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GENITALLY MUTILATED
WOMEN IN THE
WELLINGTON REGION: A
STUDY OF THEIR HEALTH
NEEDS

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ABSTRACT

The purpose of this study was to explore the health care needs of a group of Somali women in the Wellington region. Using a qualitative research method, two open-ended questions were put to Somali women in a focus group setting. The health care needs of the Somali women in relation to female genital mutilation were explored. The data generated in the group discussions were recorded. Thematic content analysis was applied to the data. Categories and major themes were extracted from the data, which constituted the findings of this study.

The findings of the study demonstrated that the identity of Somali women is defined by female genital mutilation (fgm). The findings also included physical health and childbirth perspectives that emerged and shaped the discussion. The findings are supported by some of the literature on female genital mutilation except that the Somali women in this study consider the consequences of fgm as a very normal part of their life and that of women. The Somali women do not view their health consequences as 'problems'. The findings also demonstrated a need for bridging the gap between the understanding of the cultural practice of female genital mutilation and the related health effects and the ways in which the health professionals can meet the health care needs of Somali women living in Wellington.

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*"Om bhur bhuvah swah. Tatsavitur varenyam bhargo
devasya dhi-mahi. Dhiyo yo nah pracodayat".*

PREFACE

A CRUEL CUT OF CULTURE

Female Genital Mutilation (FGM) or Female Circumcision

In New Zealand, health professionals work with an increasingly multicultural population. I have chosen to look at a specific cultural practice, female genital mutilation (fgm). Through this study I have sought to understand the health needs of Somali women who have been genitally mutilated.

In 1995 I participated in a conference entitled 'New Zealand's Role in Africa', held by the Africa Association of New Zealand. In one of the workshops dealing with ethical issues, a discussion developed between two New Zealand women and an African man. They confronted him about the atrocity of female genital mutilation. He stated amongst other things that the community he belonged to did not view this cultural practice as mutilation.

At that stage I knew little about female genital mutilation. I entered this study with the knowledge that fgm was practised in some cultures as a way of maintaining the virginity of young girls so that they are marriageable. This is slightly similar to the Indian culture where it is vital for a girl to be a virgin when she marries (however in recent times this is not an important requirement as it once used to be). I had little knowledge of the complexity of the procedure of fgm or its consequences as they emerged during this study. The discussion between the New Zealanders and the African man signified for me that there were distinctly different views on this practice. I realised then that I

would like to explore this topic further. My aim gradually began to take shape as I found out more about the practice. During the period 1995 - 1999, New Zealand experienced an increase in numbers of migrants and refugees from North African countries where the practice of genital mutilation is prevalent. The media, both local and overseas, highlighted this practice, as more and more countries around the world came into contact with women who had been genitally mutilated.

Emotive media headlines focused attention on this subject. For example, in 1997 *The Dominion* ran an article entitled, 'Cutting at the heart' (25 October 1997). The *Sunday Star-Times* featured an article on 'Culture battle over a cruel mutilation' (15 November 1998). The magazine *She and More* presented Joanna Wane's report with the introduction: 'Why would a woman hold down her daughter while a midwife cut away her clitoris with an unsterilised razor blade? - Every 15 seconds a girl is mutilated' (October 1998). *The Evening Post* featured an article headlined 'A cruel cut of culture' (2 December 1998). In February 1999 the *Evening Post* ran two articles headed 'Genital mutilation trial starts' (3 February 1999) and 'Paris court jails female circumciser, parents' (17 February 1999). One reason for the media attention may be that female genital mutilation (fgm) is increasingly becoming an immigrant health and human rights issue for western nations.

I work in a department of nursing and health studies at a Polytechnic in New Zealand. The nursing students I work with are exposed to clinical experiences at the public hospital with patients who are drawn from the multicultural population of Wellington. The population includes women who come from Africa and may have been genitally mutilated. Students who have encountered women from Africa with genital mutilation are not sure how to respond or react. In some cases students asked to perform

catheter care for patients who have been genitally mutilated, are unprepared by the appearance of genitalia different from their own, or for the effects of cultural practices different from their own, and are often surprised. These incidents, the media coverage and the students' experiences, led me to explore this area of women's health.

The study is presented in six chapters. Chapter one provides an orientation to the study and presents the historical background and definition of fgm. The different types of female genital mutilation and the procedure are described. The law relating to female genital mutilation is presented and the chapter concludes with the perceptions and roles of health professionals. Chapter two presents an overview of literature that relates to the incidence of genital mutilation, a number of studies describing the reasons for the continuation of the practice of fgm, the implications for health and a comparison of such implications with those occurring as a result of other cultural practices such as male circumcision. In chapter three the method and methodological aspects of this study are presented while chapters four and five relate to the findings. Chapter six presents with the discussion, current research findings, and implications for midwifery, other health professionals, education and further research.

Chapter One

Orientation to the study

Introduction

The primary purpose of this study is to identify and describe the health needs of Somali women who have been genitally mutilated and who live in Wellington. Groups of Somali women were asked to describe their health needs. The two questions put to the women were:

1. Tell me about your health needs in relation to your circumcision.
2. What information should health care workers have about circumcised women to ensure that their health needs are met?

This chapter presents the historical background of female genital mutilation (fgm) and defines female genital mutilation. The use of the terms 'female circumcision' or 'female genital mutilation' is discussed, followed by a description of the procedure for genital mutilation. The New Zealand Law relating to female genital mutilation is discussed. The chapter concludes with an overview of health professionals' perceptions and behaviours when working with women who have been genitally mutilated. (See Appendix F for information about the Somali community in Wellington).

Fgm-Historical background

Female genital mutilation is a deeply rooted cultural practice, with excision and infibulation by no means unique to Africa, and has at some time in history been practiced in many parts of the world (Lightfoot-Klein, 1989). Female genital mutilation is not a new phenomenon. It was in existence long before the beginning of Christianity and Islam (Smith, 1995; Anees, 1989). According to Lightfoot-Klein (1991) and Morris

(1996) a Greek papyrus in the British Museum dated 163 B.C. mentions circumcisions performed on girls. Nevertheless, the origins remain obscure as various theories are presented and different explanations put forward as to its origins, but all are speculative (Smith, 1995). Mackie (1996) states that genital mutilation is similar in many ways to footbinding and it is hoped that this practice would end but like footbinding, the abolition of female genital mutilation (fgm) seems to be slow, despite public awareness, legal prohibitions, and modernisation. According to Mackie (1996), footbinding was practiced because it was believed to promote health and fertility. It was necessary for proper marriage and family honour and was used to control females and ensure chastity and fidelity. Footbinding was defined as aesthetically pleasing and increased women's status. It was claimed to make intercourse more pleasurable. Footbinding as a cultural practice was supported and sustained by women from generation to generation. Drucker (1981) explains that footbinding was an extremely painful procedure especially in the first six to ten years, in which the female child's four smaller toes were bent under the foot, the sole forced to the heel. The foot was then wrapped in a tight bandage day and night in order to mold a bowed, pointed four-inch appendage.

There are some similarities between footbinding and female genital mutilation. The dominant schools of thought are that female genital mutilation originated in ancient Egypt and spread to East Africa. According to Abusharaf (1998), the Egyptians and Phoenicians practiced female genital mutilation or circumcision as a ritual before marriage. Ancient Egyptian myths stressed the bisexuality of the gods, so circumcision was introduced to clarify the femininity of the girls. Egyptian mummies display characteristics of circumcision. It is believed that the practice spread with trade to Sudan and subsequently, with the spread of Islam, deeper into Africa. Morris (1996) & Smith (1995) note that from the

sixteenth century on, slaves in Roman and Arab civilisations, were infibulated as they commanded a higher price.

The practice of genital mutilation was not limited to Middle Eastern and African countries. In the nineteenth century doctors in England and the United States performed clitoridectomies on women as a cure for masturbation, nymphomania and psychological problems (Abusharaf, 1998). Morgan and Steinem (cited in Wright, 1996) reported how a 'Dr Isaac Baker Brown justified scissoring off the clitoris of his patients as a cure for insomnia, sterility and unhappy marriages' (p.256). Clitoridectomies were endorsed by practitioners and practiced well into the twentieth century. The last known clitoridectomy in the USA took place in 1953, in Kentucky, on a girl aged twelve (Wright, 1996).

Female genital mutilation is not confined to any one group or religion. A survey carried out in Chad on 133 women indicated that 75 percent of the sample that were infibulated described themselves as Christian, both Catholic and Protestant. Approximately 14 percent practiced an indigenous religion and 7 percent were Islamic (Leonard, 1996). Female circumcision is reported to be practiced by Fellasha, the Jewish sect living in Ethiopia, Copts, Animists, Moslems and Christians (Hosken, 1978).

Definition of female genital mutilation

The World Health Organisation defines female genital mutilation as:

'All procedures which involve partial or total removal of the external female genitalia and / or injury to the female genital organs whether for cultural or any other non therapeutic reasons' (WHO, 1996, p.1). The organs involved are the clitoris, labia minora and labia majora.

Female genital mutilation is practiced mainly in African countries but the exact number of female genital mutilations worldwide is unknown. An estimated 135 million girls and women worldwide are affected (Mak, 1993;

Meares, 1995; Leonard, 1996). The practice also occurs in Asia and the Middle East, and is increasingly found in Europe, Australia, Canada, and the USA amongst the migrant population groups. However, the highest prevalence (90-100%) and the most severe forms occur in the North-East African countries of Djibouti, Ethiopia, Eritrea, Sierra Leone, Sudan, and Somalia (Ortiz, 1998).

Each year in Britain 2,000 girls undergo mutilation of the genitals. Many are taken back to their country of origin for this purpose (Thompson, 1989). As a result of the genital mutilation they often experience serious medical complications, pain and sometimes death. However, the majority live with the consequences as if they are a normal part of life (Gordon, 1998; Mackie, 1996).

Female circumcision or female genital mutilation?

Some literature uses the term female circumcision and others use female genital mutilation. The World Health Organisation and Amnesty International both use the term female genital mutilation. Campaigners who are fighting for the abolition of this practice have called for it to be known officially as 'female genital mutilation' (Armstrong, 1991). This term more accurately describes the radical operation. The amount of tissue actually removed varies enormously according to the type of circumcision performed (Ortiz, 1998). The Inter Africa Committee (IAC) organised a conference focussing on the presentation of the harmful effects of this traditional practice and emphasised that using the terminology 'genital mutilation' would help their campaign by describing more accurately the cruel and radical operation that women have to undergo (Armstrong, 1991). However, a Mali woman has stated that the term 'female genital mutilation' is an insult to Malians, most of who firmly believe they are doing the best for their daughters (McConville, 1998, p.35).

Types of female genital mutilation

Most of the literature (see, for example, Calder, 1993; Bashir, 1997; El Dareer, 1982; Wright, 1996; Brady, 1998; Newman, 1996; WHO, 1995; Walker & Parmar, 1993) is consistent in the description of the types of female genital mutilation. It identifies four main types:

- Ritualised circumcision
- Sunna or Type I
- Clitoridectomy or Type II
- Infibulation or Type III

Ritualised circumcision: This is the least severe form. It consists of cleaning and / or application of substances around the clitoris. In other forms of ritualised circumcision the clitoris is scraped or nicked. This causes bleeding, but results in little mutilation or long-term damage (Rose, 1994; Smith, 1995; Toubia, 1994).

Sunna or Type I: This involves the removal of the clitoral prepuce - the outer layer of skin over the clitoris, which is sometimes, called the "hood". The glans and body of the clitoris are meant to remain intact but often removal of the glans of the clitoris occurs (El Dareer, 1982; Van der Kwaak, 1992; Toubia, 1994).

Clitoridectomy or Type II: Excision or clitoridectomy is said to be the most common form of genital mutilation. It involves removal of the glans of the clitoris, but usually the entire clitoris and often parts of the labia minora are also removed (El Dareer, 1992; Toubia, 1994).

Infibulation or Type III: The most severe form of genital mutilation is infibulation or 'Pharoanic' circumcision, in which most of the external genitalia is excised. In Egypt, it is called "Sudanese Circumcision" (Smith, 1995). The entire clitoris and labia minora and much of the labia majora are cut or scraped away. The remaining raw edges of the labia majora are then sewn together with acacia tree thorns and held together in place with catgut or sewing thread. The entire area is closed up with just a small opening the size of a matchstick left for passing urine and menstrual fluid. A straw, stick, or bamboo is inserted in the opening so that as the wound heals, the flesh will not grow together and close the small opening (El Dareer, 1992; Rose, 1994; Toubia, 1994). Type III circumcision is practiced mainly by Muslims in Somalia, Sudan, Mali and northern Nigeria (Morris, 1996).

The procedure

Lay midwives or traditional birth attendants, using knives, razors or glass, traditionally perform female genital mutilation or circumcision. The use of anaesthetic is uncommon. Several women may assist in restraining the girl while the procedure is performed. The procedure can be carried out on girls from a few months old to puberty, depending on local custom (Hicks, 1993; Wright, 1996; Brady, 1998). Local customs and different geographical situations determine which 'type' of genital surgery the girls may undergo (Abusharaf, 1998).

After the procedure, the girl's legs may be tied together for weeks so that the skin grows over the wound. The woman's genitalia are cut open before sexual intercourse and childbirth and restitched afterwards (WHO, 1995; Abusharaf, 1998). The vaginal opening of infibulated women remains small until marriage when, on the day before the wedding, women from the groom's family visit and examine the bride. They check to

ensure that infibulation has been done and that she is a virgin. The genital area should be smooth as the palm of one's hand. To make intercourse easier, the vulva may be cut open slightly, otherwise during the wedding night, the groom widens the opening with his penis, which may be painful for him as well as for the bride. This 'tailoring' of the vagina to the size of the husband's penis is meant to ensure monogamy on the part of the wife (Rose, 1994; Toubia, 1994; WHO, 1994; Mak, 1993; Van der Kwaak, 1992; Hicks, 1993).

The law and female genital mutilation

In New Zealand and in many other countries such as the United States, Canada, and Australia, there are specific laws that deal with the issue of female genital mutilation. These have resulted from campaigns against the practice.

The practice of female genital mutilation in New Zealand is a crime (New Zealand Crimes Act Amendment, 1996). On 1 January 1996, Section 204A of the Crimes Act came into force. Section 204A defines female genital mutilation as a criminal act, punishable by imprisonment up to a maximum of seven years. Section 204B, Further Offences Relating to female genital mutilation, states that a child cannot be taken out of New Zealand for genital mutilation to be performed. Assisting with any arrangements for such a purpose is also an offence.

In the United Kingdom, Sweden, Switzerland, France and Canada, female genital mutilation is illegal and constitutes a criminal offence (Rose, 1994). In Africa countries such as Senegal, Burkina Faso, Djibouti, Ghana, Kenya and Togo have all banned female genital mutilation (Ciment, 1999).

According to Williams and Accosta (1999), whenever a government prohibits the practice of fgm, the practice continues, in greater secrecy. Despite the awareness campaigns there is a paucity of statistical, cultural and medical data available in the adopted countries on those who have emigrated from countries that practice female genital mutilation.

The British Medical Journal presents evidence that the circumcision operation, although illegal in the United Kingdom, is still being carried out and performed on 'girls between the ages of seven and nine' (Black & Debelle, 1995, p.1591). There are no reported cases of female genital mutilation being carried out in New Zealand.

Smith (1995) states that, 'Laws forbidding behavior which is deeply rooted in culture will neither receive extensive support nor bring about much change. Laws are expected to play a supportive role, alongside information and education and an improvement of the economic and social position of women and children' (p.25).

Perceptions of and reactions to fgm by professional groups

Many New Zealand health care practitioners are unaware of the tradition of female genital mutilation and some have never seen a woman with mutilated genitalia (RCM Midwives Journal, 1998). Often the response is one of anger when initially confronted with the practice of fgm. According to Denholm and Jama's (1998) survey in the Auckland region, many doctors were reported to be 'horrified' and their comments that followed left the woman feeling embarrassed and too shy to return to the doctor. Midwives and doctors alike felt they were out of their depth when faced with this cultural practice.

Some nursing literature uses terminology such as 'barbaric traditional practice' when referring to the practice of female genital mutilation (Morris, 1996). Sanderson (1981) uses the words 'horror and disgust' to describe female genital mutilation. However, a strong campaigner against the practice of fgm, Brownlee and Seter (1994) quote Dickemann who states that in terms of the social system the practice of fgm is logical. Efua Dorkenoo tackles this complex, difficult subject by involving both men and women in the eradication campaign and emphasises the importance of education. She states that the practice is so deeply entrenched that one cannot deal with it in a haphazard way. There has to be a long-term, planned program of prevention, with appropriate and full training of professionals (Dorkenoo, 1994). Some anthropological studies by Smith, (1994) and Calder (1993) also take into account the cultural context and are not harsh in their description or judgement of this practice. They do not support the practice but offer a balanced view. An example of an institution taking a balanced view is evident in Britain in which the Northwick Park Hospital study carried out by the local health authority found that the system of a 'waiting list' for the deinfibulation procedure before marriage was most unsatisfactory. Since the study, in 1995, an 'African Well Women Clinic' has been established, giving priority to women requiring gynecological surgery. This clinic was found to have improved the quality of the women's lives and helped to reduce the number of women who became pregnant while still infibulated.

Women from all over the world including women from countries that practice female genital mutilation deliver babies in American hospitals (Schwartz, 1994). In many cases, the women who practice fgm have had their vulva sewn shut to allow only 'appropriate' entry (by their husband) and have asked their obstetrician to sew them shut again after delivery, as their culture requires. There is a view held by some health professionals that if the patient requests reinfibulation it should be

respected and honoured. In contrast, to this view Fourcroy (1999) states that 'if a patient truly requests to be reinfibulated, having a reapproximation of the scarred edges of the labia majora, then we must say "no" for both medical and legal reasons' (p.658). She goes on to say that some physicians perform caesarian sections to avoid this issue altogether, but that most will not reapproximate the tissue or even place an extra stitch if it is not needed after delivery (Fourcroy, 1999). This article concludes that some physicians comply with the request to reinfibulate while others may not.

Health care professionals' behaviors when working with women who have had genital mutilation

Coming to terms with dealing with minority groups and their traditional practices is a common challenge for health professionals these days. The health related cultural practice of circumcision or female genital mutilation is one such challenge. Health care professionals, and in particular nurses, are responsible for identifying health needs, particularly in the most vulnerable groups who often come from diverse communities. To identify health needs effectively, culturally safe practice needs to be considered. Therefore the concept of cultural safety is about the uniqueness of individuals and being careful, considerate and respectful of the differences and uniqueness of that individual. Carryer (1995) states that:

Cultural safety addresses the need to become culturally safe towards people for whom we care; this means accepting that when people are sick or making decisions about their health behaviour, then their social class, gender, sexuality and other personal factors will significantly impact on their experience (p.5).

There is no question (in western countries) that the practice of fgm has injurious consequences for the health of the women concerned. The issue is how to bring about the best health outcomes for women who have been subjected to genital mutilation. A nurse theorist says the following about health professionals and culture:

Some cultural groups are highly vulnerable to strong dominant health professionals from outside their culture. They may perceive power, status, and professional roles as frightening and give self-protective responses. Other cultures are sometimes traumatised, left helpless and in disorganised positions following efforts of outside experts. At the same time some cultures are not soft or totally defenceless when exposed to outsiders. Somewhere in-between the extremes, the health worker treads (Leininger, 1976, p.7-8).

The health professional's view may not necessarily be the view of the client. There is no agreement about the specific concepts of health even within one single culture. How much more complex then will it be for health service providers to meet the needs of people of diverse cultures now living in New Zealand? Female genital mutilation as a health issue is complex because of the deeply held beliefs that surround it.

Summary

Female genital mutilation or female circumcision is a deeply rooted cultural belief. The origins lie in rituals linked to ancient history. The practice is more commonly known as female genital mutilation, however this study uses the term female circumcision and female genital mutilation

interchangeably. The different types of female genital mutilation and the procedure have been described. The New Zealand Law and health professionals' perceptions in relation to female genital mutilation and in the following chapter a review of the relevant literature is presented.

Chapter Two

Literature Review

Introduction

This chapter presents literature about female genital mutilation from the anthropological, social, medical and nursing disciplines. The databases World Magazine Bank, MasterFile Premier, Medline, Cinahl, Electric Library Australasia and PsycLit were accessed. The relevant literature from the period 1978-1999 is presented in this chapter. Ritual and rite of passage practices have been explored by many authors however, no detailed studies about the participants' feelings and views about the practices, the personal and social effects thereof and how their lives have changed as a result of the practices were identified in the literature search. There is much literature on the practice of female genital mutilation but not many research-based studies. In this chapter, the incidence of fgm, some reasons for the continuation of the practice, the implications thereof including HIV are presented. Comparisons are made between male and female circumcision and the health related effects.

The ritual practice of female genital mutilation is common in many countries especially in Africa however, countries outside Africa are faced with issues related to fgm, as refugee and migrant movement to western countries such as the United States increases (Ortiz, 1998). The health services and health professionals in these countries are unfamiliar with this procedure and this poses a dilemma in terms of effective management of women with fgm (Golara, Morris & Gordon, 1998).

Incidence of female genital mutilation (fgm)

Studies have shown a variation in the numbers of genitally mutilated women as well as a link between poverty and the lack of education and fgm while another study shows that education does not make a difference to the numbers of women being circumcised.

In a survey of women in Sierra Leone, carried out by Koso-Thomas (1987), 90% were circumcised. A study carried out in Egypt by Alaa El Din reported that 97% of the women surveyed were circumcised (Douglas, 1998). Ntiri (1993), a member of the Interdisciplinary Studies Program in Michigan, reports Somali women's support for the practice of circumcision as 62%, while support and preference that their daughters be circumcised was reported as 76%. The strong support for their daughters to be circumcised and for the practice to continue reveals the deep rootedness of this cultural practice regardless of the associated pain and complications.

Williams & Sobieszczyk (1997) and Gruenbaum (1996), imply that illiteracy and poverty are related to the practice of fgm. However, Douglas (1998) cited a study undertaken by Faten El Sheneite, in Egypt, in which the emergence of a slightly different pattern to Williams & Sobieszczyk (1997) was reported. Faten El Sheneite reported that an increasing number of educated women are seeking information about having their daughters circumcised by a physician. Of the fifty women interviewed, 90% were university graduates who revealed a desire to avoid complications by having the procedure performed under sterile conditions and with general anesthesia. Wright (1996) cited Savane (1984) who describes how university educated women occupying administrative posts are still victims of the traditional practice of fgm. Despite their education levels, there was a strong belief that

circumcision is still a traditional and religious requirement. Dr. El Sheneite indicates that in the last two or three years she has seen a renewed interest in circumcision and that female genital mutilation is no longer an act associated with poverty, illiteracy, and low status (Douglas, 1998).

According to a study carried out in Kenya by Chelala (1998) the number of women who participate in fgm is diminishing. In Sierra Leone, men were interviewed at random and confessed to enjoying sexual intercourse with uncircumcised women more than with circumcised women (Koso-Thomas, 1987). The literature does not present details on the number of men interviewed or the specific questions that were asked. Koso-Thomas (1987) further reports on a Sudanese study carried out on 300 men, who were interviewed, in which 266 stated that they preferred non-excised or uncircumcised women sexually. Evidence from another study carried out in Northern Sierra Leone reveals that the men and male youths interestingly were strongly opposed to the practice mainly for economic reasons. It may be assumed that having to pay a huge bride-price for an infibulated female is an economic stress for the men. Many are also convinced it is detrimental to health (Women's International Network News, 1996). Lightfoot-Klein (1991) reports on a study carried out by Megafu in which a drop in the rate of circumcisions among the Nigerian Ibo tribe was evident. This report does not detail the methodology. The drop from 85 percent to 33 percent is significant but the author of the report was unsure of the specific reason for the change. However, Megafu did speculate that Western influence played a part (Lightfoot-Klein, 1991). There is evidence of increasing refugee migrant populations who flee their homelands to new environments each year. Despite the movement of people and to new environments, which often means exposure to other cultures, laws and lifestyle, the practice of female genital mutilation appears to continue in many countries.

There are numerous reasons for the continuation of the practice of female genital mutilation in traditional societies. The central issue seems to be that the woman's role is defined by circumcision and by marriage in certain societies. Hosken (1978) states in her article that a woman is regarded as 'worthless' without the circumcision (p.618).

Reasons for the continuation of fgm

Ntiri (1993) reports on a study carried out with the support of the Women's Education Department in Somalia, in which the reasons given for the continuation of the practice of female genital mutilation was; conforming to tradition, to be marriageable, and be bonded fully with women in their world. The typical responses to questions posed by the interviewer were, 'No one will marry you without it', or 'You cannot live in Somalia and not be circumcised' or 'In Somalia you cannot avoid it' or 'It is good for women and our men like it' and one woman stated in disbelief 'You mean other women do not do it?' These responses indicate that to 'become a woman' in the Somali culture one has to be circumcised. (p.223). Lightfoot-Klein (1991) states that in Sudan, Somalia, Egypt and many other African countries there is no alternative to female genital mutilation, no option exists for girls and women in these societies. This is all they are and without circumcision they are not women and therefore are nothing (Mackey, 1996).

Wynter (1997) states that one is not born a woman and in her book *The Second Sex*, Simone de Beauvoir says:

Women: One is not born, but rather becomes, a woman. No biological, psychological, or economic fate determines the figure that the human female presents in society; it is civilization as a whole that produces this creature... If, well before puberty and

sometimes even from early infancy, she seems to us to be already sexually determined, this is not because mysterious instincts directly doom her to passivity, coquetry, maternity; it is because the influence of others upon the child is a factor almost from the start, and thus she is indoctrinated with her vocation from her earliest years (1961, p.249-250).

The literature reviewed for this study suggests a number of reasons for the continuation of female genital mutilation such as benefits to health, and socio-economic benefits (Koso-Thomas, 1987; Kopelman, 1994), while other authors perceive the practice to be detrimental to health, oppressive and patriarchal (Sargent, 1989;). It appears then that there are opposing views for the continuation of the practice of genital mutilation. The reasons for the continuation of female genital mutilation are discussed under the following headings:

- rite of passage,
- status and security,
- gender identity,
- beauty,
- religion, custom and tradition,
- economic reasons,
- health-related beliefs.

Rite of passage

Female genital mutilation is an initiation rite, a rite of passage (Toubia, 1993; McConville, 1998; Bashir, 1997). Very early in life, a little girl comes to accept and realise that circumcision will be the rite to prepare her for marriage (Lightfoot-Klein, 1989). This is a turning point in her life. After the circumcision, the girl acquires a different status. She now belongs to the women's community. Girls may go through various ordeals such as circumcision or infibulation, de-infibulation, and re-infibulation in order to be accepted and be marriageable (Wright, 1996).

McConville (1998) reports that circumcision is a fact of the Somali girl's life, just as tremendous hardship, poverty, scarce water and little food, backbreaking labor, overwhelming heat and dust storms, crippling disease, unalleviated pain, and early death are facts of life. Circumcision happens to every woman. This is the only reality, and she accepts it as every woman does. A woman from Mali explains, 'It is considered a form of purification and a rite of passage to womanhood. In our language, the word excision means, 'to clean' (p. 35).

Status and security

Female genital mutilation offers status and security (Lightfoot-Klein, 1989; Hicks, 1993). If a girl is not purified through circumcision, she may not marry, bear children, and attain a position of respect in her community (Hicks, 1993). Mothers who have their daughters circumcised genuinely believe they are doing the right thing for their much-loved daughters. The prospect of their daughters being outcasts if not circumcised is unthinkable for the mothers, in a society in which an uncircumcised woman has no status in society and is an outcast (Lightfoot-Klein, 1989; Abusharaf, 1998).

According to Lightfoot-Klein (1989) to call a man the son of an uncircumcised woman carries a huge social stigma and is an insult. A woman gains status first by being circumcised and then by marriage and having children. The woman accepts this fact, having no knowledge of any other reality. No other viable options exist for her. Her reward for conforming to this practice of fgm is favour in the eyes of God (Allah) or her husband and society (Lightfoot-Klein, 1989).

Women repeatedly have themselves infibulated, several times in a lifetime, and say that they do it for the man's pleasure. The elders urge them on so that the woman's vagina is tight and her husband will not be tempted to marry another wife (Toubia, 1994; Gruenbaum, 1996; Lightfoot-Klein, 1989; Wright, 1996). Therefore, the motivation for these women to continue with the practice of genital mutilation is connected with status and security. A woman whose husband leaves her loses both status and security. The women accept that they are there to fulfil the needs of the man and that they are his property, the same as a camel or a house (Calder, 1993; Lightfoot-Klein, 1989). Aside from the status and security that genital mutilation appears to achieve, gender identity is another reason often given for the continuation of genital mutilation.

Gender identity

The act of infibulation determines the gender identity of women (Abusharaf, 1998; Calder, 1993; McConville, 1998). The clitoris is thought to be the male part and therefore needs to be cut off (Abusharaf, 1998). An African grandmother explains that 'the clitoris grows long [like the male penis] if you don't remove it' (McConville, 1998, p. 36). After infibulation, the women, married and unmarried, believe that they become virgins and achieve a new identity. They are now regarded as

marriageable and able to give their husbands children. Those who are not infibulated will find it almost impossible to find husbands and have children (Van der Kwaak, 1992; Calder, 1993). Before the circumcision procedure a girl is called a 'qabar' which means little girl. After the circumcision she is called 'qabar dhoozil', an infibulated girl. A good 'bride-price ' is received by the father for a 'gabar gudban' (closed woman) as opposed to that for a 'buriya gab', a woman with a clitoris, a term of abuse (Van der Kwaak, 1992). Closely associated with identity is the concept of beauty (Kopelman, 1994).

Beauty

Beauty, means a combination of all the qualities of a person or thing that delights the senses and mind (Knight, 1997).

The circumcisor is often reminded by the girl's mother or relatives to make it (the circumcision) smooth and beautiful like the back of a pigeon. The circumcision enhances beauty, says Abusharaf (1998). Rendering the genital area smoother, and therefore more appealing to men is yet another rationale for circumcision or infibulation. A flat smooth surface is more pleasing to the sight and touch according to Koso-Thomas, (1987). It is believed by the women that fgm is necessary for the good health, cleanliness, and beauty of the woman (Gregory, 1994; Calder, 1993). The term 'tahara' means to purify in Arabic (Mak, 1993; Calder, 1993; Van der Kwaak, 1992). Natural protuberances are viewed as ugly (Gregory, 1994). In Somalia, it is believed that the hard male part, the clitoris, has to be removed thereby making the woman soft and feminine. However, the reality is that after mutilation, the soft parts are no longer soft, but turn to hard scar tissue most times (Van der Kwaak; 1992, Calder, 1993).

Boddy (1991) states that in other cultures too there is evidence in the pursuit of beauty and she further says 'we submit ourselves to caesarian sections and mechanized childbirth to produce the 'perfect' baby, inculcate in our daughters, albeit implicitly, that they must diet, exercise, dye, and depilate to achieve the 'perfect' body, we tweeze and pluck and color and conceal to attain the perfect face. We work hard at being women, spend considerable sums of money' (p.16). She further asks the question why should female bodies in virtually every society be subject to alteration, maiming, mutilation, and control?

Religion, custom and tradition

According to the Oxford Dictionary *religion* means a system of belief in and worship of a supernatural power or god, *custom* means usual habit, long established activity or action. *Tradition* means an unwritten body of beliefs, customs handed down from generation to generation; custom or practice of long standing (Knight, 1997). The terms religion, tradition and custom are often used interchangeably.

Religion is often stated as a reason for female genital mutilation. Fulfilling a religious requirement was the motivation for fgm amongst the Egyptian group of women (Douglas, 1998). However, the Qur'an does not condone the circumcision of women (Wright, 1996; Calder, 1993; Meares, 1995). It is not mentioned in the Qur'an (Alibhai, 1995; Digges, 1998). When Somalis are asked why they practice it, the common response is 'It is our tradition'. Most women who practice genital mutilation are under the impression that it is prescribed by the Qur'an. This is 'untrue', according to Van der Kwaak (1992, p. 780).

Boddy (1991) states that for some African women religion and tradition are related. There is an assumption, says Mukhopadhyay (1995), that culture and gender relations are rooted in religion, and that 'religion is

the only basis of the culture of a people; indeed the term religion is often used interchangeably with culture' (Mukhopadhyay, 1995, p.15). She states, however that it is incorrect to assume that people in general are slavishly subservient to their religion or the rules that govern their culture. It is a myth that practices are unquestioned within those cultures. On the other hand Koso-Thomas (1987) a Nigerian physician, states that, all societies have rules and norms to conform to, but the price for African women is far too high. Kaplan & Lewis (1993) quote Walker who says that fgm is torture, not culture.

Economic reasons

Female genital mutilation continues to be practiced for economic reasons (Sherif, 1996; McConville, 1998; Lightfoot-Klein, 1989). The women who practice fgm, both on themselves and on their daughters, are from one point of view merely being practical: 'To get married and have children is a survival strategy in a society plagued by poverty, disease and illiteracy. The socioeconomic dependence of women on men colours their attitude toward circumcision' (Abusharaf, 1998,p.28). There are economic implications for men too. The future husband of any marriageable girl has to pay bride-wealth, the weight of which is determined by the tightness of her vagina. A 'closed woman' is worth a good bride price. This is paid in camels, usually to the bride's father. The old women, the grandmothers, have a great deal of power over the lives of the young women and girls. They exercise their social and economic power to the fullest, in ways that peripherally also give them power over men. Most decisions are firmly in the hands of the grandmothers (Lightfoot-Klein, 1989). Birth attendants also gain much of their income from carrying out these procedures. In a questionnaire answered by forty midwives in Khartoum and Port Sudan, 10 percent

expressed the view that circumcision, the 'sunna' type, should be continued (Dorkenoo & Elworthy, 1992/93).

The men have an indirect control over the circumcision of women (Kressel, 1992; Van der Kwaak, 1989). They do not get involved with the arrangement of the procedure or with the procedure itself, however they often save enough money for the circumcision ceremony to take place. The father of the girl will receive a good price from the prospective husband. The husband will not accept the girl if she is not circumcised. (Opoku-Dupaah, 1995; Black & Debelle, 1995; Nelson, 1996). Therefore, it is the men, who do hold a certain power over the practice of female genital mutilation.

While men have some control over circumcision, it is the circumcisors, usually old women folk, and the midwives, who gain the most economically from genital mutilation. These procedures command an excellent fee (Lightfoot-Klein, 1989). In her study of Somali women Sherif (1996) states that women who practice fgm earn vast sums by Somali standards, whether at home or in refugee camps. It will be difficult finding replacement activities that can generate the same income as does circumcision (Sherif, 1996). In the McConville study a circumcisor says 'excision was my only source of income and I used to receive oil, cloth, millet, rice and money in exchange for my services' (McConville, 1998, p.36). The traditional birth attendants and midwives, whose incomes depend on circumcision, feel a sense of obligation to cooperate with this practice (Van der Kwaak, 1989, 1992).

The village economy is enhanced as thousands of 'Dayas', (traditional midwives), or village women, 'Gedda', as well as paramedical staff, nurses and doctors, find circumcision and its related procedures a lucrative way to earn extra money. It is the strict moral rule of virginity

that allows midwives and lay women to make their living from circumcisions and the effects of circumcisions. They not only make a living from the practice, but also derive status within the community because of their actions in the participation and the perpetuation of the practice of female genital mutilation (Wright, 1996). Another aspect in the perpetuation of the practice of fgm is the belief that, in the absence of fgm, harm will come to the mother, the baby and the male.

Health-beliefs related to the practice of fgm

The circumcised woman's position in the household is enhanced and she develops a sense of pride from being circumcised. This reality may contribute to the fact that she is unlikely to associate the many physical problems she has with the procedure of circumcision. The painful circumcision procedure, the prolonged urination and menstruation time, traumatic penetration, and unbearable childbirth are all accepted as normal for women (Williams & Acosta, 1999). The physical and mental consequences of mutilation are usually attributed to other causes or denied altogether. Women rarely connect the medical problems with the excision itself. Often the women are genuinely shocked to learn medical facts (Wright, 1996, p. 253).

A motivation for the continued practice of fgm is the belief that, if the clitoris touches the baby during childbirth, the baby will die, or that if the clitoris touches the penis there is ill health and maybe death to the man. This is a real fear motivating the women who practice genital mutilation (Van der Kwaak 1992; Kopelman, 1994).

Being infibulated is seen as a health benefit. According to Brady, (1998) an American nurse who worked in Saudi Arabia, the women request to be re-infibulated after childbirth. It is argued by Adinma & Agbai (1999) that infibulation is viewed as positive by the women as they see their

wombs and fertility as more powerfully their own as a result of the operation. Adinma & Agbai further state that female genital mutilation is a benefit as it discourages marital infidelity by reducing sexual urge and promiscuity. El Saadawi (1994), a Cairo doctor, acclaimed novelist and campaigner for over twenty years, states that the reasons for the continuation of fgm are far more than has been commonly documented. The practice of female genital mutilation is related to patriarchy. She argues that it bears a relation to the ancient, pre-monotheistic practices of monogamy for women and polygamy for men, the evolution of the class system and slavery and grew out of the historically based double standard. The idea says Saadawi (1994) is to diminish the sexuality of women, rendering them sexually insubordinate and telling them that men own their bodies. According to Saadawi (1994) men's control of reproduction has an economic-political function.

Implications/effects of fgm

The effects of genital mutilation could be likened to sexual violations such as rape and child abuse, occurring in any culture and on any victim. According to Nelson (1996), in India, the preference for sons leads to violence against female infants. Nelson, cites the 1994 World Bank Study, a national survey that suggests 'that up to one-third of women in Norway, the United States, Canada, New Zealand, Barbados, and the Netherlands are sexually abused during childhood. In the United States 78 percent of sexual abuse cases involve girls' (p.36).

Van der Kwaak (1994), El Saadawi, (1980), Calder, (1993), the WHO, (1995) and El Dareer (1983) report the following immediate and long-term effects of female genital mutilation.

Immediate effects

- Hemorrhage is unavoidable and is common due to the amputation of the clitoris.
- Shock is due to loss of blood and may also be due to the pain and anguish as often the mutilation is performed without anesthesia.
- Infection may occur due to unhygienic environmental conditions and use of unsterilised instruments. HIV transmission is an increased risk and is discussed later.
- Urine retention is common, as for hours and days after the operation no urine is passed due to the fear of burning and pain on the raw areas.
- Injury to adjacent tissues such as the urethra, vagina, perineum or rectum may occur as a result of poor light, eyesight or crude sharp tools or careless technique.

Long-term effects

- Bleeding occurs later if the wound becomes infected. The repeated de-infibulation and re-infibulation causing blood loss may develop into anaemia.
- Difficulty in micturition due to obstruction of the urinary opening or damage to the urinary canal may occur. Urinary retention may be due to the pain and may result in urinary tract infection.
- Urinary tract infection is common due to the damage often caused by the mutilation or because of complications. Infibulated women are

particularly susceptible as the perineum remains constantly wet encouraging bacterial growth.

- Infertility is a risk of infection, which may cause irreparable damage to the reproductive organs.
- Vulval abscesses can develop due to infected cysts or from the thorn or stitch used in the suturing process.
- Keloid formation and dermoid cysts as a result of wound healing, and/or scar tissue formation may occur.
- Vesico-vaginal or recto-vaginal fistulae can form as a result of injury during mutilation, de-infibulation, re-infibulation, sexual intercourse, or obstructed labour (Denholm & Jama, 1998). Continuous leakage of urine and faeces can plague the woman all her life and she may become a social outcast. A fistula often occurs between the anal and vaginal passages, during pregnancy and following childbirth, causing severe pain. Fistulae can also cause frequent miscarriages because of urine seeping into the uterus (Abusharaf, 1998).
- Difficulties in menstruation are common and are often due to partial or total occlusion of the vaginal opening. Dysmenorrhoea and haematocolpos (accumulation of menstrual blood in the vagina) may result.
- Psychosexual and psychological health: Marital conflict may result because of sexual dysfunction in both partners as a result of painful intercourse. Penetration may be difficult or even impossible, and recutting may need to take place. Genital mutilation may leave a lasting scar on the mind of the female child. The complications may be submerged in the unconscious mind and may trigger behavioral

disturbances. Loss of trust and confidence are possible side effects. Long term complications such as feeling incomplete, anxiety irritability and frigidity may result (Smith, 1995).

Effects on pregnancy and childbirth

Female genital mutilation has implications for pregnant women in the antenatal, birthing and postnatal periods. In the event, of a miscarriage, the fetus may be retained in the uterus or birth canal. Tough scar tissue may prevent normal dilatation of the cervix and may result in obstructed labour during the second stage of labour. Fetal brain damage and sometimes death of the baby may occur (McCaffrey, 1995). The obstruction of fetal descent may result in fetal hypoxia or death. It would be difficult to get a sample of fetal blood if fetal distress should occur (Newman, 1996). The tearing of scar tissue with the passage of the baby may be severe as is the pain and healing process.

It is important to note that the women who have been mutilated do not view the consequences negatively, but see this as a 'woman's lot' or a natural part of being women. They do not relate regard them as problems or associate them with the circumcision (Walker & Parmar, 1993; Dirie, 1998).

HIV/AIDS

There is some controversy about the effects of circumcision in relation to the transmission of HIV / AIDS. A 1998 report from the State of World Population Report, indicates that:

3.1 million people were infected in 1997 by the human immunodeficiency virus (HIV), and 1.5 million

died from HIV/ AIDS-related causes; another 1 million died from reproductive tract infections and sexually transmitted diseases (STDs) other than HIV / AIDS. Teenagers account for more than half of the 333 million new cases of those diseases per year (UN Chronicle, 1998, p.14).

The absence of sterile technique, the existence of genital scars, continual trauma, and bleeding that occurs during and after infibulation may carry risks and increase the susceptibility to the transmission of the human immuno deficiency virus in females who have been circumcised (Ortiz, 1998; WHO, 1987; Toubia, 1994; Adekundu & Fakokunde, 1999). There are no research data available on the prevalence of female genital mutilation and HIV/AIDS infection.

The State of World Population Report presents evidence of several studies carried out by Moses, which reveal that male circumcision reduces vulnerability to HIV infection. Researchers Dingman & Key, (1996) found that men who were not functionally circumcised¹ as were more likely to be HIV positive. This study did not describe details of the methodology used or the numbers of males examined. Hosken (1993) also states that circumcised males are probably at less risk of infection by HIV/ AIDS. John et al (1997) state that advocating for male circumcision is a means of reducing the risks of HIV infection in sub-Saharan Africa. However Halperin & Bailey (1999) state that male circumcision should not be perceived as a substitute for other HIV and STD prevention strategies but rather should be intergrated into existing prevention programmes, especially in places with a high prevalence of HIV infection.

¹ functionally circumcised: not circumcised in a symbolic manner.

Key & DeNoon (1997) used 1,410 men as a sample in a study. Of the 1,410 men, 1,033 had circumcision and 353 did not. The incidence of viral STDs, such as herpes or HIV, was 35.3 out of 1,000 for circumcised men and 32.3 for uncircumcised men. The difference is insufficient, say the authors, to indicate that circumcised men are at higher risk of contracting sexually transmitted diseases.

From the above contradictory results, it would appear that more research is required, as there are no conclusive studies to indicate whether the risk of HIV infection is substantially increased or decreased by the circumcision of males.

Male circumcision

There have not been many comparisons made between the male and female circumcision because male circumcision is regarded as being more superficial and less dangerous than female circumcision (Caldwell, Orubuloye & Caldwell, 1997). In many civilizations, surgical procedures such as circumcision have profound social and cultural meaning. Male circumcision is an ancient practice with deep importance as a symbol of religious duty. The cultures that practice male circumcision, Judaism, Islam, tribes in sub-Saharan Africa and Australian Aborigines have strong socio-cultural and religious relationships (Toubia, 1994).

Male circumcision involves the permanent removal of the prepuce or foreskin of the male, usually in infancy. The rich documented history of Jewish circumcision illustrates the religious and social context, which surrounds this cultural practice (Immerman & Mackey, 1997; McLynn, 1997). Canadian physicians say that both male and female circumcision have no medical advantage and both are nonconsensual mutilation, therefore both are unjustifiable (Eike-Henner, 1993; Williams, 1999).

Immerman & Mackey (1997) argue that male circumcision serves a definite function, that 'it lowers excitability and sexual arousal in pubescent males which would bias young males more towards tractability which enhances group efforts and less towards individual goals of amorous exchanges' (p.265). The authors state further that neurological data suggest that the early lesion of the prepuce or foreskin would generate a re-organization/atrophy of the brain circuitry. This in turn will lower sexual excitability.

A longitudinal study carried out in Canada on infant boys showed a substantially lower incidence of urinary tract infection (UTI) among circumcised boys. According to this study, there was a significantly higher risk of urinary tract infection for uncircumcised boys than for circumcised boys (To, Mohammad, Dick, & Feldman, 1998). To show the health benefits of male circumcision Roberts (1996) concluded in his study that, the practice of neonatal circumcision is an important prophylactic operation. He states that uncircumcised men seem more prone to sexually transmitted diseases, including HIV infection. Roberts (1996) is of the opinion that since the fact that male circumcision prevents UTI, pyelonephritis, and end-stage renal disease the practice should be continued. This must take place after discussions with parents, he says.

A study on circumcised men carried out by Key & DeNoon (1997) was based on analysis of data collected from 1,410 men aged 18-59 in the United States, which has the world's highest non-religious circumcision rates. Of the total number of men that participated in the study 1,033 had been circumcised and 353 were not. Among the circumcised men, the rate of bacterial sexually transmitted disease or STDs, such as syphilis or gonorrhoea, was 129.9 out of 1,000. That compares with 112.9 out of 1,000 for uncircumcised men. The difference was statistically significant.

Twenty six of the circumcised men reported contracting the STD chlamydia while none of the uncircumcised men did. There is no further explanation as to why the chlamydia rate was higher among the circumcised men.

These studies reveal that: Circumcised males are less prone to urinary tract infection and STDs (Roberts, 1996) while (Key & DeNoon, 1997), state that uncircumcised men are more prone to HIV infections. Generally it is difficult to summarise and compare results accurately because of differences in methodology, samples of infants or adult males studied, methods of collecting urine for the urinary tract infection statistics, and in some studies details of methods of study were not described. It is therefore noted that more research is required to establish the medical advantages and disadvantages of circumcision in the male population. It should be noted that there are religious and social links to the practices of male and female genital mutilation, which offer a complex dimension. Furthermore there is no medical evidence to justify circumcision of males or females.

Cultures that identify themselves by particular cultural practices often defend the practices vehemently. Groups of Africans who have faced colonialism hold onto cultural practices enabling them to maintain their cultural identity. As immigration from Third World countries increases, it is more likely that women will be in contact with the health services of their adopted country at some stage. For health care professionals and especially nurses, working towards effective outcomes for the Somali women and health professionals is the challenge. Baker (1997) states that all behaviors have meaning and health behaviors can only be judged within the person's cultural reality. Therefore, no cultural belief about what health is can be assumed to be superior or inferior to any other.

Summary

This chapter presented with relevant literature on the incidence of fgm, some reasons for the continuation of this cultural practice, the effects of fgm and concludes with some literature on male circumcision while the following chapter describes the methodology and method of this study.

Chapter Three

Methodology and Method

Introduction

This chapter presents the reason for choosing a qualitative method, a justification is provided for the use of focus group interviews and their appropriateness for the participants in this study are discussed. Thematic content analysis, as the method of data analysis, is explained. Ethical considerations in the planning and conduct of this study are addressed.

Methodology

The primary purpose of this study is to identify and describe the health needs of Somali women who have been genitally mutilated and who live in Wellington. I needed to gain insight into their health needs in relation to female genital mutilation. To gain insight into any personal subject, I realised would require a safe environment and a good relationship with the participants. The Somali women were required to personally express their health needs in relation to fgm. Thus a qualitative approach was deemed most suitable for addressing the aims of the study.

Qualitative methods are used to explore and describe issues of a sensitive nature. Qualitative methods are found to be invaluable in discovering new knowledge and to obtain insights into unknown territory and different truths (Berg, 1989; Patton, 1990). Researchers using qualitative methods increasingly use focus group interviews, as a dominant strategy for data collection (Morgan, 1988; Reed, 1997). Focus group use has become increasingly popular in nursing research in recent years (McDougall, 1999).

Focus groups

Focus groups are typically exploratory in nature but sometimes confirmatory of a phenomenon (Duffy, 1993). Focus groups should be used or considered when there is a communication or understanding gap between groups of people, for example groups who have power and those who do not, such as medical or professional groups and refugee groups (Krueger, 1994). There are strengths in focus groups that aid in the work with minority groups especially in cross-cultural research (Kitzinger, 1995). Focus groups have been used to facilitate culturally sensitive research (Berg, 1995).

The focus group discussion often facilitates cross-cultural research in a culturally sensitive manner that reflects the social realities of a specific cultural group. The focus group method helps researchers to gain knowledge about a wide range of views from individual experiences thereby identifying the strength of cultural knowledge (Hughes & DuMont, 1993; McDougall, 1999).

One of the advantages of focus group interviews is that several interviews are done at once, saving time. Focus groups are used when a very specific topic is explored and members are asked to reflect on the questions. The participant's response is of importance, as the group, in light of the comments, makes additional comments (Lankshear, 1993).

Focus group discussion provides data that explore the participants' feelings in depth and there is a personal context to the information shared and generated by the participants. The importance of group interaction in the focus group setting is the key in producing data and insights that would be less accessible without that interaction (Morgan, 1988; McDougall, 1999). The interactions among the group members stimulate discussion in which one group member reacts to or comments on information shared by

another member. Focus group discussions therefore can be extremely dynamic if they are administered properly (Berg, 1995). As with most methods of data collection, limitations can be overcome by careful planning and conduct of the focus groups.

Planning the focus group

When planning the focus group several things need to be considered.

The time, venue and transport issues should be carefully thought through long before the actual focus group sessions. Action may be taken to address some of the unexpected occurrences, for example:

"Nobody shows up or

Only few people do show up or

The meeting place is inadequate or

The group members do not participate and do not want to talk or

The group gets over involved and do not want to leave or

Hazardous weather occurs hours before the meeting"

(Krueger, 1994, p.119).

Good planning before commencement of the group interview may eliminate some of the potential shortcomings. A telephone call a day before and the morning of the focus group could be made to remind participants of the date, time and venue. Contacting the key participants to assist with reminder notices to other participants is a good idea. Precise, clear and easy to follow directions of getting to venue should be made available. However not all of the unexpected occurrences can be catered for or overcome.

Small talk is essential to make participants feel comfortable and at ease just before the ice-breaker question and group discussion. The small talk helps to create a warm friendly environment that facilitates

communication. Participants may not feel comfortable about sharing their point of view on a particular topic. There are some topics that should be avoided during small talk such as religion, politics or a sensitive local issue (Krueger, 1994), as these could lead to complicated discussions not conducive to the group discussion.

The environment

Focus group meetings should be held in an environment that is comfortable and accessible to the participants. Reasonable acoustics for audio taping are also helpful, as the quality of the data is critical to the success of each session. Inaudible material is difficult to transcribe and valuable information can be lost in the process. The provision of refreshments helps to establish a comfortable environment too. The average length of a session is one to two hours. Within this time, it is important to focus on the topic. This may mean keeping to two broadly structured questions on the topic (Morgan, 1988).

The original suggestion to hold the focus group in the community hall was not acceptable to the Somali women in the present study. The group discussions were conducted at three different homes, which were considered the most suitable venues. The women were concerned that in an unfamiliar environment they might be overheard, interrupted or as in the case of the two community centers the environment was not as warm and comfortable as a home. The venue was the home of three different families, (one family hosted the focus group meeting twice) which was the most suitable and convenient choice for all the women involved. The women came in usually about an hour late for the group session. This was 'normal' to them and they did not consider this a problem. On two occasions only there were latecomers to the group who were welcomed and filled in on what had just been discussed and the women fitted in and made their contributions without any difficulty or much disruption. Good

interviews and interactions are those in which the participants are at ease and express their point of view freely. Data produced from the good interactions are usually rich and reveal the participant's perspectives on the given topic.

Group size and composition

The focus group is a special type of group in terms of the purpose, size, composition, and procedures. This is usually a small group of people, eight to ten being the desirable number. This small non-representative, group of participants allows for in-depth description of phenomena but not for generalisation to a larger population (Hughes & DuMont, 1993). The participants should have certain characteristics in common relevant to the topic of the focus group. The composition of the group members refers to the characteristics of the participants, for example the age, gender and other common features that include them and not others in a particular group. Group composition is important because the participants are the source of the data that are required. A facilitator, using structured, open-ended questions around a specific topic runs the discussion or interview. There must be adequate space and comfort to accommodate the number in the group, including the facilitator.

In this study there were thirty-one participants in total, who participated in four focus groups. There were six, eight, seven and ten participants in each consecutive group. The ages of the participants ranged from 20 to 55 years, and the women were of various educational backgrounds. Only two of the women were not married. One of the participants was a nurse in Somalia. Some were able to speak English but chose not to, while others who spoke only Somali were also part of the group.

The facilitator

The researcher, who may act as the facilitator in some cases, ensures that a permissive environment is created that nurtures different perceptions and points of view, without pressuring participants to reach consensus. The facilitator helps to create an environment where the discussion is usually relaxed, comfortable, and often enjoyable thus encouraging participants to share their ideas and perceptions. Group members influence each other by responding to ideas and comments in the discussion. Participants are allowed to explore the topic in their own words, responding to open-ended questions (Krueger, 1988; Morgan, 1988; Lankshear, 1993; Kitzinger, 1995). The facilitator has to maintain a good discussion and keep participants on track, ensuring active participation of all group members. It is hard work and requires that the facilitator be constantly alert (Steward & Shandasani, 1990). The taking of notes by the facilitator is a common practice (Streubert & Carpenter, 1995; Catanzaro, 1988; McDougall, 1999).

The skilled facilitator usually has a sense of "what *not* to probe" (Templeton, 1994, p.44), which is an important aspect of probe questioning. When involved with a sensitive subject, there may be an opportunity to explore an issue further with a probe question. However, if that information is not directly relevant to the original aim and questions presented within the research, then the facilitator should not delve further. Excessive probing is unnecessary (Krueger, 1994). The facilitator should use his/her discretion and maturity to know which areas to probe for further information. The facilitator should not impose their own sense of what would be interesting or important (Morgan, 1988). The genuine interest shown and effective communication skills of the facilitator are essential for obtaining data that address the research questions.

The role of the researcher/facilitator is complex and requires trust, communication skills and other characteristics that enhance research. An important aspect for the researcher is to gain entrance into a particular group and access to potential participants. Establishing trust and rapport is an essential first step (Field & Morse, 1985). Getting to know the channels of communication for the specific group of people is the task of the researcher so as to fit in and abide by the group norms. There are fine lines as to how well acquainted and friendly one becomes with the group while gaining their trust and establishing rapport, keeping in mind the purpose of the study.

The characteristics of the researcher/facilitator should include open-mindedness, an ability to communicate effectively with others and to have minimal prejudice or ethnocentrism. Pernice (1994) states that the researcher should also be non-judgemental, genuine and possess intercultural empathy. It may not be possible to have all the attributes recommended, but by identifying areas that may hinder the research one can work on them positively to enhance the collection of data. While the researcher may sometimes have strong value conflicts with a participant's view, it is important to encourage the participant to express their view and what they feel is the ultimate aim. 'The researcher is not there to change views, but to learn what the subjects' views are and why they are that way' (Bogdan & Biklen, 1992, p. 99). However, the researcher needs to emphasise that as many different points of view as possible are necessary to get valuable data and that all views shared are of equal importance (Morgan, 1988).

The researcher/facilitator should be flexible, have a sense of humour, project sincerity and be able to listen, follow with appropriate probe questions if necessary *and* write notes. The researcher influences the quality of the focus group. A lack of warmth, energy or diplomacy can

jeopardise the quality of the focus group session. There must also be trust in self in the process and in the participants for effective outcomes to be obtained. As a researcher/facilitator one needs to be familiar with the facilitating of focus groups and with the researcher role. It may be appropriate to consult with experts in this field before commencement of the focus groups. It is important to guide the interview, probe when necessary, and to understand and encourage in order that information is elicited in a moral and ethically sound manner.

For this study the role of the researcher and the role of the facilitator were interchanged. The researcher frequently assumed the role of the facilitator.

Questions

Three main question types were used in the focus group interview for this study. They were the ice-breaker question, semi structured questions and probe questions (see p.47 for specific questions used).

The initial ice-breaker question is very helpful as all participants should be able to relate to it and have something to share that is common in the group. It helps to emphasize the similarities among and between group members and remind them that all contributions in the discussion are equally valuable. This format fosters conversation and interaction among the participants thus facilitating data collection. The object of focus group discussion is to get high quality data in a social context where people can consider their own views in the context of the views of others (Krueger, 1994).

The most suitable form of question structure for data collection in qualitative research is a semi-structured question format that gives the researcher more flexibility in the range of potential responses. Prompts are useful to keep the focus of the discussion on the topic (Open Learning

Foundation, 1997). Semi-structured questions also offer insights, feelings and perspectives on topics that cannot be obtained through other forms of questioning.

The probe questions used are helpful and should be posed in a way that the participants could easily relate to. The probe questions offer the opportunity and flexibility to explore issues not possible with other forms of data collection, such as the mail out survey (Krueger, 1994). The questions should be simple, clear and consistent with any previous questions asked (Patton, 1990). The probe questions are helpful in addition, when the discussion wanders a little or for extracting full information (Steward & Shandasani, 1990; Open Learning Foundation, 1997). The probe questions are used to increase the depth of the response, adding richness to the data. They are follow up questions used to deepen the response whenever necessary and should be used in a natural style and voice to enhance the responses (Patton, 1990).

Ethical Considerations

Prior to the commencement of this study ethics approval was obtained from the Massey University Human Ethics Committee, The Massey University Inter-Ethnic Research Committee and the Wellington Ethics Committee. All committees required assurance that ethical standards would be maintained such as prevention of harm to participants, confidentiality, informed consent and anonymity.

The rights of participants and their well being were protected. A full explanation of the nature of the study was given verbally and in writing (Appendix A). The right to withdraw, and the right not to answer any particular questions were emphasised and made clear and understandable to all participants, with the help of the interpreter. All participants were made aware during the initial stages of the study that

information they shared and discussed in the group would be used in the final analysis, even if they chose to leave the group before the end of the discussion. They were informed that it was impossible to separate the information provided by each individual and that any issues that were discussed in the group were to remain within the group and data obtained was to be used for this thesis and any publications or conference presentations arising from it.

The names of participants were not announced or mentioned or attached to any specific contribution and the participants were assured that it would be difficult to identify individual participants from what had been shared in the discussions. The researcher assured participants that names would not be used in any published material and their identities would not be revealed. The interpreter and the typist each signed a confidentiality agreement (Appendix D & E). After further explanation from the researcher and the interpreter a verbal consent was recorded from each participant. This consent related to the use of a tape recorder during the group discussions.

The taking of notes throughout the research process offered supportive descriptive accounts of what was happening. The noting of non-verbal behaviors, hunches and impressions, and the level and tone of voices are important aspects of note taking and add richness to the audio taped data (Patton, 1990; Field & Morse, 1985). Note taking helps the researcher to formulate new questions or probe questions as the interview moves along and helps to facilitate analysis later in the process.

In order to ensure that no harm came to participants as a result of the sensitive and personal nature of the discussion support was arranged (in the form of the women elders from the Somali community) for any

participant who may be distressed and needed specific support. None of the participants required support as a result of the group discussion.

Participant selection

The sampling method used was 'purposeful sampling', where the researcher selects participants according to the needs of the study. The sample is usually representative of participants who have knowledge of the topic to be discussed, and who have similar population characteristics such as culture or ethnic background (Morse, 1991).

The participants were recruited through the Wellington branch of the Refugee and Migrant Services (RMS) and from the Somali Community Association. The Advisor for RMS and the key leaders of the Somali Community were contacted by telephone. An appointment was made to discuss the research project. A follow up phone call was made within a week of the initial appointment to confirm their support for the study. Arrangements were made to meet, discuss the project and get a letter of endorsement.

The "invitation to participate" (appendix A), the "information sheet" (appendix B) and "consent form" (appendix E) were discussed with the key people (the male community leaders) and the package of these documents presented to them. The invitations were given to the Community Leader and the RMS Advisor, both of whom approached potential participants to discuss the research and invite them to participate in the study. At this stage the potential participants were informed that the researcher would follow up with a phone call to find out whether they were interested in participating in the research. The community leader and the RMS advisor provided the names and phone numbers, after having gained the women's verbal consent for this

information to be given to me. Telephone contact was made with those women who were interested in participating and arrangements were made to meet with them individually. All contact was made using an interpreter who spoke the Somali language. I was able to use the services of three different interpreters altogether.

The purpose of the first meeting with each potential participant was to outline the details of the research. The meeting was arranged at a time and place suitable for each participant and the interpreter, who was also present. The individual contact included an explanation about the research and the information sheet. Potential participants were encouraged to take a week to think about their involvement. They were contacted again by telephone at the end of the week.

The interpreter and I telephoned the participants again a day before each session to remind them of the focus group interviews. I asked those that were interested if I could come over and get a consent form signed. None of the participants were happy to sign the form stating 'my word should be good enough'. It was agreed they would give verbal consent at the focus group interview. According to Pernice (1994), research practice designed to protect participants can unintentionally cause psychological harm because of previous political and social experiences. For example some participants have a fear that the 'special police' are spying on them.

I requested the participants' permission to take notes as we talked and whilst the discussion was being tape-recorded. I also informed them about the process thereafter, that the cassette tape would be given to a typist to be transcribed and I would read and pick out themes that emerged and bring it back to them. These themes would be the basis for the written discussion of the study topic.

Role of the interpreter in this study

Most Somali refugees speak little or no English as was the case with the participants in this study. It was therefore necessary to use the services of a trained interpreter. It was important to the outcome of this research and in getting the data I needed. I was able to get two interpreters through the Wellington Community Interpreting Services but none of the issues discussed above posed a problem.

The interpreters used in this study were from a registered agency in Wellington who were well versed in the interpretation technique and who were also familiar with terminology regarding health issues in general. However, the interpreting of health issues e.g. the terminology for the anatomy of the female genitalia was a challenge on two occasions to one of the interpreters. This issue was overcome by a group member's assistance. One of the risks of using an interpreter was revealed when the group chatted at length on several different occasions. The discussion in Somali was regarded by the interpreter to be irrelevant to my study as it had to do with stories about childbirth that related to their husbands and their lives in Somalia. The interpreter did not think it was of interest to me. Valuable data may have been lost to the study as a result of this decision. The researcher needs to be aware of the risk of missing vital information. This can be minimised by clarifying the role of the interpreter and the need to interpret every part of the discussion. Field and Morse (1995) state that the interpreter apparently does not realise that the information shared could be beneficial and that the researcher is a better person to probe or clarify or determine whether that information is useful to the study or not.

Before embarking on this project I was fully aware of the clan division and factions that surround the Somali population. However, during my discussions regarding this issue, so as not to offend anyone and in keeping with community protocol, I found that three key people in the

community, two males and one female were against clan affiliations being highlighted. The consensus was that they are now living in New Zealand and did not want to bring clan differences into New Zealand society and that it is unimportant which clan a person belonged to. The Somali are a united people and want to remain that way. There is no need for New Zealanders to focus on their clan differences. This view held by the three key people differs from that ~~was~~ previously discussed by health professionals working with Somali in the Auckland area.

In this study the interpreter may have been from a different or the same clan to other participants. There was no evidence of any disharmony or hierarchy within the group. Each participant was heard, valued and was equally given an opportunity to speak by the interpreter as well as the researcher.

In order to overcome the possibility of missing vital data both interpreters listened to each tape to ensure that the recording was clear, their interpretation was accurate and that all parts of the interview were clearly audible.

The Process

The focus group discussion commenced with the welcome of all participants and the interpreter. An overview of the topic was given and I emphasised that I was not interested (especially in this study) in whether they or I or New Zealanders or health care professionals approve or disapprove of the practice of female genital mutilation. I was interested in the descriptions of their health needs in relation to their genital mutilation only. The general ice-breaker question "How did you find life and the lifestyle in New Zealand as compared to Somalia?" was then put forward before the discussion focussed on the main topic.

Reiteration of the purpose before commencement of the discussion set the scene. Free discussion was encouraged, questions were posed appropriately and participants were made to feel comfortable. Casual communication was encouraged. The discussion then focussed on the following two research questions:

Q1. Tell me about your health needs in relation to your circumcision.

Q2. What information should health workers have about circumcised women to ensure their health needs are met?

The two main questions were given to participants three days before the group discussion to enable them to familiarize themselves with the topic. Probe questions such as "can you tell me more about ..." were put forward to clarify and extend some of the discussion. The researcher took notes during the group sessions. The open-ended questions required the participants to make an individual response and were not limited in the range of their responses. There was opportunity to elaborate, clarify, and give reasons for the way participants felt about or viewed a specific situation.

We sat on the floor, as this was comfortable and preferred by the group members. I wore traditional Indian attire to all group sessions and social events, as I was comfortable with this. The participants were dressed in traditional Somali dress. After the group discussion, family members, children and the women participated in the refreshments. It was a very well organised refreshment break. Any children or other family members who came around during the refreshment stage also participated.

During the refreshment breaks some very relevant data were also obtained adding richness to the recorded data. I did a lot of note taking at appropriate times. This included during the formal focus group sessions, while at other times I had to scribble stuff quickly during the

conversations at refreshment break or before the formal group discussion. This was a challenge. Trying to balance note taking with having a conversation without disruption was not easy at times.

The interpreter and I had an hour to ourselves before the women would arrive. She told me that the requirement for her to translate the information sheet bored the women and that they were not interested in so many words. They simply wanted the key points that were necessary to get on with the project. They had complete trust in me and the process I was using. The women preferred relevant verbal information only.

The room was comfortable and a space was made for us to be seated. However the rest of the family were in the other parts of the house, trying to be as quiet as possible. The women brought along children and sometimes had to leave the room to attend to their needs. During the planning stage I was told repeatedly that children would not be a problem and that I was not to arrange child-care facilities as family and relatives would take care of the children. This did not happen. The children were noisy at times making it difficult to concentrate on what was being said. The noise also affected the quality of the audio taping. The cord from the tape recorder came off twice as children ran across the room. Each focus group discussion was conducted for a duration of two hours.

The women verbalised that they were happy to participate in the research and allowed this to be recorded. They said the fact that they were present for the focus group, meant they were happy to participate. They further emphasised that they trusted all the confidentiality issues and other important points that had already been shared by the interpreter and myself at the beginning of this process. The signing of forms, was very uncomfortable for them as in the Somali culture only

criminals signed papers and as one participant laughingly put it 'or unless I am to receive a large sum of money'.

Women also left very quietly one at a time during the latter part of each group discussion and as each returned another one left. After the focus group I enquired about this occurrence and learnt that they went to the prayer room to say their daily prayer, (the Islamic religious custom of praying five times a day).

I was not allowed to help with the refreshments as I was the guest and was to 'sit and be fed'. During this time the women and other family members laughed a lot and talked and sometimes the Somali women in the group who were able to speak English interpreted what they were saying so I felt included. Often during this phase one or two women at a time would arrange themselves close to me in order to share extra information that they felt needed to be shared, or would simply talk about a coming function or event within their community and extend an invitation to me.

General difficulties with data collection

Many of the research methods used by Western cultures are developed by Western cultures only and may not be appropriate or adequate for cross-cultural research. Pernice (1994) describes some of the common methodological problems encountered while working with immigrant groups. She states that there may be difficulties due to the high rate of mobility of the migrant community.

In this study some of the key women associated with the project moved from city to city and country to country therefore there were some changes to persons involved. However, it was fortunate that the

maximum number of key people were involved so that there were still many left for the successful completion of the study.

The data collection took place over a period of four months. The first two groups met in November, 1998, and one group in December, 1998. The month of Ramadaan (January) meant no activity of this nature could occur so group sessions halted. Ramadaan is the Islamic fasting month where not much activity takes place except for prayer meetings and abstinence from food, and drink occurs during hours of daylight; other cultural practices are religiously observed. The Muslim faith also requires that prayers be conducted daily at five specific times of the day (Morris, 1996). The final group meeting was held in February 1999. The movement of an interpreter to another country also affected the timing for the completion of the data collection phase. Therefore, the data collection took longer than expected.

After the first focus group I took in toys for the children that accompanied the adults. This did reduce the distractions caused in the group but did not completely eliminate the noise level. After the second group discussion 'trust-building' had to be re established mainly by the key women and researcher to reassure the participants of confidentiality and safety while publicity was being given in the media to Somali people and fgm. The interpreters were also reminded that they should interpret all conversations within the group as they may be important to the study.

Analysis of data

The challenge is for the researcher to analyse the data in a way that the findings from the study can be presented in a logical and concise manner. According to Miles & Huberman (1994) there are three stages of data analysis, data display, data reduction and data interpretation. The process

of thematic content analysis was employed to identify a number of significant themes in the data. These were organised in a systematic manner to address the aims of this study, which were to identify and describe the health needs of women with genital mutilation and to find out what information should health workers have about circumcised women to ensure their health needs are met.

The first step in this process was to have the focus group interview transcribed. Transcription facilitates analysis of the data and provides a more permanent record of the interview. Transcription is not always completed by the typist and therefore requires the researcher to listen to the tape and fill in the correct spelling or missing words and complete the sentences.

Further analysis of the data involves the researcher becoming familiar with the data. This requires focussed attention over a period of time. The volume of data collected was large and has to be reduced, into common ideas and recurrent patterns. This process required reading the data several times, to identify common patterns, themes and categories and common types of responses. The common themes and categories are grouped together into 'similar' types of categories or broad themes (Streubert & Carpenter, 1995). The overall aim is to find the pattern of ideas and arrange them into meaningful order, attempting to stay 'true' to the data collected. Burnard (1995) states that trying too hard to analyse data sometimes results in the meaning becoming too elusive.

For this study the transcribed data also included notes (observation of any laughter, side discussion, the environmental changes) taken by the facilitator before, during and after the focus group sessions. In addition to the transcribed data discussions that took place before and after the group sessions were translated and included.

In this study a third party who is a New Zealand registered practising nurse, read all four transcripts and identified similar themes to those identified by the researcher. The themes that emerged were then taken back to the key women in the community who agreed the themes were a true reflection of the discussion. The taped discussions contain more than words: they contain feeling, emphasis, and non-verbal communication and therefore my note taking was used to fill in the gaps.

Several categories or themes were arrived at and are discussed. Streubert and Carpenter (1995) and Sandelowski (1993) state that no two researchers will describe the findings in exactly the same way. The influencing factors are related to the background and culture of the researcher and the time period in which the study is conducted.

The information gathered by each researcher may differ. Each researcher may focus on slightly different things related to the same topic or may ask questions in a different manner and a different response. As culture is ever changing and dynamic, the findings from this study are applicable in the context of the time and place in which it took place. 'These discoveries bring important insights; they do not pretend to bring forward 'the truth', but rather a truth' (Streubert & Carpenter, 1995, p. 109).

Summary

This chapter presented with the methodological process for this study. The advantages of using a qualitative approach and focus group interview were discussed. The participant selection process and the data collection and analysis processes were described while in the following chapter presents with the findings, the grouping of the themes and the discussion of each theme are presented.

Chapter Four

The Findings

Introduction

From the four focus group discussions, four transcripts of the recorded data were obtained. Each script was read and re-read, with and without the audio taped recording to get familiar with the script. In each script, approximately 180-200 recurrent words, terms and phrases were highlighted, for example: tradition, pride, heritage and identity. These were then grouped together into 16 categories as follows:

1. types of female genital mutilation(fgm)
2. virginity
3. sexual issues
4. waiting list (for de-infibulation)
5. urinary issues
6. menstruation issues
7. long labour
8. cutting technique
9. Somali medication
- 10.caesarean section
- 11.shame and embarrassment
- 12.Waris Dirie - UN ambassador
- 13.pride in circumcision
- 14.need for support
- 15.need for understanding - Somali
- 16.need for understanding - New Zealand

Further grouping, collapsing and merging of some categories with others resulted in six main categories. I further merged the categories, resulting

in four and finally in two main themes. The two main themes that emerged from the focus groups were:

- **Somali women's identity defined by fgm**

- **Somali women's perspectives on childbirth**

The above perspectives emerged from data obtained from focus group discussions. The two research questions put to groups of Somali women related to Somali women's health needs and related to information that health care workers needed to know about circumcised women. The Somali women thought it important for health professionals to understand what fgm means to them, what fgm means for them and thereafter understand their health needs. In this chapter the theme of the Somali women's identity defined by female genital mutilation is discussed while in the next chapter the Somali women's perspective on childbirth is discussed.

Somali women's identity defined by fgm

The women in all four focus groups indicated that female genital mutilation (fgm) is seen as an important cultural practice, which has significant cultural value. This is consistent with the literature, which stresses the deep embeddedness and relevance of genital mutilation or female circumcision in the cultures that practise it, and the religious, aesthetic, socio-economic, mythological and sexual reasons for the practice (Lightfoot-Klein, 1989; Hosken, 1982; Smith, 1995). At the core of these beliefs is the conviction that female genital mutilation (fgm) is normal and beneficial to women and to the order of those societies in general (Smith, 1995; Leonard, 1994; WHO, 1994; Koso-Thomas,

1994). Most of the findings from this study appear consistent with a study done in Somalia (Calder, 1993).

Pride, honour and tradition, gender identity and religion, marriageability, cleanliness and beauty, status, shame and embarrassment were issues discussed by the women in the focus groups. Each issue is presented as a sub-theme and discussed in the following sections with evidence from the data provided.

Pride, honour and tradition

A recurrent sub-theme was the pride, honour and tradition associated with circumcision. During the interviews the women displayed their deep sense of pride, sense of identity, and Somali-ness.

The women expressed with pride:

"We are proud, we are not ashamed of it".

"If the girl has a circumcision it means we are so proud, she has honour and this gives indication she is a virgin".

"To have our honour is very important to us"

The concept of honour in Somali culture has huge value and therefore a huge price and meaningfulness within that society. If a woman loses her 'honour' her family is dishonoured too (Dorkenoo, 1994). The pride and honour of a family rests on the women. If a girl is well brought up and maintains her dignity, she reflects well on her family and society; if she behaves poorly, she brings 'shame' on the family and society and easily becomes an outcast (Opoku-Dapaah, 1995). For many people their sense of worth, and the value they place on the individual self, relate to situations in which they are in control (Hall, 1976). Therefore, the *pride*

may come from the only area of control that these women have. Honour relates to one's character and reputation. It regulates interpersonal relationships, and Somali and some other cultures such as middle-eastern cultures, would go to extreme lengths to preserve this honour. Calloway-Thomas (1999) states that deeply rooted values of honour are often linked to how we behave towards each other. Having *honour* is like a sense of duty with a strong conscience. In most cultures, great honour is bestowed upon those who exhibit a strong sense of duty within that culture. Honour and a sense of duty therefore are seen to be acting as internal guides to moral behaviour in a society.

The women emphasised:

"It is our tradition"

"Somali people are proud of their culture and religion. We are proud that we have this heritage".

"We are proud of our tradition."

"We have to protect ourselves, our girls"

The complexity of issues associated with fgm and the social significance and function of this practice have been poorly understood and relatively unknown. Hicks (1993) claims that 'female genital mutilation is a cultural trait deeply embedded in a historically traditional milieu and shows why it cannot be treated in isolation as a single issue destined for elimination' (Hicks, 1993, p.1). It is interesting to note that many cultures quote 'tradition' as the sole explanation for following specific cultural practices. There is, however, a complex decision making process that takes place, although perhaps not on a conscious level. There are demands on an individual within the culture that can only be understood within the cultural context of that community (Lynam, 1992; Hall, 1976). In societies that practice female genital mutilation the importance of

virginity and an intact hymen is one reason why fgm is a popular practice. The belief that the intact hymen is protection of her virginity and therefore her honour makes the woman acceptable in that society (Bashir, 1997; Van der Kwaak, 1992; Saadawi, 1992). It appears that culture, tradition, religion, and being Somali, are terms used to relate who people are and concepts such as honour and shame have deep meaning for Somali people. Related to 'honour' - one of the reasons often given for the existence of the practice of female genital mutilation is that, generally women are 'oversexed' and have to be protected from themselves and from men. It is believed if the clitoris is not cut off it will increase the women's desire to have sex; hence it has to be removed (Morris, 1996). Women are viewed as the 'weaker sex' and therefore have to be 'controlled' from their own sexuality to keep their "ird" (decency) which is directly related to the *honour* and dignity (*sharaf* and *karama*) of the family (Hicks, 1993).

The literature confirms the women's views on the importance of 'honour'. In a recent CNN programme (August 29, 1999) entitled '*Honour Killings: a brutal tribal custom*', the deaths of several women raised disturbing questions about this tribal custom in which a father, husband, brother or son is duty bound to kill a female family member who allegedly has brought shame or dishonour on the family. A conspiracy of silence often hides the brutality within these communities.

The women's overwhelming bond with 'honour' was expressed:

" We are Somali, we are shamed if we do not keep our 'honour!'"

The following is an example of the outcome if a girl loses her 'honour'. Ibtihaz, a young girl who was accused of shaming and dishonouring the

family by being unmarried and pregnant was stabbed to death by her brother. This, the brother said, was to regain family *honour* or 'we'll live in shame' (CNN. August 29, 1999). 'A girl who does not preserve her virginity is liable to be punished with physical death, or moral death. If virginity is lost, this brings almost everlasting shame which can only be 'wiped out in blood', as the common Arab saying goes' (El Saadawi, 1987, p. 27). It does appear then that the data obtained from the group reflect the literature cited on the subject of genital mutilation.

Gender identity and religion

The relationship between the cultural practice of fgm and religion is clarified. The women bring together their early emphasis on pride, religion and tradition again:

The religious requirement was described as follows:

"Our Somali girls have to be virgins". "It is in our religion".

In some cultures any act that is associated with 'religion' is viewed as critically important to the maintenance of that culture. Again the women seem to link religion to their identity. This confirms the literature that religion and tradition are not only entwined but are often one and the same. Differences in cultural practice often surprise outsiders. What may seem normal for one group may be outrageous or amazing for another. Female genital mutilation is an initiation rite (Van der Kwaak, 1989; Toubia, 1994). Very early in life, a little girl comes to accept and realise that circumcision will be the rite of passage to prepare her for marriage (Lightfoot-Klein, 1989). This is a turning point in her life. After the circumcision, the girl acquires a different status. She now belongs to the women's community. Girls may go through various ordeals in order

to be accepted and be marriageable (Wright, 1996). Girls are being mutilated at a very young age, some under a year old (Wright, p.251).

The women express what it means to be a Somali woman:

"Even though we do not like the pain it is our culture and we are proud of it."

"Whether our ancestors were right or wrong, we are so proud that we are identified as females with our circumcision"

In societies that practice female genital mutilation, individual and social identity is based on being infibulated. Women's individual and cultural identity is based on all women being infibulated (Toubia, 1994). It is this identity of 'Somali-ness' that is of paramount importance to Somali women. A Somali girl, who was circumcised at eight, married at thirteen to a fifty plus man, explains that if a girl does not marry, she is nothing (Barnes & Boddy, 1994).

The women expressed as they reflected:

*"This is our belief that this is **normal for us**".*

*"If we are **women**, we have to have this, or we are not women"*

*"It is our culture and belief and we have to follow **our religion** and practice it"*

*"We are proud of **our religion** and heritage"*

"If you are born a girl you have to have this done"

"It is a normal thing in our life"

"It is our religion"

Religion is often stated as a reason for the continuation of female genital mutilation. However the Koran neither condones nor prohibits the circumcision of women (Wright, 1996; Calder, 1993; Meares, 1995). The common response from women about circumcision, is that it is tradition and it is religion, giving the impression that it is a practice prescribed by

the Qur'an. Circumcision is a fact of the Somali girl's life, just as tremendous hardship, poverty, scarce water and little food, backbreaking labour, overwhelming heat and dust storms, crippling disease, unalleviated pain, and early death are facts of life. Circumcision happens to every woman. This is the only reality, and she accepts it as everyone accepts it. A woman from Mali explains, 'It is considered a form of purification and a rite of passage to womanhood. In our language, the word excision means, 'to clean' (McConville, 1998, p.35). Mothers who have their daughters circumcised believe it is the right thing to do. They love their children and do not want them to be outcasts (Abusharaf, 1998). Female genital mutilation is a matter of survival. To get married and have children is a survival strategy in a society plagued by war, poverty, disease, illiteracy and dependence of women on men (Abusharaf, 1998).

Emphasising just how difficult it is to change deeply embedded cultural practices, a Seattle refugee states, 'the fact that we came, as refugees don't mean we are going to leave our culture overnight. The bad parts of our culture we will try to shake off gradually' (Coleman, 1998, p.743).

The women expressed strongly:

"We cannot leave our culture just like that, we'll be nothing."

To ensure that 'we' (the outsiders) understand Somali culture, repetition and emphasis continued along similar themes related to their identity. The women said that fgm is their cultural practice, their belief and that they have to follow this practice as a duty, otherwise they would *lose who they are, and therefore their identity*. Also embedded in this is the linking of 'religious duty' with tradition and culture. Female genital

mutilation has become part of the traditional initiation into adulthood. This practice is erroneously seen as a religious duty (Wright, 1996).

Marriageability

To be married is what Somali girls look forward to. There was a serious atmosphere created during the focus group interviews in which the women related that it was important for 'others' to be aware of misconceptions:

"And yes, it is said that we do it for men, and that men want it. It's not true, men have nothing to do with it, it's the ladies will go around and check, my daughter, she did not have a circumcision. I want to prepare my daughter; you know it's kind of prudence, it is in our blood".

*"Who will **marry** us if we are not circumcised?"*

The issue of men and their involvement is very confusing; on the one hand it appears that female circumcision is exclusively a female event. Men are excluded from participating in all aspects of the ceremony. Even inadvertently, men's participation is believed to result in misfortune, including blindness and the loss of virility (Leonard, 1996; Hicks, 1993). Men do not take part in conversations about their daughters or fgm and say it is a shame to interfere in women's business. Mothers are not required to inform the girls' fathers of what is going on with them.

On the other hand there is contradiction and some confusion as to who has the major role in relation to genital mutilation, the men, or women in Somali society. It is the men who refuse to marry an uncircumcised female (Opoku-Dupaah, 1995; Black & Debelle, 1995). Dirie (1998) says that her mother had no option in the decision to circumcise her, because

as a woman she is powerless to make decisions. Her mother simply did to her what had been done to her, and what had been done to her mother, and her mother's mother. And that her father was completely ignorant of the suffering he was inflicting on her for he knew only that in Somali society, if he wanted his daughter to marry, she had to be circumcised or no man would have her.

The fact that infibulation enhances men's sexual enjoyment - 'the tighter the vagina, the more pleasurable the intercourse is said to be for the man - is certainly not the sole factor to explain the persistence of the practice. But it cannot be ignored' (Van der Kwaak, 1992, p. 782). While virginity is a major aspect of female identity, for the male it is his virility that is a crucial part of his identity (Van der Kwaak, 1992). It is the father of the girl who will not receive a good 'bride price' if his daughter is not properly circumcised (Van der Kwaak, 1992). The male believes he should control all aspects of sexual relations (Koso-Thomas, 1987). The literature thus also confirms the paradox between men and women's role in relation to female genital mutilation.

Cleanliness and beauty

The women participants explained with much pride, a different view of cleanliness and beauty:

*"The mother will prepare her own things. The things to cut with and you know the things we talked about to make her **clean** and say, 'these are my things and please make my daughter **beautiful**'.*

The organised style and system of describing the procedure with body language, facial expression, lots of gestures, a sense of pride and commitment to revealing this serious event was quite overwhelming. The

women seemed to almost relive the event. The circumcisor is often reminded by the girl's mother or relatives to 'make it smooth and beautiful like the back of a pigeon' (Abusharaf, 1998, p. 25). Rendering the genital area smoother, and therefore more appealing to men, is yet another rationale for circumcision or infibulation. A flat smooth surface area is more pleasing to the sight and touch (Koso-Thomas, 1987). It is believed that this procedure is necessary for the good health, cleanliness and beauty of the women. The term 'tahara' means to purify in Arabic, and all Somali women want to be purified (Mak, 1993; Calder, 1993; Van der Kwaak, 1992). Natural protuberances are viewed as ugly (Gregory, 1994). In Somalia, it is believed that the hard male part, the clitoris, has to be removed thereby making the woman soft and feminine. However, the reality is that after mutilation, the soft parts are no longer soft, but turn to hard scar tissue most times (Van der Kwaak, 1992; Calder, 1993).

In an interview reported by El Saadawi (1987) a woman who had been circumcised was asked if she believed that the circumcision would make her clean and pure. She stated 'Of course. I was happy the day I recovered from the effects of the operation, and felt as though I was rid of something which had to be removed, and so had become clean and pure' (p.35).

The women gave an almost carthartic description of pride at the accomplishment of something special:

"After it is done, you feel good as a mother, it is smooth and clean for our daughter".

Somali women believe that a smooth tightly stitched vagina is a beautiful clean one and gives the woman a sense of pride. Anything that

protrudes from the smooth appearance is viewed as ugly. The fewer orifices there are the easier it is to keep the area clean (Mak, 1993).

"We like to keep ourselves clean".

The 'cleanliness' does not only relate to the outside appearance. The maintenance of cleanliness seems to be an important issue for Somali women. It is said that the secretions produced by the glands in the clitoris, labiae majora and minora are foul smelling and therefore unhygienic and make the body unclean (Brady, 1998). In areas where water is difficult to obtain and there is a requirement for women to cleanse their genitals with soap and water after micturition, this becomes a problem. In addition, the hand that is used to wash the secretions or the contaminated area is not the hand that should be used with food transference. It therefore is believed very necessary that the glands that are responsible for the secretions should be removed, thus maintaining cleanliness (Koso-Thomas, 1987).

Status

Whether on a conscious or unconscious level the women see themselves as Somali women (meaning women with fgm) and no other reality exists.

"Before circumcision she is nothing, after circumcision she is a human being".

"If she be a girl, a woman she must have circumcision".

"We cannot leave our culture just like that, we will have nothing, we will be nothing"

This is explained in the book "The Hidden Face of Eve". El Sadaawi has a conversation with a girl who had circumcision, and she says:

It is done to all the girls for the preservation of a good reputation. It was said that a girl who did not undergo this operation was liable to be talked about by people, her behaviour would become bad, and she would start running after men, with the result that no one would agree to marry her when the time came for marriage. My grandmother told me that the continued existence of a very small piece of flesh between my thighs would have made me unclean and impure, and would have caused the man who would marry me to be repelled by me (1987, p34).

According to Smith (1995), Somali women do uphold the practice of genital mutilation very strongly. This may be because an uninfibulated girl/woman has no chance of marriage, and becomes an outcast in her society. A girl's career, social standing, marriage, children, family, and lifestyle depend on fgm. Due to the lack of opportunities for education, of exposure to other cultures, of discussion about cultural practices and a lack of resources, the practice of fgm is not questioned by thousands of women. To be circumcised is a measure of pride for African women who traditionally practice fgm (Koso-Thomas, 1987).

The consequences of not being circumcised was expressed by the Somali women as:

" It is a bad thing not to have a circumcision for any Somali women".

There is a sense of pride gained from being circumcised (Brady, 1998). The women who are infibulated are accepted into the community, and their position in the household is enhanced. This contributes to the fact that she is unlikely to associate the many physical problems she experiences with the procedure of circumcision. She may even wish to

be reinfibulated after childbirth to hold onto her 'proudness' (Brady, 1998). The belief that if the clitoris touches the baby during childbirth, the baby will die, is also a real fear motivating the women who practise genital mutilation. The belief too of some of the communities who practice fgm is that if the clitoris touches the penis it will cause ill health and maybe death to the man (Van der Kwaak 1992; Jama, 1995).

Shame and embarrassment

The Oxford dictionary defines *shame* as: 'feelings of distress or humiliation caused by consciousness of one's guilt or folly; thing that is wrong or regrettable; bring shame on, person or thing that brings discredit' (Knight, 1997, p.552). To *embarrass* is defined as 'make a person feel self-conscious or ashamed' (Knight, 1997, p.196). Throughout the discussion, these two words were used interchangeably by the women in relation to male health professionals in New Zealand, in relation to the waiting list and in relation to public attention.

Shame and embarrassment in relation to New Zealand male health professionals

*"The Specialist(s) here in New Zealand is [are] mostly men. Why don't they have females, we are shy of opening our legs to men- it's so hard. I was crying not because of the pain but because of the **shame and embarrassment** of the men's presence."*

Generally, the Somali women do not encourage strange men to touch them or be part of their private health conversations. It is very embarrassing and mostly they will withdraw and not communicate. It is

likely then that women will not inform male doctors of any problems, as the less they have to do with them the more comfortable the women feel.

The scarcity of female practitioners/doctors has been one of the principal barriers to health care for Somali females, particularly since cultural values prevent females from being examined by a man. Somali women in Kansas City indicated two main health care concerns. One was to have obstetricians or family physicians that were familiar with the social and medical ramifications of female genital mutilation. The other was the availability of women clinicians as opposed to men (Fourcroy, 1999).

In the development of a trusting relationship it is essential to relieve the patient of her fears, and make her as comfortable as possible. With desperation one of the women in the group said:

*"I was pleading with my interpreter **please let them go out!** I wanted to hide my vagina from the men with my hands but could not. There was the leg holder and the bed".*

The woman described in this scenario seemed to be placed in this most exposed and vulnerable position had no opportunity to hide or be less exposed or vulnerable. Her legs were held apart and she would not have been able to use both her arms freely to hide her vagina as being pregnant and lying down is an awkward position with her legs spread open is most uncomfortable. A community worker in Australia sums it up 'When circumcised women are pregnant and giving birth in hospitals in Australia they face a lot of problems and a lot of discrimination. Sometimes all the doctors, instead of helping the women, will come and gather and they say, 'Come and see, this is a circumcised woman, and some of them say 'What happened to you? Is this an

abnormality?'(Abood, 1993, p.27). Nurses, midwives, and female doctors were reported as acceptable caregivers, but not male nurses or doctors (Calder, 1993).

The women implied during my meetings with them that there is a perception among them that there are disproportionate numbers of male doctors, gynaecologists, and obstetricians, to female and therefore the cultural requirement for female doctors and nurses to attend to the Somali women cannot always be met. From the statistics indicating the proportion of female doctors to male doctors, there seems to be an increase in the number of female doctors; however, most are General Practitioners and few are specialists in Gynaecology or Obstetrics (Medical Council of New Zealand, 1998, p.1). Pippa Mackay, Medical Association chairwoman explains that women doctors, particularly those who wish to enter clinical specialty have to limit their career options, due to juggling of job, training and family commitments (Ryan, 2000).

Shame and embarrassment in relation to the waiting list for de-infibulation

De-infibulation is the term for the reversal of infibulation or cutting open the scar tissue. De-infibulation services are now accessible in all major hospitals in New Zealand (Denholm & Jama, 1998). Women may present for de-infibulation before marriage. In this instance the reason for de-infibulation is to consummate the marriage.

"Some of the ladies have to be cut open before the marriage"

De-infibulation is a surgical procedure; therefore any request from a General Practitioner (GP) for this to be done requires the women to be put onto a waiting list, a health system device used in New Zealand and some other countries to prioritise cases. The Somali Community has a

problem with this system, as it does not meet their needs adequately. The de-infibulation before marriage seems to be an urgent request by the women. McCaffrey (1995) states that de-infibulation of pregnant women should ideally be carried out in the antenatal period.

The women describe the frustration with the 'waiting list' system:

"The new husband does not want to wait 'on the waiting list' to be with his new wife".

*"Waiting list is **shameful - shameful** for others to know, overnight stay is **shameful and embarrassing**. The husband wants his wife that night. He cannot wait for the waiting list, which all the people will come to know about if she has to book, and stay in overnight. It is a silly simple thing".*

It is important for health care professionals to treat this request for de-infibulation as urgent (Denholm & Jama, 1998). Denholm and Jama describe experiences of some Somali women requesting the de-infibulation procedure and who have been put on very long waiting lists. Consequently husbands have tried to penetrate the women themselves, causing considerable trauma and pain to both partners Toubia (1994) states that usually the type I and type II clitoridectomies have short and long term complications, but they do not create mechanical obstruction to first intercourse or to labour. However the type III tightly infibulated women may need to be de-infibulated before first sexual intercourse.

Sex and sexual issues are taboo subjects among the Somali; generally, they are not discussed with males, or with strangers or with a number of people present. Sex is a private issue and therefore the fact that a Somali woman has to go into hospital to have de-infibulation is most

embarrassing and uncomfortable. As all her close friends, family, and community know that a particular woman is well and normal, they question why is she staying overnight in hospital.

The women felt very strongly about the public exposure of personal issues.

"It is horrible! It is a very private thing".

For the Somali women to have their private lives exposed is very stressful. There is the assumption if the girl is in hospital overnight and she was not known to be physically unwell that she is preparing herself for her husband and now the 'whole world knows what she is going to do'. The women or men would genuinely be concerned if there were any other significant problem/illness that they need to share in and thereby offer their support. Nevertheless, the embarrassment is huge, for the community to all know that she is going to sleep with her husband for the first time that day. The fact that they will all know that she is not going to be a virgin anymore too is embarrassing for these women.

The women view the reversal of circumcision as a simple procedure:

"Why go to theatre, it can be done in a clinic by people who know how to reverse? No need for general anaesthetic. It is urgent to open up, to reverse the circumcision".'

"We can't wait!"

"Please understand our needs it is not necessary to stay overnight in hospital for a simple thing. One of our lady's stayed overnight in hospital and everybody came to know. It is between husband and wife".

"It was too embarrassing. In Somalia the lady will go very privately, maybe her and her husband or a close friend and reverse the circumcision at a private place".

The women could not emphasise enough their embarrassment and the stress that is caused, when a woman goes on the waiting list to be de-infibulated. Because this is seen to be an everyday, normal occurrence in traditional Somalia and therefore is no big deal, the woman quietly goes to the lay-midwife, with a relative, to be de-infibulated. No one else in the community gets to know what she is doing and why. The husband is supportive of this or uses his own methods to have sexual relations. The use of special creams aids in lessening the pain and in producing a successful outcome.

"Because of this embarrassment here in New Zealand, the husband have to go through different ways and not go for the reversing"

Alternatively, the man either tries repeatedly to penetrate his wife or he may resort to the use of a sharp instrument to assist in widening the opening to consummate the marriage. The literature confirms this as common procedure in some areas of Somalia (Gruenbaum, 1996; RCM Midwives Journal, 1998). The husband has to try to penetrate his wife over several weeks sometimes months before he is successful. Here, in New Zealand, it is not known whether he uses a sharp instrument to help cut the vaginal opening before penetration. The penetration of his wife on their wedding night is proof of the husband's virility and proof that the girl is a virgin (Van der Kwaak, 1992). The women in the group displayed a lot of passion when relating how embarrassed they feel. In Somali culture, it is legitimate for the women to suppress her sexual drives and not to directly initiate intercourse (Lightfoot-Klein, 1989).

The women pleaded for understanding:

"You have to understand and feel for us that we don't need to go on long waiting list for reversing or whatever and to give us our needs at the time we ask you because it depends on the circumcision. You can't know when I want to reverse it because it depends on when I'm getting married so you can't put me on a waiting list. Secondly if I am on, if I'm giving birth you have to respect me as who I am, not feel shame or sorry for me because I had circumcision. Three, we don't like our daughters to have the same thing but we are still proud and we are not in any way feel shy or ashamed to our fathers and sisters.

The 'waiting list' system does not suit the Somali community especially for the purposes of de-infibulation. The women believe in their unique skills and knowledge relating to circumcision and de-infibulation and therefore do not seem to understand the western health care system and the 'waiting list', which is common in many countries. The women feel they can easily de-infibulate, they have the skills and knowledge so they ask, why is it so difficult for the health system to make arrangements to have this done more easily rather than using the laborious wait on the 'waiting list'. Health and illness are concepts that are culturally constructed (Baker, 1997) and it certainly frames the responses and views from the people's reference. Point three that the women make relates to them not being in favour of having their daughters going through the pain and agony of genital mutilation however they are still proud of this traditional practice. One cannot predict therefore that if there was no law against this practice whether they would voluntarily give this up.

Shame and embarrassment in relation to public attention

There was a deliberate effort by the participants to emphasise their dislike of Waris Dirie and disappointment with the publicity she brought. The focus group interviews were held during Waris Dirie's visit to New Zealand. Waris Dirie is an internationally famous model and has recently been chosen by the United Nations as a spokesperson on women's rights in Africa. She has been travelling extensively promoting her book, which exposes female genital mutilation. In October and November 1998 Dirie came to Australia and New Zealand with her message of fighting against the practice of female genital mutilation (fgm). She appeared in many prime time radio and television interviews and her book is available in the bookstores. The newspapers carried articles promoting her work and her book. The New Zealand public were therefore well informed during this time about the Somali model and her campaign against fgm.

The women said defiantly:

"We are not happy that she come [came] to New Zealand and make us feel shame"

"We know this, it is in the newspapers and television all about Somali women."

"And we feel shamed by it".

From the group discussion that occurred after the actual focus group conversation around Waris Dirie, the women indicated that they were **embarrassed** and **ashamed** to walk in the streets as everybody would be looking at them, saying 'here is another Somali women who must be circumcised' and 'they pity us'. Generally the Somali women gave me the sense that mainstream media often do not possess adequate frames of reference, so another culture's behaviour is not authentically portrayed and descriptions of it usually lack the depth of meaning behind some of

the practices they wish to highlight. They made a deliberate comment such as the following in each of the focus groups.

"Waris Dirie kills our tradition as she is giving false information. We are so proud of our heritage and tradition. It is embarrassing and shameful".

*"She is making it public and has given up her religion and culture. She is **not** one of us. Why did the UN choose her?"*

The link between the Somali cultural traditional practice of fgm and their concept of what is shame and embarrassment is strongly evident. The media attention that the practice of fgm received did cause problems in the Somali community. For example, a woman who worked at the supermarket was asked 'Are you Somali, did you see the lady on television, the model?' The supermarket worker replied 'leave me alone' and walked out. She never did return to work, due to the huge embarrassment she felt.

The women at this stage unanimously rejected Waris Dirie and regard her as an outcast. The comments made by the women in the focus group discussions about Dirie also indicate the differing views that exist within the Somali community on this subject of genital mutilation. There may be groups of women from urban areas who share Dirie's view and others from rural areas, as were most of the women in each of the four focus groups, who do not. However, it was stressed by some of the participants that women in the Somali community would like to go about addressing their health issues in relation to female genital mutilation 'in their way'. That means, to work within their own community, away from media and public attention. This may indicate a range of future possibilities for the development of new knowledge and relationships between health care professionals and their community.

*"Some of our people are doing good things in our own ways, too but not by letting the world know like the way **she** [Waris Dirie] is doing"*

Waris Dirie did affect the Somali women. They were very distressed by her visit and the publicity that it attracted. The media insensitivity could lead to a backlash. The women mentioned numerous times in casual conversations that they do not like the sensationalisation of the fgm topic or any public attention drawn to this issue of female genital mutilation and Somali society. They find it hard to cope with and find it most distressing. This leads to the understanding that the Somali community would prefer their privacy regarding this cultural practice and not have it publicised to the usually unsympathetic foreign culture.

Waris Dirie's visit coincided with the focus group discussions, which did cause concern for me as well. The community leader telephoned me, to say that, the women were not happy to meet with me for the second focus group meeting. They were feeling exposed, vulnerable and ashamed as the news in the papers and television was about Somali women and the work of the Waris Dirie's Public Campaign against the practice of female genital mutilation. In the end the women still attended the focus group meetings.

Physical health issues in relation to fgm

In a study carried out by Calder (1993) on Somali women it was found that most of the women had their circumcision between the ages of five and seven years and most of them had the type III circumcision or infibulation. The study further suggests that health care professionals and especially nurses should be aware that Somali girls past the age of seven have probably been circumcised. The urinary frequency and the girls taking at least twenty minutes to urinate must be conveyed to

school teachers and others working in the general public environment especially with school children (Calder, 1993; Denholm, 1989).

The physical and mental consequences of mutilation are usually attributed to other causes or denied altogether. Walker and Parmar, (1993) note that 'rarely do the women connect the medical problems of the many excised women with the excision itself. Often the women are genuinely shocked to learn these medical facts' (p. 253). The painful circumcision procedure, the prolonged urination and menstruation time, traumatic penetration, and unbearable childbirth are all accepted as 'normal' for women (Williams & Acosta, 1999).

The women talked about issues such as urination, menstruation and sexual relations which they regarded as a natural physiological aspect of their lives as circumcised Somali women.

Urination

"It's a normal thing. Sometimes ladies will get feverish and pain, others won't. It's like normal people, more or less"

"If the hole for the urine and her period is too small, maybe because her mother wanted it tight because of the tradition or because the lady doing the circumcision made a mistake"

Gordon (1998) states that 'what is surprising is the extent to which the procedure is accepted as part of being a woman' (p.87). In *Desert Flower*, Dirie (1998) states that she fainted often from the excruciating pain because of the blockage and the pressure of the urine and menstrual blood that flowed drop by drop only. However, her mother did not think the pain was unusual, because all women she had ever known had been circumcised, and they all went through this agony.

Health issues are a natural consequence of being a Somali woman. It is often difficult to do a speculum examination or insert pessaries if required to treat any infection. Equally, the passing of an intrauterine catheter to alleviate the pressure is not possible most times (Gordon, 1998). According to Denholm and Jama (1998) young Somali girls will not seek assistance for urinary consequences caused by fgm, because they think it is a normal part of life. For example, most girls do not consider that taking a long time to urinate is an issue for concern and are unaware that taking twenty minutes to pass urine is not normal. Denholm (1998) goes on to explain that many girls do not know how uninfibulated genitalia function, and are surprised to hear of the existence of a separate opening for urination (Calder, 1993).

"Some of them they don't get enough urine coming out".

She faces a lot of problems she has urine pain, doctors can't examine her because of the pain, most problem is with the urine and the infection"

"It takes longer to urinate, it's too tight, too narrow, insufficient urine passing"

The women emphasised the normal in terms of the problems occurring for all Somali women. They did, however, recognize that the problems such as urinary infections had a profound effect on the women such as severe and often intractable pain. Prior to commencement of this research project two Somali women who were my advisors emphasised that I should not use the term 'problem'. They said that they are aware that outsiders see their practice or the consequences as causing 'problems' but it would be unwise to use the term problem, as the women would not be willing to discuss the subject of genital mutilation with me.

The women describe the opening left for urination:

"Sometimes the small hole for urine have [has] to be opened so we can pass normal"

If the girl is not able to pass urine in a few days she is de-infibulated, and the whole process of infibulation starts again, or if the hole is not as small as a rice grain or a match stick the procedure is done over. A girl, who has been infibulated tightly, may urinate drop by drop and may need 15 minutes to void. She may be reluctant to drink fluids, as urination is painful. The result is chronic urinary tract infection (Wright, 1996; Lightfoot-Klein, 1989).

As the discussion developed about health issues that could be considered to be beyond what is 'normal' the issues of menstruation and sexual relations surfaced.

Menstruation

The women very casually said:

"Just before the periods we have this sickness, pain, vomiting, and sometimes we cannot walk or function, we are too tired."

"The pain is like a circle from your stomach to your back and to the front and the legs. Sometimes there [are] clots".

Many Somali women also consider having painful periods to be normal and a 'part of a woman's life'. Difficulties in menstruation often occur because of partial or total occlusion of the vaginal opening. This may result in dysmenorrhoea. Haematocolpos may result from the retention of menstrual blood in the uterus due to the almost complete coalescence of the labia. Distension of the abdomen induced by the accumulation of menstrual blood, together with the lack of any outward evidence of

menstruation, may give rise to suspicion of pregnancy, potentially causing severe social implications for the girl (WHO, 1995; Denholm, 1998).

Convincingly the women in the group said:

*"We are telling you all this, but it is all **very normal for us**, you see"*

"I thought my period pain was related to my circumcision, but when I was with a neighbour (an Arabian girl, - they were my friends), they too had the same pain and same problems, the backache, tummy pains and all these things I am saying like the other people!!"

"She may have pain and clots but it is normal to us because it has always been like that. Our mothers, and grandmothers had it so it's for us to have this pain".

Menstruation is painful, lasting ten days or more and often has a bad odour. Adolescent girls may sometimes collect a pool of unexpelled blood (El Sadaawi, 1980). Despite the emphasis on 'this is normal', it is interesting to note the view of an Internist working with Somali refugees in Seattle who says, 'they're not doing it (fgm) to harm their children. They're doing it because they love them. Until they got here they never realised it could be any other way' (Gregory, 1994,p.41). Therefore, it appears that exposure to new environments may involve new ways of thinking. It is unusual for the Somali to use the term 'problem'. In the above excerpt the women used this term which could be indicative of a growing awareness that there is a relationship between the genital mutilation and the consequences. There is a possibility that there might be some correlation between the two or that the Somali women's contact with the Arabian neighbour resulted in consciousness raising and therefore a different way of viewing the health-related issues.

Infection

Infection was common and related to urinary and menstruation issues:

"There is still a lot of infection problem and pain".

Chronic pelvic infections are common in infibulated women and partial occlusion of the vagina and urethra increases the likelihood of infection. These infections are painful and may be accompanied by a noxious discharge. Infections may spread to the uterus, fallopian tubes and ovaries and become chronic (WHO, 1995).

The women describe:

"When I was a virgin I had problems with passing urine, thrush and burning sensation and now I am married I have only infection problems"

"There is this burning sensation, thrush and infection.

Recurrent urinary tract infections often occur as a result of the damage to the lower urinary tract during the mutilation or because of subsequent complications, leading to painful and difficult urination. Recurrent infections of the urinary tract are common in infibulated women, partly because the perineum remains constantly wet and susceptible to bacterial growth. Retrograde urinary infections may result and affect the bladder, ureters and the kidneys (WHO, 1995).

The women said:

"Maybe you can give the medication because you cannot open, you can't open the circumcision you can't reverse it."

The women emphasised that to treat infection medication could be administered but the option of reversing the circumcision is not acceptable and that health professionals should understand that. The

Somali women desperately wanted 'us' to understand their cultural belief that the circumcision cannot be reversed for a 'trivial' reason. Infection is regarded as trivial and as insufficient justification to reverse the circumcision. In a conversation before the formal group discussion the interpreter and two Somali women explained that they were not happy to participate in the 'test for cancer'. They said in Somalia there was no such thing and why *'should you do a test and reverse the circumcision just because you think **maybe** there is cancer there. You are not sure even!'*

It therefore seems that cervical cancer in Somalia is relatively unknown and there are no statistics available. The Somali women are saying too that they do not see the need for the papanicolaou smear test that is sometimes done by health professionals.

Heavy bleeding due to the wound may start immediately or may occur as many as six days later due to infection. The possibility of HIV infection as well as vaginal and uterine infections are common (Brady, 1998; Newman, 1996). Infertility, due to the chronic pelvic infections may result. The physical effects are often chronic and lifelong (Van der Kwaak, 1992; McCaffrey, 1995; Rose, 1994). Infection, including tetanus at times, the pain, and the hemorrhaging may result in shock and death (Bashir, 1997; Abusharaf, 1998).

Sexual relations

Sexuality or sex related issues are generally not discussed among Somali, whether males or females. However, once trust has been established the women 'open up' about sexual matters (Denholm & Jama, 1998), as they did in focus group discussion. In societies that practice female genital mutilation (fgm) the importance of virginity and

an intact hymen is the reason why female genital mutilation is a popular practice. There is a belief that by removing parts of the girl's external genital organs sexual desire will be minimised, her virginity and that of her family will be protected (Bashir, 1997; Van der Kwaak, 1992; El Saadawi, 1992). Other literature suggest it is a means of controlling women and their sexuality (WHO, 1986). Gruenbaum (1996) states that men gain far greater sexual pleasure from intercourse with a woman whose vaginal opening has been surgically narrowed (1996). (See literature review chapter for some contradictory and alternative views).

A study done by Lightfoot-Klein (1989) over a period of five years in the Sudan revealed that men suffer from anxiety especially on the wedding day as the penetration of the bride's infibulated vagina could take three to four days to several months. If he cannot accomplish this a midwife, under conditions of great secrecy, is given the task of opening the bride. This reflects negatively on the man's potency (Lightfoot-Klein, 1989). In some cases, intercourse takes place without actual penetration. Many wives manage to get pregnant in spite of the infibulation.

Sexual dysfunction in both partners may be the result of painful intercourse and reduced sexual sensitivity following clitoridectomy, and even more so following infibulation. Penetration may be difficult or even impossible, and at times, recutting has to take place (WHO, 1995).

The women expressed quite casually and openly:

"Some of us still are happy, and some of us have too much pain to sleep with our husband".

"Some women have to face the pain, so the man still tries, she can get pregnant while she is still circumcised"

It is customary for Sudanese and Somali women to be passive during the sex act. The women often deny or hide the fact that they had an orgasm. Lightfoot-Klein (1989) quotes a number of studies with contradicting information regarding orgasm. El Dareer's (1982) study revealed only 27 percent of the 2,375 women had "sexual pleasure". In contrast Asaad's study reported in Lightfoot-Klein (1989) revealed that 94 percent of the 54 circumcised women reported that they enjoyed sex and were happy. Koso-Thomas (1987) contradicts the issue of women having orgasms and states that it is a misconception as there is the lack of orgasm and sexual gratification and this may be due to the amputation of the glans clitoris. Lightfoot-Klein says on the contrary that in clitoridectomized women other parts of the body are reported to be sensitive for example the lips, breasts, labia minora, neck, bellies, thighs and hips. Lightfoot-Klein cites Ogden (1988) who states that extragenital stimulation, emotional involvement and spiritual connection are also factors that enhance sexual stimulation (Lightfoot-Klein, 1989).

From a discussion that took place before the focus group session, the Somali women did say that the level of sexual enjoyment could not be measured but that circumcised women do have sexual excitement that they cannot describe to me. In addition, that it was false for outsiders to think they know and believe that they do not enjoy sex and that they should be pitied. They may not readily talk to strangers about sexual matters but they do have an enjoyable sex life, one woman assured me. A young Somali nurse revealed a conversation that she interpreted while waiting for the formal group to arrive. There was no probing from me on this issue but a conversation in Somali was in progress and I inquired and was duly informed of the nature of the conversation. The nurse said:

"How can anyone measure the level of satisfaction I or she may feel when having sex, and that no woman she [one of the participants] knew does not enjoy it to some extent and that each has different ways of enjoying it".

This confirms Accad, (1993) and Lightfoot-Klein's (1989) claim that there is sexual enjoyment despite the circumcision, and despite some information to the contrary.

The women describe the sexual act/relationship:

"The man will use his strength you know, he does not need any surgical interference, the use of the cream helped to make it [the vagina] elastic and soft".

This supports the literature on sexual relations. The vaginal opening remains small until marriage. The womenfolk from the groom's family visit and examine the bride. They check to ensure that infibulation has been done and that she is a virgin. The genital area should be smooth as the palm of one's hand. To make intercourse easier, the vagina may be cut open slightly. Otherwise, during the wedding night, the groom widens the opening with his penis, which is painful for him and for the bride. Thus 'tailoring of the vagina to the size of husband's penis' is meant to ensure monogamy on the part of the wife (Mak, 1993,p.12). According to Mak (1993) if the husband is not happy with his wife's vagina, he may annul the marriage the next day.

There are also the psychological and sexual complications associated with female genital mutilation (Morris, 1996). Relationship difficulties including anxiety and depression may be expected to occur. The fear of infertility and or the loss of her husband's attention, often because of the difficulty with penetration by the male are grim realities for circumcised women (Rose, 1994; Abusharaf, 1998).

Despite the deeply embedded cultural practice and the women being willing to share their experiences with me they said that they were aware of the New Zealand law relating to fgm which created other difficulties for them.

The law

The women's knowledge of female genital mutilation and the New Zealand law was revealed:

"When we come to New Zealand we know we are not allowed to this, circumcision. They told us this but they did not ask us if we like to do this or not".

Refugees who come into New Zealand are accommodated at the Mangere Refugee Centre. They spend six weeks, before being relocated to other areas. They have dental and health checks done, an English orientation program and interviews to determine the areas of the country in which they may like to settle. Speakers are brought in to educate them about the law and on resources that are available. The law pertaining to female genital mutilation is discussed so all refugees are fully aware of female genital mutilation being a crime under Sections 204A and 204B of the Crimes Act, 1996 (New Zealand Crimes Act Amendment 1996). Housing, clothing and financial support are other aspects that are attended to (King, 1999- personal communication). An Interpreter is used to convey all the necessary information to all new refugees coming into the country.

As the focus of the group interview was not to ascertain the continuation of female genital mutilation in New Zealand this aspect was not probed further. However the body language, facial expression and non-verbal

expression seemed to indicate the favouring of the continuation of the practice of fgm.

Summary

This chapter presented with findings relating to the Somali women's identity as defined by the practice of fgm. The findings present a view that culture does influence how people regard health and what is normal. The person's past experience of health and illness also reflects how they relate to health institutions and health professionals. The next chapter presents the second main theme, which is the Somali women's perspective of childbirth.

Chapter Five

Somali women's perspective on pregnancy and childbirth

Obstetrician to pregnant woman: "If it's a boy, do you want him circumcised?"

Pregnant Woman: "Yes, and also if it's a girl".

(Coleman, 1998, p.717)

Introduction

In this chapter the findings are presented which relate to the second theme identified from the data. The Somali women talked about what they viewed as crucial for health professionals to know especially about their birthing experiences, which they enthusiastically shared. The Somali women's childbirth experiences seemed to dominate most of the discussion in the group sessions. The women discussed their childbirth experiences passionately, emphasising their experience with hand gestures and detailed explanations. There was a lot of serious discussion in Somali, as well as laughter and a sense of shared understanding and familiarity.

The themes, which emerged from the discussion on childbirth, form the sub-headings are: antenatal care, childbirth and postnatal support.

Antenatal care

From the discussion around antenatal care the conclusion can be drawn that the women include exercise routines and antenatal checks under the term antenatal classes. The women view pregnancy and childbirth as a natural life event:

"This is a natural thing, we are responsible for ourselves we want a good baby, we take care of the baby for nine months in our body why would we not want to take care of the baby and ourselves?"

For the Somali women the need to protect the baby is a natural part of most pregnant women's lives. The need to attend antenatal classes or have antenatal checks is viewed as unnecessary. Due to the tribal nature of the rituals, customs, traditions, and religious customs that relate to everyday life, the life of the baby in the womb does not accompany much concern and the need for antenatal checks prior to delivery is viewed as futile.

The women said very proudly and confidently and somewhat dismissively:

"We are well, so why should we go to classes?"

"Most of the ladies here say they don't think it [antenatal classes] is necessary"

"We do not see the need for going to the antenatal classes, some of us don't".

It appears that most of the Somali women do not regard antenatal classes to be beneficial. They do not believe in the exercise routine or the need for exercises that are meant to help during labour. Their lifestyles back in their home country did not warrant this. They are a nomadic people whose lives involve walking great distances to fetch water food and firewood. They work in the field planting crops, take care of their camels and other animals, take care of the family and move on to greener pastures when supplies are exhausted in the one area. It is a lifestyle that does not warrant further exercise whether pregnant or not (Barnes & Boddy, 1994; Dirie, 1998).

In New Zealand exercises are not the only activity pregnant women receive advice on during the antenatal period. However it should be remembered that all cultures engage in different activities related to

significant life events. The dominant New Zealand culture has their way, for example arranging a midwife for continual support before during and after the baby is born, attending antenatal classes and making arrangements for an obstetrician, gynaecologist and/or paediatrician. The Wellington Parents' Centre runs 'Childbirth Education Classes' which include education on birthing, support groups for pre and post natal mothers, parenting classes and breast feeding. In addition newsletters are issued, special discounts on baby clothes and special courses as well as exercise classes are offered.

In Somalia the women folk, family, friends and relatives organise a social function similar to a baby shower to offer support to the mother any time during her pregnancy. Outside of Somalia the Somali women cannot see any reason for going to health professionals just because they are pregnant which they view as a normal health event in their lives (Toubia, 1994). Most Somali associate nurses, doctors, hospitals or any health professional with ill health and not with normal good health. The traditional birth attendant however is viewed as important to assist with the birth of a baby.

It does appear also that the Somali women avoid interacting with health professionals because of previous experiences. For example, the women did mention during the refreshment break, that midwives, nurses and doctors usually ask when was their last menstrual period. This they said is taken down and a date nine months from that date is estimated as the delivery date for their baby. There is an expectation then that the baby should be born on a specified day. If this does not happen the women's experience is that an induction or caesarean section is arranged. They do not agree with this and prefer to give birth naturally or when their body tells them the baby is ready to make an entrance. Based on the question about the last menstrual period and the line of management that follows,

many of the women, laughingly elaborated and said they often told the nurses, midwives or doctors that they do not know when they had their last menstrual period. This could lead health care professionals to erroneously believe that the Somali women are unaware of their body functions or have no idea of dates and times or are just ignorant.

Childbirth

The women describe how health professionals have experienced difficulties when encountering circumcised women during labour and birth. They desired a more positive attitude towards fgm in the future. Their body language and non verbal expressions signalled their distress that health professionals don't have sufficient knowledge on fgm.

"The doctors and nurses tried to understand what is this, they are facing, what's the problem? They wanted to deal with it. They contacted the other community people and asked what is this? Are you burnt? What happened to you? So we try to explain to them and other doctors, explain that we have this circumcision. So you see they need to understand us and our needs and help us to overcome the birth or whatever health problems."

In Britain health professionals have indicated that because female genital mutilation is linked to sex, sexuality and reproduction it is sensitive and therefore a barrier to the topic of fgm being dealt with (Rupert, 1995). There is evidence of insensitive and inappropriate care given to genitally mutilated women at maternity units in New Zealand (Denholm, 1998). Misdiagnoses, such as abnormal or burnt genitalia, due to the scar tissue, and routine caesarean sections that were performed, add to the fears of Somali women that health professionals are incompetent here in New Zealand, especially in providing care to genitally mutilated women. At a conference in Canada it was revealed that physicians dealing with immigrant women who had fgm were horrified with the realities of having

to deliver women who have undergone fgm. They did not know what to do after the baby was born (Younger-Lewis, 1997).

In New Zealand, there is evidence of doctors who find it difficult to cope with fgm and find it abhorrent (St John, 1997). There is also anecdotal evidence of General Practitioners and Registrars throwing up their hands in horror and running out of the room when coming across women with genital mutilation. They just don't know how to deal with the practice of genital mutilation explains St John.

The women plead for understanding regarding the importance of their circumcision:

"You have to know us to help us with the baby"

The women comment on the de-infibulation procedure. Ideally they would be de-infibulated before labour, however if this is not possible then de-infibulation just before delivery is essential. Denholm and Jama (1998) state that 'almost all primigravidas will need to be de-infibulated to allow for the delivery of the fetal head' (p.27).

"You have to learn and to know how to cut us open, a certain way, just before the baby comes".

"You have to know how to cut".

In the case of circumcised women, de-infibulation is necessary in order to allow for the passage of the baby. If a trained person is not available to cut the skin over the vagina, the passage of the baby could be obstructed. This may cause additional blood loss, injury to surrounding parts, fistulae and infection.

The Somali women view 'Somali labour' as a normal but critical part of their life. To be in labour the Somali way is essential to the whole

childbirth event. Somali labour is understood to be the waiting period from the time of first strong contractions until the baby is born. No artificial assistance is required and according to the Somali women a long labour is normal and natural. The women in the group plead for understanding:

"Somali labour, means to wait, normal natural, the nurses and doctors must know how to wait for that Somali labour and secondly they must know the ways of dealing with different cutting and needs".

"Please understand this, Somali labour is about three to four days of strong contractions and it is normal for us"

"Also I will say we all hurt a little but we wait for normal labour, Somali labour."

The women were very serious as they discussed the length of labour, and explained that labour lasted 2-3 days from the beginning of the strong pain. The women echoed that it was normal and natural for Somali women to be in labour for a long time. There was a genuine sense of security and strength that pervaded this particular discussion. The significance of 'Somali labour' was intensely emphasised to enable New Zealand health professionals to acquaint themselves with it, in order to understand the women through the childbirth experience.

The women said very proudly:

*"We like to deliver, **our way!**"*

In a study carried out on Somali women in Somalia (Calder, 1993) it was reported that five out of six women had difficult births and large episiotomies, as well as tearing of the infibulated area. The length of labour ranged from 24- 73 hours. In this same study, it was found that four out of six women had tried to limit the size of the baby by cutting down on food intake.

Similar to Somali women, other cultures may have unique childbirth practices and all may wish to 'deliver their way'. Papp & Olssen (1997) state that, family support offered during the pregnancy and childbirth period is very similar in many cultures.

Upon reflection the Somali women said:

"It is not very easy to have a baby, sometimes there is a big cut [in the perineum]- we stitch it up again, and sometimes our baby is not so good"

The women were solemn and serious when describing in a systematic manner the way in which the passage of the baby is facilitated (In Somalia):

"First I have to tell you the three stages. If the woman didn't reverse her circumcision, or if the opening is too small they will reverse in the first stage of labour. Then as the labour graduated to the last stage when the baby couldn't come and you need more space they [the traditional birth attendants] will cut the sides. And if the baby is so big or heavy the midwife used to cut up and sideways so it [the baby] will have more space, but here in new Zealand which is very strange to our culture they wait for the baby to come out. We don't because sometimes the head could push and rupture the anus. So it needs help to protect her anus, and push the head up it will come to the vagina and won't need to cut up the anus. You understand?"

The rupture of the anus or the baby coming out anywhere near the anus has huge significance for the women. It is a social norm designed to protect against the 'unclean' area coming into contact with the 'clean'. The elements that comprise 'clean', 'unclean', 'pure' or 'impure' can be understood in context within the religious and social practices of the Somali. The general discussion showed the emphasis placed on this issue of the baby not coming into contact with the anal area. The anal

area is considered 'dirtier' than any other area and is perceived to be bad for the baby. (This information was shared during a casual conversation with one of the Somali woman).

There were dramatic hand gestures to show the cutting technique and the baby coming down the birth canal. The voice of authority seems to belong to the women who know their bodies, their physiology and their precise role in childbirth, a very natural life event. The women were so familiar with the procedure of cutting on both sides that anything different to this seemed odd to them.

The Somali women said with confidence:

*"You must reverse [the circumcision] or cut **before the baby's head comes down**, and what Somali women like is to be cut on both sides instead of to cut downwards."*

"Why do you [New Zealanders] not cut upwards?"

"In New Zealand they cut down the bottom, in my country we cut on two sides if necessary and not down".

In response to the question 'why do you not cut us upwards?' that was put forward by the Somali women, a New Zealand midwife states: 'Yes the Somali women would prefer the anterior cut and it is possible to do this but, quite often inexperienced persons could subject the women to very painful, and sometimes extensive rupture of the anterior scar area. Those unfamiliar with the procedure are scared to do the anterior cut, as it is not usual here in New Zealand' (Dresher, - personal communication 1999).

The women emphasised:

*"You have to know how to cut us open, how to **do the cut**".*

According to Dresher (personal communication, 1999) the cut is done as follows:

The scar tissue is incised anteriorly (upwards) along the midline as far as the urethra, it is not physiologically necessary to cut up further in labour and if done, increases the likelihood of extension up to the clitoral area. If necessary a posteriorlateral episiotomy may be done as well, if indicated. "For severe stenosis, that is with type two 'gishiri'² cuts there is no elasticity, so an anterior as well as a bilateral posterior episiotomy may be indicated.

A British midwife explains further that:

A prolonged or obstructed second stage could occur due to excessive scar tissue, which could result in vesicovaginal or rectovaginal fistulas. The scar tissue will be rigid and if not incised could obstruct delivery. Performing an anterior episiotomy to open up infibulation would then be necessary, to allow delivery of the foetus. This should be performed when the presenting part reaches the perineum, which will minimise the length of time between incision and suturing. Performing the anterior episiotomy too early carries a risk of haemorrhage, and an increased risk of postpartum haemorrhage to genitally mutilated women. The incision is made, by placing one finger on the introitus, and cutting upwards until the urethral meatus is visible. This allows enough room for the tissue to stretch over the baby's head (Newman, 1996. p.21).

² gishiri cuts: marks or cuts on the labia.

A Sudanese physician explains the management of women with a type III circumcision. She says:

The circumcision scar is composed of a band (or bands) of fibrous tissue enclosing the upper part of the vestibule. This must be incised during the second stage of labour, before episiotomy, allowing sufficient widening of the introitus for expulsion of the foetal head. To accomplish this, a finger is inserted through whatever introital aperture is present and directed toward the pubis. With adequate local anaesthesia this flap of tissue anterior to the pubis is cut in layers in the midline, over the finger, with scissors until the urethral meatus is visualised and the pliable tissues beneath the scar are freed and are able to stretch over the head, allowing delivery. A mediolateral or midline episiotomy may or may not be necessary in addition (Baker et al, 1993, p.1617).

In some cases when a normal vaginal delivery is medically contraindicated, surgical alternatives such as caesarean sections are performed.

Caesarean section

The general Western professional rationale for Caesarean section is based on the view that:

The journey of the baby through the birth canal during labour and delivery is the most dangerous time for both mother and baby. The lethal triad of haemorrhage, sepsis, and obstructed labour causes the majority of deaths during labour and the first day postpartum. Women may be left with disabling conditions, such as severe anaemia, infertility, or

vesicovaginal fistula, while new-borns could be damaged by asphyxia or cerebral palsy (Murray, 1996, p.1).

The women in the focus group had a strong belief that:

"Caesarean became easy, for the doctors because they don't have to cut the girls vagina in horrible places. This is what we believe"

"We were afraid the [doctors] perform caesarean section because they said 'we are afraid of the baby's heart',

"But there was nothing wrong!"

"If the baby is breech or not in right position, you as the doctors should know how to correct his position within the normal ways".

The women implied that if doctors are qualified they should be able to correct the baby's position quite easily without taking the option of a caesarean section. It would appear either that the doctors are performing caesarean sections because they find this an easier option than to deal with the scarred circumcision and a vaginal delivery. It may also be possible that the Somali women are not receiving clear communication from midwives and doctors on the specific reasons for the surgical intervention. The women may therefore assume that it is 'easier' for the doctors, to perform a caesarean section than to cope with an infibulated and scarred vagina. This unsatisfactory explanation as to why a caesarean section may be necessary maybe the reason why the dissatisfaction is communicated among the Somali community and the unhappiness towards this intervention is perpetuated. The consequence of this could be women avoiding hospital care as they did in Somalia, where the foreign doctors evidently performed a lot of caesarean sections. Denholm's (1998) survey of women with genital mutilation in the Auckland region indicated that the women were concerned that New

Zealand midwives and doctors do not know how to deliver circumcised women.

The women also revealed that generally they were not in favour of caesarean section delivery and preferred their traditional Somali style labour and delivery.

"Since the UN and the other European doctors came to my country, they start performing caesarean sections as if they are doing good for my people. We used to deliver normally."

Jackson (1996) states that midwifery management in recent times is moving towards the acceptance of birthing as a normal, natural part of the life cycle. Whether the doctors were sent to the Somali hospitals to gain experience of surgical procedures or whether there was a real need is not established. The women related their disapproval of foreign doctors performing caesarean sections in some of their hospitals.

"Nobody goes to those hospitals. Many ladies went there and they said they would perform a caesarean and their family said no, we will take them home and then at home they had normal deliveries and there was no problem".

The women in the focus group posed the following question and statement:

"We would like to know if other countries have a high percentage of caesarean like in New Zealand, especially in the Somali women?"

"They said that maybe because of our circumcision they did a lot of caesarean, and we did hear that, in the local papers"

There were concerns amongst the Somali women about the high number of caesarean sections performed on Somali women who had previously

had normal vaginal deliveries in Somalia (Denholm, 1998). The frequency of caesarean section rates has varied over the last few decades. Brooks and Rogers (1989) report that the caesarean section rate in the 1950's was low in Britain. In the 1960's and 1970's it rose dramatically. In the 1980's it had again fallen. The increase in the rate may be due to a number of possible reasons such as the increase in use of anaesthesia and new technology (Brooks & Rogers, 1989). The statistics however for emergency caesarean sections among the Somali population is higher than for other population groups in the Wellington region for the 1995-1998 period (Capital Coast Health, 1999). Denholm (1998) also states that there is concern by midwives in New Zealand 'at the high number of caesareans that were performed on Somali women who had previously had normal deliveries in Somalia' (p.22).

In New Zealand in the general population caesarean births are on the increase. Bee and Kennedy, (2000) state that according to the Health Ministry the caesarean rates increased from 11.7 percent to 18.2 per cent over the past decade. The World Health Organisation recommends 10 to 15 percent as an acceptable caesarean section rate in developed countries. In France there is reported to be a high incidence of caesarean section deliveries among genitally mutilated women. The women are not in favour of this as it restricts the number of children they can have (Gallard, 1995). In Norway there were cases of caesarean sections performed on circumcised immigrant women just because the doctor in charge did not know how to perform the appropriate type of episiotomy (Sundby, 1996). Further unnecessary caesarean sections are noted to occur in parts of Europe where doctors who are unfamiliar with circumcised women resort to caesarean sections (Koso-Thomas, 1987).

"They said (referring to the women in the group) that we think that they [the doctors] cut, they don't like to cut the vagina, you know, and they put it in bad

shape, maybe so that is why they do perform caesarean on ladies who didn't need caesarean."

Somali women who see birthing as a natural normal process are psychologically unprepared for the intrusion of a surgical procedure such as the caesarean section. With a well established traditional healing system there does not seem to be the need for any invasive procedures such as caesarean section that are not well understood.

"They are just discussing her operation, caesarean, they say that though some people say that the doctors do a caesarean because we have circumcision but it is not the case. This is not the reason they all agree that it is not because of our circumcision"

The women reflect on their understanding of the reason for a caesarean section and state further:

"We can understand about the caesarean when the placenta came first, they do it, second if the baby is breech and if she has a high BP. This is the only reasons, but others they must wait for Somali Labour"

"Some of them don't believe, and the doctors do explain, but they think it is not the reason sometimes in their minds"

"They should tell us more about why they are doing what they are doing if they are doing a caesarean"

According to Brooks and Rogers (1989) and Murray (1994) caesarean sections are performed for a number of reasons. Some of the reasons are; placenta praevia, malpresentation, breech presentation, uterine scars, disease and infection of the vaginal area, pelvic tumours and emergency caesarean sections for high blood pressure with eclampsia.

The Somali women said with confidence:

"We feel proud and happy when we deliver our own baby. And don't need the doctors to help us "

The women seem to have great pride and were quite impressed with their own way of handling childbirth within their cultural system and can easily justify why they do what they do.

The women said very knowledgeably:

" We used to all deliver our babies normally in Somalia"

There are no statistics available to indicate the mortality rate in Somalia but the women seem to believe that it was not a major problem. Donley (1986) says that given support and patience, 85 percent of women can give birth normally and naturally. They don't need the routine intervention backed up by high technology that is common practice today.

Postnatal support

There are differences and similarities amongst many cultures in the way postnatal support is given to new mothers.

The Somali women said:

"We have our family there and the lady who knows us to help us to deliver"

"We always have our close family and friends around us when we deliver our babies"

For the Somali women, the attendance of the family and close friends offers support that the mother needs through the birthing process. The needs of the mother are communicated via body language, non-verbal or verbal and are well understood by those closely bonded to her and therefore play a significant role in the mother's well being and state of mind. The encouragement of the family and the relaxation techniques

unique to the Somali aid in decreasing the anxiety and aiding in the birthing.

After the formal group sessions the women talked very casually about psychological support that played a huge role in the birthing process. The women explained that the mother of the woman giving birth or the aunt or any relative would be by her side. She offers her support by talking to her about unrelated issues, also by reciting some soothing poetry and tales and sharing some humour to 'take her mind off the pain.' The other psychological method used was to tell the woman in labour that, this pain is no pain at all, it is a 'small pain' compared to the very big one you will experience when the baby is ready to come out. The women are encouraged to save their strength and their breath for the moment that she is required to help push the baby out. However the new mother apparently is already experiencing 'the big pain' but the new mother is unaware that this is the 'big pain' and therefore does not scream or shout as this is seen as 'being weak'. The soothing songs are only used and adapted for individual mothers, there are no set songs for all pregnant women, they explain. Denholm and Jama (1998) state that the 'postpartum period is an important time for Somali women' (p.28).

The support given is quite individualised according to the woman's psychological make-up and that of her family. The support that the women receive is natural and very much a part of the Somali culture. These relationships are built and are well established and therefore the new baby belongs to all the family and friends and neighbours who take care of the welfare of the child as she/he grows up within the confines of that culture.

The women said quite casually:

"If the baby's condition needs urgent help, I mean a mother will take care of her baby in her tummy for nine months. She don't want him to die, so if the condition of her baby is in danger then we accept"

The women appear to say that they accept that if there are problems they accept the death of the baby or they may be accepting of surgical intervention.

The women explain re-infibulation as a natural and normal part of the their post- childbirth experience:

"After the birth we get stitched up again and we are normal".

Re-infibulation is often demanded by tradition, but is not permissible in New Zealand or in the USA (Jama, 1995). Repetition of deinfibulation and re-infibulation will weaken scar tissue, and re-infibulation carries the same long-term risks as the original infibulation. In New Zealand, 'fully re-infibulating a woman is not permitted' (Denholm & Jama, 1998. p.28), however, the woman's scar tissue can be partially re-sutured. The importance of keeping the scar tissue as open as possible to allow for sexual intercourse and the exit of urine and menstrual blood should be explained by health professionals (Denholm & Jama, 1998; Meares, 1995).

"After the baby comes the mother does nothing she just sits on the bed with her baby, till forty days".

"We don't need to do anything for forty days, the mother had a hard time - to look after the baby in her body. She need to rest"

The new mother 'does nothing', that is, does not get involved with household chores, childminding or cooking. This is a traditional custom lasting forty days, post delivery. Family and friends help to bath and take

care of the mother and child. The first forty days the mother lies around in bed recovering, resting and feeding the baby only. The involvement of friends, family and neighbours is very prominent in the Somali culture. The mother is given lots of attention, good food and nourishing fluids. Her baby is bathed and changed by the family. The new mother is given baby to feed, cuddle and admire. She recuperates, her body heals and she is not permitted to sleep with her husband during those forty days. This period is called 'afatanbah' (Toubia, 1994).

Similar to the Maori whanau support, Somali family support is part of the life style in Somalia. Coming into a new country as refugees, they have left many of their family back in Somalia and are with fewer family members, while some do not have any family members here to support them. For some, their husbands play a role, which they never did back in Somalia. Greater understanding is required from health professionals in relation to the cultural aspects and the family support system.

In New Zealand the Somali mother may either want a speedy discharge from hospital if they are uncomfortable with the huge changes to their lifestyle and cultural practices or they allow the nurse to do all functions for baby and her. This explains why a midwife was 'very surprised' that a Somali mother would not instinctively, spontaneously or voluntarily pick up her baby to change or make comfortable or to bathe. Whilst talking to a group of midwives, one of them related this experience which she found strange. *'The Somali mother will not pick up her baby or attempt to do things for herself, she just lay there and expected the staff do things for her and the baby'* she said, and of course she could not understand this. This could result in the midwives or nurses believing that the Somali women are incompetent or cannot adequately care for their babies. The forty-day recuperation traditional style may be the reason for this misunderstanding. However, in a recent study done in Melbourne a

senior research officer in women's and children's health said that 'most mothers experienced a range of debilitating health problems after giving birth and should be given more time to recuperate' (p. 3). She concludes by stating that having a baby impacts on women's health and that women should not be expected to bounce back to normal quickly (Thompson, 2000).

"All the ladies have a celebration for the end of forty days for the new baby and mother"

In many Muslim cultures the end of the convalescence, the fortieth day calls for a huge traditional style celebration marking the end of convalescence and beginning of a normal routine for both mother and baby who then appear together in public. This form of convalescence post delivery indicates the need for cultural sensitivity and deeper understanding of the client's cultural background, by health care professionals especially nurses and midwives.

Summary

In this chapter data from the focus group revealed the Somali perspective on antenatal care, Somali labour, cutting technique and re-infibulation, which were discussed. This chapter concluded with a description of the postnatal period from a Somali women's perspective. The discussion chapter follows in chapter six.

Chapter Six

Discussion

Introduction

Women who are affected by genital mutilation have particular health needs, which this study has explored through a qualitative research approach. The study included thirty-one Somali women who participated in the focus group discussion. Four groups of women were interviewed in a group setting. Although the sample size was small, the contribution made by each participant was significant, and provided meaningful insights into the health needs of Somali women in the Wellington region who have been genitally mutilated. Consequently the data obtained identify the women's perspectives. The findings of this study confirmed and illuminated two major themes:

The Somali women's identity is defined by fgm

- Female genital mutilation gives Somali women their identity.

The Somali women's perspective on pregnancy and childbirth

- Pregnancy and childbirth are important normal life events.

Conclusions from the current study

The following is a discussion and a summary of the conclusions arising from the two questions addressed in this study.

The response from the women who participated in the present study was similar to much of the literature found in other studies, such as that of Calder (1996) and Denholm and Jama (1998) except that the women would talk about the consequences of female genital mutilation as a normal part of being a woman and not as problems. This is important for

health professionals especially nurses working with Somali women who should use language that is meaningful to the women, and to be respectful of their view. It perhaps seems normal for health professionals to 'problematise' effects while the Somali do not view these experiences in the same way.

The findings presented with links between religion, culture and tradition as terms used interchangeably by the Somali women in the group. Mukhopadhyay (1995) confirms that culture and gender relations are erroneously linked to religion. This could possibly be the reason why in general human rights groups and others sometimes are hesitant to get involved in the cultural practice of fgm, that is erroneously linked to religion. The practice of fgm is further linked to the Somali women's sense of honour, beauty and identity, or, the women were reduced to 'nothing', that is having no status or identity. Health care professionals need to be aware of what it means 'to be a woman' in the Somali culture. The western equivalent of fgm may possibly be, to a smaller extent, breast augmentation, liposuction and dieting which are viewed by some as requirements for a woman and her identity.

The women generally felt that medication was acceptable if there were signs of infection such as urinary tract infection. (see chapter four). They would not however accept, that having urinary tract infection is a valid reason to perform a reversal of the circumcision. A similar finding was the issue of Pap smear, a common western investigation for cervical cancer. The Somali women seem to say that it was not a good enough reason to do a reversal of circumcision just to perform a papanicolaou smear. They said '*because you think **maybe** there is cancer there. You are not sure even!*' (see chapter four).

These tests and the use of medical language are of huge concern for the Somali women. For health professionals working with Somali women this is important as the health system has in place specific routine tests, which are not acceptable to all cultures. The assumption that we all share the same meaning of things from a western perspective is often more harmful as there is a clash of understanding which may lead to conflict and eventually loss of self esteem and identity. The women may feel a sense of loss, loss of control over their own bodies. The example of what it means to feel 'shame' and 'embarrassment' is a very stressful part of a Somali woman's life. Living amongst people who contribute to this stress and who may not be aware of this or understand what it means to the Somali women requires consciousness raising.

In relation to pregnancy and childbirth the response generally indicated the trust and mistrust and lack of confidence between Somali women and health care professionals. There was a pleading for understanding of differences in the antenatal, birthing and postnatal period between Somali and New Zealanders. The lack of confidence in the health professionals decision making process, comes from the women's past experience of doctors who made decisions that the mother needs to have a caesarian section because of 'problems'. The mother is asked to come in the next day for the caesarian section. She would in the mean time stay home and have a normal delivery assisted by family and lay midwives. This made the women distrust the caesarian section decision. Health care professionals make decisions all the time and need to take into consideration the justification for decisions made and for communicating that very clearly to the patient. This indicates that an adequate and clear explanation needs to be given via an interpreter if necessary, of reasons why things need to be done in a specific way. Honest communication, developing the trust and rapport is essential for

good outcomes. Cultural differences need to be considered by nurses, midwives and other health professionals during the antenatal, labour and postnatal period when dealing with Somali women.

The findings may be linked to other practices that changed over time such as footbinding and widow burning (Mackey, 1996). The view of a Seattle physician in her summary stated that, Somali women had no idea that it (that is, an alternative to fgm) could be any other way until they got there (Gregory, 1994). The same could be true of refugees in other new environments, which leads us to believe that the Somali women in New Zealand may be exposed to a new way of thinking about themselves in relation to female genital mutilation. The problems encountered due to the circumcision are normally never regarded as problems but as a normal way of life for a woman. There may already be signs of changed thinking in New Zealand as indicated by the use of the word "problem" by a Somali woman in the group discussion. Signs of this change in thinking was demonstrated by a Somali woman referring to the consequences of fgm as 'problems'. This is not usually the case said the women advisors prior to the commencement of the research project. This could also be due to a lack of a suitable word when translating from Somali. It is not clear whether the Somali women do correlate health issues with genital mutilation and thus regard them as consequences of the practice or whether an unconscious correlation is made.

The Somali community and the women involved in this project were pleased to have the involvement with New Zealanders in the understanding of their health needs. They were eager to share and keen to inform about their needs, particularly during childbirth. The Somali women expect the outcome to be that greater understanding will be

established between health professionals and Somali women in the future. Accepting diversity, while trying to initiate change from within a community, is a delicate balance indeed. In New Zealand, the Somali community's practice of female genital mutilation has consequences for Somali women and New Zealand society. The issue then remains on how to strike the right balance, so that the community can continue to feel secure within its culture, and the women who have already undergone fgm can feel confident that their health care needs will be met within the parameters of the law.

Information for health professionals in relation to the two main themes.

- In relation to infection the Somali women will accept medication for treating the infection but do not view reversal of the circumcision or de-infibulation as an option;
- the routine papanicolaou smears, they again do not see the logic to de-infibulate for a test that may prove negative;
- the Somali women would prefer if health professionals would not use phrases like 'what problems do you have'? The health issues they experience are associated with their identity as women and are not usually directly associated with fgm;
- in relation to pregnancy and childbirth the Somali women would like health professionals to understand that it is a normal life event and that they often have long labours. Health professionals need to know about the Somali ways related to the onset of labour, de-infibulation and the length of labour;
- the Somali women's view is that fgm is not a reason to perform caesarean sections. If they are scarred and circumcised, have long labours or breech positioned babies it is not necessary to perform caesarean sections;

- and that it is shameful for Somali women to be exposed to a male health professional;
- the waiting list for de-infibulation is not acceptable and
- that the postpartum 40-day rest period is a traditional part of Somali women's lives.

Implications

There are implications for nursing and midwifery and these implications can be applied to other health professionals such as doctors and social workers. There are also implications for education and for further research.

Implication for nurses

Nurses and many other health professionals will come into contact at some stage with a refugee girl or woman and be confronted with the consequences of female genital mutilation. For nurses to be able to deliver health care to people from diverse backgrounds they need to be educated by developing a body of knowledge to equip them with effective competencies to meet the challenges of different cultural practices in relation to health. Denholm (1997) highlighted in her study that a considerable lack of knowledge, training, understanding and sensitivity among health professionals is a clear indication of a need for specialised services to be established for women who have undergone genital mutilation.

It is important for nurses to apply cultural knowledge in the context of the principles of cultural safety as this may be the key to effective health outcomes in the future. The emerging themes from the data gathered during the focus group discussions highlight areas where all health professionals who are involved with caring for Somali women require a

wider knowledge base. The Somali people and their particular belief system, cultural practices and the meaning of health for them all need to be taken into account, in order to achieve greater understanding and therefore better health outcomes. Reaching out to diverse communities to meet the health needs of those most vulnerable is a challenge for health service providers and health care professionals. In terms of women with genital mutilation, this may involve:

- Keeping an open mind and using a friendly, relaxed, non-intimidating approach;
- Becoming familiar with the culture and practices and actively participating in common health goals is needed. Understanding that antibiotics and other medication is preferred in the treatment of infection as opposed to de-infibulation. The women also strongly oppose the cervical smear test which they regard as not sufficient justification for de-infibulation. These are important issues to the Somali women and need to be taken into consideration.
- The use of effective communication methods that show sensitivity, and encourage informants to tell stories about their lives, beliefs, values, and life expectations;
- Encouraging membership of support groups for women who do not wish their daughters to be circumcised;
- Arranging discussions with the religious leaders or the elders, who may have an influence on the women's choices in the future. This relationship may encourage support for an alternative way of viewing this practice.

There needs to be the development of a trusting relationship and acceptance of people who are different to ourselves, so that health

professionals, in particular nurses, and the Somali community can work together towards common health outcomes. Respect, sensitivity, and valuing differences will enable us to build on what we have and work constructively towards culturally safe care. Genuine cultural safety, practiced consistently by all health professionals and nurses, will achieve success (Calder, 1993).

For nurses and other health professionals, respecting the client and listening to what is important for that person will make a crucial difference to the achievement of good health outcomes. The need to look at one's own emotions first, in order to be able to deal with the 'horrific stories' and the reality of what health care professionals and especially nurses come across when examining women who have undergone female genital mutilation. Nurses and other health professionals need counselling guidelines that include and describe how to deal with different personal attitudes towards female genital mutilation. Some nurses react to genital mutilation with horror and disgust, others with pity and some with anger. Brady (1998) states that the care of genitally mutilated women requires sensitivity, and non-judgmental language. This helps to establish a good rapport and gain their trust.

Implications for midwifery

For both obstetric and midwifery staff, the experience of experts in the area of caring for infibulated women suggests that the procedure for de-infibulation must ideally be performed antenatally in order to avoid acute problems at the time of birth (Gordon, 1998). A specialised unit dealing with all types of related issues on female genital mutilation is the ideal. Such a unit should be staffed by experts in this area, including a psychologist, an interpreter, specialist doctors, nurses, midwives, and

support staff. A specialised unit will offer the women easy access to de-infibulation, so that they do not have to go through the 'waiting list' system. Failure to provide appropriate antenatal care will result in complex problems for health professionals, with pregnant women arriving in labour still infibulated and ready to birth.

The relationship between the client and the midwife depends heavily on the cultural understandings of each group. A midwife is inevitably affected by cultural ideas about pregnancy and birth, about the role of women, about religion, and about technology. But as Murray (1996) states, unless midwifery 'makes sense' of each local culture it is involved with, positive health outcomes may not be attainable. Cultural knowledge and understanding can promote midwifery positively to maintain health. Again, this requires specific and appropriate education. Sensitive questioning techniques in the antenatal period are essential. Many women find it very difficult to talk about genital mutilation but appreciate sympathetic support. Poor handling and mismanagement could result in non-attendance at clinics and prevent women receiving the appropriate care (Newman, 1996). Midwifery care for genitally mutilated women is important, unique and a new area for most health professionals, nurses, and midwives in western countries. The midwife must first establish a rapport with the male member of the family who usually decides the health care his wife needs. Physical contact with any male other than the husband is often strictly forbidden and midwives should be aware of this. Female doctors, nurses and midwives are preferred, as the Somali women may not communicate their needs to a male.

Midwives should be aware that women who are tightly infibulated need to be de-infibulated before first sexual intercourse or first vaginal

examination can take place. Unborn babies and the mother are at serious risk if de-infibulation is not performed. The routine vaginal examination to assess progress of labour may instead be done by performing a rectal examination or by using other means of assessing progress of labour. Multiparous women usually have heavily scarred and deformed perineums from repeated de-infibulation and re-infibulation and routine posterior episiotomies (Toubia, 1994). After de-infibulation, the raw edges must be attended to prevent bleeding. Compassionate counseling of the women and their partners is important.

Midwives should be aware that women may not readily divulge the date of their last menstrual period as, from their past experience of this issue, they do not appreciate the management of events when the due date of baby (as calculated from the last menstrual period) is passed. The pregnant Somali women also do not see the relevance of antenatal classes that involve exercise classes and some do not appreciate the antenatal checks either.

Implications for education

Education for all health professionals and nurses dealing with genitally mutilated women is essential. Health professionals, especially nurses, play an important role in patients' lives and therefore need to be equipped to deal with diverse cultural health needs. Training programs can provide an understanding of female genital mutilation (fgm) and its health risks. Nursing and midwifery programs need to include information on antenatal, delivery and postnatal care for women with fgm. Good communication among staff working with genitally mutilated clients enables knowledge to be shared among health professionals, including midwives and nurses. This knowledge will in time be extended

to the wider community. Sundby (1996) states that support is also required for those who educate people to work with anti fgm programs.

There is a need to include in health education programmes, information about sexual health and the legal boundaries for the protection of children who are at risk. Awareness of the current law and status of female genital mutilation should be incorporated into the current education programs of all health professionals, and especially into the nursing and midwifery curricula. There is a need for education campaigns aimed at the men and women in the Somali community provided those expert in this area of female genital mutilation and acceptable to the community do the campaigning. However it must not be assumed that education alone, leads to abolition of any practice or lifestyle. Any change must come from the communities themselves. The exposure to a new environment, heightened awareness, education, new ways of reflecting and thinking tend to come about within individuals when exposed to new environments.

Greater understanding of cultural practices in context of the entire culture is desirable as Baker (1997) believes that all behaviors of individuals should be judged only from the context of their own cultural system. Culturally competent nursing care is based on awareness and knowledge related to ethnicity, culture, gender, sexual orientation and in explaining and understanding the situation and the responses from the clients and their reality and background. There needs to be an awareness that cultures do evolve and alternative rituals to fgm are a favourable option.

Chelala (1998), Dorkenoo, (1994) and Abusharaf (1998) present literature that suggest alternative rituals to female genital mutilation. For example in Kenya, a group of girls go through a six day training session,

culminating in a huge celebration. The girls receive books of wisdom from their parents (Abusharaf, 1998). In another initiation ceremony replacing circumcision known as 'circumcision through words' or Ntanira Na Mugambo the young girls share information have education and training ending with a community celebration with music, dances and feasting (Chelala, 1998). There are not many follow up studies which have been done to indicate the ages of the girls or how successful these alternative ceremonies have been.

In some regions in Africa, there is evidence that men prefer uninfibulated women sexually (Koso-Thomas, 1998; Abusharaf, 1998). It is not clear whether this is as a result of education on the effects of fgm or it is just the changing views and experiences of the men in these communities. More work needs to be done on alternative rituals and the education of men for a possible change to occur within the communities that practice genital mutilation.

A greater understanding is required of women from Africa now living in New Zealand, and of their history. There is debate about which approaches are most effective. Should educational campaigns focus solely on the harmful effects of female genital mutilation or should women's rights and their status be addressed? Raising the socio-economic status of affected communities is also essential to ensure the effectiveness of any education campaign, since the primary reason for the continuance of this practice is women's economic powerlessness.

Explaining the harmful health effects would be an ideal approach. Consciousness raising through education could be used to motivate those practising female genital mutilation to give up the practice (Amnesty International, 1995). Incorporating discussions on the harmful effects of female genital mutilation during routine Plunket visits, or visits

to the general practitioner as part of health education, is recommended by Denholm & Jama (1998). It is crucial to ensure that all such information is shared in a consistently sensitive manner.

In Western countries where there are large immigrant populations education of other professionals such as teachers is needed. They should be made aware of the cultural practice of fgm and its implications. Teachers at school should be aware that girls past the age of seven have probably been circumcised. They should know that urinary infection and frequency might be common and that those girls often take a much longer time to urinate than other girls do.

Thus far the Somali women's view on fgm and the implications for health professionals have been presented. Throughout this study it became clear that Somali women consider female genital mutilation as a cultural issue, part of their identity and life. The health effects of fgm were also accepted as a normal part of being a woman. The Somali people who perceive the practice of fgm as a cultural right come up against opposite views of health professionals who view this practice as a violation of basic human rights and not in keeping with the code of ethics of nurses, midwives or medical doctors. The life of the mother and baby is of paramount importance and therefore the concept of perceived cultural rights by Somali women rests uncomfortably at the doorstep of the health professional who is reared on a philosophy of health promotion, with a moral and ethical obligation to adhere to a code of ethics which governs that profession.

A "Right" is defined as "an advantage or benefit conferred upon a person by a rule of law" (Johnson, 2000, p.49). Each country may have their own laws and may choose to ignore outside laws. In Somalia fgm may be condemned or practiced, it is internal and they do as they

choose. However when the practice is taken outside to a host country, the host country may choose not to support such a practice and may choose to support human rights, which ultimately affect all human beings. This paradoxical viewpoint presents a dilemma that essentially impacts on both the health professionals and the Somali women.

Implications for further research

Implications for further research presented in this section arise from the study data, from the literature and the methodological issues identified during the conduct of this study.

Implications for further research arising from the data

Data from the participants highlighted concerns about lack of knowledge of health professions. Gruenbaum (1996) states that female circumcision should not be seen as a maladaptive pattern in a particular culture but that this procedure should be analyzed within the larger context of women's lives in underdeveloped countries (1996). She further asks the question: 'does the fact that it is dangerous and potentially harmful to health mean that it is essentially negative and maladaptive?' (p.457).

Research questions:

- What other cultural practices impact on women's health in New Zealand?
- What is the impact of such practices on the health of women?

The data suggest that Somali women are working on the issue of fgm within their community and dislike outsiders being involved. This is an area for further research so that policies and strategies to support the

Somali women to have control of their health practices can be developed.

Research questions:

- In what areas do Somali women lack control over their health practices?
- What strategies will enable them to have control over their health practices?
- What changes have taken place in the community which impact on the health of Somali women?
- What do health professionals such as nurses, midwives and medical practitioners know about different cultural practices that impact on women's health in New Zealand?

Implications for further research arising from the literature

The implication of fgm in the literature was linked strongly to what it means to be a 'Somali woman'. For health professionals, it is important to gain understanding in relation to different cultural practices that affect the health of an individual. This current study has indicated that there is still a strong link between the cultural practice and the identity of Somali women.

From the findings and the literature (Craft, 1997; Gruenbaum, 1996) it seems that the men in the cultures that practice fgm gain from the practice at the expense of the women. Yet, they absolve themselves from the act of fgm itself saying it is 'women's business'. Nevertheless in new home countries there is not the same economic pressure as in their country of origin and therefore there may be a change of attitude in both

the men and women. If the men are aware of the physical and psychological consequences for women and they pledge not to insist on marrying infibulated women then, like footbinding practices that changed in China the practice of fgm could change too. In addition the other women folk may not be around in the adopted country to support the women during pregnancy, labour and childbirth and the men/husbands may have to provide the support.

Research questions;

- In New Zealand, what role do the Somali men play in relation to fgm, pregnancy, labour and childbirth?
- What role would the Somali men like to play now that they are in a new environment?
- What are the views of Somali men on the issue of fgm in New Zealand?

In western countries such as the United States of America with large immigrant populations, Bashir (1997) states that health care professionals should understand that many immigrants are surprised by what they perceive to be flagrant sexual behavior of American youth and an apparent moral decay of society. They are genuinely and seriously concerned that having moved into a culture where values of virginity and chastity are in the minority, their children may fall victim to immoral behavior.

There was little literature found on transient groups and therefore an area for more research in relation to transient groups residing in New Zealand. There are refugees living in many parts of the world. There certainly are changes that take place over time, in the new homeland.

There are complex tensions between maintaining traditions and adapting to the new homeland. The new environment allows for the introduction of some changes that are essential to survival, and it allows for the continuation of certain cultural practices. There are also many stresses that refugees have to cope with in their new environments. However the changed environment and circumstances do bring about unique and interesting cultural changes.

Research question:

- What are the difficulties that the Somali community in New Zealand face in relation to cultural practices?

Implications for further research arising from methodological issues

The channels of communication within the Somali community required the initial endorsement from the male leaders of the Somali community. The men have been known to perpetuate the practice of female genital mutilation (Wright, 1993). The men in the communities that practice fgm may feel exposed and therefore may demonstrate some resistance to future research if it was evident from specific research that the men have a role in this practice. For this study I gained entrance into the Somali community and gained access to participants.

Finally in this research study the women emphasised the way in which I conducted the whole process from the initial negotiation to the end of the study. I was careful to follow protocol and therefore gained their trust and confidence. It is essential that research be done in a culturally safe manner. To conduct culturally sensitive research means it must be done with a raised consciousness concerning the impact of culture on the persons being studied, on the research process itself and most

important on the researcher. Research methods should include frameworks that incorporate gender, racial, cultural, political and economic diversity (Hall, Stevens & Meleis, 1994).

Limitations of this study

While this study has explored Somali women's descriptions of their health needs in relation to female genital mutilation, it does have limitations. The sample was of thirty-one women only, all from the Wellington region. The findings, general themes, and categories of information are representative of the Somali women's in the Wellington area that participated in the study.

The use of interpreters in a research study can lead to a loss of valuable data. There is always the risk for the researcher of missing out on valuable information as was the case in the present study. The interpreter has the power to decide what information is relevant or irrelevant to a study and therefore may not interpret parts of the discussion. This could limit the amount of rich data available for analysis. Being aware of the risk before embarking on research of this nature is recommended.

There was the issue of the mobility of the members of the Somali community for this study. The many changes in the numbers of contact persons varied throughout the research project making this study more complex and difficult to accomplish. The Somali community members seem to move from one city to another and from country to country in a short space of time. There were eventually many changes and re-negotiations with key leaders, support persons and interpreters.

The religious and cultural practice of Ramadaan usually occurs in the month of January when most Somali are confined to some specific

rituals and activities and are not willing to participate in outside activities other than those required by their culture. This impacted on my research as the process came to a standstill until the Ramadaan month was over, thus extending the period of data collection.

Summary

The Somali women living in New Zealand pose unique health needs which require nurses, midwives and other health care professionals to have a wide knowledge base relating to female genital mutilation and its consequences. This will prevent isolation and alienation of individuals and may improve the general health of the community. Finally, it must be acknowledged that education and access to information relating to Somali and their cultural practices is necessary for better understanding and therefore has the potential to improve health delivery.

This chapter presented with the summary of the two themes that emerged from this study, the implications for midwifery, other health professionals, education, for future research and concluded with the limitations of this study.

Concluding comment

The law alone cannot facilitate change; but greater support, deeper understanding of cultural values and practices, supportive structures that allow for consciousness raising and genuine cultural sensitivity are the most desirable and most effective ways to motivate those practising genital mutilation to change. Sensitive communication with the Somali and other immigrant women and their partners, and with their religious leaders, will help create a safe environment in which the serious and multiple health needs arising from genital mutilation can be discussed,

and its harmful effects documented. The Somali women may question the practice of fgm over time, in their new country of residence.

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Appendix A

INVITATION TO TAKE PART IN RESEARCH

You are invited to participate in a research project aimed at identifying the health needs of North-East African women in Wellington.

The research will involve taking part in talking with a group of five other women and will take up to two hours.

Options for the venue and time will be discussed with you before a final agreement is made.

There will be an interpreter present throughout my contact with you. The Interpreter and myself will explain the details of the research to you.

I will make contact with you to arrange a meeting to explain more about the research.

Transport to the venue will be provided.

Refreshments (tea, coffee, cold drinks and eats) will be made available.

Mr. Ismail Ibrahim from the Refugee and Migrant Services (RMS) and Mr. Abdurahman Jama Osman the Chairman of the Wellington Somali Association have endorsed the research project.

Appendix B

INFORMATION SHEET

My name is Nisha Kambaran. I am a Registered Nurse undertaking research to complete my Masters thesis. In this research I wish to identify and describe the health needs of women who have come from North-East Africa and live in the Wellington region. I will arrange for us to meet together with five other women from North-East Africa and talk about your health needs. I will ask you two questions and you can discuss these together. The questions I want to ask will be given to you three days before the group meeting so you can think about the topic. The group discussion will take up to two hours at a venue and time suitable to you. Two venues will be suggested and the choice will be based on majority agreement. With your permission the discussion will be audiotaped. Included in the group will be an interpreter so that if you do wish to talk in Somali you may do so. A professional typist will type up the information. The typist and Interpreter will sign confidentiality agreement forms.

I will be meeting with you after analysing the data to check the information I have is accurate. If you wish you may read the findings of the completed research. The purpose of the research is to share the information with other educators and health workers in order to raise awareness in the area of women's health, particularly women from North-East Africa. All tapes, transcripts and consent forms will be stored in a secure place at Researcher's home. At the conclusion of the research they will be stored in the School of Health Sciences at Massey University for at least five years.

Kambaran: Home Phone: (04) 385 1097

Supervisor: Prof. Julie Boddy, Department of Nursing and Midwifery,
 Massey University, Private Bag 11-222-Palmerston North Ph. (06) 3504334
 Fax (06) 3505668

Appendix C

CONSENT FORM

Genitally Mutilated Women in the Wellington Region: A Study of their Health Needs

I have read the information sheet dated _____ and have had the details of the study explained to me. I have had the opportunity to discuss this study. I am satisfied with the answers I have been given, and I understand that I may ask further questions at any time.

I understand that taking part in this study is my choice and that I have the right to withdraw from the study at any time.

I understand that my participation in this study is confidential and that no material, which could identify me, will be used in any reports on this study.

I agree to the interview being audiotaped. I agree to participate in this study under the conditions set out in the Information Sheet.

I have had time to think about taking part in the research.

I know who to contact if I have any concerns.

I _____ hereby consent to take part in this study.

If you have any concerns about the study, you may contact: The Wellington Ethics Committee, Wellington Hospital, Telephone 385-5999 ext. 5185

Signature: _____

Date: _____

Appendix D

Confidentiality Agreement (Interpreter)

I agree that the information shared during this research project is confidential information.

I agree to maintain confidentiality by not disclosing any aspect of the discussions with any other persons, apart from the researcher, and the transcriber for the sole purpose of clarifying content.

No other person will have access to information shared with me during the focus group discussion or outside of group discussions, when assisting with interpreting.

Signed: _____

Dated: _____

Appendix E

CONFIDENTIALITY AGREEMENT (TYPIST)

I agree that the tapes that I am to transcribe contain confidential information.

I agree to maintain confidentiality by not disclosing any aspects of the tapes or typed transcripts with any other person apart from the researcher, for the sole purpose of clarifying content.

No other person will have access to the tapes or typed transcripts while they are in my care.

Tapes, transcripts and the computer disc will be returned to the researcher as soon as they are finished with.

Signed: _____

Dated: _____

Appendix F

The Somali Community in Wellington.

Statistics New Zealand, the Immigration Services and other key Somali people consulted regarding statistics unanimously stated that apart from an estimated total number of Somali people in New Zealand it is very difficult to obtain precise statistics in specific cities as the Somali people are very mobile

Often Somali move from place to place depending on job opportunities. For example during apple picking season many Somali move to Nelson and Hastings. Many move to Gisborne, Dunedin and Wellington for freezing work jobs when sheep are ready for slaughter. It is therefore difficult to monitor the movements of the Somali community in general.

Mr Bihi, who is the Refugee and Migrant Services Executive Member stated that there are approximately 2,800 Somali in New Zealand. Their distribution through the main centres in New Zealand is as follows:

Wellington	700
Hamilton	600
Christchurch	500
Auckland	1000

(Personal communication 19th October 2000 - Mr Abdi Bihi)