistic nuances suggest that there may be cross-cultural differences in how orgasm is understood, and hence both what can be expected in sexual life as well as how it will be termed. Research projects on orgasm do not always give sufficient information to clarify whether the informant and the researcher have the same understanding of the term and what sensation it refers to.[28] Hence it is difficult from words alone to estimate the extent to which women orgasm.

Another challenge in sexual research is the private character of the practice, and the strong moralities concerning sexual behavior. This may be why one also has to listen to "gossip" as social discourse on sexuality often takes indirect forms. One such form is to present private experiences as those of somebody else. This allows a person to test out or discuss the social acceptability of personal experiences, without being vulnerable to social sanctions. One example of this was Waris's story of "a friend" being asked by the doctor how she could have sex in such a minor opening (due to only partial defibulation). She laughed heartily, "But that's a totally different situation, being at the doctor's and being with your husband in bed. He should know that!" She later revealed that it was actually she personally who had experienced this. I had similar experiences with several other women. Often, though, the listeners understand that it is a personal experience and concern and relate to it as such; still, however, they are often "playing along" as if they did not know. That is, they do not hold her personally responsible for what she says.

Another frequent method of indirect speech is the use of poems and songs (see for example Abu-Lughod 1996). At every Somali wedding or party numerous member of the audience would approach the band to sing songs that are often understood as private confessions, though the songs where highly standardized and known to virtually all present, who sang along. Somalis expressed particular love for singers who were known to use their own private experiences in their songs. In traditional songs, sexual activities are at times directly referred to. One day, when Asha was humming a traditional song to herself, she suddenly burst into laughter at realizing that the words,

praising the taste of the sperm of her beloved one, were about oral sex. “How can they know if they didn’t taste?” she laughed heartily.

A frequent method of indirect speech about sexuality is the use of jokes and humor. Humor is a creative mode of communication that is simultaneously set aside from everyday modes of serious discourse, while building on them. Humor offers a unique opportunity to play with social norms and discuss muted or taboo issues, including intimate personal experiences. But, importantly, without being held personally responsible, “it is just a joke” (Johansen 1992; Lear 1997). The frequent use of humor in sexual discourse may also be a way to reduce the tension and shyness involved in discussing such intimate matters.

My first encounter with social discourse on sexuality among Somali women was actually through a game played during a holiday camp arranged for Somali mothers and their children. Many also brought along younger single women to assist them in the daily chores. After our children were tucked into bed, it was time for the adults to enjoy themselves, and Hawa introduced the game, Truth or Lie, which she considered to be of Norwegian origin. She twirled a bottle. It stopped, pointing at Asha, who was in her mid-thirties and pregnant with her fourth child. She was challenged: Would she answer any question by telling the truth or a lie? The social pressure to tell the truth was compelling, and Asha gave in. Hawa fired off the question: “When did you have your last fuck?” Roars of laughter rang out from the women while Asha proudly announced that it was only two days ago, the evening prior to our departure. The question set the scene, and for the several hours we played the game of intimate sexual interrogation. Idil, who had not seen her husband for a year, was challenged on sexual desires and actions in his absence and laughingly offered fruits and vegetables, and even the baby bottle used for twirling, as remedies. Laughing allusions to this incident colored our conversations for months thereafter. Through the game and the jokes, sensitive themes, such as women’s sexual desire and pleasure, masturbation, lesbian sex, premarital and extramarital sexual experiences, marital relations, and being sexually desirable were raised and discussed.

In the game, women were supposed to present “the truth” about their sex lives, and I had the impression that the answers revealed many private experiences and

concerns, although of course a great deal was probably kept secret. I particularly sensed a difference in the self-presentation of the unmarried women. They presented a strong image of sexual prudence, in spite of taking pride in having many suitors and boyfriends. The adult married women, on the other hand, whose stories brimmed over with rule-breaking behavior, also provoked and teased the young girls: “You didn’t even kiss him? What sort of boyfriend was that? When I was your age …”

It is my impression that the games and jokes present something new in exile, a more positive evaluation and expectation of female sexual desire and pleasure. It also seems that exile has created a change in the acceptable ways of talking and joking about female sexuality. This relates both to the discrepancy between the jokes, games, and laughter, which present a positive and playful discourse of sexuality in my Norwegian research, and sexual descriptions in terms of necessary evil, pain, and fertility, which are frequent in many other studies from societies practicing infibulation (Abdalla 1982; Boddy 1989; Gruenbaum 2001), as well as in my experiences in Somalia.

Sexual experience is basically private in character, however, and it can diverge significantly from public expressions. Hence one cannot make a direct connection from such public discourses to private experiences. For example, Asha, who often joked of sexual matters and frequently showed me with pride gifts from her husband that she related to his sexual interest in her, also said that she generally tried to avoid sex as much as possible, as it was painful to her and gave her no pleasure.

Male perceptions of female sexuality

Somali women often claim that FGC is performed to satisfy men. Men are expected to demand that a prospective wife has been circumcised and this was the most frequently expressed worry about uncircumcised daughters – that they would not get married. However, this was never related to male sexual pleasure, as has been suggested elsewhere (Gruenbaum 1996 and 2001). With one exception, none of my Somali

informants believed that infibulation increased male sexual pleasure. On the contrary, they considered that the pain and delay associated with defibulation was also a burden for the men (see also Almroth et al. 2001; Dire and Lindmark 1992; Rye 2002). Men's demands for a circumcised bride, then, had nothing to do with male sexual pleasure, but a lot to do with the desire for a *moral* wife.

The same view was found among my male informants. Men's main concern regarding FGC was about sexual complications, particularly the painful and painstaking procedure of defibulation, and their perception that it reduced women's "sexual responsiveness." Many men had experienced painful defibulations; some had also experienced painful, sore penises. Their main concern, however, was the women's suffering during the process. As Abdi said: "How can I enjoy sex when it causes pain to my wife?" Abdi, a man in his late fifties, at first regarded the pain in defibulation as the only negative consequence of infibulation, having experienced it in his first marriage. He insisted that FGC had no further effect on women's sexuality and that infibulated women were warm and passionate, enjoying sexual intercourse as much as any other women. When asked if there was no difference in his encounters with his former wife, a Norwegian, his response changed: "Oh, you mean that. That's a completely different thing. Of course, if you think like that, then it is different. Very, very different." Abdi had recently married his second Somali wife, and he introduced me to her, as well as discussing our conversations with her. They seemed to be very much in love and showed great affection and care for each other. Once, after his wife had told me that she did not consider her sexual feelings to be affected by her circumcision, Abdi commented in a voice of remorse, "You know, she doesn't know the difference. How can she know?"

A similar concern was expressed by Yonis, a man in his late twenties. He suggested that, as men often had more sexual experience, they would "compare" women with different genital states. Such experiences could, of course, not be discussed with their wives and therefore contributed, he said, to the silence on the topic in conversations between men and women: "You know there is a difference. But you can't say that to your wife, that 'other women I have been with have more feelings.' You cannot say such a thing in a marriage. So we don't talk about it. But we are both, me and my wife, against circumcision, especially me."

Like Yonis, most men said they had never discussed their wives' circumcision with them, neither in relation to pain nor sexuality. This confirms frequent references that men and women seldom share thoughts on this topic (Abdalla 1982; Almroth 2001a ; Johnsdotter 2002; Rye 2002). Hence both men's and women's knowledge of the other sex seemed to rely mainly on information from same-sex conversations.

Male informants who thought that FGC reduced women's sexual pleasure usually associated it with the absent clitoris, as suggested by Zackaria[29]: "A woman with an antenna (i.e. clitoris) is much more responsive and active in bed. It is a big difference. A very big difference. So most men prefer uncircumcised women for sex. But, for marriage they would go for one who is circumcised. It is safer that way." We also see here that Zackaria clearly separated pleasure from morals and thus sexually exciting women from prospective wives, a dichotomization that is also found in the Christian whore/Madonna complex. The uncircumcised women in his case came from other ethnic groups, and this was also the framework in which the distinction between circumcised and non-circumcised women was often seen by the Somali. The distinction confuses the FGC state with ethnicity, and there is a general tendency to see the "other" women as more alluring, though immoral, than those in one's own community (see also Ahmadu, forthcoming).

In many ways, women's sexual desires and pleasures were presented not only as positive and exciting, but also as dangerous and animalistic (see also Abusharaf 2000; Hernlund 2003; Johnson 2000 and forthcoming; Thorbjørnsrud 1999). While men in Somalia sometimes used negative terminology about circumcised women, likening them to "mattresses," "cars without a battery," or "without an engine," uncircumcised women were just as often derogatively described as "running around and chasing men" or biting and screaming during intercourse, ruining their reputations and morals, and harming and scaring their husbands. Though these comparisons were often made in a jocular vein, they suggest some of the ambivalence and fear about women's sexuality.

The bases on which men evaluated their female partners' sexual pleasure may vary, but the most usual "measurement" seemed to be the extent to which the women moved during intercourse. There seemed to be a general belief, a cultural model, adhered to by both men and women that female sexual pleasure was directly related to

physical movements in bed. That is, the more pleasure the more movement, and vice versa. One example of this was Shukri's fear that she would experience no sexual pleasure due to her circumcision; hence she would not move during intercourse, and her husband would be dissatisfied with her. In Somalia uncircumcised women (most probably from other ethnic groups) were often described as "dancing" in bed. Sounds, biting, and violent behavior were also believed to occur, behaviors that seemed largely to be considered negative, a sign of savagery.

Many men and women, including Zackaria, also suggested that reduced responsiveness could be as much cultural as physical, reflecting the dictates of proper female conduct, trying to avoid showing sexual desire or excitement for fear of being regarded as "oversexed." The Western equivalent would be women's tendency to fake orgasm. Thus, whereby Somali moral culture would encourage hiding the sexual pleasure that women actually feel, European present-day sexual culture tends towards expressing more pleasure than is actually felt in order to satisfy cultural standards of femininity.

How the women actually felt, including to what extent their feelings or expressions of feelings were subdued because of cultural notions of prudence or physical changes can obviously not be known from the men's statements. However, male perceptions of "good" or "desired" and "bad" or "feared" sexual behavior in their different categorizations of women throw some light on male concern over female sexuality. And this concern suggests an increased emphasis on women's sexual pleasure and a concern that this may be hampered by female genital cutting.

Marriage in exile – changing relations, changing sensations

One reason why the concerns over sexuality seem to change in exile may be found in the changing relationships of which sexuality is a part. Somali marriages seem to go through changes similar to those described in Giddens' analysis of *the transformation of intimacy* that has accompanied industrialization and modernization in the West (Giddens 1992). Giddens links this to greater equality between the sexes and the related

assumption that sex should be a pleasurable act for both parties in order to function as a key to intimacy and as the glue of marriage. Similar changes were pointed out by many informants of both sexes. They were particularly attributed to changes in labor division within the family, from a clear gender-based division of labor in Somalia to increased interdependence and mixed gender contributions in Norway. These changes were said to affect marriages both positively and negatively, depending on how the couple coped with them.

Informants described the Somali society at home as based on a gender division of labor: women were responsible for the house and childcare and, in some cases, petty trading. Men were said to work and contribute economically to the household, and also travel a lot. Socially, the men spent more time with male relatives, friends, and business colleagues, and women with other women. All things related to female sexuality and reproduction, such as FGC and childbirth, were entirely women's business.

In Norway, on the other hand, women generally expected men to involve themselves more in the women's world, including childcare, hospital attendances, and delivery, and some housework. One reason for this was that women felt the stress of work more than at home. Here, women participated to some extent in studies and paid work outside the home, including new burdens due to the unfamiliar context of exile. Simultaneously they had smaller and less accessible networks of female relatives and friends to help them out. Furthermore, the high unemployment rate of Somali men has led the majority of families to rely on social welfare. Thus, many of the women felt that gender-divided labor was a greater burden in exile, complaining that Somali men "do nothing, except sit in cafés, chew *qhat*[30] and dream about the good old days at home."

These new demands on the couple often contributed to marital conflicts. Because many women felt the men's contribution to the family was minor, men's entire role was questioned. As Fardosa suggested, "I ask myself sometimes what the point of having a man is. It is just another person to cook and clean for. Somebody who bosses you around, but gives you nothing in return." There was a perception among Somalis that divorces have increased in exile.[31] Although divorces have historically been widespread and fairly socially accepted in the Somali society,[32] the causes of divorce, and particularly gender roles, seem to have changed significantly in exile (El-Solh 1993;

Griffiths 1997). Whereas divorces in Somalia were generally understood to be initiated by men and feared by women, partly due to the practice of patrilineal child custody and women's economic dependence on men, the situation in Norway was experienced as turned upside down. Now it is women who mostly initiate and "benefit" from divorces, while men's usual description of a divorce; "She has kicked him out of the house," clearly expresses a male sense of increased vulnerability vis-à-vis women.

Such drastic changes probably also affect the sexual and emotional relationship of the couple, in ways similar to those described by Giddens. This was suggested by Halima, from whom many Somali sought advice. Since men's contributions to the household were very low, sexuality had become a more important part of married life in exile, she claimed: "If the man contributes nothing, not money and not help to the wife in the house, then at least if he has sex with her, if he uses her body once in a while, she can forget about those other things." These words concluded a story of her advice to two women who had contemplated divorce due to sexual neglect from their husbands. In Halima's account, the women's frustrations were related to not being loved and desired, fuelled by a fear of the man having extramarital relations. Halima, however, understood the men's negligence to be caused by psychological frustrations in exile.

For some women, women's sexual pleasure was not a theme in marriage. Fardosa, for example, considered sex just another burden in marriage and attributed her lack of pleasure to her infibulation. However, she did not see this as unequivocally negative. She suggested instead that it strengthened women's position in marriage: "In some ways FGC is good for the woman, because you become more independent of the man. You don't miss him as much, and you don't degrade yourself by clinging to him and accepting anything" (see also Hernlund 2003; Johnson, forthcoming).

Thus, it seemed that men experienced an increased sense of vulnerability to divorce, and this, combined with experiences of sexual encounters with uncircumcised women, may be a reason why men seemed more concerned about the influence of FGC on women's sexual pleasure. As a result of other changes in social relations, employment, and the need for female services such as cooking and cleaning, it seemed that men also experienced an increased need for women.

Concluding remarks – antennas and barriers

Encountering a new society that presents cultural models that challenge those of their home culture, Somali women and men have been stimulated to reflect more upon, and to voice their concerns. Their exile situation includes an encounter with contrasting models of gender, genitals, and sexuality, as well as an intense debate over whether FGC should continue. Women's concerns with sexual experiences in connection with FGC also include worries about the future prospects of their cut and uncut daughters.

It has been my intention to present a broad picture of the relationship between sexuality and FGC, allowing space for personal experiences in terms of both physical sensations and intimate relations. Sex is neither fully culturally nor fully physiologically determined; rather it is experienced, explored, and lived in a complex interconnection with body, culture, and personal experiences and relations.

A major difference between home and exile is that "at home" women's sexual drives and pleasures are generally talked about as unwanted or irrelevant aspects of their lives or marriages. Similar attitudes have been reported by Aud Talle, especially from rural areas. In clear contrast is the different way women reacted when men publicly claimed that FGC reduces female sexual feelings. Whereas women in Somali areas seemed to accept such statements, they reacted with fury in Norway (see the opening paragraph of this article).This positive evaluation of women's sexual sensations in exile also seems to have created a sense of vulnerability and sorrow in women. The widespread sense of loss was a sensitive matter, as women did not always know whether they missed some sensations or what they could be like.[33]

In addition, many Somali women felt great discomfort with the Norwegian emphasis on female sexual pleasure and the belief that circumcised women are deprived of such pleasure. Many experienced such allusions as humiliating. This may be one reason why women often presented different views on sexuality and FGC, depending upon whether they were alone in an interview or in a public social context.

It also seems that moving into exile transfers the relative weight of sexuality from social control (including checking the closed vagina in children and on the wedding

night) to the increased importance of intimacy and sexual pleasure in marriage, coupled with a privatization of the vagina (no longer open to public inspection of an intact infibulation). There is also a change in marital relations, including a transfer of the fear of divorce from women to men. This seems to inspire an increase in male concern with female pleasure and intimacy, and an increase in women's expectations of sexual pleasure as a part of marriage.

Furthermore, migration seems to have given voice to some formerly doxic and tacit experiences and knowledge. Research in an exile community can help cast new light on cultural processes that were less accessible in the home context, because in exile they are voiced and debated to a higher extent. These debates may also give insight into some of the discrepancies between personal experiences and cultural models, making them more visible for research. The main concern for Somali men and women is, however, the opportunity this gave to negotiate change, to move towards the abolition of a practice they felt to be difficult and painful.

There is a need for further analysis of FGC and infibulation in a broader framework of cross-cultural models of femininity. Forms of genital manipulation and cultural focus on women's genitals are in no way exclusive to societies practicing FGC. It seems to be a widespread idea that the female body is in need of physical alteration in order to meet local cultural standards. I think a key to increased understanding can be found in Solheim's analysis of the significance of a woman's body as a cultural core symbol for social borders in many societies (Solheim 1998). She sees the female body as the ultimate symbol, both in the "function" of our own bodies as the means through which we understand the world (see also Czordas 1994; Shore 1996), and how this is related to the symbolic construction of the body. Solheim goes beyond Douglas's analysis of the body as a model of society, suggesting that it is primarily *the female body* that serves this symbolic function. Due to the "openness" of a woman's body, in which her "inside overflows its shores – as milk, children, blood," how the woman's body in the sexual act is invaded from outside, and how women "surround men" and "take them in" (1998, 74), the woman's body and its borders, particularly its sexual border, play a core symbolic function in society. Though her analysis focuses on Norwegian and modern Western culture, it draws parallels between all the Judeo/Christian/Muslim monotheistic

cultures. We are all, she suggests, deeply concerned with maintaining woman's borders and closing her openings, whether in anorexia and extreme housecleaning in Norway and the Western sexualization of women's bodies, including genital cosmetic surgery, or in infibulation in Somalia. Thus, to fully understand FGC we may have to deepen our understanding beyond the particularities of each culture. The failure to do so may be one reason why so many projects to stop FGC fail. They may alter the forms or conditions of the practice, but they do not challenge the very root of FGC: the worry over the openness of the female body, and hence the vulnerability of social structure, and hence society itself.

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Notes

[1] Similar challenges are experienced by many researchers working within the so called multi-culture field, and especially so in relation to gender issues.

[2] This concerned my study of female initiation rituals among a group of Makonde immigrants in Tanzania.

[3] To make my points clear, this presentation is a simplification of a much more nuanced debate, which is better presented elsewhere (see for example Gruenbaum 2001; Shell-Duncan and Hernlund 2000).

[4] Several French activists have adopted the term "sexual mutilation" to emphasis the fact that most forms of FGC mainly or only cut organs significant for women's sexual pleasure. Hence they see sexual control of women as an emic key factor of FGC.

[5] Descriptions of the clitoris are often unclear, confusing the clitoral gland, the prepuce, and the shaft. I generally employ the term "clitoris" to describe the external part of the clitoris (the gland and the prepuce), because this was the way the term was used by all my informants, both Somali and Norwegian.

[6] Boddy relates the emphasis on fertility partly to women's preference to focus on their main goal, which is to have children, thereby producing a new patrilineal sub-segment (which is also significant in achieving self-esteem and social and economical security and status), rather than on the often unpleasant duty of sex that was associated with pain and humiliation.

7 For an interesting analysis of the dual view of African women as both "exotic" and oppressed, see Fadel et al. 2000. This theme is also frequently elaborated on by Queendom, a "black women's' theater group" in Norway,.

8 One example is the focus on women in all-covering black hijab in a TV-program about FGC. The presentation is striking, as this dress is very rare in Norway and many infibulated girls wander the streets in jeans and tight T-shirts.

9 Their worry was expressed both as fear of moral degeneration in exile, abuse of social assistance, and concern for the single mothers. Statistical evidence, however,

documents relatively little difference in the divorce rates in Norway and Somalia (SSB; Lewis 1962). See also note 36.

10 An Act specifically prohibiting genital mutilation was passed in 1995. It also prohibits FGM carried out during trips abroad as well as reinfibulation after delivery.

[11] For a more accurate description and analysis of the program, see theses by journalism students Gylseth 2001 and Figenshou 2000. Similar programs have since been made in Sweden (see Johnsdotter 2002 and forthcoming).

12 The social security system gives many women economic incentives to divorce their husbands and is often partially blamed by Somali men for the high divorce rate. Generally, the social security system makes it economically profitable to get divorced if the husband is unemployed or underemployed and/or the family has three or more children. Divorce gives the women more financial control. As a divorcee the woman receives social support money as well as money for childcare. Social support to married couples is generally paid to the husbands.

13 Some examples: One single mother maintained her social esteem by referring to a husband abroad, while moving between relationships in Norway. One informant changed her identity and applied for asylum in another European country to get away from her abusive and controlling husband. One informant presented herself as a widow in the Norwegian public system, as her divorced husband had eventually died. At the same time, she was officially married to another immigrant, and at the same time successively "married" to two Somali husbands during our years of contact.

[14] It would take too long to explore here the reasons why some women claimed to be more severely circumcised when talking to Norwegians than to people in their own community, but they are probably related to the political discourse in which power, gender, and minority/majority issues and "race" are central elements.

[15] This stigmatization of "open unmarried women" has been used as an argument in applications for asylum in Norway.

16 Sixteen years of age is the age limit for operations without parents' consent. The most frequent reasons young girls and women gave for demanding defibulation was to ease the flow of menstruation and urine, to look "natural," and to engage in coitus.

[17] A woman's moral reputation could also be endangered by the behavior of other members of the family, in spite of her own moral conduct. For example, there was a heated debate on the Somali internet pages on whether it was safe to marry a woman whose sister had married a non-Somali or had had premarital sex.

18 Interethnic marriages where one partner is Somali are much rarer than among other African nationals in Norway (SSB).

[19] Some women described how they were assigned a "ritual specialist" or a "bride's mate" – *kowiso* – upon first marriage, who accompanied her through the first week of marriage, the defibulation procedure, and first sexual encounters with her husband. The kowiso was said to give advice on how to reduce pain, treat the wound, and other sexual questions, as well as assisting the bride in practical chores. The kowiso comes from the same clan as the circumcisers – the *midgaan* – who may be called to assist with the defibulation.

20 When suffering is seen as glorified it may ease the burden. Melhuus describes how Catholic women in Latin America identify with the Virgin Mary in their suffering, thus making it meaningful and glorified (Melhus in Solheim 1998).

21 Such physical changes to the female body are known all over the world, Chinese foot binding and European corsets being the best known. In recent years breast implants and vaginal surgery in the West also suggest a strong emphasis on the necessity for a cultural "carving" of women's bodies. For a wonderful theorizing on this, see Solheim 1998.

22 Male genital cutting is sometimes interpreted along similar lines, and research suggests that all societies practicing FGC also practice circumcision of men. But the opposite is not always the case. Emically, most societies see the two as complementary (see Rye 2002).

[23] A poem about the clitoris refers to it as a masculine, free-willed body. The author, a Somali male teacher working against the practice we encountered during our study tour to Somalia, said the masculine associations were added "to show it respect."

[24] We encountered similar reactions among circumcisers in Somalia, and heated internal discussions on the need to "reduce" the clitoris to prevent excessive growth.

25 There are some complicating elements, however. Whereas sexual drive is believed to reside in the clitoris, “sunna” circumcision which often cut more of the clitoris than what is done through infibulation, is not believed to affect sexual drives or pleasure in any significant way.

[26] Somali women generally described young people, both boys and girls, as having strong sexual desires and a strong curiosity that would overcome any moral teaching. Libido among women was believed to decrease through the years, and several informants said that after their fertile age, women were not supposed to be interested in or engaged in sex. This seems to contrast strongly with Western research suggesting that although a woman’s sexual desire diminishes with age, enjoyment and degree of satisfaction increases. Such studies were generally met with disbelief among Somali women.

27 A cultural model of vaginal orgasm as somehow “better,” morally or qualitatively, than clitoral orgasm, is known from many of the societies practicing FGC, as well as from Freud’s writings (Abusharaf 2000; Karim and Ammar 1965).

[28] Terms of reference to describe orgasm in general sexual studies are equally vague. Descriptions such as feelings of “dizziness,” “pleasure,” “sweetness,” “warmth” may describe both sexual pleasure in general as well as the orgasm itself.

[29] Zackaria was from Ethiopia, but I include this because it expresses an evaluation similar to that made by many Somali men.

30 When chewed, the leaves of the *qhat* (or khat) plant act as a narcotic stimulant. Although illegal in Norway, it is quite common, and most Somali cafés have a qhat room.

[31] About 30% of Somali mothers are officially registered as single, that is divorced, widowed, or never married (SSB). The “real” number of single mothers may be smaller because of the various marital systems mentioned earlier in the article. That is, many mothers who were officially registered as single, nonetheless defined themselves as married, as they were single according to Norwegian regulations, but married according to Muslim tradition. Remarriage was frequent; hence many former divorcees were now married.

32 On divorces in “traditional Somalia,” especially the northern regions, see Lewis (Lewis 1962); on southern regions see Helander (1988). The sense of increased divorce

and family instability was also frequently expressed in Somali areas (see also “Impact of the War on the Family,” a video film made by Academy for peace and Development, Somaliland (www.apd-somaliland.org).

[33] There are some major methodological challenges in describing change when only doing in-depth fieldwork in one of the contexts. Hence comparisons with “before” or “home” are made partly through informants’ own stories. Thus there is a risk of comparing stories colored by romantic nostalgia about home and childhood with the difficult and homeless experiences of exile. Partly comparison is based on my own fieldtrip. As this lasted less than a month, with a maximum of ten days spent in each place, the information necessarily was less in-depth.

Paper III

R. Elise B. Johansen 2006

"Care for infibulated women giving birth in Norway- An anthropological analysis of health workers management of a medically and culturally unfamiliar issue"

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R. Elise B. Johansen
Institute of General and Community Health
University of Oslo, Norway

Care for Infibulated Women Giving Birth in Norway:

An Anthropological Analysis of Health Workers' Management of a Medically and Culturally Unfamiliar Issue

The focus of this article is on Norwegian health care workers' experience and management of birth care of women who have undergone infibulation. Because infibulation is the most extensive form of female genital cutting, infibulated women experience a higher risk of birth complications, and health workers generally experience delivery care for this group as challenging. Infibulated women, who come from recently arrived immigrant groups, are a challenge to the predominant Norwegian birth philosophy of "natural childbirth" and the positive evaluation of everything considered natural. The challenges relate to a mixture of technical know-how and a complex set of interpretations of central cultural elements of gender, nature, health, and gender equity. The findings suggest that a combination of taboo, silence, limited knowledge, and emotional difficulty along with a wish to be culture sensitive may at times prove counterproductive to giving the best help. Health care workers often seem to impose "imagined" cultural values on infibulated women, rather than clarifying them through personal communication.

Keywords: [female genital cutting, infibulation, birth care, Somali, exile community]

This article examines Norwegian health workers' care for infibulated Somali women in childbirth. An overall objective is to investigate why the efforts of highly qualified Norwegian health workers do not always produce optimal results although they are generally dedicated to their work and try to be culture sensitive toward Somali women. My study shows that their emotional challenges in dealing with female genital cutting (FGC) tend to lead to silence and an overinterpretation of culture, which affects care procedures in a negative way.

Norwegian health workers expressed concern about birth care for Somali women with regard to their almost universal practice of infibulation, the most extensive form of FGC. In infibulation, most of the vulva is covered by scarred tissue, with just a tiny opening left for the passage of urine and menstrual blood.[1] Thus, infibulation

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presents the health care provider with such profoundly altered genitals that many of the customary procedures for delivery care cannot be done routinely. Many health workers described these deliveries as challenging—technically, emotionally, and ethically. At the same time, however, most health workers also described birth care for Somali women as a "simple procedure of cutting the seal of infibulations." Nor did they consider infibulation a risk factor, so they did not expect higher rates of birth complications among Somali women than among ethnic Norwegians.

To understand this apparently contradictory perception of Somali deliveries as being both simple and difficult, two interdependent aspects seem central. First, many birth care practices pertaining to the Norwegian ideal of "natural childbirth" appear less adequate for infibulated women. Second, health workers tend to see infibulation, or "total circumcision" *(totalomskjæring)* as they usually call it, as a symbol of oppression and cultural determination. Thus, although the infibulation is often described in rather technical terms as "just a seal of skin" that has to be cut, it is also highly emotionally evocative and seems to give rise to "culturalization," that is, an overemphasis of culture and "othering" of Somali women.

The tendency of culturalization can be linked to the Norwegian health care workers' efforts to be culture sensitive. Out of respect for what they considered to be a taboo practice, the health workers dealt with FGC in silence, rarely discussing it with the women or documenting it in their case sheets. However, this silence also reduced health workers' access to knowledge of each woman's experiences and preferences. Their efforts to be culture sensitive also seem to include a tendency toward attributing cultural traits to Somali women, including traits the Somali women themselves did not share. Furthermore, although health workers did not define FGC as a risk factor, studies have shown that FGC in general and infibulation in particular markedly increase the birth risk (Banks et al. in press). Research I conducted with colleagues revealed that this is also the case in Norway (Vangen et al. 2002). This study also revealed that many Somali women fear stigmatization and health workers' lack of knowledge about how to deal with infibulation.

These findings suggest that a key to improving health care for Somali women would be to increase our understanding of the perceptions and experiences among health workers that inhibit their caregiving to Somali women. This article, then, focuses on the perceptions and experiences of health workers. Data concerning the views and experiences of Somali women are included but are used as a background against which to analyze the actions of the health workers, rather than being the main unit of analysis (see Vangen et al. 2004).

Field and Method

The arrival of a large number of Somali refugees after the Somali civil war in 1991 brought attention to FGC in Norway, in the media, politics, and health care facilities. Between 1990 and 2002, around 12,000 people of Somali origin settled in Norway. Between 1986 and 1998, 1,733 babies were born to Somali women in Norwegian hospitals (Vangen et al. 2002). The first case that highlighted FGC occurred in 1993, when the media accused the municipal hospital in Bærum (near Oslo) of performing FGC, based on rumors that it had reinfibulated Somali women after delivery. Although the hospital staff refuted this, the incident and subsequent debate were

probably significant reasons why the law passed against female genital mutilation (FGM) in 1995 contains a clause forbidding "reconstruction of genital mutilation."[2]

This article is part of a larger study on FGC in Norway. The part presented here is based on data gathered in the health sector, focusing on the experiences and practices of health workers. Another part of the study focuses on the experiences and perspectives of Somali women and men (see Johansen 2002, 2006, in press; Vangen et al. 2004). Information from this last part of the study is not the major focus here but is used as a background against which to better analyze the perceptions of the health workers.[3] The anonymity of the informants has been secured by changing names and biographical data.

In the health sector, I held interviews with 40 health workers: 25 midwives, 12 medical doctors (nine gynecologists and three general practitioners), and three nurses. Of these, I interviewed 36 in 2000 and four in 2002. All but five were of Scandinavian origin, four being from societies practicing FGC. I recruited informants from three hospitals and three antenatal clinics with a high proportion of immigrant patients. Most of the health workers volunteered to be interviewed because of their special interest or experience, so they were probably more knowledgeable about FGC than the average Norwegian health worker.

About one-third of these interviews were general in-depth interviews, concentrating on the health workers' perceptions and experiences of circumcised women in antenatal care and delivery. The remaining two-thirds were mainly case interviews concerning specific deliveries and conducted immediately after delivery. This was done to get "fresh impressions," as memory and emotions fade over time. Case interviews were carried out to compensate for the limited access to participant-observation during actual deliveries.

I did a few days of participant-observation in a perinatal clinic and in a maternity ward. In the perinatal clinic, I participated in classes for pregnant women, to learn about pregnancy and delivery. In the maternity ward, I looked at the work of the midwives and participated in deliveries of women of various origins (African, Asian, and European). In addition, I studied medical records of 20 Somalis, covering 32 deliveries.[4] I also made a quantitative measure of birth outcome in collaboration with gynecologist Siri Vangen (Vangen et al. 2002).

I carried out most of the data collection and analysis between 1997 and 2001. However, this analysis has also been deepened through my continuous work on the issue in the ensuing years in a national project on FGC, which included more than 40 Somali women's discussion groups and a four-week study tour to Somali areas.[5] I also draw on experiences from numerous seminars, workshops, and guidance and counseling work from 1996 until today.

Shukri's Delivery

I was first introduced to Shukri during her early stages of labor. At that point, Shukri was cheerful, talking, and even joking in between her contractions. Her excellent mastery of Norwegian contributed to an easy flow of conversation. She was a bit worried about her (unborn) baby, as it had been less active recently. She had contacted the hospital to check on it, but no extra tests had been run. Thus, she was still worried and asked if they could examine the baby now. Her midwife,

Susan, did not respond directly to her request but tried to divert her attention from the worry by turning to other subjects.

At this first visit, the midwife asked Shukri whether she had been circumcised, which Shukri confirmed. Apparently there was no need to dwell further on the subject. Shukri had already given birth twice, and, although she had been infibulated in her childhood, she had long since been defibulated. The clitoris and the labia minora were absent, but there was no seal covering the vagina and thus no physical hindrance that would obstruct a vaginal delivery.

When I came back to Shukri during her second stage of labor, her behavior had changed dramatically. Her bulging eyes expressed fear and pain. She cried for help, waving her arms around, grabbing anyone nearby. She talked incessantly, saying things like, "I am not clever. I am not a good girl. I can't do this." The midwife seemed irritated at her complaints, telling her to stop talking like that, that she was clever, that she would manage. As the crying went on, the midwife placed a wet cloth in Shukri's mouth. Every time Shukri's screams intensified, she was told to bite it. Midwife Susan tried to calm her down by talking to her: "But you don't have a contraction now. There is no pain now. Try to relax. Look at me. Concentrate." Shukri's husband also looked scared and worried, his eyes searching the midwife for clues to what was happening.

Shukri's pain behavior was intensive and violent: her arms waving, her legs shaking. She could not concentrate her powers to push out the baby. She seemed to be in a panic and totally overwhelmed by fear and pain. The midwife asked Shukri whether her former deliveries had also been "like this," but Shukri did not respond. To guide Shukri's forces, the midwife instructed her husband and me to hold her legs in a particular position. The midwife held her hands in the vulva during most of the expulsion period to monitor the child's progress through the birth channel. When the child's head was crowning, Shukri's screams increased. She cried for pain relief: "It pains so much down there, can't you give me something? Just give me an injection!" The midwife did not really answer but tried to calm her down by telling her that the child would soon be out. The husband also pleaded with the midwife to help his wife. Shukri cried again: "Can't you just get the child out? Please help me!" Finally the child was out.

But it was not over yet. There was no peaceful mother coming back to her senses and looking with wonder at the baby on her belly, as I had witnessed in many other deliveries. Shukri was still out of reach, screaming, begging for pain relief, begging for the baby to be removed from her belly, shaking and shivering. She struggled to remove the hands of the midwife who was stitching her vaginal tears. Even after several injections with pain reliever, Shukri's suffering did not seem to diminish. Not until the stitching was completed some 20 minutes later was Shukri able to relax, and eventually she came back to her senses. As I observed her delivery, I questioned the cause of her screams and visible terror. Had her behavior anything to do with her infibulation? Could something have been done to reduce Shukri's apparent terror and pain?

When I later discussed Shukri's delivery with her midwife, Susan initially evaluated this as a normal birth. She said the expressions of fear and pain, during both delivery and the sewing period, had been "normal." However, Susan continued, "In the case of a Norwegian woman, the expressions would probably not have been so

intensive." She later discussed this and other cases with a colleague and subsequently concluded that

> Somali women are usually very expressive in labor. They show pain much more. I don't know if they have a lower tolerance for pain, or if they want to demonstrate to their husbands how much they are suffering, or if they have any culture on that. . . . You know they only have painful experiences with that area. It is all pain to them, the operation, sex, and everything.

After discussing the delivery with a colleague in the break room, they both agreed that "Somali deliveries are always more chaotic."

Several aspects of Shukri's delivery are relevant to the present analysis. A typical aspect is the way her circumcision was barely mentioned. I also had the impression that the question was asked mainly to confirm that this was a case for my study, rather than for the sake of the delivery itself. Nor were any special precautions taken because of Shukri's previous infibulation; she was not offered pain relief, the possible need for episiotomies was not discussed, and she was not offered closer attention and support. At no stage of her labor or delivery did the midwife touch Shukri's body, apart from her genitals. I also saw how the midwife struggled to make sense of Shukri's apparent terror and wondered whether it should be understood as personal traumatization, cultural ideals, or relational challenges. As I will discuss below, the interpretation of the cause and meaning of the pain may affect the care given.

The midwife never explained why she put the wet cloth in Shukri's mouth, but it was probably because she believed the cloth could help Shukri focus her forces on pressing out the baby rather than on screaming. However, knowing that a similar practice is frequently used during infibulation itself, one could expect such a practice in delivery to function as a reminder of that and thus increase the risks of flashback and painful memories (Abdalla 1982:108).

Finally, Shukri continued to express extreme fear and pain during the stitching of her vaginal tears, and extensive medication did not seem to bring any relief. Both Somali women and health workers said that this was a widespread experience. Somali women related this to physiological and mental memories of their original circumcision and later complications (Hassan 2002). This experience suggests a need to investigate alternative methods of pain relief.

Shukri posed various medical challenges, and routine procedures for delivery care may not have sufficiently taken into account any physical and psychological needs that may have arisen out of her infibulation. This description of Shukri's delivery illustrates several key issues discussed throughout this article.

Norwegian Birth Care and Care for Infibulated Women

Although birth care in the West is generally considered to be a result of medical science, medical anthropology has provided insight into the cultural construction of modern birth care.[6] Brigette Jordan's (1993) groundbreaking study that compared the United States, Sweden, and the Netherlands shows large cultural variations among birth practices that everyone claimed were based on the same evidence-based medical research. More recent studies have looked at birth and delivery care

for immigrant populations. Areas of study have included problems of majority–minority relations, imbalances of power, and racism (Jahn 2001) and encounters between divergent expectations in host and immigrant birth systems (Sachs 1987). Birth care for Somali women has also been the subject of midwifery research (Hassan 2002; Nienhuis and Haaijeer 1997; Widmark et al. 2002). The experiences of Somali women during delivery are analyzed in several studies (Chalmers and Hashi 2000; Nienhuis 1998; Vangen et al. 2004; Wiklund et al. 2000). A study of the current Norwegian birth system also includes perspectives on birth care for immigrant women (Fjell 1998). Torunn Fjell's findings parallel those of mine, and my analysis of birth care for infibulated women builds on her more general findings.

In Norway, health services during pregnancy and birth are free, frequently attended, and of a high standard. Almost all pregnant women attend the required antenatal checkups at the maternity and child health centers, and almost all deliveries take place in public hospitals. There seems to be no significant difference in antenatal care attendance between immigrant women and ethnic Norwegians.[7] Maternal mortality as well as child health outcome are among the best in the world (World Health Organization [WHO] 2004). During perinatal screening, pregnant women are categorized as "normal" or "risk" deliveries, and risk deliveries receive increased follow-up and care. FGC in any form is not regarded as a risk factor. Births are, in principle, attended by a midwife alone, and she decides on basic care and manages all normal deliveries on her own, including episiotomies and the opening of infibulations.

The present-day Norwegian birth system is based on a strong ideal of "natural birth" (Anonymous Student 2002; Fjell 1998). Several routines can be related to this ideal, such as the central role given to the midwife rather than to an obstetrician, resistance to medication and incisions, supporting the presence of partners, placing the baby on the belly, and having the mother breast-feed immediately after birth. Thus, although deliveries take place in modern hospitals, the ideal is to use as little medical intervention as possible. This is because birth is considered the most natural process of the body. As an intensive experience of pain and being overcome by bodily processes, birth is believed to bring women into contact with a sort of "female essence" and "primitive female power." This is seen both as intrinsic to a good outcome of birth and as a gateway for women to become more in touch with their female essence.

However, the revelation of and contact with this primitive female power are not seen as equally accessible to all women. Among modern women, this female essence is described as "buried below layers of modernity" and thus has to be retrieved. In contrast, African women are perceived as being in closer contact with this female essence. "It is all natural for them," health workers often said. At times, health workers expressed such views to explain why they sometimes treated African women differently than other women (e.g., not changing them into hospital clothes and giving them less medication and less instruction about child care after delivery).

Several researchers have discussed how people in the West often regard Africans as representing "ultimate nature" in matters of the body, especially sexuality and delivery (Aria 1991; Arnfred 2004; Fadel et al. 2000; Fjell 1998; Johansen 2006, in press). In a sense, Africans tend to be regarded as more natural than most Norwegians, as

"children of nature" *(naturmennesker)* or representatives of "the noble savage." And what could be more natural than African women giving birth?

Somali women, however, are not completely natural because their genitals have been profoundly altered through infibulation. Their total circumcision was generally understood by health workers as the ultimate expression of female oppression and male dominance. Thus, infibulated women in the delivery ward present a confusing mixture because "the natural wild" has culturally constructed genitals. I see this apparent paradox as being central to understanding the challenges facing health workers in looking after infibulated women during delivery.

The infibulated vulva is created by an operation in which tissue from the clitoris and labia minora are removed, after which the labia majora are cut or scraped so that, when clasped together, they heal into a seal of skin covering the vulva. To close the wound and ensure the formation of a seal of skin covering the vulva, the labia are often fixed with thorns, threads, or herbs before the girl's legs are tied together for a few weeks. At the lower end of the seal, a vaginal introitus of around one centimeter or less is left for the passage of urine and menstrual blood. The end result is thus a closed, smooth surface of skin that is emically associated with highly esteemed moral and aesthetic values.

These values are closely linked to cultural ideals of virginity, as infibulation is believed to prevent both the possibility of and the desire for premarital sex. In that way, the seal of skin forms a culturally constructed hymen that should be carefully guarded from the time of the operation (usually between five and nine years of age) until the girl is married. Marriage ceremonies often include an inspection of an intact infibulation, which is taken as a proof both of the woman's virginity and of her morality (Abdalla 1982; Johansen 2006, in press; Talle 1993). Subsequently, when she is married, the infibulation has to be opened by an operation called defibulation to make sexual intercourse possible. This is a culturally significant procedure, as it is associated with the onset of sexual life and fertility, and it is often ritually marked (see Johansen 2002, in press; Talle 1993). Hence, infibulation is associated with women's virtue prior to marriage, whereas its opening is associated with marriage and fertility.

In contrast, Norwegian health workers generally regarded FGC, total circumcision in particular, as the ultimate expression of female oppression. They often described dealing with infibulated women as being emotionally and ethically difficult. Many expressed feelings of sympathy and pity for the woman, often combined with anger at the men, the culture, and the patriarchal structure that they regarded as responsible for the practice. The health workers, therefore, considered the seal of infibulation not only as a physical obstruction for the passage of the baby that they had to deal with professionally but also as a symbol of strongly emotionally loaded messages of the culture of "the other."

In this sense, infibulation functioned as a social stigma in Erving Goffman's (1984) sense of the term. Stigmatization is a social process whereby the majority attributes a negative role or personality to a person with a physical mark. The infibulated scar is a physical mark that in Norwegian eyes marks the person as incomplete, disfigured, and oppressed (see also Talle in press). To understand health workers' difficulties in dealing with Somali women in birth, certain of Goffman's aspects are of particular relevance. A major aspect of this is the way in which the stigma is

deeply discrediting, and the stigmatized person is not given the social respect she would otherwise have been granted. Moreover, the stigma is somehow "polluting," as it is not only the stigma itself (the physical mark) that is negatively attributed but the whole person. This may be a part of the process whereby health workers tend to perceive circumcised women as "victims of culture" rather than as self-assertive individuals. The general view that Somali women are oppressed because they are African, infibulated, and Muslim, was, however, frequently challenged during actual encounters, when health workers often found Somali women to be both strong willed and demanding.

Last, Goffman discusses how being forced to deal directly with a stigma, which is necessary when providing birth care for infibulated women, is generally experienced as an uncomfortable situation for both parties. The "normal" person will try to manage the discomfort by resorting to avoidance and silence, which was a striking feature in birth care for Somali women. Health workers rarely discussed FGC with their patients; nor was circumcision status written on the health cards or found in the medical birth registry.[8]

Most health workers explained their silence and avoidance as their expression of respect for what they perceived to be a taboo subject in practicing cultures, as expressed by Nana, the leading midwife in a large prenatal unit with many Somali patients: "I cannot talk about that! It is a taboo for them. It is very sensitive." A midwife in the maternity ward looked shocked when I asked if she discussed FGC with her patients: "But I couldn't ask her about that! It would be like an insult." "It would be like accusing her of being a criminal," another midwife argued. These reactions also suggest that the respect for what they perceived to be a taboo subject was based on an expectation that Somali women are ashamed of their infibulation and share the health workers' negative understanding of the practice. The perception of FGC as a taboo subject was generally taken as self-evident and rarely investigated or documented. This perception is strange, particularly as most health workers who had brought up the issue with Somali women were surprised at the ease and eagerness of the conversation.

It is my impression that FGC is often described and treated as if it is more taboo than it is really considered to be in practicing communities and that this perception of a taboo subject may be related to the outsiders' own moral and emotional difficulties with the subject. This is indicated by the way several health care workers related their silence to their own unpleasant feelings about the practice. To appear "professional" and not let their personal emotions affect the situation, they thought it best to "pretend nothing was wrong." Similar processes have been suggested in other studies (Gruenbaum 2001; Malmström 1999).

My concern here is that this deafening silence often seems to increase discomfort in both health workers and birthing women. It also reduces the parties' chances of exchanging vital information. The silence affected health workers by reducing their access to sufficient information about the needs and fears of the patients. This is a significant loss, as most health workers have only a rudimentary knowledge of how to deal with infibulated women in childbirth. None of my informants had received any formal training in birth care for infibulated women. Nor had the national guidelines yet been published. Many health care workers had actively searched for information. However, although they had found basic information on the practice of FGC, they

had found little on care procedures and on how to relate to circumcised women in general. The major need expressed by health workers was for information on how to increase their competency in how to "talk about it."

However, the silence deprived the Somali women of information that could help them better understand their own situation and care procedures and options. This may be why so many Somali women were uncertain about the knowledge of Norwegian health care workers and the workers' ability to take proper care of them during delivery. Such insecurity could further contribute to an increase in the fear and pain that may affect both the birth experience and the outcome. That is, Somali women's fear of childbirth was related not only to painful memories of their original genital cutting or fear of retraumatization but also to fear of inadequate care procedures. Below, I will outline certain care procedures that I found significant for birth care for Somali woman: cutting and stitching during delivery, the management of delivery pain, and the patient–midwife relationship.

Cutting and Stitching in Birth Care

A central midwifery duty is to evaluate the need for vaginal cuts. These incisions are sometimes deemed necessary to secure the passage of the child and to avoid dangerous ruptures. For uncircumcised women, episiotomies are the only available incisions. Infibulated women also need defibulation, whereby the infibulated seal is cut. All medical guidelines for infibulated women prescribe defibulation as an essential procedure, and most also suggest that infibulated women may need more extensive episiotomies because of loss of elasticity in the scar tissue (Toubia 1999). However, Norwegian health workers generally did not share this opinion (see also Nienhuis 1998). On the contrary, they seemed more opposed to cutting infibulated women than women in general with regard to both episiotomies and defibulation.

Conversely, Somali women generally considered significant cuts to be essential to avoid extensive tearing and prolonged labor, and their main worry about Norwegian birth care concerned insufficient cutting. Some felt this made deliveries harder in Norway than at home, as they believed that restrictive cutting increased the hardship of birth and demanded too much pushing. Similar experiences and fears have also been documented in other exile communities, such as Canada (Chalmers and Hashi 2000), Sweden (Conricus and Frank n.d.; Widmark et al. 2002), the United Kingdom (Bulman and McCourt 1997), the Netherlands (Nienhuis 1998), and New Zealand (Denham and Idil 1997).

Hence, the health workers' inclination to restrict cutting seems to be based on a misconception of Somali women's concerns and wishes. A striking aspect of this is that several health workers had encountered Somali women who demanded extensive cutting. However, these women were believed to be rare exceptions, a sign of progress and modernity related to life in exile. This did not change the informants' view that Somali women in general would, if possible, resist any cutting. The different motivations underlying these strong misconceptions will be outlined after a clarification of the different types of cutting accessible.

Midwives often deal with two different types of cutting: episiotomies and defibulation. Episiotomies are lateral (sideways) incisions of the perineum. Some years back, episiotomies were a routine procedure in every birth in Norway. However,

the policy of the last 10–15 years has been to avoid them if possible. Presently, the overall frequency in Norway is about 34 percent in primipara deliveries and about 10 percent in multiparous women (Norsk Medisinsk fødselsregister 2000). But, whereas international literature suggests that women who have undergone multiple genital operations may experience a further decrease in elasticity, thus increasing the need for episiotomies even in defibulated and multiparous women, the study with my colleagues found no significant increase in the number of episiotomies among infibulated women (Vangen et al. 2002).

Defibulation is the surgical separation of the adhesion between both labia by cutting the infibulated scar along the midline. The lay expression in Norway is usually "to open," whereas "reconstruction" is used in English-speaking countries. To make the change permanent, the two edges are sutured separately on either side to prevent regrowth. The operation has been recommended in the national medical guidelines (Statens helsetilsyn 2000). The procedure restores the anatomy of the vulva to a more "natural" shape and therefore reduces the need for further surgery later. Women who are still fully or partially infibulated at the time of their delivery, however, need defibulation during the delivery itself, as the vaginal introitus would otherwise be too small and inelastic to allow the passage of the baby. Without defibulation there would be an increased risk of delayed delivery and uncontrolled tearing, as tight and less elastic scar tissue causes harder pressure on the remaining tissue. In some cases, fistulas may appear (Ginzel 2003).

Health workers generally considered defibulation physiologically advantageous to the women, as it would ease the flow of urine and menstruation, sexual activity, and deliveries. Defibulation was also considered less physiologically violating than episiotomies, because the infibulated seal consists mostly of a thin, bloodless layer of skin with few nerves. In contrast, episiotomies cut through muscular and blood-filled tissue. However, although defibulation was considered the best option by medical standards, informants generally resisted it. Some of them avoided defibulation by resorting to more extensive episiotomies or, in a few cases, even restored the infibulation through reinfibulation. Similar tendencies are found in other exile countries, such as Sweden (Widmark et al. 2002), New Zealand (Denham and Idil 1997), the United Kingdom (Bulman and McCourt 1997), and the Netherlands (Nienhuis and Haaijeer 1997). In the discussion below, I explore the apparent paradox of the health workers' reluctance to perform a procedure they consider beneficial to the woman.

Health workers referred to the general resistance to any cutting to explain their unwillingness to perform episiotomies and defibulations. This resistance was based on both medical and cultural perceptions. One central aspect is the general objection to episiotomies in any delivery. As most Norwegian women prefer to avoid episiotomies, health workers assumed that infibulated women also felt this way about defibulation. As one midwife said, "Nobody wants to be cut, you know, if it can be avoided." Several midwives told of incidents in which they had tried to calm a panicking mother by assuring her that they would try to avoid any cutting. Thus, what health workers believed would calm a Somali woman is exactly what most Somali women feared (i.e., not to be cut).

Another key issue is the health workers' unfamiliarity with the procedure of defibulation. Some considered it to be a technically difficult or impossible procedure. Midwife Nana, for example, stated vigorously: "It is impossible to cut in front. There

is the urethra and everything. That would just destroy and not help anything." Her lack of knowledge on the need for, and possibility of, defibulation was particularly surprising because a journal was on the top of her desk opened at a page with an illustrated description of the procedure. Nana was also the head of a prenatal unit with many infibulated patients, and she seemed to have studied the subject extensively. Her lack of knowledge, therefore, could not simply be explained as lack of information. Rather, I suggest that there is resistance against absorbing this information.

Lack of knowledge of defibulation promoted a variety of solutions. Several health workers told me that they had at times performed C-sections because of ignorance about how to deliver infibulated women; this was particularly the case in the early years of Somali immigration. Nowadays, it is more usual to perform multiple episiotomies to avoid defibulation. Sometimes, this is simply because there is familiarity with the procedure. As one midwife put it: "I think I do it [episiotomies rather than defibulation] because that's what I am used to doing."

However, the most frequently reported reason health workers gave for trying to avoid defibulation regarded an attempt to provide culture-sensitive care. In a desire to respect the women's cultural integrity, health workers were concerned about preserving their infibulations. Health workers assumed infibulated women wanted to remain infibulated, and they considered episiotomies to be a more culture-sensitive procedure than defibulation. Health workers knew infibulation to be a culturally significant tradition for Somali women, related to key values of womanhood, identity, sexuality, beauty, and morals. Thus, they assumed that women needed to remain infibulated throughout life and that defibulation would endanger these values. Many health workers were concerned that defibulation might lead a woman's husband to reject her. An additional argument was that defibulation would make the suffering of the original operation worthless, as one midwife said: "If a woman has gone through all that pain and trouble to be closed, we can't just cut it open." Given these beliefs and the aspiration of culture-sensitive treatment, defibulation becomes problematical. "Who are we to decide that a woman should go out of the delivery room differently than she was when she came in?" many asked rhetorically.

A case in point is a midwife who decided to perform triple episiotomies to avoid defibulation. The midwife, Katrine, described her efforts and considerations during the delivery of Amina, who had been fully infibulated upon arrival at the hospital: "I tried to ask Amina whether she wanted me to reinfibulate her, in case there were any tears in her infibulation. But I didn't feel that she understood the question. It is very difficult to reinfibulate you know; it has to be stitched in two layers. Therefore, I just made episiotomies, to avoid tears in front." When asked whether she had considered that Amina might have wanted defibulation, Katrine replied in surprise: "No! Of course she wants to remain the way she is." Katrine's conviction that Amina wanted to remain infibulated and her own obligation to respect this made defibulation inconceivable to her.

Hence, as Katrine thought Amina wanted to remain infibulated and believed that she, as a midwife, was obliged to respect this choice, she considered only two options. She could refrain from any cutting but then risk spontaneous defibulation or tears that she thought she would have to restitch. (She was apparently unaware that reinfibulation is illegal.) Or she could perform extensive episiotomies to avoid

spontaneous tearing of the infibulated scar. She chose the second option, as she considered it an easier cut to restitch.

Another example is a midwife who told me in a whispered confession that she had secretly performed a tiny defibulation during a delivery. She had done this because she considered it to be (physically) beneficial for the woman. However, she feared that her act had been both illegal ("we are obliged to repair what we cut") and against the woman's wish, which she thought was to remain infibulated.

Thus, although health workers generally evaluated defibulation to be less physically intrusive than episiotomies, they considered it both culturally and personally intrusive. Faced with choosing between the two types of cutting, many were more inclined to perform episiotomies than defibulations. In this way, they seemed more hesitant to cut the cultural mark of infibulation than the natural vulva. This preference to cut "nature" rather than "culture" may seem to contradict the Norwegian devotion to natural birth. This may indicate that the concepts of nature and culture are symbolically differently understood with regard to perceptions that emphasize differences and dichotomies between "us" and "them." In a sense, it seems as if the culture of immigrant women was perceived as natural and hence essentialized (see also Fjell 1998:156). Their culture was described as derived from a combination of long traditions—"knowledge passed down from generation to generation" and "female sisterhood": "They have this women's society that we in the West have lost."

The Dilemma of Reinfibulation

We have seen how the assumption that infibulated woman want to remain so for life, as in the case of Katrine, gave rise to another dilemma: whether to ensure a permanent opening by defibulation or to restitch the cut and thereby re-create the infibulated seal. Although present medical guidelines prescribe procedures that ensure that the opening remains permanent, health workers often described this as a dilemma. As mentioned above, defibulation was considered to be medically beneficial to the woman, as it generally improves women's well-being and reduces the need for repeated cutting in future deliveries. Furthermore, although most health workers knew that reinfibulation is illegal, many found this clause in the law ethically challenging because they believed a permanent defibulation would violate the personal and cultural integrity of Somali women. In some cases, this led health workers to avoid defibulation altogether to avoid the dilemma of whether to restitch or not. In a few cases, health workers actually performed reinfibulations, either because of ignorance of the law or because they saw reinfibulation as a medical necessity or as an act of respect for what they perceived to be the best way to secure women's cultural and bodily integrity.

In contrast, all but one of my Somali informants were opposed to any reinfibulation, with only one wanting a partial procedure. In fact, many complained of having been reinfibulated against their will.[9] Other studies support the finding that the vast majority of Somali women resist reinfibulation. In a study from Canada, 70 percent did not want reinfibulation, whereas 27 percent did, and 60 percent of the husbands did not want their wives to be reinfibulated (Chalmers and Hashi 2000). Although health workers generally interpreted requests not to be reinfibulated as a sign of

"modernization" in exile, there is no evidence that reinfibulation has ever been a customary practice among the Somali.[10] Culturally speaking, a major function of the seal of infibulation is to be intact to prove virginity at the time of a woman's first marriage (see also Abdalla 1982; Johansen in press; Talle 1993). As discussed previously, women are supposed to be defibulated after marriage to enable them to enter into an active sexual and reproductive life. Reinfibulation was virtually unheard of among my Somali informants, and most sighed and shuddered at the thought of what they considered a cruel and primitive practice they knew to be widespread in Sudan.

Before trying to understand the strength of health workers' conviction that Somali women expect reinfibulation in spite of Somali resistance, I will give a brief description of the variety of practices often subsumed under the term *of reinfibulation.* Confusion between different understandings of the term has been at the heart of many discussions since the subject was first raised in connection with the Bærum case, in which the hospital refuted accusations that it had performed FGC by suturing infibulated women after birth. Some of the hospital staff explained, "We do not perform reinfibulation; all we do is repair what we cut." Others said, "What counts as reinfibulation anyway? We have to sew a few stitches."[11]

These statements appear confusing, because "repair what we cut" or "sew a few stitches" could be defined as reinfibulation. Neither Norwegian law, medical guidelines, nor international literature is clear on what would constitute reinfibulation (Berggren 2005). And as people rarely clarify their understanding of the procedure, discussions are often confusing concerning what the participants actually mean.

First, I rule out of the use of *reinfibulation* in cases in which the woman has been defibulated at an earlier stage. In such cases, reinfibulation would generally never be considered (see n. 12). Because there is no infibulated seal to cut, there is also none to restitch. In such a case, then, reinfibulation would actually entail a new circumcision because healed tissue would have to be scraped to create wounds that could adjoin. I never heard of anyone even contemplating such a procedure after delivery. Hence, it is generally only when a woman is still fully or partly infibulated at the time of delivery that reinfibulation has to be considered by the health workers. Many birth attendants suggested that there should be "a few stitches" sewn (see also Gullestad 1992; Jordmorveilederen 2000). This was usually described as closing the infibulation over the clitoris to just above the urethra. These stitches were said to be necessary for medical reasons: to avoid further tearing, to reduce the "openness" of the area, to cover any naked nerve endings in the clitoral area, and to cover the mucous membrane; and it was seen as a means to avoid pain and friction. Another reason to perform reinfibulation is to prevent bleeding when the infibulated tissue is thick. However, the stitches were also sometimes described as a compromise between medical and cultural concerns, a way to avoid having the woman "feel too open."

Second, the infibulation may be restitched after the delivery to the shape it had prior to delivery. The descriptions of the Bærum doctors that they had to "repair what we cut" and "let her leave as she came in" may refer to this procedure. However, because the size of the vaginal introitus at the time of birth varies greatly among women, this would apply to any repair. In most cases, women's infibulations had been at least partially opened beforehand, and any restitching could be described as partial reinfibulation. That would leave sufficient vaginal introitus for a free flow

of urine and menstrual blood, as well as allow sexual intercourse without pain caused by tightness. However, defibulation might then be necessary again at a future delivery.

A final possibility is total reinfibulation, in which the vagina is sewn back together so tightly that a "virginal" state is re-created. That would hamper the flow of urine and menstrual blood and prevent sexual intercourse without a new opening. The medical procedure for this operation would again vary with the shape of the genitals upon arrival. If the woman arrived for delivery fully infibulated, "to repair what we cut" would entail re-creating a full infibulation. However, if partly defibulated, total reinfibulation would demand a new operation, as discussed for the fully defibulated.[12] Health workers generally seemed to believe that Somali women expect to be closed to almost a virginal state to ensure a tight opening for the sexual satisfaction of their husbands. Somali women, however, as well as Somali men, generally described the process of defibulation through sexual encounters as a painful and difficult procedure they would prefer to avoid (Almroth 2005). The large increase in requests for defibulation by unmarried, newly wedded, and longtime married Somali women suggests that tight and lifelong infibulation is generally not desired by the Somalis themselves.

In looking for the basis for this misconception that Somali women want full reinfibulation, one is again struck by the lack of empirical evidence. Few health workers had actually encountered patients demanding reinfibulation. On the contrary, many experienced requests for defibulation. Again, however, these were generally interpreted as rare exceptions and signs of modernity and Westernization. Hence, the health workers' fear of being culturally intrusive by not granting reinfibulation stands in sharp contrast to the Somalis' general resistance to the practice, and their ethical dilemma of balancing physical well-being (through defibulation) against cultural well-being (through reinfibulation) appears largely to be based on mistaken perceptions of Somali culture. This misconception is not limited to health workers but, in fact, is represented internationally in both scientific and political publications. For example, several studies on infibulated women in exile asked them how they feel about being refused reinfibulation, rather than enquiring whether they want it at all (see, e.g., Chalmers and Hashi 2000; Wiklund et al. 2000).

As indicated by the response of the Somali women, one cause for the misconception may be the prevalence of the practice in Sudan (Berggren 2005). A large proportion of research on infibulation is based on empirical studies in Sudan, where reinfibulation is widespread. It seems that infibulation as practiced in Sudan has been taken to represent infibulation in general, so that the practice of reinfibulation in Sudan is taken as evidence that reinfibulation must also be common in all other societies practicing infibulation. However, as we have seen, this is not always the case.

Another reason for the misconception may be a human inclination to remember the most extreme information best. This can be seen in most writings on FGC. For example, though excision (removal of the clitoris or labia minora) is the most prevalent type of FGC worldwide (85 percent), most literature and education materials are based on infibulation, which is practiced by the remaining 15 percent of affected communities. A concrete example is found in the way lists of complications from FGC generally include long-term complications that are mainly caused by

infibulation as if they were applicable to all forms of FGC. Several researchers have pointed to problems of such misinformation in, for example, anti-FGM campaigns (Hernlund 2003; and my own experience from Burkina Faso and Ethiopia).

My main concern in this article is the dilemmas health workers experience in their efforts to respect what they believe to be the cultural and personal desires of Somali women but which are actually based on misconceptions. These misconceptions persist because of the general silence and lack of communication, which is again caused by health workers' desire to show respect for what they believe to be a taboo subject for Somali women.

Why do health workers often seem to go to great lengths to respect cultural practices that they consider oppressive and detrimental to women's health and well-being? I see this as an expression of "culturalization," in that infibulated women are seen mainly as "products of their culture," rather than as individuals with varying personal experiences and concerns. Health workers' decisions or dilemmas were at times based on their perception of the moral guidelines and cultural tradition of the patient, rather than those of medical care. Examples of this include incidents in which Norwegian health workers appeared more concerned with Somali women's virginity and Muslim morality than the Somalis were themselves. This tendency may have been one reason why young Somali girls were refused defibulation by general practitioners who told them to wait for this until delivery. In one case, a gynecologist expressed regrets and a guilty conscience for defibulating a young girl, feeling that by doing so she had compromised the girl's morality by making it possible for her to engage in premarital sex. The young girl came back later to terminate an unwanted pregnancy. This was also considered by the gynecologist to be inappropriate to the girl's cultural background.

Part of the picture is health workers' respect for the roles of the husband, patriarchy, and religious leaders. At times, health workers seemed to give more respect to the statements and demands of men than to those of women, possibly for fear that the women would be punished if they went against the men's will. We see this in the fear that refusal of reinfibulation would cause the husband to divorce or disrespect his wife. One midwife told of how her ward had granted privacy to a couple to indulge in sexual intercourse the day after delivery, in response to the man's claim that this was a Somali tradition. This demand, however, contrasts sharply with Somali women's praise of the traditional 40 days of abstinence and rest after birth. In a sense, then, men were perceived as being more powerful that they actually were, and the patriarchal structure was often respected for fear that not to do so could negatively affect the woman. Thus, the health workers' good intention of respecting Somali culture may turn them into moral guardians of cultural traditions and power structures, even of the whims of some men who take advantage of the situation.

C-Sections

C-section is another aspect of birth care in which the perceptions of health care providers differed from those of Somali women. The main concern of health workers was what they saw as Somali women's unwillingness to have a C-section leading to dramatic deliveries and occasionally a bad outcome for the child. They wanted to know the reason for this resistance so as to increase their ability to convince women

of the necessity of the procedure.[13] In contrast, a major worry among Somali women was dissatisfaction with what they saw as too frequent and unwarranted C-sections. Again, we see an apparent contradiction that needs to be explored.

In general, Norway strongly discourages C-sections. The operations should be performed only to avoid a serious health risk to mother or child. The present rate is low in comparison with rates in most other Western countries, at about 15 percent in general and 12 percent among ethnic Norwegians. Of these, about 7 percent are carried out at the women's request (Norsk Medisinsk fødselsregister 2000). Such requests are normally granted only in cases of extreme fear of childbirth. However, the total number of C-sections has been increasing over the last few years, and health workers are especially worried about women requesting C-sections without medical indications.

The unwillingness to perform C-sections is grounded in the greater risk of complications compared with vaginal deliveries. But in public debates and in my interviews and conversations with midwives and doctors, considerable emphasis was put on a moral concern. They were lamenting how comfortable city life has made modern women, who seemed unable or unwilling to stand this "natural female pain." This worry about the increasing demand for unnecessary C-sections by Norwegian women stands in sharp contrast to the worry about Somali women refusing necessary ones.

Health workers believed Somali women's resistance to C-sections was motivated by "Somali culture," which they thought placed a high value on "natural delivery" as a part of womanhood, a value on women's burden, and a fatalistic acceptance of God's will. One example of this expectation is two health workers' interpretation of a birth in which a Somali couple first refused a C-section and then changed their minds after a phone call. The family's initial refusal was believed to be based on Somali cultural values, discussed above. The husband's phone call, which seemed to cause the couple to finally agree to a C-section, was assumed to be a request for permission from a clan or religious leader. Hence, both the family's resistance and their final acceptance were interpreted within a framework of perceived Somali culture as well as culturally appropriate patriarchal and religious power structures.

When this story was recounted to Somali women, they bent over with laughter at the interpretation of the health workers. "That is not how the clan works! We are just scared of C-sections. It is dangerous to be operated on, and we don't think it is necessary," they said. So, whereas health workers saw Somali resistance to C-sections as based on cultural values, Somali women saw it mainly as caused by fear of the surgery itself. Their fear of the danger associated with C-sections may be related to the vernacular expression for a C-section, which is identical to the term for slaughter.[14] Somali women often told stories of how rare C-sections are in their home countries, only performed in an extreme emergency and often with a fatal outcome. They also believed the operation to be unnecessary and often taken as "an easy solution" by health workers unable to deal with their circumcision or too impatient to wait for the natural progress of birth. There were also a host of rumors of a more conspiratorial nature, such as rumors of C-sections as a way to reduce the number of their children, of being secretly sterilized, or of being used as training objects for medical students. Although these beliefs did not always seem to

be firmly held, they reflect a general skepticism and questioning of the necessity for C-sections.

Although Somali women were concerned about a high prevalence of C-sections, most health workers believed the practice to be less frequent among Somalis. Our research confirms the impressions of Somali women. In contrast to about 12 percent prevalence among ethnic Norwegians, the prevalence among Somalis was 19 percent (Vangen et al. 2002). Another key finding is an even higher risk of emergency C-sections.

How can we explain the increased prevalence of C-sections among a group of women who desperately want to avoid them, when health workers are, in general, opposed to C-sections and do not see any reason why infibulated women should run a higher risk? The health workers themselves expressed surprise and puzzlement when confronted with the numbers. They simply did not understand it. There were no indications that C-sections were still being performed because of uncertainty about how to handle infibulation. Nor did health workers believe the infibulation itself could cause the increase in C-sections, as the physical obstruction of the infibulated scar only becomes a problem at the end of the expulsion stage and is easy to cut. I believe that infibulation may obstruct labor in more indirect ways because of its association with a higher risk of fear and pain in Somali women and the health workers' difficulty in dealing with the situation.

Delivery Pain and Its Management

Pain is an integral part of childbirth, and estimating the intensity of pain is an important component of birth care. This is a basis for several decisions about delivery care, including the use of anesthetics, instrumental delivery, and emotional support. How health workers estimate women's pain therefore directly affects the care women receive. A challenge I will come back to is the differences in how people express pain and how different "pain languages" may affect how pain is estimated.

As discussed above, the general attitude in Norwegian birth care is to minimize the use of pharmacological pain control. The resistance of health workers toward administering drugs was explained partly by associated health risks and partly by the emphasis on natural childbirth.[15] This analysis focuses on the latter. For example, although pregnancy literature provides information about available medication, it discourages its use. Moreover, the issue is rarely raised during delivery. On the contrary, midwives at times avoided women's requests (see also Fjell 1998). The only medication given relatively freely was nitrous oxide. This is a gas that is said to take the edge off the pain in a matter of seconds and may not be used during the period of expulsion. Apart from this gas, about 30 percent of birthing women in Norway receive pharmacological pain relief during labor or expulsion.[16]

There are no statistics available on the use of pharmacological pain relief among Somali women, but earlier studies have demonstrated that immigrant women generally receive less than ethnic Norwegians (Vangen et al. 1996). Although the health workers had diverging perceptions of Somali women's pain during delivery, there was a relatively shared expectation that Somali women needed and wanted less pain relief. Few, if any, considered that the experience of infibulation increased the

women's needs or desires for medication. Considering their view of Somali deliveries as "more chaotic," this conviction may seem strange and in need of investigation.

Somali women often described delivery as a dramatic experience. One woman exclaimed: "Giving birth is like entering a tunnel. You never know if you'll come out dead or alive." This could be related to their background in a country, Somalia, with a high maternal mortality rate. Most women knew someone who had died or lost a child during birth. However, they mostly related their fear and pain to their infibulation. Almost all Somali informants considered that infibulation caused harder deliveries because of both the physical obstruction and memories of the pain, including flashbacks or a general fear of genital pain (see also Essen 2001; Wiklund et al. 2000). As one woman said, "Imagine how painful birth is in itself. And then we have this [infibulation] in addition." These aspects—the pain, the memory of the pain, the fear of repeated pain, and flashbacks from the circumcision—all seemed deeply entwined. Similar findings are reported from other studies (Chalmers and Hashi 2000; Essen 2001; Johansen 2002; McCaffrey et al. 1995; Vangen et al. 2004). Sarah was one of the few Somali women who had requested special care because of her fear of pain and retraumatization during delivery. However, although she received special care, she still experienced her delivery as traumatic and eventually ended up having an emergency C-section (see Vangen et al. 2004).

The experiences of numerous Somali women, such as Amina described above, Sarah here, and Leyla below, suggest that the pain suffered during circumcision may seriously increase infibulated women's sense of pain and fear during delivery. Although some researchers suggest that "ritual pain," such as FGC, is less traumatizing than less meaningful pain, Somali women almost unanimously and quite strongly said the pain of infibulation was traumatic, an unforgettable experience that many believed affected childbirth, both emotionally and physically (Johansen 2002; Vangen et al. 2004).

Another cause of discomfort during birth was the widespread uncertainty about whether Norwegian health workers knew how to handle Somali women. In addition, women feared stigmatization. Although few had personally experienced it, they shared a large repertoire of stories of women who had been treated awkwardly (see also Chalmers and Hashi 2000). Another major complaint was that they experienced loneliness and lack of care. Other studies have also found an increase in women's worries and fears because of their infibulation (Chalmers and Hashi 2000; Conricus and Frank n.d.; Hassan 2002; Nienhuis 1998; Vangen et al. 2004). All these experiences and concerns are likely to increase fear and pain. Below, I will discuss the possible shortcomings of the Norwegian ideal of natural childbirth in taking sufficient care of infibulated women who suffer excessive pain and fear.

As already mentioned, one reason why health workers resisted using pain medication is that delivery pain was seen as natural and thus good for the woman, both physically and emotionally. It was seen both as a way to ease the birth itself by triggering her female instincts and "primordial female power" and as a way to bring the woman into contact with her inner essence. Many health workers saw the pain of childbirth as the only chance for modern women to have such an existential experience. Fjell's analysis shows how the positive evaluation of natural delivery is intrinsically linked to the transformation of childbirth in Norway from a life-threatening ordeal to a generally safe process. This reduction of risk can be

measured statistically, and the present maternal mortality rate in Norway is one of the world's lowest, at less than six in 100,000 (Norsk Medisinsk fødselsregister 2000). This transformation, Fjell states, has also brought about a transformation of the symbolic meaning of birth pain from something to be endured and survived into a positive force and significant experience and "test" of womanhood. An extreme expression of this is found in the "alternative birth movement," in which labor pain is described as "birth joy" and "creative pain" (Endresen and Bjørnstad 1992).

However, modern birth care is not available to all women in the world. In poor countries such as Somalia, childbirth is still a risky ordeal. Maternal mortality in the Horn of Africa is among the world's highest, at around 1,100 per 100,000 in 2000 (WHO 2004). The WHO has estimated a lifetime risk of maternal death to be one in ten, with a fertility rate of about 6.8.[17] It is no surprise, then, that most Somali women view birth as a dangerous event.[18] Furthermore, FFG in itself, and particularly infibulation, is associated with increased risk of birth complications (Banks et al. 2006; Vangen et al. 2002).

Both research and personal experience clearly show the close relationship between the experience of pain and conceptions of risk and danger, and fear constitutes a significant part of the pain experience (Munster 1997). Furthermore, fear itself may affect the physical process, and thus the outcome, of the delivery (Munster 1997; Ryding et al. 1998). Therefore, reducing the fear may reduce the intensity of the pain experience as well as the actual risks during delivery and should be an important part of midwifery care.

Another aspect that may be of significance is the fundamental difference in the content of the fear between Norwegian and Somali women. Although Norwegian women seemed mostly to fear for the health of their child and rarely questioned their own survival, Somali women frequently expressed fear for their own lives. Many health workers told us of Somali women screaming in fear of death during birth. We see a similar distinction in the discussion of C-sections, in which health workers focused on the health of the child, whereas mothers often feared for themselves.

Although health workers know in general that fear and pain are integral parts of the birth experience, several studies have pointed out that they tend to avoid relating directly to women's fears (Fjell 1998; Homans 1982; Munster 1997). The studies demonstrate how expressions of fear understood as "normal fear of childbirth" are considered best solved by avoidance and silence (Munster 1997). Another common technique is to calm the woman by informing her about normal (unproblematic) birth (see also Fjell 1998; Homans 1982). My informants said that the purpose of avoidance was to reduce women's fear. However, it is also possible that the reduced risk in modern birth care also reduces health workers' attentiveness to fear, as it is seen to have fewer bases in real danger.

In contrast to what is considered normal fear of childbirth, which is considered not necessary to deal with, some women display what is understood as "extreme fear of childbirth," for which all hospitals have special procedures. Most hospitals have a midwife who is trained to take care of just such deliveries, which involve more liberal use of medication and more assistance and support during delivery. Extreme fear of childbirth is commonly related to earlier traumatic experiences such as sexual abuse or traumatic delivery, although infibulation was generally not considered as a potential cause. However, even in cases in which infibulated women

expressed extreme fear of childbirth, it seemed that health care workers tended to forget the general knowledge they had to handle such situations, as expressed by a Somali midwife: "But why did I never think of this? Somali women are often traumatized, and we have specialized training in dealing with traumatized women and fear of childbirth. I just never thought of it, that this knowledge could be applied to Somali women." Sahra, whose story is told above, is the only case I encountered in which such knowledge had been applied. To determine why health workers rarely considered infibulation traumatic and rarely used their general knowledge about extreme birth even when Somali women showed extreme fear, I investigated the indicators health workers used to estimate pain and fear.

The main basis of the estimation is the woman's "pain behavior." Somehow, pain behavior tends to be understood as a direct reflection of actually felt pain, and all societies share some common methods for estimating pain behavior. A key to the Norwegian pain language is a high evaluation of stamina. The experiences of a Norwegian woman who was almost not taken seriously when she fell ill in Italy, a culture with much more expressive pain behavior, illustrate how diverging "pain behavior languages" dramatically increase the risk of misinterpretation (Horntvedt 2003). In contrast, a couple of Norwegian health workers who had attended deliveries in Somalia expressed wonder and admiration for the silent deliveries and stamina showed by Somali women in their home areas. However, whereas the Norwegian health workers interpreted this as an expression of Somali women experiencing pain differently (for cultural and other reasons), Somali women themselves often told of their relief to be allowed to scream freely when giving birth in Norway.

Health workers shared a common knowledge that people experience and express pain differently and that there are considerable cultural variations in pain languages. Still, there was a tendency to measure pain behavior against a Norwegian "gold standard." This was described as "a deep inner groan," which was seen as a natural and "good" expression of pain and a direct expression of the woman's "real" pain. In contrast, pain behaviors that deviate from the Norwegian standard of stamina and control needed interpretation. They tended to be seen as "culturally imposed" and therefore somehow "artificial," as we see in Susan's efforts to interpret Shukri's pain behavior. And the interpretation of pain behavior was important in care procedures.

In some cases, excessive pain behavior was seen as a sign of a lower pain threshold. As such, it can be seen as a sign of weakness and being a sissy, rather than as a symptom of real pain. In such cases, birth care would focus less on the use of pain relief and comfort and more on encouragement. This may have been the case when Susan made light of Shukri's pain between contractions by telling her that "it's not hurting now." But it may also give rise to irritation and contempt. This may have been why Shukri's midwife seemed irritated at her screams. If cries of pain are seen as demonstrations of suffering, they can be read more as a communication tool than as a representative of actual, felt pain. Think of Susan suggesting that Shukri may have cried out to appeal for sympathy from her husband.

Furthermore, if the patient uses a noticeably different pain language, the habitual understanding of the relationship between expression and experience (sign and signifier) is challenged. In contrast to the "deep inner groan" seen as "a natural expression of real pain," recognizable or repetitive sounds, such as the "ay ay ay" described as a typical Asian cry, tended more often to be understood more as a

"cultural show." This interpretation also suggests an understanding of culture as a sort of list of rules. One example is a discussion during a conference in midwifery in which an immigrant man was asked: "Why do your women cry so much during birth?" Both the question and the man's reply suggest an understanding of culture as a sort of "shopping list," as he answered: "It is not our culture or that we think she will receive special help from God or achieve anything by this. She cried only because she was in pain." The discourse, then, reveals an understanding of culture as less embodied and intrinsic to personal experience as it is seen in most anthropological understandings (see also Johansen 2006; Shore 1996). Such an understanding of culture-specific expressions of pain may be taken as a sign that expressions of pain among immigrants are not related to their actual pain experience and may have been why one woman who had undergone FGC was refused pain relief during delivery and was told that "it was only my culture that made me cry."

In all these cases, pain behavior is not mainly interpreted as symptoms of pain. By seeing it as signs of lower tolerance, demonstrations, or "fake" expressions, it is understood mainly as expressions of culture. The women therefore were not seen to be in need of pharmacological pain relief. In contrast, Somali women were often also seen as more natural than Norwegian women. This interpretation may lead to less inclination to use pharmacological pain relief, as has been found in several studies (Bulman and McCourt 1997; Fjell 1998; Vangen et al. 1996).

The perception of Somali women is hence complex. On the one hand, they are seen as more natural and authentic than most Norwegian women; on the other hand, they are seen as victims of patriarchal culture. It may thus be said that they are simultaneously seen to be more natural and more cultural, the two seemingly opposite views unified in a perception of Somali culture as naturalized. As one midwife expressed it: "Their culture has become natural for them, as it is transmitted from generation to generation." This also included infibulation, as was made clear in the way a midwife responded to my suggestion during a lecture that good medical and psychological care could help infibulated women cope better with any traumas caused by their circumcision. "It is not traumatic for them. I know a lot about this. I have read many books. It is their culture! Everyone there goes through the same thing. So it is not traumatic at all!" she exclaimed with conviction. Hence, she suggested that culturally meaningful pain could not be experienced as traumatic. That is, the culture of the Somali woman has become her nature, and as such, it is good for her.

These different, even contradictory, interpretations of pain and culture were not clearly distributed among people. On the contrary, the health workers seemed to relate to several different perspectives and interpretational keys simultaneously, as we see with Shukri's midwife. The interpretation of pain behavior was also used as a key to measure the need for emotional care and support.

The Patient–Midwife Relationship: Care and Emotion

A major concern for Somali women was a feeling of insufficient attention and support from the health workers, and many expressed feelings of abandonment, loneliness, and neglect (Vangen et al. 2004). From the previous discussions of pain and fear, it seems evident that such feelings may have a negative effect both on the birth

experience and on the birth itself. Furthermore, studies have shown that the presence of another person in the delivery room significantly reduces birth risks, even when the person present has no relation to the birthing woman and does not intervene in any way in the care procedures or support (Hodnett et al. 2003). Thus, it is possible that the feelings of loneliness and insufficient attention among Somali women are detrimental to their deliveries.[19] This section will investigate key aspects of the Norwegian birth system that may cause such experiences among Somali women. I will focus mainly on three aspects: the physical abandonment of birthing women in certain stages of delivery, the health workers' major focus on the safety of the child rather than of the woman, and the absence of supportive touch.

A main aspect to the feeling of abandonment was the women's solitude during the dilation period. During this period, the midwife on duty checks from time to time (about every 30 minutes) to estimate the progress of the opening of the cervix and the woman's condition. In cases in which the mother needs technical monitoring, the midwife can follow the graphs in the duty room. From discussions with Somali women, to them this felt like abandonment. They were in the hospital, they were in labor, and they were alone. The midwives, however, did not see this as a period during which their assistance was needed. "There is not much to do apart from waiting anyway," as one said. Health workers also explained their absence partly as a way of granting privacy and partly by referring to other duties. The fact that the Somali women complained that they were left alone all the time, although the health workers insisted on their continuous presence, may be based on a different definition of childbirth. Although Somali women defined birth as the whole period of labor from onset to expulsion, midwives generally defined birth as the expulsion period.

The midwives' definition of the expulsion period as the birth and the time during which their assistance was needed is closely related to midwives' perceptions of their duties. It also appeared that Somali women and midwives had different understandings of what constitute midwifery duties. Ahsan, a Somali midwife who was frequently asked to take care of Somali deliveries in her ward, said that she often felt these deliveries were very difficult, particularly as she sensed that Somali women tended to cling desperately to her, "making it difficult to concentrate on my midwifery duties." That is, holding and supporting the woman were probably not what she considered her main duties as a midwife, although this may have been what some women wanted.

Jordan (1993) describes many traditional birth systems as mainly being ways of supporting the woman in labor. Key methods here are massage and different ways of holding the woman. This is defined by Sheila Kitzinger (1997) as a "supportive touch," in contrast to a "diagnostic touch" that includes procedures such as checking the cervix opening and the elasticity of the vagina and supporting the baby on the way out. According to Kitzinger, modern birth care has almost totally abandoned supportive touch and has replaced it with diagnostic touch. This diagnosis seems equally applicable to Norwegian birth care. In the deliveries I observed, the midwife's attention and touch were almost entirely focused around the mother's genitals, as shown in Shukri's delivery. Midwife Ahsan also described her midwifery duties as mainly concentrated around the woman's genitals to check the opening of the cervix and to monitor the birth. Kitzinger relates the change of touch regimes

to the professionalization of birth care, in which supportive touch is taken out of the hands of the midwives and may only be reintroduced into the delivery room in the name of professional massage. The absence of supportive touch is in some ways also related to the ideals of natural deliveries in which women are expected to take charge of their own deliveries. Health workers explained restricted interference as a gesture of respect for women's strength and ability to deliver by themselves and considered this a large improvement.

Although Kitzinger defines the loss of supportive touch as intrinsic to modern birth care, it may also have a specific Norwegian flavor, relating to strong Norwegian cultural ideals of independence and privacy (Gullestad 1992), values that were often cited by midwives. Maybe the midwives' feelings were similar to mine as a participant observer during deliveries, when I sensed a dilemma between an urge to hold the woman crying out in pain and a fear of intruding on her bodily and familiar privacy. Like the midwives (and the husbands), I mostly kept my distance. Another peculiarity about the lack of supportive touch in the deliveries I observed is that it contrasted sharply with the self-presentation of the midwives, in which they described supportive touch and massage as if they were regular practices.

This discussion has shown how birth routines that may be efficient in reducing fear and pain and empowering for Norwegian woman during birth may be experienced as abandonment and lack of care by Somali women, who do not fully share either the Norwegian ideal of natural delivery or identical fears and worries with most ethnic Norwegian women. Further, infibulation may increase these tendencies by increasing the emotional distance between health workers and birthing woman. Most health workers had strong negative emotions about infibulation, describing it in terms such as "horrible," "makes me furious," "how can they do anything like that to their children," "helplessness," "taboo," "feeling sorry," "oppression," and "humiliation." Such intense and negative feelings may cause increasing detachment (see also Malmström 1999; Widmark et al. 2002). Although Somali women may expect more supportive touch than Norwegians, they may receive less because of the negative feelings of the health workers.

In addition, there is uncertainty about how to deal with birth care for infibulated women. This uncertainty was particularly noticeable in the most traumatic deliveries in which health workers said they felt they had been placed in the position of committing abuse. One such birth was that experienced by Leyla, in which midwife Anne was in charge. When I encountered Anne immediately after the delivery and asked her how it went, she replied in an agitated voice: "With a scream! Such births are difficult. When the women have been circumcised, it feels as if they reexperience the violation of the circumcision. I felt as if I was violating her. It is a terrible experience." Leyla had screamed with terror and expressed fear of death from the onset of late labor until the child was delivered, Anne told me. But she had rejected any gynecological examination or intervention, including injections of pain relief. Communication had been impossible, Anne said: "It was like a veil over her eyes. She did not see us or hear us. We couldn't reach her." As Leyla had fought to resist the bearing-down pains, closing her legs and thus blocking the birth channel, the midwife and an assistant had to use physical force to separate her legs. Anne felt she had to violate Leyla to be able to assist her delivery and saw herself as a part of Leyla's retraumatization.

Concluding Remarks

This article has shown how health workers in Norway experience encounters with infibulated women. This involves technical challenges related to how to cut, interpretative challenges related to how to understand the pain behavior of Somali women, and emotional challenges related to caring for women who had undergone what health workers saw as the ultimate expression of male oppression and occasions of retraumatization.

An important finding is that health workers' efforts to provide culture-sensitive care at times led to an overinterpretation of culture. This affected care in the sense that health workers sometimes provided care procedures that were detrimental to birth care and contrary to medical guidelines and which differed from Somali personal and cultural needs. Furthermore, tendencies of stigmatization caused a high degree of silence and taboo surrounding the issue of FGC, thus reducing communication that could have increased mutual understanding and resolved misunderstandings. Stigmatization and negative emotions related to FGC may also have created an emotional detachment. This distanced health workers personally from the women they were trying to assist, who, in turn, became typified rather than being treated as individuals. Health workers' polarized view of African women as simultaneously "victims of an oppressive culture," of which infibulation is the most extreme sign, on the one hand, and representatives of the "noble savage," on the other hand, was a complicating factor.

The article illustrates how medical practices are affected by cultural ideas about otherness, gender, and the naturalness of the female body. It also suggests that infibulation may be an indirect cause of the increased health risks infibulated women experience in exile countries because of the way it negatively affects health care procedures.

Notes

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1. I use the term *female genital cutting* (FGC) when talking about the practice in general and *female circumcision* as used by the informants. *Female genital mutilation* (FGM), which up until recently was the most frequently used terminology of international nongovernmental officers, is used in Norway in legal and governmental plans and is thus used when referring to these documents and discourses. *FGM* is rarely used in daily Norwegian; *female circumcision* is generally used in daily discussions by health workers and in the media.

2. Act no. 74 of December 15, 1995.

3. Clearance was granted by the Regional Committee for Medical Research Ethics. In addition, hospital forms for professional secrecy were signed.

4. Ethical clearance for this part of the study was granted by the Norwegian Board of Health (Statens helsetilsyn 2000).

5. The study tour to Somali areas included Somalia, Somaliland, Djibouti, and Somali areas in Kenya (Mandera). For more information on the Omsorg og Kunnskap [Care and knowledge] Project and its activities, see http://www.okprosjekt.no.

6. International research on birth in the field of medical anthropology has, in recent years, raised significant cultural critique of the medicalization of birth (Anonymous Student 2002; Davis-Floyd and Sargent 1997; Endresen and Bjørnstad 1992; Martin 1989).

7. There were no available statistics on attendance by ethnic minorities, but the health workers' impression was that the attendance was high, though initiated slightly later and attended slightly less frequently.

8. A study of the hospital records for 32 deliveries of Somali women shows that circumcision status was noted only in nine cases, two of which were noted after delivery because of late complications. In the medical birth registry, circumcision status was noted in less than 15 percent of Somali women, whereas the frequency of circumcision among the Somali is almost 100 percent (Norsk Medisinsk fødselsregister 2000).

9. In a few cases, especially those described by Somali women, this may have been based on a misunderstanding of what was actually done, in the sense that the midwife may have talked about restitching an episiotomy, although the patient related it to reinfibulation. However, some seemed to be real reinfibulations, often in spite of the women's expressed demand not to be closed again.

10. Talle (1993) recounts rare occasions of reinfibulations after divorces among some pastoralist Somalis.

11. Sources for this debate are newspapers (Dommerud 1993a, 1993b; NTB 1993; Olsvold 1993; Skogstrøm 1993), tapes of debates on radio and TV, and interviews with some of the parties involved at the time.

12. Health workers discussed this as a dilemma only in hypothetical discussions of cases of abortion or the rape of an unmarried girl, out of respect for sociocultural demands of her virginity. I have reliable information on only one case of total reinfibulation performed in Norway—on a young woman who wanted to re-create the sign of virginity before moving back to her country of origin.

13. A woman who is considered to need a C-section by the doctor may refuse to have it, even at the risk of her child's health and life, although she may not refuse it if her own life is in danger.

14. The Somali word *qalliin* means "slaughter" when used on animals but "operation" when used on humans.

15. The medical disadvantages of medication are that they, for example, reduce the child's physical fitness (petidin), reduce the elasticity of the vaginal tissue (local anesthesia), and reduce the efficacy of labor (epidural).

16. Of these, about 10 percent receive petidin, and 20 percent, epidural. Local anesthetics are also used frequently during cutting and stitching episiotomies.

17. Some traditional birth attendants we met in Somalia said that half of the primipara mothers died during delivery. Although this number is probably exaggerated, as the meager existing statistical evidence does not support it, it still can be read as an expression of the extent to which mortal danger is present in the women's minds.

18. The tradition of hosting a party *(koraisi)* prior to delivery to pray for a healthy outcome of the birth for both mother and child may be seen as one way to manage the fear and take control of the outcome of childbirth. The widespread reluctance to ask when the baby is due, which I have encountered in many African societies, can be understood as another way to handle this risk emotionally. This stands in sharp contrast to present-day Norway, where this is one of the first questions asked of pregnant women.

19. This is one reason why a project was initiated at Bærum Hospital to promote the presence of another Somali woman during childbirth.

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Paper IV

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Qualitative study of perinatal care experiences among Somali women and local health care professionals in Norway

Siri Vangen[a,b,*], R. Elise B. Johansen[c], Johanne Sundby[c], Bente Træen[d], Babill Stray-Pedersen[a]

[a]*Department of Obstetrics and Gynecology, the National Hospital, Oslo, Norway*
[b]*Division of Epidemiology, Norwegian Institute of Public Health, P.O. Box 4404 Nydalen, N-0403 Oslo, Norway*
[c]*Institute of General and Social Medicine, University of Oslo, Oslo, Norway*
[d]*Institute of Psychology, University of Tromsø, Tromsø, Norway*

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Abstract

Objective: To explore how perinatal care practice may influence labor outcomes among circumcised women. *Study design*: In-depth interviews were conducted with 23 Somali immigrants and 36 Norwegian health care professionals about their experiences from antenatal care, delivery and the management of circumcision. *Results*: Circumcision was not recognized as an important delivery issue among Norwegian health care professionals and generally the topic was not addressed antenatally. The Somalis feared lack of experience and sub-optimal treatment at delivery. All of the women expressed a strong fear of cesarean section. Health care professionals were uncertain about delivery procedures for infibulated women and occasionally cesarean sections were performed in place of defibulation. *Conclusion*: We hypothesize that neglect of circumcision may lead to adverse birth outcomes including unnecessary cesarean sections, prolonged second stage of labor and low Apgar scores. We suggest that infibulated women need a carefully planned delivery, correctly performed defibulation and adequate pain relief.

Keywords: Female circumcision; Perinatal care; Infibulation (defibulation)

1. Introduction

Female circumcision is an ancient tradition widely practiced in Somalia and in other parts of Africa. Nearly 100% of women of Somali origin have been circumcised. About 80% have undergone infibulation, which is the most extensive form of circumcision [1,2]. Infibulation leaves a pinhole introitus of about 1 cm in diameter. The vulva is closed by a seal of varying thickness created after adaptation of labia majores [3]. As a result of the migration of Somali women to Europe during the past 10 years Norwegian doctors and midwives have encountered an increasing number of infibulated women. Since 1998, there have annually been more than 300 births in Norway to women of Somali origin. Available studies and practical experience indicate that women of Somali origin represent a high-risk group in obstetrics. The risk of intrauterine fetal distress, emergency caesarean sections, low Apgar scores and intrauterine death among women of Somali origin is approximately three times greater than among ethnic Norwegians. However, the risk intrapartum and neonatal death was not significantly increased [4,5].

It has been reported that circumcision gives rise to a number of obstetric sequelae, and the number and severity of complications increases with the severity of cutting [2,6–8]. Antenatal opening of the seal of infibulation (defibulation) is considered essential for the course and outcome of labor [9]. Are health care professionals adequately prepared to handle deliveries of Somali immigrant women, or do we leave the care for these women to chance and improvisation [10,11]?

Previous epidemiological studies have provided limited knowledge and we believe that a qualitative approach is appropriate to add knowledge on these issues. By means of qualitative data, we studied ethnic Somali's and local health care professional's experiences from antenatal care and delivery. Our intention was to generate hypotheses about how care in pregnancy and birth may influence on the perinatal outcome among ethnic Somalis.

* Corresponding author. Tel.: +47-23-408198; fax: +47-23-408252.
E-mail address: siri.vangen@fhi.no (S. Vangen).

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2. Materials and methods

2.1. Study population

The Somali participants were recruited for the interviews at meetings through the Somali's association and in health facilities. A snowball sampling technique was used in which women who had agreed to be interviewed referred the interviewer to other women they knew [12]. The inclusion criteria were born in Somalia and now living in Oslo or the near by region, had gone through female circumcision and had childbirth experience from Norway. Initially, 29 women were willing to be interviewed. Three of them had no childbirth experience, two were not circumcised and one woman did not show up for the appointed interview. Thus, the final sample included 23 Somali women, who had given birth to a total of 58 children in Norway (Table 1). Twenty-two women were infibulated and one woman had been exposed to a milder form of cutting (excision). The age span was from 18 to 55 years. Two women were illiterate, but the majority ($n = 17$) had finished 2–4 years of primary school in Somalia. Four women had higher education including two nurses, one teacher and one accountant. The nurses were educated in Norway. None of the women had university education. The majority came to Norway as political refugees while two women had come prior to the civil war in Somalia to work or study. The time of residence in Norway varied from 1 to more than 10 years. Some may have attained Norwegian citizenship, but for simplicity they will be referred to as Somalis.

The majority of Somali women are attending the maternal and child health centers for antenatal care. The midwife plays a central role, but the woman has to be seen by a public health doctor at least four times during an uncomplicated pregnancy. Three different maternal and child health centers and three different obstetric wards in Oslo were chosen to

Table 1
Overview of the Somali participants

	Circumcision status	N[a]	Experiences from birth and defibulation
1	Infibulated. Opened at marriage.[b]	3	Traumatic births. Two last births ended in cesarean sections that she considered unnecessary. Received no information. Felt not taken seriously.
2	Infibulated. Present status unknown.	3	Traumatic first birth ending in a cesarean section that she thought was unnecessary. Received no information. Felt lost and lonely.
3	Infibulated. Opened at marriage.[b]	1	Unproblematic birth.
4	Infibulated. Opened.[c]	3	Infections after defibulation at first birth. Did not seek medical assistance.
5	Infibulated. Opened and re-stitched at birth.	1	Series of infection in clitoral area after delivery, seeking and receiving medical care that was associated with extreme pain.
6	Infibulated. Opened.[c]	4	Repeated infections prior to and after defibulation. Painful deliveries. Received no information on pain relief.
7	Infibulated. Opened at birth.	3	Prolonged labors. Needed assistance to push out the babies.
8	Infibulated. Opened.[c]	1	Extreme pain when urinating after defibulation. Fear of re-experiencing her circumcision during delivery that ended in a caesarean section.
9	Infibulated. Opened.[c]	2	Prolonged labors. Traumatic birth experiences.
10	Infibulated. Not opened.	2	Traumatic pregnancies and births.
11	Infibulated. Opened.[c]	4	The births were considered unproblematic.
12	Infibulated. Present status unknown.	4	Three normal deliveries. Several weeks of hospitalization after cesarean delivery of the last child due to complications caused by the anesthesia.
13	Infibulated. Opened at marriage.[b]	1	Vacuum delivery, large vaginal tear that became infected.
14	Infibulated. Opened at marriage.[b]	1	The birth was considered unproblematic, content with the care.
15	Infibulated. Not opened at birth.	1	Lack of communication with health worker. No pain relief.
16	Infibulated. Opened during pregnancy.	6	Request for defibulation in pregnancy was first refused, admitted at the second request. The births were considered unproblematic.
17	Infibulated. Opened and re-stitched at first birth. Opened at the second birth.	5	Large anal rupture at the second birth. The last three births were considered as unproblematic.
18	Infibulated. Opened at birth.	1	Episiotomy and defibulation, the birth was considered unproblematic.
19	Infibulated. Opened at birth.	1	Episiotomy and defibulation, generally content with the birth.
20	Excised (clitoris and labia minora removed, but no closure of vagina).	1	Unproblematic birth.
21	Infibulated. Opened at birth.	2	Extremely painful deliveries. Request for pain relief was not acknowledged.
22	Infibulated. Opened at marriage.[b]	4	Three normal deliveries. Felt not taken seriously after ruptured amnion in the last pregnancy. Finally, after several requests labor was immediately induced due to lack of amnion. No pain relief in any delivery.
23	Infibulated. Opened and re-stitched at first birth. Opened at the second birth.	4	At first delivery she had to guide the attending midwife, which she could, as she herself was a midwife. Re-stitched at first birth, a written statement demanded permanent defibulation at second delivery.

[a] Births in Norway. The number of births completed before coming to Norway varied from zero to six.
[b] Surgery in Norway.
[c] Surgery in Norway independent of birth or marriage.

recruit health care professionals (in total 36) for interviews. Eight gynecologists and 15 midwives were recruited from the obstetric wards. Three public health doctors, seven midwives and three public health nurses were recruited from the maternal and child health centers. The project was presented during meetings in the health facilities. The health care professionals were all recruited voluntarily at such meetings or they followed the interviewer's request to call her during or immediately after attending a delivery with an infibulated woman.

2.2. Interviews

Repeated in-depth interviews with the Somali immigrants and health care professionals were conducted during two time periods: the latter half of 1997 and the first half of 2000. The same anthropologist REBJ performed all the interviews. The interviews were open, exploratory, but thematically structured. The themes included education, training, knowledge about the management of circumcised women, birth complications associated with circumcision, experiences from antenatal care and delivery, attitudes to defibulation and present legislation. We chose the term 'female circumcision' in interviews and presentations as the alternative expression 'female genital mutilation' may have offensive connotations. The most extensive form of circumcision is termed 'infibulation'. 'Re-infibulation' is the process of re-stitching back to the infibulated state after delivery.

Most interviews took place in the women's homes. Four women were interviewed in public cafes, one interview took place in the interviewer's office and two women were interviewed at the hospital some days after childbirth. Generally, only the interviewer and the woman were present at the interviews. In three cases, the woman's husband took part in the interview. All the health care professionals were interviewed in the conversation room at their working place. New ideas and research questions were followed up during the interview process. Most interviews lasted from 2 to 3 h, and about half of the participants were interviewed more than once and up to six times. Saturation, when no new themes appeared in subsequent interviews, was observed after around 20 women had been interviewed. Generally, there was no problem with communication between the interviewer and the participants, and the interviewer felt more reluctant to ask personal and private questions when an interpreter was present. In three cases, a professional interpreter was used. One of these women was interviewed later without an interpreter as her language knowledge had improved. The interviews were tape-recorded or reported by notes. Most interviews with health care professionals were taped. Two doctors refused to have their interviews tape-recorded that were reported by notes. Interviews with Somali women were reported by notes because taping hampered their willingness to talk. All the interviews were transcribed immediately after completing the interview.

2.3. Analyses

The interview material was analyzed systematically by three of the researchers including anthropologist REBJ, and the gynecologists S. Vangen and J. Sundby. Through a detailed interpretation of the interview transcripts the following main themes were generated: care for circumcised women in antenatal clinics and delivery wards, the defibulation procedure and health care professionals' and Somali women's experiences from antenatal care and delivery. The data was interpreted according to the main themes and contrasting views on the various issues raised [12].

2.4. Theoretical framework

Being pregnant in a foreign country or being a Norwegian health care professional providing care for an infibulated woman are situations in which the individuals involved may have limited knowledge and experience. Empowerment in connection to these encounters and in relationships may be defined as ways and routes through which individuals attempt to take control over their own activity and/or environment [13,14]. Empowerment is a process of achieving cognitive and behavioral skills to make adequate decisions. Disempowerment refers to the lack of empowerment. Empowerment and disempowerment are not static concepts, but dynamic processes between the interacting parts. Central to the understanding of empowerment and disempowerment is that actions can be conceptualized at two levels. The first level is the intellectual (knowledge, expectations and intentions people bring with them to an encounter, i.e. 'theory'), and the second level is the experiential (the sum of previous experiences in the area, i.e. 'practice'). The relationship between these levels, between theory and practice, is not static. For the purpose of this paper and through the accounts of the informants, we will regard the encounter between Somalis and Norwegian health care workers as processes where disempowerment and empowerment are central features.

2.5. Ethical considerations

All participants received both a written and oral description of the study. The written presentation was translated into Somali. The study was presented both when they were asked to participate, and when they showed up for the first the interview. The health care professionals gave a written consent. To ensure anonymity the Somalis gave an oral consent. The study was approved by the Regional Ethical Research Committee.

3. Results

3.1. Routines of care

In the first interview period none of the perinatal units had established routines for the management of circumcised

women and the circumcision status was seldom noted in the records. Information on the defibulation procedure and stitching was also missing. During the second period one of the hospitals had established such routines, and was working to improve them. The outpatient clinics had also discussed the issue and decided to routinely record the circumcision status in the medical records. However, the hospital records revealed that the circumcision status was noted in only one of four cases.

The communication between outpatient clinics and the hospitals regarding the management of infibulation was poor. The antenatal clinics had stopped referring women to the hospital for antenatal defibulation because their requests had been refused. One of the Somali women told that she requested defibulation during pregnancy, but the request was refused by the hospital (Table 1). She was admitted by the second request. Outpatient clinic personnel considered it to be the duty of the hospital staff to discuss defibulation and other delivery issues concerning circumcision with the Somalis as a male doctor at the antenatal clinic stated:

> I didn't discuss these things with her (a pregnant Somali women).
>
> Did you notice what type of circumcision she had been exposed to or whether she needed to be defibulated?
>
> I didn't study her genitals very carefully as I think that would have been intrusive and I don't think it is necessary. When she comes to the hospital they will see that she is a Somali and they will know that she may be infibulated. It is the hospital's job to take care of the delivery and they will do whatever they think is necessary.

But, the hospital staff considered it to be part of the antenatal care program to discuss issues concerning the circumcision with the Somali women. Midwife A at the delivery ward expressed it this way:

> The women come here to deliver their child and not to discuss circumcision. Our job is to attend the delivery. You can't discuss with a woman when she is in labor pain.

On their own initiative, some of the health care workers had attained knowledge about the cultural aspects of the tradition, its distribution and different forms. None of the health care professional had received theoretical information or practical training on delivery procedures in infibulated women during their formal education.

3.2. Health care professionals' experiences

The majority of health care professionals requested communicative training as they usually found it difficult to talk about circumcision with their clients. They felt uncertain about how to address the circumcision and which words to use when raising the topic during the consultation. The Somali's strong fear of cesarean sections that was clearly indicated by clinical signs such as a pathological fetal heart rate was particularly frustrating for health care professionals.

Some midwives had experienced extraordinary high levels of fear and pain during the delivery among Somali women. As midwife C said:

> Somali deliveries are always more chaotic. There is always some problem.

Midwife D expressed after a particularly difficult delivery:

> I had to use physical force to hold her legs apart so that the child could be delivered. This made me feel like an abuser. She was screaming in death fright. It was as if she re-experienced her circumcision.

Other midwives, however, considered Somali women more 'natural' and praised their ability to 'suffer in silence'. The midwives considered this as a sign of strength indicating that they should not interfere.

3.3. The defibulation procedure

Midwives and gynecologists had different ideas about the best way to deliver infibulated women. The most controversial topic was defibulation. Where and when to carry out the defibulation, the size of the defibulating incision and how to sew after delivery were unresolved questions. In nearly all cases, the issue of defibulation and the procedure to be adopted was not discussed with women in labor and no plans had been made in advance. Defibulation was usually not performed until late second stage of labor, and occasionally the defibulation was not performed at all. Health care professionals commonly assumed that the Somali woman in labor did not want to be defibulated. Midwife B explained it the following way:

> I tried to ask the woman whether she wanted me to re-infibulate her if there were tears in the infibulated area. However, I felt she did not understand the question. It is very difficult to re-infibulate you know; it has to be stitched in two layers. Therefore, I just made an episiotomy to avoid tears in front.
>
> You did not consider that the woman wanted to be opened?
>
> No?! Of course she wants to remain the way she is.

Re-infibulation after delivery had also been performed. In two cases the midwives did not know that it was illegal while one stated that re-infibulation was necessary to avoid excessive bleeding.

A doctor exclaimed after her first delivery with an infibulated woman:

> When you don't recognize the anatomy, you are sort of taken aback.

Many midwives considered the defibulation procedure to be a difficult and/or risky procedure. Some did not even think about the possibility of performing an anterior cutting due to fear of damaging the urethra while others resorted to double and, in two cases, triple episiotomies. Some midwives remembered cases where cesarean section had been performed due lack of knowledge on how to perform the defibulation.

Most midwifes and doctors were unaware of an association between infibulation and an increased risk of birth complications. They were very surprised when presented with reports indicating that infibulation is a risk factor of prolonged labor, neonatal distress and delivery by cesarean section. The midwives were not aware of the importance of performing a timely defibulation to prevent a prolonged second stage of labor.

According to the tradition in the northern regions of Somalia five of the women in our sample had been defibulated when they married (Table 1).

3.4. Somali women's experiences

Generally, Somali women had a positive attitude towards the Norwegian health care system. The critical voices, however, expressed fear of not receiving adequate care during the delivery. They feared lack of experience with infibulation and were afraid of not being opened sufficiently. The Somalis expected health care professionals to talk about the circumcision during antenatal care. However, due to shyness, language problems, pain and fear of stigmatization few Somalis took the initiative to speak about these issues.

The Somali women had not perceived information about the different methods of pain relief and other delivery procedures, such as the routines for fetal monitoring and episiotomy procedures. While they received written information, they did not read it. Those who had read the information, however, found it difficult to understand and could not relate it to their own situation. The advantage of fetal heart monitoring had not been perceived. All of the women expressed a strong aversion against cesarean section, as this procedure was associated with great danger.

Somali women A narrated the following:

> They had tied this belt so tight around my belly, it pained me and I tried to pull it away. I tried to tell the nurse, but she didn't listen. She was angry and yelled at me that the heartbeat was indicating danger. I don't know whether it was true or if it was just because I kept on adjusting and pulling the belt. So it ended like that, in a cesarean section. I still don't know whether it was necessary to cut me.

Generally, childbirth was associated with fear of dying. Somali woman B claimed:

> Childbirth is like going into a tunnel, and you never know whether you are coming out alive.

Some women openly expressed that the experience of their own circumcision that was associated with extreme pain was revived during pregnancy and delivery. Recalling her first pregnancy, Somali woman C told:

> In my dreams, my delivery and my circumcision are sort of mixed up. I am lying there pregnant, but only six years old as I was at my circumcision, and there are people around me with knives cutting me up everywhere. It is just awful.

Many Somali women had experienced or heard about ignorant and offensive comments from health care professionals. A doctor asked one woman whether her genitals had been burned, a question which she found embarrassing. Others could tell about expressions of surprise and disgust in the midwives faces when being examined.

Expressions of loneliness and fear of being abandoned during delivery were common. The women who had undergone a cesarean section did not understand why and they were not convinced of the benefits or necessity.

Somali woman D expressed it this way:

> I felt so lonely and lost. I did not know the language, and my husband could not be there all the time. If I had stayed at home in Somalia, there would have been people around me, people who cared. Here I was all alone, helpless and in pain. I felt so miserable. And then it ended in a cesarean section. I do not know why, and I don't think it was necessary.

4. Discussion

4.1. Strength and weaknesses of the study

We have chosen a qualitative method to deepen the insight into perinatal care provided to circumcised women. To what extent are the results of this study relevant for the background population? Even though generalizing is not the purpose in qualitative research, the existence of phenomena may be generalized in such research. Our sample was relatively large and heterogeneous with respect to age, parity, education level and origin in Somalia. This gives a higher potential for generalizations so that our results may be relevant to Somalis living in Norway and other similar societies. The extended sample and the thorough follow-up of the participants increased the validity of the study. The preliminary analyses were also discussed with health care professionals and Somali immigrants who agreed with the findings.

Compared with the general educational level of Somali women giving birth in Norway, women with higher education were over-represented in our sample [5]. To the extent that this introduces a bias, we believe that communication difficulties between Somali women and health care professionals revealed in this sample would underestimate the problems existing in the total population. Selections of

health care professionals with a greater knowledge concerning female circumcision than average could introduce a similar bias.

As regards the qualitative data, it is important to bear in mind that cultural analysis always involves the researcher's attempt to interpret the interviewee's account of their social reality [15]. In narratives people tend to interpret their experiences relative to purposes, to describe their actions as seeking to express value or justification in the process, to demonstrate efficacy and control, to portray themselves as attractive and competent, all in a manner to preserve their own self-esteem and sense of self-worth [16]. The researchers' personal and intellectual biases may also have influenced the results. We examined themes and issues running through the interviews in the light of these factors.

4.2. Are we prepared to care for circumcised women?

Our findings show a lack of consciousness among health care professionals regarding circumcision as a medical problem. The neglect of circumcision may have been due to a reluctance to interfere with a phenomenon that evokes strong emotional reactions and is unfamiliar in the health care worker's own culture. Lack of knowledge as to how the situation should be handled may also contribute to the neglect. This may be a source of disempowerment, both on the intellectual and experiential levels.

Generally, Somali women may feel disempowered in their meeting with the Norwegian health care system. Condemning attitudes may strengthen their feelings of disempowerment. This may be so because that, which is considered normal within their African culture such as genital cutting, is not only abnormal, but also socially unacceptable and illegal within the Norwegian health care setting. This may put the women under strain and induce fear, particularly as they also need the services provided by the Norwegian health care system.

All the Somali women had a strong aversion against cesarean sections. A study of pregnancy and childbirth experiences among Somali women residing in Sweden found that the women's behaviors were related to their background in Somalia [17]. In Somalia, a cesarean section is often associated with severe complications and maternal mortality is high. The Somali women's perception of childbirth and their fear of dying during the delivery must be related to their background where maternal mortality is high, 1400/100,000 births. The respective number in Norway is 6/100,000 births [18].

Pain and fear of pain was a common issue in the Somali women's narratives. The pain of infibulation has been described as a lived bodily experience, an intolerable pain that you never forget, a heavy burden that you always carry with you [19]. A Somali woman was asked why she was opposed to infibulation. She answered, "because it is pain three times. It is the pain when the infibulation is done, the pain when it has to be opened again at marriage, and the pain when it has to be further opened when giving birth" [19]. The revitalization of the embodied pain from infibulation during pregnancy and childbirth was also demonstrated in the current study. The close association of infibulation and childbirth has also been reported in a study performed in Canada [20]. Health care professionals' lack of awareness of the increased pain caused by the infibulation was specifically addressed here. This indicates that pain management is important. The good effect of epidural analgesia in labor for infibulated women has been described in a study from the USA [21]. On the other hand, half of the women interviewed in the Canadian study wanted a vaginal delivery without pain relief.

4.3. Associations between care and birth outcomes

Being confronted with infibulated women, midwives and doctors showed signs of disempowerment. Often the health care professionals did not have the knowledge or skills for decision-making and control of the current situation, and they did not know what was correct to do. In some cases, cesarean section had been performed due lack of knowledge on how to perform the defibulation. This could indicate that unfamiliarity with defibulation might lead to unnecessary cesarean sections. Data in the Medical Birth Registry of Norway strengthen this hypothesis indicating that the frequency of emergency cesarean section among ethnic Somalis is tripled (15%) when compared to ethnic Norwegians [5].

Data in the Medical Birth Registry show a significantly increased risk of prolonged second stage of labor and neonatal distress among ethnic Somalis that may be related to sub-optimal handling of delivery [5]. A positive effect of performing defibulation in the second trimester has been reported [9]. Thus, the normal delivery procedures including urethral catheterisation and assessing the progress of labor is not hindered by the presence of a pinhole introitus [21]. Antenatal defibulation will also prevent acute problems at the time of delivery related to the staff's unfamiliarity with defibulation. However, a study from Saudi Arabia in which the staff was familiar with circumcised women, reported that intrapartum defibulation was simple and safe [22].

There is evidence that women's fear may interfere with the normal course and outcome of labor [23]. Data in the Medical Birth Registry of Norway showed increased frequency of fetal distress, secondary arrest, low Apgar scores and emergency cesarean sections among ethnic Somalis that may be associated with high levels of fear and pain [5,23]. Cultural sensitivity, empathy and individual support may change this pattern.

4.4. Summary

There is a need for empowering health care professionals and Somali women. Local health care professionals had not recognized infibulation as an important delivery issue. We hypothesize that neglect of circumcision may lead to adverse birth outcomes. There is a need for increased knowledge

about obstetric care for circumcised women among health care professionals. We suggest that circumcised women should be identified in the antenatal setting and obstetric issues including defibulation, the procedure to be adopted and adequate pain relief is discussed with the individual women. Cultural sensitivity and non-judgmental care is important. Discussions about circumcision and individual support may also help the Somali couple to reject the practice when the time comes for their daughters to be circumcised.

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