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Special Issue: Female Genital Cutting in the Past and Today

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About the Journal

The Finnish Journal of Ethnicity and Migration (FJEM) is devoted to the high quality study of ethnic relations and international migration. Published biannually by the Society for the Study of Ethnic Relations and International Migration (ETMU), this peer-reviewed, interdisciplinary, open-access journal provides a forum for discussion and the refinement of key ideas and concepts in the fields of ethnicity and international population movement. The Editors welcome articles, research reports and book review essays from researchers, professionals, and students all over the world. Although international in its scope of interests and range of contributors, The Finnish Journal of Ethnicity and Migration focuses particularly on research conducted in Finland and other Nordic countries. Opinions expressed in the FJEM articles are those of the authors and do not necessarily reflect the views of ETMU.

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Marja Tiilikainen and Janneke Johansson

Introduction

Female circumcision or female genital cutting (FGC) is an ancient cultural tradition, which is practiced in many African countries, but also in some areas of the Middle-East and Asia. In the past twenty years, as a consequence of increased mobility and migration, female genital cutting has become known all over the world, even in the Nordic countries. According to WHO estimates, there are 100–140 million girls and women living today who have been subjected to the practice, and annually approximately 3 million girls are at risk of undergoing female circumcision. The procedure itself may range from minor pricking and piercing to excision of the clitoris and narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia. (For the classification of different FGC types, see Johansen et al. in this issue.) The consequences and complications of female genital cutting vary according to the extent of the operation, the instruments used, the skills of the circumciser, as well as other circumstances during and after the operation.

Medical experts, human rights activists, feminists, and also many circumcised women themselves see the practice as harmful to the health of girls and women and as a violation of their human rights. Recently, also some religious authorities have openly opposed the continued practice of female genital cutting, at least the most radical operations. Furthermore, legislation in almost all European countries as well as many countries where the practice of female genital cutting is widely spread, forbids the act. In Europe and Africa, several campaigns and projects against FGC, both on national and international levels, have been conducted. Despite all these efforts FGC continues to occur both in Western countries and in the countries with long history of FGC. Is it possible to eradicate a deeply-rooted, culturally significant tradition, and on what conditions? What kind of a challenge is FGC today, and whom does it concern, considering the historical and present circumstances like the relatively easy travel and border-crossings? These questions are being addressed in this special issue of the Finnish Journal of Ethnicity and Migration (FJEM). This thematic issue is based on selected papers presented during the 4th FOKO Conference in Finland, arranged jointly by the KokoNainen (Whole Woman) Project of The Finnish League for Human Rights, Hanasaari – The Swedish-Finnish Cultural Centre and Kvinnoforum – Foundation of Women's Forum in Sweden, 7–8 September, 2007. The aim of the conference was to bring together scholars and other experts to discuss the multi-faceted phenomenon of FGC from historical and present-day perspectives. In addition to academic work, experiences from projects, community work and good practices were presented. The conference attracted 120 participants from Finland and other Nordic countries, as well as from other European countries, North America, Africa and Asia. During the two days over 30 presentations were given, including the key note speeches of Professor Janice Boddy from the University of Toronto, Technical Officer, PhD Elise Johansen from WHO and Molly Melching, founder and Executive Director of Tostan, an organization that was awarded the Conrad N. Hilton Humanitarian Prize in 2007.

FOKO is a Nordic, multidisciplinary network for research on female genital cutting (Forskning om Kvindelig Omskæring) that was founded eight years ago by two doctoral students in anthropology, Elise Johansen and Sara Johnsdotter. The first FOKO conference was held in Oslo, Norway in 2001, the second in Malmö, Sweden in 2003, the third in Copenhagen, Denmark in 2005 and the fourth in Espoo, Finland in 2007. In her opening speech Dr. Sara Johnsdotter reminded the audience of the history and the essence of the FOKO network and FOKO meetings:

FOKO was, and is, meant to create a zone free from political correctness and rebukes of dissidents. Debate – yes; censorship – no. That is why it is of minor importance if a conference participant chooses to say "female circumcision," "female genital cutting," "female genital mutilation," "female genital modification" or something else. It is ideas, arguments and results that are in focus. We will have all these presentations and discussions in an air of respectfulness.

There is an ongoing and sometimes heated discussion on appropriate terminology regarding female genital cutting. The term FGM, female genital mutilation, has been widely adopted. For example, in the 6th General Assembly of the Inter-African Committee on Traditional Practices Affecting

the Health of Women and Children that was held in April 2005 in Mali, an appeal was made to use the term FGM. However, as the term FGM is politically as well as emotionally very charged and does not reflect the variety of circumcision types nor its cultural meanings, other terms have also been recommended and used, particularly in preventive work at the grassroot level. In the Helsinki conference as well as in this theme issue, we have preferred the terms female circumcision and female genital cutting, FGC, which we find to provide a more neutral platform for academic as well as other discussions on this highly sensitive issue. However, many other terms including FGM and local concepts are also presented, which mirrors the multi-sidedness of the phenomenon.

Indeed, the texts in this special issue show the complex nature of female genital cutting and question universalizing definitions and practices in relation to it. The articles and reports address the historical and cultural variation and specificity of female circumcision as well as new interpretations and practices following social, religious and political changes.

In the opening article, Janice Boddy provides a historical view on British attempts to stop female genital cutting in colonial northern Sudan and their eventual failure. The analysis of past initiatives entails important lessons for contemporary work against female genital cutting. The three following articles form an interesting section as they all discuss female genital cutting in Southeast Asia, an area that has been largely ignored in the study of female genital cutting. These articles by William G. Clarence-Smith, Basilica Putranti and Claudia Merli highlight the controversial relationship between Islam and female genital cutting. They show the strongly Islamic connotations of FGC in Southeast Asia and describe how Islamic discourses may lead to the dismissal of the practice, or on the other hand, to its intensification.

Brigitte Bagnol and Esmerelda Mariano contribute to the discussion on WHO's definition of FGC by describing women's vaginal practices in Mozambique that are positively related to notions of femininity, sexuality and health. Courtney Smith examines the construction of the female body by contrasting two different ways of modifying the body in two cultural contexts – female genital cutting in Senegal and breast augmentation in the United States. The last two studies focus on female circumcision in the context of migration. Aud Talle is concerned with how Somali women, as circumcised women, rework their identity in urban European milieus in Oslo and London. She suggests that the moral excellence Somali women strive for continues to be embodied even in exile ─ not primarily symbolized by genital cutting, but by increased veiling. In the final article, Sara Johnsdotter discusses a court case on female genital cutting in Sweden and argues that the conviction of a Somali father had to do with the political context of FGC in the West and the emotional power field surrounding it.

The project reports highlight current activities, achievements and challenges in the work against female genital cutting. R. Elise B. Johansen, Heli Bathija and Jitendra Khanna outline ongoing research and policy discussions in the World Health Organization that has set international standards for FGM, including the classification of different types of FGM. The writers also present a revised classification of FGM effective in 2008. Ugaso Jama Gulaid provides information about FGM eradication activities carried out by civil society organizations in Somaliland as well as current attitudes towards FGM. Faduma-Hagi M. Hussein describes the change in attitudes towards FGC among the Somali community in London, based on experiences gained from a health clinic. Finally, Janneke Johansson introduces the aims and activities of the main project in Finland that aims at preventing FGC in the country.

The articles and reports of this special issue inevitably reveal that the issue of FGC is far from being emptied out by researchers or "solved" by activists and professionals aiming at stopping the practice. On the contrary, more studies are needed on topics such as the definition and terminology of FGC; medicalization and commercialization of the practice; women's agency, knowledge and power in relation to FGC; female body, including different kinds of bodily markings, modifications and mutilations, constructed and lived in social, cultural and political worlds; FGC and re-creation of identities in exile; the interconnectedness of male and female circumcision particularly among Muslim populations; and current Islamic discourses and impacts on the practice of FGC in different parts of the world. In particular, an operation referred to as *sunna* needs to be studied further ─ what kind of an operation does it mean in different contexts and what kind of consequences may a possible transfer to *sunna* have for the continued practice of FGC?

We want to express our gratitude for all the anonymous reviewers, whose valuable suggestions significantly sharpened and improved the manuscripts. We also thank all the authors, who patiently corrected their texts during a long editing process. The final editing and language checking was done by Assistant editor, Dr. Maarit Forde. Without her expertise and experience this publication would not have been completed in the given timetable. Information Officer Susan Villa from the Finnish League for Human Rights has also been of great help in the editing team. Finally, we cordially thank Hanasaari – The Swedish-Finnish Cultural Centre and Kvinnoforum ─ Foundation of Women's Forum in Sweden, which acted as partners in organising the 4th FOKO conference and the sponsors who made the conference, and ultimately this publication possible: Finland's Slot Machine Association and The Nordic Council of Ministers.

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Janice Boddy

Clash of Selves: Gender, Personhood, and Human Rights Discourse in Colonial Sudan

Abstract

This paper follows British attempts to stop female genital cutting in colonial northern Sudan through three phases: an initial period of midwifery reform which engaged with local practice in order to bring about change; a period in which local practice was suppressed and western-style education was deployed in an effort to reshape Sudanese gender sensibilities; and a final phase that saw the enactment of legal measures to curtail the severity of the custom. I suggest that each of these methods produced contradictory results that owed much to an incompatibility between British and Sudanese concepts of self.

Introduction

In February 1924, Harold MacMichael, civil secretary for the Anglo-Egyptian Sudan, opened a file at his desk in Khartoum and labeled it "female circumcision." What led him to do so, and why at this time? Why were colonial officials attending to female circumcision now, when for over twenty years of Anglo-Egyptian rule the matter had been all but ignored? Indeed, few field officers even knew what the practice was or that it was universal in their districts. Not so the medical department, which in 1920 had agreed to open a midwives training school in Omdurman, across the Nile from Khartoum, ostensibly at the insistence of a British woman who had "witnessed the barbarous customs at circumcision and birth"[1] and been appalled by what she had seen. It is telling that in colonial imaginations the midwifery school owed its start to a spectacle of 'African barbarity,' resonant as this is with popular anti-FGM discourse today.

In northern Muslim Sudan, most prepubescent girls undergo infibulation, locally known as pharaonic circumcision or pharaonic purification – a form of genital cutting in which the vaginal opening is obscured. My recent book (Boddy 2007) examines British measures to stop this practice, using these as a lens through which to study colonial incursions into selfhood. International concern over female genital cutting first arose in the 1920s, six decades before the practice was 'outed' as a violation of women's human rights by Fran Hosken, Mary Daly, Gloria Steinem, and Robin Morgan in the western feminist press. The lessons of colonial efforts are illuminating, but remain largely unavailed. Past and present campaigns, framed first in the discourse of civilizing, now of human rights, have been similarly caught up in an antiquated evolutionary teleology – the ladder from 'savagery' through 'barbarism' on which 'civilized' critics find an agreeably lofty perch. They differ only as to the body parts deemed salient to the cause, parts whose physical effacement in African women furnishes a mirror for contemporary anxieties in the west. When the clitoris was 'rediscovered' in the 1970s and became a symbol of women's emancipation and equality in Europe and North America, the FGM literature focused on the denial of African women's right to bodily integrity and the ostensible loss of their ability to experience sexual pleasure. But in the 1920s, following the devastating loss of life in WWI and the influenza pandemic that ensued, international concern focused on female reproduction, epitomized by the vagina and the womb. Thus, infibulation was condemned as barbaric, but not so-called "simple clitoridectomy."

In the Anglo-Egyptian Sudan, government interest in women's bodies was more prosaic than ideological, a point that begs us to examine present international interventions in similar geopolitical light. At the end of World War I, the British sought to stabilize their presence by making Sudan financially independent and free of Egyptian influence. Relations between

The article has been previously published in *Canadian Journal of African Studies*, Vol 4 Number 3 (2007):402–26.

the co-domini were strained, as Britain, the de facto colonial power, had rebuffed Egypt's expectation of full autonomy after the war, and nationalist dissent threatened to unite the upper and lower Nile in a pan-Islamic coalition. Work on an immense cotton plantation in Sudan's Gezira region, planned before the war, now got underway with funding from private investors and the colonial government, that was backed, in a clear message to Egypt, by Parliamentary loan guarantees. The project required building a dam to divert the Blue Nile, leveling fields, and digging a network of irrigation ditches and canals, the ultimate purpose of which was to feed England's textile mills in light of increasingly uncertain supplies of long-staple cotton from Egypt. The scheme would also serve to control the flow of the Nile, thereby strengthening Britain's economic and political hold over all territories downstream.

But the Gezira's success depended on securing a reliable and disciplined workforce, and Sudan was plagued by a perennial shortage of labour that "suitable" migrants had been unable to fill. Slaves, freed or yet tied to their masters, were considered too unruly to perform such regimented work. Most freeborn Arab Sudanese, whom British officials deemed tractable workers, could be drawn to colonial projects only for brief stints, attracted by high rates of pay, because the late nineteenth century had seen widespread depopulation in the north and a corresponding rise in available arable land. With British-enforced peace, people were encouraged to return to their villages and farm. Yet their numbers did not recover quickly enough to produce a useful proletariat for colonial projects, a situation exacerbated by the post-war influenza pandemic and, according to Sudan's medical director in 1924, by a rise in the prevalence of malaria ironically linked to leveling and flooding the Gezira for cotton (Bell 1998:296). Political officials, unwilling to blame stagnant growth on the boons of progress, held the customary practice of pharaonic circumcision to account for low birthrates and high infant mortality.[2] In the shadow of a growing rivalry with Egypt for the hearts and minds of northern Sudanese, the government in Khartoum sought an ample, loyal, and orderly Arab population now more than ever before. Phrased in the language of humanitarian advance, and surely inseparable from this in officials' regard, starting a midwifery school was one means to achieve that end. The plan was to raise the birthrate by bringing reproduction under closer scrutiny and control, while providing – and being seen to provide – compassionate care. Not surprising, then, that MacMichael opened his "female circumcision" file in 1924.

What is surprising, perhaps, is how little had changed by 1945, when a widely circulated government pamphlet warned against the pharaonic practice. Governor General Huddleston supplied a foreword cautioning northern Sudanese to abandon "a cruel custom" whose continuation "is an offence against humanity." He did not press for "the rapid political emancipation of women ... [only] for a reasonable status for Sudanese girls and women within your households, based on humanity of treatment and an opportunity for sound domestic progress" which, he claimed, is impossible "so long as the evil of Pharaonic circumcision is allowed to rot the fabric of your home life."[3]

The view was shared by Ina Beasley, the controller of girls' education in Sudan from the late 1930s through the 1940s, who confessed "the difficulty" she and her colleagues had experienced "in trying to understand the mentality of people, who could practice this human cruelty and yet be first-rate individuals in other ways" (Beasley 1992:401). Beasley repeatedly taught her pupils that "such operations are useless as a means of promoting chastity," [a common rationale] because virtue "can only be implanted by proper moral education and maintained by the individual's own conscious effort."[4]

The words of these colonial figures invoke notions of self, body, and society that, I would argue, were unpalatable to the majority of northern Sudanese. The concepts of 'will' and 'virtue' as personal dispositions, of progress, humanity, emancipation, rationality, sensibility, and indeed, normality, were trotted out endlessly by officials seeking to sway Sudanese from the "evil" of pharaonic circumcision. Although implicitly meaningful to the British, the discourse of liberal, indeed Protestant, individualism was opaque to most Sudanese. Even the educated local elite at the core of Sudan's nationalist movement did not engage with that discourse unskeptically. To Arab Sudanese men schooled in European ways, 'women's customs' such as lip-tattooing and female genital cutting were an embarrassment, and justified making women targets for social reform. Yet they also signified authenticity, indigenous culture. Because such practices distinguished Muslim Sudanese from Egyptians, Africans, and Europeans, "nationalists," writes historian Heather Sharkey, "... did not want [women] to change too much.... Indeed precisely because of their local particularity, women's customs provided a rationale for Sudanese nationalism" (2003:130). Thus, pharaonic circumcision figured, ambivalently, in struggles to extricate Sudan from colonial rule.

The government pamphlet mentioned earlier was intended to prepare Sudanese for a law that in 1946 made performing a pharaonic circumcision illegal and punishable by seven years imprisonment. Predictably, however, news of the law's impending passage sparked a rash of pharaonic procedures – an "orgy of operations" in Beasley's words – performed even on very young girls, sometimes with distressing results.[5] Yet Sudanese who so responded acted not from superstition or ignorance, as British officials claimed, but from reason within the parameters of cultural knowledge; they sought to create properly gendered moral persons before they would be forbidden to do so by the state. For them, morality was not something intangible, the property of an autonomous mind and will, but eminently social and embodied.

Autonomy

It hardly needs to be pointed out that, for anthropologists, the notion of autonomy is remarkably fraught. As a purportedly objective description of a realizable human state, it stands as a universal possibility, an evolutionary endpoint associated with politically "developed" societies. More tractably, it is an ethnographic construct of societies strongly influenced

by enlightenment thought and, as such, a culturally specific ideal. The social constructedness of autonomy as a potential or ideal human state is, to quote Veena Das and Renu Addlakha (2001:10), "fetishized," hidden, or elided in western liberal discourse that has lately been globalized as truth. Its wide adoption as a universal imperative has lead to the classification of other (equally specific) models as aberrant. Or different, where this implies unnatural, irrational, and unfree.

Many academics use western common-sense terms as if they were analytic tools, in describing social institutions (such as 'the family') or ideas such as agency, identity, and self. But such concepts regularly need to be exhumed and critically examined, lest even the most cautious and ethnographically sensitive studies be weighed down by untenable assumptions. Anthropologists and allied scholars continuously confront our own contingency, knowing that the "facts" of life which we have been schooled to consider ontological are indeed provisional, continuously produced by social interaction, ethnographically real, yet not unalloyed reality.

This excursion into Anthropology 101 has a purpose. My earlier work (Boddy 1989) struggled to maintain a tension between readability and conveying palpable difference in implicitly comparing Sudanese women's worlds and my own. Yet, Saba Mahmood (2005:7–8) has recently argued that when I suggested at the end of the book that women's participation in *zar* spirit possession encouraged an incipient feminist awareness, I uncritically invoked normative liberal assumptions of human nature rather than ethnographic detail. To see in women's possession narratives and events "an active female consciousness articulated against ... hegemonic male cultural norms" crossed the fine line between – to use some timeworn terms – thick description and 'etic' interpretation. Mahmood writes: "Agency, in this form of analysis, is understood as the capacity to realize one's own interests against the weight of custom, tradition, transcendental will, or other obstacles (whether individual or collective). Thus the humanist desire for autonomy and self-expression constitutes the substrate, the slumbering ember that can spark to flame in the form of an act of resistance when conditions permit" (2005:8).

These cautions are useful.[6] Mahmood advises that we decouple the notion of agency from the goals of progressive politics, and situate agency within the discourses that create the conditions of its enactment. As such, "agentival capacity is entailed not only in those acts that resist norms but also in the multiple ways in which one *inhabits* norms" (Mahmood 2005:14–15). Subjects are not produced in advance of power relations but, she notes, following Foucault, through such relations, which furnish the necessary conditions of their possibility. Thus self is ineluctably embedded in sociality, and, drawing on Judith Butler (1999), continuously produces itself through performance or iteration. Selfhood is never autonomous of the social, nor is it fixed, despite the model of liberal humanism (prevalent within human rights discourse) that envisions a stable self existing prior to the impress of society and in part transcending it.

Furthermore, the analytical *immanence* of the self just discussed must not be confused with western notions of an interior, private self – a realm of belief, virtues, desires, and independent thought that is coterminous with a singular body. Talal Asad, critiquing the notion that "faith" is an interior condition antecedent and superior to practice, writes: "Any view of religious life [that] requires the separation of what is observable from what is not observable fits comfortably with the modern liberal separation between the public spaces (where our politically responsible life is openly lived) and the private (where one has the right to do with one's own as one pleases). The idea seems to be that one's beliefs should make no difference to publicly observable life and, conversely, that how one behaves can have no significance for one's "inner" condition" (2001:214).

The position referred to here is again premised on a self that transcends its context, is separate from, prior to, and in those ways autonomous of the social world in which it came to be. It is also based on the assumption that feeling, thought, or mind precedes practice or bodily behavior and manipulation. This logic, derived from a distinction between private and public domains that developed in early modern Europe in an effort to separate Church from State, underlay the conviction of colonial officials that a Sudanese bodily practice held to have religious import played no part in cultivating moral sensibility.

Asad, Mahmood, and others have also argued that in Islamic societies, the work of cultivating moral sensibilities rests only in part with the individual (contra Beasley and her colleagues). Indeed, quoting Asad, "... the body-and-its-capacities is subject to a variety of rights and duties held by others as fellow Muslims. There is [in Islam] a continuous, unresolved tension between responsibility as individual and metaphysical, on the one hand, and as collective and quotidian, on the other" (2001:220).

I am mindful that most Muslims would exclude pharaonic circumcision from the sorts of Islamic practice, such as prayer, to which Asad refers. Yet an anthropologist would be rash to deny informants' claims that ensuring their sons and daughters are circumcised is a religious responsibility, a collective act intended to cultivate moral dispositions and proper social orientations in the young. But in neither case, not that of the British in advocating the supremacy of mind over flesh, or of the Sudanese in impressing children's bodies with culturally prescribed sensibilities, should the process be described as one of individuals acting autonomously. I am convinced that the interventionists' inability to appreciate themselves as culturally and historically situated contributed to the failure of their mission and, quite possibly, helped to ensure the custom's persistence.

Midwifery reform: the Wolffs

Information from the colonial archives and my ethnographic findings from northern Sudan reveal some strategies that British officials used to reshape the minds and bodily practices of Sudanese in the 1920s, 1930s, and 1940s. In 1921 a British nurse-midwife, Mabel Wolff, opened the Omdurman Midwifery Training School; her sister, Gertrude, joined it a few years later. The Wolffs' mandate was to train women in biomedical methods of birth, while convincing

existing (traditional) midwives to practice scientific hygiene and abandon "harmful customs" that encouraged maternal and child mortality. Such harmful customs included upright birth posture as well as pharaonic circumcision.

The British could not understand the significance of female genital cutting to Sudanese. So repulsed were they that its meanings were only superficially explored. The practice seemed utterly irrational, much as Beasley later claimed. In all but closing the wombs of prepubescent girls, older women and men inflicted untold suffering on their daughters in order to control sexual reproduction and maintain family honour, while in fact compromising the fertility they wished to protect. In the process, they also deprived young women of their agency and choice.[7]

Yet by grounding their assumptions in liberal notions of choice and free will, colonial agents assumed that selves are pre-social, comprised of minds that transcend their social and historical contexts. They acknowledged that selfhood is mediated by social relations, but not that these very relations, along with the humanly produced objects and humanly organized spaces through which and in which they occur, produce the knowing self and the virtuous subject, although not in a self-conscious or teleological way. In other words, they overlook the process of embodiment, the immanence of selfhood, the way that people, as Mahmood puts it, "inhabit" dispositions and values and produce themselves as subjects within the context of their own possibility.

A much truncated and well-worn ethnographic example will help explain. In the region of the main Nile where I worked, wombs were deemed analogous to houses in function and form. Wombs, moreover, shared qualities with jars used for mixing bread, *kisra,* the thin moist pancake that is the staple in northern Sudan. *Kisra* in turn is analogous in composition to the body of a child. In the womb, male seed is combined with female blood (in local conception theory) just as grain produced by male labour is combined with water that women fetch from wells or the Nile and store in the household's large clay water-vessels. These, because they are porous, keep their contents fresh and cool. However, the jar used for mixing *kisra,* a pot called a *gulla,* often substituted for by an enamel bowl (*korîya*), must be impervious, so that the contents cannot seep out when the batter is left to prove overnight, sometimes for several days. In these features, and in its shape, the *kisra* container resembles an infibulated pregnant womb. Foods that are enclosed, such as eggs, tinned fish, and fruits surrounded by rinds or peels are prized as "clean" (*nadîf*), for their envelope conserves moisture and protects the contents from contamination. Hence, the adage "a Sudanese girl is like a watermelon because there is no way in" works also because, like blood, the melon's flesh is moist, red, and clean, and protects the seeds inside. Consuming foods defined as "clean" is said to "bring red blood," thereby capacitating female fertility. Orange pekoe tea is referred to as "doctor's blood" and highly recommended for pregnant women. Foods that are white are also regarded as clean and said to increase the body's red blood; those that are both white and enclosed (such as eggs) are considered especially beneficial to women who wish to conceive.

These associations ramify: a fetus miscarried during the second trimester is placed inside a *gûlla,* like the unfinished *kisra* it resembles, then buried inside the courtyard, or *hôsh.* The unmarked grave is usually dug near the kitchen, the women's area in the back of the *hôsh*. Customs for handling other failed pregnancies are intelligible by this cultural logic. A stillborn is wrapped as a corpse and buried along the outer wall of the *hôsh* just to one side of the men's entrance which is called the *khashm al-bayt* or "mouth of the house." As the infant's body has emerged from the womb / house fully formed (formed by the womb's internal heat much as *kisra* is cooked by the heat of a woman's griddle), it rests near the wall of the house / maternal body next to the door / orifice (*khashm al-bayt* / vagina) through which it has passed and its father (formally, legitimately) comes and goes. Moreover, the term *khashm al-bayt* is an idiom for the descent line arising within the *hôsh.* The path of the stillborn babe is arrested in the womb; he/she does not enter society, the world of other families, descent lines, and houses, for that requires breath, the obvious presence of a soul. Infants who breathe then die are buried like any other person, in the cemetery on the fringe of the desert beyond cultivated and humanly occupied space.

Such features of everyday logic locate infibulation – the practice of enclosing the womb – in a historical and cultural order that made that practice possible, indeed thinkable. The ideals and meanings of this order must, to invoke Marshal Sahlins, be "understood as positional values in the field of their own cultural relationships rather than appreciated by categorical and moral judgments of our making" (1999:43). The values linked to infibulation suggest a world where meaning resides in qualities that persons and objects share, where images do not reduce or condense to underlying truths but are themselves truths – iconic, recursive, non-reductive. Bodies and identities are inherently relative, implicating other bodies, objects, and humanly constructed space. When I worked in Sudan infibulation was normal, deeply rooted in this world, as it was when the Wolffs began to teach.

Undergoing infibulation orients a girl to a particular universe of probabilities and significances (see Bourdieu 1990, chapter 3). Through exposure to the connections immanent in the practical acts and objects of quotidian life, the meaning of her reconfigured body is gradually built up and continuously replenished. The everyday tasks of fetching water or baking bread that girls assume as they grow up, even peeling an orange or opening a tin of tomato paste, reverberate with unspoken significance. They associate her life with protecting the fertility that is her great gift and bearing children in morally approved ways. They are practical metaphors, means by which subjective reality is embedded in bodily memory and periodically renewed. Girls, especially, are asked to relive their painful initiatory experiences as they mature: actually, when their bodies are opened and resewn with each delivery; vicariously, when they witness others' circumcisions and births; and metaphorically in their daily tasks (Boddy 1989;

1997; 1998a; 1998b). The very walls of a *ḥôsh,* its lay-out, with women's quarters in the back, men's in the front, its highly charged thresholds and doors, speak to the woman of her self, and indeed inform it. For she is housed within her own body when she is bodily present in the *ḥôsh* (Boddy 1998b:102). The congruity and interwovenness of ideas that identify infibulation with womanhood and procreation render them especially powerful, compelling, and politically effective.

Viewed from this angle, female circumcision was not an obsolete or isolable trait thatcolonizers (or their successors) could extract from its matrix like a rotten tooth, or expect women to discard as "evil" on outsiders' advice. Nor was it separable from male circumcision which, according to villagers, opens or unveils the male body to confront the world. The practices define the genders in complementary ways. Yet to Europeans arguing from a scientific view of human anatomy as ideologically neutral and historically transcendent – unmediated, culture-free – they were wholly incommensurable, and male circumcision a minor procedure. The fact that there was little British outcry about unhygienic operations performed on Sudanese boys suggests that colonial interest lay less in the altruistic betterment of native health than in simple population growth. And, because male circumcision is religiously required, in avoiding affronts to Islam.

Knowing that native midwives also performed female circumcisions, the Wolff sisters took a pragmatic stance at the Midwives Training School. They did not support a peremptory ban on the pharaonic procedure. Controversially, they taught a less damaging operation using sterile implements, local anesthetics, and antiseptic solutions, hoping to effect a gradual "reduction of harm," and eventual abandonment of genital cutting as Sudanese became better educated. The trainee who was literate was rare. The sisters therefore elected to work with rather than against local knowledge, taking heed of pupils' experiences and invoking their embodied memories. They used images that first summoned, then attempted to revise, women's cultural dispositions. They taught in Arabic, incorporating words from "women's vocabulary."[8] They built discursive bridges between local understandings and their own by creating scientific analogies to the objects and acts of Sudanese daily life with which women's bodies are metonymically linked – although how far they grasped that relation is not clear from the evidence at hand. By these means they devised an ingenious and powerful synthesis of biomedical and lay techniques that bent to local custom even as they strove to undermine it.

The strategy of linking lessons to women's daily lives was hardly novel or unique, but here it may have complicated the sisters' aims. In a report about her first year's work, Mabel Wolff wrote: "I illustrate by local colour all their lectures as I find they understand and assimilate them better, – viz. in giving them an anatomy and physiology lesson I compare the body to a house and the organs [to] the furniture – the functions of the lungs as windows that air the house etc. etc."[9] She lectured, "the body resembles a furnished house and all the contents have a special use."[10]

Did students experience a shock of recognition? Or were their responses subdued, the wisdom so recognizable and banal, so matter-of-fact? For these were analogies they could readily understand, a native house (*ḥôsh* or *bayt*) being not just homologous with the body of a woman in local thought, but with an infibulated body at that. The Wolffs did not invent this association but, unwittingly perhaps, invoked it. Student midwives may well have gleaned from classroom images that their much maligned commonsense was more modern than they had been led to believe. Or perhaps that their teachers understood things as did they. Undoubtedly students creolized instructional terms,[11] creating notional malapropisms – at least from the sisters' point of view. To the Wolffs, any resonance between local ideas and biomedical constructs was fortuitous or heuristic, not sincere. Their mission remained uncompromised: to substitute rational science for harmful practice and fallacious belief.[12]

Central to the Wolffs' pedagogy was hygiene. "The first lesson a midwife must learn," exhorted Mabel, "is the importance of good manners, morals and cleanliness." Cleanliness was demanded of the midwife's person, hands and nails, her children, husband, house, midwifery equipment, and work.[13] To the Wolffs cleanliness meant more than the material absence of dirt and germs. It was, in itself, a moral state (Bell 1999:209). In this perspective, one detects the impress of Christianity, where washing clean is an idiom of social and spiritual "enlightenment." Thus, they counseled: "You must remember that in midwifery there are two or more lives dependent on your skill and care, each baby you help from darkness to the light of Day, is a gift from God and you should be at all times worthy to receive it."[14]

The image was at once Christian and Muslim Sudanese: an infant is indeed considered "Allah's gift" who, in being born, moves from the darkness of the womb (enveloped by now exhausted "black" blood), into the social world, toward divine Light (*Nûr*, one of the names of God). Thus, in their inaugural lecture, addressed to each new class of recruits, Islam and the northern Sudanese principles of morality, purity, and bodily cleanliness with which it is entwined, were at once invoked and deposed, for to be truly worthy of receiving "Allah's gifts" a midwife needed the civilizing guidance of the Midwives Training School. Judging from the persistence of pharaonic circumcision throughout the colonial period and beyond, such practical and discursive blending may well have supported the practice by linking it to extant cultural meanings despite, or indeed because of, the endorsements of cleanliness and purity they contained.

Moreover, pharaonic circumcision may have acquired new layers of meaning. For one thing, given the midwife's role as both circumciser and birth attendant, the partial medicalization of birth naturally entailed a partial medicalization of circumcision. The Wolffs' lesson book advised: "... should a midwife do circumcisions ... she must perform the operation with all cleanliness just as she would a labour case, and attend the case daily for seven days, or more if necessary, in order to avoid infection of the wound."[15] Although clearly benefi-

cial, such counsel insinuated biomedicine into local practice, thereby wrapping "tradition" in modern medical mystique, lending it new authorizations (although it needed none), and fostering further syncretisms that seemed likely to enhance the custom's resilience.

While reading the following passage from the Wolffs' lecture book, recall the local logic of enclosure that informs infibulation:

Most illnesses are caused by the entrance into the body by way of the mouth [khashm], the eyes, the nostrils, through the skin or a wound (or ulcer) of minute living things which cannot be seen except under a microscope. Just as there are a great variety of insects and seeds, so there are microbes... There are microbes that will turn milk sour and meat putrid and food poisonous, but if food is sterilized and kept in sealed tins, the microbes cannot penetrate and the contents such as tomato sauce, milk, sardines and numerous other foodstuffs, will keep good for long periods but as soon as the tin is opened microbes get on the food and it will soon be poisoned and unfit to eat. If our bodies are healthy and strong like the sealed tins*, the microbes cannot harm us, but if microbes get a hold of us, they may give us some illness according to what microbe has infected us (my emphasis).*[16]

Their analogies made perverse yet perfect vernacular sense. There are few records of MTS midwives themselves, and we can only speculate how they absorbed and re-transmitted the lessons they learned, what inflections and nuances they gave such words and deeds. Yet the Wolffs' similes are homey and suggestive, and the sisters may well have relied on Sudanese staff midwives in devising them. We do know that senior midwives were regularly sent on rural inspection tours to keep track of trainees' work, appearances, and midwifery kits, as well as to preach hygiene and exhort villagers to abandon "pharaoh's" circumcision (Bell 1998, 1999; Boddy 2007).

The sisters achieved incremental success in the midwifery portion of their task, especially in the region of Khartoum. By 1932, prenatal care was added to trainees' responsibilities, and introduced with a signature Wolffian analogy: "[We asked,] when they put a cooking pot (halla) with food on the fire, did they leave it until the food was burnt and spoilt or was it usual to occasionally inspect the contents of the pot? Now amongst the womenfolk, the words "Kashf el Halla" [pot check] have become a recognized meaning for "Ante-Natal Examination" and attendances are so far very encouraging."[17] Here again, wittingly or not, in likening gestation to cooking the Wolffs had tapped into local meanings while shifting them to accommodate a biomedical view. The women with whom I lived compared pregnancy to making the batter for bread: mixing (female) fluid and (male) seed in an impervious container, something only enclosed, circumcised women are properly able to do. As depicted by the Wolffs, pregnancy is like making a stew: a mechanical, curiously disembodied, and asexual physical process that needs to be monitored, helped along, indeed disciplined by continuous visual surveillance. But the midwife, not the mother-to-be, is here the cook responsible for care of the pot.

The civilizing of midwifery was intended to both expand the Muslim population and improve the 'degraded' condition of women, indicating progress for Sudan as a whole (see Arnold 1993:256). Yet it effectively denied women's worth, their agency as reproducers within their own milieu. The changes to birth posture – recumbent rather than upright – and the suggested need for pre- and post-natal checks conveyed the sense that women are inherently passive beings, at the mercy of physical processes beyond their ken and control. At the same time, they enhanced professional midwives' agency and independence under protection of the state.

That said, trained women received little financial support, despite the Wolffs' unstinting interventions. The sisters' last years in Sudan were arduous and strained, their efforts increasingly belittled by senior officials.[18] The problem was that Sudanese midwives were encouraged to preach against circumcision while being taught to perform it themselves. With northern Sudan pacified, the need to tread lightly on 'tradition' had dissolved, and the paradox now struck British officials as absurd. The Wolffs departed in 1937 demoralized, but no less convinced that their methods were sound.

Moves to end accommodation

In 1937 Elaine Hills-Young, former matron of Khartoum hospital, succeeded Mabel Wolff as principal of the Midwives Training School. Hills-Young had been chosen for her refusal to tolerate "retrograde" Sudanese customs. Soon after taking over, she witnessed a modified pharaonic operation performed by one of the school's staff midwives. Although it was carried out "under more hygienic conditions than were customary," she nonetheless found "the spectacle ... so revolting" that she at once forbade trained midwives to do circumcisions of any kind.[19] She intensified lessons against any form of female genital cutting and ceased all instruction in the modified technique (Sanderson 1981:79).[20]

It is hardly surprising, however, that few trained midwives complied. The majority continued to circumcise in secret, lest they forfeit the public trust that they had taken such pains to win. And their small irregular stipends meant that illicit infibulations and post-partum repairs remained "the most lucrative part of their work."[21]

Privately, Hills-Young conceded that it was impossible for trained women suddenly to stop doing circumcisions (Sanderson 1981:80). She nonetheless prohibited the use of government supplies for the purpose, and if a trained midwife was found to have performed the procedure, her credentials could be revoked.[22] Lessons continued on how to open the genital scar during labour and "the best method of dealing with the ... wound after delivery."[23] Yet the outcomes she proposed could hardly have matched clients' expectations or desires. To Hills-Young, tactical compromise was anathema where female genital cutting was concerned.[24] In this view, she joined a growing

group of British expatriates, Sudanese doctors, teachers, other professionals, and several staff midwives originally taught by the Wolffs, who campaigned to end "the barbaric institution"[25] once and for all.

Among them was Ina Beasley, mentioned earlier in her role as controller of girls' education. During World War II, Beasley and Hills-Young collaborated in what they called their anti-circumcision "crusade." They were supported by Sudanese staff midwives and several teachers at the Girl's Training College who traveled to outlying areas to preach against the practice (Sanderson 1981:87; Beasley 1992:129, note 91). Most mothers were reluctant to change. Yet if they seemed beyond reach, their daughters, future mothers, might be won; future fathers too.

For much of the early twentieth century, education for northern boys was largely provided by Muslim clerics, few of whom were formally trained, some of whom received government stipends. Sweeping reforms were advised in 1932 when a standardized curriculum was proposed as a cure for "indifferent agriculture, fanatical Mahdism [Islam], disease-carrying dirt, female circumcision, and all the cruelty and barbarity of a backward people" (quoted in Beshir 1969:97).

Reforms to boys' education got underway in 1934 with emphasis on applied subjects, and creating a rural teaching service in keeping with Sudan's agricultural character. In practice, this meant teaching through local tradition in the interests of political stability, while cultivating boys' dispositions in ways useful to the state. A regular newsletter sent to practicing teachers kept the message alive. During the 1930s and 1940s, for instance, instructors were encouraged to extol "the importance of money as a means to civilization."[26] Another bulletin tellingly counsels that a teacher's task is "not only to spread new knowledge but also to train the next generation to be enterprising and hard working."[27] And to train the next generation to want to consume: "Civilisation means, amongst other things, having more possessions – more furniture than the man in the grass gutia [hut], books, better clothes, a clock – and at a more wealthy stage, perhaps a car, a gramophone, a refrigerator, a radio."[28] Note: before the luxury items, a clock, classic disciplinary tool, means to ensure punctual habits of work that bring newly imaginable rewards. Indeed, teachers were urged to consider "what sort of things the civilized man should have in his house."

[T]hose who have given thought to the difficult question of what are the characteristics of a civilized man are agreed that he hates ugliness and loves beauty and orderliness. His furniture must be of good design, his walls of a pleasant colour and perhaps decorated with pictures of suitable size and design, his books he will like to have decently bound and in repair. He will buy coloured rugs that are in general keeping with the rest of the room. His tea cups and plates will be chosen for their good shape and colour and so on.

Now this choosing or designing of beautiful things is not easy.... If you are unpracticed you may easily choose something which attracts you very much for the moment but which after you have bought it, quickly bores you. People, who have been poor and therefore unused to this difficult art of choosing, often make this mistake when they first get money. They fill their houses with china, rugs, curtains etc. which do not agree together and which are very ugly to anyone who has thought a little and observed a little as to what is really beautiful and orderly.

How then are we going to help the Sudanese boy as he grows up, to avoid wasting his money on things that are really ugly and instead choose what is beautiful and orderly? The most important ... way to learn to appreciate what is really beautiful is [by] trying to make beautiful things yourself. Hence both in the Elementary School and in the Training School Handwork lessons are giving boys opportunities for trying to make designs, use different colours, create varying forms in various substances so that by experience each one for himself may gradually form a standard of judgment.[29]

Sensible if patronizing as this sounds, the seemingly non-coercive rhetoric of universal aesthetics, rationality, and individual choice is remarkable. Native teachers were schooled to shape pupils' sensibilities, cultivate their work skills, discipline their habits and material desires.

Female education was agonizingly slow to develop and anything but inclusive. Despite a growing demand, by 1932 girls' schools had graduated less than one percent of the elementary aged population. By 1960, four years after independence, that figure had risen to four percent – a humble improvement (Sanderson 1961:91; see also Beshir 1969:96–98).[30] The curriculum stressed "domestic science:" housework, cooking, sewing, hygiene, and raising children in a rational, disciplined way (Beasley 1992:185.) "Progressive" mothering techniques were expected to generate healthier, better adjusted, more mature citizens from a European point of view. Students were enjoined to abandon practices such as sleeping with their babies and nursing them on demand as these were thought to induce character weakness in adults.

Although the young were now the focus of colonial interventions, mature women were not neglected. In 1941 Hills-Young and her staff opened a Government Child Welfare Centre in Omdurman near the Midwives Training School. She wrote:

We had a room converted into a model women's quarter, with all native furnishing but kept clean, tidy and simple. The mothers would often say: "Oh, but this is just like ours." Then I would say, "Yes, to a certain extent, but we have shelves for the dishes and do not stack them on the mud floor under the bed or table. Also our windows have wire netting to keep out the flies and the beds have mosquito nets, even baby's cot, also we have small beds for children so that they can sleep alone."[31]

Women were taught to limit and schedule feeding times, using the position of the sun for reference, as few households in fact owned a clock.[32] Although babies in northern Sudan were (and are) seldom out of their mothers' arms, those of

pupil midwives were placed in wooden playpens while their mothers attended class.[33] All this was supposed to amend "character deficiencies" in Sudanese young by encouraging greater independence, wholesome self-restraint, and a rational, measured sense of time.

The novelties of playpens and scheduled feedings are as revealing as they must have seemed pragmatic. Not only do they show how British envisioned ideal character and typified Sudanese, but they also proposed a remedy for Sudan's deplorable statistics. Attention to mother and child welfare in Sudan was part of a global campaign championed in the 1930s and 1940s by the International Save the Children Union in Geneva, and supported by prominent women parliamentarians. The approach was ideological and particularistic, stressing individual responsibility and aiming to create self-aware, self-disciplined female subjects who would naturally abandon "backward superstitions" and "evil" customs. These initiatives, however, left women's social and economic situations largely unaddressed (see Vaughan 1991).

When, despite their efforts, Sudan's resilient evil showed no sign of being abandoned, Hills-Young and Beasley took more drastic steps. They mobilized British medical professionals and politicians to ask embarrassing questions of the British government and press, suggesting that colonial policy was too lax. Hills-Young proposed a draconian move: "Higher education for girls in the Sudan should be conditional upon their being uncircumcised... The refusal of admission to Intermediate and Higher Schools of circumcised girls would have considerable influence with the parents and the rising generation."[34] She and her colleagues were betting that because educated young women attract educated, well-placed husbands who enhance their wives' family status, upwardly mobile parents would refrain from circumcising their daughters in order to protect them as a resource. This, however, ran counter to cultural logic, for such protection was availed not by avoiding circumcision but by practicing it. Moreover, the transfer of status went both ways: an honourable wife enhanced the position of her husband's family, just as an honourable daughter contributed to the status of her parents, siblings, and other kin. And a daughter attending school far from home was susceptible to aspersions that being circumcised partly allayed. In seeking to pit western education against local standards of integrity, British professional women wrongly believed that virtue in Muslim Sudan was an individualizable trait.

The law

Hills-Young and her supporters may have forced the hand of Sudan's colonial masters before the latter considered the time politically opportune. In 1945, government passed the law against pharaonic circumcision (but not all forms of the operation) with which this article began. A few months after it came into effect, a midwife was found guilty of committing an unlawful circumcision. To the leader of the Republican (Gumhuriya) Party, which advocated immediate independence for Sudan, the conviction was unjust.[35] Rioting broke out. It was promptly quashed and blamed on the actions of "a few fanatics," but by their own admission it had taken administrators "by complete surprise."[36]

In 1947, more propaganda was released, reminding Sudanese that the new law fell within the purview of Islam. A leaflet to complement an anti-circumcision talk given in girls' elementary schools asked:

Which ... do you believe, Pharaoh the enemy of God or Mohamed the Prophet of God? ... The holy men of the Sudan ... have agreed that Pharaonic circumcision should be abolished. Is your opinion different from that of the holy men?

Do you understand more than they do?

The doctors have advised that Pharaonic circumcision may cause sterility. Do you wish for sterility?

Your religion forbids doing harm to the body. Will you disobey your religion?[37]

The lesson had unforeseen results. Beasley reported a tendency to keep girls away from school after its delivery,[38] endangering the modest success of female education and no doubt prompting some parents to settle the matter forthwith. Circumcisions would thereafter be carried out in school holidays, with curtailed celebrations lest the revelry alert the police.[39] Especially in rural areas, but not only there, Sudanese *hôshs* became more tightly closed to colonial scrutiny than before.

By the start of 1949, the situation was more dismal still. In Khartoum, untrained rural midwives ran a brisk trade in pharaonic and modified pharaonic operations. British officers everywhere were too stretched to inquire into "so difficult a subject."[40] Indeed, the illegality of the procedure magnified Sudanese reluctance to report what was taking place. Even the most educated, highly placed men had infibulated kin and could not "talk with ease."[41] The issue remained polarized until independence in 1956, and indeed beyond.

Incompatible selves?

In colonial Sudan, British teachers, nurses, and government officials clung to a model of the subject as an individuated entity capable of autonomous behavior and transcendent of her social context. To them, this was self-evident truth, not historically and culturally contingent, and all who failed to agree were simply "wrong." Officials, of course, inhabited this model, much as northern Sudanese inhabited theirs of collective and embodied morality.

Contemporary human rights discourse is clearly empowering for Sudanese who work to improve their own and others' lives; still, there are lessons to be gleaned from past initiatives. The Wolffs' techniques and compromises – however fraught – may have offered the best chance at the time for reducing the harm that attends female genital cutting and setting a course for locally relevant change. Yet one wonders

if a mutual recognition of the immanence and situatedness of selfhood might have provided firmer ground for constructive collaboration. Or would that have required a level of self-consciousness that none of us can sustain?

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Notes

[1]M. Wolff to British Social Hygiene Council, February 1933, Sudan Archive, Durham University (hereafter cited as SAD) 582/10/16.

[2]Willis to DCs, 19 February 1924, National Record Office, Khartoum (hereafter cited as NRO) CIVSEC 1/44/2/12.

[3]E.D. Pridie et al. 'Female Circumcision in the Anglo-Egyptian Sudan.' Khartoum, 1 March 1945, SAD 658/9.

[4]E.D. Pridie et al. 'Female Circumcision in the Anglo-Egyptian Sudan.' Khartoum, 1 March 1945, SAD 658/9, 6; and Beasley's marginal notes Pridie's account.

[5]Local Vernacular Press Summary: 'Untimely Circumcision,' *El-Sudan El-Gedid,* 8 June 1945, Bodleian Library of Common-

wealth and African Studies at Rhodes House, Oxford (hereafter cited as RH) Mss Perham 575/3; NRO CIVSEC Intelligence Report No.87, 8 June 1945, RH Mss Perham 571/1/18–19; Beasley to Robertson, 16 August 1945, SAD 657/4/51; 'Translation of a speech given by Sitt Nafissa to the mothers of Omdurman,' 7 March 1946, SAD 657/4/107.

[6]Though I would point out that they reflect the development of our thinking since the late 1980s when that book was written, a book whose argument was therefore formulated in response to other theoretical concerns. The cautions are therefore chronocentric, to use Michael Lambek's apt word.

[7]Sudanese physician and prominent anti-circumcision activist, Nahid Toubia, echoes this view. Toubia maintains that if a girl understands the medical consequences of the operation and, at eighteen years of age, still chooses to have it done, she should not be prevented, but younger girls should not have their options foreclosed (Discussion in Project Body, University of Hannover, 2002).

[8]'Elementary Practical Lessons for Midwives of the Sudan,' no date, SAD 581/5/5.

[9]M.E. Wolff, Speech to the Committee of the Guild of Service, 1922, SAD 579/3/29.

[10]'Elementary Practical Lessons for Midwives of the Sudan,' no date, SAD 581/5/8.

[11]See Hunt (1999) for a sustained discussion of western trained native mediators, or 'middles' as she calls them, in colonial Zaire.

[12]See also Bell (1999, chapter 7) on the Wolff sisters and their methods.

[13]'Elementary Practical Lessons for Midwives of the Sudan,' no date, SAD 581/5/7.

[14]'Elementary Practical Lessons for Midwives of the Sudan,' no date, SAD 581/5/7.

[15]'Elementary Practical Lessons for Midwives of the Sudan,' no date, SAD 581/5/13.

[16]'Elementary Practical Lessons for Midwives of the Sudan,' no date, SAD 581/5/16.

[17]MTS Annual Report, 1932, SAD 581/1/46.

[18]M.E. Wolff to Dickens, 12 February 1946, SAD 581/4/19.

[19]Hills-Young, 'Female Circumcision in the Sudan,' November 1944, SAD 631/3/36–37.

[20]Hills-Young, 'Female Circumcision in the Sudan,' November 1944, SAD 631/3/36-37; M.E. Wolff to Dickens 12 February 1946, SAD 581/4/18.

[21]M.E. Wolff to Dickens 12 Feb. 1946. SAD 581/4/18.

[22]Hills-Young, 'Female Circumcision in the Sudan,' November 1944, SAD 631/3/36–37.

[23]Hills-Young, 'Female Circumcision in the Sudan,' November 1944, SAD 631/3/36–37.

[24]British medical personnel, like those in the political service, did not voice concern about male genital cutting, even though it too was performed under unsanitary conditions. This was, in part, because male circumcision is decreed by Islam, and administrators were loath to offend their Muslim subjects for reasons of keeping the peace. In part, too, it was because male circumcision was considered not to jeopardize population growth to the extent that infibulation did. Indeed, the lesser form of female circumcision, called *sunna* or 'religiously approved,' was not discouraged by male officials in the least.

[25]Hills-Young, 'Female Circumcision in the Sudan,' November 1944, SAD 631/3/38.

[26]*Bakht er Ruda Newsletter,* No.13, 21 March 1942, RH Mss Perham 561/3/93.

[27]*Bakht er Ruda Newsletter,* No.5, 13 March 1938, RH Mss Perham 531/3/8.

[28]*Bakht er Ruda Newsletter,* No.7, 10 March 1939, RH Mss Perham 531/3/53.

[29]*Bakht er Ruda Newsletter,* No.7, 10 March 1939, NRO CIVSEC 2/10/2/4.

[30]G.C. Scott, 'Note on Education in the Northern Sudan' quoted in Daly 1987, 386.

[31]Hills-Young, 'Care of the Child in the Sudan,' Address to the Nurses League, 4 November 1944, SAD 631/3/34.

[32]Hills-Young, 'Care of the Child in the Sudan,' Address to the Nurses League, 4 November 1944, SAD 631/3/34.

[33]Hills-Young, 'Care of the Child in the Sudan,' Address to the Nurses League, 4 November 1944, SAD 631/3/47.

[34]The proposal had also been put to Newbold by C. L. Armstrong, Governor of Khartoum. RH Mss Perham 538/1/68.

[35]See Abusharaf (2001, 119) for more on Taha's position.

[36]Civil Secretary to Governors, October 1946, SAD 524/11/12.

[37]SAD 657/4/172, SAD 657/4/180 (Beasley).

[38]SAD 657/4/184 (Beasley).

[39]SAD 657/4/183 (Beasley).

[40]Summary of Reports from Provinces, 14 March 1949, SAD 6573/4/232–233.

[41]Beasley to Robertson, 4 February 1948, SAD 657/4/197.

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Islam and Female Genital Cutting in Southeast Asia: The Weight of the Past

Abstract

Scholars writing on FGC in the Islamic world have ignored Southeast Asia, and yet there is the potential for serious problems, even if the procedure has traditionally been minor in nature. Reformers have been divided, but 'fundamentalists' call for more severe operations. Islamic Southeast Asia overwhelmingly adheres to the Shafi'i school of law, the only one to make FGC obligatory. It marks the entry of a woman into the faith, whether as an adult convert, or as a child born into the community. In more 'orthodox' areas, babies are circumcised, in a ceremony hidden from the eyes of men. In less 'orthodox' areas, it is more a rite of puberty, and may be publicly celebrated. FGC arrived with Islam, and is not an Animist remnant. Hindu-Buddhist rejection of genital mutilation means that the greatest opposition is found among Java's syncretic Muslims, or Javanists, some of whom perform a symbolic operation on a turmeric root. The UN policy of 'zero tolerance' may be stiffening the resolve of the pious, and Southeast Asian Muslims should rather be encouraged to probe the religious underpinnings of FGC.

Writing on Female Genital Cutting [FGC] as a general phenomenon, scholars have generally ignored Southeast Asia. The recently published *Encyclopedia of Women and Islamic Cultures* considers only Africa and the Middle East (Kassamali 2006). The second edition of the *Encyclopaedia of Islam* acknowledges the practice among Muslim Malays, but says little more (Bosworth et al. 1978:913). Jonathan Berkey, in a learned survey of the medieval Near East, includes comparative material on Africa and Central Asia, but not on Southeast Asia (Berkey 1996). Kecia Ali does mention the region in her recent and lively contribution to the debate, while admitting that she found little information on this far-flung periphery of the Islamic world (Ali 2006:100).

This lacuna is unfortunate, because FGC's strongly Islamic connotations give it the potential to become a serious problem in Southeast Asia. The procedure has traditionally been minor, falling under WHO's Types I or IV. Pricking is usual, with, at most, flesh the size of a grain of rice being removed. Indeed, some FGC is purely symbolic in nature, an object being cut instead of the girl's genitalia. It is therefore difficult, even impossible, to verify physically whether a woman has been circumcised. However, growing calls for deeper, purer, and more 'orthodox' forms of Islamic practice are already leading to more severe operations.

The Shafi'i connection to the wider Islamic world

The ulama, the scholars of Islam, quite quickly came to agree that FGC was a recommended practice for women, but this at times conflicted with local custom, which enjoys a recognized status in Islam. For the ulama, whether Sunni or Shi'i, FGC was ritually purifying, initiated girls and converts into Islamic womanhood, and moderated excessive female lust. Al-Ghazali [d. 1111], whose influence on mystical Sufi forms of Islam was immense, endorsed this position. However, local customary law overrode the views of ulama and Sufis in places, for example in the Romanised Maghrib and Iberia, and in the Turkic lands (Berkey 1996).

The ulama's position was by no means self-evident, for the Koran is silent on FGC. Indeed, the only point of real consensus is that the holy texts do not specifically prohibit the practice (Berkey 1996:20; Awde 2000:192,n28). FGC is known as *khafd* or *khifad* in Arabic, with the basic meaning of 'lower-

ing,' but it is much more often placed under the general rubric of *khitan*, circumcision for both men and women, related to words indicating kinship and marriage (Berkey 1996:20). FGC might seem to run counter to an Islamic prohibition of bodily mutilation, based on an interpretation of 4:118 in the Koran (Levy 1957:77, n1; Meinardus 1969:50–1). However, this is countered by a general acceptance of male circumcision (Bouhdiba 1982:213–14).

As for the Hadiths, the sayings and deeds of the Prophet and his companions, those dealing with FGC are either of uncertain authenticity, or lend themselves to different interpretations. Furthermore, any tradition can be over-ruled by deploying the fundamental injunction in the Koran to command good and forbid evil (Ali 2006:110–11). The most explicit Hadith cites the Prophet saying to a female circumciser: "Do not cut severely, as that is better for a woman and more desirable for a husband." Although much quoted over the centuries, this command only appears in the canonical collection of Abu Da'ud [d. 817], who classified it as unreliable in terms of its transmission (Ali 2006:105; Berkey 1996:25, 28; Davis 2006:359, n1). Another weak tradition, collected by Ibn Hanbal, refers to FGC as *makruma*, noble, for women (Berkey 1996:25; Ali 2006:105). A Hadith commanding circumcision also enjoins trimming one's moustache, indicating that this was not directed at women (Awde 2000:199, n8; Berkey 1996:24–5). A sounder tradition imposes ritual ablution when the two circumcised parts have touched in sexual congress, but this implies no obligation to circumcise, and the translation is contested (Ali 2006:105–6; Berkey 1996:22). Less canonical is the story that Sarah, in a fit of jealousy, circumcised Hagar [Hajar], the servile concubine of Abraham [Ibrahim], and the 'Eve' figure for all Arabs (Kassamali 2006:131; Berkey 1996:22).

The Shafi'i school of law, one of four that survive in Sunni Islam, is the only one to deem FGC to be not only honourable, but actually obligatory, *fard* or *wajib*. In the thirteenth century CE, this was clearly spelled out by the revered Syrian scholar al-Nawawi, claiming the authority of Imam Shafi'i himself (Berkey 1996:25; Kassamali 2006:131). In 1958, Shaykh Hassan al-Ma'mun, *mufti* [jurist] in Egypt, reiterated the obligatory nature of FGC for Shafi'i adherents (Masry 1962:45).

Southeast Asia's overwhelming adherence to the Shafi'i school of law creates danger that more severe forms of FGC may be adopted in future. Predominant in Lower Egypt, Syria, and western and southern Arabia, the Shafi'i *madhhab* retains some adherents in Iraq and Persian-speaking lands. Its supremacy is clearest in East Africa, Southern India, Sri Lanka, and Southeast Asia, areas intimately tied to one another for centuries by maritime communications across the Indian Ocean (Chaumont 1997:187; Snouck Hurgronje 1931:183–4). The coincidence between Shafi'i traditions and FGC is not absolute, however. Southern Indian and Sri Lankan Muslims appear not to circumcise their girls, in contrast to the Isma'ili Bohra of the sub-continent (Ghadially 1991). Even in Southeast Asia, the established Shafi'i doctrine that FGC is obligatory clashes with popular perception that it is merely *sunat* [*sunna*], or recommended (Snouck Hurgronje 1923–24:IV, 205–6).

The Hanafi school of law, for which FGC is honourable but not obligatory, prevails among small Muslim communities scattered around northern Burma and northern Thailand, with historical roots in Chinese and Bengali Islam (Yegar 2002; Forbes 1988-89). Some Hui [Chinese Muslims] circumcised their girls prior to the Republican Revolution of 1911, especially in western China (Broomhall 1978:249, n1; Shui Jingun, personal communication to Maria Jaschok). In contrast, Bengali Hanafi traditions did not encompass FGC (Ghadially 1991:20, n3).

'Orthodox' Islam and FGC in Southeast Asia

Some authors suggest that FGC had pre-Islamic roots in Southeast Asia, but they cite only vague references, possibly relating to cutting males rather than females (Putranti et al. 2003:19; Laderman 1983:206). In reality, there is no compelling evidence that any Animist speakers of Austronesian languages practiced FGC prior to the spread of Islam. Indeed, B. J. O. Schriecke, after consulting 56 reports from all around Indonesia, in 1921 denied that Animists anywhere in the archipelago ever circumcised girls (Feillard and Marcoes 1998:345–8). Only on the furthest periphery of Southeast Asia, among non-Austronesians of New Guinea and Australia, are there traditions of types of FGC that diverge considerably from Southeast Asian forms (*New Encyclopaedia Britannica* 1993:II, 318; III, 390).

What is often ignored in this debate is the spread of Hindu and Buddhist beliefs across Southeast Asia during the first millennium of the Common Era. These influences were particularly pronounced in Java, overlaying earlier Animist concepts (Hefner 1985; Koentjaraningrat 1988). Hindu notions would have entailed a prohibition of genital mutilation, as in modern India (Ghadially 1991:20). Hindus and Buddhists in today's Southeast Asia certainly reject the circumcision of boys or girls (Hanks 1968:126,128; Hefner 1985:144–5; Putranti et al. 2003:44).

It therefore appears that FGC is an Islamic phenomenon in Southeast Asia, brought to the region as part of the package of conversion from the thirteenth century CE (Ali 2006:100; Feillard and Marcoes 1998:340, 342–3). This interpretation subverts the mantra that FGC is everywhere a pre-Islamic custom, tolerated by the new faith (Bosworth et al. 1978; Hodgson 1974:I, 324). The theory of an Islamic origin for FGC is reinforced by the prevalence of Arabic terminology among the 'orthodox.' A common Indonesian term is *sunat perempuan*, emphasizing that this is the woman's *sunna*, in the sense of 'way' or 'recommended action.' Similarly, *khitan perempuan* and *khitan wanita* are expressions that add a Malay word for female after the generic Arabic expression for circumcision (Feillard and Marcoes 1998:339–41; Koentjaraningrat 1988:361; Moore 1981:182–5; Newland 2006:399; Putranti et al. 2003:16–17).

Debates have long existed about the age at which a girl should be circumcised. Al-Nawawi, writing in the thirteenth century CE, recommended that FGC be implemented shortly after birth, while recognizing divergent opinions in this domain (Wensinck 1986:20). In the nineteenth and twentieth centuries, Southeast Asian girls were most commonly circumcised between about six and ten years of age, typically prior to making the formal declaration of the faith [*shahada*] and beginning to learn to recite the Koran (Feillard and Marcoes 1998:339–40, 343–9). The onset of puberty might also be chosen, notably if it was desired that the event should coincide with a brother's circumcision. In Sundanese-speaking West Java, circumcision accompanied the filing of a girl's teeth, a breach of the Islamic prohibition on mutilation. Indeed, the two practices were even known in Sundanese by the same name, *gusaran* (Snouck Hurgronje 1923–24:IV, 206).

The age at which FGC is performed has been coming down over time, as more 'orthodox' forms of Islam have prevailed. In the early twentieth century, areas known for their Islamic piety were already likely to circumcise girls in infancy, before the age of two. This was the case in parts of the Outer Islands and West Java, although by no means everywhere (Feillard and Marcoes 1998:342–8; Snouck Hurgronje 1906:I, 395). Muslim mothers progressively assimilated circumcision to the ceremonies that marked the end of the postpartum phase of a girl baby's life, celebrated some 40 days after birth, although it could still occur as late as ten years of age (Berlie 1983:88, n42; Feillard and Marcoes 1998:357; Jaspan and Hill 1987:13, 22; Merli 2008:270; Newland 2006:399–400; U.S. State Department 2001). Increasingly, FGC is being 'packaged' with piercing the ears and the first cutting of hair, both early rites of passage for a girl (Budiharsana et al. 2003:27–8). Piercing the ears would also seem to breach the Islamic prohibition on mutilation.

To be sure, James Siegel reported that girls in Aceh were being circumcised around the age of twelve in the 1960s, but this would have meant that they were being cut later than boys, who underwent the operation at around eight years of age (Siegel 1969:154–5). Siegel's report is of doubtful reliability, both because Aceh was renowned for it Islamic 'orthodoxy,' and because it was generally the case that girls were circumcised at a younger age than boys in Southeast Asia (Koentjaraningrat 1988:359, 361; Peacock 1978a:62–5, 160).

Adult women are circumcised on conversion to Islam, with reports dating from at least the fifteenth century in Southeast Asia (Feillard and Marcoes 1998:347). This was justified by the example of the rightly-guided Caliph 'Uthman, who ordered the circumcision of captive Byzantine women converting to Islam as a form of ritual purification (Abdu'r-Razzaq 1998:48, 53; Berkey 1996:25). It was historically linked to the conversion of slaves (Clarence-Smith 2006:81, 158). Thus, Animist Dayak women, raided or purchased from the interior of Borneo in the 1840s, were converted and circumcised (Low 1968:119).

More generally, marrying a Muslim man entails the obligatory adoption of the husband's faith, and thus the possibility of FGC for an adult woman. Indeed, this was routinely expected in the southern Philippines, when marriage to Catholic women was common, and in North Sulawesi, where marriage partners could be Protestants or Animists (Budiharsana et al. 2003:35; Moore 1981:135, 196, n7). In the Lesser Sunda Islands, containing many Christians and Animists, circumcision was apparently only demanded of male converts (Feillard and Marcoes 1998:346). In southern Thailand, where Theravada Buddhist women quite often marry Muslim men, spouses are apparently able to decide whether the woman should undergo FGC or not (Merli 2008:271–2).

Al-Nawawi called for a limited operation, writing that 'it is obligatory to cut off a small part of the skin in the highest part of the genitals' (Wensinck 1986:20). Descriptions of the procedure in Southeast Asia do not exist for early centuries, but the first known reports, dating from the late seventeenth century, confirm this approach. In South Sulawesi, a region that had only recently converted to Islam in the 1680s, Muslims alone engaged in FGC. Circumcised girls could walk about again the next day, indicating that the intervention was minor in nature, and that it was not performed shortly after birth. A boy to whom a girl was promised in marriage would preferably be circumcised on the same day, albeit in a different location (Gervaise 1971:139–40). Tomás Ortiz recounted that the *sonad* [*sunna*] of Muslims in the Philippines was a minor procedure in the early eighteenth century, which had spread to some extent to non-Muslims (Blair and Robertson 1903–07:XLIII, 110).

Evidence is most abundant from the 1950s, when social anthropologists began to record the procedure in greater detail. FGC was part of complex ceremonies, ending in a ritual meal. A midwife or healer was usually entrusted with the job, and made a minor cut, prick, scratch, rubbing, or stretching, to the clitoris or the labia minora, or to both. A sharp piece of bamboo was perhaps the most traditional instrument, but *pandanus* thorns, needles, pen-knives, kitchen-knives, finger-knives for cutting rice, razor-blades, and scissors were all used. Witnessing a single drop of blood was a common sign that the operation had been successfully performed. A small piece of flesh might be removed, said to be no larger than a grain of rice, and buried ceremonially (Budiharsana et al. 2003:29–38; Feillard and Marcoes 1998:339–45,359–60; Hanks 1968:128; Jaspan and Hill 1987:22; Laderman 1983:205–7; Merli 2008:270–3; Moore 1981:182–5; Newland 2006:394–400; Putranti et al. 2003:32–3; Strange 1981:58; U.S. State Department 2001).

The complete excision of the clitoris, the removal of a large part of the labia minora and infibulation thus all appear to be alien to Southeast Asian traditions. In southern Thailand, villagers boycotted a midwife with the reputation of cutting too deeply (Merli 2008:271). James Peacock writes about 'clitoridectomy' in Singapore, but really refers to circumcision (Peacock 1978a:160). Budiharsana's team report on 22% of 'excisions' in their sample, but use the word to refer to any removal of flesh, which was most common in West Sumatra (Budiharsana et al. 2003:viii, 28). Jeff Hadler mentions reports of complete excision in Aceh, North Sumatra, but admits that they are unconfirmed ('Women in Indonesia' 1998).

Christiaan Snouck Hurgronje, the famous Dutch scholar of Islam, stressed the obsessive secrecy surrounding the circum-

cision of girls by 'orthodox' Muslims in both Java and North Sumatra, but the word 'secrecy' is something of an exaggeration. To be sure, the procedure was usually hidden from the eyes of men, celebration was muted, and the only outsider certain to be present was the officiating midwife or healer (Snouck Hurgronje 1923–24:IV, 206; Snouck Hurgronje 1906:I, 395). Already in the 1680s in South Sulawesi, this was a private and unostentatious ceremony, reserved for female family members (Gervaise 1971:139–40). Female relatives and neighbours from outside the household might be invited, however, and even fathers or grandfathers were present on occasion. Moreover, it was often widely known in the community that the ceremony had taken place (Feillard and Marcoes 1998:343; Merli 2008:271). If secrecy there was in Snouck Hurgronje's time, it may have been a consequence of colonial disapproval.

The main justification for FGC put forward by Southeast Asian Muslims, both men and women, has long been that it marks the full entry of a woman into the Islamic faith (Budiharsana et al. 2003:24; Feillard and Marcoes 1998:340–1, 360; Putranti et al. 2003:10; Snouck Hurgronje 1923–24:IV, 205). As an essential form of religious purification, FGC enables women to pray in the mosque, marry, and have children. A wider and less precise notion of physical cleansing, *kebersihan*, is also frequently asserted (Feillard and Marcoes 1998:360–1; Merli 2008:271; Moore 1981:182; Newland 2006:399–401). In southern Thailand, it is said that uncircumcised girls become 'stubborn' (Merli 2008:272).

Circumcision has occasionally been mentioned as serving to regulate women's lust. This is portrayed as excessive, and thus as threatening the stability of families, and, more widely, the moral order of society. Male religious specialists typically hold such views, which may be shared by some mothers (Feillard and Marcoes 1998:348–50, 361; Newland 2006:401; Putranti et al. 2003:48; U.S. State Department 2001). In Negeri Sembilan, southwestern Malaya, FGC was considered necessary to prevent a girl's clitoris from continuing to grow and becoming too big (Peletz 1996:208).

Conversely, there are reports that FGC of the minor Southeast Asian type may serve to enhance women's sexual pleasure (Feillard and Marcoes 1998:361; Newland 2006:401). An article appearing in a West Sumatran newspaper, probably *Singgalang*, on 17 September 2004, alleged that women who had been circumcised were more easily stimulated and aroused when touched, and thus more loved and honoured by their husbands (Lyn Parker, personal communication). It may be relevant that contemporary beauty clinics in the West purportedly remove the prepuce of the clitoris to heighten a woman's sensual pleasure.

Anthony Reid makes too much of this, however, suggesting that FGC right across Southeast Asia was linked to increasing women's enjoyment, as a survival of pre-Islamic beliefs and practices. This assertion is based on Ruth Moore's observations on Sulu, in the Southern Philippines, in the late 1970s (Reid 1988:148–9). Leaving aside serious problems inherent in generalizing and projecting backwards in time, Moore's Tausug informants only told her that FGC enhanced sexual proficiency, and they insisted that it was a classically Islamic procedure (Moore 1981:183).

'Syncretic' Islam and FGC

In the early 1890s, Christiaan Snouck Hurgronje believed that large numbers of Indonesia's Muslim women were not circumcised because of resistance by Muslims who were profoundly affected by older Hindu and Buddhist norms (Snouck Hurgronje 1923–24:IV, 205). Numerous Southeast Asian Muslims adhere to forms of 'syncretic' Islam, especially in East and Central Java, where it is known variously as *kejawen*, *kepercayaan*, or *kebatinan*. They oppose *santri*, or 'orthodox,' Muslims, who abide by Shafi'i principles. Clifford Geertz further divided syncretists into two groups, *abangan* peasants mostly influenced by Animism, and *priyayi* aristocrats clinging more to elements of Hinduism. This simple binary distinction has been strongly challenged, however, and it is safer to consider 'syncretic' Islam as a single, albeit highly fragmented, group (Geertz 1960; Woodward 1989).

The refusal of both Dutch and Indonesian authorities to accept 'syncretic' Islam as a census category makes it impossible to know how many people adhered to such notions over time, but the majority of Southeast Asian Muslims may always have been of this persuasion, given remarkably high population densities in East and Central Java (Clarence-Smith, forthcoming a). Other syncretic Muslims exist outside Java, albeit in smaller numbers, for example in the island of Lombok to the east of Bali, in South Sulawesi, and among the Cham of Vietnam and Cambodia (Aymonier 1891; Kraan 1980; Pelras 1996; Taylor 2007).

Some of these Muslims altogether turned their backs on *tetesan*, seeing the practice as a symbol of adherence to the 'orthodoxy' that they so disliked (Koentjaraningrat 1988:361). Opponents of FGC today refer to it as an 'Arab custom' (Lyn Parker, personal communication). This is significant, because Arab mores were among the greatest *bêtes noires* of militant 'syncretists' of the nineteenth century. There may have existed repulsion at the very idea of genital mutilation, given that people in the East Javanese enclave of Tengger, which clung to Hindu beliefs through the centuries, shunned male circumcision (Hefner 1985:34, 143–5, 256).

Although the elite *priyayi* were most obviously influenced by Hindu notions, by no means all of them refused to circumcise their daughters. Indeed, FGC has survived to this day at one of Java's royal courts, that of Yogyakarta, where it remains a ritual associated to a complex set of ceremonies, notably the *slametan*, or ritual meal. FGC is perceived by court women as one *rite de passage* to adulthood, usually imposed on girls between the ages of seven and nine, albeit with a tendency to occur earlier in recent times (Putranti et al. 2003:21, 37–9).

Some 'syncretists' simply declared FGC to be optional, as with so much else in the Islamic canon, even if they might accept that it was in some sense *sunat*, or honourable (Snouck Hurgronje 1923–24:IV, 205). As well as indicating a general

adherence to religion, the ritual marked the transition to adulthood through menstruation, facilitated marriage and childbirth, protected from bad luck, and cleansed from various kinds of pollution. The ritual was also portrayed as an ancient Javanese custom (Putranti et al. 2003:18–19, 22, 26, 37).

The Javanese of such persuasion usually called FGC *tetesan*, or other variants on the root *tetes*. The linguistic origins of these expressions are unclear, but they may refer to the traditional bamboo knife used to cut girls, a drop of blood, lineage, fertility in eggs, or the 'opening up' of a woman's womb (Feillard and Marcoes 1998:343, 357; Jaspan and Hill 1987:22; Putranti et al. 2003:17; Basilica Putranti, personal communication). In any event, these Javanese words and phrases lack Arabic elements, in marked contrast to those used in *santri* circles.

Another difference with *santri* Muslims was that 'syncretists' who circumcised their girls celebrated the occasion openly and solemnly and waited longer to perform it. Although the operation itself remained private, a *gamelan* orchestra would signal that the deed had been done, and a ritual feast, equal to that for a circumcised boy, would be offered (Snouck Hurgronje 1923–24:IV, 206–7). Moreover, a girl would often be circumcised after her first menstruation, a time considered too late by the 'orthodox' (Koentjaraningrat 1985:361).

Most strikingly, a number of 'syncretists' performed only a symbolic operation. In Java, a peeled turmeric root [*kunyit*] was often placed over the girl's clitoris, and the root was cut instead of the flesh. The turmeric was then buried or thrown into the sea. The yellow colour of the root symbolized Malaikat Kuning, the 'yellow spirit' who removes bad luck from children (Putranti et al. 2003:19, 31). This substitution may have evolved from an older practice of using turmeric root as a natural antiseptic and burying root and flesh together after the procedure (Feillard and Marcoes 1998:343; Jaspan and Hill 1987:13, 22). Another symbolic object might be substituted. In South Sulawesi, a cock's comb, at times wrapped in betel leaves, was cut, and the blood was smeared on the girl's clitoris (Budiharsana et al. 2003:34, 37) Betel leaves had many ritual associations, as well as antiseptic properties (Clarence-Smith, forthcoming b). Bohra Muslims in India sometimes cut these leaves, instead of the clitoris, when girls were 'born circumcised' (Ghadially 1991:19).

The incidence of FGC

Divisions between 'orthodox' and 'syncretic' Islam are reflected in the incidence of FGC. A Dutch survey of 1921 revealed wide observance of female circumcision in the piously Islamic zones of Indonesia's Outer Islands and in West Java. In contrast, slackness was discerned in East and Central Java, where even the *santri* did not always circumcise their girls (Feillard and Marcoes 1998:349).

Contemporary surveys and reports indicate that almost all women in regions reputed to be *santri* consider themselves to have been circumcised, notably in Madura, West Java, West Sumatra, North Sumatra, North-Central Sulawesi, and South Sulawesi. Moreover, they foresee the same fate for their daughters and grand-daughters (Budiharsana et al. 2003:12, 22; Newland 2006:396–7; Lyn Parker, personal communication; Putranti et al. 2003; U.S. State Department 2001). One partial exception is East Kalimantan, where the procedure appears to be less widespread (Budiharsana et al. 2003:22).

In contrast, only 43.5% of female respondents in the Yogyakarta area, central Java, reported themselves as having been circumcised in 2002. This fell as low as 31% according to other figures cited. The 2002 survey even noted that some of the older girls and women attending *pesantren*, Javanese rural Islamic boarding-schools of an 'orthodox' bent, declared that they had 'not yet' been circumcised, an Indonesian locution which can carry the sense of not intending to do anything about it (Putranti et al. 2003:18, 22, 25).

Islamic reform movements and FGC

With the emergence of Islamic reform movements in late nineteenth-century Southeast Asia, the *muda* ('young') camp of radicals might have been expected to oppose FGC, leaving the *tua* ('old') group of conservatives to defend it. Indeed, this is the situation in southern Thailand today (Merli 2008:272–5). However, sharp divisions have rather surprisingly surfaced within individual movements, blurring the dichotomy between *tua* and *muda*. Southeast Asian fatwas, opinions on points of Islamic law, are shot through with contradictions on this matter (Feillard and Marcoes 1998:361–6). A significant point of dispute between religious leaders is whether FGC is obligatory, or merely honourable (U.S. State Department 2001).

Arabs from Hadhramaut, today in eastern Yemen, transmitted some of the earliest reformist impulses of the modern age to Southeast Asia (Freitag and Clarence-Smith 1997). Their main contribution may have been to help to lower the age of the procedure, as *khafd* was practiced in Hadhramaut shortly after birth, together with piercing the ears and nose of babies (Ingrams 1949:99; Rodionov 2007:144–5; Snouck Hurgronje 1931:113). In western Malaya in the 1830s, it was noted that piously Shafi'i Islamic inhabitants, much influenced by their Arab teachers, circumcised both males and females (Moor 1968:250; Newbold 1971:I, 247).

The Muhammadiyah movement, founded in Java in 1912 and claiming tens of millions of members after 1945, grouped Indonesian *santri* modernists influenced by the teachings of Muhammad 'Abduh and Rashid Rida in Egypt (Alfian 1989; Peacock 1978b). However, it is not clear whether these two luminaries ever pronounced on FGC. Although the leaders of Muhammadiyah generally did not circumcise their own girls, they avoided head-on conflict over the issue by relegating the habit to the sphere of harmless folklore (Feillard and Marcoes 1998:355–7, 363–4). Similar divisions emerged in the Hadhrami Arab modernist movement al-Irshad, founded in 1914 and closely linked to Muhammadiyah (Feillard and Marcoes 1998:363–4).

In more recent times, opinions in Muhammadiyah have remained divided. Some contemporary leaders in Yogyakarta

simply state that there is no backing for the practice in the Koran or the canonical Hadith collections. Others accept that FGC is recommended or noble, even if they rarely impose it on their own girls. Yet others relegate the practice to the domain of acceptable Javanese custom (Putranti et al. 2003:25–6).

Sarekat Islam, founded at about the same time as Muhammadiyah and influenced by radical currents in British India, was more resolutely modernist, but had few members from the mid-1920s (Melayu 2002; Shiraishi 1990). The main ideologue was Haji Agus Salim (Kahfi 1997). Although it is not clear whether he ever pronounced on FGC, a medical student close to him, Ahmad Ramali, published a dissertation in 1951, dealing with health and Islamic law. He explained that FGC was obligatory in Shafi'i law, and that devout Muslims circumcised their girls earlier than others. He noted that FGC was essential for a woman to be considered a Muslim, although touching the clitoris and labia with the knife might be equivalent to actual cutting. He cited some dubious medical notions about improving female hygiene, removing repulsive odours, restricting female libido, lessening the chance of premature ejaculation for male sexual partners, and feminizing a woman in Freudian terms. Even if this was essentially a descriptive exercise, it is striking that Ramali did not overtly condemn FGC (Feillard and Marcoes 1998:350–2).

Modernists were especially strong in West Sumatra, where they made repeated attempts to reform or abolish the matrilineal *adat*, customary law, of the Minangkabau people (Noer 1973:31–56). However, an article appearing in a local newspaper, probably *Singgalang*, on 17 September 2004, decreed that Islam and custom were at one in the matter of FGC, which was an acceptable practice for local Muslims (Lyn Parker, personal communication).

Elite 'syncretic' organizations emerging from the 1900s, notably Buti Utomo and Taman Siswa, might have provided another obvious home for opponents of FGC, as the leadership became increasingly imbued with secularism and European ideas (Nagazumi 1972; Tsuchiya 1987). However, a Taman Siswa student in the 1930s explained that circumcision was necessary to reduce female libido and maintain fidelity in marriage, especially when a man had more than one wife (Feillard and Marcoes 1998:349–50). A male 'native doctor,' from a group strongly associated with these movements, expressed similar ideas in the Dutch survey of 1921. Abdul Rajid, active in Tapanuli, West Sumatra, declared that female circumcision diminished a woman's sexual desire, which was necessary because women were naturally much more lustful than men. He also opined that the operation fattened women, thus making them more attractive (Feillard and Marcoes 1998:348).

Looking at the matter from the other side of the divide between the 'young' and 'old' camps, the logical defenders of female circumcision were the ulama of the Shafi'i school of law. They were grouped in the Nahdatul Ulama [NU] from 1926, which today claims tens of millions of members (Barton and Fealy 1996). Surprisingly, some early NU leaders overtly failed to circumcise their girls, whereas others clung to the notion that it was obligatory to do so prior to puberty. A compromise fatwa of 1928 merely termed the practice 'permitted' (Feillard and Marcoes 1998:351, 355–6).

In more recent times, the NU has remained divided. Abdurrahman Wahid [Gus Dur] set his face against FGC, and this was especially important because he briefly became president of Indonesia in 1999–2001. However, most NU ulama went no further than to downgrade FGC from obligatory to recommended status (Feillard and Marcoes 1998:362–3). This was also the position taken by the *mufti* of the Kuala Lumpur federal territory of Malaysia, in 1979, when pressed by the World Health Organization (Strange 1981:58). Most NU ulama in the socially conservative island of Madura continue to consider FGC to be compulsory, and activists in East Java cling to the same position (Feillard and Marcoes 1998:356; Putranti et al. 2003:23–5).

Organizations created by the state, or closely supervised by it, have tended to defend FGC as a requirement of Shafi'i practice, while insisting on cutting as little as possible. This was the position of the mufti of Singapore in 1994, and it was repeated recently in a fatwa on the website of the city-state's Islamic Religious Council (Mardiana 1994; Islamic Religious Council of Singapore 2007). The Majlis Ulama Indonesia, or Council of Indonesian Ulama, long avoided issuing a fatwa on the matter, but one female member declared FGC to be obligatory (Feillard and Marcoes 1998:364). The Council cooperated from November 2000 in a National Action Plan to End Violence against Women, taking the stance that ritualistic or 'non-invasive' techniques of FGC should be promoted, at least during an initial phase of raising social awareness (U.S. State Department 2001).

Even fundamentalist or literalist movements have been undecided as to how to handle FGC. Persatuan Islam, or Persis, was refounded on literalist lines in 1926, with strong South Asian influence (Federspiel 2001). For some in this movement, female circumcision was reprehensible, a throwback to the age of ignorance before the rise of Islam (Feillard and Marcoes 1998:364). However, one Persis scholar in the 1990s took the position that since the Prophet had ordered that his wives be circumcised, this should be the model for the faithful of all ages. FGC was necessary to perform acts of devotion, and also exemplified cleanliness and hygiene. In addition, it was said to enhance sexual enjoyment, although it is unclear for which of the partners (Newland 2006:401).

In recent decades, a more extreme kind of fundamentalism has emerged in Southeast Asia, notably the currents that go under the name of Jemaah Islamiyah (Barton 2005). Although some of these literalists merely treat FGC as honourable, others, including women, call for FGC to be observed more strictly, due to the need to reduce or regulate women's excessive lust (Putranti et al. 2003:26, 48). In southern Thailand, envoys from South Asia are said to be preaching the need for deeper cutting (Merli 2008:273). Literalists remain a tiny minority among Southeast Asian Muslims, however, and it seems that only a minority of this minority adopt a strong position on FGC.

Conclusion

There have been worrying trends for reformists since Southeast Asian nations regained their independence. Far from withering away with modernity and progress, FGC has seemingly become more widespread, especially with the wave of Islamic revivalism that began in the 1970s. The rise in the incidence of FGC has been greatest in densely populated East and Central Java, where even the 'orthodox' had been lax in their observance in former times. In addition, the ritual is more frequently performed on infants than in the past. Often, it is part of a post-natal package that includes piercing the ears of the newborn baby girl. Moreover, even if most circumcision is still so minor as to leave no evident physical trace, there is a growing stress on cutting more deeply, and on reducing female libido. The invasive nature of the operation has grown through medicalization and commercialization, which are most noticeable in urban areas (Budiharsana et al. 2001:viii–ix,25; Feillard and Marcoes 1998:354, 356; Newland 2006:395–6, 401–2; Putranti et al. 2003: 24, 47–8; U.S. State Department 2001).

Indeed, the group circumcision of numerous girls has been growing in West Java, a development that parallels the rising popularity of mass circumcision rituals for boys. In 2001, an advertisement in a local paper, *Pikiran Rakyat*, called attention to such a ceremony organized the Assalam Foundation (Budiharsana et al. 2003:10). By 2006, this foundation, working for education and social services, was circumcising groups of girls in the city of Bandung, where it had its own mosque. Every spring, in the lunar month marking the birth of the Prophet, large groups of girls, many under the age of five, come together in prayer-halls or class-rooms. Women circumcisers, who have served an apprenticeship, use sterilized scissors to cut a small piece of the prepuce. The procedure is free, and each girl receives a small gift afterwards, and a cup of milk to drink. The foundation's chairman explained that FGC would stabilize a girl's libido, make her more beautiful in the eyes of her husband, and balance her psychology (Corbett 2008). If adopted across Southeast Asia, mass circumcision is likely to make FGC more prevalent.

The United Nations policy of zero tolerance, established in 1998 and partially adopted by a hesitant Indonesian government, is possibly the wrong response to such trends. Lynda Newland argues that repression appears to have stiffened the resolve of the pious (Newland 2006). The attempt to eliminate female circumcision can all too easily be made to look like an assault on Islam itself, thereby playing into the hands of a noisy fundamentalist minority.

A better strategy might be to encourage Southeast Asian Muslims to probe and evaluate the underpinnings of FGC in Islam. Embarrassment prevents many from thoroughly discussing the issue, but there are good theological grounds for declaring FGC to be uncanonical. Indeed, some reformists in the wider Islamic world have come to reject FGC entirely, condemning it as an unacceptable survival from the *jahiliyya*, the age of ignorance (Abdu'r-Razzaq 1998:39; Ali 2006:ch6; Bosworth et al. 1978:913–14). Manifold divisions, which have rent every Southeast Asian variety of Islam over the issue, indicate that many Muslims might be prepared to repudiate an imported pre-Islamic Arab custom, as long as this was seen as a necessary aspect of Islamic reform.

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To Islamize, Becoming a Real Woman or Commercialized Practices? Questioning Female Genital Cutting in Indonesia

Abstract

As a preserved ancient tradition in Indonesia, female genital cutting is often neglected because its incidences are not readily visible. This paper attempts to make this practice more visible by exploring its origins, meanings and the challenges surrounding it. This exploration shows how local contexts serve as an important basis for the presence of female genital cutting in Indonesia. In both research sites, Javanese court tradition was established prior to the introduction of Islam. The coastal Islamic tradition developed since the 16th century, and the spread of western medicine since the colonial period generated ceremonial 'symbolic only' practices of female genital cutting. However, the medicalization process has lead to the commercialization of the practices, while the recent rise of Islamic fundamentalism allows 'real cutting' and even more harmful practices to be carried out among Muslims throughout the archipelago. This study points out how patriarchal myths surrounding these practices affect the women's sexuality and health and help shed light on the true challenges of female genital cutting in Indonesia today.

Reframing the problem

As often noted in previous studies, in contrast to many African countries, problematizing female genital cutting[1] in Southeast Asian countries is incredibly challenging due to the invisibility of such practices. Without the global campaign aimed at eradicating this harmful practice, the incidences of female genital cutting which spread throughout the Southeast Asian region might have never been questioned. Female genital cutting began to gain attention within Indonesia's intellectual world quite recently, since the late 1990s. While some previous studies have succeeded in exploring the prevalence, contexts and significance of this practice, it remains difficult to delineate the true challenges faced by the Indonesian people in regard to this practice.

In their relatively comprehensive study on female genital cutting in Indonesia, Andree Feillard and Lies Marcoes (1998) found that though minimized as 'symbolic gestures' and surrounded by a certain amount of secrecy, the practice evolved as subsidiary to male genital cutting and spread in most regions in Indonesia through the process of Islamization.[2] Their findings were followed by several studies conducted in different regions which focused more on the variations of the practice, its motivations between religion and tradition, and its implications in terms of women's health (i.e. Budiharsana et al. 2003 in Padang, Padang Pariaman, Serang, Sumenep, Kutai Kartanegara, Gorontalo, Makassar, and Bone; Ida 2005 in Madura; Musyarofah et al. 2003 in Lampung; Newland 2006 in West Java; Putranti et al. 2003 in Yogyakarta and Madura; Rahman 1999 in West Java; Suryandaru 2004 in South Java; and Sumarni et al. 2005 in Yogyakarta).

All of these studies have noted similar techniques of practice. In each research site, operations removing a part of the clitoris persisted. In other cases, these operations were often replaced by "only symbolic" gestures. The studies also indicate how elements of Islam are presented as factors either contributing to the disappearance of indigenous female genital cutting practices or competing with the more medicalized practices. The most persuasive discussion has questioned the harmfulness of "minor" female genital cutting operations performed in each of the research sites, and its significance either in reconstructing gender ideology or in affecting the state of women's health in Indonesia.

Until now, female genital cutting in Indonesia has not been fully delineated. My previous studies (Putranti et al. 2003; Putranti 2005) conducted in the Yogyakarta and Madura regions describe the religious, cultural and medical connections that have influenced the development of this practice, but the question of when female genital cutting actually began to be accepted in Indonesia remains unanswered. My studies also address the preserved meanings attached to these operations, although what is actually experienced by babies or girls and whether they consider the practice harmful to their health is difficult to assess.[3] Indeed, this phenomenon remains a puzzle with no available data from pre-Islamic periods and the lack of an appropriate method to verify its factual incidences. The aim of this article is not to tackle these unfinished tasks, but to reframe the "problem" in local contexts to find out the true challenges surrounding these practices: How prevalent is female genital cutting in Indonesia? How far can we possibly trace its origin? How meaningful are these practices for the society? Are these practices challenging to women and if so, in what ways?

In order to trace the origins of female genital cutting, the following discussion deals with its prevalence, history and terminologies. The techniques, logic, and ceremonies are then analyzed to show how meaningful female genital cutting is for the society. Lastly, I discuss the several possible challenges this practice presents to women, particularly in connection with the rise of medicalization over the last two decades and the recent rise of Islamic fundamentalism. Although the problem discussed here relates to Indonesia in general, it should be noted that most of the analysis is based on Javanese cultural contexts. This article, therefore, calls for the conduction of follow-up studies of other ethnic and cultural contexts in order to paint a more vivid and complete picture of female genital cutting throughout the archipelago. This is particularly important in order to compare the challenges female genital cutting presents for women in different ethnic contexts.

Notes on methodology

To answer the questions addressed in this article, I depend methodologically on the results of field research conducted in 2002 in the Yogyakarta and Madura regions, some updated data gathered in 2007, in addition to a comprehensive literature review about these practices in other regions of Indonesia. Data was primarily obtained from in-depth interviews during the field research in 2002. The informants included women who had personally experienced genital cutting, female modern and traditional health practitioners conducting such operations, male religious leaders promoting the practice, and community leaders possibly knowledgeable of the historical aspects of female genital cutting. Some of the statistical data presented in this article is also based on a survey with 383 male and female respondents in Yogyakarta and Madura. During 2007, I updated the existing data to ensure its relevancy in the current context. In-depth interviews with female modern health practitioners were carried out in several hospitals in Yogyakarta, and clippings pointing to the national polemic of these practices were collected from newspapers, magazines and websites. Both methods provide information on the most recent tendencies of female genital cutting in Indonesia, especially after the recent rise of Islamic fundamentalism throughout the archipelago.

Yogyakarta and Madura are important research sites for this study because female genital cutting is practiced in both areas. Moreover, both societies share the syncretism of Javanese culture in which the local worldviews have been influenced by historical waves of animism, Hinduism, Buddhism and, finally, Islamic spiritual elements. This historical background is useful in identifying whether female genital cutting practices originated from Islamic tradition or prior to Islam's spread to the region. These research sites are significantly different demographically, however, Yogyakarta being more heterogeneous in terms of ethnicity, religion and social class. In contrast, Madura is relatively homogenous with most of its population consisting of Muslims with lower levels of education. Another reason for the selection of these sites in this study is that these differences in demographic characteristics help delineate the varieties of and motivations behind the practice of female genital cutting in Indonesia.

Terminologies and origins

While there are only limited data on the prevalence of female genital cutting in Indonesia, we are lucky to have access to the documented work of Dutch scholars from the second half of the 19th century. As summarized by Feillard and Marcoes (1998), the Dutch scholars' work reveals that female genital cutting practices were found in Indonesia at the end of the 17th century. Gervaise first reported in 1670 the existence of these practices among Muslims in the Makassar, Sulawesi region, describing how "women should be allowed to save their souls through circumcision, it is practiced in secret, quietly while men are never present" (Feillard and Marcoes 1998:339). Dutch scholar Winter's work in 1843 noted the cutting off of part of the clitoris of girls 6–7 years of age in Surakarta, Java. Riedel's work in 1870 points to similar practices among girls 9–15 years old in Gorontalo, Sulawesi; Dr. B.F. Matthes' work in 1875 describes this practice among Buginese girls of 3–7 years of age in Sulawesi; and A.L. van Hasselt's work in 1882 shows genital cutting occurring among girls at an earlier age than boys in Minangkabau, Sumatera. Later documentation includes the work of Hurgronje in 1924 which confirms these earlier findings among the Sundanese, Javanese and Acehenese, however delineating differences in secrecy based on local context. According to Hurgronje, Sundanese girls were circumcised within secrecy. The greatest secrecy, however, was found among Acehenese girls. Oppositely, secrecy was absent among the girls of Javanese aristocrats.[4]

Perhaps the most comprehensive scholarly work on female genital cutting is Schrieke's in 1906, documenting cases of female genital cutting throughout almost the entire archipelago. Schrieke mentions numerous regions that carried out the practices

with similar operations, including: Java island (Batavia, Ciamis, Tasikmalaya, Bogor, Kutoarjo, Kebumen, Muntilan, Parakan, Demak, Ungaran, Surakarta, Ngawi, Nganjuk, Mojowarno, Lawang); Sumatra island (Indragiri, Asahan, Medan, Selat-Panjang, Penjabungan, Bangkinang, Lampung, Belitung); Alor and Pantar islands; Borneo island (Pontianak, Sintang, Smitau, Tenggarong); Celebes island (Gorontalo); Buton island; Kei island; and Moluccas islands (Bacan).[5]

Feillard and Marcoes (1998) conclude from these Dutch scholars that the practice of female genital cutting was indeed introduced by Islamic influences, pointing to the presence of this practice in Islamic regions and absence of the practice in regions not yet reached by Islam like Nias, Timor, Batak pagans in Pearaja, Muara Siberut, Lombok, Sumba, Flores, Solor, Roti and ethnic Dayaks in Borneo.[6] This conclusion is confirmed by contemporary Indonesian scholars in their studies of female genital cutting in Muslim communities (i.e. Budiharsana et al. 2003; Ida 2005; Musyarofah et al. 2003; Rahman 1999; Sumarni et al. 2005; Suryandaru et al. 2004).

My findings from field research in Madura (Putranti et al. 2003 and Putranti 2005) also indicate female genital cutting practices to be initiated by Islam, or more precisely, by the "coastal" Islamic tradition. This tradition dates back to the influence of Arabian, Persian and Gujarat cultures brought by Muslim traders to Madura's coastal areas in the 16th century. Not very long before the introduction of Islam in Madura, political efforts were made by the Yogyakarta Court to unite the Javanese Kingdom throughout the archipelago, including the attempt to conquer the peripheral court of Sumenep in eastern Madura. The efforts did not succeed, however, and consequently 'pure' Islam flourished more in Madura than did Javanese cultural beliefs. The practice of female genital cutting in these areas, therefore, developed more as Islamic religious practice.

Among Javanese people, genital cutting is comprehended in several local terms such as *sunat*, *khitan*, *tetak*, *supit*, and *tetes*. Each term sheds light on which syncretic element and socio-cultural circumstance is being referred to. In a contemporary Javanese-Indonesia dictionary, for example, we can find the term *sunat*, which is synonymous with *khitan*, *tetak* and *supit* (Prawiroatmodjo 1981). These terms refer exclusively to male genital cutting, though in practice, the terms *sunat* and *khitan* can also refer to female genital cutting. It is interesting to note that there is no term *tetes* (Javanese) or *tetas* (Indonesian) mentioned in this contemporary dictionary, but it is found in an old Javanese-Indonesia dictionary, referring to two general meanings: 1] to pierce, to prick and 2] 'to hatch' (an egg). There is also a mention of the term *anetes*, meaning: 1] to crack open (an egg); 2] to scratch; 3] to cut with a sharp tool and 4] to release from, while the term *tetesan* means a child (of bird) which is hatched (Zoetmulder 2006:1245).

In social practices, the meanings of all these terms depend on the contexts. The term *sunat* (Javanese) or *sonat* (Madurese) is often emphasized to imply the 'real cutting' operations. Meanwhile, *sunatan* (Javanese) or *sonattan* (Madurese) signifies the ceremonies associated with genital cutting. Particularly among the Javanese, these terms are more likely used to pronounce male genital cutting. Therefore, the term *sunatan masal* (mass genital cutting) refers to a male genital cutting ceremony, not a female one. Notwithstanding, in the Madura region, the term *sonattan* can also be applied to female genital cutting ceremonies initiated by traditional religious leaders.[7] The term *sunat* or *sunatrasul* is also connected with the Arabic word *Sunah*, referring to the doings and sayings of Muhammad, so that in case of genital cutting, it denotes advisable religious actions to be carried out (Echols and Shadali 1981:533).

Based on my observation in Yogyakarta, the term *sunatan* is interchangeably used with *tetakan* (from *tetak*, hitting with a sharp tool) and *supitan* (from *supit*, a tool for clamping) to refer to male genital cutting ceremonies. Associated with Islam, the ceremony personally signifies the process of "becoming a Muslim." In a wider social context, however, it is considered as a cycle of the core rituals of the Javanese community aimed at maintaining order and safety for all, including activities of eating together, the animistic element of burning incense, and Islamic prayers. In the circle of the Javanese kingdom, in which power was centred in the Yogyakarta Court and polarized to the peripheral areas of Java, the term *tetakan* is more often used to be paralleled with *tetesan*, a female genital cutting ceremony, which its operation involves symbolic only gestures. Both *tetakan* and *tetesan* uniquely signify a process of "becoming a man or a woman."

Meanwhile, *khitan* is another commonly used term among Indonesia's Muslims. This Arabic term stands for "cleansing" and is said to be rooted from the word *khatana* (verb), meaning to cut. There is also another term, *khifad* (noun), which means lessening or lowering. *Khifad* is paralleled with *khitan*, but in hadiths, it often refers to female genital cutting, meaning removing a small part of the tip of the clitoris (Munawwir 1997).[8]

It is important to remember that though the available data points in the direction of female genital cutting as an Islamic invention, we must keep in mind that there is very little data from the pre-Islamic period. I am far from uncovering the exact origins of female genital cutting in Indonesia, and this article is only able to indicate the spread of beliefs in genital cutting as a Javanese animistic practice which existed prior to the coming of Islam and even of Hinduism. This belief, for instance, was expressed by an elderly believer in Javanese mysticism I interviewed in Yogyakarta:

To my knowledge, before mosques, churches and temples existed, the Javanese had already been there. As well as tetakan or tetesan, the Javanese have been there before everything happened… just like an instinct. But then tetesan has been known as the court culture. It is because in the time of the Javanese kingdom, the common people followed the Sultan's order as taken for granted, including his order to carry out Muhammad's birthday, village cleansing, and tetakan or tetesan ceremonies.

In other words, beliefs surrounding ancient female genital cutting practices still exist though evidence of such practices would be very difficult to obtain. I will discuss this more in

the following sections not only to indicate the various cultural references of female genital cutting today, but also to show how meaningful the practice is for particular groups in Indonesia.

The spread of FGC and its cultural meanings

In female genital cutting throughout Indonesia, various operational techniques are employed. For example, Feillard and Marcoes (1998) discovered the following: cutting off part of the clitoris "that is in excess" either with or without bleeding using a knife, razor or scissors (in Pekalongan, Purbolinggo, Jombang, Madura, Denanyar, Lombok, Banten, Bungotebo, Wedi, Klaten, Jember, Gresik); rubbing off the skin of the clitoris using a pincer or piece of bamboo (in Jombang, Tegal, Jember, Sepanjang, Situbondo, Madura); and piercing the clitoris with a needle or knife to extract a single drop of blood (in Yogyakarta, Jakarta). The research of Budiharsana et al. (2003) similarly identifies the techniques of rubbing, scraping, scratching, pricking, piercing, incising, and excising to be used in Padang, Padang Pariaman, Serang, Sumenep, Kutai Kertanegara, Gorontalo, Makasar and Bone.

Although the female genital cutting techniques employed in Indonesia appear not to be as extreme as those found in many African countries, some form of 'minor real cutting' does indeed occur throughout the country more often than 'symbolic only gestures.' This can be seen in the statistical data analyzed in Ida's research in Madura (2005), wherein the proportions of scratching (34,2 percent), cutting (33,8 percent) and rubbing (23,3 percent) are higher than the 'symbolic only gesture' of cleansing (2,5 percent). In some other areas, however, 'symbolic only gestures' occur more often than 'minor real cutting'. As indicated in my research in Yogyakarta (Putranti et al. 2003), the proportion of 'symbolic only gestures' (16,7 percent) is higher than cutting the genital parts (11,2 percent), scratching without bleeding (5,6 percent), and scratching with bleeding (2,8 percent).

The presence and tendency for ceremonial 'symbolic only gestures' and 'minor real cutting' techniques in Indonesia today does not mean that female genital cutting has lost its significance. I find that the way female genital cutting is carried out is always bonded to the various meanings attached to it, which in turn helps shape the ceremonies surrounding the practice. The various cutting practices in Indonesia all share the idea of purification, of purifying the body from dirt. The following discussion elaborates this assertion through explaining the two basic techniques for female genital cutting that I discovered in my research sites of Madura and Yogyakarta, namely the techniques of 'minor real cutting' and 'symbolic only gestures'.

The word 'cutting' in this context does not only refer to removing part of the genitals, but also to wounding the genitals until bleeding results. While there is no clear explanation for the reasons behind removing or wounding female genitals until bleeding results, the diversity of practices of female genital cutting suggests that different interpretations and techniques are utilized throughout Indonesia, especially in the Islamic regions. As explained by my informants,

Usually, it is the foreskin which is cut… only something excessive on the tip that should be removed... using a razor until there is a little bit of bleeding. According to male traditional religious leaders, the proper way includes bleeding. After that, a slice of turmeric should be applied on it (a female traditional healer in Madura).

I just cut a small part… no more than a half centimetre. Basically it is only the foreskin, so there is not much change. But it is enough according to Islam (a midwife in Madura).

When I studied fiqh, I was inspired to experience genital cutting even though it is only recommended. Thus, I went to the doctor… At that time she used a boiled scissor to cut my genitals … only a small part. My genital was bleeding a bit but I almost didn't feel anything. After that, my genital was sprayed… maybe with alcohol. Two days later, it had already healed (a female student of an Islamic orthodox school in Yogyakarta).

Indeed, it is religious motivation that often underlies female genital cutting operations. The term 'cutting' itself refers to the idea of removing dirt from human bodies as the prerequisite for Islamic prayer. Several religious leaders I had met in Madura and Yogyakarta asserted that the idea refers more to male genital cutting, while for female genital cutting, there is no explicit rule mentioned in the Koran or Hadith. Notwithstanding, they believe that the idea can also be associated with the female practice. As a result, various interpretations of the practice have emerged. An Islamic leader in Madura elucidated his point of view,

Devotion, especially Islamic prayer, is obligatory, and the absolute requirement for this is to be clean. When the time of devotion is coming, a servant of God has to be clean. There is no dirt in or on his/her body. Because urine is considered as part of dirt, khitan is purposed to remove the rest of the urine, which sticks to the human body. By contrast, if one is not genitally cut, the purity of their body is questioned.

My interviews with other Islamic leaders in Yogyakarta and Madura also confirmed that there might be some religious motives to practice genital cutting. For Muslims who follow the Syafii mainstream interpretation, genital cutting is considered obligatory (*wajib*) for both men and women. One the other hand, for those who follow the Hanbali mainstream interpretation, genital cutting is considered obligatory for men, but only recommended (*sunah*) for women,while yet another Islamic interpretation says that it is honourable (*makruma*) to carry out female genital cutting. My observations, however, assert that even though Indonesian Muslims predominantly follow the Syafii mainstream, it may not always be in term of practices. There are interpretations that advise against the practice because of the lack of a strong legitimizing foundation in either the Koran or Hadith[9]. Besides, some who maintain

Javanese tradition would base their opinion much on mystic beliefs about female genital cutting. But in any of these cases, both female and male genital cutting significantly determine a person's social identity as a "true" Muslim. By stating that one has experienced genital cutting, he/she is acknowledged as a member of the Islamic community.

It is also interesting that Muslims and non-Muslims have different attitudes towards genital cutting. Among Javanese Muslims, if one has not experienced genital cutting he/she is often considered a non-believer, connoting Protestants or Chinese. Unlike Muslims, the assimilation of Protestants and Chinese into Javanese communities has historically been difficult, due to cultural tensions. A Protestant priest I interviewed in Yogyakarta explains,

Formerly, the missionaries believed that Western culture was higher than indigenous cultures. It created the superiority of Protestantism which had been spread among Javanese people at that time. Western is superior, and thus Protestantism is superior. It is an evolutionist thinking, and as a result, the missionaries often subordinate and prohibit everything related to Javanese culture. Traditional puppet show "wayang" had even been prohibited, much less genital cutting. Indeed, that was the missionaries failure in approaching the Javanese.

This historical background still influences the way in which the Protestant community considers genital cutting among Javanese today. An interview with a priest in Yogyakarta revealed that among Javanese Protestants, genital cutting is regarded as a disavowal to God and may lead to excommunication from the church community.[10] In case of the Chinese, almost similar attitudes prevail. Since the Chinese living in Java are usually Christians and culturally relatively isolated, prejudices about them often emerge among Javanese Muslims. A community member I have interviewed in Yogyakarta, for example, said that a boy who is afraid to endure genital cutting is often mocked among his friends who may sing the song "*cina liding, peli cina wedi lading"* (your penis is like that of the Chinese who is afraid of the knife).

In the Catholic, Hindu and Buddhist communities in Yogyakarta, however, I found a relatively neutral attitude toward genital cutting due to their acceptance of Javanese norms and traditions. As a result, these non-Muslim communities also practice genital cutting similar to Muslims. An interview with a member of the Buddhist community in Yogyakarta uncovers their motivation to experience genital cutting:

There is no clause in Buddhists' holy book that obligates one to undergo genital cutting. Buddhists perform genital cutting just because it is customary among people in Yogyakarta to do so when their children are getting mature. Thus, the reason behind it is because of cultural tradition, aside from of health.

The Catholic community in Yogyakarta seems to have similar motivations with the Buddhists. Although Catholicism had formerly prohibited genital cutting like Protestantism, the practice has continued for both cultural and health reasons. A Catholic priest in Yogyakarta formulated,

Most members of the Catholic community here are practicing male genital cutting. The first reason is for healthiness, and the second is for a holy sexual pleasure of husband and wife. As regards female genital cutting, it is rarely practiced among Catholics. But for them who live in rural areas, it is still practiced because of cultural traditions.

Hindus for their part practice genital cutting when a Balinese-Hindu marries a Javanese-Muslim and they live in Java.

The second technique of female genital cutting practiced in Indonesia, particularly in Yogyakarta and in some parts of Java, is 'symbolic only gestures.' Known as *tetesan*, the technique is rooted in Javanese syncretism and symbolizes purification from dirt, but it has a slightly different logic and perception of 'dirt' than the technique of *khitan* rooted in Islamic beliefs. In this view, the Javanese believe that all humans were born in a condition of suffering from dirt due to the curse of Batara Kala, the god preying on humans. Hence, everyone needs to be purified from this dirt while still a child in order to shield one's life from bad luck. Through the ceremony of *tetesan* for female or *tetakan* for male, the yellow angel, or Sang Hyang Manikmaya, is called to accomplish this goal. In line with this, 'real cutting' only occurs in the *tetakan* ceremony, while in *tetesan* ceremony, there is nothing to be cut. An elderly Javanese believer in mysticism in Yogyakarta maintained:

I argue against those who say 'cutting' is applied in tetesan. This violates the Javanese authenticity and instict. The truth is that it only includes 'sticking a slice of turmeric on the clitoris.' Of course there is a reason behind it. In ancient times, people believed in four angels that manifest: a white one named Sang Hyang Setomoyo, a red one named Sang Hyang Klekomoyo, a yellow one named Sang Hyang Manikmaya, and a black one named Sang Hyang Maniksuderi. In tetesan, removing dirt is the task of the yellow angel. This is why turmeric is used to symbolize the removal of dirt by means of cutting the turmeric not the clitoris, then throwing it into the sea or burying it in the ground. In tetakan, however, the foreskin is buried or thrown.

He also connected female genital cutting with an ancient animistic-Hindu belief that a set of ritual offerings like burning incense, preparing food, throwing symbolic materials into the sea, etc. might validate the practice. Through time, Islamic elements became incorporated in the ceremonies. For this reason, *sunat* among Muslims, as well as *tetesan* or *tetakan* in syncretised belief systems are usually accompanied with the reading of Islamic prayers during the ceremony.

Today, most Javanese people are no longer familiar with mystic explanations of *tetesan* and simply understand the practice as a puberty rite as exemplified in the Yogyakarta courtly tradition. In this sense, *tetesan* symbolizes the female reproduc-

tive functions of pregnancy and childbirth. In the Yogyakarta Court, as well as among common people, *tetesan* is usually carried out when a girl is eight years old. This age not only signals a critical moment before entering womanhood, but also helps to develop her awareness of upcoming changes in her body and behaviour. According to a Javanese historian in Yogyakarta,

Up to the age of eight, a child is in a risky condition… at risk of everything, including getting diseases. Therefore, if a child is able to reach the age of 8 years in a healthy condition, we should express our gratitude. Especially for a little girl, it must be ensured that she will be able to netes – meaning that she is not infertile in many senses. After having menstruation at the age of 10 to 15 years, she is hoped to be able to get pregnant, deliver and breastfeed a baby. In other words, she should become a real woman… really a woman, not a tomboy.

In the courtly tradition, the meaning of *tetesan* as puberty rite tends to manifest itself in a set of rigid rules pertaining to womanhood and in sophisticated ceremonies. A woman of the royal family I interviewed in Yogyakarta Court elaborates as follows,

At the age of eight, a little girl must undergo the tetesan ceremony. At that moment, several senior women guide her to go through the ceremony; bathing her, clothing her in traditional outfit, and offering her herbal drinks. Then, a female traditional healer will take her role to do tetesan *inside a bed covered with cloth so that people cannot see inside. After* tetesan *is done, the girl must pay tribute to all senior women. At that time, she is considered to be entering womanhood. As a consequence, there are different rules she needs to adjust to. Becoming a woman is no longer as free as being a child. For that reason, she must be careful in her relationships to the opposite sex.*

This kind of a ceremony is also carried out for *tetakan*, and its celebration is allowed to be much livelier than that for *tetesan*. While these ceremonies continue to be practiced by the royal family of the Yogyakarta Court, they appear to have been gradually forgotten among common people, especially in urban areas. Nonetheless, some meanings behind the idea of *tetesan* and *tetakan* still exist, serving as a basis for gender divisions in Javanese society today.

I conclude that the utilization of both 'minor real cutting' and 'symbolic only gestures' techniques in female genital cutting are meaningful for socio-cultural processes in Javanese society, particularly among Muslims and contemporary syncretised religions. However, an important question remains in terms of whether female genital cutting practices in Indonesia are truly challenging for women. The next section will address this question, especially in connection to the recent rise of western medicalization and Islamic fundamentalism in the archipelago.

Commercialization and Islamic Fundamentalism: Challenges for Women?

At that time, my parents were Muslims. For that reason, they carried out the tetesan ceremony when I was eight. The day before the ceremony, my mother took me to the market to buy new clothes, which of course made me happy. People were also busy preparing food, cleaning the house, and arranging the ceremony. Early in the morning of the ceremony, my family bathed me with flowers mixed in water. After bathing, I was asked to lie down in my bedroom which was decorated like a wedding room. There was only my mother and a midwife accompanying me. Then, the midwife asked me to spread my legs. I was not sure what really happened at that time. For me, it looked like the midwife took something from my genital area and packed it with a piece of paper. But I did not feel anything. I just realized it when she cleansed my genital area with wet cottons. This occurred for 3 minutes only. At noon, many neighbours came to my home and prayed together. After praying, each of them took a basket of food home.

The story told to me is a testimony of one female informant in Yogyakarta about her experience of the *tetesan* ritual. As can be deduced from the story, it is likely that 'real cutting' did not occur. It also seems that she was not that affected by this experience. This leads me to question whether the practice is truly challenging for women. In fact, it is not easy to obtain a satisfying answer from the women themselves. Besides occurring in secrecy, the practices are usually conducted between the ages of 0–15 years, most often when the girl is still a baby (for those following Islamic tradition) or between the ages of 7–8 (for those following Javanese tradition), so that most of them do not remember what really occurred when the rituals were carried out. This is supported by Newland's study on female genital cutting in West Java, which highlights the zero tolerance policies towards the practice that seem out of touch with the realities at the grass-roots level, as in her view, female genital cutting is not performed with any intention of violence, abuse, or even harm towards girl-children and does not seem to have any measurable effect on their lives (Newland 2006:403).

However, my findings point out at least two main issues that resituate female genital cutting practices as potential challenges for Indonesian women today. On one hand, there is the increasingly powerful western medicalization process that for decades has been contributing to the dismissal of 'real cutting' operations, particularly among Islamic believers. Although this medicalization has kept women away from harmful operations, the popularity of Islamic female genital cutting has led to the more commercialized practices of female genital cutting either with or without 'real cutting' involved. One the other hand, the rise of Islamic fundamentalism in late 1990s has brought a new significance to female genital cutting as a religious obligation. Possible implications of this rising fundamentalism include the re-emergence of harmful operations based on literal readings of hadiths as well as an increase in religious institutions' control over women's sexuality and reproduction. Perhaps the

biggest challenge is the potential for these powerful forces to combine, with the notion of female genital cutting as an obligation based on Islamic beliefs gaining support from the medicalization and commercialization processes.

Discussions about the medicalization of female genital cutting operations began to appear in studies in 2000. Based on information from several midwives I interviewed, however, it can be estimated that medicalized operations have been popular since the 1990s when Indonesia's government persistently promoted medical services by female doctors/midwives to replace the use of herbs given by female traditional healers. The medicalization process has changed the practice of female genital cutting substantially, especially in terms of technique, practitioners, tools and the medication applied. My observations in both Yogyakarta and Madura illustrate this trend, with an apparent change from 'minor real cutting' and 'symbolic only gestures' employed by female traditional healers to a preference for 'genital cleansing' and sometimes 'minor real cutting' as performed by female doctors/midwives. Tools used in this practice have also changed from using a knife, razor or cutter to using medical scissors. Sometimes no tools are utilized, but cotton buds are used to apply alcohol and Betadine to the female genital area. In the case of 'symbolic only gestures,' there is no significant change in terms of the tools used, except for the medication. In traditional practices, a slice of turmeric is usually put on the clitoris to work as an antiseptic. In the medicalized practices, turmeric is replaced by alcohol.

The medicalization process is more than a technical change; it is also a cultural one, with western medical knowledge replacing to some extent the local beliefs surrounding female genital cutting. The most obvious change concerns the motives for carrying out the ceremony. In traditional practices, one is motivated to carry out the practice because of a desire to maintain the cosmological order (in Javanese mysticism) or to fulfil religious obligations (in Islam). This spirit has been getting increasingly weaker through the presence of midwives, nurses and doctors who promote modern health beliefs and replace female traditional healers in childbirth. As a result, *sunat* or *tetesan* ceremonies usually led by female traditional healers or female traditional religious leaders have also lost their significance.

Another result of the medicalization process involves the seemingly unintentional commercialization of female genital cutting practices carried out by both female doctors/midwives and female traditional healers. Among female doctors/midwives, the practice is usually "packed" together with ear-piercing and the pinning of gold studs, while among female traditional healers, the "package" includes baby massage, hair-cutting, ear-piercing and bathing services. A standard cost for female genital cutting is 15,000 rupiahs (equivalent to 1.25 euro or 1.6 dollar), while for ear-piercing the cost is 10.000 rupiahs (€0.8 or $1.1). In practice, however, the costs may vary. In Madura, a typical female genital cutting package carried out by a female traditional healer costs between 5,000 to 10,000 rupiahs (€0.4 to €0.8 or $0.5 to $1.1), although some charge more, between 30,000 to 50,000 rupiahs (€2.5 to €4.2 or $3.3 to $5.5). If performed by midwives, female genital cutting services require an additional administrative fee of between 5,000 to 10,000 rupiahs (€0.4 to €0.8 or $0.5 to $1.1). Similarly in Yogyakarta, the midwives usually require an administrative fee of 5,000 rupiahs (€0.4 or $0.5). Other midwives charged higher rates, between 50,000 to 70,000 rupiahs (€4.2 to €5.8 or $5.5 to $7.8), which includes ear-piercing and the pinning of gold studs. Female traditional healers in Yogyakarta, however, do not ask for any payment for carrying out female genital cutting – they only accept money as gratuity.

It appears that more and more people believe that by choosing a package of female genital cutting with a female doctor/midwife, their obligations to follow religious laws and/or preserve cultural traditions are fulfilled. In addition, they consider female genital cutting carried out by female doctors/midwives the best choice because it is more hygienic than if it is carried out by female traditional healers. This tendency actually points to nothing more than a fashioned religious/mystic practice.

Although becoming commercialized, female genital cutting services are usually carried out by request – not all parents who ask for a childbirth service of the female doctors/midwives will also ask for a 'package' of female genital cutting services. Furthermore, these 'packages' are not very popular among Islamic fundamentalists largely because they fear these commercialized practices do not follow Muhammad's prescriptions. As I observed in Yogyakarta, Islamic fundamentalists usually have their own reference guide to doctors trained in carrying out female genital cutting properly, in accordance with literal readings of hadiths.

The medicalization process has not only resulted in the emergence of commercialized female genital cutting practices among Muslims in general, but has also supported the increase in 'real cutting' based on literal readings of hadiths among Islamic fundamentalists. These tendencies became stronger in 2000 when Islamic fundamentalists imposed a *Shari'a* agenda on the new foundation of the Indonesian state. Indeed, the legal status of female genital cutting has not been defined today, but the issue has become debatable; it polarizes opinions between health professionals who intend to ban female genital cutting and religious leaders who support its legalization.

It is clear that women's reproductive rights are the very reason for health professionals banning commercialized female genital cutting practices. Their position is clearly expressed in a 2006 Circular Letter by the Indonesian Ministry of Health that bans female doctors/midwives from performing female genital cutting as the practice is dangerous and harmful for women. This political effort has also received much support from the Ministry of Women's Empowerment and NGOs concerned with women's health issues (http://www.depkes.go.id/index.php?option=news&task=viewarticle&sid=2328&Itemid=2). Perhaps unsurprisingly, the Circular Letter does not get any support from either MUI (Majelis Ulama Indonesia, the Indonesian Council of Islamic Scholars) or the Ministry of Religion.

It should be noted that the MUI is posited as a national non-state organization that acts as an umbrella for intellectuals as well as religious and community leaders, and aims to guide, develop and protect Muslims throughout Indonesia. For

Islamic organizations in Indonesia, it is very important that any action they purpose is politically accepted not only by the government, but also by the MUI. In relation to this, Islamic fundamentalists, though representing only a small portion of the total population, have politically succeed in influencing both the government and the MUI to produce Islamic-inspired regulations on both regional and national levels. Their successful effort has inspired the emergence of regional regulations on health services in some areas of Indonesia that include female genital cutting as a part of health services. For example in the Regional Regulation of Bandung City no. 11/2002 on Retribution of Health Services, female genital cutting was one of the services provided by the child clinic, while in the Regional Regulation of Batam City no.1/2007 on Retribution of Health Services, it was included in the emergency services with the average retribution of 15.000 rupiahs.[11]

It is said that the inclusion of female genital cutting in the regional regulations on health services is not fostered by legislation at national level. But it is a reflection of the society's awareness to perpetuate such traditions, further strengthened by religious fundamentalists' desire to materialize the *Shari'a* agenda. There are yet to be any *fatwa* (religious guidance) issued by the MUI that would ban or legalize female genital cutting.[12] Notwithstanding, the ethos of continuing female genital cutting is evident in the MUI leader's personal statement that the practice is permissible (*halal*) (http://www.depag.go.id/index.php? menu=news&opt=detail&id=514). A similar statement is also expressed by the Ministry of Religion for Islamic Affairs, which suggests that the decision to perform female genital cutting should be made personally, as it is socially accepted as Muhammad's prescription (*Republika*, October 4, 2006):

If female genital cutting is recommended by Muhammad, it must be a good thing. But as far as the techniques are concerned, it is necessary to teach health practitioners to cut in the proper way. Don't ban the practice (Co-chair of Health Services Institution Nadhatul Ulama, http://www.depag.go.id/index.php? menu=news&opt=detail&id=514).

Female genital cutting is etymologically believed to cleanse dirt from human genitals. Moreover, there have not been any complaints from women who have experienced genital cutting. So, I think it is impossible to ban female genital cutting at all (Chair of MUI, Republika, October 4, 2006).

The fact that MUI and the Ministry of Religion for Islamic Affairs as powerful Islamic institutions refuse to problematize female genital cutting allows Islamic fundamentalists to actively promote 'real cutting' operations based on literal readings of hadiths. This also helps preserve other practices rooted in Islamic laws which support patriarchal ideology. My interviews with some women in Yogyakarta and Madura prove that many religious interpretations were misused to spread patriarchal myths surrounding female genital cutting. A Muslim woman in Yogyakarta, for example, stated:

The proper technique of female genital cutting according to Islam is not too much, but also not too little… The best thing is in between these extremes. If it is too much, it reduces lust so that sexual intercourse does not reach satisfaction. However, it is good for hypersexual females because it reduces her lust. On the contrary, if it is too little, it results in homosexuality.

In some cases, sexual myths surrounding female genital cutting are experienced by women as a kind of religious pressure. Aside from being burdened with the obligation to serve their husbands sexually, women are afraid of being sinners due to their inability to satisfy their husbands. Some other women believe that failing to undergo genital cutting would result in uncontrollable desire. There is also a myth maintaining that female genital cutting contributes to the establishment of a harmonious relationship between husband and wife, a myth which seems to idealize equality between husband and wife. In practice, however, it works within a society where men have privileged status both in family circumstances and in society at large. As a consequence, women's sexuality and reproduction remain under the control of a religious-patriarchal ideology.

Conclusion

I conclude that the meanings of female genital cutting have changed over time and create different challenges for women. Indonesia's experience shows that female genital cutting is historically connected with Javanese syncretism, either as a puberty rite for entering womanhood or as a socio-religious practice of Islamizing. As a rite for entering womanhood, the Javanese mysticism allows nothing to be cut in the operations. Contrarily, as a practice of Islamizing, literal reading of hadiths often results in minor operations of female genital cutting. These two kinds of operations, however, are currently determined by the interplay of a medicalization process and the new Islamic fundamentalism. The medicalization has introduced genital cleansing to replace either symbolic gestures or minor operations, so that it has discouraged more traditionally practiced operations. But at the same time, the new Islamic fundamentalism has brought along a form of medicalized female genital cutting that requires real cutting and has encouraged the practice among particular Islamic groups, especially in Islamic orthodox schools.

In fact, the existence of genital cleansing and Islamic fundamentalist's real cutting operations have not only marked current tendencies of female genital cutting in Indonesia, but have also brought further challenges for Indonesian women. The first challenge is the commercialization of the practice by including female genital cutting as part of a package of maternal health services in hospitals. The second one is the legislation of the practice as part of materializing *Shari'a* agenda. Even though it is still debatable, such efforts to legalize the practice need to be realized as potentially violating women's rights.

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Notes

[1]The definition of "cutting" I employ in this context relates to physical wounding, whether it results in bleeding or not.

[2]Feillard, Andree and Lies Marcoes, 'Female Circumcision in Indonesia: To "Islamize" in Ceremony or Secrecy,' Archipel 56, Paris, 1998.

[3]Putranti, Basilica D. et al., *Male and Female Genital Cutting among Javanese and Madurese*, CPPS–GMU, Yogyakarta, 2003; Putranti, Basilica D., 'Female genital cutting: A Reflection on the Social Construction of Sexuality among Javanese and Madurese,' Populasi 1, Yogyakarta, 2005. I would like to thank Faturochman, Muhadjir Darwin, Sri Purwatiningsih and Issac Tri Octaviantie for their worthy collaboration in this work.

[4]Pp. 338–342.

[5]The authors also identified the practices in terms of age, techniques, practitioners, and ceremonies, pp. 342–347.

[6]Pp. 347–348.

[7]Although rarely carried out, a male traditional Islamic leader from an Islamic traditional school in Madura told me that he had held *sonattan* for adult women who had not experienced genital cutting. The ceremony aims to legitimize their Islamic identities.

[8]See Munawwir, K.H. Warson, Kamus All Munawwir, Edition XII, Surabaya, 1997.

[9]Koran is "the recitation," the central religious text of Islam. Hadith is an oral tradition relating to the statements, actions and affirmations attributed to the prophet Muhammad. Fiqh is Islamic jurisprudence, an expansion of Islamic law complemented with the ruling of Islamic jurists to direct the lives of Muslims.

[10]Excommunication is defined as a procedure to counsel a person who is considered to not be carrying out the church's dogmas properly. In practice, excommunication gains negative connotations.

[11]Regional regulations on health services that clearly determine the standard cost of female genital cutting and ear-piercing services are found, among others, in Bandung and Batam.

[12]So far, MUI has produced several fatwa with a spirit of Islamic fundamentalism, for example fatwa that urge regional regulations on immoral acts, drug use and prostitution, fatwa that urge the legislation of an anti-porn bill, fatwa on anti-pluralism and secularism, fatwa on deviant religious teachings, etc.

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Sunat for Girls in Southern Thailand: Its Relation to Traditional Midwifery, Male Circumcision and Other Obstetrical Practices

Abstract

Among the Thai- and Malay-speaking Muslims living in southern Thailand, the traditional midwife (alternatively called mootamjae in Thai or bidan in Malay) performs a mild form of female genital cutting (FGC) on baby girls. This article is based on material collected in the Satun province, located on the Andaman coast, bordering on the Malaysian state of Perlis (once part of Kedah). People have different views of the practice: men question the cutting, considering it both un-Islamic and un-modern, whereas women generally support it. In evident contrast to this debate and to the privacy surrounding FGC ritual, a large public male circumcision ritual takes place once a year. Both practices are called sunat by the local people, distinguishing sunat perempuan for girls and sunat lelaki for boys. Both forms should be analysed with regard to the increasing medicalisation of birth, which while depriving bidan and women of their agency and authority, performs other forms of genital cutting in the delivery room, in the form of routine episiotomies, strongly opposed by local women.

The unstable periphery

The increasing attention recently devoted to southern Thailand by anthropologists, political scientists and sociologists can be traced to the historical, social and ethnic complexity of the region, partly due to the fact that the Malay Muslims are a majority in the area while they are an ethnic minority at the national level (Muslims are calculated to represent 5 to 8 per cent of the national population). The constitution of Siam first and Thailand later, in relation to international events and colonial powers, brought the inclusion of the Muslims once subjects of the Patani kingdom (including the present-day provinces of Pattani, Yala and Narathiwat) and the Kedah Sultanate (from which Satun was separated) inside the gradually shaped national borders. The difficult relation between the southern periphery and the central government has been marked (much more so in the past than nowadays) by a communication barrier, as the Malay-speaking Muslims resisted the educational system and the Thai language as carriers of Buddhist values and perceive them as vehicles of assimilation. The political turmoil which has cyclically characterised the history of the southern region has recently manifested in a dramatic re-enacting of ethno-political violence since 2004 (for recent analyses see Chaiwat 2006; Imtiyaz 2007; McCargo 2006a; 2006b; Srisompob and Panyasak 2006; Tan-Mullins 2006; Ukrist 2006; Wattana 2006). However, the violence has not touched the Satun province, site of my research, and the local Muslims are considered to be more integrated than those residing in the other three southern Muslim provinces.

The statistical data on the national and regional Muslim population provide rather contrasting counts, which are produced by different sources but are also expressions of different discourses, and are possibly subjected to manipulations (Chaiwat 1987:19; Imtiyaz 2007:323; Omar 1988:2; 2005:4). According to the statistics of the 2000 Census the population of Satun amounts to 247,900. Of these, 67.8 per cent are Muslims and 31.9 Buddhists. Approximately 10 per cent of the Muslims are bilingual in Thai and Malay (NSO 2001). The Muslims in this region are mostly Sunni of the Shafi'i school, but the recent increasing influence of Wahhabi or Salafist elements (visibly represented by the growing number of women using the complete veiling, or *niqab*) plays an important role in upholding or neglecting ritual practices once uniformly considered the expression of local Islam. Female circumcision is one of these practices, and it is at the centre of local debates concerning both male and female circumcisions as well as the obstetrical cut-

tings, strongly resented by the local women, that are performed in hospitals. These intersecting discourses open our eyes to the way Westerners sometimes apply a biased evaluation to *others'* genital practices but do not submit our own to the same kind of scrutiny. I will also briefly discuss new gender dimensions associated with a ritual of public male circumcision.

Female genital cutting (FGC) in Southeast Asia, its practitioners and performances

While there is a large debate on female genital cutting in Africa, the literature on these practices in Asia is scant (for Indonesia see Feillard and Marcoes 1998; Newland 2006; Putranti et al. 2003). Heather Strange (1981) recorded the performance of *sunat* in the Malaysian Terengganu state, but not on all girls; the cutting amounted to an incision of the clitoris or the removal of its tip, and several religious local authorities stated that the removal should be limited (ibid.:58). Since several forms of FGC are often referred to as *sunna*, sometimes even infibulation, we should investigate how people interpret the association with the Islamic tradition, even though religious texts do not support this relation (cf. Boddy 1991:15; Gordon 1991:8; Silverman 2004:428). The WHO definition of these practices under the all-encompassing term mutilations creates a specific negative perception that could be attenuated by un-naming the different forms of cutting (cf. Boddy 1998), thus avoiding any exotisation (Christoffersen-Deb 2005:405). In the contemporary scientific literature the different modes of intervention on the male body have seldom been grouped together and termed "male genital mutilations" or MGM, apart from a few cases (see for example Bhimji 2000; Harrington 1968; Korotayev and De Munck 2003), although this was the original definition in the Ethnographic Atlas of George Peter Murdock (1967:161; cf. Ciminelli 2002:39). The term mutilation was adapted to identify female practices during the 1970s and used in 1979 at the Khartoum Workshop on Traditional Practices Affecting the Health of Women and Children. But it was only in 1995 that the WHO proposed a definition of female genital mutilations (FGM) (Ciminelli 2002:39–40).

In order to avoid the term FGM, Sheldon and Wilkinson proposed instead 'feminization rites' (1998:264). In 1995 the WHO issued a classification of 'female genital mutilations' in four types, on a scale of increasing alteration of external genitalia, from the cutting of the clitoral prepuce (more similar to male circumcision) to excision and infibulation, plus a fourth type termed 'unclassified' which includes all those instances not corresponding to the abovementioned types, and described as follows: "pricking, piercing or incision of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissues; scraping (*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 into the vagina with the aim of tightening or narrowing the vagina" (cit. in Ciminelli 2002:40 n. 4).

As often happens in Western scientific classifications, a residual category for atypical or uncertain cases is created. This undecided type is glossed differently by various authors. Shell-Duncan calls this category 'symbolic circumcision' and recognises it as the one prevalent in the Southeast Asian region (2001). To distinguish this kind of incision from clitoridectomy, the term clitorodotomy has been proposed, as there is neither excision nor impairment of the organ's functions (Laderman 1983:206). In the Malaysian state of Kedah, the cutting has been described as a female subincision (Berlie 1983:88). For Indonesia, there are regional variations and individual differences from one practitioner to another, but usually people agree that "[t]he amount of flesh cut is described as a *mata holang*, the size a grain of rice and white" (Newland 2006:400). For both regional and cultural proximity the description above also applies to southern Thailand.

Across Southeast Asia we can identify several kinds of practitioners performing the cutting, passing from the 'traditional' to the 'modern' medical sphere. In Kedah the traditional midwives specialised in performing circumcisions were called *bidan mudin* (Berlie 1983:88), combining the Malay term for traditional midwife (*bidan*) and the term for male ritual circumcisers (*mudin*). Sometimes people in Melaka prefer to resort to the government-trained nurse instead of the traditional *bidan* as the former can provide antibiotics and anaesthetics (Roziah 1992:60–62). Jane Richardson Hanks writes that in central Thailand the To Imam would circumcise girls, cutting "a little piece of the labia" (1963:128), but I am very sceptical concerning the real identity of this practitioner as in the Islamic discourse in general and among my informants in Thailand in particular, men are not allowed to circumcise girls, and women are not allowed to circumcise boys.

The timing of the circumcision for girls in Southeast Asia also varies, but the ritual is included in the series of practices related to the postpartum period, and therefore usually falls under the competence of traditional midwives. In Malaysia it was performed in association with the extinguishing of the postpartum fire, which the new mother lay by for forty days following birth (Laderman 1987:206). In Indonesia the cut is carried out between a few days after birth and nine years, depending on the local preferences, but it is commonly performed shortly after birth (Newland 2006:399–400). In Satun, as with the male circumcision, there is also no upper limit of age for the female. If converting in connection with a marriage to a Muslim man, a woman could be asked to circumcise, but not all women who convert to Islam are circumcised, as there are different interpretations of the *hadith*. The practice seems therefore to be affected by the extent of the pressure exercised by the immediate kin group or community, with individual variations in compliance. According to my own observations, if performed on a girl born into a Muslim family, the cutting is done at a very young age, usually between a few weeks after birth and one to two years. On one of my first visits to a *bidan*, a woman had brought her seven-month-old daughter to the aged midwife to establish if the circumcision could be performed. The *bidan* put on her glasses, examined the baby's genitalia and said that it was not the right time as the clitoris was very small.

Reasons for performing female circumcision diverge as well, at times including aesthetic considerations, as for example to prevent the excessive growth of the clitoris (Peletz 1996:208). In central Thailand, female circumcision (which Hanks calls *akiko*, a term which in Satun refers instead to the name-giving ceremony proper) was performed on girls up to the eleventh year and was considered as marking the full entrance of the child into the human group (Hanks 1963). But the acceptance of the baby as a human being is usually associated with simple acts of recognition (cf. James 2003:199), such as the feeding with a small amount of rice (as among the Tai Yong of northern Thailand, see Trankell 1995:168), or the whispering of a few words in the newborn's ears as in the case of Muslims in Satun, whereas circumcision would be the formal/full acceptance into the Islamic community. In other Muslim provinces of southern Thailand the *bide*[1] makes the *sunat* at the end of the third day after birth, when she also formally ends the period of care for both mother and child (Lamom 1994:166). In order to perform the circumcision the *bide* must bring 1 *setang*, a special version of the coin no longer in circulation, produced with a hole in the centre. The coin is positioned with the hole over the clitoris and a needle is used to pinch the clitoris and obtain a little drop of blood (Lamom 1994:167).

Changes in circumcision practices in Satun

In Satun, male and female circumcisions are denoted by the same term, *sunat*, adding the specification *lelaki* for the male version, and *perempuan* for the female one. Male circumcision has always been a more openly celebrated event in Satun, followed by quite a large meal and feast with several guests. It could be arranged as an individual or group ritual (the latter referred to as *sunat muu*, literally group *sunat*), involving boys of the same family or village. In the past the circumcision was performed by the *mudin* (always a man) and with the passage of time also by medical personnel. Since 2001, once a year a large group circumcision for boys aged six to twelve, and involving medical and public health personnel, has been organised in the central provincial mosque, under its arcades, with a large audience watching the one hundred boys (on average) who are circumcised in one morning. Other group circumcisions at smaller mosques in the province are arranged but are neither subject to the same kind of spectacularisation nor performed on an open stage. The medical discourse presenting the cutting of the foreskin as a hygienic measure has been promptly assimilated by local Muslim men, who consider this statement a sort of modern scientific corroboration of their religious tenets. The public event brings the boys under the visual scrutiny not only of medical and religious authorities but also of the large audience of both male and female spectators, transforming a usually private event into an unusual display of bureaucratic and medical dexterity, an expression of the increasing government control over this religious practice. The public ritual involves female medical personnel as well, the majority wearing a veil, who assist the male physician or paramedic who is the one materially performing the cutting. Female personnel are allowed to suture and to perform the application of medication to complete the operation (see Merli 2008).

By contrast, only *bidan* perform female circumcision and the ceremony has not undergone the same changes that have occurred in the practice of male circumcision. To my knowledge no group circumcisions are organised for girls, and the only meaning of 'group' in this case would be that several girls belonging to the same family are circumcised on the same occasion in a house, as it was arranged in the past. Therefore, unlike the present public display of the male circumcision, it is extremely difficult to attend and observe a female circumcision.

Comparing the two practices in Satun, one may speculate about their possible development, as both *bidan* and male traditional circumcisers (*mudin*) are disappearing. The *bidan* is being progressively excluded from the birth scene as the increasing use of medical facilities restricts and limits her practice to traditional antenatal care, postpartum massage and ritual expertise. The new generation of *bidan* is also excluded from the formal training sessions organised by the public health authorities, which in the past led to obtaining a license, as the long-term policy is to eliminate the *bidan* altogether. These women will then be left with the choice of either abandoning their family tradition, which is often perceived as a mission, or pursuing a practice that verges on illegality. The elder *bidan* are periodically summoned to refresher courses and receive visits by officers who have the duty to supervise their activity. The traditional *mudin* is also being progressively marginalised as male circumcision is increasingly performed by paramedical personnel. In sharp contrast to what has happened with male circumcision, according to the local interpretation female circumcision cannot pass under the control of public health and medical personnel. As one informant said, "Nurses cannot perform female circumcision, because it must be done by a traditional midwife. In the new generation there are fewer *bidan* but there are still some." A *bidan* told me that in general terms it is not appropriate to witness a female circumcision, and that the only man who could be allowed in the room is the girl's father, while usually the only people present are the *bidan* and the girl's mother. The female ritual is therefore markedly gender segregated. Despite the fact that I broached the topic with several *bidan* very early in my research, I was able to be present at a *sunat perempuan* only once, in 2006. Not all *bidan* in Satun perform female circumcision, and information about those who did was uncertain. One *bidan*, Mak Mariah, talked about the practice with a sort of shyness and discretion, indicating another person living close to the local *pondok* (traditional boarding Islamic school) who performed it, while she herself did not. It proved impossible for me to locate this practitioner. Another *bidan* in the same area, who performed circumcisions on girls in the past, had moved to Malaysia some time ago and was said to have stopped practicing due to old age. One of the oldest *bidan* I met, considered one of the most knowledgeable, also performs the *sunat*, and she let me observe and film (with the girl's mother's consent) the event.

A sunat perempuan

When I attended the female *sunat* in April 2006, the ritual began very early in the morning, when the family started preparing the food for the small *kenduri* (ceremonial feast) which was served afterwards. The sitting room was cleaned, the furniture removed and large carpets covered the floor, to accommodate the men who came to chant parts of the Prophet Muhammad's life. These men, all from a Malay-speaking area and very renowned for their performances, are considered very religious and pious. Before the *bidan* arrived the women of the house arranged a ceremonial tray with offerings, with half a roast chicken, betel leaves and areca nuts, and a plate of glutinous rice. A chiselled metal bottle with a perforated lid containing perfumed water was set beside the tray. These offerings were placed on a small table outside the room where the circumcision was to be performed, on the upper floor of the large wooden house.

The *bidan* arrived at around 10 a.m. and was accompanied upstairs, where only women were allowed. Sitting in the shade on the large balcony, the *bidan* recited *doa*, prayers, to prepare a glass of sacralised water which was added to the other offerings on the tray. After that, the *bidan* took a skein of partially spun cotton out of her bag and separated and broke off some threads from the hank. She passed this long bundle of thread around her big toe, stretched it by holding one end in each hand, and began spinning it by twisting each end between her forefinger and thumb. Then she uncoiled the thread, folded it to half its length and rolled it over her thigh using the palm of her right hand. The cotton thus prepared was used to form protective bracelets and a loose waistband for the baby girl. Small pieces of *kunyit terus*, a variety of turmeric with a woody consistency specifically used as magic protection, can be threaded on the cotton through a hole bored in the middle of each piece.

During this operation, the one-year-old baby girl was being given a cold bath, meant also to desensitise her genitals. The *bidan* extracted from her bag a disposable razor blade and a small bottle of iodine with cotton swabs. When the girl was ready we entered the room, followed by other women and young girls of the family, and the tray with the offerings was set down on a low stool. The girl sat on her mother's lap on another stool and the *bidan* started preparing for a brief series of actions meant to protect both the baby and herself, as the view of the female genitalia could make the *bidan* blind. A similar but simplified ritual is performed by this *bidan* also on the occasion of childbirth. The Malay term she used for this ritual is *buang cangerai*, the same term other informants used with reference to the shaving of the newborn's hair, meaning literally "to get rid of bad luck."[2] A paste is formed by mixing talcum powder and water, which the *bidan* smears on twelve different points of the girl's body, making circular marks in all cases but one, and in the following order: 1) forehead, 2–3) on the shoulders (though she had previously told me the mark would be on each side of the breast), 4–5) the inside of the elbows, 6–7) on the back of the hands in the proximity of the thumbs, 8) a long horizontal line just above the pubis, 9–10) knees, 11–12) feet. Finally, the *bidan* puts the paste also on her own forehead. The paste has been sacralised with the recitation of a prayer, for which the *bidan* used neither the word *doa* nor *khaathaa*[3] but *mujab*, saying that this is a prayer with the names of the prophets. In the past the *bidan* used rice flour mixed with *kunyit* and water; this paste was called *tepung tawar*, the neutralising rice paste widely used in Malay spiritual healing, and also in midwifery, for example during the seventh-month ritual *melenggang perut* (swaying of the abdomen) in Malaysia (cf. Laderman 1987:360). *Tepung* means flour, and *tawar* is an adjective that translates as tasteless, flat, or figuratively as cool, but turns into verbs as *menawar* and *menawari* which mean, respectively, "to counteract poison with a spell," and "to treat diseases with a spell" (KM 2000:582). Its efficacy is attributed to the qualities of earth and water as neutralising and thwarting the negative fire and air elements, of which all the spirits are constituted (Laderman 1987:361); therefore the general meaning would be 'cooling paste.' The *bidan* states that what is used to make the paste is not very important as it is the recitation, *mujab*, which is effective. As *bidan* 'make water' they can also make other substances, empowering them with words.

The *bidan* took the razor blade and disinfected it with iodine. She spent several minutes trying to adjust her position in front of the baby, whose legs were kept wide open by her mother. As the *bidan* and the baby's mother told me before the ritual, the cut must be slight, in order just to draw some blood and to "clean" the area. From the movement of the *bidan*'s hands it seemed to me more a scratching on the tip of the clitoris, and I could not detect any tissue or blood on the razor blade. When the baby started crying the *bidan* applied a cotton swab soaked in iodine to the genitals and started soothing the baby. The razor's edge was rubbed with a betel leaf which was immediately wrapped and thrown away. The mother gave the baby to the *bidan*, who held her briefly in her arms, but the baby refused the embrace and wanted to return to her mother, who shortly afterwards calmed her down by offering her the breast. We descended the stairs to the ground floor where the men were assembled in the sitting room and were offered the *kenduri* of *nasi minyak* (rice with oil) with turmeric and curry dishes, served by other men of the house. All the women remained confined in the kitchen area or nearby, arranging for the trays to be served. As I was allowed to film the event, I was invited to enter the room with the men, who immediately after the meal started singing, passing among themselves the book in Arabic, which rested on a large pillow, from which the most gifted made solo recitations to which the others responded in chorus. This blessing lasted for about forty minutes. Towards the end the men rose and stood along the walls of the room while two men of the family distributed small memory gifts and poured perfumed water from the chiselled bottle onto the guests' hands.

Local discourses

On the occasion of the female *sunat* only a small *kenduri* is served, whereas for a boy's circumcision a larger celebration takes place. My informants explain this difference by the fact that from a religious point of view the female *sunat* should be done, while the male *sunat* must be done. I asked why female circumcision is performed if it is not compulsory, and some answered that if a girl is not circumcised she becomes *ketegar*, stubborn or obstinate. Other midwives claim that the female circumcision *must* be performed or the girl would not properly be a Muslim. One of the oldest *bidan* agreed that to be circumcised is not a choice, that the women who convert to Islam also "must" be circumcised.[4] My informants did not explicitly associate the cutting with either becoming a woman or differentiating the genders, but the reference to a "softening" of the girl's character and personality may be read in this sense. The most explicit reference is instead to a fulfilled or acquired religious and ethnic identity, expressed as "to be a Muslim" or "to become a Muslim." In southern Thailand 'to become a Muslim' is formulated in local Malay as *masuk Jawi*. *Masuk* literally means "to enter" and "to become a member." Jawi is the simplified Arabic script used to write Malay in southern Thailand, extensively identified with the Malay language and ethnicity, and therefore also with Islam. In the Pattani province *masuk Jawi* is used to indicate the male circumcision (Fraser 1966:71). However, whereas the obligation to perform male circumcision is undisputed and diverse opinions concern the modalities of organising and carrying out the ritual, no uniform consensus exists on the necessity to perform female circumcision.

In most of the literature I have examined there is a general reference to the fact that Islamic jurisprudence does not consider female circumcision obligatory, and that the practice is not mentioned in the Koran. The contemporary international debate relates to some extent also to male circumcision (see Aldeeb Abu-Sahlieh 2006:55–60). The argument is often used to support anti-circumcision movements in Islamic countries. Positions differ depending on the school of law, or *madhab*. The majority of Muslims in Southeast Asia follow the Shafi'i *madhab*, even if other Sunni schools are represented (Hanafi, Maliki, and Hanbali) as well as Shia. The pre-eminence of the Shafi'i would explain the existence of the practice in Southeast Asia and its interpretation (Ali 2006:100). The Shafi'i position concerning circumcision is stated in a work by one of its major exponents, al-Nawawī (631–676 A.H./1233–1277 C.E.), *Tahāra* ('purification,' a term used to refer to both male and female circumcision, see Ali 2006:103).

Circumcision is obligatory (wādjib) according to al-Shāfi'ī and many of the doctors, sunna according to Mālik and the majority of them. It is further, according to al-Shāfi'ī, equally obligatory for males and females. As regards males it is obligatory to cut off the whole skin which covers the glans, so that this latter is fully denudated. As regards females, it is obligatory to cut off a small part of the skin in the highest part of the genitals (Wensinck 1986:20).

Obligatory, not just *sunat* ('duty' or recommended), and for both men and women (cf. Rizvi et al. 1999; Ali 2006:100). However, while for the boys it is specified to which length the circumcision should go, that "small part" for the girls is left to the discretion of the midwife or circumciser.

This plurality of views characterises Islamic discourses both internationally and locally. Contrary to a simplifying popular view that sees a worldwide Islamic trend towards extremist positions and the polarizations of macro-ethnic or religious conflicts as a process of progressive Islamisation, we can recognise as a widespread phenomenon the existence of a multiplicity of views and debates internal to Islam. As Michael Peletz illustrates for Malaysia, "The key debates – and certainly the ones that are most intensely felt – in other words, bear on intra-civilizational clashes, not those of an inter-civilizational variety" (2005:243). In other words, the opposition between 'good Muslims' and 'bad Muslims' is more important than the one between Muslims and non-Muslims (ibid.). The focus of moderate reformism is on individual morality, which in its turn leads to good governance (Mandaville 2005:316).

An internally fragmented Islamic reality is what characterises also the regional focus of my analysis. The Malay speakers in southern Thailand consider the relation between a Muslim and the scriptures in accordance with two main interpretations that follow different teaching traditions. On the one hand there are Tok Guru Kaum Tua or orthodox religious teachers (*kaum tua* means "the old group"), who refer exclusively to the Shafi'i School of law and its traditional scripts. On the other hand, there are those intellectuals who try to extract the Islamic precepts directly from the Koran and the *hadith* and are called Kaum Muda or "young group" (Hasan 1999:17–18).[5] The arguments between the two groups are purely religious (ibid.:18). According to Angela Burr, among Thai-speaking Muslims the difference between the two groups, which she calls Phuak Kau (The Old Group) and Phuak Mai (The New Group), is that people belonging to the latter "emphasize doctrine and underplay ritual," disagreeing with the merit-making customs and prayer-group feasts which were followed by the old group (Burr 1988b:127). Raymond Scupin (1980) described the same division into Khana Kau (old group) and Khana Mai (new group), but according to his interpretation the Khana Mai are also concerned about socio-political issues (Hasan 1999:19). The focus on purely religious matters or also on political issues might be seen as steps in a development of the basic characteristics of these movements as recognised by Robert Hefner, passing from a mobilization of civil society on a pietistic basis towards political ends (2005:20–21).

When talking about *sunat perempuan* in Satun, the Muslims opposing the practice were usually identified as Islam *muda*, or "young Muslims." Among the men I talked to who opposed the practice are two religious teachers who have studied abroad, one in Egypt and the other in the Middle East. The first referred to the debate on human rights, while the second stated that there are no mentions of female circumcision either in the Koran or the *hadith*, respectively advancing two ver-

sions of the modern discourses representing the plurality of contemporary Islamic attitude towards the topic.

During a conversation, a very devout woman whom I will call Hajja said that even if the "modern group" opposes or ignores the practice, Shafi'i Muslims must perform it, adding resolutely "and we are Shafi'i." While Hajja and I sat talking about the subject in a local coffee shop that served *roti*, two of my male acquaintances and breakfast companions came and joined us. They were both around sixty years old and among the most open and knowledgeable conversationalists I met. We often talked about Satun history and society, traditional medicine and religion. Upon listening to our conversation about female circumcision, they started talking very animatedly with Hajja in Thai (whereas I was talking to Hajja mainly in Malay with the support of my assistant whenever the conversation switched to Thai). My assistant did not translate their exchange and looked embarrassed. The conversation turned into something more serious as I saw one of the men addressing Hajja in a raised voice, shaking his head. The other man tried to mediate this unexpected, and rarely seen, open conflict. Hajja continued smiling at me. Only when the two men left did my assistant tell me that they were reproaching Hajja for talking to me of these "backward" practices, something which could "scare me and make me think that they do *these sorts of things to women*." The man who was most upset had said "This is not Islam, this is not in the religion," and the sequel was a series of "You are stupid! Stupid!" Hajja told me that they did not know much about the matter, but that a woman knows better and "must do it."

The man who mediated the squabble was the person who first accompanied me to see the public male circumcision in Satun in April 2004 and introduced me to the event, explaining how it had been organised and carried out on previous occasions as well. He never showed a comparably judgemental attitude towards the male ritual. What was interesting in the whole episode was that the two men located me very specifically as a Western, educated woman, who would probably be against these practices (apart from the fact that they probably would be as well). That to talk about this would have given me, after several stays in the course of three years, the impression of being among un-modern people. Moreover, but this is just my personal impression, to hear that upon conversion a woman should be circumcised would scare me off actually converting to Islam, which several people had invited me to do. After witnessing a private male circumcision, I interviewed the religious teacher who had studied in Egypt, whom I have mentioned above. While talking about the practice of female and male circumcision in Satun, he referred to the ban on clitoridectomy issued by the Egyptian government following the United Nations and other international debates. In his opinion the ban matches what is written in the Koran, that "The person performing female circumcision should not cut too much." Actually, this reference is not found in the Koran but in one *hadith*. The fact that he referred to the source of the highest religious authority conveys the conviction that the highest religious leadership does not consider the practice necessary. Contrasting this textual source with contemporary practices, he told me that some *dakwah* people from India who had recently arrived in Thailand are trying to introduce a form of female genital cutting with a deeper excision. The same people would also advocate a change for the male circumcision, eliminating "all the skin" in support of hygiene.

The contrasting discourses were well known also at the village level, as the following example shows. In fulfilling the postpartum rituals for her daughter, Wati arranged for the hair-cutting ceremony nine days after birth, while *sunat* was performed after nineteen days. She had discussed the topic of *sunat* with a man well versed in Islamic law who had not let his own daughter be circumcised, claiming that the practice is neither necessary nor compulsory because it is not mentioned in the Koran. Despite this conversation, Wati and her husband decided to follow the local tradition, with a sense of pressure coming from other villagers, whose disapproval they wanted to avoid. The local *bidan* was not taken on as she was ill-famed for cutting away "too much," some even said the whole clitoris. Another *bidan* was summoned from another location. However, Wati could not bear to watch while the midwife was doing the incision, and shied away. She supported the choice to perform the cutting, saying that it was better to do it when the baby was only nineteen days old, because later on it would be more painful.

Janice Boddy cleared a new path in the study of female genital practices by reconstructing the web of complex symbolism and accepted gender roles in the light of which these rituals should always be considered (Boddy 1982, 1991). She also examines the contrasting discourses of Sudanese men and women with respect to the acceptance of a less invasive form of cutting (Boddy 1982:685). Ellen Gruenbaum echoes this position and suggests that future research on FGC should investigate and gain insights about culture, and "from hearing about the differing points of view of individuals, families, health practitioners, and students of religion; hearing how people debate about what is the right thing to do; and listening to the rationales for their choices" (2005:431). In my opinion, this should apply to male and female genital cutting alike, certainly since the first is advocated by the most authoritative medical international organisations as a public health measure (see WHO et al. 2006; WHO and UNAIDS 2007), whereas even the less invasive forms of cutting on female genitalia are branded as mutilations.

The medicalisation of female genital cutting in Africa has passed from the phase of training traditional midwives in hygienic procedures to the total referral to the hospital and modern obstetrical services (cf. Christoffersen-Deb 2005; Shell-Duncan 2001). While these services certainly improve the hygienic conditions and the medical measures limiting complications in the case of more invasive interventions, the use of anaesthesia has received contrasting interpretations. On the one hand the anaesthesia is considered to facilitate a lesser degree of cutting because by desensitising the girl's genitalia it prevents sudden movements caused by pain; alternatively, others think that it would enable the operator to cut

more deeply because the girl would not struggle (Shell-Duncan 2001:1022). With regard to Southeast Asia, the effects of medicalisation of female circumcision have been recorded as deleterious. In Indonesia, the procedure as performed in hospital settings has led to some unexpected outcomes.

[T]he medical practice involved the use of scissors to cut away more of the genital tissue than the village midwives ever removed using needles and penknives . . . Thus, in 2004 female circumcision was being offered as part of a package of surgical procedures performed in hospitals for just-born girls . . . The Indonesian health authorities announced a ban on medics (presumably meaning the clinic midwives) performing female circumcisions by mid-2005 in an effort to prevent hospitals from continuing the practice (Newland 2006:402).

In the Satun province, the *bidan* hold the exclusive authority to perform female circumcision and reject the idea of this operation ever passing into the hands of medical personnel. In my view this is associated with two reasons, one physical and one ritual and religious. The first is that medical obstetrics is already largely considered to be characterised by unnecessary invasive cutting of female bodies and genitalia in the increasing rate of Caesarean sections and the routine performance of episiotomies on women at their first childbirth in Satun hospitals. A gynaecologist who is present at the birth would perform a midline episiotomy (with an incision at less than 45 degrees in relation to the sagittal plane) whereas a nurse would perform a mediolateral (more than 45 degrees). Medical personnel stated that episiotomies are not performed on women who have already had three children, as the tissue of the perineum has loosened and softened enough to permit the passage of the baby without either tearing or having the episiotomy performed. As a gynaecologist in Satun General Hospital told me, the routine performance of episiotomies during the first childbirth is a recent introduction, whereas in the past the usual procedure was to wait and see if the childbirth proceeded without tearing. He also acknowledged that this recent trend is identifiable nationwide. Nurses in the local hospitals contend that a spontaneous tear takes a longer time to suture because of its irregular edges and justified the episiotomy performed with the scalpel or scissors from both a medical and a practical point of view, as the incision allegedly facilitates birth. The gynaecologist identified the immediate complications involved with the scar, but according to him no future consequences ensue, not even at the sensory level. Moreover, he stated that the mediolateral episiotomy does not affect the rectal muscles as these are located along the midline.

In Satun, *bidan* express their pride in saying that generally when they attend births the tissue around the vagina neither tears nor breaks. They consider episiotomy as the specific mark of hospital childbirth, whereas the spontaneous lacerations which occasionally occur during home births were in their opinion never serious and could heal in a few days without suturing. Traditional midwives explain why the perineum remained uninjured when they attended births. Mak Hitam, a Muslim midwife, says that the vagina does not break because the position the woman assumes (lying down and keeping her heels very close to her buttocks while the midwife touches on the stomach and presses slightly) facilitates the labour and birthing process. The *bidan* also smears the genital area and vagina with warm coconut oil, and stresses the desirability that the woman's vagina remains beautiful, without scars. Another traditional midwife treats small tears with salty water, and referred also to the application to the vaginal area of the heated tool (called *koon saw* in Thai and *tungku* in Malay) used for massage during the traditional postpartum period of lying by the fire. Specific foods are considered helpful in healing the episiotomy: milk, fish with scales, pineapple and oranges. Traditional midwives in Satun consider cutting the vaginal tissue an unnecessary and awful practice, as a woman's elastic skin can stretch with no major injuries if it is just "allowed," I would stress, to do so. From several testimonies collected, it seems that when women gave birth with *bidan*, their perineum did not tear.

The second reason offered for why female cutting should remain in the hands of *bidan* is that only they possess the ritual expertise and religious appropriateness to perform it. In this way Muslim women claim the right to cut the genital area in a way which opposes and contests the medical cutting. Moreover, the same people who reiterate the necessity of performing female circumcision to be (or become) a Muslim also strongly criticise the recent appeal of arranging public male circumcisions, especially for the presence of women in the audience and female medical personnel who assist in the cutting and perform the suturing. The participation of women was perceived by these Muslims as offensive and inappropriate, whereas the female circumcision is still an area off limits to men, maintaining the gender segregation that is followed to some extent on other ritual and festive occasions.

Concluding remarks

In order to understand the local practice of female genital cutting, it is necessary to contextualise the ritual in the broader discourse on obstetric modus operandi, and discourses on both female and male circumcisions. The latter is increasingly medicalised and internationally gains the status of a preventive measure against sexually transmitted diseases and infections, including HIV (cf. WHO and UNAIDS 2007; WHO et al. 2006), following encouraging results of studies claiming for the operation a certain, although incomplete, protection against contagion by the HIV virus in some African countries. The possible outcomes of this policy have been analysed with regard to both male sexual behaviours and the extent of the reduction of transmission to female partners (Aldeeb Abu-Sahlieh 2006:69–71; Bonner 2001; Williams et al. 2006).

To consider a practice abstracted from its social and historical context reifies existing categories without explaining how the people upholding or contesting it perceive the relations between the practice itself and other practices belonging to the same realm. *Sunat* for girls in Satun occupies a specific place

in relation to male circumcision, the past and present conditions of activity of the traditional practitioners performing them, and ethnic and religious identities. Paradoxically, other modern obstetrical practices which, despite being intensively debated inside the contemporary medical profession, could be considered by many as either neutral or justified by a superior medical reason are deeply opposed by local women, who consider them disfiguring and unnecessarily mutilating.

One of the best ways for anthropology to grasp local understandings is to approach the topic holistically, comparing the discourses and perceptions belonging to a cosmological and social landscape that is always far from monolithic. As I have showed, coexisting modernist Islamic discourses can produce opposite outcomes, on the one hand proposing the total dismissal of the practice because it is not supported by the written sources, and on the other hand asking for an intensification of the practice as fervent missionaries seek to introduce a deeper form of excision for reasons of religious zeal, with the implicit aim of thwarting female sexuality. In the latter respect, the modernist Islamic discourse finds support paradoxically in medical modern practice, and this match can produce unexpected outcomes, as in the case of Indonesia, where an increase in the amount of genital tissue removed in medical settings is reported by several scholars. One of the reasons women in Satun do not consider the medicalisation of the female *sunat* possible is the experience they have of the routine medical interventions on female genitalia during childbirth, which they find inexplicable and harmful. Where medical authorities have monopolised women's bodies in the context of human reproduction, the *bidan* and other Muslim women guard their authority and autonomy to perform a slight cut which perpetuates their ethnic and religious identities. This they do in opposition to certain discourses and practices which are instead dominated and mastered by men, in the contexts of medicine and religion.

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Notes

[1]*Bide* in the local Malay dialect of the three Muslim provinces located on the eastern coast of southern Thailand (Yala, Pattani and Narathiwat) corresponds to the standard Malay *bidan*.

[2]The shaving of the hair is performed on both boys and girls, along with other rituals formally introducing the child to the community (Merli 2008:230–234).

[3]*Khaathaa* is the Thai term for incantation.

[4]As I was learning the traditional massage with this old *bidan*, she regretted the fact that I was not Muslim; otherwise she would also have taught me how to perform female circumcision, i.e. with the corollary of undergoing one in order to perform one.

[5]The Islamic resurgent movement in Malaysia has its roots in reformist movements of the 1920s and 1930s, associated with the Kaum Muda or Young Group (see Peletz 2005:245).

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Brigitte Bagnol and Esmeralda Mariano

Elongation of the *labia minora* and Use of Vaginal Products to Enhance Eroticism: Can These Practices be Considered FGM?

Abstract

Both the elongation of the vaginal labia minora (Southern Africa) and practices aiming at tightening the vagina (Central and Southern Africa) are under scrutiny due to the need to find possible reasons for the spread of HIV/AIDS in the region. These practices show multivalent resonance between body, society, eroticism and health. They are a "women's secret" and express an area of power that women have been developing and protecting despite many forms of oppression over generations (Tamale 2005). Resembling the practice of elongating labia minora to close the vaginal orifice, considered "open" following childbirth and frequent coitus, the majority of women use a variety of substances in order to close up, contract, or reduce the vaginal canal. These practices are related to notions of femininity, womanhood, eroticism, pleasure and health. They are an expression of female strategic power. A joint statement by WHO, UNICEF and UNFPA (1997) has defined these practices as Female Genital Mutilation (FGM) of Type IV. Although their categorization as FGM has raised many concerns, the new definition of FGM (OHCHR et al. 2008) maintains this classification. The article discusses the appropriateness of considering these practices as FGM and stresses the need to rethink discourses on sexuality. It raises the issue of developing a clear definition on genital mutilation. The article is part of a WHO multi-country research project on Gender, Sexuality and Vaginal Practices and is based on ethnographic data gathered during 2005 in the Tete Province in Mozambique. It studies local notions of femininity that include beauty, sexuality, pleasure, well-being, health, reproduction, fertility and pain.

Introduction

Women, in different periods of their lives and with various motivations and purposes, carry out interventions on their genital organs. These may include incisions, elongation, ablation of the *labia minora* and *majora* or clitoris; the stitching up of the *labia majora* or *minora*, the ritual breaking of the hymen; and incisions in the vaginal and perineal area. Some women modify the diameter of the vagina, its temperature, lubrication, humidity and consistency through steam baths, smokes and application or ingestion of various preparations. References to vaginal practices can be found in studies of various countries of the Asian, African and American continents. Daily or regular hygiene methods to wash the vagina, eliminate secretions, semen or odours, using various products via topical or internal application are the most widespread of these and may be observed in various countries and on different continents (Joesoef et al. 1996; Ombolo 1990:149–50; Preston-Whyte 2003; Utomo 2003). Reasons for the various practices include, but are not limited to, the control of women's sexuality and the sexual satisfaction of one or both partners. They are also connected to personal hygiene, health and well-being, socialisation of the woman's body and fertility (Brown and Brown 2000; Van de Wijgert et al. 2000). These practices are the result of a learning process. They are representations of gender behaviour generally associated with femininity and masculinity and incorporated as a result of social norms amongst which heterosexuality and reproduction play a

fundamental role (Butler 1990). The incorporation and imposition of these gendered behaviours are based on the sexed body of the 'woman', but modify it so as to adapt it to prevailing values. These practices express an ethics of sex and sexuality, and an *ars sexualis* in many respects similar to that described by Michel Foucault (1984).

According to the WHO/UNICEF/UNFPA Joint Statement (WHO et al. 1997) "all procedures that involve partial or total removal of female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reason" are considered female genital mutilation (FGM) and should be banned. With the exception of excision and infibulation[1] found on the African continent (Hosken 1979; Boddy 1989; WHO 2000; Almroth et al. 2005) and defined as female genital mutilation (WHO et al. 1997) of Type I, II and III, vaginal practices have been scarcely documented and studied, especially as far as their links to sexual pleasure are concerned. Little has been written about the role of non-surgical interventions defined as FGM Type IV, which include the insertion, application or ingestion of various substances to attempt to tighten the vagina and/or change the level of its lubrication and the elongation of the *labia*. According to the definition, it includes: "pricking, piercing or incising of the clitoris/or *labia*; stretching of the clitoris and/or *labia*; cauterization by burning of the clitoris and surrounding tissues; scraping of tissues surrounding the vaginal orifice (*angurya* cuts) or cutting of the vagina (*gishiri* cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it; and any other procedure that falls under the definition given above" (WHO et al. 1997). Curiously there is no description of its prevalence in the world or in particular countries, neither a description of the health consequences of the practices. The new statement on FGM (OHCHR et al. 2008:4) is more careful and aware about the debate and includes in the Type IV "all other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterisation." However, "stretching" and "introduction of harmful substances" is still included and described in the document (OHCHR et al. 2008:27).

This article, based on ethnographic data collected in 2005 in the Tete Province of Mozambique as part of the WHO multi-country research project on "Gender, Sexuality and Vaginal Practices" provides detailed information on non-surgical vaginal practices and advocates for their removal from the classification of FGM of Type IV (WHO et al. 1997). It shows that considering the elongation of the *labia minora*[2] and the use of vaginal products as female genital mutilation is inappropriate because it ignores both the motivations and the consequences of the practice. In addition, the article stresses that in Mozambique, this line of labelling runs the risk of antagonizing women and being counter-productive.

The research context

In Mozambique, 54 percent of the population is considered poor. Compared to men, women occupy a position of social and economic disadvantage. Due to interconnected ideological, symbolic, legal and practical factors, women have less access to education and employment than men and are not equally able to make decisions over sexual and reproductive issues like safe sex, number of children, or family planning. These factors contribute to defining power relations between people in general, and between men and women in particular, influencing their behaviour, including sexual relations. This dynamic process is further modified by social class, cultural group, age and individual history.

In the Tete province, 87 percent of the population live in rural areas and 67 percent are illiterate (INE 2004). 22.7 percent of the population is Catholic, 17.5 percent Zionist, while 43.9 percent state that they do not have any religion (INE 1999:37). The predominant African languages are Nyanja, Nyungwe and Sena (INE 1999:32). It is important to highlight that the lineage system of the Nyungwe-speaking population, the largest group interviewed for our research, is patrilinear (i.e. transmission, succession and inheritance rights follow the male line). Exogamous marriage and polygynous marriages are common, mainly in the rural areas. Marriage ceremonies are characterised by the husband handing over goods and money (called *lobola* – bride wealth) to his wife's family.

Methods

The ethnographic research was carried out in the urban areas of the city of Tete and in the rural areas of the district of Changara between July and September 2005. Semi-structured interviews were carried out to get a broad understanding of notions of sexuality and treatment connected to sexual problems or relationships between partners. We tried to evaluate the perceptions of the interviewees concerning the benefits or consequences of vaginal practices on the women's reproductive and sexual health. The notions of eroticism, pleasure and sexual desire were also considered as part of the investigation.

A total of 103 people (25 men and 78 women) over eighteen years of age participated in the study, in individual interviews or in focus groups. Twenty individual interviews were carried out with key informants in addition to eighteen in-depth interviews. The key informants included male and female community leaders, midwives/traditional midwives, potters,[3] mother-and-child health nurses and gynaecologists. These in turn invited other people, using the snowball technique, following the criteria indicated by the researchers (age, sex, knowledge and experience on vaginal practices). The in-depth interviews involved sellers of vaginal products, sex workers, potters, women with children and traditional doctors.

Seven focus group discussions were carried out with women with common characteristics (young, married with children, or old, traditional midwives),[4] plus four discussions

with reference groups.[5] The interviews with the reference groups served to confirm the information gathered in the course of the research, and were carried out in the last week of fieldwork. In addition to the interviews, we monitored and observed the activities of some traditional doctors of both sexes for a period of two months, in order to better understand the kinds of problems connected to social relations and sexual and reproductive health that their patients sought to solve. We also observed their clientele and the products they sold. All of the interviews were recorded with previous consent, generally in Nyungwe, and translated into Portuguese.

In general, men and women of various ages, both in the urban and rural areas of the Province of Tete, were eager to talk about their sexuality – in line with local norms connected to sex and age which define how the topic can be approached and the words used in the conversation – justifying it as a central aspect of life. There was almost unexceptionally an open and intimate atmosphere at the interviews, which was necessary in order to deepen and clarify some of the topics.

Men and women told the researchers of the sexual education given to young girls, ranging from movements and positions during sexual intercourse, massages carried out to partners, bead belts worn by women and the ways to treat and speak to their partners to all the love medicines used to manipulate sexuality and relationships. They explained how to place the vaginal medications and what kinds of plants and preparations could be used. In some cases, women offered to show their genital organs to the researchers. Although declined, this reveals the great confidence and complicity which at times develop between women on these matters.

The stretching of the labia minora: an overview

On the internet, several websites publicize the elongation of *labia minora* as an erotic asset based on an "ancient art" to enhance sexual performance, also used by western women.[6] This adoption of the practice shows its wide attraction for the enhancement of sexuality. In the Southern African region the elongation of the vaginal *labia minora* is quite widespread and is practised by many ethnolinguistic groups (Parikh 2005). It is found amongst the Venda (Blacking 1967, 1998) and Lovedu (Krige and Krige 1980) of South Africa and amongst several groups in central and northern Mozambique (Arnfred 1989, 2003; Ironga 1994; Enoque 1994; Bagnol 1996, 2003; Geisler 2000). It is a common cultural practice in the south of Tanzania amongst the Makonde-speaking people (Dias 1998; Johansen 2006), in Uganda among the Baganda linguistic group of the central region (Tamale 2005) and in some groups in the western region (Parhik 2005), and in Zimbabwe amongst the Shona (Gelfand 1979:19; Aschwanden 1982:77; Lafon 1995:179). The Khoisan are also reported to have elongated *labia minora* (Welz 1995:24–25). However, none of these authors gives a full account of the motivations of this practice, and the voices of women who perform it are rarely expressed

The idea that elongation of the *labia minora* is part of sexual education and aims at improving both partners' sexuality is shared by several authors who have described the practice. Parikh (2005:132–139) explains that in Uganda, despite the fact that girls' sexuality is manipulated essentially in order to respond to male desires, the pulling of the little lips increases the women's sexual desire and the pleasure arising from masturbation. The author also stresses that the "girl received a stern warning that if she did not pull she would either be unable to give birth or would experience complications during delivery" (Parikh 2005:133). Gelfand (1979:19), referring to the Shona linguistic group, says that the process begins one or two years prior to menarche. Aschwanden (1982:77), in relation to the same group, notes that a woman who has not elongated her lips is called a "cold woman" or even "a man" and stresses its importance in the construction of female identity. These practices are part of the context of preparation for sexuality, which also includes scarifications on women's body in order to increase eroticism (Aschwanden 1982:77–78). Blacking (1967:83–4) observed that among the Venda "this operation is begun often long before puberty, its importance is emphasised at *vhusha* [puberty school]." Recent data from both Mozambique and Tanzania indicate that the practice aims at transforming young girls into real women and that it is very much connected to sexuality and reproduction (Arnfred 1998; Johansen 2006).

In the *Systematic Review of the Health Complications of Female Genital Mutilation including Sequelae in Childbirth* (WHO 2000), there is no mention at all of the stretching of the *labia* except in the definition of FGM. No negative consequences of the stretching of the *labia minora* were found in the literature except in a report by Makerere University and the Uganda AIDS Commission which states that the practice encourages young girls to start their sexual life earlier, and makes them vulnerable to HIV (Etyang and Natukunda 2005).

On the contrary, authors such as Arnfred (2003) have encouraged research on this practice to better understand the motivations behind it and to accumulate evidence of the fact that it does not constitute a form of genital mutilation. Tamale (2005), an African scholar describing the *Ssenga* institution in Uganda, which is set up to educate women specifically in relation to their sexuality, stresses its role in women's empowerment and the part it plays in women's silent struggle against colonialism and postcolonial forces, including religion, which aimed at imposing a "modern" view on sexual behaviour. In her article, one of the first African voices on the practice of elongation, she contextualizes "the strict regulation and control of African women's sexuality" and reproduction (2005) and its importance for capitalism. She also synthesizes Marxist[7] and feminist theories to show how capitalism, colonialism and religious proselytism attempted to modify African beliefs and practices.

In Mozambique, elongation of the vaginal labia was first reported by Henri Alexandre Junod, a Swiss missionary, in an annex written in Latin in the French version of his book on the Ba-Ronga (Junod 1898:482–485) of southern Mozambique. Nowadays in Mozambique the practice is frequent in the cen-

tral and northern region of the country and has been documented by both domestic (OMM 1983; Ironga 1994; Enoque 1994) and foreign researchers (Arnfred 1989, 2003; Bagnol 1996, 2003). It is important to mention that after independence, in 1975, following the discourse of the colonial State and the missionaries, the Frente de Liberação de Moçambique[8] (FRELIMO), the Mozambican Women Organization[9] (OMM) and other mass organizations fought against healers, initiation rites, lovolo, polygamy, extra-marital relations and early marriages. FRELIMO's position toward tradition is well expressed in the following quotations (Honwana 1996):

Traditional ... society is a conservative, immobile society with rigid hierarchy ... [It] excludes youth, excludes innovations, excludes women (Vieira 1977).[10]

(In traditional society) women are regarded as second class human beings, subjected to the humiliating practice of polygamy, acquired through a gift made to their families (lovolo) ... and educated to serve men passively (Machel 1970).[11]

Many practices, particularly those concerning women, such as polygamy, initiation rites, and *lovolo* (bride wealth), were rejected by FRELIMO. "Obscurantism," "superstition," religious belief, ignorance, and rituals such as initiation and *lovolo* were considered by FRELIMO to be mechanisms by which women were alienated. It was felt that these mechanisms were used both in the context of colonialism and capitalism to oppress men and women, but also by men to maintain women in a position of subalternity and passivity. This view of women and of initiation rituals shows how the revolutionary leadership had adopted Christian and colonial views on their own culture, rejecting it violently. In contrast to FRELIMO's official discourse, when people had the possibility to express themselves during the preparation of the Mozambican Women Organisation (OMM) Conference in 1983–84, elongation of the *labia* "was highly praised by women as well as by men, as a contributing factor to a pleasurable life" (Arnfred 2003). The report from the Tete province (OMM 1983) indicates that "during coitus they (elongated *labia*) increase the sexual pleasure of the man, and later when the woman is older, the lips are used to strengthen the diameter of the vagina."[12] The same report, in analysing initiation rituals and practices aiming at the elongation of the *labia* or the increase in the size of the penis, states that "neither boys nor girls should use products which may damage their health and sexual organs" (OMM 1983). The focus on health issues is important and shows that these practices were not considered as something that should be eradicated, although health-related consequences should be avoided and monitored.

During our research, some interviewees stressed that after independence, foreign doctors, mainly from the former USSR, would cut the elongated *labia* at delivery as they found them cumbersome. These mutilations of women's *labia* appear to have been decided upon by individual doctors and not related to any political decision on the matter. However, of course, they showed a lack of awareness of female identity construction and discouraged women to go to the hospitals to give birth. It fuelled women's fear for their physical integrity and their right to make decisions about their own body. This indicates how violent and disrespectful of women's bodies and rights some of the interventions were.

Arnfred (2003) has contrasted the discourses on initiation rituals by colonialists and religious and independence movements with women's voices supporting what they consider an important part of their femininity construction and an instrument for their empowerment. She juxtaposes the meanings that women give to these practices with interpretations of the rituals by outsiders and shows the need for a participatory approach to the subject (Arnfred 2003:16). Bagnol (1996, 2003) has analysed the implication of the elongation of the *labia minora* on homo-attraction and gender roles. She argues that the elongation of the labia aims at achieving womanhood "as a woman without long labia is not a woman" (Bagnol 2003:11). Some authors refer to this practice as responding to a male request, inasmuch as it enhances sexual pleasure (Raimundo et al. 2003), or they suggest that its absence may constitute a motive for divorce (Ironga 1994). Another line of research relates to the implication of elongation and application of vaginal products for women's health and condom use (Bagnol and Mariano 2008).

Stretching of the labia in the Tete province

In the Tete province, one of the most widespread vaginal practices is the elongation of the vaginal labia minora (kukhuna, kupfuwa or puxa-puxa). It is part of the process of initiation to female sexuality, which includes the use of a belt of beads, scarifications on the body as well as the modification or alteration of the genital organs. This initiation is led by godmothers who are chosen by the girls' mothers or aunts. They are remunerated for providing teachings and following the evolution of the elongation. Normally this process starts from the age of eight to twelve and lasts for four to six months. The first times that a godmother demonstrates how to do it, she pulls the young girl's labia (matingi) herself and makes sure that the girl is proceeding correctly. The labia are massaged and stretched from top to bottom, with the tips of the thumb and index finger of each hand. Oily substances extracted from the kernel of the nsatsi (castor-oil plant) are used. The interviewees insist that one does not pull the clitoris, and that the latter remains withdrawn between the two lips. However, others say that the clitoris is also stretched. Although most women indicate that they are stretching only the labia minora, other information suggests that in some cases the labia majora may also be elongated.

The elongation is done daily, generally early in the morning and at sundown, and in discrete places. The labia are elongated individually or sometimes in a group of girls pulling each others' labia. According to a nurse, "They pull each other in order to not feel pain, amongst friends, one in front of the other, and they pull each other at the same time for thirty

minutes every day. Only the unmarried girls pull each other, when they are young" (TET, Mother-and-Child Health Nurse, Provincial Hospital).

While the above interviewee speaks of pain, one potter explains that the process may be pleasurable:

When the girls or women do puxa-puxa, they feel sexual pleasure (...) when she's grown up. Also as an element to amuse oneself and masturbate when she doesn't have a man beside her (...) When she reaches around fifteen years of age she starts to do it, to feel pleasure (CHI3, Potter, around 45 years old, Chipembere, August 2005).

The above quotation shows that even if the official goal is heterosexuality and "holding onto one's partner," young women explore many aspects of their sexuality, pain but also pleasure – individually or with girlfriends. The elongation of the labia is ritualised learning in auto-eroticism and homo-eroticism, as various interviewees explained and as suggested in previous works (Bagnol 1996, 2003).

The elongation process may take several months, until the ideal length of three to four centimetres is reached. Feminine beauty is thus evaluated by the presence or absence of the matingi and by their length. If they are too short, the woman is considered "lazy," but when they are too long, they "can create water" in the vagina. According to the interviewees, the right size of the lips allows the vagina's dampness to be drained and ideal vaginal dryness to be obtained. A female traditional healer in the city of Tete summarises this idea well: "When the matingi are very long water comes out, because they perspire. When they are average, they absorb water at the time of sex, the man doesn't feel that there's water, because of those matingi (…) if she doesn't have them, the water fills up because it's only a hole" (FSM7, Healer, a widow with four children, 38 years old, Filipe Samuel Magaia).

Elongating the *labia minora* is related to a basic notion of femininity. The main motivation is to use the *matingi* to close the vaginal orifice – naturally open at birth but also by regular coitus or after the birth of children. The elongated vaginal *labia* are often described by the metaphor of a "door." Prior to the sexual act the partners should "open the door," "the man can't come in just like that;" these notions illustrate the importance of the woman being closed – perhaps as a form of protection – and possible foreplay prior to penetration. People use the word "hole" when the *labia* are not elongated as a form of ridicule or insult to a woman who does not have *matingi*. The interviewees also explained that if the girl does not elongate the *labia*, she will not manage to keep her partner, as he would prefer to have sex with a woman who has the *matingi*. If girls are not "prepared" (i.e. sexually initiated and familiar with the manipulation of genitals), later on they may be disrespected as women and even considered to be men.

It is a widespread idea that the *labia* tend to shrink after childbirth and with the menstrual cycle. In order to maintain the ideal size of the *labia*, every woman continues to pull them and "maintain them," ensuring their length and smoothness are constant and that their elasticity remains as long as they are sexually active, until menopause. The male partners also help their female partners to stretch the lips, "making use" of them as an erotic stimulus through massages and oral sex. Depending on the interviewees, some consider the clitoris irrelevant, all the emphasis being given to the *labia*, whereas others consider it fundamental since it is the point of departure for the sensation which propagates along the *labia*. At times, the *labia* are placed inside the vagina in order to reduce its diameter and make the entry of the penis difficult on first attempt, creating greater friction and increasing the "heat" in the sexual act. Using metaphorical language, they may be referred to as "the firewood to light the bonfire."

Use of vaginal substances: an overview

Women use various substances in order to reduce the size of the vagina and its lubrication so as to increase friction, thus creating favourable conditions for men's and sometimes women's pleasure in Asia (Hull and Buiharsana 2001; Primus 2003) and Africa. Brown et al. (1993:991) explain that in Zaire, women use little balls of ground leaves which they insert in the vagina prior to coitus in order to increase sexual pleasure. The authors mention the need to avoid noise during the sexual act (Brown et al. 1993:990). Practices aiming at tightening the vagina are also found in Central and Southern Africa and have been documented by several authors (Braunstein and Van de Wijert 2002; Civic and Wilson 1996; Morar and Karim 1998; Reed et al. 2001; Runganga et al. 1992). Ombolo (1990:51–52), analysing sexuality in central and southern Cameroon, explains that a wide vagina is considered a serious problem, as the vagina is ideally "narrow and hot." Ombolo underlines that this attitude is also common in sub-Saharan Africa (1990:52). A study on STIs carried out in Mozambique explains that the use of products "in order to reduce lubrication and increase friction" aims at increasing men's sexual pleasure to the detriment of that of women (Mahomed et al. no date:27).

Literature on these practices focuses mainly on their health impacts, and only few in-depth ethnographic studies have been carried out to better understand the motivations (Awusabo-Asare 1993; Green 2001). The increased susceptibility to infections and disease transmission due to the modification of the vaginal flora is mentioned by some authors, as well as the risks of inflammation and irritation of the genital organs of both partners (Baleta 1998; Braunstein and van de Wijert 2002; Brown et al. 1993, 2000; Dallabetta et al. 1995; Kun 1998; McClelland et al. 2006; Orubuloye et al. 1995; Sandala et al. 1995). Many studies have shown that some sexually transmitted infections facilitate HIV transmission (Fleming and Wasserheit 1999). However, vaginal infections such as bacterial vaginosis (BV) as well as yeast infections, which are likely to result from vaginal practices, have not yet been clearly established as co-factors for HIV infection (Myer et al.

2005; Taha et al. 1998). Some studies also suggest that different products may have completely distinct effects, with some limiting and others increasing the risks of disease transmission (Myer et al. 2005), and that outcomes may differ according to the product and the quantity used. Yet, little is known about variations within the same culture, or women of different social class and cultural background (Awusabo-Asare 1993; Bagnol 1996, 2003; Green 2001). Further study is needed to discern which practices are potentially the most harmful, and which have a high-potential association with STIs and HIV (van de Wijgert 2005).

Insertion of substances into the vagina in the Tete province

As in the case of the elongation of the *labia minora,* the majority of women use a variety of substances in order to contract or reduce the vaginal canal. These products are called "*mankwala ya kubvalira,*" which means literally "medicine to put," as they are to be used specifically in the vagina. Most women who are sexually active and of childbearing age use products to "prepare" their vagina. Moreover, many women use products after childbirth to close up the vagina as rapidly as possible, so as to resume having sex with their partner.

Amongst the various reasons for the use of vaginal products is the association of the idea of virginity with narrowness of the vaginal orifice. Many interviewees uses the expression "to seem to be a virgin" as the ideal condition for a more satisfactory sexual encounter. The vagina ought to be tight, dry and hot in order to allow friction, sexual pleasure for both partners and women's "well-being." The following quotation highlights the sexual pleasure of the two partners:

When the woman gets together with a man [has sex], the body doesn't usually end up well (...) the body gets separated [because the vagina is too open], so with kubvalira the body returns [the vagina is tightened], that's the way the men like it (...) The women also like it (MPD7, Widow of 64 years of age, M'padwe).

Friction is thought to be fundamental for sexual pleasure and to that effect, the penis should not enter the vagina easily. This condition is also associated with good health:

(...) One has to put the kubvalira product in order for the man to not end up entering right away, just like that. (...) If she doesn't put the kubvalira product, she ends up as if she had just been with another man, she's open, very open, without feeling right herself (MPD6, Female traditional healer, M'padwe).

When "excess water" is mentioned, women are said not to be "sweet" or to be "tasteless." Seeking heat, sweetness, and friction implies a certain way of having sex *"nyama na nyama"* (flesh on flesh), which appears to be the most satisfactory. When a woman has a very lubricated vagina, her partner complains and may accuse her of having had another partner beforehand, or of not having "prepared" herself properly. If he is angry with the woman and if this partner is casual, he may even comment on this as a way of insulting her, or in the form of ridicule with his friends. However, many women think that men do not know that women place products in their vaginas in order to modify its lubrication. This is quite a highly guarded "secret," inasmuch as women want this to [appear to] be natural, an individual characteristic. Speaking of a sexual encounter with a "watery" woman, the man may say: "it's like having sex in a glass of water," in reference to the absence of friction and to the resulting noise. Sometimes "water" is related to some disease or to "a rending." "When the woman gets a tear, water comes out constantly," explains a (female) traditional doctor who is also a potter and midwife in the village of Chipembere in Changara District. Thus products ought to be inserted into the vagina so as to treat it. A traditional doctor explains as follows: "Amongst some women there has been that white dirt that doesn't smell, that is normal, but in others there has been one that smells, which comes out a lot, it usually being linked to a dirty uterus, but with that drug all of the water comes out and it's dry" (FSM7, Female traditional healer, widow with four children, 38 years of age, Tete). Following childbirth, the vagina may also end up "torn," and it's necessary to close up the vagina once again by inserting products into it.

Usually, products are provided by women's relatives (godmothers, aunts, grandmothers) or by traditional doctors. These different *mankwala* may be bought in the market in the city of Tete, from itinerant vendors (Zimbabwean or Mozambican women) who circulate in the rural areas, from traditional doctors (m/f), or they may be prepared by family members, neighbours or the user herself. The *mankwala* produced locally are leaves, roots, and dried and pounded tree bark (reduced to a powder), applied in three ways: placed in the panties, in the vaginal orifice with the fingertip, or inside the vagina. There are also kinds of "vaginal eggs" made with natural substances, similar to those mentioned above, and mixed with an egg in order to form little balls. Eggs are used in the preparation as they are impenetrable and are consequently considered to have the characteristics of the desired vagina.[13] Within the *mankwala ya kubvalira*, one may find household products such as Colgate and Vicks. The massive immigration of women from Zimbabwe has intensified and diversified the use and type of substances. Amongst the *mankwala* coming from Zimbabwe are stones and alum or copper sulfate.

As explained by health workers of the city of Tete interviewed in a focus group, the majority of women use *mankwala ya kubvalira*: "Eighty percent use them here. We Africans ought to use such products (…) In the city it's 80% and in the countryside it's almost everyone" (TET4, Focus group, health personnel, Tete).

All sexually active women tend to use *mankwala ya kubvalira*, but pregnant women stop using them after the third month of gestation. In some churches, women are advised

against using traditional products. The opinion is widespread that women in menopause cease having sex[14] and also very frequently abandon the use of these products. However, some continue to use them in order to "be well" and to have "weight" as opposed to the lightness they feel when their *labia* are open. In a situation of sexual competition with others, whether in rural or urban areas, women tend to make greater use of vaginal products. According to the majority of women, *mankwala* inserted or applied in the vagina, or ingested, tends to improve their sexuality when they are concerned about keeping an unfaithful or polygamous partner. Sex workers also tend to use vaginal products in order to be able to provide satisfactory sexual performances and ensure that the sexual partner "doesn't suspect that they have just had sex with another man." Thus, the frequency with which vaginal products are used varies according to the needs of differently positioned women and the efficacy of the substance.

Perceived consequences of the practices

Most women and men in the province of Tete see the elongation of the *labia minora* as having a very positive effect on men and women's sexual lives and relationships. It is extremely rare to register negative effects. However, excessive length of the *labia* "creating water" or the fact that the elongating process is painful, especially at the beginning, were mentioned. Sometimes, some products used for elongation can also cause lesions.

In relation to the vaginal products, a large majority of the women who use them stated that they did not have negative effects. However, excessive use of these products as well as new products can in fact have unexpected effects. Some women reported experiences of exfoliation of the vaginal mucosa, vaginal lacerations, burns, swellings and increased secretions:

I know the kubvalira which I bought and inserted. I started to moan, then straightaway I fell ill, on that day I had to take a fan and direct it on [my vagina] (...) The next day, that exfoliated, something white scaling right off and that ruins the uterus (...) that thing is salt from Zimbabwe, small stones (TET4, Focus group, Women Organisation of Mozambique, Tete).

Despite their awareness of the high prevalence of vaginal products, discussions of the issue amongst health personnel are still limited. Little research has been conducted on them in relation to public health, so as to understand their cultural dimension and impact on the transmission and prevention of STI/HIV.

Pain reported by men and women during intercourse is generally a consequence of vaginal products. Lacerations on the penis and in the vagina are said to result from the effort needed to penetrate and the friction occurring during coitus.

The vaginal products appear for some as being in direct opposition to the use of a condom, that the argument being that with the insertion of vaginal products the sex act ought to be unprotected (with no condom) in order to allow a direct contact between the vagina and the penis and to obtain greater sexual pleasure. It was thus found that the majority of the interviewees did not use a condom. However, some people, including sex workers, explained that *mankwala ya kubvalira* may be used at the same time with condoms. Yet, they leave no doubt that the lubricant on the condom leads many people to question its reason for existence. Since most men and women seek to reduce lubrication in the vagina in order to create greater difficulty for penetration, using a lubricated condom is an absurdity which is difficult to justify.

During the meetings held with health workers, it was noted that frequently, during clinical observations, women show residues of vaginal substances, or vaginal complications (discharges) assumed to be caused by the use of vaginal products, as explained by a (male) nurse:

After inserting the stones (women) had a reaction involving discharge which never passes, a vaginal discharge. (...) When they arrive here [in the Health Post] they [women] seem to have an STI which is not STI. (...) The roots may provoke lesions outside or inside the vagina and represent a danger ... with this problem of STIs and HIV/AIDS, she goes along there with those lesions and it's easier to catch them (MPD2, Male health-care provider, Mpadwe).

Daily or regular washing with soap and other products used with water is not seen as having any negative consequences and is even recommended by most nurses. The possibility of infection and laceration due to the daily or regular internal washing process has however been mentioned.

According some health workers, cancer of the uterus may have its origin in the vaginal insertion of some products as they may provoke infections, inflammations, or lacerations. Daily washing of the inside of the vagina with various substances destroys the vaginal flora, thus modifying its pH (acidity). According to them, this set of situations leads to a greater vulnerability to sexually transmitted infections, including HIV.

Can these practices be considered FGM?

To understand our effort to remove the elongation of the labia and the introduction of products in the vagina from the definition of FGM, some background information is necessary. In the 1960s and 1970s the debate around sexuality and the role of women in society exploded. Several feminists from the south such as Awa Thiam (1978) and Nawal el Saadawi (1980) engaged themselves in the debate, presenting their personal experience on female sexual mutilation. In the same period Fran Hosken (1978) published the first comprehensive article on the epidemiology of FGM worldwide.[15] The debate was extremely fierce with French feminists like Benoite Groult (1979) condemning the practices and anthropologists from the French Association of Anthropologists (AFA) publishing a collective text (Association Française des Anthropologues

1981:37) aiming at showing "how a certain feminism resuscitate (today) the moralistic arrogance of yesterday's colonialism." They urged to look at the context and to understand the motivation of the practices. The article concluded: "Let's stop making the Africans look like savages, let's stop imposing on them our models for living and now our models of pleasure, let's stop to perceive horror in others to better deny them in our society. For now to whom is the scandal benefiting? Isn't the barbarian the one who believes in barbarism?" (Association Française des Anthropologues 1981:37). In the same period WHO was pressured to condemn the practices. The first Joint Statement appeared in 1997 (WHO et al. 1997). The second statement reviewing the knowledge grasped over a decade was issued in 2008 (OHCHR et al. 2008:27).

The debate around the issue is still very intense. In recent research and publications, a need to *Re-think Sexualities in Africa* (Arnfred 2004) has emerged in order to re-conceptualize old colonial and post-colonial paradigms and to give voice to an African understanding of health, sexuality and eroticism. Far from a vision of African sexuality that focuses on otherness and difference, new points of view on the issue stress the diversity and the contextualised ways in which individuals shape their sexuality in light of a myriad of factors including the linguistic group to which they belong as well as their religion, social class, gender and "race/colour." The book *Female Circumcision and the Politics of Knowledge, African Women and Imperialist Discourses*, edited by Obioma Nnaemeka, opens with the sentence with which the French anthropologists ended their article quoted above twenty four years earlier: "The barbarian is first and foremost he who believes in barbarism" (Nnaemeka 2005:3). The questions and debate seem to be the same. It is not about disagreement over the need to put an end to harmful practices; it is rather about the discourses around the practices that lack respect. Labelling some practices "barbaric" or a "torture" without contextualizing them brings along negative effects instead of helping to eradicate them. It disempowers and antagonizes women. As Abusharaf wrote: "In large part because of the European animosity towards circumcision, the practice became a focus of African resistance to foreign encroachment and interference" (Abusharaf 2001).

The question remains, why are elongation and use of vaginal products considered to be female genital mutilation while aesthetic vaginal surgery[16] such as labiaplasty, vaginoplasty, vaginal reconstruction, vaginal rejuvenation or tightening are publicized and well know surgeons and clinics are allowed to perform definitive modification of the vagina? Why is the use of play lubricants[17] bought in shops in the West not defined as female genital mutilation, if the use of products with the same objective and results are considered as such when they are home produced in Africa or bought in a shop in Asia? Who decides who is barbarian? Who decides what is female genital mutilation and what is not? The answer lies in the understanding of the ethnocentrism underlying the production of discourses and the objectification of the African and Asian female body, in the "othering," the stigmatisation of others' practices.

People are objects and subjects at the same time – within a dynamic process of submission and resistance – of a process of transformation which places them within the local culture and overall conception of society including notions of sexuality, health, social well-being and relationships between persons and spiritual forces. It is in the process of transformation and care given to bodies and their functions (essentially sexual and reproductive) that the biologically male and female individuals become "men" and "women," learning the appropriate gender behaviours at each phase of their life. Thus the biological body acquired at birth is one of the elements which determine the way individuals behave as "men" or a "women," but in itself it is not sufficient. Interacting in particular institutions and with particular people, individuals invent and define their belonging to the categories "man" and "woman." And it is in this context that individuals continually negotiate and exercise their agency.

The data collected strongly demonstrate that the practices under study (elongation of the *labia minora*, use of vaginal products or ingestion of potions to modify the condition of the vagina) do not constitute mutilation.

The findings from the Tete province bring evidence of the need to remove the mention to vaginal practices that do not involve surgical interventions such as the insertion, application or ingestion of various substances from the definition of FGM. The consequences of the elongation of the *labia minora* and the use of vaginal products do not require a ban as in the case of FGM Type I, II and III, and these practices cannot be targeted through human rights legislation on violence against children and/or women, bodily harm and child abuse. Nevertheless, some practices can result in injuries – e.g. lacerations, tears – and might need to be discouraged when evidence of an increase of STIs and HIV/AIDS transmission is confirmed.

In the Tete province, vaginal practices constitute an institution in which women develop their knowledge of interaction with others and transmit it to younger women (Tamale 2005). It is a female institution and a locus of expression of women's power over their own body and their sexual relationships. These aspects have to be taken into consideration for the development of an approach that empowers women to control their sexuality, but also recognises vaginal practices as their secret to influence their partners' sexuality.

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Notes

[1]Infibulation is the excision of parts or all of the external genitalia and stitching or narrowing of the vaginal opening (WHO 2001:20).

[2]In this paper we refer to the *labia minora* as women interviewed explained that they elongate the "little lips". However, data indicate that some women also elongate the *labia majora*.

[3]The importance of working with potters has to do amongst other aspects with the fact that clay pots are compared to the uterus. There are some rules and taboos associated with reproduction and production of pottery, this being a strictly female activity, and its conditions as regards hot/wet, cold/dry.

[4]Two group sessions were held with women with children, one group with adult males, one with male adolescents, a mixed group of traditional healers, a group of sex workers and a group of midwives.

[5]One group session was held with women from the OMM, one with nurses of both sexes, one with female traditional doctors and one with young students of both sexes.

[6]http://www.labiastretching.com/ (consulted on 8/01/08).

[7]Engels viewed the establishment of private property and the development of agriculture as the "historical defeat of female sex." He believed that women's oppression would cease with the dissolution of the private property. This analysis has been criticized by feminists who refute the association between the origin of man's control over woman and the establishment of private property or patriarchy.

[8]The Mozambican Liberation Front, which after fighting an armed struggle against colonial rule, proclaimed Mozambique's independence in June 1975. FRELIMO took a Socialist and Marxist approach, which rejected some values of the so-called "traditional" society. This agenda was in many ways similar to that of the missionaries of the pre-independence era.

[9]The women's organization (OMM) was conceived as a wing of FRELIMO and implemented FRELIMO's strategy. The process by which the "new" woman would be "constructed" included women's participation in productive activities, the development of scientific and cultural education, and the modification of relationships between couples.

[10]Quoted in Honwana 1996.

[11] Ibid.

[12]Here the document refers to the possibility of introducing the labia inside the vagina in order to reduce the diameter of the orifice.

[13]Janice Boddy (1989), in her book *Wombs and Alien Spirits. Women, Men and Zãr Cult in Northern Sudan,* also refers to the egg as a sexual symbol in the context of Sudanese society, which practices infibulation.

[14]Due to the fact that the sexual act is linked to procreation in this phase of the woman's life, the sperm would not result in conception and would be disposed of. The interviewees explain that because the sperm is not evacuated with the menstruation, it goes rotten inside the woman's body and she gets a swollen belly, which may result in health problems and death.

[15]In 1979 a book called *The Hosken Report: Genital and Sexual Mutilation of Females* was published.

[16]www.urogyn.org/aestheticvaginal.html, www.labiaplastysurgeon.com/, www.inlandempirevaginalsurgery.com/, http://www.boloji.com/wfs5/wfs648.htm, http://www.onlinesurgery.com/plasticsurgery/vaginal-rejuvenation-default.asp (consulted on 12/05/08).

[17]http://www.durex.com/CA/PlayRange_lubs_tingling.asp (consulted on 12/05/08).

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Courtney Smith

Creating Spaces: Challenging Conventional Discursive Norms Surrounding the Marking of Women's Bodies

Abstract

This paper examines the profound ways in which the female body is constructed. Specifically, female genital cutting in Senegal, West Africa and breast augmentation in the United States are explored, as they each illustrate inscribed social norms upon female bodies. The argument of the paper is based upon eighty in-depth interviews in Senegal, as well as sixty-one interviews in various cities of the United States. Each set of interviewees were asked open ended questions regarding each practice, with the goal of learning how diverse people understand their physical bodies and how they view "other" bodies. Though a direct comparison of the practices is by no means implied, opinions concerning each practice are gathered, which illustrate dissociation both among and between American and Senegalese women. This dissociation is problematic because despite various critiques of the practices in both contexts, the social mechanisms that embed cultural and physical norms remain covered. Some interviewees express discomfort with either or both practices, yet ideological linchpins such as autonomous choice and gendered identity trump this discomfort. Further, the disconnect between women prevents unified national or global feminist movements from forming that could challenge various patriarchal forces effecting women's bodies in an effective manner.

Introduction

The fact that women are universally subordinated is hardly groundbreaking news. "The secondary status of woman in society," Sherry Ortner writes, "is one of the true universals, a pan-cultural fact" (Ortner 1996:21). The notion of a universal patriarchy, however, that causes this subordination of women "has been widely criticized in recent years for its failure to account for the workings of gender oppression in the concrete cultural contexts in which it exists" (Butler 1993:6). Thus, though many feminist scholars examine the various ways in which women are subordinated (Dworkin 1974; MacKinnon 2006; Walker 1993; Young 1990), many of them reject the idea that there is one overarching patriarchal source of this oppression (Charusheela 2006; Mohanty 2003; Narayan 1997). These latter ideas are based on the cultural variations of subordination that cannot be enveloped by Western understandings of justice and women's rights. Yet, as Ortner asserts, "both of these points – the universal fact and the cultural variation – constitute problems to be explained" (Ortner 1996:21).

One way of attempting to explain how universal subordination manifests in varying cultural ways is by focusing upon the physical bodies of women (Bordo 1993). The literature concerning the corporeal control of individuals is well studied and originates in the work of Michel Foucault (1976). Foucault contends that power, specifically *biopower,* forms individuals into subjects, both physically and mentally. Biopower is omnipresent and in it exists "an explosion of numerous and diverse techniques for achieving the subjugations of bodies and the control of populations" (Foucault 1976:140). In other words, the form that docile human bodies take is the product of social forces, or biopower. There are structural mechanisms that transport these social meanings onto bodies while at the same time rendering them unrecognizable (Bourdieu 1990).

Unpacking how these mechanisms work to embed cultural norms in bodies, or, in Iris Marion Young terms, examining how broad social and symbolic structures are expressed in the lived body (Young 1990) is important for feminists.

As examples of social structures expressed in lived bodies, I specifically examine the body modification practices of female genital cutting (FGC) in Senegal, West Africa and breast implantation in the United States. In these practices, the ways in which women's bodies are marked demonstrate patriarchal social forces embedding themselves differently in the physical existences of women. Empirically, the project stems from open-ended, in-depth interviews from communities both in the US and in Senegal. Six months of 2005 and one follow-up month in 2007 were spent in Senegal where I conducted eighty interviews with women and men throughout the country about the two practices. Then, ten months in 2007 and 2008 were spent conducting sixty-one interviews with American men and women also about the two practices. As many different people as possible in each country were interviewed, as the goal was to garner the most inclusive understandings of the ways in which people view their bodies and the bodies of others.

I also conducted these interviews in order to determine if women outside of certain cultures are able to recognize the mechanisms of social control that do regulate the bodies of women. Bourdieu claims that an individual's *habitus* develops according to the social sphere of action in which the individual lives. This sphere that he calls a "field" places certain limits on those who inhabit it (Chambers 2008:52). Accepting Bourdieu's limiting "fields," I am led to the question of whether individuals both internal and external to that field are able to identify the social norms that are embedded within it. If certain norms exist in the United States that regulate the form of the female body, are women in the US cognizant of the *sources* of those norms? Are people from an outside field such as Senegal able to locate those sources?

In interviews in the US, the recurring emphasis concerning both FGC and breast implantation is *not* on where norms originate but rather on the existence of autonomous choice. The perceived existence of choice trumps any harm or disadvantage women experience during either practice, according to many interviewees. As Martha Nussbaum asserts, however, "we should critically evaluate structures of choice and desire" (Nussbaum 1999:256). Claire Chambers agrees because "choice does not *suffice* to render an outcome just: there are circumstances in which a chosen practice remains unjust, and this is because practices are inherently social and thus do not depend on individuals' choices" (Chambers 2008:39, italics original).

On the other hand, a thread running through Senegalese interviews is fundamental gender identity. Unlike some of the Americans who view women as individual agents with autonomous choice, many Senegalese interviewees emphasize that women are by definition wives and mothers. FGC can be seen as indeed inscribing social norms upon women that create or enhance this identity. Christine Walley recognizes: "…female genital operations also play an important role as markers of social, ethnic, religious, and other forms of identity" (Walley 2002:31).

Through these interviews, I hope it will become clear that though women have diverse experiences with their bodies, they all go to lengths – albeit different lengths – to conform to normalized sex roles. In examining these experiences, I arrive at the conclusion best put by Claire Chambers. She asserts: "Specifically, nobody (in this case, women) should have to harm themselves (by undergoing breast surgery or FGM) in order to receive benefits (such as a successful career, a sense of self-worth, or the ability to be married) that, for other members of society (in this case, men) do not carry similarly harmful requirements" (Chambers 2008:197, parentheses original).

Section I: Senegalese interviewees on female genital cutting

Aside from viewing female genital cutting as an inherited cultural tradition, the eighty Senegalese interviewees do not express a homogenous viewpoint regarding FGC. As the interviewees themselves vary in terms of where they live, levels of education, whether they are cut[1], which ethnic identity they belong to, etc.: their responses to questions regarding FGC reflect this diversity. The opinions of the Senegalese men and women do tend to fall into three categories, or explanations of why FGC exists. These are: FGC as part of the passage to womanhood, FGC as a hygienic measure, and, finally, FGC for the protection of virginity. Along with these explanations, however, interviewees also express negative opinions regarding the practices. These opposing viewpoints are based on the decrease, or elimination, of female sexual pleasure, and the negative health consequences resulting from female genital cutting. Each of these response groupings will be examined below.

FGC as a rite of passage

The development of girls into adulthood begins, in many practicing societies, with the rite of "circumcision," which usually occurs between the ages of six and ten. Often times this rite includes a ceremony, special songs, food, dances and chants, all intended to teach girls the duties and desirable characteristics of a good wife and mother (Dorkenoo 1994:39). Girls in various parts of Senegal report their experiences with this education and ceremony connected with cutting. One interviewee from the southern region of Senegal, the Casamance, explains that "cutting is how a girl learns to be a woman. It's a school in itself – when the girls learn how to keep a house, how to carry herself in front of men and how to be a mother of a house. It's the passing of information and not just cutting." This importance of an "…education preparing girls for womanhood" going along with the cutting is repeatedly emphasized.

Mandinka women interviewed also report ceremonies of this type. A woman in Koungheul Socé explains that in their community, "girls have a big ceremony away from the village. The *griot* comes, there is a big feast, singing, dancing, girls are dressed up, but they do not know what is going to happen. It is an education ritual where they essentially learn to be a true

Mandinka woman in society." This idea of becoming a "true" Mandinka woman – or a woman at all – is introduced by interviewees from practicing communities.

The two elements involved here – the education and the actual cutting – are beginning to be separated by some Senegalese women. One woman whose village abandoned female genital cutting[2] explains that "now that the cutting is gone, the education and knowledge still exist, but it just happens at home with the mother." A woman from the same village agrees: "With the abandonment, there will be no problems – the education will be replaced by taking young girls to school." A current runs through the data that "you can have all of the education without the cutting" and therefore some Senegalese are less inclined to continue cutting as a rite of passage into womanhood.

FGC as a hygienic and aesthetic measure

Hygienic arguments for FGC presented by Senegalese interviewees rely on the idea of external female genitalia as dirty and unsightly and thus requiring removal to promote hygiene and provide aesthetic appeal (El Dareer 1982:73). A circumciser from Koungheul illustrates this idea. She explains: "The clitoris is cut off because it is smelly and dirty. If a woman goes one day without washing, she'll stink. Nobody can eat an uncut woman's food because it smells so bad." Uncut women cannot cook, and "they couldn't even pray or do other things because they weren't clean," as one woman in Ablaye Fanta points out. The genitalia of women, particularly when intact, as well as biologically female processes such as menstruation[3] indeed have the stigma of impurity and uncleanliness.

Much like male circumcision in the United States, FGC is often seen as a sanitary measure, allowing for easier cleaning and less folds of skin to hold dirt and odor. The desire for a clean, smooth body is achieved through excision, and in an even more pronounced way, through infibulation. In Senegal, interviewees make the connection between health and hygiene, in responses such as: "An uncut person is seen as unclean. A disease definitely comes to women who are uncut because of their dirtiness." These hygienic motivations contribute to the reasoning for female genital cutting and represent another way in which the female sexual body is seen as impure.

The importance of virginity

The idea of controlling female hypersexuality and consequently protecting virginity is the most common response from Senegalese interviewees during discussions of female genital cutting. One Mandinka woman interviewed in a village in central Senegal explains that "an uncut woman cannot be prudent because what is cut off is what excites her, so if it isn't cut off, she will always be excited," which reinforces the notion of the clitoris as the physical location of uncontrollable female sexuality. Similarly, several Pulaar women and men communicate this idea of controlling women's sexualities, which physically manifests in their genitalia. One woman clearly explains that non-excised girls "chase after men," while another provides more specific detail by stating that it was "previously thought a girl was willing to run 50 kilometers at any time to chase a man, but after being cut, she could remain calm." Put simply, the clitoris is the source of unmanageable sexuality and unrestrained desire. Consequently, the excision of the clitoris is a rational measure to take for the protection of the health, morality, and future of women in practicing communities.

The expectation of female virginity itself has a constant presence in the societies under study. For instance, one university student in Dakar expressed the importance placed on pre-marital virginity, as she states it "is a proud victory for the mother. The husband says on the day of marriage 'Thank you, you have raised your daughter well, she is well brought up.' It is a source of pride for the whole family." Implicit in this description is that the sexuality of a woman is not hers in the individualistic sense. Her sexuality and virginity status are monitored by her own kinship network, as well as by the kin of possible husbands. The same young woman from Dakar, who herself is not from an FGC-practicing family, elucidates this external monitoring. "If," she notes, "on the day after the marriage, the woman isn't walking funny, all of the relatives take notice." If remaining a virgin until marriage is a "source of pride for the whole family," engaging in pre-marital sexual relations (and thus not "walking funny" the day after consummation) therefore shames the family and disrespects structures of kinship. As this woman demonstrates, the importance of virginity is evident among ethnic groups in Senegal who do practice FGC, as well as those who do not. The difference belongs in the measures to which families and communities will go to protect – or regulate – the virginity of their girls.

Linked with this idea of self-control and respect is the idea that girls and women need assistance in the preservation of their virginity. Girls are not solely pressured by the principles of their social and familial environment – they are given physical aid for remaining virgins. A 24 year-old male student from Koungheul remarks: "A pregnant girl outside of marriage dishonors the family, so the older women of the village will do whatever possible to keep her a virgin." In the same vein, a woman in the small village of Koumbidja explains that "excision was done to keep young girls away from boys – to protect them." Female genital cutting is a measure of protection taken by communities to assist girls in controlling their sexualities, and thus being able to remain chaste until marriage.

Diminishing sexual pleasure

Though interviewees by and large emphasize the importance of virginity[4], the view that females ought to have the ability to physically enjoy sexual contact also is communicated. For the most part, women are only intended to enjoy sexual intimacy within the confines of marriage, which does not leave this opposition to genital cutting incompatible with preserving virginity. Rather, for opponents of FGC, the removal of the clitoris takes away some or all of the pleasure that women can experience during normal, marital, appropriate sex. For instance, a woman in a non-practicing family living in a community where other families from differing ethnicities practice, provides her understanding that "excision is not a good thing. They cut the clitoris where women are actu-

ally able to feel pleasure." Likewise, a Pulaar male griot, ironically with a cut wife, notes: "If a woman cannot have pleasure sexually, this is not interesting for either person, the husband or the wife." Another Pulaar interviewee agrees with the griot that FGC "is unfair for women because it diminishes pleasure." Therefore, according to interviewees in both practicing and non-practicing networks, the sexual pleasure of women is affected by genital cutting.

One trend evident in interview data is that of an urban/rural divide concerning sexuality and virginity. I found that the ten interviewees living in Dakar tend to be more lax concerning sexuality in comparison with interviewees living in rural areas. Students at the University of Dakar in particular were open about sharing accounts of sexual experiences, even when that meant alluding to their noncompliance with virginity regulations. For example, a young man in Dakar explains his personal sexual experience with cut women:

I've been with circumcised women and they can still have pleasure but it takes more time. They don't react much when touched. Their sexuality is definitely diminished. All girls should have the same sensation – if it's taken away, she can go for years without pleasure if the man isn't strong. Also – cut women get more pleasure from oral sex than penetration.

Though this report is from the man involved in the sexual encounters, not from the circumcised women themselves, it points to the fact that pre-marital sexual relations occur despite female genital cutting, particularly, I gathered, in Dakar. Further, contrary to the Alice Walker-esque belief that women become "sexually blinded" by the practice, perhaps women *can* experience sexual pleasure, albeit "diminished" pleasure[5].

Negative health consequences

Women and men interviewed were cognizant of the physical health consequences of female genital cutting. A Mandinka woman noted that "during cutting, you can lose a lot of blood, or during childbirth it has major consequences." A man from Dakar similarly touched upon the debilitating effects on a woman's health in stating: "excision isn't good because it handicaps women, diminishes their sexual pleasure, and can bring negative health consequences." An ex-circumciser herself acknowledged that "sometimes cutting gets excessive and there are problems…" Many interviewees do recognize (or experience themselves) negative ramifications from the practices and are thus motivated to oppose the continuation of FGC. As Janice Boddy concludes, "These are not harmless procedures. It is sadly ironic that a custom intended to defend women's fertility can actually damage it" (Boddy 2007:204).

Section II: American interviewees on female genital cutting

Similar to the interview data collected in Senegal concerning female genital cutting discussed above, the American responses to FGC fall into categories. Unlike the Senegalese viewpoints, however, these categories are not based on the various rationales for FGC – Americans I spoke with are largely unaware of the reasoning behind the practices – but rather on their opinions about FGC in general. These responses from the sixty-one interviews are distributed in three main camps that can be understood as markers on a scale. On one end of the scale are interviewees who communicate cultural relativistic positions in that they view FGC a practice from another culture, as a tradition that perhaps is harmful, though one that they have no right to judge. Constituting a smaller camp in the middle of the scale are more humanist responses focusing on a connection with the women who undergo FGC as fellow women. On the far end of the scale are the most responses to FGC, which are ideological liberals who view FGC as a barbaric mutilation of women's bodies. Each of the camps will be unpacked below.

Cultural relativist responses

On one end of the scale are the opinions that female genital cutting is a practice from another culture that perhaps is harmful but that should not be judged by Americans outside of that culture. One woman explains: "This is cultural for reasons that I don't understand. Who am I to impose my beliefs on them? They can't on me either, for that matter. We do things in the US that other people don't do. Who am I to say that something is wrong?" Implicit in this response is that culture – both American and Senegalese – is seen as protected from individual judgment. It is not the place of this woman to deem FGC wrong, nor is it acceptable for a Senegalese person to pass judgment upon practices in her life. Also, the woman's question 'who am I to impose my beliefs' is encouraging for proponents of anti-imperialism as she recognizes her unfamiliarity with the communities who practice FGC and the limits to her relative power.

A woman in Eugene, Oregon explains her inability to relate to cultures in which FGC in practiced: "It is so far removed from our culture so it is hard to put into perspective how devastating it can be. I don't have any way to associate with it or experience it, so it is difficult to understand. It makes me sad." For this young woman, female genital cutting is located in another culture and she does not connect on a human or woman level with those who are cut.

Finally, there are interviewees who simultaneously recognize their own cultural biases while viewing the practices of FGC as part of a broader phenomenon of the oppression of women. An interviewee from Ohio is a clear example of this type of response:

I have terrible cultural bias toward my own culture. But knowing that, I see this as another way to repress women. And women, in my opinion, throughout the rest of the world are

terribly repressed and treated as property. And this is another form. I don't know if it is fair to equate those things, and I am biased by my own culture, though.

She therefore does see FGC as oppressive and understands it as part of the global subordination of women, yet she grants her own cultural biases in the formation of that judgment. These responses addressing privileged or influential roles of culture highlight relativistic ways of understanding female genital cutting.

Human connection

A smaller grouping of responses from Americans concerning FGC can be placed in the center of the constructed scale. Unlike the dissociation experienced by some of the women mentioned above, these respondents communicate a connection felt with the cut women. The connection was an empathetic physical reaction, emphasizing the human or woman element involved. Interviewees often make physical movements, either in a symbolic gesture of protection of their own genitalia, or in a touching of their hearts.

The verbal responses come in forms such as "it makes me cross my legs every time I hear about it," "everything tenses up when I hear about it. Ouch goes in my head," and "I just touch my body and think about how much that would hurt." In these statements, Americans are associating with the pain Senegalese women and girls perhaps experience during cutting.

Within this group, the theme stood out that "a woman is a woman;" a human with common features, even if those common features are only physical. Likewise, children are children who deserve the love and protection of adults, regardless if they come from Africa or North America. One woman asserts this idea: "I don't think it is right to hurt anybody for any reason. I'm sure there are reasons behind it, but I don't see the benefit of inflicting pain on children, no matter where they live." The links made between the bodies of American women and Senegalese women and between the protection of children all demonstrate the ways in which cultural boundaries are trumped by broader claims of humanity.

FGC as barbaric mutilation

Just as both academic and mainstream Western literature have historically presented female genital cutting as a barbaric, mutilating ritual (Daly 1978; Hosken 1979), many American interviewees also see the practices as such. Of the sixty-one interviews conducted, thirty fit into this third category of responses, as they address FGC as a horrible atrocity and a mutilation of women. The idea that female genital cutting is carried out by undeveloped and uncivilized people is evident in responses such as: "I think it is barbaric and I am angry. I am really angry that this goes on. It is primitive, a primitive practice;" "I am horrified. The fact that a woman would be cut like that to – I'm not even really sure why they do it. The practice is so barbaric;" and, "It is barbaric and beyond inhumane!" Female genital cutting is obviously seen by some Americans as primitive, and why this is so will be discussed shortly.

Another way that American interviewees express disgust at FGC is by equating the practices with torture or mutilation. One woman exemplifies this in saying: "It is beyond my wildest imagination why you would torture somebody like that." Another interviewee directly asks, "How could you mutilate somebody like that?" One man highlights that this mutilation is sex-based and thus has complex layers of power attached. He notes: "If you mutilated men like that, it would stop. I just don't understand that, especially if it is your own flesh and blood." A fellow interviewee also emphasizes the effect the mutilation has on the female body: "That is female castration. Even if they never have sex. It is just mutilating the body."

Because interviewees see FGC as a barbaric, mutilating, torture of women, many of them have visceral responses to it. They make statements such as: "…deforming a child – with complications like death – is horrendous;" "It is an atrocity, I don't even know how to describe it;" and "I think FGC is disturbing and horrible," which clearly communicate their disdain toward female genital cutting. The question of *why* interviewees have such strong emotional reactions to questions concerning FGC remains. In looking at this question, two main issues arise: autonomous choice and female sexuality.

The element of choice

The first issue repeatedly emphasized by American interviewees is that FGC is performed upon children, who have no choice in the matter. Since liberalism pervades most American ideologies in profound ways, it is no surprise that the interviewees take seriously autonomy, choice, and freedom (Chambers 2008). As one woman notes, "at least here in this country you do have choices," and girls and women are not forced to undergo dangerous practices like FGC. Another interviewee adds in age to the question of consent. She says: "What really makes it bad is that the practice is on children who don't have a choice. They have no idea what's going to happen. The choice is made by their mother or grandmother or whatever and they have no choice in it.

That FGC occurs in large part on young girls is troubling for interviewees because the future capabilities of the girls to choose what to do with their own bodies are decreased. "A woman should be able to choose what she wants to do with her body," a woman notes, "and I know that it is their culture and background, but if they don't want it, they shouldn't have to be forced." If female genital cutting occurred on adults who consent to the procedure, American interviewees express openness to accepting the practice, even if it is not beneficial to the health or sexualities of women. The fact, though, that it does occur mainly on unconsenting children is problematic.

Diminished sexual pleasure

Similar to Senegalese opponents of FGC mentioned earlier, the second element of why half of the American interviewees were vehemently opposed to FGC relates to the effects upon female sexual pleasure. American interviewees view the enjoyment of sexual relations as a natural right of women. For example, one woman states: "To me it is an unnecessary pro-

cedure that takes away what should be a very natural feeling during sex. Women have every right to have pleasure during sex as a man does." This equal right of women is an important aspect of life for interviewees. Another woman adds to this emphatic disdain: "I can't believe they would take that gratification away from women. How dare they?" "They" are not revealed by this woman. The harm to female sexual pleasure, along with the interconnected issue of choice, motivate many American women to oppose female genital cutting.

Section III: American interviewees on breast implantation

Interview data show two main explanations for breast implantation, while there are two core reasons Americans view them negatively. A division does not exist with implanted women on one side (presumably on the positive side of the discussion) and non-implanted on the other. Rather, the data reveal both implanted and non-implanted women providing rational justifications for the practice. Oppositional viewpoints, however, do exclusively come from non-implanted women. The overarching liberal element of autonomous choice seeps into all perspectives concerning this practice. The issues of physical proportionality, femininity, pity, and corporeal damage will be respectively discussed.

Natural proportionality

Women who undergo breast implantation often seek a proportional, natural, feminine body. The proportional measurements of women have been a focus within the academy as well as in mainstream American culture, from evolutionary psychologists (Miller and Kanazawa 2007; Miller, G 2000) to American rappers (Sir Mix-a-Lot 1992). The messages from these sources are embedded in the mentalities of women, and thus various measures are taken to achieve natural proportionality. One woman with breast implants explains her case: "I had a conservative boob job done. I wanted to be proportional to my hips and butt. So I had a doctor look at my body style and see what would look best." Another woman echoes this desire in stating "I wanted my body to be proportional. Normally you can't even tell that I have them done."

Not only is proportionality important in terms of chest – waist – hip ratios, but also between the two breasts themselves. Despite the fact that the majority of all women have breasts of different sizes, plastic surgeons pay attention to this discrepancy and correct it during surgery (Davis 2003). A plastic surgeon in Atlanta notes: "The goal is to achieve proportionality and what will look good." A woman gives her more specific account of achieving proportionality: "I went to a very normal or natural size. No one can tell. I always wore a padded bra before. One was slightly bigger than the other, so they ended up filling 270 cc in one and 290 cc in the other to make them proportional."

This desire for proportional breast size is not irrational to Americans. Many interviewees achieve this status through wearing padded bras or through surgery, while others report remaining self-conscious about breasts that are too small, too large, disproportionate, or deformed. Put logically by a man from southern California, "I think women get implants because they don't feel their body is proportionate. It is like me feeling that my arms aren't big enough so I go to the gym to make them bigger." Throughout these discussions, it is clear that proportionality is a common desire of American women.

Femininity

Interview data, particularly with women who have breast implants, provides much evidence that women do often seek augmentation to "look like a woman," "feel more feminine," or "look natural" rather than to hypersexualize themselves or have unnaturally large or disproportionate breast size. However, there are some women, for instance some who work in the sex industry, who do undergo breast implantation for other reasons than the above mentioned and with different results. No statistical data is available concerning the occupations or other socio-economic categories of all women seeking breast implants, but I asked a cosmetic plastic surgeon in Atlanta what proportion of her patients seeking breast augmentation work in the sex industry. She responded:

We definitely see this type of clientele, but all in all it's still the minority. My best guess is 15% – 20%. Admittedly, this number can be not only regionally dependent (i.e. I'd guess you'd see more women in the sex industry in metropolitan markets than small towns) but can also be doctor dependent.

While a higher proportion of workers in the sex industry may have implants – compared to teachers, for instance – I have found they do not constitute a majority of all women with implants.

Interviewees with implants themselves communicate this idea that women undergo breast augmentation in order to achieve a higher level of femininity. One woman from Phoenix, Arizona who augmented her breasts reports: "I feel more feminine. I just feel more feminine." Another woman in southern California explains: "I do feel more like a woman, having breasts." These are just two examples of the power that implantation can have in the creation of femininity.

Finally, a breast cancer survivor provides a striking illustration of the role that breasts – and therefore breast implants – have in constructing femininity. This woman from Albany, Oregon underwent a double mastectomy after rounds of chemotherapy eliminated the cancer. After the mastectomy, she chose reconstructive surgery, and refers to her implants as "prostheses." She discusses her experience:

I am sure I would not feel as much 'like a woman' without my prostheses. It is difficult to explain, but even though they help me feel 'like a woman,' they do not feel a part of me like my natural breasts. For the general population, though, my prostheses 'make me a real woman.' They function as a 'gender prostheses' if you can understand that."

This is a clear example of what role breasts play in the gendered life of this woman. As she phrases it, the general population understands her as a woman because the implants make her so.

Feelings of pity

Not all interviewees saw breast implantation as an effort to gain a proportional and feminine physical form. Interviewees who do not have implants tend to share feelings of pity for women who do undergo the procedure. "I feel pity – why do women have to do that? Why is their self-confidence so low they have to do that?" asked one woman. "I think it is sad that women feel they need that," added a male interviewee. These feelings of pity are often outweighed by individual choice. Thus, even when interviewees express opinions like those above, they fall back upon the fact that the woman chose this for herself. This is clear in statements such as: "I feel sad for the woman [who gets implants]. Because she chose to have that and I think that is sad. But I also respect that every woman has a choice, even if I don't identify with it or understand it."

One of the main reasons why interviewees have these feelings of pity are due to the belief that women get breast implants in order to garner male attention. Breast implantation is seen as something women do not for themselves but for men. "Women get breast implants to seek the attention of a male," one interviewee notes. This is because "men like to look at them and they are advertising what they have when they do that." Granting that this is a heterosexist framework with which to study the practice, evidence such as "when I see it I think they have done it for the attention of a male," and "I think ultimately it is to please a man," points to male attention as a perceived motivation for implants.

Mutilation or damage

Finally, American interviewees convey the idea that breast implantation is a mutilation of the body. The surgery inserts unnatural substances into the body and requires significant recovery. Americans are aware of these facts. One woman asks, "Why would you do that to yourself and pay money to damage your body? I think it is damage," because of the permanent transformation of the body. Once implantation has been done, a woman's breasts can never return to their pre-implantation state (Chambers 2008). Also, almost all women will require a re-implantation surgery ten to fifteen years after the first procedure due to various bodily changes (Davis 2003). These physical consequences are worth the price of implanted breasts for some women, such as one woman who asserts: "Going into it I was very aware of the risk involved and I know that I may need another surgery. And I'm ok with that."

Even women who consider implantation a damaging mutilation are clear that it is the woman's right to make the choice to get implants. As long as women retain the right to make whatever choice they wish – regardless of the social context that creates available "choices" or the physical, emotional, and social ramifications of those choices – practices of body modification are acceptable. For example, one woman responds: "I think people have to choose what they want to do. I can only decide for me." Another woman agrees: "It is a woman's right to do that if she wants to. It is her business, her money. It is none of my business."

Section IV: Senegalese interviewees on breast implantation

The reactions of Senegalese interviewees to women with breast implants range from repulsion to understanding. An initial clarification often had to be made concerning the role of breastfeeding. Many interviewees had the first impression that women undergoing breast implantation were doing so to increase the amount of breast milk in order to breastfeed longer. Thus, some initial responses were supportive of the practice. When I explained that breast augmentation does not increase milk production, and that often women with implants cannot breastfeed[6], the responses change dramatically.

For instance, a Pulaar mother explains: "Babies need the milk of their mothers. It's true that men prefer women with breasts, but it's only so they can feed their babies." Likewise, a woman in Koungheul reasons that if "it doesn't augment the milk then it isn't a good thing. Better to stay natural if there isn't more milk," demonstrating the triumph of breasts as functional organs over breasts as aesthetics body parts. For many interviewees, the opinion is clear that "breast milk is too important to lose," and therefore, "if you can't feed your babies, then this practice must be abandoned."

Initial reactions of disgust

Many interviewees subsequently respond with disgust, as illustrated by the following excerpts. First, a 24 year-old cut Pulaar woman exclaims that "people should stay natural, they way they were born!" A married 20 year-old woman in Sedo Abass responds similarly: "I have never heard of this *catastrophe artificielle*. I'm scared of the idea. Why would women put something in their bodies that God didn't give them? I have no idea why people would be against female genital cutting and not this practice." Co-wives in Sedo Abass have a parallel take on the practice. The first wife responded: "I have never heard of this, and never in my life do I want to know about it. The women who do this aren't really women," while the second wife adds that "All operations of that sort must be caused by a sickness." Among these negative responses concerning breast implantation, the consensus appears to be that "a person should be content with what God gave her and this should not happen."

Patterns in responses

Along with initial disdain stemming from the role of breastfeeding, other patterns also occur in Senegalese responses to breast augmentation. Interviewees communicate in various ways discomfort with the practice due to its unnatural character. Women, many argue, should not insert a foreign, unnatural object into their bodies. As a 28 year-old female student in Dakar responds: "It is also a problem of unnaturalness. It is unnatural to change the body like that. It's psychologically

problematic – having foreign objects in the body." Likewise, this unnatural implantation of material into the body goes against God's will. "You must stay the way that God created you. How would you explain that to God?" asks one male farmer from Keur Lamine. The distinction here between taking away something from the body – like in the case of excision – and implanting an unnatural substance – such as in breast augmentation – is apparent.

Demonstrations of understanding

At the same time, respondents express understanding of the importance of having particularly sized and shaped breasts. The motivation for getting implants can then be seen as rational, even when Senegalese respondents take issue with aspects of the practice, such as the unnaturalness. One motivation of American women that Senegalese interviewees assume, and some sympathize with, is that the women undergoing breast implantation want to remain young. "Breasts like that [implanted] are like young girls' coming into womanhood. They draw the interest of men because they show the vigor and readiness of a woman," explains a 35 year-old man.

Additionally, Senegalese interviewees explain that having breasts allows people to tell if you are a man or a woman. So, they reasoned, for women with small breasts, they might augment their breasts surgically in order to distinguish themselves as women. A young man from Koungheul states that "if a man sees a woman with big breasts, he'll be attracted to her because it shows femininity. She's a real woman with breasts. If you see someone without them, or with really small breasts, she's missing something in her femininity," thus highlighting the link between womanhood and breasts. An older woman reiterates these ideas in saying that "women do this to enhance their beauty. It's a symbol of beauty because it works with clothes. People can see that you are a woman, but without breasts, they can't tell if you're a man or a woman." The role that breasts play as the most obvious outward symbol of sex is evident in this discussion, and implantation can be seen as a tool in obtaining that symbol.

One common Senegalese reaction to breast implantation relates to beauty and aesthetics. Many women explain that women will do whatever is necessary to increase their beauty so that they can get and keep a husband. Having beautiful breasts is one facet of their appearance, so perhaps some women choose this procedure to improve their appearance. "Women have been working trying to find ways to be more and more beautiful, this is just a next step," responds a 55 year-old male interviewee. Another man brings up the goal of beautification in stating that implants "…make women beautiful. There is no harm in trying to be beautiful. Isn't this why women wear bras? Why else would a woman wear one but to have perky, firm breasts?" As mentioned, this attainment of beauty appears to most as not being a goal in and of itself but rather as connected with the larger goal of attaining a husband. Breasts in particular play a key role in this as, according one interviewee, "Men won't love a woman without breasts – most men at least." Breasts therefore not only represent femininity and womanhood in the differentiation of the sexes, but specifically sized and shaped breasts uphold social standards of beauty and thus lead to the improved chances of being considered desirable and marriageable.

Non-verbal and "re-colonizing" responses

In addition to the variations of confusion, disgust, and understanding discussed above, Senegalese women also exposed their breasts to me in a deliberate display of what a "true" breast, representing a "true" woman was. More than ten women thrust their bare breasts at the translator and myself as a non-verbal exhibition of their opinion regarding this issue. A woman thrusting her breast this way is demonstrating how her own body fits the communally accepted definition of what a woman *is*. This action is telling me that a woman is not a person who fills her chest with unnatural substances in order to be more beautiful. Rather, a real woman has breasts like the ones exposed by the interviewees. These breasts have nursed five, seven, or nine children, look "old" and hang low, and are not perky the way a pre-maternal young woman's are. To these women, that is what a true "woman" is.

Further, respondents also discursively reclaim colonized spaces. What I mean by this is that women throughout Senegal are in disbelief; disbelief that people would travel across the globe to fight female genital cutting while the unnatural and ungodly practice of breast implantation exists in their own communities. One Pulaar woman explains, "If we had the money, we would mobilize, go there and send Senegalese organizations to *sensibiliser*[7] the Americans who do and accept that!" A woman from the same community reiterates these concerns in exclaiming: "How could women choose to do something that is possibly bad for their health? Maybe we [the women of Sedo Abass] should go to the US to *sensibiliser* people about health risks. Americans have spent forty years coming here to talk about FGC, maybe it is time to go to the US!" Based on their reactions to the questions at hand, there are other interviewees who would gladly join in her mission.

Finally, when asked if there are any practices similar to breast implantation in Senegal, the responses vary, depending on the ethnic identification of the interviewee. Approximately half of all respondents adamantly answer "no!" to the thought of a similar practice existing in their kinship networks. For example, one man asserted: "There is nothing similar here in Senegal. We would never have a practice like that here. People in the US are truly bizarre." There is a considerable sense of foreignness and disdain that pushes many respondents away from forming an association with this practice.

However, the other half of the interviewees reply that similarities can be found in the forms of: *khessal*, which is the depigmentation of the skin; *timmi soo*, which is the tattooing of the gums with black ink; fattening pills; abortion; and, notably, female genital cutting. A Mandinka woman in Koungheul Socé reasons that, "in Senegal, excision is similar because something is changed or taken away from the woman in both cases." On the other hand, another Mandinka woman notes that the "… difference between FGC and breast implants is that Western

women know all of the consequences where African women don't. They never learned the health information, for instance." The connection is being drawn by some interviewees between breast implantation and female genital cutting as both are considered fundamental alterations to the female form.

Conclusion

My essential point in examining the practices side by side is to be able to look deeper into the ways that the female body is transformed. Having outsiders discuss the practices of others helps to uncover societal expectations that are placed upon women, which are concretely enforced and not often recognizable. People from outside a particular social field often have varying takes on cultural practices within that field.

Two main elements that are revealed in the cases of the US and Senegal are those of autonomous choice and gender identity. Through the information presented, I am left with these questions regarding those elements to be explored in future research: Why does the idea of autonomous choice override harm or disadvantage for American interviewees? Why, despite coming from the same cultural context, do some women disparage women with implants, while acknowledging the important role breasts play in gendered identity? Can Senegalese women understand their own identities isolated from their roles as wives and mothers? Would doing so be of any benefit to them or rather just a Western imposition? Delving deeper into the varying sources of biopower and social control would help to arrive at answers to these questions.

Finally, one interviewee expresses: "I feel sorry for [a woman with implants] that felt she was so lacking in acceptability in our society that she had to mutilate her body to be accepted. And what is the matter with us as a society to make her feel that way?" This is precisely what I want to ask. What *is* in society that makes women feel the pressures they do? Where do these pressures come from? And, most importantly, should we try to stop them?

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Notes

[1]The estimated rate of female genital cutting in Senegal is approximately 28% (FGM Network, http://www.fgmnetwork.org/intro/world.php Accessed 24 July 2008). Excision is reported to be the most common form of cutting, though infibulation is also reported. During my field research, I spoke with women in the Fouta region of northeast Senegal who were "sealed" – a form of cutting very similar to infibulation, without the actual sewing shut of the labia majora. I did not, however, directly ask interviewees whether they were cut. Women often provided that information, such as the women in the Fouta, yet it would have been inappropriate and offensive to ask that question directly.

[2]The Senegalese government banned female genital cutting in 1999, though the practices continue despite their illegality. The Senegalese based non-governmental organization Tostan has had much more success encouraging the abandonment of FGC and other harmful practices such as early and forced marriages. This particular village is one that participated in a Tostan non-formal education program and made the unified decision to abandon FGC.

[3]For example, during the holy month of Ramadan, women who are menstruating cannot take part in the fasting or other religious traditions. They must wait until they are finished bleeding and then "make up" the days missed during their periods.

[4]Of the eighty interviews, only one person expressed directly the opinion that virginity is not a precondition for marriage. An eighteen year-old man was the anomaly in this case, as he stated: "virginity isn't necessary – my wife must only love me." The ten interviews conducted in Dakar hinted at either the interviewees' non-adherence to virginity requirements or their ambivalence concerning a potential spouse's virginity, though this opinion was not directly stated.

[5]See Gruenbaum (2001: Chapter 5) for a thorough discussion of sexuality and female genital cutting.

[6]The breastfeeding abilities of women post-implantation depend upon whether the implant is below or above the pectoral muscle and whether the milk ducts are damaged during surgery. There is no data available concerning the percentages of women able to breastfeed with implants.

[7]*Sensibiliser* can be translated as to enlighten or to inform.

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Aud Talle

Precarious Identities: Somali Women in Exile

Abstract

The civil war in Somalia in the early 1990s produced a Somali diaspora of unseen dimensions. Men, women and children in hundreds of thousands fled a country ravaged by fighting and violence and sought refuge in new lands. In exile, Somali women negotiate problems of alienation and identity loss. Their genitally cut bodies generate insecure and awkward encounters with the mainstream society which often cause them to search for security in withdrawn positions. In diaspora as well as in their home countries Somali women have begun to dress and veil themselves in Muslim style. Women explain this change in dress code as a consequence of religious enlightenment. The overall objective of this paper is to discuss reterritorialisation of local practices, with particular reference to memory, pain and identity making.

Introduction

Many years ago, in Mogadishu, the capital of Somalia, a male colleague claimed that "we Somalis do not have to confine our women [as the Arabs do], we infibulate them instead."[1] He was offering his remarks as a comment on the widespread conceptualisation among his countrymen (and women) of the protective nature of female circumcision. The genital operation of cutting and closing, as it is traditionally performed in Somalia, is meant to secure women's dignity and the social worth of a nubile woman (see for example, Talle 1993; Widstrand 1964). I heard what my colleague was saying, but then in Somalia I took his words to be yet another mark of a perceived difference between Somalis and Arabs, frequently spoken by Somali people at that time. His words, however, have often come back to me as I have carried out field research among Somali refugee women in exile – in London, and recently in Norway[2]. In the Somali diaspora[3], the relationship between female circumcision and bodily confinement, by way of the 'veil'[4], alludes to an interconnection that is worth pursuing in order to understand the coping of refugee women, their well-being and perception of self.

In this article, I am specifically concerned with how Somali women, as circumcised women, rework their identity in their situated lives in exile. The reterritorialisation of local practices such as for instance female circumcision in a Western setting is a contradictory process of negotiation and renegotiation where people find themselves located in shifting contexts of meaning and power relations. When Somali refugee women arrive in Europe for the first time, many of them express feelings of what Kirsten Hastrup has termed 'identity loss' (Hastrup 2005), that is an existential state of being where your conceptualisation of self in relationship to others is seriously contested. Identity is to find one's feet among and with others and, according to Anthony Cohen quoting Epstein, 'a concept of synthesis', a process of integrating 'various statuses and roles, as well as […] diverse experiences, into a *coherent image of self*' (1994:11, my emphasis), through which one can relate to others and act meaningfully in the world. This is a processual approach to identity, acknowledging that both the statuses people have or acquire as well as the relations they engage in contribute equally to the forming of their identity and image of self (Cohen 1994; Hastrup 1995). I argue that the redefinition (or deconstruction) of their genitally cut bodies in exile constitutes existential dilemmas for many Somali women. The

hegemonic discourse on circumcised women in the Western setting constructs them as an anomaly – a deviation from the norm. When debated or discussed in the media or in conversations among the general public, the phenomenon usually stirs up strong emotions of disgust and rejection. One example of such a reaction was by an otherwise sensible taxi driver who recently (in May 2008) took me to an Africanist conference at a Norwegian university. When our conversation on Africa in general slid into the topic of female genital cutting, he just said *Å, fy fan*! (Oh, hell!). He swore four or five times as I tried to explain the issue more broadly. This young man was obviously not willing to challenge his immediate visceral reaction to a social practice that he believes destroys women. How is it possible then for Somali women, and others, to craft an identity as a woman in a context in which you are by definition *not* a woman? In other words, how is it possible to constitute a female subject and a female self in Western exile when missing outer genital organs? These foreign 'gazes' on their own bodies alienate the cut women themselves and stigmatise (Goffman 1963) them as different women. In Somalia, the clitoris is defined as a male (and unclean) part of the female body and is excised under great suffering in order to feminise (and humanise) a woman; in contrast, in the gender (and sexual) discourse in London and Norway, a present clitoris is a core definition of a complete and attractive woman. In the sexual liberation of the 1970s throughout the Western world, the clitoris was celebrated as a centre of female pleasure and its revival was, in fact, a significant issue in women's emancipation at the time. As the clitoris was recognised in the West, so to say, reports of clitoridectomy and other forms of female genital cutting were reported from other parts of the world, especially from the African continent. The simultaneous concurrence in contrasting female genitalia between 'ours' and 'theirs' may not be a sheer coincidence; however, this is another story that I will not dwell on here.

Veiling and circumcision: a kind of relationship

The increasing practice of 'veiling' in classical Islamic dress code among Somali women in the diaspora (also recently in Somalia), compared with the situation in their home country before the war, is striking. This change in dress has been observed in many places of exile (see for example, Johansen 2007; Koskennurmi-Sivonen et al. 2004). Of the 33 women I interviewed in Norway, all were 'veiled' in hijab or jelbab[5] apart from three highly educated young women (all of them unmarried, two being sisters) and a middle-aged woman brought up in Kenya. One-third of the women in this sample donned the jelbab, but none wore *niqab* (the face cover). The latter is observed occasionally, even among Somalis. The difference between hijab and jelbab is a matter of degree: a woman in jelbab is considered more covered than one in the headscarf. Somali women may however alternate between hijab and jelbab during their lifetime or according to circumstances, such as perception of modesty and personal faith. Among the Somali there is no simple relationship between education and veiling in the sense that educated women reject the veil and illiterate women use it: far from it. In my sample, a young, unmarried student of political science wore the hijab, while many highly educated elderly women dressed in the jelbab. It is also true that the few women in the sample who rejected the veil were all highly educated. Of all the different immigrant groups in Norway, Somalis have by far the strictest religious dress code. Among other ethnic groups, such as Iraqis, Iranians and others, it is possible to see some single women wearing the jelbab and even the niqab. The Somalis, on the other hand, have more or less indiscriminately accepted the Islamic dress code (Johansen 2007). In Somalia, before the war, only very few women would don the kind of jelbab that is common today, and even wearing the less covering hijab was uncommon at that time[6]. Those who did fully cover their bodies (except for the face), in Mogadishu at least, used the transparent black *buibui* (commonly seen in towns along the East African coast) and belonged to zealous religious sects, who were often quite marginal within their own society.

In Somalia, however, adult women would always wear the *shaash*, a small, thin scarf, often in black, tied around the head, usually with a knot on the lower end at the back of the head. The black shaash was particularly common among nomadic women whereas women in towns would often wear more colourful scarves. Above the scarf, on their head and shoulders, they would usually wear a light, transparent and loose-fitting wrap (*garbasaar*). The close connection between female modesty and clothing was definitely a cultural theme even when clothing practices were more moderate. The following incident may illustrate my point. One afternoon in the mid-1980s I was walking with a dear friend to the court in Mogadishu. My friend was seeking divorce from her husband and had initiated the process herself – without his consent. As we approached the court building, I noticed that my friend folded the gauzy wrap more tightly around her face and neck. I asked her why she did that. "I have to perform decently in front of the male judges," she replied, quite aware of her controversial initiative in asking for a divorce.

In many Somali social contexts, decent clothing in terms of concealing body parts defined as private is a statement about a woman's moral status. However, the *garbasaar*, even when tightly wrapped, does not give the impression of 'veiling'. Among the nomads of the Hiran region in central Somalia, where I also did field research during the 1980s, women were clad in the traditional *guntiino*, a piece of cloth that is knotted on one shoulder and folded across the body and usually tied up around the waist by a wrap. The latter may be loosened from the waist and folded on the shoulders when resting or receiving visitors. The hijab and more so, the jelbab cover the female body much more radically, and their style produces a foreign look (to this observer at least), harbingering messages of profound changes. Whenever I brought up the topic of comparing their present style with the way women dressed in Somalia in the 1980s, my female informants would ponder the issue and offer their comments, advancing a variety of reasons and arguments, religious piety being the most prevalent. The eth-

nic Norwegians with whom I discussed the issue commonly thought that 'veiling' was the generic female dress for Somalis. Many of them were actually surprised to hear that wearing the hijab or jelbab was a rather recent phenomenon. During the 20 years since the civil war broke out, Somali women have, in fact, 'naturalised' an Islamic dress code. Even though it is a contested issue and sometimes the focus of lively discussion on the Internet and elsewhere, veiling has not met with any severe or concerted resistance by the Somali diaspora.

At the same time as my research findings in European exile contexts reveal that women have changed their way of dressing, they also demonstrate that women living in these places express, to a great extent, opposition to female circumcision, in particular infibulation, which has been very common among Somalis for centuries (Talle 2008). All 33 women in the Norwegian sample claimed to hold a position against female circumcision. Three of them, however, admitted that *sunna*[7] was acceptable – religiously on a par with not being cut – but they would not necessarily recommend it. Opposition to the practice of female genital operations by various populations living in exile is not uncommon (see for example Ahmed 2005b; Johnsdotter 2002; Johnson 2007; Morison et al. 2004).[8]

A major explanation suggested by the informants for this change in clothing practice and resistance to female circumcision was religious enlightenment; they had become more learned in religious matters in recent years. They claimed that they had begun to read the Koran in a more conscious way, and now understood that nowhere in the Koran is infibulation prescribed. In contrast, in Somalia they had been unaware of scriptural correctness and had followed a more vernacular interpretation of the Holy Book. According to this interpretation, infibulation is thought of as a religious obligation, with the procedure of cutting and closing being embedded in a Somalised Arabic vocabulary. This semantic veneer gives people an impression of religious sanction. For instance, the cutting of the clitoris, which is the first part of the procedure before the stitching, is referred to as *halaalays* (from the Arabic *halaa*, religiously clean). The cut is perceived as an act of purification, whereupon the women present ululate and rejoice (Talle 1993). Sometimes the whole intervention is spoken of as halaalays, a term that in the cultural context emphasises the humanising and gendered nature of genital cutting. A cut woman is considered a 'pure' woman (Talle 1993). The word sunna is also Arabic and means in 'the way of the Prophet' – in the sense of a good deed. The positive ring of sunna in religiously inclined ears may, at least as far as some of my informants in London were concerned, continue to legitimise the procedure. They believe that the term should be banned from the circumcision vocabulary altogether in order to fight the practice more efficiently. A difference between a learned and vernacular interpretation of religious scripts with regard to the issue of female circumcision has also been documented in Orthodox Ethiopia (Rye 2002).

In my sample, one educated woman from North Somalia who has been a refugee in Oslo, the Norwegian capital, for almost 20 years, was very explicit concerning the relationship between infibulation and Islamic dress code. "You see," she said, "the reason for the changed clothing practices is exactly the same as for rejecting infibulation. Before we did not know that infibulation was *haram* (forbidden by religion) and we did not know that complete covering of the body (except for hands and face) was religiously commanded. So religion has now taught us both things." The situation is, of course, more complex than the one depicted by this woman. Her argument is, however, illuminating and, curiously enough, she makes the connection between infibulation and Muslim social practices in much the same way as did my Somali male colleague many years ago. She drove her point home by arguments of religious enlightenment and community, while he pointed to a cultural difference between Arabs and Somalis which was commonly portrayed in Somalia at the time.

One may ask whether the practice of veiling has something to do with infibulation? Perhaps not directly as a causal relation – one being the cause of the other or vice versa – but in the shifting context of exile, there may be a possible connection. It appears that the protective and enclosing character of both practices makes considerable sense to Somali women (and men) in the diaspora. All the women in the Norwegian study, except for the youngest three, had been circumcised and, apart from two, with infibulation. For the women of this study – circumcised at home and now living as immigrants in foreign lands – it was not a question of choice between veil or circumcision, as indicated in my male colleague's quote above. The majority of them were both circumcised and veiled.

Marking by pain

Until very recently, infibulation, or Pharaonic circumcision, has been performed on almost 100 per cent of Somalian women[9]. The closed vulva has been a sign of distinction in Somalia and elsewhere where infibulation is practised (for example Boddy 1982); it is believed to enhance female fertility, add to a woman's beauty and secure her (and her family's) moral standing (Talle 1993). It is also held to protect the nomadic girl against dangers, particularly against ill-willed males – epitomised in the unruly camel herder who is deemed a potential rapist. Hence, in possession of a closed vulva, a young woman could roam around freely with the flocks of sheep and goats (the responsibility of women within the nomadic production unit), collect water and firewood in far-away places and go to the market to sell milk and purchase goods. With the bodily seal intact, a young woman did not have to be confined physically, as observed by my colleague. (A pragmatic point is that a nomadic lifestyle requires mobile individuals.) It was common to hear people in Somalia claim that a 'sewn girl' (*gabar tolan*, or *qodob,* 'closed') could not be raped. In fact, this reason was occasionally given as an explanation for the continuation of the practice.

This radical marking of women's bodies at the hands of close relatives and in extreme pain (often violence, as the girls had to be held forcefully) was reckoned a necessary act in anticipation of marriage and what is culturally understood as a

complete life (Talle 1993). Following the late French anthropologist Pierre Clastres' article 'Torture in primitive societies' with reference to initiation rites in South America, the outrageous pain inflicted on young girls during the operation is an inscription of societal (patriarchal) power as well as an act of social inclusion – by sustaining the pain, you become one of 'us' – neither more nor less. The 'law' is inscribed directly on the body through a painful mark (Clastres 1982). Every Somali woman carries a circumcision tale of her own, and the memory of that pain inscribed in the infibulation scar connects her with a social group, a country and a common identity. Pain and infibulation is one and the same thing for women in Somalia; in fact, the link is so obvious that it does not have to be spoken aloud[10]. The memory of the pain is forever fixed in a bodily scar (Clastres 1982). "How can I forget that day which had so much pain," said a woman in Mogadishu when I asked her whether she remembered her own circumcision or not. The circumcision pain appears to linger on in women's lives, and repeatedly surfaces in feminine bodily problems of chronic abdominal pain and ailments (Johansen 2002; Rymer and Momoh 2005; Talle 2007; Tiilikainen 1998). Many years later, in the exile context of London or Norway, the painful intervention on their bodies when they were still very young is brought to mind in diffuse and contradictory feelings of shame and otherness, and sometimes leads to opposition against cultural practices. The newly experienced negative attention on their infibulated genitalia may evoke both pain and belonging to the place where the scar was initially carved.

Insecure lives

The exodus of Somali refugees to the West began in 1988 after the bombardment of the northern parts of the country by the Siad Barre regime. Some of the women in the Norwegian sample had been political refugees since that time whereas others had arrived much later on humanitarian grounds or through family reunion. Two of the women, reunited with their husbands only a year ago, were newcomers to Norway. When a full-blown civil war broke out in 1991, great numbers of people from all the parts of the country fled to neighbouring countries, in particular to Kenya, Ethiopia and Yemen. From these places many have moved on to Europe and other parts of the world (Al-Sharmani 2006). Until the present, people have been fleeing unrest and violence, which have continued to haunt the country.

The refugee condition is paradoxical in the sense that people who, in great distress, flee from conflict and violence are forced to find security in places that in their sheer otherness or difference are often experienced as 'insecure'. The lack of familiarity with language, religion, modes of conduct as well as landscape intensifies the feeling of loss and vulnerability inherent in displacement/emplacement processes. According to Liisa Malkki, who has studied Burundian refugees in Tanzania, the loss of "culture, place and history" as a consequence of sudden uprootedness has turned refugees into people without identity within the "national order of things" – they are "naked" in their humanity (Malkki 1995:12). Even after years in exile, refugees often continue to bear the stigma of (unwanted) 'outsiders' (Goffman 1963; Malkki 1995). A Norwegian sociologist studying young Somali immigrants in Norway reported that many of them frequently experience humiliation and racism in encounters with the majority (Fangen 2006). Many refugees also express sentiments of loneliness and a lack of unity with the people around them (Assal 2006). In Norway, I frequently heard women say "we greet them, but we do not associate with them," meaning their neighbours. Few of them had personal friends in the Norwegian community other than professional contacts; however, their relationships with social workers, teachers, nurses and employers were often close and friendly. Most of the time it was not that the women did not wish to socialise, it was just that they had little in common with Norwegians. Both parties (Somalis as well as Norwegians) seemed to be very aware of that and did not actively seek each others' company. The situation was quite similar in London. Several times when I visited women in their homes, I realised that I was the first 'British' woman ever to do so. The widespread tendency of Somalis (like many other immigrants) to shift home and seek the company of countrymen in order to avoid 'loneliness' reinforces isolation from the majority community (Lindley and van den Heer 2007). Statistics also point to a great degree of intermarriage within Somali communities, not least in Norway. The fact that the Somali diaspora has produced such large numbers of children encourages social self-sufficiency and helps people find marriage partners among their own ethnic group.

The context of exile (London, Norway or elsewhere in the West) locates the circumcised body (and the circumcised woman) within a universalising discourse of 'mutilation' (the abbreviation FGM – female genital mutilation – is commonly heard; see for example Toubia 1995; WHO 1998), thus transforming a harmful injury in the name of a social identity into a personal deficiency[11]. Getting rid of a dirty body part, which is how Somalis used to understand and appreciate the practice, has not purified the circumcised woman. On the contrary, in exile, the circumcised woman has been 'mutilated', she has 'lost' something that cannot be put back. Within the global FGM discourse, the difference between 'cut' and 'uncut' women is often articulated in an idiom of loss; by lacking vital body parts and, thus, being physically diminished, a 'mutilated' body is literally a body of less worth. In Somalia, in contrast, the severing of the outer genitalia rendered added value to the female body – the closed vulva was a sign of cultural distinction. There an uncut female body was the abnormality.

The uncertainty of Somali refugee women in exile and their acute and often distressed awakening to being 'different' is embodied in many ways – clothing, diffuse illness conditions, tense limbs and aching hearts (Rymer and Momoh 2005; Talle 2007; Tiilikainen 1998). As refugees and immigrants, Somali women experience considerable discomfort and lack of confidence because of living in what they frequently consider a

'hostile' and incapacitating environment. In London and Norway, many are forced into encounters and situations in which their own 'losses' are painfully revealed to them. In European places of exile, infibulated women are the subjects of great concern and marked attention from powerful institutions of governance, from the media as well as from the general public. Legislation, political action plans, education campaigns and medical treatment guidelines target circumcised women – all to their benefit, it would appear (see for example Leye 2005). However, the balance between focused and marked attention is delicate in this context. Uninformed comments and inquisitive questions, often in arbitrary social encounters and public spaces, contribute to an unpredictable and insecure life situation. During the interviews in Norway, it became quite apparent that women find the public exposure of their cut bodies intimidating. They feel that they cannot defend themselves, as they have no arguments against the stereotypical and stigmatising representation of their cultural selves. Withdrawal may be one strategy to cope with outside pressure.

In private situations, for instance consultations in hospitals and other shielded places, they may talk freely; it is the public exposure that marks them. The Somali women in Norway appeared to have more trust in the health system than those in London. All the women I interviewed in Norway emphasised that Norwegian doctors showed considerable understanding and care when treating them. The women reported that most doctors, in fact, paid little attention to their infibulation, for which women appeared to be grateful. Only two women (out of 33) mentioned controversial episodes. One recounted how a doctor had asked her what had happened to her genitalia, and whether she had burnt herself or not? She told him that she was from Somalia and had been infibulated, whereupon the doctor nodded affirmatively, but said little and continued treating her. Another woman had given birth in Oslo and had been asked by her doctor whether he could call in colleagues when she was delivering. She was in pain and did not have the strength to refuse, she said. However, once she had delivered and regained her senses, she became angry and asked her husband (who was present at the delivery) why all these people were at her bedside. She told him to send them away. (This incidence happened a few years ago and she narrated the episode with a playful hindsight.)

In London, in contrast, circumcised women more often complained about rude and harsh treatment from medical personnel (Ahmed 2005b; Morison 2004; Talle 2007). During discussions about their association with hospitals and health authorities, complaints regularly emerged and examples of what they considered ill treatment and abuse were given. One such example was from a woman who went to her local general practitioner and asked for a reversal of her infibulation scar[12]. Upon examining her, the doctor had asked her how it was that her vaginal entrance was not large enough for her husband? The woman took the doctor's words as a serious insult to both her own and her husband's personal integrity. Marwa Ahmed who has carried out a focus group study of Somali women in London on their experiences of being infibulated and living in the UK reports similar negative encounters between Somali women and health professionals (Ahmed 2005b). After quoting a few statements by informants, she continues "Such comments sadly were common, as pointed out by the women. Every time they were confronted by such remarks, they felt humiliated and ashamed" (Ahmed 2005b:114). Chalmers and Hashi, who surveyed the birth experiences of 432 Somali women in Toronto (all had undergone circumcision), found that 87.5 per cent reported that they received hurtful comments from their physicians, witnessing verbal and non-verbal expressions of surprise, being regarded with disgust, being asked for permission to call in a colleague and having no respect shown for their cultural preferences (Chalmers and Hashi 2000). It is hard to say whether the difference reported between Norway and the UK (or Canada) is a coincidence, depending upon research methodology, or whether it reflects different treatment standards and patient evaluation in these countries. The inequality of British society compared with that of Norway has been reported to have an effect on patient treatment (Dunkley-Bent 2005). Furthermore, the course of time may be of importance, as health professionals are gradually acquiring knowledge about female circumcision. My informants who had lived in Norway the longest observed this change. They claimed that health professionals "now understand the practice better." When Vangen et al. did research in hospitals in Oslo some ten years ago, they reported communication difficulties between Somali women and Norwegian health staff. These difficulties were mostly due to the language barrier as many of the immigrant women spoke little Norwegian or English (Vangen et al. 2002).

The relocation of circumcised bodies in exile places women as actors in shifting contexts of meaning and hegemonic power, which are of profound consequence to Somali female identity, perception of self and ability to act. The gaze of others becomes embodied, not that women automatically accept it, but when articulating personal experiences of pain, suffering and cultural discourses among themselves as well as in negotiation with others, they contribute to generating heightened reflection and revaluation of their own insights and given truths (see also Fangen and Thun 2007). "When I came to London, I just found myself against circumcision," said one. That was the explanation she felt she could give for suddenly coming to terms with her position against the practice. "We are fat because we are circumcised," said another, reducing the issue of their widespread overweight to their cultural heritage. When I countered her statement, she looked at me and asked rhetorically: "But why then are we so fat?" A woman in Norway used a drastic image to visualise her opposition to the practice: "I have lost a whole body part, it is only the wheel chair lacking and I am a handicapped person I have no sexual feeling," she concluded. The woman uttered the words just as we were about to leave the café where a few of us had been sitting for a couple of hours. Another, more timid woman in our company hurriedly seconded the last speaker, as she was busy folding her hijab tighter around her face in anticipation of outside exposure. "Neither have I, I only do it [sex] for my husband," she said in a matter-of-fact voice. I was struck by their directness about these inti-

mate matters, which in fact they had not been asked to volunteer. The processes of reflection and revaluation can obviously be both liberating and distressing at the same time.

The veil

The increasingly common practice of embodying the Islamic faith through style of dress among Somali women in diaspora (also recently in Somalia), compared with the situation before the war, can be considered as both protection against views from the outside and against looking towards far-reaching horizons. The 'veil' protects and encloses the female body and integrates Somali women, now living in a dispersed and heterogeneous world, into a recognisable unit. Their Muslim clothing must be regarded as a re-emphasis of their identity as 'true' Somalis, where the link between religious and ethnic identity is barely distinguishable (El-Sohl 1993). I argue that the Muslim dress code has become an ethnic marker (Barth 1969) that helps Somali women rework their feminine identity in the diaspora context. It expresses a heightened piety and dignity; in their religious cum ethnic performances, whether dress, prayers or conduct, women seek to appease God and ask for mercy for whatever wrong their people have done. During the last two decades, they have seen their country dissolve, being torn into pieces and fall into moral decay. They themselves in their transnational lives face substantial difficulties and problems but, at the same time, are also engaging in new opportunities (Al-Sharmani 2006).

Their religiosity is not only intensified in expressions and practices, but has also become more learned. The women in this study claim they have become more enlightened in religious matters. One woman used the expression 'civilised' to differentiate this process from a local interpretation of Islam to an understanding of Islam as a world religion. It is worth noting that orthodox Islam does not prescribe female circumcision, at least not the severe type traditionally practised by the Somalis. On the contrary, many Muslim groups in Europe criticise African Muslims for such non-religious practices. Through studying the Koran, Somali women are now learning that infibulation is not religiously commanded. The woman quoted at the beginning of this article who made the connection between infibulation and Islamic dress code referred to their increased knowledge of the religious texts in diaspora and how this recently acquired learning had practically effected their lives. To her, an educated woman married to a highly educated man, the new scriptural insight compelled action and change on their behalf (women in Somalia also claim the same; Talle 2008). As she and other saw it, veiling is just a natural consequence of this religious awakening. When we look at the Norwegian material, not only the adult women, but also the majority of their daughters wore the headscarf. For instance, in the two local communities in western Norway included in the sample, all the girls in the four families having daughters (ten families in all), except for one, were veiled. The girls not wearing the hijab were daughters of a former Koran teacher, who came from a minority and victimised clan in Somalia. The father was an enlightened and well-informed man (the mother had no formal education) and he made a point of not enforcing or trying to convince his daughters to cover themselves, neither had he circumcised them. The family lived in a rather isolated community and he regarded it as important that his three girls were fully accepted among their Norwegian classmates and the peers. Later, as the girls grew up, they would choose for themselves, he claimed. This man was openly critical of the 'conservative' attitude of one of his female Somali neighbours, whose eight-year-old daughter put on the hijab as soon as she got out of the house.

At one level, women (and men) adamantly claim that veiling is a voluntary act of the individual and that parents should not enforce it on their children. Donning the hijab is innately an expression of a person's relationship with God, and thus must be a willed act and spring from inner conviction. The hijab in terms of decent dressing mediates the relationship between women and God, and as such is a religious garment. In order to emphasise the voluntary aspect of veiling, women often give the example of two sisters who may employ different clothing practices, one wearing the hijab or even the jelbab while the other does not. Some mothers admit that they recommend that their daughters wear the hijab, while others are against it. "If you begin early, you will get used to it," said one woman in Oslo, regarding the point of getting into the habit of wearing a rather cumbersome outfit. Her point was that once a dress-code is 'habituated' (Hastrup 1995), it becomes natural and preferable. During a group interview in Oslo, I was struck by the fierceness of one woman scolding another for having too pragmatic and lenient an attitude towards the use of the jelbab, which she normally donned. This woman said that she removed the cloak at work because that was what her boss expected her to do. It was difficult to perform her work satisfactorily wearing heavy and bulky clothes. She herself had no problems with that. The other woman reprimanded her for not being pious enough in front of God and emphasized that God was more important than her employer. I heard other similar stories in Norway where women had to compromise their heavy clothing for work efficiency. During documented research I also heard many more pragmatic reasons for donning the jelbab; when wearing full-length outfits women did not have to worry about what clothes they wore underneath. In other words, it was a way of lowering expenses. Somali women may also cover themselves at some point in their life but abandon it later, or vice versa. One woman only began to wear the jelbab after she was divorced (before she 'just' wore a light headscarf), while another abandoned it because it was too tight around her head and gave her headache. The definition of private-public contexts and when to veil is not always straightforward. Furthermore, others talked about the nomads back home who dislike the jelbab, claiming that the unfamiliar and awkward sight scares the animals. Even though it is a contested garment, the jelbab is commonly used by Somali women in diaspora and by many at home. Because of its popularity among Somalis, compared to many other immi-

grant groups, it has come to identify a particular Somali fashion style (Koskennurmi-Sivonen et al. 2004).

"You just feel you have to, or the other Somalis will look at you as if you were indecently dressed, as if you were naked," said one woman in London about the recent change in style of dress. She was hinting at the pressure of a common morality, and also at the vulnerability of the exile situation. When she used the expression 'naked' she was referring to a new moral conceptualisation of the female body. However, she did not interpret what she termed a 'pressure' as an order or a directive; quite the opposite, she claimed, as do many others, that wearing the hijab or jelbab is a willed act chosen by the women themselves. Nevertheless, in the mosque imams tell women to dress decently and be devout Muslims, and Somali girls wearing Western clothes in public places report that they are frequently disciplined verbally by male passers-by for their 'non-Somali' appearance, often phrased in the words "from where are you coming?" Somali men in general, however, regard the hijab, and in particular the jelbab type, as non-traditional Somali dresses. If they do not oppose it as some do or defend it, they often display an indifferent attitude. Veiling is chiefly a women's issue.

Reconstructing identity

The insecurity and continuous exposure to foreign people and awkward questioning, coupled with the turbulence and grief of migration and the loss of home and disintegration of families, require 'protection' in a wide sense. 'Naked' in the quote above can also be interpreted symbolically in line with Malkki – Somalis in diaspora are nothing else than humans without a history and without a community (culture). By dressing decently in Islamic style, Somali women inventively craft an identity as "accepted others" within the "national order of things" (Malkki 1995).

To expose oneself to an insecure and 'hostile' environment is a precarious project. The exiled women handle their existential uncertainty by defending the body. The female body shrouded in 'non-conspicuous' clothes is hidden and turns inward but, simultaneously, is very outwardly visible in the ethnic landscape of London or Norway. The protective clothes draw boundaries between outside and inside, between 'us' and 'them', and define what counts in relations. A woman enclosed in a jelbab can more easily maintain distance from 'others' and avoid contact. Also, in Kenya where I conducted an interview study among Somali refugee women in one locality, the women in their jelbab or niqab (the latter was quite common there) constituted a contrast to the surrounding society, to the extent that the local children feared them. As noted above, it appears that the female Islamic dress has become a marker of Somali ethnic identity in many different social settings and situations.

To identify with Islam through clothes and practice creates a meaningful continuity in the discontinuous lives of Somali women. Somalia was Islamized in the tenth century and religion has always been a unifying factor in the country's otherwise divisive clan-based society. By re-emphasising their Islamic identity, Somalis attach themselves to a larger Islamic world and to the history of their country. In European exile, veiling can also be an expression of sympathy with a devalued religion and thus have wider political undertones (Ahmed 20005a), but this position was not consciously expressed by the women in this study. The way the veiling is practiced in exile among Somali women cannot automatically be regarded as a sign of oppression of women, as is often the case. It is as much a sign of female capacity to act and negotiate relations (Hastrup 1995; Watson 1994). In no way has the veil refrained Somali women in London or Norway from being outwardly active – in the labour market, in language classes, in voluntary associations or driving their own cars. It is a fact that in the diaspora context, women more often than men for various reasons have become responsible for feeding and supporting their families (see for example Al-Sharmani 2006).

In their exiled condition (even in their home country), Somali women have taken the lead in upholding an ethnic identity through a commonality in religion. In contemporary times, they are giving form to a specific Somali Muslim identity, and to that end the female body is an important instrument. The image of a closed woman continues to make great sense in the Somali consciousness – given the long-standing averse to and fear of the 'open' female body. Here I think the veil is of importance. The veil affords protection and comfort; it encloses the body and shields women against evil forces from the outside, and from the gaze of outsiders. In much the same way as with the infibulation of their genitalia, the more covered (the smaller opening), the better in terms of moral excellence. In Norway, I often thought that women in a jelbab demonstrated a more pious impression than those less covered. Other women also claimed that those heavily covered looked upon themselves as 'better' in terms of moral (religious) distinction. We may conclude then that if hijab is commanded by religion as a dignified way of dressing, more veiling is even more dignified.

By the act of being veiled in a capital city such as Oslo (or London), women maintain distance from those around them, both Muslims and others, and as they mark that distance outwardly, they craft their identities as Somali women. In that process of dichotomisation and boundary making, common cultural preferences and moral standards are generated. As a marker of religious devotion and piety, the veil protects women, their physical selves, against the outside world, as well as against infibulation, now being understood as an unreligious and 'bad tradition' (*ado xun*). For perhaps the first time in Somali history we see a relation between education (read enlightenment) and rejection of infibulation, the lever being religious knowledge. On the other hand, some very religious people may perform 'sunna' on their daughters, perceiving the intervention as an extra-religious practice, making them even more morally outstanding. Higher religiosity and performance of sunna may, under certain circumstances, go hand in hand.

I am not saying here that the veil substitutes for infibulation. It is not that Somali women change one for the other. The relationship is more complex than that. There are young women who

are not infibulated who wear the jelbab, both for personal and political reasons, and most of the women dressed in full-length cloaks in this sample are indeed infibulated. They were operated upon as young girls, often a long time ago, in their home country. However, the widespread use of the veil, I argue, is meaningful to Somali women: it helps them to pass through turbulent times and reconstruct a 'coherent image of self', linking them to each other in space and in history. Adhering to an Islamic dress code helps Somali women to retain an identity as dignified women, now living in a dangerous and threatening world (Ahlberg et al. 2004). It may be seen as a way of holding their worlds together. Their vulnerable position in the diaspora, their split families, the memory of pain inflicted on their bodies and their longing for a beloved country call for shelter in a broad sense. The moral excellence of Somali women, essential for upholding the social order, as it were, continues to be embodied, not primarily by carving human flesh, but by covering it.

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Notes

[1]During the 1980s I was involved in a research collaboration programme between the then Somali Academy of Sciences and Arts (SOMAC) and the Swedish Research Collaboration with Developing Countries (SAREC). Female circumcision was one of the many research issues included in the collaboration agreement. The colleague quoted interviewed men in Mogadishu on their perception of female circumcision.

[2]The material is based upon sporadic field sojourns in northeast London (Talle in press) and in-depth interviews with 33 Somali women of diverse age, level of education and length of residency in different parts of Norway. A preliminary report on the findings of this study has been published in Norwegian (Talle 2008).

[3]There are approximately 800,000 Somali refugees, 430,000 of them living in exile outside Somalia/Somaliland, many of them in Europe and North America (UNHCR 2006). Today, Somalis are spread more or less all over the world, and families are split between different countries and languages, and between exile country and homeland (UNHCR 2006, Farah 2000, Al-Sharmani 2006).

[4]The veil is a general term for hijab, the principle within Islamic teachings of female modesty. Hijab is regarded as a commandment from God and part of a larger code of (gendered) conduct which emphasises privacy.

[5]*Hijab* is a general term for decent dressing or veiling, but hijab also refers specifically to the headscarf, a piece of cloth covering the head and the neck. The *jelbab* (or *jilbab*) is the loose-fitting, ankle-length cloak. Both are usually worn in moderate colours: black, grey or brown. For more information on this way of dressing, see Koskennurmi-Sivonen et al. 2004.

[6]During the socialist regime of the late president Siad Barre (1969–1991) religious clothing was discouraged.

[7]Sunna used to refer to a mild type of circumcision in which only the clitoral hood or parts of the clitoris were removed. In recent years, and in many places, the term is being used in contrast to infibulation; while infibulation is considered a severe intervention, sunna is perceived as a milder one. A recent study among circumcisers in Hargeisa, Somaliland demonstrates that sunna may imply both clitoridectomy and stitching (Talle 2008; see also Gordon 2005).

[8]Recent interviews among circumcision practitioners in Somaliland (2007) and among Somali refugees in Kajiado district in Kenya (2008) also reveal widespread verbal opposition to the most severe forms of cutting (cf. Talle 2008).

[9]Infibulation was not practised among the artisans' and traders' families in the town states along the coast (e.g. Mogadishu, Brava). After independence in 1960, however, informants claim that individual families among these minorities were influenced by the majority (the nomadic clan families) and begun to infibulate their daughters.

[10]In the towns in contemporary Somalia and Somaliland, the operation is often carried out with local anaesthesia. The reason for the widespread use of anaesthesia is in part due to availability, but also the fact that parents claim that their daughters cannot tolerate the pain. Furthermore, operations under anaesthesia are held to be safer for the girl. In the countryside, however, infibulation continues to be performed without any kind of painkiller.

[11]I have written about this transformation from a 'complete' to an 'impaired' body in another context (Talle 2007).

[12]Reversal or defibulation of the infibulation scar has become an option for women in exile. It is carried out routinely on primapara, ideally between 20 and 25 weeks of pregnancy or upon delivery (Gordon 2005). Even young, unmarried women may ask for defibulation. The reversal is a quick operation, usually carried out at polyclinics under local anaesthesia and is usually free of charge (Momoh 2005).

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Sara Johnsdotter

Popular Notions of FGC in Sweden: The Case of Ali Elmi

Abstract

In 2006–2007, the Swedish citizen Ali Elmi Hayow was sentenced to prison for the female genital mutilation of his daughter. In this paper I argue that the popular understanding of FGC, seeing African men as the true perpetrators, rendered it impossible for this man to get a fair trial. The facts presented during court proceedings were interpreted within a radical feminist framework, and the political will to sentence a male for FGC made it possible to overlook this citizen's legal rights. The case is discussed in its specific social context and in relation to the wider social and political context of FGC in Sweden. I try to show that this case cannot be fully understood without the knowledge of Somali culture and that the court members, rather than aiming for a well-grounded understanding of the case, leaned toward popular and stereotyped notions of FGC as well as of Somali men and women. Ethnocentric ideas of family organisation also affected the outcome of the court proceedings. With more realistic preconceptions of the Somali practice of

Introduction

In June 2006 the Swedish Somali Ali Elmi was sentenced to prison in the district court of Göteborg, Sweden, for the female genital mutilation of his daughter in Somalia. In this paper I will argue that he was imprisoned without sufficient evidence to prove his guilt and that his conviction had to do with the political context of female genital cutting (FGC) in the West and the emotional power field surrounding this issue.

This story is complicated and full of sidetracks. For the purposes of this article I have to highlight some aspects while overlooking others.[1] In the field of law, there is a principle called *in dubio pro reo*: if there is doubt, let it be to the benefit of the defendant. In the words of a legal expert, "only the one who has broken the law is to be punished, not those who probably or likely broke the law" (Dreher 2005:16; see also Diesen 2002). I will argue that in Ali Elmi's case it was not even likely that the person sentenced committed the crime.

This article is an attempt to offer an understanding of the process that ended in the verdict of guilty. I start by relating the social context of the case and give a description of the court proceedings. Some factors that may contribute to an understanding of this whole process are suggested. The main purpose of the article is to show how popular notions – popular in the sense that they are contrary to scholarly knowledge – of FGC may have disastrous consequences for persons who have migrated to Western countries from settings where FGC is practised. The case raises issues of how enforcement of Western legislation banning FGM, a legislation created to protect migrant women and girls at risk of being subjected to the procedure, may unjustifiably penalise men in these groups, if applied in a politicized way.

The social context

Ali and his wife Safiya[2], who came to Sweden to marry Ali, got divorced in 2001, after ten years of living in Sweden as a married couple and the birth of four children. There are conflicting versions of what was their agreement on custody of the children. Ali says that the two families, representatives of their clans, met to negotiate the contents of the divorce and custody agreements. Then it was decided, he claims, that the two older children, Muna and Adam, would go with him to Somalia, and the two younger ones would stay with Safiya in Sweden.

Safiya, on the other hand, claims that all four children were supposed to live with her, but that she agreed that Ali could take Muna and Adam to Somalia for a few months in 2001. She says that he refused to take the children back to Sweden as promised. During a trip in 2002 she visited the children's school and filled in an application for Muna and Adam. A copy of this sheet was handed over by her to the Social Insurance Office. According to Swedish regulations, a parent can get child benefits for children living abroad if it can be proven that they go to a school equivalent to a Swedish school. A copy of the application Safiya filled in and a description of the school's curricula made it possible to release a sum of money that the Social Insurance Office had held back since Muna and Adam had been away from Sweden for such a long time.

In September 2002 Safiya reported Ali to the police for a crime called "dealing arbitrarily with a child." She says that she went to Somalia in the summer of 2002 to collect her children, but that she was prevented from doing that by Ali's family members and a group of armed men. In October 2002 she took back this report and said that all the misunderstandings between Ali and her had been resolved. This was a couple of days after the Social Insurance Office had decided that the children's school in Somalia was approved and that they were going to start paying child benefits for Muna and Adam to Safiya again. She was also given the accumulated child benefits that had been withheld for six months.

There are conflicting versions about what happened in Somalia in 2005. Ali related in court how everything was fine with Muna and Adam until late 2004. Muna, then twelve years old, changed:

When it comes to my daughter Muna, she used to do well in school, she had no problems. She was happy. But I could see that something was wrong with her in 2004. I asked her, "What's the problem?" She didn't want to tell. In the end of 2004, she disappeared. She was away for two days. And then she called home and said that she was in Mogadishu, in a place called Qaran. She said that she was in the home of a [girl] friend. We went to collect her. I told her, "You should stay here, you shouldn't be out, it's not good for you." She was really sad; she didn't want to tell us much. But I realized that she hid something. I asked her several times what had happened… She used to have a healthy appetite, she used to sleep well at night, she used to do her homework. She usually woke up at six, brushed her teeth, went outdoors to wait for the school bus… but [now] she cut class. She didn't want to go to school. She listened to music all the time. She wanted to watch TV all the time. She didn't want to have dinner. She used to say that she had stomach ache.

[Ali in district court, June 2006]

In March 2005, according to Ali, Muna said to him that she wanted to talk to him. "Daddy, I know that you love me lots and that you always take care of me, but I want to know if you really love me." Ali asked her to tell him what has happened, and she said that she was no longer a little girl and that she wanted to marry. Ali was shocked, he says. She asked Ali if he knew of a journalist who is famous for hosting children's programmes on TV and radio. "Daddy, I really do love him. I want him to come here and visit us." Ali replied, "Stop this nonsense, you are only twelve years old. You have to wait until you are of age." Muna cried.

Relatives of the journalist, here called Khalid, called Ali and asked for permission to visit him, and Ali said no. Then they called Ali's brother to convince him (in Somalia, courting of this kind often involves entire families). Ali and his family agreed to a meeting. There Khalid's family offered 1,000 American dollars in *yarad*, bridewealth to Muna's family, if Ali agreed to let the couple marry. Ali refused.

In July 2005, Muna ran away. Ali and his family had no idea where to look for her. A few weeks later they found a few things in a bag in her room: a cassette tape where Khalid talks about how much he loves Muna and that he wants her to run away with him to the Swedish embassy in Addis Ababa. They also found a letter suggesting that Muna had agreed to this plan. Ali sent a fax immediately to the Swedish embassy in Addis Ababa, but there was no reply from the embassy.

When Muna and Khalid arrived at the Swedish embassy, she accused her father of several things. She claimed that he had beaten her and abused her psychologically for years, that he had threatened her with a gun, that he had sent her to jail for some time, that he planned to marry her away by force, and that he had had her circumcised. Further, she was not allowed to socialize with friends or to watch TV. Later police interrogations with her younger brother Adam, twelve years old, contradicted this description of their life in Somalia. For instance, he could easily name several of Muna's friends that she used to spend time with.

Ali then received the news that Muna was alive and safe in London. Swedish authorities arranged for Muna to go to her mother. Later that year Ali received a summons regarding custody. Safiya wanted to be the sole legal custodian of all four children. In the documents that reached him in Mogadishu it was stated that he was suspected of FGM. Ali left Somalia for Sweden to partake in the legal proceedings. He knew that he was accused of having had his daughter circumcised. He did not worry about that at first, as he was sure that his daughter was not circumcised. But then, a physician's examination indicated that she was, and that made him upset. Ali then tried to find out when his daughter had been circumcised. He realised that this must have taken place many years ago, when Muna was four or five years old and his ex-wife and mother-in-law wanted to have her circumcised together with Safiya's younger sisters. He did not give his consent then, and there was a serious conflict. He had stayed at a friend's apartment for a couple of months before reuniting with his wife. Since then, he had not heard anything more about circumcision and had always thought that it had not been done to Muna.

Arriving in Sweden, Ali was detained. A district court sentenced him to four years' imprisonment for holding Muna and her younger brother in Somalia against his ex-wife's will and for FGM. The Court of Appeal issued the same verdict. The Supreme Court dismissed the prosecution regarding the

children being held in Somalia and referred the case back to the Court of Appeal. There Ali was sentenced to two years in prison for FGM. In July 2007, Ali was conditionally released after having served two thirds of his penalty.

The court proceedings

In court, word stood against word. Medical examination showed that Muna had gone through a milder procedure, type II, "loss of tissue of parts of the inner labia, in the area around the clitoris, and loss of clitoral hood." It was not possible to establish when the circumcision had taken place. The only evidence to prove Ali's guilt was his daughter's statement that her father was involved when she was circumcised. Ali denied. In the first interrogation Muna said that the circumcision took place in January 2005, and that her father and her father's sister (here she will be called Meriam) were present with the circumciser in the room during circumcision. Ali's sister Meriam went to Sweden in July 2006 to support her brother's testimony. She turned herself in to the police in Gothenburg, knowing that she too was accused of FGM. She was detained immediately and stayed detained for four months.

There was, however, no prosecution against Ali's sister Meriam. Muna, when pressed during an interrogation in August 2006, admitted that her father's sister was not present during circumcision:

Policewoman: Well, then we have three persons in there and you lying in the bed, that you have said, and then we wonder about Meriam, was she in the room or was she not in the room?

Muna: I can't say she was there and I can't say that she wasn't.

Policewoman: No. Do you remember what you said about Meriam in the first interrogation, do you remember that?

Muna: Mmm.

Policewoman: Then you said that Meriam was there.

Muna: Don't know.

Policewoman: You don't know. Do you know why you said so then?

Muna: Because I hate her.

Policewoman: You hate her.

Muna: Yes.

Policewoman: Mmm, was that why you said so?

Muna: Maybe.

Policewoman: It is really good that these things emerge now. In what ways do you hate her?

Muna: I just hate her, I don't know.

Policewoman: What is the reason that you have said that she was there…? That you said that she was in the room when you in reality don't know if she was there, please explain that one more time. Can you explain one more time why you said in a previous interrogation that she took part in the genital mutilation, but that you actually are not sure about that, can you explain why you said so about Meriam?

Muna: Because I hate her.

Policewoman: What, what did you think of when you told me during interrogation that she was there; what did you think then? What did you want for her to happen since you hate her so much?

Muna: That she would die… I actually wanted her to die.

Policewoman: What has she done to you since you hate her so much?

Muna: I don't know. I hate her like hell.

[Interrogation record from the police, 7 August 2006]

Figure 1. Major contradictions in Muna's statements during interrogations.

	Date of circumcision	Present during circumcision
Interrogation I March 2006	January 2005 (possibly autumn 2004)	Ali, Ali's sister, circumciser
June 2006: Ali is sentenced to prison in district court		
Interrogation III August 2006	Muna has "forgotten everything" (possibly August 2005)	Ali, Ali's wife, circumciser
October 2006: Ali is sentenced to prison in court of appeal		

The background of Muna's negative feelings toward her aunt Meriam has been revealed in a previous interrogation (in March 2006):

Muna: And that woman, my father's sister, she will see one day what I'll do to her.

Policewoman: How do you feel?

Muna: I hate her at the moment; she will see one day what I'll do to her.

Policewoman: What will you do?

Muna: I don't know, but she'll see.

Policewoman: Are you more resentful toward her than to the women who did it [FGM] to you?

Muna: Her.

Policewoman: The woman who did it?

Muna: No, my father's sister.

Policewoman: Your father's sister?

Muna: Yes.

Policewoman: Is it toward her you are that resentful?

Muna: Yes, and my father, both of them. And she used to tease me every day.

Policewoman: What did she say then?

Muna: Tease me, and… "she looks for boys all day," "she is," how do you say it, "a whore." She constantly teases me.

Policewoman: Does she say that you are a whore?

Muna: Yes, she and her mother. And now that she came back to Sweden, she told other women who live here in Sweden, that I, I, that I am a whore.

Policewoman: Did you hear her saying that?

Muna: Yes.

Policewoman: Who did you hear it from?

Muna: My mother came one day […] and she cries… she said "your father's sister tells all the women that you are a whore."

[Interrogation record from the police, 27 March 2006]

The Court of Appeal was faced with a problematic situation when Muna withdrew her allegation against her aunt. The only evidence against Ali that the prosecution could present on the charge of FGM was Muna's statements. Consequently, high credibility was required of Muna. How was the fact that Muna took back her initial statement handled in the Court of Appeal, where it was insisted that Muna was reliable?

Muna's reliability was discussed in the verdict:

Muna speaks comprehensible Swedish, but it is obvious that her ability to express herself in Swedish is limited and that she sometimes has problems understanding the exact meaning of the questions asked in Swedish. The interpreter intervened occasionally during the last interrogation. […] It is clear from the interrogation that Muna is spiteful toward Meriam NN.

The court notes that Muna's statements about Meriam's participation [during FGM] are not exact enough, given what was said above about Muna's lack of proficiency in Swedish, to draw the conclusion that Muna actually claimed that Meriam NN was physically present during the genital mutilation.

[Verdict from the Court of Appeal, October 2006]

During interrogations Muna claimed 19 times that her aunt Meriam was present before she took it back. Further, her words expressing her feelings towards her aunt, "I hate her like hell" ("*jag hatar henne som bara fan*") was a rather advanced phrase showing a good linguistic competence in Swedish.

In the first interrogation Muna's statements gave the impression that she was circumcised by Meriam and her father in August 2004, but later during the same interrogation she said that she was absolutely sure that the circumcision took place in January 2005. In the last interrogation five months later, she "remembered nothing" about that point in time. When pressed, she said that she thought the circumcision took place in the summer of 2005.

Muna's description of the circumcision itself was short and yet full of contradictions: for instance, she said Ali had held her down by pressing her chest. In a later interrogation he had only held her knee. Her story is ended by a blunt "and then I went to the bathroom," "I went to pee." This description of peeing directly afterwards does not resemble the descriptions given by other women of their circumcisions. They usually emphasise the pain and agony of peeing, or even the inability to urinate. It seems harsh to say, but Muna's story lacks detail to give it credibility.

Partial court?

Was Ali sentenced beforehand? The presiding judge is expected to be impartial (in contrast to the defence and the prosecutor). However, there are reasons to question whether the judge in district court complied with his duty in this regard. There were several occasions during proceedings when he spoke to Ali in a way that reveals that he has made up his mind beforehand. One example out of several:

Ali [giving a complex explanation to why Khalid arranged a false passport for Muna]: They wanted to go to Ethiopia. Do you understand?

The judge: Elmi [Elmi is Ali's second name], you talk to me in a way as if you try to convince me. I have listened to Muna, we have all listened to what Muna said. This is not any…

Ali: I have told the police…

The judge [in an angry voice]: Yes, but I do not want you to talk to me like that. Like I should understand that what you say…

Ali: No, no. I did not mean to.

The judge: I certainly hope so.

Ali: I am so sorry. I didn't mean to.

[District court, June 2006]

The judge never spoke to Safiya in a sceptical or scornful way. Muna's contradicting statements did not seem to lead to the conclusion that she might not be reliable or trustworthy. Safiya, it seems, could change her statements many times without being questioned about it by anyone save for the defence attorney.

Another remarkable detail in the legal process was a testimony labelled *supporting evidence* in the district court verdict: Muna, "shaken," was said to have told a secretary at the Swedish embassy in Addis Ababa "that she had been genitally mutilated by her father and his sister" (district court verdict, June 2006). In reality, what this secretary had actually said in her testimony was:

The prosecutor: Did she say something else about the genital mutilation, who… what happened?

The embassy secretary: She told… well, she did not tell me, I think she told the doctor, because the way I remember it, I think I read in the doctor's report that it was performed by a woman. But that she told the doctor. Not me.

[District court, June 2006]

Scrutinizing what questions were asked and what questions were not asked of the leading actors of this court case, we get the overall impression that Ali Elmi was not given a fair trial.

What the court members were unable to understand

There are some details in the verdict and in the case that stand out to an anthropologist. I am going to discuss a few of them here.

Somali fathers' unthinkable presence

Somali fathers are not present during the circumcision of their daughters. I have found no case described in the literature where a Somali father was present in the room, let alone holding his daughter during circumcision. Fathers are expected to keep away. Most Somalis I have asked so far say things like: "It is good that a father was imprisoned for FGM, for he should have protected his daughter from it. But… present in the room? No way!" Nobody has ever heard of a case where a father was present.[3] Given the improbability that a Somali father is present in the room during his own daughter's circumcision, such a claim would need hard evidence.

All women in the family of Ali's ex-wife are circumcised. In Ali's family, only his oldest sister (53 years old) is circumcised, his other five sisters are not. His parents were opposed to female circumcision. His wife, whom he married some years ago, is not circumcised. The social context points at a direction where it is unlikely that Ali would opt for circumcision of his own daughter.

When it comes to Safiya's family, Safiya is pharaonically circumcised. Safiya's sisters are also circumcised. If we believe that Ali's version is true, these sisters may have been circumcised in 1997, when Ali says that Safiya and her mother wanted to have Muna circumcised with them. If we are to believe the other side of the story, these girls were circumcised at birth in Mogadishu (as stated by Safiya's mother in an interrogation). Circumcision is not known to be performed on newborn babies. There is good reason to doubt what Safiya's mother claims in this respect. Hence, seen in a wider perspective, the risk for a girl to be subjected to circumcision is higher in Safiya's family than in Ali's.

"She says that I am a whore"

What does it mean when Muna says she hates her aunt because she had called her a "whore?" According to traditional Somali values, young women are categorised as either "good" or "bad" in a social and moral sense. Refraining from pre-marital sex is an important aspect of a girl's reputation. If she fails in this respect, all her family members – especially her mother, who is ultimately responsible for her daughter's education – will lose their good reputation and face malicious gossip (Johnsdotter 2002). In a Finnish study Salmela (2004) describes how Finnish Somali girls move around the town according to a "moral geography." There are places (cafés for instance) where young women should not be seen by other Somalis, since they may risk a bad reputation. If they are labelled "bad girls" or "whores," their families will suffer in the end.

It was a serious blow to Muna when her mother told her that her aunt Meriam had said to other Somalis that Muna was a whore. Her good name among the Swedish Somalis was at stake, with serious social consequences for her: She risked social exclusion from the group. Considering this, it is not surprising that Muna wished revenge on Meriam. Given the hostile attitude Muna expressed toward Meriam during interrogation, we can imagine that she achieved this revenge when she stated that Meriam was present during circumcision. Meriam was detained for six months.

Somali family organisation

When the authorities cut short the benefits paid to Ali's ex-wife, she initiated a dispute over custody and suddenly, after several years, claimed that Ali was holding the two oldest children in Somalia against her will. The court members took her side, and this, I argue, was due to their ethnocentrism.

Among Somalis, children are 'mobile' to a high extent (in anthropological literature the technical term is 'child circulation'). A child may grow up with the biological parents, but he or she may also spend his or her childhood in another family of relatives, or in several families. Children are sent between households for a host of reasons, from the countryside to the town, or the other way around. From Somalia to Sweden, or from Holland to Canada. Families may include several foster children, for shorter or longer periods (Johnsdotter 2007a; 2007b). This is a way of organizing family life that differs from the Swedish or Western way. In the Somali family system, there is nothing peculiar about a mother who lets her own biological children be raised by other people, most often relatives. In 'our' cultural construction of motherhood, family and family bonds, a mother letting her children go is a 'bad' mother. This is not the case among Somalis. Yet the court members were convinced of what is 'normal' and 'natural' in family organization – in fact, they seemed to see the Swedish ways as universally valid – and that made Ali's ex-wife seem credible when she claimed that Ali had held their children in Somalia against her will. I quote from the verdict: "That she willingly would

sustain from being with her two children during several years of their childhood, they being in a sensitive age, does not seem very plausible." Ali's ex-wife benefited from the fact that the court members held ethnocentric views of family life. Obviously, they had no idea of how these issues are culturally constructed, or that Swedish ideals may not be universal. Consequently, when Ali assured that they had agreed on this arrangement with the children, they did not believe him.

How could it happen?

Yet there is something strange about this case that makes it hard to grasp. Most Swedes probably agree that in the Swedish legal system, the defendant should be given the benefit of a doubt, *in dubio pro reo*. So, how come was this principle downplayed in the trial? Why was Ali sentenced to prison with no other evidence than statements from a young and angry teenager who proved that she may not be that reliable after all? I propose four possible explanations for Ali's conviction without sufficient evidence to prove his guilt.

I suggest that popular explanatory models of FGC played an important role. What did the court members know about this custom? That it is a patriarchal attack on women. That it is what African fathers do to their daughters. When the practices of female genital cutting in Africa were introduced to the public in the West at the end of the 1970s, the whole issue was framed within a radical feminist explanatory model. The key actor was the American activist researcher Fran Hosken, who coined and propagated the phrase 'female genital mutilation' to replace the less offensive term 'female circumcision.' I quote Fran Hosken here:

"FGM is a training ground for male violence. It is used to assert absolute male domination over women not only in Somalia but all over Africa" (Hosken 1993:5).

"[F]or African men to subject their own small daughters to FGM in order to sell them for a good bride-price shows such total lack of human compassion and vicious greed that it is hard to comprehend" (Hosken 1993:16).

"Somalia is the classic example of the results of male violence: the practice of infibulation as family custom teaches the children that the most extreme forms of torture and brutality against women and girls is their absolute right and what is expected of real men" (Hosken 1994:1).

Hosken's and other radical feminists' view of FGC became hegemonic and still is very influential when it comes to the public understanding of FGC. Men are seen as the real perpetrators behind all practices involving cutting of female genitals irrespective of women's agency (e.g. Daly 1979; Hosken 1993 [1978], 1994; Levin 1980).[4] Consequently, when a Somali father is accused of having circumcised his daughter, the system has to side with the young girl for political reasons. The popular view of FGM has its origin in radical feminist writings and it is firmly rooted in the public mind today. When Ali Elmi was prosecuted for FGM, the court members were not surprised that the defendant was a *man*. That was just what they expected.

The stereotypes of Somali men and women in Sweden are those of dominant, patriarchal men and oppressed women.[5] Somali women are in a sense reduced to being owners of mutilated nether parts, an assumed result of men's collective willingness to control women's sexuality (see e.g. Finmo 2008); their very appearance seems to evoke images of cut genitals. A Swedish journalist relates how he was made aware of his own prejudice, when he was about to interview women in a Swedish Somali association:

But how am I supposed to establish contact with the women from Somalia? Will they say anything at all? In several books I have read about the patriarchal societal system and about the pharaonic genital mutilation of the women. Will the Somali men perhaps prevent me from talking to the women? (Wingborg 2000:20–21).

After ten minutes, he says, he realised that his expectations lacked substance. Nobody prevented him from approaching the women and the women he turned to were really talkative.

A columnist of a Swedish newspaper stated that the civil war was partly due to the fact that women were genitally mutilated: "thus broken, physically as well as psychologically, the Somali women simply do not have the energy to work for social cohesion" (Jönsson 1993). In the debate that followed it was argued that Somali women are in fact pillars of their society and the real heads of the Somali family (Jama et al. 1993). A Swedish anthropologist specialised in Somalia and married to a Somali woman stated that:

It seems that Per Jönsson never met a Somali woman. He does not know anything about how she manages her husband and family with obvious authority. […] Few Somali women would concede that they are in any way inferior to the men. Surely they serve the men food first, apparently servile, but not until they have provided themselves with the most delicious pieces in the kitchen. […] Neither the Somali women as individuals nor the roles that the Somali society has defined for them have anything in common with the oppressed, secluded status that Jönsson ascribe to them (Helander 1993).

He relates that already in 1856 a British traveller, Richard Burton, described a Somali woman as "the cock of the roost," whose husband would hesitate to scold her; he had seen quite a few scared men slip off to avoid their wives' bitter remarks (Helander 1993). He ends his article arguing that Somali women are far from passively licking their wounds – they are remarkably strong: "So strong, in fact, that Somali men occasionally express some dreariness at their women's hectoring ways" (Helander 1993).

There may be a risk that the image of the strong-willed, dominant Somali woman turns into just another stereotype. Nevertheless, *that* stereotype was not even close to being at work during the legal proceedings involving Ali and Safiya. Whatever questions Safiya got, she had the possibility to escape accounting for her actions by saying that "Ali forced

me." Even when such a defence from Safiya was absurd, it seems to have been accepted in court. Safiya admitted during police investigation that she had lied to the Social Insurance Office about the date when their children moved to Somalia, because she was afraid that she would have to pay back undue benefits for six months. In court, she said instead that Ali had forced her to lie. Nobody but the defendant seems to have questioned this allegation, even though it is hard to imagine why Ali would have forced her to lie in a way that benefited only her (she got the financial benefits, not he), particularly as he was not even in Sweden when he "forced" her.

Prosecutor: Why did you say that they went away in January 2002?

Safiya [through interpreter]: Because when we quarrelled, he told me, "you tell the Social Insurance Office that the children left in 2002."

Prosecutor: So you were obedient then?

Safiya: Yes. Because my children were away, I was forced.

Prosecutor: You were forced.

[District court, June 2006]

Even the judge confirmed Safiya's version through utterances like: "it seems that you were rather dominated by Elmi and did what he told you to do…" (District court, June 2006).

Another situation where deeply rooted gendered stereotypes may have played an important role concerns Muna. In the videotaped interrogations Muna appears wearing a *hijab* (the Arab-inspired head garment). This fact probably evoked one of the most forceful stereotypes of today's Western world: that of young Muslim women living under hard pressure from patriarchal fathers. The fact that Muna gave conflicting statements seemed to be erased by the fact that she wore a *hijab*: the *hijab* made her stories about the cruel father plausible. And who wants to fail an oppressed young Muslim woman, member of one of the most vulnerable groups in today's Swedish society?

Lately, we have had a huge debate in Sweden concerning men who have been imprisoned for sexual abuse of their daughters or other young women. In several cases it has been proven at a later stage that the men have been innocent, and they have been released from jail and received damages.[6] The structure of these court cases has been similar to Ali's case: the men were sentenced although there was no other evidence to support their guilt beside the plaintiff's statements. According to the guidelines of the Prosecutor General, there should be no prosecution when supportive evidence is lacking (2002:3). Consequently, according to the guidelines of the Prosecutor General, in the case of Ali there should not have been a trial at all, since the evidence was too weak.[7]

It seems that in some legal cases, the usual standards of the legal system are downplayed. In this case of FGC, the emotional power field surrounding this issue was crucial. When we, as human beings, are deeply emotionally involved, our cognitive faculties are affected. FGC is experienced by most people in Sweden as a hideous crime. This is my personal guess: emotional turmoil made the court members abandon reason and their sense of fairness. They sentenced Ali, because someone had to pay for the fact that this young girl had been circumcised.

In governmental preventive work against FGM, criminalisation of the practice and legal procedures have been emphasised. France, with more than 30 cases of FGM taken to court since 1988 (Weil-Curiel 2004), has been held up as a model.[8] Sweden was the first Western country to legislate against FGM in 1982.[9] Even so, it took almost twenty-five years before the first case appeared in court. In 2006, both Ali's case and another one in the same city, Sweden's third largest city Gothenburg, resulted in custodial sentences.[10]

Most of the suspected cases of FGM reported to the police during these years have turned out to be unfounded. In quite a few instances genital examinations have been performed, sometimes in a compulsory manner and in conflict with the will of the parents. The amount of suspected, unfounded cases reported to the police shows a high level of alertness in the Swedish society and a general willingness to report (Johnsdotter 2004). This also indicates that estimates on how many girls are at risk of being subjected to FGM are clearly exaggerated (Johnsdotter 2002; 2007c; Johnsdotter and Essén 2005).[11]

The lack of FGM cases taken to court is generally not understood as a result of changed attitudes in immigrant groups due to migration, internal debates in these groups, or preventive work in state campaigns and among activists. The situation is rather understood in terms of a failure on the part of the Swedish authorities: if only the police, the prosecution, and the social authorities improved their efforts, all the clandestine FGM would soon be brought into the open. The lack of documented cases is seen as failing Swedish Somali girls.[12]

The detention and sentence of Ali in 2006 was a piece of news that spread all over the world. Writing his complete name in Google gives hits not only in websites in English, but also in Czech and Japanese. It is hard to know if the judge and the lay judges in the court rooms realised that Ali's case was of interest to people all over the world and whether this influenced their assessment of the case in any way. But the atmosphere surrounding FGM in Sweden and the political importance of a case taken to court probably made it more difficult to let Ali Elmi walk free. Finally there was an opportunity to jail someone for FGM, after more than two decades of legislation. And the world was watching.

Summary

Ali Elmi was sentenced to prison for FGM with no other evidence than his daughter's account which carried serious flaws. In this paper I have argued that there were some aspects of Somali culture that the court members did not understand, and that they were therefore unable to assess various components of the case. If they had had insights in Somali family organisation, if they had appreciated the full meaning of the social risks of being categorised as a "whore," and if they had had correct information on the role of Somali fathers in relation to circumcision of their daughters, they would have judged differently.

Other contextual dimensions are crucial if we are to understand the sentence Ali was given. The radical feminist explanatory model affects public opinions of FGM Given the popular understanding of African men as the true perpetrators, nobody was surprised to see a *man* accused of FGM. Related to such attitudes are Western notions of dominant and patriarchal Muslim men and oppressed women and daughters. Safiya's and Muna's accounts were never questioned in court, although their statements were contradictory. The flaws in their versions were overshadowed by the wish to make an example, perhaps even a political statement. Yet the sentence can not be fully understood unless we take the emotional dimension into consideration. FGM evokes such strong feelings that normal critical thinking seems to be put aside.

Ali was taken to court after almost twenty-five years of FGM-legislation. For years, key actors – activists, politicians and officials – had spoken of the necessity to get a case to court. Finally they succeeded.

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Notes

[1]The case is described in detail in Johnsdotter 2008.

[2]Fictitious name. All persons but Ali have fictitious names.

[3]This conclusion is supported by at least three international FGC experts: the Norwegian anthropologist Professor Aud Talle (personal communication, 26 May 2008) who has conducted research on FGC in Somalia for decades; the American anthropologist Professor Ellen Gruenbaum (personal communication, 7 Nov 2006) with extensive fieldwork experience in Sudan; and the American historian Professor Charles Geshekter (personal communication, 8 Aug 2007) who has worked for several years in Somalia and other African countries, FGC being one of his fields of expertise.

[4]Lately, there has been a growing critique of this oversimplified version of the logic behind FGC practices, not least among feminist scholars of African origin (e.g. Abusharaf 2000, 2001; Ahmadu 2000, 2007; Obiora 1997a, 1997b; Njambi 2004).

[5]For further discussion on the Western stereotype of the Somali woman as "chattel, commodity, and a creature of little power", see Ahmed (1993, 159).

[6]Several cases are described in the book *Felaktigt dömda* ["Incorrectly sentenced"] published by the Attorney General [Justitiekanslern] in 2006. Before the 1990s, Sweden practically lacked cases where people were sentenced at first, but later freed after a new trial. During 1992–2005 there were eleven such cases, the majority of them concerning sexual crimes.

[7]Guidelines from the Prosecutor General (2002-07–12, p. 3): "The central evidence in form of a plaintiff's account must be supported by other evidence, which can verify the information given by the plaintiff and this documentation must be of a kind that makes it possible to establish the course of events even when scrutinizing it afterwards, after a short or long period of time."

[8] The court cases in France have all concerned West African parents and circumcisers. In Sweden, a vast majority of immigrants from countries where FGC is practised are from East Africa.

[9]The Swedish *Act Prohibiting Female Genital Mutilation* [Lag (1982:316) med förbud mot könsstympning av kvinnor] reads: Section 1: Operations on the external female genital organs which are designed to mutilate them or produce other permanent changes in them (genital mutilation) must not take place, regardless of whether consent to this operation has or has not been given. Section 2: Anyone contravening Section 1 will be sent to prison for a maximum of four years. If the crime has resulted in danger to life or serious illness or has in some other way involved particularly reckless behaviour, it is to be regarded as serious. The punishment for a serious crime is prison for a minimum of two and a maximum of ten years. Attempts, preparations, conspiracy and failure to report crimes are treated as criminal liability in accordance with section 23 of the Penal Code. (Quoted from Rahman and Toubia 2000:219.)

[10]The other case concerns a Swedish Somali woman who was sentenced to three years in prison for FGM of her daughter (aged 16 at the time of the legal proceedings) and integrity violation. According to the account of the criminal act, the girl was circumcised during holidays in Somalia in 2001. Further, the woman had physically abused her daughter for years, and also repeatedly carried out genital examinations to check for signs of sexual intercourse. Records show that this woman had filed six reports to the police that her children had been raped.

[11]Nyamko Sabuni, minister of integration in the Swedish government, stated in 2006 that FGM "is often performed in Sweden: First and foremost, we need to reach a consensus that FGM is going on. Every week Swedish girls are mutilated" (interviewed in the morning paper *Sydsvenskan*, 1 October 2006). Needless to say, she has not reported any case to the police – a duty according to the Act on FGM, which states that failure to report information about cases of FGM is an offence.

[12]See e.g. the Barnombudsmannen, *ombudsman* for the children, in a debate article (Lena Nyberg, *Göteborgs-Posten*, 18 January 2002).

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Work of the World Health Organization on Female Genital Mutilation: Ongoing Research and Policy Discussions

Female genital mutilation (FGM) involves "the partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons" (WHO 2008). FGM is a deeply rooted traditional practice prevalent in more than 28 countries in Africa and in some countries in Asia and the Middle East. Between 100 million and 140 million girls and women living in the world today have been subjected to this practice, with about 3 million girls undergoing the procedure every year (UNICEF 2005).

Within the United Nations system, the World Health Organization (WHO) has the responsibility for providing leadership on global health matters. Recognizing the scale of the problem of FGM, and the severe health consequences and suffering associated with it, WHO has set itself two objectives:

- to advocate vigorously for the complete abandonment of FGM; and
- to ensure that the girls and women who have undergone FGM receive adequate care to prevent and treat all health-related sequelae of FGM.

The major activities undertaken by WHO in support of these objectives include: generation of sound evidence through research for informed policies; advocacy; setting of standards for health care; development of guidelines aimed at health-care professionals; and provision of technical assistance to countries. WHO Headquarters as well as the relevant regional and country offices all contribute to the coordination and implementation of these activities. This paper focuses mainly on the work carried out at WHO Headquarters.

Advocacy, policy support, and standards

For any idea to be put into action successfully, the actors involved (policy-makers, programme managers, communities and individuals) first need to be informed and convinced. Then, based on local needs, the responsible authorities need to develop informed polices for action. The specific actions (especially health-care provision) themselves then need to be standardized to ensure uniform, measurable results. In the area of FGM, WHO supports countries in all these steps.

In support of advocacy against FGM, WHO supports and conducts epidemiological as well as social scientific research as a first step. Then, in collaboration with Members States and international partners, the knowledge generated through research is packaged and disseminated widely (via publications, the mass media, at meetings, etc.) for maximum impact.

Advocacy and policy development are closely linked and are largely carried out in, and by, the countries where FGM is actually practised. Hence, national governments play a crucial role in both. A particularly important aspect of this work is building consensus among national and international players so that actions at local and international levels can be coordinated. The required consensus for action is build through the organizational structure of WHO – e.g. through the deliberations and resolutions of the World Health Assembly (and other international forums such as the United Nations-sponsored meetings) in which Member States actively participate. Achieving consensus is critical to securing political commitment from affected countries.

History of WHO's work in the area of FGM

At the international level, discussions on elimination of FGM began in the early 1960s. It appears that originally the United Nations system and WHO were hesitant to take up the issue of FGM. At that time knowledge about the practice was very limited. The international organizations regarded FGM as a culturally sensitive topic that was best dealt with directly by the affected countries themselves. The organizations believed that international pressure on those countries might provoke defensive and counterproductive reactions.

However, gradually the FGM-affected countries themselves began to question the practice and started to request international assistance to deal with it. Then, as knowledge about the health risks associated with FGM expanded, WHO decided to tackle the practice directly. The meeting in Sudan in 1979 set the issue of FGM firmly on the international agenda, and WHO, together with the rest of the United Nations family, began to pursue elimination of the practice in earnest. Nearly 30 years on, WHO work in the area of elimination of FGM saw its culmination in May 2008 when the 61st World Health Assembly for the first time adopted a resolution specifically targeting FGM.

In the years that followed the Sudan meeting, WHO passed two resolutions: the first was adopted by the WHO Regional Committee for Africa in 1989, and then in 1994, the World Health Assembly adopted a resolution against harmful traditional practices, which included FGM. Both these resolutions urged all Member States to establish policies to eliminate the practice. Following these resolutions, WHO developed a series of documents (political, scientific as well as guidelines) to assist countries and to secure health care for girls and women suffering the health consequences FGM.

In 1997, WHO, together with United Nations Population Fund (UNFPA) and United Nations Children's Fund (UNICEF), issued a joint statement on FGM. This was the first internationally accepted document to set standards related to FGM: it defined FGM within the framework of human rights and as a health issue and classified it into four categories based on the degree of mutilation. The statement also outlined the most promising interventions for abandonment of the practice.

Recent work

In recent years there has been a significant increase in local, national and international initiatives to eliminate FGM, which has now come to be recognized internationally as a violation of human rights. Policies and legislation to prohibit the practice have been put in place in many countries, and there is growing support in many communities for discontinuation of the practice. A wide range of research projects has helped to increase information about the practice itself, the reasons for its continuation, its health consequences and which interventions work in the prevention of FGM.

However, in spite of these successes, the rate of decline in FGM has been slow. Also, some setbacks have been documented. Of particular concern to WHO is the growing trend towards medicalization of the FGM – i.e. FGM is increasingly being performed by health-care professionals in bid to make the practice "safer." This includes reinfibulation (the closing again of the vagina after, for example, delivery), which has been shown to be harmful to women's health; in some countries reinfibulation is partly driven by health-care professionals who wish to be "culturally sensitive."

The slower than expected rate of decline of FGM, the menace of medicalization of the practice, and the realization that investment in this issue remains inadequate, have all spurred WHO to reinforce its efforts, commitment and resources to the goal of eliminating FGM within one generation and to ensure health care for all girls and women affected by it. One important result of WHO's reinvigorated efforts has been updating of the joint statement published in 1997 (WHO 2008). Publication of the new expanded statement in 2008 was coordinated by WHO with the participation of nine United Nations agencies: Office of the High Commissioner for Human Rights (OHCHR); Joint United Nations Programme on HIV/AIDS (UNAIDS); United Nations Development Programme (UNDP); United Nations Commission for Africa (UNECA); United Nations Educational, Scientific and Cultural Organization (UNESCO); UNFPA, United Nations High Commissioner for Refugees (UNHCR), UNICEF, and United Nations Development Fund for Women (UNIFEM). The support and commitment of these agencies to the elimination of FGM highlights the fact that FGM is now seen as a much wider, social and human rights issue rather than merely a health issue.

The new statement summarizes findings from research on the reasons why the practice continues. It argues that the practice is a social convention which can only be eliminated through coordinated collective action by the practising communities. It also presents recent epidemiological research on the harmful effects of FGM on the health of women, girls and newborn babies (WHO 2006). Drawing on experience from interventions in many countries, the new statement describes the elements needed, both for working towards complete abandonment of FGM, and for caring for those who suffer from its consequences. Also included in the statement are updated estimates of the number of girls and women currently living with the consequences of FGM, as well as amendments and further descriptions of the types of FGM. The latter are designed to improve the accuracy of a wide range of research studies, especially those that document direct relationships between types of FGM and health risks, and those that monitor changes in FGM practice by type.

The WHO classification of female genital mutilation

A classification of FGM types was created for the first time at a WHO technical consultation in 1995 (WHO 1995). As Annex 2 in the new interagency statement on FGM (WHO 2008) explains, this classification was deemed necessary for purposes such as: research on the effects of different forms of FGM; collection of data on the prevalence and changing trends in FGM practice; gynaecological examinations and management of health consequences of FGM; and for legal use. While such a classification as can assist with comparability of data sets, it inherently involves grouping of variations into a few simple categories, and therefore cannot be expected to cover the vast number of variations in actual practice. To see if some of the limitations of the existing classification could be overcome, WHO convened a number of consultations with technical experts with a view to reviewing the classification and evaluating possible alternatives. Experts at these consultations concluded that although available data were insufficient to propose a brand new classification, some of the wording of the current classification could be slightly modified; they also recommended the creation of new subdivisions in order to capture more accurately the wide range of FGM procedures.

Genital practices should be classified as FGM depending on whether they infringe a human right, including the right to health, the rights of children and the right to non-discrimination on the basis of sex. Some genital practices – such as those classified under Types I–III, in which genital tissue is removed

Table 1. Comparison of the 1995 and 2008 classifications of FGM types (WHO 2008; WHO 1996).

Original classification, 1995	Revised classification, 2008
Type I: Excision of the prepuce, with or without excision of part or the entire clitoris.	**Type I:** Partial or total removal of the clitoris and/or the prepuce (clitoridectomy). When it is important to distinguish between the major variations of Type I mutilation, the following subdivisions are proposed: Type Ia, removal of the clitoral hood or prepuce only; Type Ib, removal of the clitoris with the prepuce.
Type II: Excision of the clitoris with partial or total excision of the labia minora.	**Type II:** Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). When it is important to distinguish between the major variations that have been documented, the following subdivisions are proposed: Type IIa, removal of the labia minora only; Type IIb, partial or total removal of the clitoris and the labia minora; Type IIc, partial or total removal of the clitoris, the labia minora and the labia majora. Note also that, in French, the term 'excision' is often used as a general term covering all types of female genital mutilation.
Type III: Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).	**Type III:** Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris infibulation). When it is important to distinguish between variations in infibulations, the following subdivisions are proposed: Type IIIa, removal and apposition of the labia minora; Type IIIb, removal and apposition of the labia majora.

(usually in young girls) – clearly violate several human rights. However, what practices should be included under Type IV category is less straightforward. That category originally covered a range of less well studied practices (pricking, piercing, incising, stretching, cauterization, scraping, etc.), and as such was not a clear-cut FGM type. Many researchers had been critical of classifying some of these practices as FGM. For this reason, the new classification has a wider definition for Type-IV category. The definition leaves room for further discussion on this matter, proposing inclusion of such practices into the classification on a case-by-case basis as more information becomes available. For a more detailed discussion of the rationale behind the definition of Type-IV category, readers are referred to Annex 2 of the new interagency statement (WHO 2008).

Introduction of harmful substances into the vagina is another genital practice that has been found in several countries. Like genital practices, in this case too there are a large variety of reasons and potential health hazards. WHO is currently supporting a study in several African and Asian countries that looks into the prevalence of such practices, reasons for their continuation, and health risks associated with them (Bagnol and Mariano 2008). Generally, these practices are performed regularly by adult women on themselves for either cleaning the vagina before or after sexual intercourse or tightening and strengthening the vagina to enhance their own or their partner's sexual pleasure. The consequences and health risks related to these practices depend on the substances used, as well as on the frequency and technicalities of the procedures (McClelland et al. 2006). Though the insertion of harmful substances could be considered as a form of genital mutilation, particularly in the case of practices that are associated with health risks and performed under high social pressure, they are no longer included among the examples of Type-IV FGM.

Collection of baseline data and development of guidelines and manuals

WHO conducts research to fill gaps in knowledge, especially on the prevalence of FGM, on its health consequences, and on interventions to help eliminate the practice. Evidence-based data are then used to develop guidelines and manuals to assist countries with the formulation of policies and interventions.

In 1999, WHO compiled baseline data on FGM and published it in the form of a review of the best approaches for elimination of the practice (WHO 1999). Data from this review were subsequently used to developed a handbook for frontline workers with practical guidelines on how best to work against the practice (WHO 2000).

Another major activity was the publication of a systematic review of health complications of FGM, including sequelae in childbirth (WHO 2001a). This review formed the basis for the development of a series of manuals and guidelines directed at health-care professionals: *Female genital mutilation: integrating the prevention and the management of the health complications into the curricula of nursing and midwifery, a teacher's guide* (WHO 2001 b); *Female genital mutilation: integrating the prevention and the management of the health complications into the curricula of nursing and midwifery – a student's manual* (WHO 2001 c); *Female genital mutilation: the prevention and the management of the health complications, policy guidelines for nurses and midwives* (WHO 2001d).

Research on obstetric outcome in women who have undergone FGM

Between 2001 and 2003, WHO carried out a large multicentre, multicountry study to explore the effects of different types of FGM on a range of maternal and neonatal outcomes during and immediately after delivery. The study involved 28 393 women attending 28 obstetric centres in Burkina Faso, Ghana, Kenya, Nigeria, Senegal and Sudan. The systematic review, mentioned above, had demonstrated that previous evidence on the impact of FGM on obstetrics outcomes was sketchy because most available studies on this issue had been small and had not used the most reliable research methods

The obstetric centres in which the study was carried out ranged from rural hospitals to teaching hospitals in capital cities. The women recruited for the study were carrying a singleton pregnancy and prior to delivery their FGM status was checked and they were classified as having undergone, Type I, Type II or Type III FGM. Then, the women and their infants were followed through delivery until discharged from hospital.

Effects of FGM on maternal health. The women who had undergone FGM were significantly more likely to have their deliveries complicated by caesarean section, postpartum haemorrhage and prolonged maternal hospitalization compared with those who had not undergone FGM. Women who had undergone Type III FGM had a 30% higher risk for delivery by caesarean section compared with those who had not had genital mutilation. Also, Type III FGM was associated with a 70% higher risk of postpartum haemorrhage compared to FGM-free women. The need for episiotomy was also higher in FGM-affected women who were delivering for the first time, ranging from 41% of those who had not undergone FGM to 88% in those who had undergone Type III FGM. Among women who had delivered previously, the corresponding figures were 14% and 61%, respectively.

Effects of FGM on infants. A greater proportion of infants of women who had undergone FGM required resuscitation and a greater proportion suffered perinatal death compared with infants born to women who had not undergone FGM. Also, the severity of the adverse outcomes studied increased with the severity of FGM. The rate of resuscitation was 66% higher for infants of women who had undergone Type III FGM than for those who had not undergone FGM. The death rates among infants during and immediately after birth were higher for those born to mothers with genital mutilation than those without, being 15% higher for women with Type I, 32% higher for those with Type II and 55% higher for those with Type III.

This study has highlighted the importance of not only preventing FGM, but also of providing health care to FGM-affected women to reduce the risk of adverse obstetric outcomes. With regard to the latter, there is a need for further research to improve interventions for reducing such risks. There is also a need for creating greater awareness among health-care practitioners of the role they can play in providing sexual and reproductive health care for women living with FGM. WHO is planning actions that will help improve the knowledge and skills of health-care professionals in FGM-affected countries. While WHO is seeking financial support for further research in this area (notably for systematic reviews of obstetric interventions suitable for women who have undergone FGM), plans are under way to produce information and training packages for health-care providers, including video-based training materials. Health-care providers can play a key role in preventing FGM, caring for those who have undergone FGM and reducing the spread of medicalization of FGM.

FGM numbers and costs of care and prevention

Following the WHO study on obstetric complications, WHO has commissioned a new study to estimate: (i) the economic costs of managing the obstetric and newborn health complications related to FGM; (ii) costs to society (in Disability Adjusted Life Years – DALYs) attributable to FGM; and the cost–effectiveness of a hypothetical intervention that can lower the incidence of FGM by 10%.

This study will draw on existing data from the WHO multicentre study on obstetric outcomes. Additional data will come from Demographic and Health Surveys (DHS), published systematic reviews of the literature, and WHO's tabulations of regional variations in hospital and health-worker costs supplemented by expert opinion from relevant WHO Collaborating Centres. This study, among other objectives, aims to build models of the DALY burden of Types I–III FGM and of the medical costs attributable to each of the three FGM types.

Estimates of FGM prevalence based on large-scale, national surveys have now become available for most of the countries in Africa where FGM is known to be practiced. Hence, it is now possible to make a better estimate of the number of girls and women who have undergone FGM. Following a study

commissioned by WHO, Macro International estimated that approximately 92 million girls aged 10 years or more in Africa and Yemen are currently living with the consequences of FGM. Though this number is lower than previous estimates, including the one made by WHO and presented in the first joint statement on FGM in 1997 (UNICEF/UNFPA 1997), it does not indicate a reduction in prevalence. Rather, it represents a more accurate estimate for a specific age group of girls and women. It is important to note that the new estimate neither includes girls under 10 years of age who have undergone FGM nor those who live outside Africa (Yoder and Khan 2007). WHO plans to follow up this work by issuing regular estimates of FGM prevalence in collaboration with partner agencies.

Research on decision-making with regard to FGM

Literature suggests that a key obstacle to the elimination of FGM is the paucity of information on how families make decisions related to FGM (Population Reference Bureau 2006; UNICEF 2005; WHO 1999). Also, large-scale studies have identified a large discrepancy between the number of women who, on the one hand, say that they are against the continuation of FGM, but, on the other, plan to have their daughters subjected to the practice (Yoder et al. 2004). In an effort to understand better the models of behaviour change, WHO supported a pioneering, qualitative-cum-quantitative study that integrated theoretical models of behaviour change into the study design. While the results of the latter component are still awaited, the qualitative component has found that, regardless of the setting (urban or rural), decisions on FGM are generally taken by the extended family; the grandmothers and paternal aunts exercise considerable influence in the decision-making process. Men are rarely involved in decisions related to FGM, and both men and women regard FGM as "women's business." Neither the parents having higher education nor having relatives living abroad was a significant influencing factor in decision-making on FGM (Hernlund and Shell-Duncan 2007; Shell-Duncan and Hernlund 2006).

The quantitative, follow-up component of the study was carried out in 2007. It included questions on: individuals' history of FGM and the related decision-making process; factors motivating change in behaviour and practice; and questions on which social networks are involved in discussion of FGM. The results, which will be published soon, are expected to provide more information on the importance of social networking in FGM decision-making. The new information would be used to test the theory of social convention that is now relied upon in many FGM prevention projects.

Operations research on community interventions

In 1999, WHO published a review that evaluated programmes that aimed to eliminate FGM. Conducted on behalf of WHO by the Program for Appropriate Technology in Health, this review was designed to serve as a programming tool and/or a baseline for monitoring the evolution of efforts to eliminate FGM.

To further update information in this area, a research protocol has been developed in collaboration with the International Centre for Reproductive Health Research, Ghent University, Ghent, Belgium. This research initiative is to be conducted in Burkina Faso and Sudan, and will focus on community-based intervention targeting behaviour change towards elimination of FGM. The specific objectives of the project are:

- to identify successful determinants of design, implementation, monitoring and evaluation of best practices related to elimination of FGM and to develop guidelines for those practices;
- to develop and test an intervention adapted from a theoretical model and based on existing community-based interventions;
- to create a social mobilization process in the intervention communities; and
- to generate a sustained momentum towards behaviour change with regard to FGM in the intervention communities.

The project involves collection of baseline data followed by situation analysis, planning, intervention, monitoring, evaluation and dissemination. The study will use a participatory approach to guarantee close collaboration between all parties involved. Operations research will be conducted to make it possible to document all stages of the intervention study. The intervention itself will be based on *Communication for social change: an integrated model for measuring the process and its outcomes* (Figueroa et al. 2002). As per this model, it is assumed that FGM is a sociocultural practice, and to eliminate it, it would be necessary to address the wider range of people's values, beliefs and interactions within the community that go hand in hand with the practice.

Research on how FGM is locally perceived as related to women's sexuality

Among communities in which FGM is a cultural tradition, the practice is associated with a variety of sociocultural meanings, and FGM is often considered necessary for social acceptability. It is believed that major gaps in knowledge regarding the sociocultural underpinnings of FGM are impeding efforts to eliminate the practice. While continuation of FGM involves many factors, including the support of religious leaders and men, few studies and interventions have specifically examined women's involvement in continuing or ending the practice. Among the factors that are believed to influence women's decision-making, an area that has been less well studied is sociocultural beliefs regarding the relationship between female sexuality and women's decision to continue practising FGM.

To fill gaps in knowledge in this area, in 2006, WHO issued a call for proposal for studies exploring the relationship between FGM and female sexuality. The main aim of this call was to collect data about people's perceptions in FGM-practising commu-

nities about FGM, women's sexuality and marriageability, and how these perceptions influence women's intention to continue, abandon or change practices with regard to FGM. The call for proposal yielded more than 30 concept papers, from which three studies were selected for support – one in Egypt and two in Senegal. These studies are expected to be completed by 2009.

Plans for future research

As stated at the beginning of this paper, two key priorities of WHO are to advocate vigorously for the complete abandonment of FGM within one generation and to ensure that the girls and women who have undergone FGM receive adequate care to prevent and treat all health-related sequelae of FGM. With regard to the latter, WHO plans to launch specific information dissemination and training activities aimed at health-care professionals. These will include, among others, the setting up of a dedicated Internet web site on FGM focusing on techniques of managing obstetric sequelae FGM (including counselling). In addition, research is planned on the following topics.

Research to understand the psychological consequences of FGM. Studies have found indications of post-traumatic stress disorder and other psychological consequences after FGM, but the evidence is extremely scanty. It is possible that the observed increased risk of complications in childbirth in women who have undergone FGM is not related to anatomical changes only, but is also related to fear flashbacks and other long-term psychological effects of FGM. Increased understanding of how women cope with the trauma of FGM may help to improve counselling and other approaches to encourage change in behaviour to end the practice. Also, further research is needed on the immediate and long-term psychological aspects of birth complications in women who have undergone FGM, and the need for extra care during delivery.

Implementation and impact of laws on FGM. A number of countries have enacted specific laws or have started applying existing legal provisions for prohibiting FGM. While legal measures help to make explicit the government's disapproval of FGM, imposing sanctions alone runs the risk of driving the practice underground. Legal measures need to be accompanied by information provision and other measures that promote increased public support for ending the practice. Very few comprehensive studies have been done so far to document the implementation of anti-FGM laws and their impact on eliminating the practice. WHO plans to initiate studies in countries with different cultural, religious and legal environment to investigate how laws, regulations and policies can contribute to elimination of the practice.

Research on obstetric fistula and FGM. There is a link between FGM and obstructed labour (4), which is a known risk factor for developing obstetric fistula. However, the association between FGM and obstetric fistula has not yet been scientifically investigated. If such an association is found, this evidence can be used to strengthen advocacy and to improve birth-care for women who have been subjected to FGM to reduce the risk.

Research on the immediate complications and emergency health care. A wide variety of immediate health risks from FGM have been documented, but in most cases their prevalence is unknown. More research is needed to document accurately the extent of immediate risks of FGM and to develop and implement guidelines for appropriate care procedures.

Research on obstetric care and care for newborns. Research is needed to improve standards of medical care on how to manage and reduce the adverse health effects caused by FGM during labour.

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The Challenge of Female Genital Mutilation in Somaliland

The overwhelming majority (98%) of Somali women have undergone genital mutilation. FGM/FGC among Somalis is often associated with religion and traditional beliefs that have prevailed in the communities for a long time. For over a decade, civil society organizations in Somaliland have been involved in FGM eradication activities, yet these efforts, which have mainly focused on awareness creation and provision of alternative skills to circumcisers, have proved to be slow in the absence of a national policy on female circumcision. There is no law specifically prohibiting FGM in Somaliland. Until recently, the Type III circumcision, or infibulation, the most severe type of FGM was the only socially acceptable form of circumcision. This type involves cutting of all the external genitalia and sewing up the vagina almost entirely, allowing a tiny hole for the passing of urine and menstruation. The health and psycho-social effects and hazards of female circumcision are well documented.

Over the past 7 years, Candlelight for Health, Education and Environment (CLHE) has been carrying out FGM eradication activities almost continuously in most of the regions of Somaliland. CLHE is a local developmental organization founded in 1995 with focussing on health, education, environment and income-generation. CLHE's activities related to FGM include awareness-raising, trainings, workshops and consultative meetings targeting different community representatives and groups such as traditional birth attendants, circumcisers, teachers, youth groups, religious leaders, female scholars as well as public and private institutions and IDP camps. The health team of CLHE which consists of social workers and a religious leader takes part in community education related to FGM in the project areas. Mother and child health care centres have proved to be very important venues for these awareness-raising activities. As the majority of the targeted populations are illiterate, the use of audio-visual material and drama are encouraged. Moreover, training for traditional birth attendants (TBAs) has been conducted. They have been introduced to safe motherhood practices, complicated pregnancies as well as the consequences of FGM and its impact on women's health. Circumcisers from rural villages have further been trained as TBAs as a means of motivating them to abandon circumcising girls and to enable them to earn their living in a decent way.

Achievements in the fight against FGM/FGC

Despite the fact that behavioural change is a slow and a complex process, there are some emerging positive trends resulting from the considerable efforts of local and international organizations over the past few years.

Some community members, although small in number, have already abandoned the practice of female circumcision. These are mainly those who return from the Diaspora and Arabian countries where FGM is not practiced. They are usually town people. No statistics are available on their number, but from the feedback we are getting from project staff, they are in the hundreds. The risk of getting cross-infected with HIV/AIDS and Hepatitis is also a contributory factor to the increasing preference for abandonment of female circumcision. Total abandonment of the practice, however, is constrained by the existing stigma on uncircumcised girls and peer pressure.

Today, a less severe form of circumcision referred to as *sunna* is preferred. Again, this applies particularly to people living in towns. An assessment on the socio-cultural dimensions of female genital cutting carried out in Burao, Togdheer region, during April 2007 by Candlelight with the support of the International Solidarity Foundation of Finland shows that the level of willingness to stop Pharaonic circumcision (infibulation) was high among those interviewed. The majority of interviewees showed preference to the *sunna* type of circumcision.

Younger and more educated females and males tend to disapprove of the practice more than their parents. Males of the younger generations see FGM less and less as a marriage requirement. Although hundreds of marriages are arranged each month in Hargeysa and other major urban centres, family conflicts arising due to brides being found un-circumcised are becoming rare and something of the past. All in all, rigid cultural norms and demands related to female circumcision among the population seem to be softening.

More grass-root organizations and groups are becoming involved in the eradication of female genital mutilation. These include women's and human rights organizations. Declarations against FGM have also increased over the past years. People who speak publicly about the practice are not stigmatized in the way they were before. There are also educational programmes on the radio and TV.

Challenges and opportunities in the fight against FGM/FGC

No coherent strategic action plan and policies are in place for the eradication and outlawing of the practice in Somaliland. This hinders the work against female genital cutting on all levels. Most opinion leaders and community gatekeepers do not consider or recognize FGM as a priority issue. Because of the economic gains, some circumcisers are swayed by the demand resulting in their return to practicing FGM. This phenomenon shows that the practice is demand-driven and addressing the root-causes is a matter of great importance in the fight against female genital cutting. FGM practitioners are not only respected members of the community for the sake of their role and work, but at the same time, it is a profitable skill.

In most urban areas, communities are now shifting to *sunna* type of circumcisions. However, even though people may admit that they have now stopped doing infibulations, in reality, the *sunna* type that many people have adopted is not very much different from infibulation. Moreover, many people are now shifting from the traditional circumcisers to nurses working in public and private clinics. The fear of HIV/AIDS transmission through the cutting encourages more people to go to hospitals and clinics, thus creating the institutionalization of FGM.

It has been difficult to get a clear statement from religious leaders to support the eradication of female genital cutting. There are different interpretations of the *hadiths*. Imams, who may agree privately that FGM is not a requirement in Islam, fail to speak out against the practice in public. Some imams preach that whilst infibulation is not acceptable, the *sunna* type of circumcision is.

For future work against female genital cutting in Somaliland, a promising step is the formation of the new national FGM network NAFIS. The main objective of the forum is to exchange experiences and share relevant information among organizations involved with FGM eradication initiatives in the country. The Ministry of Family Affairs and Social Development has also shown interest to initiate the formation of a FGM policy. In addition, the government and civil society organizations seem to be willing to work together for the abandonment of FGM. Finally, there is a growing awareness of the existence of human rights conventions as well as of FGM not being an Islamic obligation. These recent developments provide new opportunities and hope for the accelerated eradication of female genital mutilation in Somaliland.

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Changing Attitudes towards FGM in the Somali Community in London

Introduction

Female genital mutilation (FGM) is a common practice in Somalia. Reasons given for it vary: religious obligation, tradition and culture, hygienic and esthetic purposes, preservation of virginity and need to control women's sexual desires.. Due to the Somali civil war, a large number of the population have left the country. While many refugees have settled in Europe, North America and Australia, others moved either to the neighbouring countries or to the Middle East. Following this relocation, the way the Somali community in London thinks about FGM has changed. However, this change is not due to the UK law of 2004 which prohibits the practice, but to the fact that people have recognised that FGM is not a religious obligation. Meeting with other fellow Muslims and learning more about Islam has contributed to this process. Education and lifestyle in London have also empowered women, and they do not advocate the practice any more. This report is based on observations made at *Waltham Forest African Well Woman Clinic* in London, where I work as a community health advisor.

The Somali Community in London

The Somali community in London is large: according to a 2003 report, there are ca. 70 000 Somalis in the capital and 95 000 in the UK as a whole. Most have come as asylum seekers since the late 1980s because of the civil war and lack of stability in Somalia. The Somali community originates from different parts of Somalia and from different educational or socio-economical backgrounds. Women in this community have one thing in common, however; they all have undergone female genital mutilation. Most of the Somalian population are Muslims and many UK Somalis used to believe that the practice of FGM is a religious obligation practised among all Muslims, and no one ever questioned its legitimacy. For a long time it was also a taboo to talk about the practice, but now at *Waltham Forest African Well Women Service* women are able to discuss it and they do ask a lot of questions about the reasons for the practice.

The Waltham Forest African Well Women Service

In 1997, a large number of asylum seekers and refugees from the Balkans, Somalia and some North African countries came to the UK. Many of these settled in the borough of Waltham Forest (WF) in North East London. The Community Health Project in WF took the lead to open a clinic for the newcomers in order to give information on the healthcare system in the UK and help them to register with a family doctor. It was obvious that this group of people needed support and assistance in the new environment. It is very difficult for refugees and asylum seekers to become familiar with the system, to know what rights they have and where to go when they have health problems. The clinic, located in Leyton, was called *Refugee Access Clinic* and was delivered from *Refugee Advice Centre* in Leyton, because it was a place where refugees and asylum seekers came for advice on every issue concerning them. The staff of the clinic included a lead nurse and two refugee doctors, one of whom was a gynaecologist with experience in working with women who have undergone female genital mutilation.

This service gave women an opportunity to come and discuss issues related to FGM and to describe the difficulties they had encountered when talking to local health professionals about their problems. The clinic began advocacy and health link work in order to assist clients. Given the high proportion of female clients, it became necessary to establish a service especially designed for them in order to respond to the needs of women who had undergone FGM and to fill the gap in the local health services.

In 1999, the Waltham Forest African Well Women Clinic was established under the management of Waltham Forest Community Health Project. Operating on one day a week, the clinic aimed at dealing with women's needs. In 2003, the management of the clinic was taken over by the Waltham Forest Primary Care Trust, and it was developed into a service – The Waltham Forest African Well Women Service. The staff of the service includes a lead service nurse, a community health advisor, and an outreach and youth worker.

Our mission statement is: The team at the African Well Women is dedicated to providing culturally sensitive and holistic service for women who are affected by the practice of female genital mutilation. We are committed to our mission of rising both professional and community awareness in order to safeguard girls at risk of FGM and to work with other organisations to help eradicate the practice.

The service focuses on reaching out to young people from communities in which FGM is practiced. It is important to raise their awareness on the health consequences of FGM and empower them with information and knowledge about the subject. These young people will be parents in the future, and if they are equipped with appropriate and correct knowledge, they will not carry out FGM on their daughters and the practice will gradually be eradicated. This service provides a weekly drop-in clinic and two advice sessions by me as the community health advisor.

15–20 women attend the clinic every week. The majority of the clients are from Somalia, but there have been women from Sudan, Eritrea, Gambia, Nigeria, Guinea Conakry, Zimbabwe, Liberia, Kenya and Ghana as well. Although most of our clients are Muslims, we have also had a small number of Christians who have undergone FGM. Occasionally we see women from communities in which FGM is not practiced for consultation and cervical smear tests. In the clinic, we promote screening tests and perform cervical smear tests to a lot of women, who have either never had one or do not want to have it again because they have undergone FGM or because they do not understand why the test is important. The clinic also carries out screening for infections and refers clients to other services such as counselling, reversal and deinfibulation, and homeopathy. We offer support and advocacy for our clients.

Women come to the clinic and the advice sessions for different health issues, but the majority comes because of health problems associated with FGM. Lots of women complain about lower abdominal pain and discomfort with no pathology and need some help with these symptoms.

In 2003, we won an Innovative Creative Practice Award from Queen's Nursing Institute. A protocol was established for a pilot study to introduce homeopathy for the treatment of women's symptoms. A homeopath worked in the Community Health Centre for a trial period of six months with successful results.

Although the AWWS was meant for local women from communities in which FGM is practised, it is also attended by women from outside of Waltham Forest. It offers monthly awareness rising sessions for a local women's association in Waltham Forest and for another women's group in North London. The sessions focus on women's health, FGM and healthy eating. During these community sessions, we discuss health as well as social issues and offer one to one for women. From time to time, we conduct health education sessions and awareness rising on FGM in other parts of London.

In 2004, a law prohibiting FGM came into action in the UK. This law criminalises FGM performed to a British Citizen or a permanent resident in the UK or abroad with a penalty of 14 years imprisonment. We inform women of the legislation at consultation and advice sessions and discuss it in detail with them during awareness sessions, where it always opens and generates important debates on FGM in general. Women are invited to contribute to the discussions and to express themselves. It is rewarding to see that women open up and want to share their experiences of the practice with the group when discussing this culturally sensitive issue.

The staff have also contributed to the development of a protocol for Waltham Forest regarding safeguarding children, as FGM is considered to be a form of child abuse. It has become necessary to develop a training package for multi-agency professionals and the neighbouring area on FGM and child protection.

As health adviser, I listen to my clients, discuss FGM with them and give them information on the subject. The majority of them remember the day it was done to them even if they have not had any complications. They usually talk very openly about the day, but although they talk about it in detail, they do not want to remember it. They often say: "Don't remind me of it," and do not wish it to happen to their beloved ones. Especially young mothers strongly oppose the practice and do not want it to happen to their daughters. Others do express their sorrow that it happened to them and regret that it happened to their elder daughters back home out of ignorance, especially after they came to know that it is not an Islamic practice.

Each woman attending the Waltham Forest African Well Women Service has a story to tell about the day they underwent FGM, and many of them still have post-FGM complications. For example, Mrs X said:

I was only 5 years old and it was not planned for me to be circumcised on that day, because I was young. My elder sister and some of my cousins were supposed to be done. When the girls asked who would go first to be circumcised, no one came forward, because they were all afraid and scared. Then I raised my hand and volunteered to go first and I had it done. I did not know what was going to happen and what I was going for. It was very painful, but what was worst, I felt that I lost part of my body. After that I continuously asked my mother to bring back the parts which had been removed. And I still have complications.

This quote tells us about the deep feelings of the persons who have undergone FGM, especially type III.

Most women, and especially those from communities that practice type I or type II FGM, do not know which type of FGM they have had. A woman who brought her young daughter to the clinic for consultation and advice said: "I did tell the circumciser to perform Sunna, just a little touch, but now the girl is having a lot of difficulties. I have been explained that it is due to the type of FGM that she has undergone." Another young woman from the same community was shocked when she found out that she had undergone infibulation and needed reversal. Throughout the entire consultation period she repeatedly asked: "This is not Sunna what I have undergone? Why was it done to me in this way?" I understood that she needed to ask her parents, who also might not know the answer.

Women often ask questions about the practice such as: what does the Koran say about FGM, how is the practice related to Islam, and why did religious people not speak about it in the past? They start to wonder about the religious legitimisation of FGM when they are told that it is practised among all religions in Africa, the Christians, the Ethiopian Jews and the unbelievers (Lockhat 2004). Women also discuss other reasons and express their opinion clearly and openly that FGM has nothing to do with Islam. What is important, most of them now understand that FGM has been practiced due to ignorance and that the main reason behind it has been the need to control girls' sexuality. At this, many express their sorrow. I think a significant change is taking place.

During consultation at the clinic women are also asked about their views about FGM. The majority of women are against it, especially women with type III. Those with type I or II always want to know more about the relation of the practice to their religion. When we explain to them that the Koran does not support FGM, they begin to agree that there is no need for it. I come across a lot of young women from practising communities who were born in the UK or have come to the country at very young age, and who have not been circumcised. I also meet a lot of women who have spared their daughters from this cruel practice. Some of them did not have it done to their daughters during the civil war for very simple reasons. They say: "I did not have to think about it, because I had other problems." The main reason for this cultural change is that women have gained more education on religious matters and begun to understand that FGM is not an Islamic practice, that it is not prescribed by the Koran and that it causes a lot of health problems. Education, knowledge and change of environment can lead to changes in attitudes, and I think this is what is happening with FGM. It is not only about formal education, as life experiences play a big role in the process (Ahmed 2005).

Today, women speak openly about FGM, which was taboo in the past. They even discuss some intimate and sensitive issues related to the practice and they want information and explanations. Many of these women lead their lives and support their children on their own as single parents, which gives them more power. I believe that attitudes towards FGM are changing, because people have started to discuss the practice, ask questions and seek answers for a lot of issues affecting their lives due to FGM. Not only in London, similar transformations may be taking place elsewhere in Europe for the following reasons:

• There is no pressure from the community or relatives, as people do not live in extended family houses.

• Previous experience and health complications, especially women with type III. Women with type I or II are questioning the religious legitimisation of the practice.

• Awareness of the health impacts of the practice is rising and women are reflecting it on themselves.

• The UK law of 2004, which prohibits FGM and prescribes an imprisonment of 14 years for performing FGM on a British citizen or a permanent resident of the UK.

• The most important factor is religious education and the rising awareness of the fact that FGM is not an Islamic practice and that it is not mentioned in the Koran.

The FGM law has become a tool for some women who have been pressured by a family member. I have met women who have been asked to circumcise their daughters while on holiday, and the law has helped them to strongly refuse.

In 2006, we started asking women about their views on FGM and documented the interviews. I have observed that a lot of families stopped having it done to their daughters long before the 2004 law. Between January and June 2007 I saw 263 women at the clinic. 153 of them attended the clinic for a follow up and 110 came to the clinic for the first time. I asked these women

1. What they thought about FGM?
2. If they had daughters?
3. Had the daughters undergone FGM?
4. If not, what was the reason?

Figure 1.The number of clients between January and June 2007.

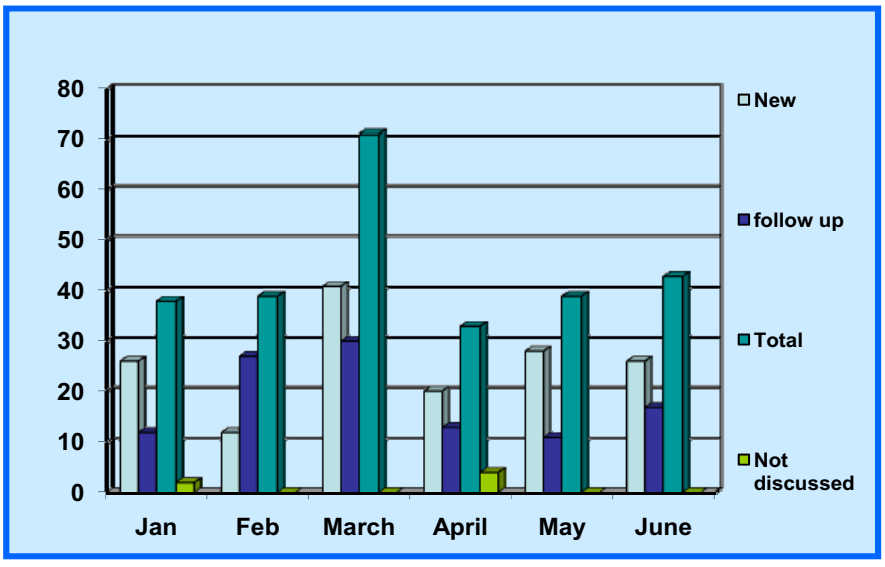
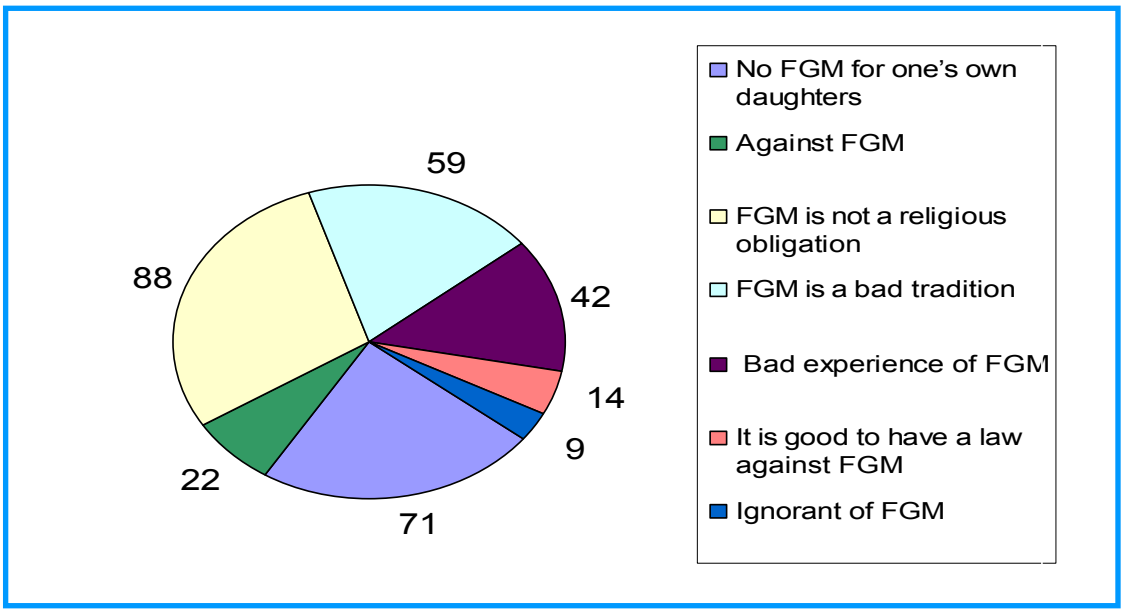


Figure 2. Clients' views on FGM.



I have to note that a woman can give many reasons for not performing FGM on her daughters, saying for example that she herself has had a bad experience, a lot of complications and that she knows now that it is not a religious obligation, which is why she is against it. Others might say it was ignorance to have it done to girls and that they are totally against it. What I mean is that there is not necessarily only one answer from one woman, but one person might give several reasons to why she has not had FGM performed to her young daughters.

Conclusion

Most of the clients at the Waltham Forest African Well Women Service are Muslims who used to believe that FGM is an Islamic practice. I believe that raising their awareness of the complications and of the position of Islam in regard to FGM, as well as mixing with other fellow Muslims have brought about a change in attitudes towards the practice. I also believe that the law against FGM will help to bring the practice on UK citizens to an end. Although I have highlighted women's ideas and practices in this report, I am sure that many men oppose the practice. There is a need for wider research, reaching more people in the community.

Finally, I hope that FGM will be history in the near future among the Somali community in the UK and among other African migrant communities, and that the future generation will be free from it. I also hope the Somalis in the UK will educate their families in Somalia to similar ends.

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Methods for the Prevention of Female Genital Cutting in Finland

Female genital cutting has been known in Finland since the 1990s when asylum seekers and refugees started to arrive to the country. The biggest ethnic group bearing the tradition in Finland is Somalis. In 2007, there were almost 10 000 Somalis in Finland, about half of them women (Statistics Finland 2008). Other smaller groups are from Ethiopia, Eritrea, Egypt, Sudan, Kenya, Ghana and Nigeria. We might roughly estimate there to be around 15 000 people in Finland who are familiar with the tradition of female genital cutting. In 1994 Mulki Mölsä, a Somali born doctor living in Finland, conducted a study about the attitudes of Somali immigrants towards FGC for the *National Research and Development Centre for Welfare and Health* (Mölsä 1994). According to her results all interviewees wanted some kind of genital cutting for their daughters. Most of them stated that they wished to make *sunna*, a less harmful operation, while the rest preferred the most radical type of cutting, infibulation. At that time nobody announced that they would abandon the tradition.

Female genital cutting continues to be a sensitive issue, and both immigrants and authorities require more information and better tools to be able to address it constructively. Existing legislation and general appeals to human rights form the basis for the work against FGC in Finland. However, top priority should be given to preventive work. Preventive work must begin before any suspicion of a girl being threatened by FGC even arises. For this reason, many different factions require information on questions related to female circumcision, so that they can then inform relevant parties of the prohibitive stance of Finnish legislation towards the practice, and intervene in particular cases if necessary. Preventing FGC is the duty of all authorities that encounter immigrants in their work. Enhancing the knowledge and skills of professionals in relation to this issue can only be achieved by training all relevant vocational groups. Training should be intensified and targeted at different vocational and multi-vocational groups on a national scale to enable and encourage efficient cooperation. Information on how to prevent FGC and how to treat girls and women who have already undergone the practice should be included in the basic education of all relevant vocational groups.

Even though there have been no court cases concerning female genital cutting in Finland, it is possible that the procedure is performed during trips abroad. Finland will continue to receive individuals and families from countries where the tradition is still upheld. Furthermore, there are already families living in Finland who may want to have FGC performed on their daughters. Such families require information on various questions related to female circumcision. It is also crucial to recognise that FGC is no longer simply a "Somali problem," as it might have been at the beginning of the 1990s, when the first refugees and asylum seekers from Somalia started to arrive. Moreover, attitudes are changing in a way that nowadays the less severe *sunna* form of FGC is generally preferred over the more extensive forms and more and more people are abandoning the tradition entirely (Mölsä 2004). Continuing the preventive work is vital in order to reinforce this positive development and thus gradually advance towards the complete abolishment of the tradition.

The KokoNainen project

The KokoNainen (Whole Woman) project, funded by Finland's Slot Machine Association and coordinated by the Finnish League for Human Rights, was launched in 2002. The first phase of the project lasted till the end of 2004. The project was then granted additional funding for the years 2005─2007 and at the end of the year 2007 KokoNainen was granted permanent funding for its valuable work. There are two employees, one of Finnish and one of African background. The primary objective of the KokoNainen project is to prevent the genital cutting of girls and women amongst the immigrant groups that practice the tradition and to improve the welfare of those girls and women who have already undergone FGC. The goals are that:

1) the immigrants who live in Finland and in whose country of origin the tradition of female genital cutting is upheld are aware of the health hazards, the human rights considerations and relevant Finnish legislation as well as all other aspects that may encourage them to abandon the tradition
2) most health care, social and child welfare workers as well as vocational students in these fields have at least a basic knowledge of female genital cutting, preventive work and treatment and/or know where to find more information and support if needed

3) the work against female genital cutting is organised on a permanent basis in Finland.

During the first phase of the project the prevalence of and knowledge about FGC in Finland was mapped through two studies, one of which was based on interviews with immigrants (Mölsä 2004) and the other on a survey targeted at public health nurses working in the Helsinki Metropolitan Area (Tiilikainen 2004a). Educational material was then produced on the basis of these studies. These included the informative booklet *Tyttöjen ja naisten ympärileikkaus Suomessa. Asiantuntijaryhmän suositukset sosiaali- ja terveydenhuollon henkilöstölle* (Female circumcision in Finland. The recommendations of an expert group for the personnel in social and health care) (Tiilikainen 2004b). The recommendations, published also in English and Swedish in 2007, targeted at social and health care workers, whereas the film *KokoNainen / The Whole Woman / Idil* (produced by Dream Catcher / Alexis Kouros, 2004) targeted at immigrants. They provided the basis for the training scheme that was developed during the continuation phase of the project and utilised in the basic and supplementary education of professionals and vocational students who encounter immigrants in their work. The training package *Ei! Tyttöjen ympärileikkaukselle* (No! To Female Circumcision), created by Training Coordinator Mai Salmenkangas, was completed towards the end of 2005. In addition, the employees of the project prepared power point presentations for different training events. Since many immigrants regard anti-FGC work as an attack against their culture, preventive work has to be carried out in a discreet, respectful and confidential manner. The only way to achieve this is to train and educate the personnel that come in contact with the issue. They need to know

1) how to question the ancient tradition without questioning the person him/herself
2) how to draw attention to the fact that FGC is prohibited by the Finnish law without adding to the reservations that immigrants may have towards Finnish society
3) how to achieve mutually respectful and open dialogue over such a sensitive issue.

(Salmenkangas 2005)

Preventive work as well as work related to treatment has been carried out amongst immigrants at the grassroots level throughout the project. The main activities have consisted of work done in small groups (separate peer groups for women and men), individual discussions and awareness-raising. Materials produced by the project have been utilised in group work and individual discussions to facilitate interaction. The main target group is the Somali community, as the Somalis form the largest group in Finland that practices FGC. Group events have also been targeted at Sudanese, Ethiopian, Eritrean and Nigerian immigrants. In 2007, the KokoNainen project began to further develop the work done at the grassroots level. The goal is to include FGC in a larger thematic unit which aims to enhance immigrant women's knowledge of their body in different stages of a woman's life. Collaboration in the creation of a suitable training package was preliminary discussed with Stadia Helsinki Polytechnic. Students specialising in midwifery could compile such a training package as their final project.

During the project, many different stakeholders have indicated that there is a strong demand for information, material and training related to FGC. Many professionals are unsure of how to deal with such a sensitive cultural tradition. As a result, the issue is often deficiently addressed or it is not addressed at all (Tiilikainen 2004a). In particular, the issue concerns social and health care personnel, including midwives, public health nurses, doctors, social workers, child welfare workers, day-care centre employees and school teachers. It is important to include the topic of FGC in the core curriculum of students aspiring to work in one of these fields, so that they already have the required expertise when they begin their professional careers. All the training events organised by the KokoNainen project have clearly shown that having a trainer of immigrant origin is crucial for the success of the training. This makes it easier for the professionals to appreciate the severity of the issue and understand their own vital role in preventive work.

Finland does not have a separate law prohibiting female genital cutting. In a possible court case, the Finnish Penal Code and the Child Welfare Act would be applied. In light of the Penal Code, FGC would probably be equated with aggravated assault and battery. In addition to the national legislation, Finland is also a state party to the key human rights conventions and treaties of the UN and the Council of Europe. The two most important instruments in this regard are the UN Convention on the Rights of the Child (1989), which obliges Finland to take effective measures with a view to abolishing traditional practices prejudicial to the health of children (Article 24), and the resolution Women and Religion in Europe, adopted by the Council of Europe in 2005, in which forced marriages, honour-related violence and female genital cutting are identified as violations of human rights. States must take effective action to abolish these harmful traditions. It must also be taken into account that there are numerous girls and women living in Finland that have already undergone FGC. Supporting them and disseminating information on existing methods of treatment must be key objectives as well.

The importance of cooperation between different stakeholders for the success of preventive work has become evident during the project. The project has provided nationwide training related to female genital cutting and intercultural communication for social and health care personnel, day-care personnel and school teachers as well as polytechnic teachers and students aspiring to work in one of these fields. The starting point of the training has been the insight that both those who practice FGC and those who oppose the tradition can actually have the best interest of the child in mind. The training events have raised wide-scale interest and received positive feedback. There are two underpinning questions guiding the work carried out among immigrants and authorities: first, to understand the phenomenon of female genital cutting and why families continue to circumcise their daughters and second, why the rest of the world condemns the practice (Figure 1.).

Figure 1. Starting points for the preventive work.

Female genital cutting is based on the belief that	**The global work against female genital cutting is based on the assumptions that**
- a woman is normal as circumcised - religion demands it - a circumcised girl/woman is ready for marriage - a uncircumcised girl will be discriminated	- the tradition is legally prohibited in all its forms - no religion demands it - female genital cutting is a health hazard
Parents all over the world want the best for their child	Female genital cutting is a violation of the rights of the child
The best for the child	**The best for the child**

Preventive work against female genital cutting is extremely important, but forms only a small part of all the work carried out among immigrants by the KokoNainen project. As FGC is still a delicate topic, it is deemed necessary to include it in a larger thematic unit. In August 2005, the KokoNainen project began to collaborate with the Family Federation of Finland, the Mannerheim League for Child Welfare and Monika-Naiset liitto (Multicultural Women's Association). The work done with authorities within the framework of this collaboration has focused on training. The objective was to produce joint training material in order to support the integration of immigrant families into the Finnish society, and the book *Ahaa – Avaimia monikulttuuriseen kohtaamiseen* (Keys to multicultural encounters, Salmenkangas 2006) was jointly published. Under the umbrella theme of integration also more sensitive issues like honor-related violence, violence against women and female genital cutting can be addressed. The collaboration partners have organised joint training events based on this material for both immigrants and authorities. The KokoNainen project also participated in the drafting of a new handbook on midwifery with a chapter on female genital cutting (Tiilikainen et al. 2006).

The KokoNainen project has achieved good results in preventive work against female genital cutting despite the challenging nature of the task. Attitudes have changed through awareness-raising and by training both immigrants and authorities. Attitudinal changes cannot be achieved by being appalled and judgmental. Instead, preventive work must be based on correct information and be carried out respectfully and confidentially. The KokoNainen project has succeeded in creating, among both immigrants and authorities, an atmosphere in which the tradition prejudicial to the rights of the child is understood from a historical and cultural point of view, but not accepted. The work against female genital cutting has thus been successfully launched, but achieving the set objectives requires sufficient and continuous resources.

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