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**FLUID IDENTITIES: CONTEXTUALISING
GENITAL RECONSTRUCTIVE SURGERY
AFTER FEMALE CIRCUMCISION IN
BURKINA FASO**

**A thesis presented in partial fulfilment
of the requirements for the degree of**

**Doctor of Philosophy
in
Social Anthropology**

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ABSTRACT

Female circumcision procedures were traditionally performed on many girls and women in Burkina Faso. These practices were outlawed in 1996, and are now termed ‘female genital mutilation’ by the government and activists trying to stop them. About thirty-five years ago, Pierre Foldès, a French urologist who was on a humanitarian mission to West Africa, developed a surgical procedure to alleviate health problems associated with these practices. He later refined his procedure and started using it to also restore clitoral anatomy and function. This surgery, which is presented as two distinct procedures in Burkina Faso, is now performed by some indigenous doctors in Ouagadougou and Bobo-Dioulasso.

In this ethnographic study, I explore the reasons motivating some Burkinabe women to seek genital reconstructive surgery, the impact this surgery has on them and societal attitudes towards this surgery and these women. I discuss concepts of gender and embodiment in relation to Burkinabe girls’ and women’s health and sexuality by considering their understanding of what is normal, healthy, natural, complete, sexually attractive and feminine. I also consider the manner in which the meanings of these notions are changing depending on the prevailing discourse.

I argue that the salience of the discourse promoted by the Burkinabe government and activists working to end female circumcision in the urban areas of Burkina Faso is compounding the harm associated with this practice. It has led some circumcised women to view themselves, and to be viewed by others, as unhealthy and sexually defective, and to believe that they need genital reconstructive surgery. Yet, limited information about this surgery, its cost and taboos associated with sex and sexuality limit women’s access to the surgery. I further argue that that some Burkinabe women in the Raëlian Movement are co-opting the discourse that paints circumcised women as victims to create spaces where they can remodel typical Burkinabe values, but also exercise those which are particular to their religion. They have thus embraced genital reconstructive surgery to reconstruct not just their bodies, but also their identity as healthy and sensual women.

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CHAPTER 1

INTRODUCTION

Background

In 2004 I went to the French Cultural Centre in Nairobi to do research for an assignment. It was there, while I was momentarily side-tracked from the task at hand, that I came across a magazine article about a French urologist, Pierre Foldès, who had developed a surgical procedure about twenty-five years previously to repair the damage occasioned by female circumcision in Burkina Faso. Having grown up in the countryside in Kenya, I was familiar with the politics of the body, particularly the female body, as a site that was inscribed with messages that spoke of various levels of beauty, readiness and suitability for marriage and childbearing and other processes of production and reproduction. It was also a site from which people inferred messages of health, ill health and even morality and immorality. Moreover, I was aware that girls and women in various societies were always making and remaking their bodies in different ways. I had also heard that some were put through practices that modified their genitalia to meet the expectations of their societies.

Reading the article about reconstructive surgery after female circumcision fascinated me on several fronts. Firstly, I knew that female circumcision was practised in some ethnic groups in Kenya, and that there had been efforts by some non-governmental organisations and, to some extent, the government of Kenya to discourage the practice. Those efforts had generated a lot of debate particularly in the 1990s when a female member of parliament had defended the practice (Okoko 2000) even as non-governmental organisations worked to get it prohibited by law. In addition, there were indications that in some communities the practice had evolved from a 'traditional' ritual carried out in communal rites of passage ceremonies into a 'modern' and more individualised form performed by medical personnel at home or in some hospitals in the country. The little knowledge I had garnered about female circumcision from these public debates had led me to believe that it was an irreversible procedure. I was therefore quite intrigued to learn about that new surgical procedure and the French doctor who made such claims as restoring "both clitoral anatomy and clitoral function in afflicted women" (Foldès 2006:1091).

Secondly, it surprised me that the procedure had seemingly been in place for over twenty-five years and yet there did not seem to be much knowledge about it. I wondered why there was so much silence about reconstructive surgery when there seemed to be a lot of open discussion about female circumcision in general. I also wondered why the surgery had been pioneered in Burkina Faso, considered one of the poorest countries in Africa – where there were presumably ‘more important’ things to worry about than the impact of female circumcision on women’s health and sexuality – and not in more ‘developed’ countries where these practices were also done. In addition, I wondered why Foldès did not develop his procedure in a country such as Sudan where more extreme forms of female circumcision like infibulation were performed and where discussion about these practices started during the colonial period.

However, perhaps the part that intrigued me most about the surgery was the experience of Burkinabe women who sought it. I wondered, given that many other women had seemingly lived with female circumcision and its effects, what motivated some Burkinabe women to seek reconstructive surgery, and whether once they had it their expectations were met. What or who did they become after the surgery in their societies and in the specific reference groups that mattered to them? Did they become physically ‘complete’ but less marriageable women? More marriageable women? Was marriageability even an important value for these seemingly subversive women? For whom were they ‘remaking’ themselves? For themselves or perhaps for the men in their lives (who maybe now preferred ‘unmutilated’ women)? Were they doing it to fit into Western-inspired perceptions of what was considered normal and attractive? Further, I wondered how widespread the surgery was and what people’s perceptions about it were in that poor, predominantly Islamic, society. In fact, the more I thought about genital reconstructive surgery, the more questions came to my mind and the more I realised that there were very few answers in academic or other literature at the time. It was with these unanswered questions in mind that I began to make a gradual shift in my studies, from linguistics through African studies into social anthropology, in order to find an appropriate base from which to study the phenomenon.

Choice of research site and research participants

I based my research in two sites in Burkina Faso: the capital city, Ouagadougou, and the second-largest city, Bobo-Dioulasso. Burkina Faso is a landlocked West African country bordered by Benin, Ivory Coast, Ghana, Mali, Niger and Togo (see Figures 1.1

and 1.2). Previously known as ‘Upper Volta’, the country gained independence from France in 1960 and was renamed ‘Burkina Faso’ in 1984, a term which means ‘land of upright people’ or ‘the country of honourable people’ (World Almanac Education Group n.d; US Department of State 2012). The country has a surface area of 272,967 km² and is divided into administrative units comprising 13 regions, 45 provinces, 350 departments, 33 communes and more than eight thousand villages (Painter 2011; INSD and ICF International 2012:1; INSD and ORC Macro 2004:6).

In 2010 the country had an estimated population of 15,730,977 people from 63 ethnic groups which fall within two significant cultural groups: the Voltaic and the Mande (INSD and ICF International 2012:2; Painter 2011). Most of the people in Burkina Faso’s 63 ethnic groups descend from the precolonial Mossi Kingdom (Jirovsky 2014:29). Some of the larger language groups from these ethnic groups include the Mossi, Mandé, Peul, Lobi, Gourmantché, Gourounsi, Tuareg, Bobo and Senoufo (Drabo 1993, cited in Jirovsky 2014:29). Other minority groups in the country, particularly in the big cities, include Lebanese, European and Chinese people. There are also a large number of expatriates from different countries working in ‘development’ organisations (Jirovsky 2014).

Ethnicity is important to many people in Burkina Faso in that they reference it when talking about themselves. It influences one’s everyday interactions with others and in some cases can have economic advantage (Jirovsky 2014:34, citing Chevron 2002; Comaroff and Comaroff 2009; Gingrich 1998). Older people, in particular, are wont to speak of the traditions of their forebears and their origin. Younger people, on the other hand, attribute less importance to ethnicity and instead focus more on the solidarity of their mixed peer group or religious affiliation. Even though interethnic marriage is common and widely accepted, marriages between people of different castes (such as gentlemen, bards and blacksmiths) are still frowned upon (Jirovsky 2014:34).

Ouagadougou, Burkina Faso’s capital city, is located near the centre of the country and its population is officially termed as one million people (Jirovsky 2014:26, citing INSD 2012). Even so, the city is fast growing with migration increasing every year. Currently, the capital and its surrounding areas are thought to have more than two million people, making about 12% of the total population of the country (Jirovsky 2014:26, citing DESA 2011; Yahmed 2005). Located in the south-western part of the country, Bobo-

Dioulasso is Burkina Faso's second largest city and has a population of 471,426. It is a diverse city with more than 20 different ethnic groups including the local Bobo groups and others who have moved in from the northern territories (Jirovsky 2014, citing INSD 2012).

Although there are no definite statistics to indicate religious representation in the country, the available data shows that Burkina Faso has a majority Muslim population (more than half of the population), a Christian population (mainly Roman Catholic and Evangelical Protestants) accounting for 20-30% of the population and a significant number of people who follow indigenous African religions (Ouédraogo 2010:393; INSD and Macro International 2000, cited in INSD and ORC Macro 2004:3). There is a very low correlation between religion and ethnicity in the country and, indeed, most ethnic groups in the country are religiously heterogeneous (Jirovsky 2014:30; cf. Hayford and Trinitapoli 2011; INSD/ORC 2004). There is a mixed population of Muslims and Christians in Ouagadougou whereas Bobo-Dioulasso is predominantly Islam with a smaller, mainly Catholic, Christian population. Most believers in these cities, be they Muslim or Christian, also practice diverse rituals from traditional religions, visit soothsayers and make sacrifices to different fetishes (ibid). Different members of the same family can adhere to different religions (cf. Jirovsky 2014:30).

Ranked 161st out of 169 nations in the 2010 United Nations Human Development Index, Burkina Faso is considered one of the poorest countries in the world, with a per capita gross domestic product (GDP) of \$580. Parts of Burkina Faso have good agricultural conditions and about 80% of the population relies on subsistence farming with only a small fraction directly involved in the industry and services sector (US Department of State 2012; Jirovsky 2014:37; cf. Beauchemin and Schoumaker 2004; Roth 2005a; Lejeal 2002, cited in Jirovsky 2014:33). The overall unemployment rate in urban areas of the country is 17.7%. This rises to 21.4% for people aged between 25 and 29 years and 29.4% for those aged between 15 and 24 (OECD/AfDB 2008: 179, cited in Jirovsky 2014:37). Three to four million Burkinabe are migrant workers mainly on cocoa farms in Ivory Coast (US Department of State 2012). Although by law children in Burkina Faso are required to attend school until the age of 16, only about 44% of school-age children attend elementary school with many families choosing to send their children to work as they cannot afford school supplies (Painter 2011). The average literacy rate is thus only 21%, 29.4% among men and 15.2% among women. The

country has a median age of 16 years, and, according to 2011 estimates, an average life expectancy of 51 years for males and 55 years for females (ibid.).



Figure 1.1 Location of Burkina Faso

(Source: <http://www.worldatlas.com/webimage/countrys/africa/bf.htm>).



Figure 1.2 Burkina Faso with neighbouring countries

(Source: <http://geography.about.com/library/cia/blcburkinafaso.htm>).

Due to the precarious economic conditions in the country, it is difficult for many people, especially young men, living in such towns as Bobo-Dioulasso to meet many social expectations including marriage and taking care of a family (Jirovsky 2014:37; Lejeal 2002, cited in Jirovsky 2014:33; cf. Calvès 2007). Furthermore, many people who were employed lost their jobs in the 1980s when the government was implementing ‘structural development programmes’. Unemployment and underemployment therefore causes a lot of social pressure relating to “the generational contract, general social solidarity among families and friends, and interfamilial dependencies” (Jirovsky 2014:33; Höpflinger and Roth 2012; Roth 2005a; Roth 2008; Roth 2012; Roth 2005b).

My choice of Burkina Faso as a research site was influenced by the consideration that the country was potentially a ‘big’ research site in regard to information about genital reconstructive surgery. It was also a rich setting in which this surgery seemed to be one of several interconnected issues linked to female circumcision. From the reading that I had done in preparation for field research, I had learnt that reconstructive surgery aimed at restoring clitoral and labial integrity and/or function (after female circumcision) was carried out in a few locations in the world including Burkina Faso, Egypt, France, the United Kingdom and the United States of America (Ogodo 2007; Prolongeau 2006; Thabet and Thabet 2003; Momoh 2005:24; Paterson et al. 2012:7, citing Johnson and Nour 2007 and Nour et al. 2006; Tsai 2010).¹ Out of all these locations, it appeared that it was only in Burkina Faso and France where these surgeries were carried out in significant numbers and using procedures that had been explicitly documented in a manner that made them amenable to study.

In France, female circumcision was an illegal and clandestine activity whose practice appeared restricted to a small section of immigrant communities (Prolongeau 2006). There, reconstructive surgery was carried out on some women from those communities living in France and elsewhere in Europe (Aziz 2004, 2005). In contrast, in Burkina Faso, female circumcision procedures had been perceived in the past (and perhaps by some people in the present) as positive cultural, and even religious, practices which

¹ After my return from the field, I learnt that this surgery is also performed in Spain (BBC Radio 4 2013a; Pressly 2013) and possibly other parts of the world where it has not yet been widely documented.

were carried out on a large section of the female population – up to 77% of Burkinabe women aged 15 to 49 in 2003, according to INSD and ORC Macro (2004:203). The Burkinabe government outlawed the practices in 1996, and since then had been actively supporting measures to eradicate them (INSD and ORC Macro 2004:203; Jirovsky 2010:85; Lockhat 2004:63-64; Prolongeau 2006:108-109). It was in that setting that reconstructive surgery was being performed by a number of Burkinabe doctors, some of whom had been trained by Foldès, mainly in the capital city, Ouagadougou (Ouédraogo, n.d.; Ogado 2007; Jirovsky 2010), but also, to a less extent, in the second largest city, Bobo-Dioulasso.

Another notable angle to the phenomenon of genital reconstructive surgery in Burkina Faso was the involvement of Clitoraid, a non-profit association that was building what they referred to as a ‘pleasure hospital’ in Bobo-Dioulasso to “offer free medical services for the restoration and rehabilitation of female circumcision victims” (Clitoraid 2012). Clitoraid, which was based in the United States, had attracted negative publicity on various Internet platforms such as blogs and social networking sites for what was perceived as the members’ ethnocentric and ignorant approach to the issue of female circumcision, but also because they were affiliated with a controversial religious group called the Raëlian Movement (Boynton 2010; Kamau-Rutenberg n.d.; Care2Petitions n.d.; Facebook n.d.).² There were indications that the presence and influence of members of the Raëlian Movement was not welcome in Bobo-Dioulasso because their religious philosophy – which, as I explain in Chapter 9, among other things advocates “open sexual expression” (Palmer 1995:111) – was regarded as being contrary to local moral concepts and sexual taboos (Jirovsky 2010:86). In addition, there were potential legal problems emerging from the Raëlians’ use of Foldès’s name and image in their Clitoraid project (Jirovsky 2010:86; Bangré 2009). I was interested in understanding the implication of these controversies in the practice and perception of reconstructive surgery in Burkina Faso. The involvement of various players and their views in this context – Burkinabe women seeking reconstructive surgery, Burkinabe doctors carrying out these procedures, the Clitoraid/Raëlian members in Ouagadougou and Bobo-Dioulasso, the government of Burkina Faso, organisations working to eradicate female

² See Boynton (2013) for a more recent critique of Clitoraid’s activities in Bobo-Dioulasso.

circumcision and other ordinary Burkinabe people – presented a rich interaction of personal, social, medical, religious, legal and cultural angles, and made Burkina Faso a potentially highly productive setting for the study that I was seeking to carry out.

To conduct this research, I based myself not in a remote village as orthodox anthropologists did/do, but in the urban areas of Ouagadougou and Bobo-Dioulasso, and zeroed in on particular research participants. While an extended stay in a village in Burkina Faso would have enabled me to better contextualise some of the stories I tell in this thesis, the research participants holding the specific information I was seeking in my research – particularly information pertaining to genital reconstructive surgery – lived in different locations in these two urban areas. Furthermore, as I explain in Chapters 2-7, given the taboos surrounding female circumcision and genital reconstructive surgery, observing people's daily life in one fixed setting would not have been an effective strategy in garnering information about these procedures. It was therefore more productive to use targeted interviews as a research strategy and focus on people closely involved in these procedures.

Research objectives

I went into this study seeking to understand why some Burkinabe women who had undergone female circumcision sought reconstructive surgery, the impact of genital/clitoral reconstructive surgery on these women, and the views held by people in the Burkinabe society regarding this surgery and these women. In regard to the first objective, as I show in Chapters 3 and 5, in the communities where they were (or are) carried out, female circumcision procedures were not performed in isolation but as part and parcel of other long-standing customs, traditions and values. They were linked, to varying degrees and in different places, to communal identity, maturity, notions of purity and femininity, and ideas of suitability for marriage and motherhood. It was therefore important to consider what motivated some Burkinabe women to undergo a procedure that could be construed as a reversal not just of these earlier procedures but also of the values and ideals that were linked to these practices. In other words, it was important to explore how and why these women were different from their peers in this respect.

In regard to the second and third objectives, female circumcision is a practice that has implications that go beyond the individual; it is a practice that is related to culture and

tradition (Barber 2010:65), and that takes place within a larger social setting. As such, it could be anticipated that the reconstructive surgery carried out in Burkina Faso affected the women who had it in private and personal ways but that it also inspired opinions and reactions in the larger community. These opinions and reactions were in turn bound to affect the social standing of the women in question. It was with this in mind that I aimed to explore the impact that this surgery had on these women in their private lives but also the opinions that it inspired in the wider society, and ultimately, the impact that this had on these women as social beings: daughters, sisters, wives, girlfriends, mothers, grandmothers and community members or even leaders.

To address these three objectives, I gathered views from four main groups of people: women who had undergone female circumcision and genital reconstructive surgery, or those seeking to have reconstructive surgery; doctors trained to carry out genital reconstructive surgery; people working with organisations involved in activism against female circumcision; and members of the general public who did not fall into any of these groups. I conducted semi-structured interviews with twenty-five people. Among these were six doctors, a psychologist and seven women who had undergone female circumcision. Two of these women had had reconstructive surgery in Ouagadougou and another two of were waiting to have it done at the Clitoraid hospital. Six of my research participants worked with organisations involved in activism against female circumcision and another five were members of the general public involved in diverse occupations. Even so, as I explain in Chapters 2 and 4, these categories often overlapped as some of these people spoke to me in multiple capacities. I also spoke informally to many other people during my fieldwork, a process I explore in more detail in Chapter 2.

My main objective in speaking with circumcised women who had had reconstructive surgery was to understand what motivated them seek the surgery and how their lives had changed as a result of having it. That included finding out what impact, if any, their choice to have the surgery had had on their lives and their relationships with ‘significant others’ in the community: their husbands, boyfriends, parents, members of their extended families and other members of their communities. From those who were yet to have the procedure, I wanted to find out why they wanted to have the procedure and how they expected it to affect their lives. From medical personnel, I sought to understand the surgical procedures that they performed, their reasons for carrying them out and the effects they thought their work achieved. Although my research was not

focused on advocacy efforts against female circumcision, it was also important to find out what members of organisations working to eradicate female circumcision thought about the issue of reconstructive surgery and the effect, if any, that it was having on their work especially in changing people's attitudes towards female circumcision. Finally, I was also interested in hearing thoughts regarding female circumcision and genital reconstructive surgery from other members of the community (adult females and males), some of whom were aware of these procedures and interacted with women who had had them.

Scope of the study

Female circumcision is a vast subject whose breadth and depth is reflected in the expansive literature from various disciplines on the matter. This literature is rife with propositions and counterpropositions with some of the key themes reflected therein being: the origin and naming of these practices, types of female circumcision and their prevalence in various parts of the world, the evolution of these practices and their contexts over time, the social and cultural importance of these practices to individuals and communities and parallels between female circumcision and other cultural or bodily practices. Other key discussions include: the health, psychological and sexual consequences of female circumcision, efforts by various governments and non-governmental organisations to discourage or eradicate these practices on health but also human rights grounds and the impact of these efforts.³

It is in view of this backdrop of a rich repertoire of highly enlightening but also often conflicting information about female circumcision that I sought to study the relatively new theme of genital reconstructive surgery as developed and performed in Burkina Faso. While some of the areas highlighted directly relate to my study, I draw on them only in as much as they inform the Burkinabe experience. That is to say, for instance, that although there is a lot of information in the literature about the negative effects of female circumcision, my exploration of these effects is limited to the ways in which these are implicated in the need for reconstructive surgery in Burkina Faso. In the same way, while there are a lot of efforts by the Burkinabe government and other agencies to eradicate female circumcision, my engagement with these bodies is limited to the

³ Refer to Chapters 3 and 5 for an extended discussion of some of these themes.

framing of their messages and how this influences the understanding and uptake of genital reconstructive surgery in Burkina Faso.

My discussion of genital reconstructive surgery is limited to the context of female circumcision, that is, surgical procedures done to alleviate problems associated with female circumcision. Even in this context, as shown in Chapter 7, the concept of reconstructive surgery can apply to a variety of procedures done in various countries to treat the negative effects associated with different forms of female circumcision. The specific procedure developed by Pierre Foldès is currently practised by Foldès himself in France but also by many other doctors who have been trained by him who work in different parts of the world. However, my focus in this study is the practice of Foldès's procedure as currently practised in Burkina Faso, specifically, in Ouagadougou and Bobo-Dioulasso. Here, the scope of my study includes surgical procedures aimed at alleviating health problems linked to female circumcision such as widening the vaginal opening if it has become too small due to adhesions, or the removal of perturbing scar tissue and vaginal keloids (Jirovsky 2010:86), as well as the procedure termed clitoral reconstruction.

Significance of the study

Broadly, this study contributes to anthropological literature on gender and embodiment particularly in relation to girls' and women's health and sexuality. Exploring the reasons motivating women to seek reconstructive surgery and the impact this surgery has on their lives will provide useful insights into the ways in which Burkinabe women conceptualise notions of womanhood and femininity, and the manner in which these notions are represented in their bodies. This includes the consideration of what, according to them, is normal, healthy, natural, complete, sexually attractive and feminine, the ways in which these notions may be changing and how they relate to the values held by other members of their society. It will also provide insights into the different sources – for example, personal perceptions and decisions, ideas articulated by various groups of people within Burkina Faso and attitudes from the West – that are contributing to the construction of womanhood and femininity among Burkinabe women.

More specifically, this study gives an additional angle to anthropological literature on female circumcision in particular and bodily practices in general. As already indicated,

there are numerous debates in anthropological, medical and popular literature regarding the practice of female circumcision and other practices that alter the body. However, there are hardly any discussions taking place regarding procedures of repairing or reversing these alterations, the motivations behind these reversals, their impact on the affected people's lives and the impact, if any, that they have in discouraging or further entrenching body modification practices. I therefore see my study as one that takes these discussions beyond their present focus into new debates around the motivations behind the initiative that women are taking in having their genitalia, and maybe their lives, reconstructed.

Furthermore, this study endeavours to bring to light insights into genital reconstructive surgery from the perspective of the women concerned, an aspect that I believe would be beneficial not just to Burkinabe women who seek to undergo reconstructive surgery but to other people who focus on female sexuality in one way or another as well. For example, for activist groups working to discourage the practice, learning about why some Burkinabe women are seeking genital reconstructive surgery and the impact that this is having on their lives might infuse some fresh ideas into the current areas of focus and help determine whether there are any gains to be made out of considering the experiences of these women. My aim in doing this is not to cast these women in a positive or negative light but to tell their stories from their perspective so that people reading this study may get an insider's view of reconstructive surgery.

In carrying out this study, therefore, and by bringing out the perspectives of women who are choosing to undergo genital reconstructive surgery and those of the doctors who are carrying it out, it is my view that deeper and more nuanced perspectives will come to the fore regarding the motivations behind reconstructive surgery and the impact that this reconstructive surgery is having on these women's lives. This information might in turn serve to address some of the concerns expressed by community members and even some members of organisations working to end female circumcision. In other words, perhaps by gaining an insight into the lives and experiences of these women, the larger community may be disposed to better understand the issues at hand, and this will perhaps contribute not only towards forming informed opinions about reconstructive surgery but also towards the rethinking of attitudes towards such practices as female circumcision and their effects on women's lives.

‘Afropolitanism’ and my research participants

Given the location of my research in urban Burkina Faso, it is important to highlight the nature of African cosmopolitanism and how it is implicated in positioning of my research participants. A number of African and Africanist researchers (for example, Eze 2014:234; Appiah 2006; Mamdani 1999; Mbembe 2007; Gikandi 2010) rightly point out that Africa is a complex and diverse continent and her people do not fit the undifferentiated identity often imposed on them. Because of colonisation, modernisation, globalisation and democratisation and their sociocultural and economic impact, there has been a shift in the manner in which people from the continent perceive themselves and construct their identity (cf. Eze 2014:234). Rather than shaping their identity by geography, blood or culture, which puts them in oppositional terms with other people (especially Europeans), people see their identity on relational terms (Eze 2014:235). In the present day, many aspects of the notion of African identity show “an intermeshing of relationships across ethnic, religious, and racial lines, thus blurring cheap dichotomous categorizations of persons” (Eze 2014:235). As a result of what Eze terms “elective affinities due to cultural and racial intermixing”, many African families are now multi-ethnic, multi-racial and transcultural, and are as likely to live a cosmopolitan lifestyle in Ouagadougou or Bobo-Dioulasso as they are in Abidjan, Paris, Hong Kong, Melbourne or Seoul. As such, ‘African’ is no longer perceivable in purist and essentialist terms, but needs to be viewed as incorporating Asians, Europeans and other groups from elsewhere in the world (Eze 2000:238, 240).

Given that the nature of my study led me to deliberately seek information from participants who had specialised medical knowledge of Western provenance, who were closely involved in the Burkinabe government’s quest to end female circumcision and who had been exposed to different discourses about femininity and sexuality, my sample size had a very high representation of what Mahmood Mamdani calls “culturally creole” people or “postcolonial intelligentsia, with one foot in colonial culture and another in that of their ancestors” (1999:129, cited in Eze 2014:238). Most of my research participants were highly qualified people who had been educated in Burkina Faso, France, Abidjan, South Africa and elsewhere. Most of them were medical doctors, university lecturers, current or former senior government officials and civil servants and other people pursuing professional occupations. They were well travelled and well-spoken in their local languages, French and, for most of them, English. A good number

of them lived in affluent parts of Ougadougou and Bobo-Dioulasso and worked in plush private clinics which were a major contrast to their poorer surroundings including the public hospitals in which some of them also worked. They could be said to have been living a cosmopolitan life (cf. Appiah 2006, 113) in that they had embraced and had been shaped by many influences from different places.

Cosmopolitanism has been described as allegiance to the worldwide community of human beings (Nussbaum 1996:4). According to Eze (2014:241) a very important aspect of this definition of cosmopolitanism is its emphasis on human beings from diverse ethnic origins, beliefs and political persuasions being viewed in relational rather than oppositional terms. Distinguishing between cosmopolitanism and pluralism, and highlighting the greater pull of cosmopolitanism, Hollinger (1995:86, cited in Eze 2014:241) suggests that cosmopolitanism presents the individual as a member of several different communities simultaneously whereas pluralism, which relies on ascribed identity, always presents the individual as a member of a primary community.

The term used by some writers to refer to the complex cosmopolitan environment in Africa is Afropolitanism. This term was coined in 2005 by Taiye Tuakli-Worsonu to explain her own complex identity and is now used in cultural and political discourses about Africa (Eze 2014:239). Eze (2014:239-240) suggests that Afropolitanism is an imperfect and flawed effort to explain the diverse nature of being African or of African descent in the current world. Its major weakness, according to him, is its exclusivity and elitism in that it also seems to address a certain groups of Africans: those associated with a “funny blend of London fashion, New York jargon, African ethics, and academic successes” borne out of elite Western universities (Eze 2014: 239, citing Tuakli-Worsonu 2005). However, Eze (2014:240) suggests that Afropolitanism need not be limited in its application to elites or even those living in big cities in Africa or in the West. Rather, it can be understood as the cultural face of cosmopolitanism which displays an intellectual and aesthetic openness toward divergent cultural experiences or a way of managing “meaning in an interconnected but culturally diverse world” (Eze 2014:240, citing Hannerz 2006:6). For Gikandi (2010:9, cited in Eze 2014:240), to be Afropolitan is “to embrace and celebrate a state of cultural hybridity – to be of African and other worlds at the same time” (cf. Mbembe 2007:28).

Within a cosmopolitan environment, Afropolitanism therefore prompts a moral reexamination of the world which is centred on the ethics of how “persona A relates to person B regardless of person B’s gender, ethnic, religious, or cultural background” (Eze 2014:244). This kind of morality enables people to reexamine how their understanding of the world can help them relate to others in a way that enhances humanity, rights and dignities, and fosters negotiation with people of diverse ethnic, cultural and ethnic backgrounds by necessarily challenging rigid binary constructions of the world (Eze 2014:245).

Even though they might not choose the term ‘Afropolitan’ to describe themselves, in different ways my research participants embody a lot of the characteristics presented through this concept. They draw on different knowldges, cultural understandings and schools of thought to examine the issue of female circumcision. As I will show in the chapters ahead, some of them promote genital reconstructive surgery as a way of restoring integrity and dignity to women to enable them live healthy and fulfilled lives. Perhaps none of my research participants embody the concept of Afropolitanism more than the Raélians I met in Burkina Faso. They seem to relate the other people with a great deal of openness and indeed a good number of them have espoused a live and let live attitude that is akin to Eze’s (2014:245) concept of Afropolitanism which is based on complementarity and the “flourishing of life for everyone”. As I will elaborate in Chapter 9, what has partly enabled this outlook for these Raélians is their ability to coopt ideas from different worldviews – the Raëlian Movement which they follow, feminist ideas from Western scholars, current local discourses about female circumcision and its impact, ideas from their own cultural heritage, precepts from Islam and Christianity, as well as ideas from different academic and professional domains – to craft a worldview which enables them to thrive in an otherwise restrictive environment. Eze (2014:245) suggests that even though individuals might conceive of themselves in “Afropolitan, hypercultural paradigms, they are still rooted in geographical spaces, and are still ‘parts of’ a larger community through which they construct meanings”. As I will show in Chapter 9, for the Raëlian women in Burkina Faso, this ‘larger community’ seems to be the International Raëlian Movement whose membership draws from several different countries, ethnicities, professions and cultural groups.

Moreover, I will show the manner in which these Raëlian women have able to use the precepts of the Raëlian Movement to sidestep societal expectations imposed on them,

particularly those relating to familial obligations, expected sexual conduct and gender relations. These include expectations that women should be married and have children in order to attain and maintain respectable social status, be respectful and subordinate to their husbands and their in-laws, keep personal matters private even from close friends, take good care of their husbands and the children, raise respectful children, have a clean and well kept home, dress respectably and not get out of the homestead unnecessarily (Jirovsky 2014:39-43). These ideals are very difficult, if not impossible, to meet but the social pressure to meet these ideals is very high (ibid.). I will show the manner in which women in the Raëlian Movement are able to use the “imaginative modes of survival” (Comaroff and Comaroff 2012:19, cited in Eze 2014:237) provided by their religion to circumvent some of these expectations and cope with the challenges of identity brought about by globalisation and modernity in general and by the changing discourses about the female body in particular.

In the chapters ahead I refer to the discourses – ways of speaking associated with a particular institutions and conventions and values of that institution (Schirato and Yell 2000:61) – which have been constructed or coopted in Burkina Faso to talk about female circumcision and genital reconstructive surgery. These discourses are implicated in the genres and narratives employed in a bid to end female circumcision (cf. Schirato and Yell 2000:61, 73). I will show the ideologies which are being used to determine and prescribe the ‘right’ thing to do and think in regard to female circumcision and reconstructive surgery. By ‘ideologies’, I refer to discourses and narratives that circulate in a culture which can be based on class, occupation, race, skin color, gender, age, sexual preference, religious affiliation, nationality or general physicality (Schirato and Yell 2000:73). In this context, the meanings that these ideologies construct and promote are those of the Afropolitan urban elite with the greatest economic and political capital: the medical doctors, university lecturers, government officers and, to a large extent, those following mainstream religious teachings (cf. Jirovsky 2014: 31; Hayford and Trinitapoli 2011; Otayek 1984). On the other hand, the ideologies of other groups in Burkina Faso, particularly those who still esteem circumcision and those following minority movements with different views about sexuality (such as the Raëlians), are denigrated. As I will show in Chapter 6 and 7, one of the ways in which the dominant ideologies are privileged and naturalised (Schirato and Yell 2000:75) is through repetition using various media. This has been done to the extent that few people in

urban Ouagadougou and Bobo-Dioulasso question the bases of the values and assumptions propagated by these ideologies.

Terminology: terms and contestations

A number of terms have been used to describe the cultural procedures that involve the removal of flesh from female genitalia or other modifications to these organs. Needless to say, there is a lot of debate about the choice and use of specific terms by researchers, scholars, activists, medical professionals, and representatives of governments and non-governmental organisations. Some of the terms used to identify and describe these practices include ‘female genital mutilation’, ‘female genital cutting’, ‘female circumcision’, ‘feminisation rites’, ‘female genital operations’, ‘female genital alteration’, ‘female genital excision’, ‘female genital practices’, ‘female genital surgery/surgeries,’ ‘ritual genital surgery’, ‘sexual mutilation’ and ‘female genital modifications’ (Christoffersen-Deb 2005:405; Momoh 2005:6; Rahman and Toubia 2000:3-4; Meyers 2005:405; Boyle 2002:25). Each of these terms conveys the discursive and political positioning of those who use it, and encapsulates the key arguments of the users. In choosing and using specific terms in this study, I am therefore aware that I am identifying myself with a certain position in this debate, and that indeed my choice of terminology conveys a certain personal, if not moral, stance regarding the practices in question.

While I do not have the means to do an analysis of the indigenous terms used in the communities where these procedures are carried out, I highlight what other scholars have discovered; when talking about cultural practices which alter female genitalia, locals often use the same term that is used to refer to male circumcision or terms that relate to it (Boyle 2002:25). In the scope of my study, which is effected in English and French, the practices in question are commonly referred to using the terms ‘circumcision’ and ‘*excision*’ respectively (Rahman and Toubia 2000:4). The term ‘female circumcision’ first appeared in reports of Western explorers and missionaries in Africa as early as the late nineteenth century, and continued to be used in international literature until the 1980s when the term ‘female genital mutilation’ was introduced (Toubia and Izett 1998:2; Boyle 2002:25; Rahman and Toubia 2000: note on terminology).

In spite of its widespread use in the literature, and even its preference by some writers because it is stripped of the emotive reactions associated, for example, with the term ‘female genital mutilation’, ‘female circumcision’ is a problematic term. One of the main problems associated with its use arises from the conflict over whether or not the procedure is analogous to male circumcision. For example, Toubia and Izett (1998:2-3) suggest that in medical literature, the term ‘circumcision’ is used specifically to mean removing the prepuce or foreskin of the penis or the clitoris but that in general use, the term is not so precise and merely describes ritualistic cutting of the genitals for cultural or religious reasons. In addition, they point out that the most common types of female genital cutting rituals involve amputation of part or all of the clitoris and the *labia minora* resulting in irreparable physical damage and increased risk of health complications (ibid.). On her part, Abusharaf (1998:25) finds that the word ‘circumcision’ (literally, ‘cutting around’) which was borrowed from the male operation, is a striking misnomer when applied to the procedures performed on women because unlike female circumcision, male circumcision, in which the foreskin of the penis is removed, is not associated with health problems, nor does it interfere with sexual functioning or enjoyment.⁴ According to her, in women, this procedure is “intended to dull women’s sexual enjoyment, and to that end it is chillingly effective” (1998:24; cf. Boyle 2002:25 and Meyers 2000:470). The term ‘female circumcision’ is therefore rejected by many writers because it “seems to trivialise the damaging act and the huge scale of its practice” (Gruenbaum 2001:3-4).

There are other terms used by indigenous people to refer to the practices in question which imbue these practices with religious and moral overtones. The extensive use and acceptability of these terms has earned them a place in contemporary discussions on the subject. For instance, the colloquial Arabic terms *tahara* and *tahur* are used in Egypt and Sudan respectively while the word *bolokoli* is used in Mali. These words used in these predominantly Islamic countries to refer to female circumcision are translated as ‘purification’ and are associated with the attainment of cleanliness through ritual (Rahman and Toubia 2000:3-4; Boyle 2002:24-25). Hadi (2006:107-108) points out that

⁴ Historian Robert Darby and “attorney for the rights of the child”, J. Steven Svoboda (2007), contest this perception of male circumcision as a harmless practice and propose detailed parallels with the practices referred to as ‘female genital mutilation’.

in Egypt, the classical Arabic term *khitan al inath* signifies the female equivalent of male circumcision, which is required by religious laws and teachings, while the more specific Arabic term *khifad* has been propagated by those who support female circumcision as an Islamic practice parallel but not identical to male circumcision in its severity. According to her, *khifad* literally means lowering or decreasing the height of the clitoris and is based on a disputed *hadith*, or teaching, in which the Prophet Mohammed is said to have advised a circumciser to lower the clitoris but not to cut out too much flesh.

Recurrent in the literature particularly in relation to Sudan and Egypt is also the contentious term *sunna* which means ‘tradition’, and specifically a tradition that the Prophet Mohammed engaged in or supported during his lifetime (Boyle 2002:25). Shell-Duncan and Hernlund (2000:4) suggest that *sunna* is the least extensive type of these procedures and is the only one that can be construed as analogous to male circumcision as it involves only the cutting of the prepuce or the clitoral hood. However, Toubia and Izett (1998:2, 5, 24) point out that that this procedure is extremely difficult to perform on young girls because the prepuce is not well developed at that stage (measuring only two to three millimetres) and is difficult to separate from the glans. In addition, they point out that what is locally referred to as ‘*sunna* circumcision’ in many countries such as Egypt and Sudan often includes the removal of part or all of the clitoris. Similarly, Lightfoot-Klein (1989:5) who has conducted research in the country asserts that “[t]rue *sunna* is virtually unknown as a procedure in Sudan”. The term ‘pharaonic circumcision’ is used in Sudan to refer to infibulation (Toubia and Izett 1998:5), a procedure which is also sometimes referred to as ‘Sudanese circumcision’ in Egypt, perhaps announcing the contested origins of the practice (Gruenbaum 2001:43). Hadi (2006:107-108) explains that such terms as *tahara*, *tahur*, *khitan*, *khifad* and *sunna* (which she says is sometimes used as a synonym for infibulation) “cast religious sanctity on the circumcision ritual and depoliticise the debate by distancing it from discourses on women’s rights”.

The most contentious label for the procedures in question is without doubt ‘female genital mutilation’, a term associated with condemnatory and ethnocentric attitudes of Western provenance, and thought to be alienating to the people who practise these procedures. This term was coined by the American feminist and social activist Franziska P. Hosken. In an article entitled ‘Genital mutilation of women in Africa’

Hosken (1976:3) criticised the position taken by the World Health Organisation that practices of ‘genital mutilation’ – which the United Nations called ‘operations based on customs’ – were based on social and cultural backgrounds and thus beyond its competence. She advocated for its use for many years from the 1970s before it was adopted by the World Health Organisation, non-governmental organisations and governments (Johnsdotter and Essén 2010:30; Boyle 2002:25). In 1990, the term was adopted at the third conference of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children held in Addis Ababa, Ethiopia, and in 1991, the World Health Organisation, abandoning its initial stance which erred on the side of cultural relativism, recommended that the United Nations adopt this term (WHO et al. 2008:22). According to the World Health Organisation, the word ‘mutilation’ “establishes a clear linguistic distinction from male circumcision, and emphasises the gravity and harm of the act [and] ... reinforces the fact that the practice is a violation of girls’ and women’s rights, and thereby helps to promote national and international advocacy for its abandonment” (ibid.).

The adoption of the term ‘female genital mutilation’ by United Nations agencies occurred in a period during which, as I further show in Chapter 3, early second-wave American feminists such as Fran Hosken, Mary Daly and Hanny Lightfoot-Klein were drawing attention to practices such as female circumcision in some African societies, foot-binding in China and widow immolation in India, as forms of women’s subordination. These and other early second-wave feminists began to gain ground in the middle of the twentieth century, calling for gender equality (Aulette and Wittner 2012:13; Jackson and Jones 1998:1). Inspired by this idea of a ‘global sisterhood’ united against patriarchy, Fran Hosken coined the term ‘female genital mutilation’ in 1976 and began writing about the practices in her feminist newsletter, WIN News, thus mobilising a generation of Western feminists for whom these practices symbolised the extreme nature of gendered oppression in Africa (Wade 2012:27, citing Boyle 2002 and Gruenbaum 2001). The abandonment by the World Health Organisation of its earlier cultural relativist stance, presumably under pressure from the traction gained by feminist voices which focussed on the harms perpetrated on women’s bodies by the practices in question, underlines the political nature of the naming of these practices, and its ability to shift depending on the prevailing circumstances.

Even so, the World Health Organisation has also acknowledged the potential that the term ‘female genital mutilation’ has to offend and alienate people in communities where these procedures are done. According to its researchers, there is evidence that the use of the word ‘mutilation’ was estranging practising communities and hindering the process of social change aimed at ending these practices (WHO et al. 2008:22). Given this realisation, from the late 1990s the terms ‘female genital cutting’ and ‘female genital mutilation/cutting’ have been increasingly used by some United Nations agencies such as UNICEF and UNFPA in a bid to find strike a balance between the perspective of these agencies (whose members see female circumcision as a form of mutilation) and that of people in practising communities who risk being offended and alienated by this judgemental term (WHO et al. 2008:22; Johnsdotter and Essén 2010:30).

This term evokes different reactions among writers in academic, medical and advocacy circles. Some researchers consider the term ‘female genital mutilation’ to be accurate in designating the practices in question even though some of them avoid using it because of its alienating potential. For example, writing under the auspices of the World Health Organisation, Toubia and Izett (1998:3) use this term “because of the severity and irreversibility of the damage inflicted on a girl’s body”. On her part, American anthropologist Ellen Gruenbaum (2001:3-4) finds the term “technically accurate because most variants of the practices entail damage to or removal of healthy tissues or organs”, but also points out that for most people ‘mutilation’ implies intentional harm and is tantamount to an accusation of evil intent. Because of that, she uses the term ‘female circumcision’ “despite its clearly euphemistic character, to avoid the connotations of evil intentions or the wanton mayhem associated with the term ‘mutilation’” (ibid.; cf. Obermeyer 1999:8). Other scholars, however, do not find the term ‘female genital mutilation’ accurate and urge caution in its use. For example, Canadian anthropologist Janice Boddy points to the need to examine the ‘preconstructedness’ of the term which, “though seemingly descriptive, forges a single decontextualized fact out of diverse practices and meanings and imbues it with specific moral and ideological significance” (1998:80).

Other scholars condemn the appellation more vigorously because they see it as arising from the patronising and condemnatory attitudes of some Western feminists. For example, while seemingly overlooking the fact that the girls and women who undergo these procedures rarely make the choice to have them done, political philosopher Diana

Tietjens Meyers (2000:470) rejects the “morally condemnatory language of ‘female genital mutilation’ [which] prejudices the question of women’s autonomy vis-à-vis this practice”. She attributes this language to Euro-Americans whom she deems unable to empathise with contemporary women in other societies who make such choices as consenting to or authorising such procedures (ibid.). Cook et al. (2002:282), on their part, rightly point to this terminology as arising from the elevation of feminist scholarship and advocacy in Western countries, perhaps under the influence of exposure to the most extreme forms of the practice. Suggesting that ‘female genital cutting’ is a more appropriate and less judgemental description, as does Meyers (op cit.), they question the ethics of using such a condemnatory description and point to the undesirable effects of imposing the views of “some women, especially women who are most advantaged, on other women who are differently and often less well placed” (Cook et al. 2002:282; Naffine 2002:90, cited in Cook et al. 2002:282). Even so, they suggest that the term ‘mutilation’, meaning to cut off or severely wound a bodily organ, may be appropriate to describe the more extreme forms of these practices (2002:282).

A more scathing critique of the term ‘female genital mutilation’ comes from some scholars of African descent living in the West such as Obiajulu Nnamuchi and Wairimu Njambi, both of whom are based in the United States of America. Nnamuchi (2012:85-86 Footnote 1), who employs the term ‘female genital ritual’ to describe “a constellation of all forms and versions of the procedure”, posits that ‘this is an unnecessarily offensive, outrageous and counterproductive descriptive term which lacks cultural sensitivity. He suggests that it is unfitting to use this term which has “spread like wild fire” since 1991, and is “embraced not only by the U.N. and its agencies, but also by a plurality of scholars, pundits, and activist groups pushing various agendas” (Nnamuchi 2012:91, 93). Singling out philosopher Martha Nussbaum (1999) for employing this term, Nnamuchi (op cit.) explains that such usage, which conveys extremely exaggerated meanings, serves no purpose other than to obfuscate the issues (ibid.).⁵ In line with the position that terms such as ‘female genital mutilation’ are imperialist in nature, Njambi (2004:281) points to an “anti-FGM discourse” which, according to her,

⁵ For a more recent critique of this term and the portrayal of these practices, see Nnamuchi (2014).

perpetuates “a colonialist assumption by universalizing a particular western image of a ‘normal’ body and sexuality in its quest to liberate women and girls”.

However, there are some scholars who seek a more measured consideration of both the naming of the practices under consideration and the reactions to this naming. For example, sociologist Lisa Wade finds that the heat in this terminology debate is derived as a result of both sides “erasing diversity in favour of stereotyping” (2012: 27, 42). Thus, according to her, “[m]uch in the same way that some scholars conflate ‘Africans’ with ‘barbarism’ and construct a thing called ‘female genital mutilation’ out of a wide range of practices, some postcolonial critics (Western and non-Western alike) conflate ‘Western feminists’ with ‘cultural imperialism’ and construct a thing called ‘anti-FGM discourse’ out of a diverse set of arguments, only some of which reproduce a culturally imperialist narrative” (Wade 2012:42).

I am in complete agreement with Wade (2012:42) that what is in consideration is a “wide range of practices” which differ from one community to another, and which are evolving in their practice in societies that are themselves constantly changing. As such, there is not a single, all-encompassing ‘correct’ term to use to refer to them. I am also in agreement with Boddy (1998:80) who says that these “diverse practices” already have indigenous meanings of their own, and as such, I am cognisant of the fact that using terms that are imbued with “specific moral and ideological significance” sometimes clashes with the meanings that these practices carry in their indigenous communities. It is with this in mind that I attempt to explain below my choice of the term ‘female circumcision’ in this study.

‘Female genital mutilation’ or ‘female circumcision’?

When I began this study, I unequivocally adopted the condemnatory term ‘female genital mutilation’ to refer to the procedures under discussion. At the time, I perceived these practices as promoting the control and oppression of girls and women in the name of upholding “social order and virtue” (Cook et al. 2002:284). Moreover, my choice was informed by the shifting cultural contexts underlying these practices, as well as the negative consequences associated with them, which I discuss in the chapters ahead. I therefore adopted the World Health Organisation terminology which defines ‘female genital mutilation’ as comprising “all procedures involving partial or total removal of

the external female genitalia or other injury to the female genital organs for non-medical reasons” (WHO et al. 1997, cited in WHO et al. 2008:4).

Acknowledging that the practices under consideration are diverse and rarely fit into one neat description, prior to conducting fieldwork I had intended where possible to specify in my writing the procedures in question using such terms as clitoridectomy or excision thus avoiding using ‘female genital mutilation’ unless absolutely necessary.⁶ To do this, I drew from the World Health Organisation’s 2008 revised classification of these procedures (published jointly with OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF and UNIFEM) which defines them as:

Type I: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).

Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).

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

Type IV: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterisation (2008:4).

However, as I explain in Chapter 5, once in Burkina Faso, I realised that it was extremely difficult to determine the specific procedures performed in the country and thus decided to use the umbrella term ‘female genital mutilation’. I acknowledged in my initial writing that this is a highly controversial term, and that my aim was not to endorse it or the classification proposed by the World Health Organisation as being more appropriate than other terms or classifications. Yet, I explained, since the focus of my study was on genital reconstructive surgery, it seemed appropriate to espouse as a starting point the premise that reconstruction implies putting right or repairing a part of the body that has suffered injury or harm. I also considered, as I explain in Chapters 3 and 5, that in some societies, the cultural context that demanded and supported these procedures had changed so much over time that the procedures in question were performed in isolation and disconnected from the other social processes which initially

⁶ Some writers (for example, INSD and ICF International 2012:289, 297; Lockhat 2004:63; Toubia and Izett 1998:11-12) suggest that the procedures done in Burkina Faso are mainly those classified as clitoridectomy and excision.

underpinned them. That meant that a great deal of the original purposes and meanings associated with these practices had been lost. In such contexts, it appeared to me that girls' and women's genitals were being cut, nay mutilated, without any useful purpose, and indeed some older people in such communities considered these practices, now largely performed outside their original contexts, as being useless (cf. Moruzzi 2005:217-218; Christoffersen-Deb 2005:410).

Informed by the literature I had come across, I took the view that the practices in question were not only normally imposed on young girls and women who had little say about what was being done to them, but that they were also unnecessary and went on to have a host of harmful physical, social and psychological effects on women's lives. In adopting the 'female genital mutilation' label, I was therefore aligning myself with the school of thought which posits that these practices, and other cultural practices which are oppressive to women, not just in African societies but throughout the world, often have their foundations in patriarchal societal dictates and expectations that are imposed on women compelling them to comply with highly prescriptive concepts of womanhood and/or femininity in a bid to survive and live 'normal' lives in these societies. Indeed, one of the often cited, and equally disputed, reasons for carrying out these procedures (and which influenced my choice) is their perceived role of attenuating sexual desire in women which, as Cook et al. (2002:284) point out, seeks to both reduce the likelihood of a woman's voluntary surrender of virginity before marriage and ease her demands for sexual attention that her husband may be unwilling or unable to provide (cf. Abusharaf 1998:24).

In spite of this resolve, it occurred to me during fieldwork that perhaps I should use a term that reflects the cultural and social motivations of the people who perform (or performed) these procedures. Indeed, being acutely aware of the political and moral connotations of these terms, during interviews I kept oscillating between using *mutilations génitales féminines* (female genital mutilation) and *excision* (circumcision) as I tried to take into account and respect the positioning of my research participants. However, as I heard the manner in which most of my research participants portrayed the procedures in question, I thought that a lot of them had come to believe that these were harmful procedures, and that indeed they were a form of mutilation. That further cemented my decision to use the term 'female genital mutilation'.

Moreover, once I started analysing the archival data I collected, particularly films depicting these procedures being carried out on babies and other young girls, this perception became even stronger. As I contemplated the gruesome and invasive nature of the procedures portrayed on film, considered the erosion over time of the meaning attributed to them and read about the consequences they were said to leave in their wake, I felt that the term ‘female genital mutilation’ was the most appropriate one to adopt to capture the manner in which most of my research participants experienced and/or portrayed them. I felt I could not in good conscience refer to these procedures using any other term, the motivations of the practitioners notwithstanding. That is to say, I did this even while acknowledging that as with the other procedures which alter otherwise healthy bodies, the people who perform these procedures do not set out with the intention of causing harm. I also recognised that some of the people who undergo them do not necessarily experience them as harmful or horrible events, and indeed some of them might depict them in a different, even positive, light.

Once I started writing my thesis, the designation ‘female genital mutilation’ fitted well with the arguments I was making in the early chapters of my thesis. However, as I continued to write but also give presentations about my research, it became increasingly difficult to use this term and by the time I got to Chapter 7, using it in my writing was no longer tenable. Even though I still held the views explained above which had earlier informed my decision, and still relied on the World Health Organisation’s typology of these procedures, I increasingly became concerned about the manner in which I was portraying my research participants and, by extension, other people in communities where these procedures were practised. At that point, I decided to adopt the term ‘female circumcision’.

My disquiet first arose when I began to notice the manner in which these practices were portrayed in academic and media articles and maps, including those produced by such influential organisations as the World Health Organisation and UNICEF.⁷ In a lot of instances it was indicated that these procedures were mainly carried out in 28 African countries and in Yemen. Yet, increasingly, some of my colleagues began to mention to

⁷ See, for example, the UNICEF map reproduced by the British Broadcasting Corporation (BBC News 2014e).

me that these procedures were carried out by some ethnic groups in their countries of origin including India, Indonesia, Iran and Malaysia. I began to wonder why these places were not mentioned in most of the literature and/or media. More importantly, I realised that by reinforcing the mapping and representation of these practices by such organisations as the World Health Organisation, and using the terminology advanced by them, I was also contributing to the ease with which this representation was propagated.

Another issue which made me question my naming of these procedures (and even the wisdom of studying these practices and discussing them in a Western country) arose when I observed the manner in which people reacted to presentations I made about the context of female circumcision and reconstructive surgery in Burkina Faso, or even about my experience researching these practices. In some academic conferences, there seemed to be stunned silence at the end of my presentation as though the matters I had discussed were so shocking that the audience needed time to ‘recover’ before they could begin to react to them. Even after they had ‘recovered’, it seemed that few people found anything to contribute to the discussion; presumably, the issues discussed were very far removed from their realities.⁸ In some instances, even when I was talking about fieldwork experience, or even specifically about reconstructive surgery, some people seemed to get fixated on ‘female genital mutilation’ itself and only asked questions about that. In one class where I gave a guest lecture, a couple of students left the classroom during my presentation. One later apologised for leaving and explained that the subject matter was too disturbing for him to absorb, and the other indicated that she had assumed that the speaker was going to talk about apartheid in South Africa, and that they should have been informed about the subject matter beforehand. Even though my discussion in that class had been at a more general level, these reactions made me question the manner in which I was representing the Burkinabe women who had so freely shared intimate details of their lives with me. These experiences left me frustrated and disillusioned as I felt I was not communicating with my interlocutors whom I had assumed would be so steeped in cultural relativism as to openly and comfortably discuss most anthropological subjects, including the one I was studying, in a productive manner.

⁸ A former colleague who wrote her thesis in a university in Switzerland on HIV/AIDS reports encountering similar reactions.

Perhaps these reactions should not have surprised me given the taboos associated with genitalia in many parts of the world. Still, I got increasingly frustrated as I got the sense that immediately I began talking about the concept of reconstructive surgery after ‘female genital mutilation’ I ‘lost’ my audience who presumably found these practices too horrifying and incomprehensible that they had little to say about them (even though as I show in Chapter 2, such practices have routinely occurred in Western countries, only under different names and, perhaps, on a much smaller scale). Alternatively, I only succeeded in arousing in people a sort of morbid fascination, sometimes veiled in what appeared to be concern about whether I was born in Burkina Faso (and had presumably undergone these procedures) rather than a desire to discuss the subject at hand.⁹ Given these experiences, I decided to use the term ‘female circumcision’ first of all to avoid contributing to the stigmatisation of my Burkinabe research participants and other people who do/did similar procedures. I did this in a bid to portray them in the eyes of my Western interlocutors as ‘normal’ or ‘ordinary’ people rather than as ‘exotic others’ who have extreme cultural practices. Secondly, I changed my naming in a bid to ‘normalise’ discussions about these practices, and shift focus from the horror, fascination and pity they seemed to inspire to a point where it is possible for people to access and perhaps discuss the themes I bring out in my study.

Thesis outline

In the next eight chapters I explore the issues introduced above in more detail. In Chapter 2, I discuss the ethics surrounding the study that I did in Burkina Faso, as well as my actual experience of conducting fieldwork in the country. In Chapter 3, I focus on the portrayal of practices of female circumcision by various writers. To do this, I examine in some detail the views of some feminists and cultural relativists regarding these practices. In Chapter 4, I focus on the stories of five Burkinabe women who have undergone female circumcision. Two of these women have also had reconstructive surgery. I present the stories of these women from their own perspectives to enable

⁹ With time, whenever people asked out of curiosity what the topic of my study was, I inevitably responded: gender, sexuality and identity. I do not mean to imply that every single person who heard about my study or listened to my presentations had these reactions. In fact, I did have a few insightful discussions on both male and female circumcision with some Westerners, scholars and non-scholars alike. However, these reactions were frequent enough, particularly in the academy, as to be troubling.

them to articulate the manner in which they have been affected by the procedures in question. In the subsequent chapters, I refer back to these women and their stories, as well as to other research participants, to explain the Burkinabe people's understanding of female circumcision and genital reconstructive surgery.

In Chapter 5, I present the context of female circumcision in Burkina Faso, which presents the reader with background information relevant to understanding genital reconstructive surgery as practised in the country. In Chapter 6 and part of Chapter 7, I delve into the manner in which practices of female circumcision are presented in Burkina Faso particularly in regard to the problems they are thought to cause. This then leads on, in Chapter 7, to a discussion on the impact of the discourse detailing the harm caused by female circumcision and the understanding that some Burkinabe people have regarding the importance or necessity of genital reconstructive surgery. In this chapter, I further explain the forms which this surgery takes in Burkina Faso. In Chapter 8, I present the views of some of the doctors who carry out this surgery in Burkina Faso to provide a deeper understanding of the manner in which these procedures are done and why they are done from the perspectives of these medical practitioners. In Chapter 9, I interrogate the place that the philosophy of the Raëlian Movement holds in the lives of some of the women who seek genital reconstructive surgery and the manner in which it differentiates them from other members of their society. I close my thesis with a short overview of the issues discussed in the content chapters, and highlight a few of the changes that have happened in Burkina Faso since this research was carried out and the impact they are likely to have on female circumcision and genital reconstructive surgery.

CHAPTER 2

LIVING IN BORROWED SPACES

I believe firmly that ethnography cannot be understood independently of the experience which produces it (Berreman 1972:vii).

* * *

Introduction

In this chapter, I explore the practical details of conducting field research in Ouagadougou, Burkina Faso's capital, and Bobo-Dioulasso, the country's second largest city. I begin by exploring the ethical issues raised by researching a topic which not only dealt with sensitive and delicate matters of sexuality but also the potentially upsetting subject of female circumcision. These include displaying sensitivity to research participants' social and cultural contexts so as to interact with them in a thoughtful and respectful manner and portray them with dignity in my writing, obtaining informed consent from research participants, handling sensitive information prudently and safeguarding the identity of participants during fieldwork but also at the point of data publication.

In detailing my actual fieldwork experience, I explore the material and security concerns I face and the manner in which these compounded the challenges of collecting information. I examine the ambivalences of straddling multiple negotiated, sometimes bordering on fabricated, identities to access information but also to stay safe. Moreover, I show how the quest to make the 'right' impression and to control the research participants' perception of me (Berreman 1972:xxxvi), became so overwhelming as to overshadow the main task of collecting data. I conclude this chapter with a brief exploration of the concepts of discourse and discourse analysis as applied in this thesis.

The ethics of researching genitalia

In preparing for and conducting this research, I was mainly informed by three sets of codes of ethics: the Massey University code of ethical conduct for research, teaching

and evaluations involving human participants; the code of ethics and ethical procedures of the Association of Social Anthropologists of Aotearoa/New Zealand (ASAA/NZ); and the code of ethics of the American Anthropological Association (AAA). The principles contained in these documents point to the researcher's responsibility to research participants, the wider society, the discipline and colleagues, sponsors, funding agencies and employers, to one's own government and to host governments. The specific ethical principles cited by the Massey University code of ethical conduct (2010) are: respect for persons; minimisation of harm to participants, researchers, institutions and groups; informed and voluntary consent; respect for privacy and confidentiality; avoidance of unnecessary deception; avoidance of conflict of interest; social and cultural sensitivity to the age, gender, culture, religion and social class of the participants; and justice.

In applying these ethical principles, I recognise the observation voiced by some scholars (for example, Meskell and Pels 2005:1; Simpson 2011; Sluka 2012) that incorporating ethics in research is not merely adhering to a list of requirements prepared before fieldwork notably when seeking approval from the ethics committee. Rather these codes of ethics provide useful guidelines so that handling ethical issues in the field is an ongoing process in which "ethical research relationships must be actively, if not creatively, negotiated, maintained, and adapted to specifics of the situation or context" (Sluka 2012:303-304; cf. Simpson 2011:380, 387). It is that context, which recognises a human being as a social being (Simpson 2011:387), and which views ethical considerations as arising before, during and after the research process, that I discuss the application of ethical guidelines drawn from the codes cited above in my research project.

In order for people to give informed consent about participating in a research project, they need to have a reasonable understanding of the nature of the project and both the risks and the benefits of participating in it (Angrosino 2007:65; DeWalt and DeWalt 2011:215, 217; Cohen 1976:84). Regarding this, the Massey University code indicates:

[p]articipation in any research project ... must be voluntary and based on understanding of adequate and appropriate information about what such participation will involve. Researchers have a responsibility to provide prospective participants with all information relevant to their decision to participate, in a manner comprehensible to prospective participants. Such information, and participants' consent to participate, should normally be in

written form and provided in a style appropriate to the participant. This may include translation into the participant's first tongue (2010:8).

In line with these requirements enforced by the Massey University Human Ethics Committee (MUHEC),¹⁰ prior to departing for fieldwork I prepared an information sheet to explain the nature and aims of the research that I was proposing to carry out. I translated it, together with the participant consent forms, confidentiality agreement forms (which I prepared in case I needed to work with translators) and interview schedules into French, the national language of Burkina Faso and the language in which my research participants and I would communicate (see Appendices I A-VIII B). The understanding that my research participants obtained regarding the nature of my research came from the information sheet but also from the conversations we had as I sought consent and, later, as I continued to interact with them during the fieldwork period. The Massey University code (2010:9) indicates that for research participants to give informed consent, there must be information on which to make the decision, comprehension of the information, competence to make a decision and give formal consent, and absence of pressure or coercion. My interaction with these research participants convinced me that these conditions were met and that before they agreed to participate in my research, they understood both the nature of the information I sought and the use to which I would put that information (cf. Simpson 2011:379; Kahn 2005:117, 120).

The major ethical concern in conducting this research had to do with interviewing women who had undergone female circumcision about the impact that this had had on their lives and their reasons for seeking reconstructive surgery. Even in ordinary circumstances where female circumcision is not involved, subjects dealing with genitalia and sexuality are difficult to broach in most societies (Mackie 2003:147-148). What made this task even more difficult was the necessity to conduct this research while at the same time paying attention to the emotional and social well-being of research participants and respecting their privacy and dignity. This was because the nature of the subject itself demanded discussion of issues that were potentially upsetting and

¹⁰ My application for permission to conduct research in Burkina Faso was discussed by the committee on 27 September 2012 and approval granted on 9 October 2012.

embarrassing to research participants and which, as I demonstrate in the Chapters 4-7, might have put their social standing at risk.

The codes of ethics which informed my research are categorical that researchers must do everything in their power to protect research participants from physical, social, economic and psychological harm (AAA 1998; ASAANZ 1992 [1987]:2; Massey University 2010:7). For example, the Massey University (2010:7) code demands respect for persons which involves recognition of the personal dignity, cultural and religious beliefs, and privacy and autonomy of individuals. Further, it points out that it is not acceptable to expose participants to unnecessary harm such as pain, stress, fatigue, emotional distress, embarrassment, cultural dissonance and exploitation. One of the anticipated risks of harm to some research participants in the context of my research was the arousal of painful emotions associated with female circumcision, or “stress related to discussion of difficult or sensitive topics” (DeWalt and DeWalt 2011: 217). There was also the very real likelihood that difficulties in discussing matters relating to female circumcision and even reconstructive surgery would be exacerbated by my participants’ knowledge that these matters engendered varied feelings, ideas, perceptions and value judgements in the Burkinabe population. It was therefore expected that some research participants would be extremely concerned about discussing these matters (and ensuring that the discussions remain confidential) because disclosing, for instance, that they had undergone female circumcision and/or reconstructive surgery could invoke negative reactions such as pity and derision in other people.

One of my major ethical challenges in this regard was interviewing women who had not spoken openly about their experiences with female circumcision and/or reconstructive surgery in their communities or in the media as some others had. This had to do with setting safe and acceptable boundaries to the discussion, and respecting the boundaries put in place by research participants even when these were not overtly expressed. Fundamentally, it included knowing when to stop following a line of enquiry that may be upsetting or embarrassing to the research participant. Sometimes I spoke with women who seemed to have deep inside knowledge about these practices, and, although I got the impression they had undergone them, there did not come a point in the interview when they acknowledged this. I often felt conflicted when interviewing such women as my instinct was to keep asking questions to lead them to talk to me about

their experiences. However, I was not sure whether it would be acceptable or not to broach the subject. As a result, early on during the fieldwork process I decided that these women themselves would be my guide; if they mentioned their specific experiences, I would ask more specific questions about that, but if they did not, then we would discuss the information I sought in a general manner.

Sometimes people who worked with doctors and were privy to my research interests told me about impending cases of reconstructive surgery and implied that I should go and observe these surgeries. However, I chose not to pursue this and did not approach the concerned doctors to ask for permission to observe them operating on women. I felt that I would be unnecessarily invading these women's privacy and was concerned that they might think my observation was part and parcel of the hospital protocol and feel that they had to consent to my being there. I later felt vindicated for having taken this approach when I was repeatedly told that a lot of women who had undergone female circumcision felt a deep sense of shame and, as such, were not comfortable admitting this.

These realisations demanded that I respectfully acknowledge and handle the various attitudes and beliefs of the people with whom I interacted and called for what Meskell and Pels term "the moral 'duplexity' of research: the fact that engagement with people living in one's field of study requires one to negotiate 'other' values instead of implicitly assuming that [Western] principles of ethics and expertise are universal" (2005:8; cf. Pels 1999). For example, to be sensitive to the cultural context of my research participants, I needed to be well-informed about and use terms that were acceptable to them to refer to the practices I was researching. In regard to female circumcision procedures, I was dealing with people with diverse perspectives: some viewed them as valuable cultural practices; others considered them harmful to the health of women and girls, and were perhaps working to eradicate them; others were women who saw them as the mutilation of their bodies and were seeking reconstructive surgery; others were doctors who were conducting reconstructive surgery on these women and viewed these practices as a form of violence perpetrated on women.

The French terms mostly commonly used in Burkina Faso to refer to female circumcision were *excision* (circumcision/excision) and *mutilations génitales féminines* (female genital mutilation). I had to be careful in using these appellations because, for

instance, using the term ‘mutilation’ in some of these contexts may have been construed as implying deliberate ill-will on the part of parents and respected leaders, and may have only served to cause alienation (Hadi 2006:108; Lockhat 2004:149). In other contexts, for those women who already perceived their experience of these practices as negative and damaging, and who already felt sad, bitter and distressed, referring to their bodies as ‘mutilated’ might have reinforced their humiliation and psychological damage (Lockhat 2004:149). On the other hand, terming these practices ‘circumcision’ may have also alienated some people who felt that these practices were reprehensible and needed to be unequivocally condemned. Even while recognising that there was not one ‘correct’ way to name these procedures, I translated the term ‘female genital mutilation’ (which I was still using at this stage) into French as *excision* in my information sheet to avoid alienating some people who may have considered the term ‘female genital mutilation’ condemnatory. In conducting interviews, I followed my research participants’ lead in naming these procedures. However, in regard to consent forms, I followed the advice of MUHEC members who indicated that given the fluidity of understandings that people in Burkina Faso were likely to have regarding these practices, it would be better to obtain oral consent (provision for which is made within the Massey University code, see page 8) as opposed to having research participants sign a document whose wording might offend them.

In the same way, although the ethical guidelines informing my research required that transcripts of interviews be provided to participants for editing (Massey University 2010:7), in practical terms this was extremely difficult to do given the sensitive nature of my research and the security, logistical and cost implications of sending documents between New Zealand and Burkina Faso. After discussing the matter with my supervisors and members of the ethics committee, I decided that it would be best to avoid sending back transcripts of interviews to research participants after I left the field. That was because some of my research participants spoke to me in confidence without the knowledge of members of their families and it was possible for such communication to end up in the wrong hands thus compromising their confidentiality and, possibly, safety. In addition, not all research participants had viable postal or email addresses where that information could be delivered and returned to me in good time to use in my thesis.

There are also ethical concerns to deal with during the process of analysing, writing up and disseminating one's research findings. These have to do with ensuring privacy and confidentiality but also paying attention to the manner in which research participants and their communities are represented (DeWalt and DeWalt 2011:218-219,121; Hansen 1976:134; Massey University 2010:9). As Simpson (2011:389) points out, "decisions must be made ... regarding what cuts to make: what goes into the text and what is to be left out; who gets named and who doesn't; what is legitimate to expose on ethical grounds and what must be concealed on ethical grounds".

It was fairly straightforward to mask the identity of my research participants and some of the institutions I dealt with by changing their names, and I did this as early as the coding and transcription stage of my data handling. However, ensuring that these participants and institutions remain completely anonymous, particularly to people in urban Ouagadougou and Bobo-Dioulasso once my thesis is accessible to them, is less straightforward. The difficulties in concealing the identities of some people and places in my research arise because of the professional links among these people, and their prominence. Some of my research participants are well-known in some circles, for example, among people involved in one way or another with reconstructive surgery or activism against female circumcision in urban Ouagadougou and Bobo-Dioulasso, and information about them is widely available in written reports and even on the Internet. It would therefore be possible for some people in Burkina Faso to identify them particularly if the information I give in my thesis overlaps with that which is in the public domain. Harrell-Bond (1976:111, 119) raises similar ethical difficulties of maintaining confidentiality in handling information collected during research on marriage and family life among the Western-educated elite of Sierra Leone some of whom were connected through kinship or were acquainted with one another.

I told my research participants that I would protect their identities while in the field but also at the time of data publication by changing their names and other details that may enable others to identify them. Even so, I acknowledged to those in public circles that it was "not possible to give an **absolute** guarantee of confidentiality" (Massey University 2010:10, emphasis in original) given their public profiles. In response to this, some of them indicated that they did not care whether they were anonymised or not. Still, I decided to anonymise all my research participants to the extent that I could with the knowledge that they may have given me information that was not in the public domain

and which in hindsight they may not wish to have publicised especially if their identities were undisguised.

A similar problem arose when dealing with unique institutions, such as the national committee that coordinates activism against female circumcision in Burkina Faso and the teaching hospitals, which would be extremely difficult, if not impossible, to disguise. In my writing, I used the real names of these organisations but strived to mask the identities of my research participants working there. The concern that it is not possible to guarantee complete confidentiality for all the people who participated in my research and the institutions in which they worked calls for a lot of consideration in using the information they gave me in the chapters ahead. As Simpson (2011:389) states, this is “the moment at which an anthropologist’s judgements about just what is the appropriate relationship between informants, truths, and publics is laid open to challenge”.

My other ethical challenge at the writing stage is that of presenting my research participants, particularly women who have undergone the procedures at the centre of my research, with dignity. This is a big challenge because, as I show in Chapters 1, 3 and 5, these practices are often viewed through ethnocentric lenses which often portray the women who undergo them, particularly those in ‘third world’ settings as victims of culture or, worse still, seem to focus only on their body parts without acknowledging them as complete functioning social beings. Regarding the representation of research participants, Hansen (1976:134) points out that in telling others the details of their lives, “we must make every effort to do so in ways that do not violate their integrity as fellow human beings whose actual thoughts, acts, and feelings are far more complex than our descriptions can convey”. In the same way, Kahn (2005:101, citing Pels 2000:138)¹¹ posits that in matters of professional ethics, an anthropologist’s “first and paramount responsibility is to ‘protect the physical, social, and psychological welfare and to honour the dignity and privacy of those studied’”.

The weight of this responsibility is further highlighted by the AAA’s code of ethics (1998) which indicates that anthropological researchers are not only responsible for the

¹¹ Pels on his part was referring to the American Anthropological Association’s Principles of Professional Responsibility drawn up in the early 1970s (see Pels 2000:138, citing Fluehr-Lobban 1991:247-252).

factual content of their statements but also the social and political implications of the information they disseminate. As such, they must do everything in their power to ensure that such information is well understood, properly contextualised and responsibly used. Likewise, the ASAANZ code of ethics (1992 [1987]:3) indicates that in providing professional opinions, anthropologists are responsible not only for their content but also for integrity in explaining both these opinions and their bases. Furthermore, they bear a professional responsibility to contribute to an “adequate definition of reality” upon which public opinion and public policy may be based. Given the challenge of presenting my research material in a factual manner but which also ensures a dignified representation of my research participants, and the quest to portray the Burkinabe women I interviewed as complex social beings whose worlds are far more intricate than just their experiences with female circumcision and reconstructive surgery, in the analysis chapters ahead I give voice and space to some of these people to speak for themselves.

I presented my research as a platform through which to make better understood, in a sober, mature, fair and sensitive manner, the issue of reconstructive surgery, the reasons why some women in Burkina Faso choose to have it and the impact that this surgery has on their lives. Cohen (1976:84) posits that when a social scientist asks for consent to conduct research, he/she is in effect asking the research participants to weigh their desire for privacy against the possible benefits of the study either to themselves or to society (cf. Massey University 2010:8). My research participants did not challenge me to explain the benefit of my research to them. Still, some of them indicated that they saw my research as a forum through which to clearly explain the context of genital reconstructive surgery and to make the procedure known on a wider scale, particularly among women affected by negative consequences of female circumcision who may not know much about reconstructive surgery.

Do you know anybody?

I arrived in Burkina Faso after approximately 35 hours of travel. My field notes record my first impressions of the country – the oppressive heat, relentless dust, bare infrastructure and the friendliness of the people – and my frustrations at the unreliable Internet access, high telephone costs, lack of potable tap water and a general sense of insecurity. Prior to going to Burkina Faso, I was aware of some of the difficulties that would come up in the field and had done my best to prepare for them. I also knew that

many things would come up which I had not thought to prepare for and I would have to address them as I progressed with my research. However, probably because of my lived experience in Africa and the fact that I had easily adapted to life in other countries before, I underestimated the amount of physical and mental resilience I would need to cope with the fatigue engendered by the fieldwork experience and the harshness of the climate and terrain. Feminist geographer Jennifer Mandel (2003:198, 201, 207) considers a similar disjuncture between her expectations and experience as she conducted fieldwork in Benin in 1997 and 1998, attributing it to arrogance and naiveté.

I recorded my observations of the fieldwork experience in my field diary which reflects some of my own naïve assumptions. Although my diary was my own private document, since I was conscious of the fact that I was conducting academic research, I tended to record events in a detached manner as if trying to remain as balanced and as fair as possible in my representation of events and people. In some places the notes lacked colour in the form of my true feelings and emotions at the time. Fortunately, I also regularly kept in touch with various people: my primary supervisor, my family in Kenya and a few friends and acquaintances in the United Kingdom and in New Zealand.

I was much less restrained in that correspondence although even there, the manner in which I expressed myself depended on the nature of the relationship I had with the person and the manner in which he/she was likely to react to the information that I gave. With some people I tended to downplay the insecurity I sometimes felt so that they would not unduly worry about me. In writing to some of my contacts based in 'developed' countries, I felt guilty and thought that by complaining about my experiences in Burkina Faso, I was creating or cementing impressions of Africa (and specifically of Burkina Faso) as a homogeneously extremely poor and rough place, and of Africans as dangerous and untrustworthy people. However, with other people, particularly those who knew me a bit better, I was able to honestly talk about my frustrations but also my joys in the field.

Still, I was acutely aware that in discussing my experiences, I had a responsibility to protect the identity of my research participants and treat them with respect and dignity. It was only with my supervisor that I was able to discuss in any depth experiences that I was having with specific research participants (whose names I changed) particularly when I sought advice on how to handle one issue or another. I structured those emails to

her as fieldwork progress reports because, in addition to letting her know how I was getting on in the field, I intended these reports to be a way for me to summarise weekly events and gauge the progress I was making in my research activities. In the sections below, I draw information from my field notes and my private correspondence to discuss the various issues that came up in my bid to find my footing in the field. I also show how my entry into Burkina Faso and my access to research participants was facilitated by the incredible kindness of ‘ordinary’ Burkinabe people and other well-placed people in the country.

Reliable Internet access was crucial at the early stages of my research. Although I had already got in touch with a few potential research participants before getting to the field, I still needed to identify and contact more people. To that end I needed to use search engines such as Google to locate organisations, addresses and telephone numbers. Even in communicating with the participants I had already contacted, I found it was preferable to use email instead of the telephone as quite often they were not able to take telephone calls during working hours. Moreover, although Google Maps did not have very well developed maps for Burkina Faso, it felt safe to know beforehand the general direction the taxi driver I sometimes hired to take me to meet research participants was supposed to be taking. It was therefore extremely frustrating for my research activities that the Internet connection was so bad that I could barely use email and, more often than not, I could not use search engines at all. (Furthermore, the modem I used to access the Internet quite often caused my computer to display a message that there had been a ‘fatal error’ and to shut down. I constantly worried that using the modem would destroy the computer’s hard disc). During my last week Burkina Faso, the Internet service providers that served most of urban Ouagadougou went on strike, so for several days it was utterly impossible to contact the outside world through that medium. These problems therefore also meant that reaching out to people in my support networks outside Burkina Faso was much harder, compounding my feelings of isolation.

Given my research topic, I was aware that that the ethnographic research I was carrying out would focus not on “small-scale, traditional, culturally isolated societies” but on a “community of interest” (Angrosino 2007:15-18, 26). While I expected that this would include some ‘ordinary’ adults in urban Ouagadougou and Bobo-Dioulasso, I was particularly interested in speaking to women whose lives had been specifically touched by female circumcision and reconstructive surgery, and other people in special interest

groups whose work revolved around these areas. My first major disappointment in the field was with a potential research participant, Madame Sawadogo,¹² whom I had contacted before I left New Zealand and who had indicated that she would be willing to meet me and answer my questions. She worked with the *Comité National de Lutte Contre la Pratique de l'Excision* (the National Committee for the Fight against the Practice of Circumcision, hereafter the CNLPE), which coordinates efforts to end female circumcision in Burkina Faso and to provide access to surgical repair to women with health problems associated with these practices. I had hoped that she would be one of my key informants and that through her I would access other research participants. However, after exchanging several email messages with her, and although she invited me to her office, it later appeared to me that either she had not really meant to help me or she had changed her mind. Of course, it is also entirely possible that she was simply very busy and talking with a researcher was not high on her list of priorities amidst the other pressing tasks requiring her attention. When I went to the CNLPE, I was met by Adèle, a very friendly and helpful person, who spoke to me for a while until Madame Sawadogo arrived and put an end to our discussion with a promise to get in touch with me later. I never did hear from her.

In a strange twist of circumstances, soon after that visit my landlady in Ouagadougou asked me about my research activities and I briefly explained my study to her. A few days later, she called to tell me she had instructed an associate of hers – a former permanent secretary – to introduce me to some people who might have relevant information for my study. These people turned out to be senior staff at the CNLPE. One of them kindly granted me an interview and gave me some archival material relating to activism against circumcision. In addition, she gave me the contact details of three medical doctors and a coordinator of a local non-governmental organisation who were well-versed in matters pertaining to circumcision and reconstructive surgery. I was able to meet two of these doctors and they both accorded me short interviews. Following this facilitated visit to the CNLPE, I noted in my diary that it was “great to ‘know’ people in high places” (28 January 2013).

¹² Pseudonyms are used throughout this study.

I had also hoped to meet sociology and anthropology scholars at the University of Ouagadougou (and later the University Polytechnic of Bobo-Dioulasso) who would provide me with more information about Burkina Faso and possibly put me in touch with more people whose experiences were relevant to my research. However, my bid to reach them was also fraught with frustration. University offices were staffed by administrators but, unfortunately, most of the time these administrators were unable to indicate when the lecturers would be available or whether they would be willing to meet me. I did not have the email addresses or phone numbers of these lecturers and therefore could not contact them without going through their administrators. Although I eventually met one lecturer who gave me contact details of some people, it was only after I had been in the field for a while that I was able to meet more lecturers at a monthly seminar run at a research centre. Some of them gave me very helpful ideas about other possible avenues for my research. My access to the research centre was facilitated by personnel at the *Centre National de la Recherche Scientifique et Technologique* (National Centre for Scientific and Technological Research, hereafter CNRST) who granted my research permit. One of the staff members at the research centre, Albert, eventually turned out to be one of my key informants.

Another key informant was Madame Leila Abdi, a former government official who was at that time the head of a foreign-funded non-governmental organisation. She helped me understand the overall official (government and activist) position regarding female circumcision and reconstructive surgery and facilitated my access to a doctor renowned in reconstructive surgery circles in Burkina Faso. Furthermore, she introduced me to the other people who worked with her, who subsequently accepted to be interviewed. In the same way, I was able to get some limited access to members of the Raëlian Movement in Burkina Faso. Before leaving for fieldwork, I had contacted the global coordinator of Clitoraid who was based in the United States of America. After explaining my research interests to her, she put me in touch with the local coordinator of the *Association Voie Féminine de l'Épanouissement*¹³ (Association of the Feminine Path to Fulfilment, hereafter AVFE), the organisation coordinating Clitoraid activities in Burkina Faso. The coordinator in turn put me in touch with a few

¹³ In some instances, particularly on the Internet, this is rendered as *Association Voix Féminines de l'Épanouissement* (Association of Women's Voices for Fulfilment).

women who had undergone reconstructive surgery and others waiting to have it done once the Clitoraid hospital, which was under construction at the time in Bobo-Dioulasso, became operational. There were other people I met as I went about my everyday activities in Burkina Faso who eventually became research participants. Some of them in turn put me in touch with others whom I also interviewed.

I had envisaged my interaction with my research participants as a gradual process where I would meet with them on various occasions over a period of several months and learn about their lives and work. While I was able to do this with some research participants, with others, particularly medical doctors, this was not possible as they seemed to have little time to spare. Some people promised to talk to me but when I went to see them, they indicated that they were occupied and that maybe I could try and meet them on a different day. While I managed to see some of them, I did not get to meet others because, as I explain below, my departure from the field was precipitated by security concerns. While these difficulties I experienced in meeting research participants were frustrating and disappointing for me, I acknowledge that from the perspective of these people's lives, what happened was understandable. I was attempting to enter their lives mid-flow and while some of them accommodated me and my requests easily and willingly, it would have been difficult for others to do so given the commitments that they already had.

Being Kenyan, unmarried and introverted

Before going to Burkina Faso, I had considered how personal characteristics such as gender, age and ethnicity may affect my interaction with research participants and the nature of the information that I collected (cf. DeWalt and DeWalt 2011:95). I also thought about other factors such as my marital status, manner of dress and appearance, the status of being a Kenyan studying in New Zealand, my choice of fieldwork residence (see Figures 2.1 and 2.2) and the manner in which I expressed myself. Berreman (1972:xviii) points out that “[e]very ethnographer, when he reaches the field, is faced immediately with accounting for himself before the people he proposes to learn to know. Only when this has been accomplished can he proceed to his avowed task of seeking to understand and interpret the way of life of those people”. In my case, this process of positioning myself in the field demanded considerable effort and sometimes seemed to eclipse the main task of collecting information.



Figure 2.1 Dassassgho neighbourhood where I lived in Ouagadougou



Figure 2.2 The main gate at my house

The feeling of not belonging I had already experienced in other places prepared me for the isolation of fieldwork and enabled me to get on with the job of collecting data without being too caught up in my circumstances. Still, having as a point of departure a place that was not home, and moving into yet another foreign space, made my sense of displacement more acute and made finding a ‘home space’ for myself in Burkina Faso even more difficult. Australian anthropologist Richard Madden (1999:259) details his

experience conducting research about Aboriginal and non-Aboriginal relations in his “home-town field” of the State of Victoria. For Madden, the notion of home – which is familiar, parochial, discrete, habitual, permanent, birth, death and ambivalence – is “a mixture of emotional, social, geographical, and cultural components, which are brought together under the rubric of familiarity” (1999:261). Africa was familiar to me and carried some of these attributes which Madden assigns to the ‘home space’. However, my case was different from his in that even though at a superficial level I shared a black ethnic identity with the Burkinabe people, I had never been to the West African region before and, in that way, their country was to me “an unfamiliar locale in a familiar landscape” (Madden 1999: 266). Moreover, my way of life differed sufficiently from that of some Burkinabe people so that I had to adapt my habits to blend as much as possible with theirs especially if my African identity was the dominant trait through which I wished to be identified.

Without consciously making a decision to, when I got into Burkina Faso I was quick to foreground my Kenyan identity and would introduce myself to research participants as a Kenyan studying in New Zealand. If someone introduced me as “the student from New Zealand”, I was quick to add “but I am of Kenyan origin”, and I did not correct people who referred me to as “the Kenyan student”. To people who were not research participants, I simply said that I was from East Africa. Abu-Lughod (2000:13, 15) who conducted long-term research in Egypt indicates that being introduced to the Awlad ‘Ali community by her father, and being subsequently assigned the role of an adoptive daughter in a local family, identified her as a Muslim and an Arab even though her Muslim credentials were shaky and her mother was known to be American. Likewise, Roschanak Shaery-Eisenlohr (2012:106) indicates that in the first few months of her research in Lebanon, she noticed that she was introduced as a *Bahitha Iraniyya* (a female Iranian researcher), an introduction which implied that she had gone to Lebanon from Iran to conduct research. When she explained her ethnic and national background, she was struck by how little interest prospective interlocutors showed in her German or American background and how much they focused on her ‘Iranianness’. If she presented herself as ‘German-Iranian’, many interlocutors assumed that she was ashamed of her Iranian Muslim parentage.

Although questions of identity and positioning plagued me in Burkina Faso, since my “complex and layered identities” (Shaery-Eisenlohr 2012:106) were not underwritten by

my ethnicity or nationality, I determined that I could lay legitimate claim to my Kenyan and African identity, particularly when I thought it would serve my research interests. To do that, I concealed the ways in which my experiences in the United Kingdom, New Zealand and other parts of the world I had visited before, had contributed to shaping my opinions, attitudes and practices. Some of the challenges I faced while in Burkina Faso were caused by my need to portray myself as a 'true' African woman while in the African 'home space'. Because I was preoccupied with staying safe, but also with ensuring that I was "positively positioned" (Madden 1999:263), I tempered the information I revealed about myself to research participants. This process of persistently constructing, adjusting and fronting multiple identities depending on circumstances at times felt deceptive and self-serving (cf. Abu-Lughod 2000:11). The feeling that I was not being completely candid with my Burkinabe interlocutors did not dissipate throughout my fieldwork experience because although I wanted them to identify me with the persona I presented to them, I did not wish to become that persona (ibid.). Even so, while I did not tell blatant lies, the constant acts of partially revealing and concealing myself in the face of people I was asking to reveal incredibly private information about their lives weighed heavily on my conscience particularly when such people seemed honest and solicitous.

I understood the need to be recognised as African, and specifically as Kenyan, to be an unconscious effort to align myself with the Burkinabe people as an African. This was undoubtedly influenced by my awareness that the framing of discussions around female circumcision by some Western scholars came across to some practising communities as extremely ethnocentric. It was very important for me to let my participants know that although I was based in a university in a 'developed' country, I had not gone to Burkina Faso to condemn these practices. Instead, I was merely seeking to learn about the context of these procedures and, more so, about reconstructive surgery.

Emphasising my Kenyan identity was also a bid to show that I acknowledged and valued my identity as an African and had not become overly 'westernised' or, worse still, I was not pretending to be non-African. My discomfort with inadvertently passing myself off as a Westerner when I was indisputably Kenyan stemmed from the fact that I was privy to ingrained elements of the superiority-inferiority and master-servant complex that were ubiquitous during colonial times and still persisted in relationships between Westerners and non-Westerners in many official and non-official settings.

Those elements also sometimes served to make sweeping associations of things Western – education, religion, way of life – as better, superior, developed and civilised and things ‘third world’ as bad, inferior, underdeveloped and uncivilised. Although I was at peace with the choices I had made, for example, by pursuing ‘Western education’ in Western countries, I was concerned about inadvertently implying to the Burkinabe people that I thought of myself as superior to them or of their way of life as inferior.

I had thought that most people, particularly those in advocacy circles, would be aware that the practices they termed ‘female genital mutilation’ existed in many other African and non-African communities, including some in Kenya. I hoped that by knowing this, these people would think of me as more understanding of the context of these practices and would be less suspicious of my intentions. My intuition about this was right since, in some instances, research participants commented on or asked about these practices in Kenya even as they shared their knowledge about the Burkina Faso context. The foregrounding of my Kenyan identity, therefore, helped to spur conversation and maybe enabled more open discussion. However, some research participants asked me why I had not based my study in Kenya given that these practices existed there. It could be that they were just curious about this, but perhaps some were also questioning why I had chosen to expose their culture, and not mine, to scrutiny. In such cases, I explained that I wished to learn more about genital reconstructive surgery, a procedure that seemed unknown in Kenya and even in other countries where female circumcision was practised on a much wider scale. Thus, Burkina Faso was a more fitting setting for my study.

Formative experiences, my personal attributes and the personas I assigned myself in the field influenced the way I positioned myself, the interactions I had with research participants and, ultimately, the nature of information I collected. Citing Kondo (1986), anthropologist Lejla Voloder (2008:29) posits that “[t]he determinants of distance from, or proximity to, participants are largely understood in terms of positioning within or outside the culture, and degrees of identification with participants”. Evoking her Australian and Bosnian identities in describing her fieldwork experience, she explains that she was familiar with the field as it was located within her home environment. She also possessed Bosnian linguistic and cultural skills and identified as Bosnian. Thus, the notion of ‘home’ in that context invoked a “‘nation’, a shared cultural and linguistic group with whom one identifies and feels a sense of insidersness” (2008:30). These

factors worked to suggest a high degree of proximity between her and her Bosnian-born participants and led to assumptions of shared experiences and understandings between the two. However, she indicates that she did not necessarily always share the sentiments of her research participants (pp.29-30). According to her, “it was this divergence, despite so many similarities, that spoke of the diversity of insider experience” (2008:28).

In my case, foregrounding aspects of my identity sometimes proved counterproductive for my research. Some research participants assumed that by sharing an African identity we also shared ideological positions on female circumcision and on reconstructive surgery. As such, for example, I felt that one of my respondents tried to capitalise on our shared African identity to get me to publicly condemn female circumcision and endorse clitoral reconstructive surgery, perhaps in a bid to demonstrate that this surgery had widespread support. Unfortunately, as a result of the manner in which she went about doing this (which I revisit towards the end of this chapter), I was not able to trust her intentions and curtailed my association with her, thereby bringing to a disappointing end what I had hoped would be a long-term association. Moreover, because of that incident, I became less trusting of people as I began to question their intentions when they asked questions about my origins and the nature of my study. That eroded the gains I had made trying to immerse myself in urban Burkinabe society and I became less confident in the way I presented myself to people. I wondered whether it would not have been wiser, safer and more productive for my research if I had foregrounded my identity as a graduate student based in New Zealand looking to learn about these practices for the sole purpose of writing a PhD thesis.

Regardless of our shared African ethnicity, the Burkinabe people I met tried to determine my nationality or even place me within certain ethnic groups in their country by relying on my physical attributes such as skin hue, stature and facial appearance. That, coupled with fact that I sometimes told people that I was Anglophone (in explaining why I might have trouble expressing myself in French or understanding them), saw some Burkinabe people fix my identity and origin in such diverse places as Ghana, Sierra Leone, Ivory Coast and, curiously, the United States and even France! While I did my best to adopt acceptable practices and to belong in Burkina Faso, I did not often succeed. In such cases, I hoped that they would look to my outsider status and forgive my mistakes more readily. A number of people, research participants and non-

participants alike, helped make my stay in Burkina Faso comfortable because they knew I was an outsider. Notable among these was my landlady who indicated that she had done her studies abroad in her younger days and therefore appreciated the difficulties I must be facing being in a new environment alone, difficulties that her own children, who were studying abroad, faced. She indicated that she was not Burkinabe of origin and had only relocated there when conflict broke out in her country. This background probably made her more sympathetic to my situation.

Prior to fieldwork I had wondered whether my introverted nature would make me an ineffective researcher. I had no problem interacting appropriately with people in official or professional situations such as when conducting interviews. My problem was more in breaking into and immersing myself in social situations since under normal circumstances it took me a long time to form genuine relationships. I had resolved, prior to going to the field, that when I was not out meeting research participants and doing active observation, I would spend as much time as possible interacting informally with people in a bid to learn more about their society but also in an active attempt to overcome my social awkwardness. Needless to say, in practice this proved extremely difficult and, in time, I decided to make do with the personality with which I had always lived.

In spite of that, I did manage to make some much valued social connections in Burkina Faso. For example, I got to know Eliza, a young woman in her early twenties who lived across the road from my house. She often ran errands for the agent who managed my accommodation and I was able to get close enough to her to periodically ask about things I did not know or to send her on errands for a small fee. She also acted as my unofficial minder when I first arrived by providing useful suggestions about my stay. Moreover, I looked at Eliza as some sort of barometer for what was an acceptable or at least tolerable mode of dress in the soaring temperatures of Burkina Faso.¹⁴ Eliza also served to dispel some of the assumptions I had made prior to going to the field. For example, I knew that Burkina Faso was predominantly Islamic, but I was puzzled at the beginning as I rarely came across people (particularly women) who wore Islamic dress

¹⁴ Although by late February daylight temperatures went as high as 44 degrees centigrade, a lot of women, particularly older ones, wore long garments referred to as *pagne* or *bazin* made of large yards of cloth.

such as veils. I was utterly shocked a few weeks into my stay when I realised that Eliza herself was Muslim because there was nothing in her name, mode of dress or manner to suggest it. I came to make similar observations among other people – Muslims and Christians alike – and this made me realise that I had to put away the various markers and identifiers I had been relying on to classify people and start to look for new ones.

The other important social contact I made was David, a British national who taught English, and whose wife, Hannah, was seconded to a government department by a volunteer organisation. Hannah shared with me some of her knowledge about female circumcision in Burkina Faso. David introduced me to students at the University of Ouagadougou and made an effort to include me in some of the activities that he, his wife and their friends took part in. I was grateful to have this social contact, and it also felt safe to know other people who were not Burkinabe and who might offer advice or assistance in case of any problems.

When I was setting out to Burkina Faso, I was aware that the question of marital status would come up. When I got to the field I realised that it came up with considerable frequency and sometimes caused concern particularly when it implicated personal safety. In asking whether I was married, some people seemed to be merely curious. Some female research participants expressed concern about the passage of time and the importance of getting married sooner rather than later. From the examples they cited, I got the impression that even if a woman of marriageable age was economically independent, she would not be viewed as suitably integrated in Burkinabe society unless she was married. While I came across a few women in their thirties who were not married, particularly those pursuing postgraduate studies, the conversations I had with most people on the subject made me realise that from their perspective marriage provided social and probably economic security.

Initially I answered the question about marital status with a simple, “No, I am not married.” However, when I realised that answer sometimes implied I was free to pursue romantic liaisons, I started saying, “No, I am not married but I have a boyfriend back home.” By saying “back home” I was being deliberately ambiguous; it could mean back in New Zealand, back in Kenya or simply back at my house in Burkina Faso. I felt that that ambiguity protected me from insistent unwelcome attention or even well-intended suggestions about the need to get married but which I did not necessarily agree with. At

such times, I considered that if I was married and had travelled with a spouse to Burkina Faso, my research might have been a bit easier in that I would have been able to engage more productively with the men I met. Moreover, I would not have been so constantly worried about personal safety, for example, when travelling home late in the evening.

I also sometimes felt that I needed to defend my expenditure in Burkina Faso and that some of my contacts were critical of my seemingly extravagant lifestyle. This mainly had to do with my mode of transport and my choice of accommodation. The vast majority of people used motorcycles to travel (see Figure 2.3), while others used public service vehicles, bicycles and personal cars. I initially thought I would identify a taxi driver with whom I would negotiate a reasonable price and who would take me from one place to another, particularly in the early periods when I did not know my way. However, I realised that there were very few vehicles, if any, which could be classified as private taxis and indeed what were referred to as taxis were public service vehicles (see Figure 2.4) that one could hire by the hour, but which would nevertheless carry other passengers at the same time.

I was adamant about getting a reliable way of getting to interviews, particularly in the mornings, and eventually managed to explain to a public taxi driver that I needed to hire his services on and off over several weeks, even months. This arrangement worked well until he indicated he wished to pursue a romantic relationship and I stopped hiring his services. Fortunately, by then I knew my way around Ouagadougou. Occasionally, although extremely apprehensive, I travelled on motorcycles. Sometimes people stopped as I was walking in the heat of the day and offered me rides and it seemed rude, even unwise given the heat, to refuse. At other times, when it was extremely difficult to get transportation at rush hour, I took motorcycle rides offered by kind strangers. The longer I stayed in the field, the better I got at getting around either on foot or in public taxis which I did not hire by the hour.

The fact that I was staying alone in a spacious rental house raised questions among some people, even though the house was not in one of the more expensive neighbourhoods of Ouagadougou. I had made this decision after considering that the cost of renting a room and getting meals in a guest-house would be more than that of renting a furnished house and living autonomously in it. However, perhaps more than that, I knew that it was important for me to have my own private space where, at the end

of the day, I could get away from constantly having to negotiate issues of identity, belonging and even intent. Although this choice limited my interaction with people, I knew it was the only way I could effectively live in Burkina Faso and carry out my research.¹⁵



Figure 2.3 A section of Ouagadougou city centre

¹⁵ In Bobo-Dioulasso where I stayed in a busy guest house, the proprietor chided me, not unkindly, for “living in my room”. While I often freely mixed with other guests and staff, there were also times when I withdrew from them, a choice that was difficult to explain. My stay in Ouagadougou was much easier as I did not feel scrutinised and judged for sometimes needing to be alone.



Figure 2.4 A taxi station near the central market in Ouagadougou

Challenges of observing and interviewing

To conduct ethnographic research, I used the methods of participant observation, interviewing and the examination of archival material. Participant observation – a method in which a researcher takes part in the daily activities, rituals, interactions and events of a group of people as a means of learning the explicit and tacit aspects of their life routines and culture (DeWalt and DeWalt 2011:1, 5) – was only applicable to my study to a small extent. Female circumcision and genital reconstructive surgery affect people in ways that are private and not open to discussion in normal day to day interactions. My observation and participation was thus limited to areas and events in the Burkinabe community where conversations about these matters were conducted in a relatively public manner, and which I was allowed to attend. For example, I once attended a meeting between members of the CNLPE and Burkinabe musicians which addressed effective ways of disseminating messages about the negative effects of female circumcision and the possibility of reconstructive surgery. My observations in that setting included the issues discussed, the manner in which they were discussed and people's reactions to them. I also regularly visited hospitals, clinics and other centres where these issues were dealt with. Although I did not speak to the patients, I observed

the running of activities in such places and this in turn generated specific lines of enquiry during interviews.

Prior to going to the field, I had prepared interview schedules outlining topics for discussion for four different kinds of interviewees: women who had had or were seeking reconstructive surgery, medical personnel, activists and the general public (see Appendices IV A-VII B). These schedules were similar in their themes but the specific questions posed differed depending on the role of the research participant and on the prevailing circumstances. In thinking about questions for these semi-structured interviews, I borrowed ideas from Kvale and Brinkmann (2009:135-136) who propose using introductory, follow-up, probing, specifying, direct, indirect, structuring and interpreting questions.

Some people, particularly the doctors, maybe because of lack of time, indicated that they would have preferred questionnaire-type interviews where they could tick the 'right' box and then move on with their work. I explained that I had an interview schedule to guide our discussion, but there were no fixed questions that they had to answer. Adapting the discussion to fit the time the doctors could spare was a challenge, particularly as I did not know beforehand how much time they would be able to accord me. In some instances, I started with general questions on female circumcision only to have to rush through questions on reconstructive surgery when they indicated they needed to leave. In other instances, anticipating this rush, I would start with very specific questions only to realise that the doctor in question was willing to accord more time for my questions. Later, I started by not only telling them that the interview would take approximately one hour, but also explicitly asking them if they were able to spare this time. In most cases, they indicated they could not and so I adjusted my interviewing accordingly. With other research participants this was not a problem and indeed they allowed me to take all the time I needed.

Interviewing women who had undergone female circumcision and those who had undergone, or were seeking, reconstructive surgery was a delicate undertaking. A couple of them were already outspoken about their experiences and I had already got

their names from press articles.¹⁶ Once I got to Burkina Faso and obtained their telephone numbers and email addresses, I contacted them separately and finally met them face to face. As I explain in Chapter 4, I had in-depth and extensive interviews with these women and was appreciative of the candour and patience with which they explained their experiences, the decisions they had made and how these affected their life. Some women I was interviewing in their capacity as activists or medical personnel revealed mid-interview that they had undergone female circumcision. When they did this, I adapted the interview to include a discussion of their experiences. At the beginning this was difficult to do, particularly when I was interviewing women who were considerably older than me. Regarding this I wrote:

It is extremely hard to ask elderly women very personal questions, so sometimes I don't exhaust a line of questioning because it becomes too awkward. It is equally difficult to talk to men because in some cases I would be asking about their wives – which I feel is disrespectful. I think the easiest people to interview so far... are activists and medical doctors because they are used to talking about female genitalia as part of their work, so there is no shame in it (personal correspondence, 2 February 2013).

The other challenge I faced was in regard to questions about reconstructive surgery. While some of my interviewees, particularly doctors, senior members working in advocacy organisations and members of Clitoraid/AVFE were aware of these surgeries, some research participants had never heard about them. Some were aware of the procedure termed surgical repair for circumcision sequelae but not of clitoral reconstruction. In such cases I had to explain my understanding of these surgeries drawn from the scarce literature available and from general information I had got in the field. Since some of those people were hearing about these surgeries for the first time, I was quite anxious that I might give them misleading information. In addition, I was acutely aware that I was asking them to form an opinion about something they were just hearing about.

French is the official language in Burkina Faso, and most of my research participants were able to clearly express themselves in the language. Most of them held professional jobs and used the language as the medium of communication. I was able to converse and conduct interviews in the language but when I had trouble expressing something,

¹⁶ To safeguard these women's anonymity, I have omitted details of the media articles which contain their real names.

most research participants were very patient with me and in some cases helped me complete a thought.¹⁷ Indeed the fact that I was not francophone became one of the tools I used to create rapport. When I started interviewing, I thanked research participants for granting me time and explained that my French was not very good but that I would do my best to make myself understood. Their demeanour became noticeably friendlier which made the interview process much easier. The vast majority of people I interviewed were also able to understand and speak English but almost all indicated that they preferred to converse in French.

Most of the semi-structured interviews were held at the research participants' places of work or in public spaces near their places of work or study. A couple of times I conducted them in the homes of research participants and once at my accommodation. These interviews happened when it was convenient for research participants but they tended to be early in the morning or late in the afternoon. (Office or business hours were 7.30am to 12.30pm and 3pm to 5.30pm). Given these locations, there was sometimes ambient noise such as from air-conditioning in the offices or from outside traffic. Sometimes there were interruptions, some at crucial moments in the interview, but they did not completely hinder the flow of conversation.

I avoided making notes during interviews as I thought these would distract the participants and instead relied heavily on recording the interviews on a small audio recorder. I explained to research participants that my main reason for recording our conversations was to recall with precision the things they had said. For me, it was also to avoid interrupting them when I did not understand the occasional difficult word, the meaning of which I could clarify later. Most participants easily consented to my recording these interviews. However, it was notable that for some people, recording their speech was a kind of formal or official act for which they felt they needed to have and give 'correct' information. To such participants, I explained that I was just looking to hear their opinion or understanding of the issues we discussed. Only in one case did a respondent decline permission for audio recording because she felt she was not authorised to speak on behalf of the organisation for which she worked.

¹⁷ I had learnt French for over 20 years, so I understood and spoke it with relative ease. Before leaving for the field, I also learnt some key words and phrases in Dioula, a language spoken by a number of ethnic groups in Burkina Faso (Painter 2011).

These semi-structured interviews complemented the informal conversations I had with people which enabled me to understand my research site better. Some conversations happened in prearranged meetings with participants. However, more often than not they were unplanned and occurred as I was going about my daily activities and meeting people – taxi drivers, market people, motorcyclists, university students and academic staff – who enquired about my stay and then went on to share information about their lives and their country.

Although my communication with research participants went well, this was not always the case when I interacted with some members of the wider society particularly in the ‘blue collar’ sector. Differences in language register brought on not just difficulty in communication but also frustration and an alienating feeling, especially when they led to my being identified as a foreigner. In the market, as with some taxi drivers, I felt this led to an instant increase in prices and a desire to swindle me as these people assumed I was a tourist. In other places, I felt I was being pitied and treated as a curiosity or a helpless, even petulant, person. However, quite often I experienced acts of kindness which washed away that feeling of alienation and made me feel warmly towards the Burkinabe people. That fluctuation between resentment and affection was also mirrored in the feelings I had regarding my successes and failures in my research. When I had a particularly good interview, I capitalised on the elation I felt and immediately called or visited other potential research participants to set up interviews. When a promising lead fell through, I got quite discouraged and had to force myself to keep going.

While I had a notebook in hard copy to record summaries of events that occurred at the time of observation, at the end of each day I also wrote expansive field notes on my computer. In those, in following the suggestions made by various researchers (DeWalt and DeWalt 2011:158-159, 160-171; Angrosino 2007:40; Blommaert and Jie 2010:37), I recorded both the events and my impressions of them. Initially, I had intended to have a separate personal diary in which I could honestly and privately articulate my feelings and thoughts regarding the fieldwork experience. However, in practice I found I could not keep those private thoughts out of my field notes and, in the end, I amalgamated the notes and the diary. Thus, the field notes which I had initially conceived of as a semi-private academic document became incredibly private. I also had a schedule that I updated regularly indicating the interviews I planned to carry out and activities I planned to attend. Finally, I had a file on my computer where I kept my budgetary plans

and records of expenditure. That was important because I had to keep track of my finances in multiple currencies: the New Zealand dollar in which my research funds were denominated, the Euro into which I changed this money before travelling, the West African CFA Franc which was the medium of exchange in Burkina Faso and the Kenyan shillings which I used to determine the real value of my expenditure.

In addition to my field notes and audio files, at the end of the fieldwork period I also had a body of archival material I had been given by research participants. This was comprised of brochures and information sheets, reports, films and educational and/or policy materials from the CNLPE and other non-governmental organisations. It also included media articles and brochures from Clitoraid/AVFE about their upcoming activities and about clitoral reconstructive surgery.

Miscalculations and security concerns

In my interaction with research participants, I felt it was important to maintain my identity as a student researcher. I felt that if people thought I worked in the establishments that I visited – hospitals, clinics and offices of non-governmental organisation – they may have thought I could provide some form of assistance. Moreover, I felt that by identifying myself fully with certain groups or individuals, I would be inadvertently indicating that I was advocating their positions, something I did not want to do as I did not know those people or their positions adequately. In most situations, therefore, I adopted the position of ‘observer-as-participant’, more rarely I took the role of ‘participant-as-observer’ but did not allow myself to become a ‘complete participant’ (Gold 1958, cited in Angrosino 2007:54-55). That is to say, I interacted closely with people and observed the activities they organised or performed, but I did not perform activities that could identify me as one of their team such as declaring a stance regarding female circumcision or reconstructive surgery, or taking an active role in condemning or endorsing these procedures.

Most research participants accepted that position and helped me with my research without expecting much in return. If they did ask for anything, it was for things – such as translating documents or information about overseas study – which I was able to do and which did not leave me ethically compromised. Some male associates of research participants (who the participants sometimes asked to transport me on their motorcycles) asked to meet me socially but I said, dishonestly perhaps, that I was bound

to see them again when I returned to meet my participants. Everyday decisions regarding what was safe, ethical and proper brought on periods fraught with turmoil for me and I often felt that the way I interacted with people, even research participants, was on my terms. I wondered whether I was being fair by hoping that research participants would help me while I rigidly controlled the way I interacted with them and second-guessed their intentions. I tried to assuage this conflict by reminding myself that I always verbally expressed my gratitude to research participants and other people who had been helpful. Where there was no ethical dilemma, I also showed my gratitude by giving out material goods such as foodstuffs, books, stationery, mobile phone credit, clothes, shoes and perfume.

Nonetheless, a couple of incidents with one of my key research participants in Bobo-Dioulasso made me consider that perhaps some research participants expected me to interact with them on their terms. On one occasion the informant kindly offered to get someone to show me around the town centre. Instead, the man she sent took me to a local pub where we were joined by six other men. Although I was not clearly told of the intention of this meeting, I got the impression that it was to pair me up romantically with one or more of those men. I managed to extricate myself from the situation with some difficulty and took a taxi back to my accommodation because it was getting late and I was increasingly getting apprehensive about the intentions of the meeting. In the second incident this informant promised to introduce me to some women who were seeking to undergo reconstructive surgery but when we arrived at the meeting venue there was a television crew waiting and I felt I was being coerced into making a statement intended to show my support for my informant's activities.

It could be that the research participant, who had received me so affably and answered my questions so comprehensively, had not meant me any harm and I had misinterpreted her actions. Even so, these events and other tell-tale occurrences soured my association with her, created major safety concerns for me and brought our research relationship to a premature end. The fact that the research participant was affiliated with the Raëlian Movement (whose attitudes towards sex I explore in more detail in Chapter 9) exacerbated the concerns I had for my personal safety and my ability to always safely extract myself from potentially problematic situations. Medicine (2001:5) points out that in all anthropological investigations mutual trust and understanding must be built carefully and sensitively, and that as with any human relationship, reciprocity,

responsiveness and responsibility are essential. In this context, I felt that the research participant and I had not cultivated mutual trust and understanding, and I felt I could not safely continue to conduct research in Bobo-Dioulasso as I could not predict the outcome of our continued association or proximity. Perhaps if we had discussed beforehand the involvement she wished me to have with her group, it might have enabled us to find a mutually acceptable way of collaborating in the research. Even though I was able to meet and interview a few more people in the town, the mistrust created by this encounter left me feeling extremely isolated, anxious and worried about my safety while in Bobo-Dioulasso. I did not know whom I could trust and felt exposed as I had not had time to identify reliable people and safe places that I could turn to if I got into problems. Eventually it made more sense to renounce my activities there and return to Ouagadougou.

More than that, however, it was concerns with overall security in the region and the conflict in Mali that influenced my decisions to greatly curtail my movements in Burkina Faso and, ultimately, to get out of the country. Mali, which borders Burkina Faso to the north, was experiencing political instability following a military coup in March 2012 and its northern territories were under the control of “The Saharan branch of al-Qaeda” (BBC 2012b). My sense of insecurity was heightened by the knowledge that Burkina Faso was directly involved in the Mali conflict in that there were Burkinabe troops fighting alongside French and Malian forces (Valdmanis and Lewis 2013) and Burkina Faso provided passage for French troops en route to Mali (Aljazeera English 2013a). This knowledge alarmed me because I knew that when the Kenyan government sent Kenyan troops to join the African Union troops fighting the Al-Shabaab extremist group in neighbouring Somalia, there began a series of attacks in Nairobi and other parts of Kenya in retaliation (BBC News 2011a; BBC News 2011b; BBC News 2012c; BBC News 2012d; BBC News 2012e; BBC News 2012f). I was therefore apprehensive that similar attacks may follow the entry of Burkina Faso troops into Mali.

I was particularly jittery following the Algerian hostage crisis which happened soon after my arrival in Burkina Faso where a number of foreigners were seized and killed or died in the ensuing stand-off with the Algerian army (Aljazeera English 2013b), seemingly in retaliation for the involvement of foreign troops in Mali. Although I was not from any of the countries involved in the conflict, I was constantly afraid of being at

the wrong place at the wrong time. In addition, the fact that some people in Ouagadougou and Bobo-Dioulasso knew I was a foreigner, and a good number knew where I lived, increased my fear. I did not know where to get official security updates in Burkina Faso, if there were any. I was also not entirely sure on whom I could rely for dependable information about what really was happening and how to know when the situation was so dangerous that I needed to leave. This perpetual sense of insecurity eventually made me to decide to leave Burkina Faso after just about two months, even though I had planned to stay there for up to four months.¹⁸

Discourse and discourse analysis

In discussing my fieldwork data in the chapters ahead, I will refer to various discourses and their implication in conveying messages about female circumcision and genital reconstructive surgery in Burkina Faso. To define discourse, I borrow from Carabine (2001:268, citing Foucault 1972:8) who describes discourse as “consisting of groups of related statements which cohere in some way to produce meaning and effects in the real world”. Carabine (ibid.) suggests thinking of discourses as the ways in which an issue or a topic is ‘spoken of’ through speech, texts, writing and practice (cf. Schirato and Yell 2000:58). These different, and sometimes contradictory, ways of speaking about an issue cohere (that is, come together) to create a representation of the issue under discussion. Discourses are productive and constitutive, that is to say, they produce the objects of which they speak and construct a particular version of the product as real. Furthermore, they have power outcomes and effects in that they define and establish what is the ‘truth’ at particular moment and also influence the way people come to understand, experience and respond to a particular issue (Carabine 2001:268-269, 273).

The concept of discourse can be used to distinguish different ways of speaking or meaning associated with particular institutions and their practices, for example, law, religion, the education system and the family (Schirato and Yell 2000:58). One of the important functions of discourse is to express the meanings and values of an institution. The concept of discourse was developed by French philosopher and theorist Michel

¹⁸ My supervisor was also very concerned about the events in Bobo-Dioulasso detailed above and the growing insecurity in the region, and indicated that she felt it was very risky for me to remain in the country.

Foucault. Foucault's concern with discourse was its power to structure, classify and normalise the social world (Schirato and Yell 2000:58, citing Foucault 1972). Foucault argues that discourses owe their control over their material and subjects, that is, their portion of the social world, to their ability to seem natural and self-effacing. Given this characteristic, identifying ways in which discourses operate makes them 'visible' and reduces their degree of control (ibid.).

Discourses do not exist in isolation. They have the capacity to travel across cultures and interact with and get mediated by other other dominant, sometimes more powerful, discourses to produce new, different and forceful ways of presenting the issues (Schirato and Yell 2000:59-60; Carabine 2001:273, 279). Carabine (2001:269) perceives discourses as being at once "fluid and opportunistic". That is to say, they draw upon existing discourses about an issue while using, interacting with and being mediated by other dominant discourses to produce new and potent ways of conceptualising the issue. By so doing, they co-opt normative ideas and common sense notions about the topic. This in turn "produces shortcut paths into ideas which convey messages" about the issue (Carabine 2001:269). Not all discourses have the same force; some are more powerful than others and have more authority and validity. As such, although a discourse might try to impose its values within and even beyond its sphere of influence, other discourses may challenge it, check it or coexist with it (Carabine 2001:275; Schirato and Yell 2000:59).

Discourses are displayed using discursive strategies. This is the means through which a discourse is given meaning and force, and through which its object is defined. It can also be seen as a device through which knowledge about the object is developed and the subject constituted (Carabine 2001:288). In the context of my research some of the ideas created by different discourses – those formulated within the local Burkinabe sociocultural context, those arising from global concepts of human rights, those coming out of feminism as conceptualised in the West, those relating to health and wellbeing, those speaking about sex and sexuality, those propagating ideas from different religions – and which mediate one another include: what a feminine woman is and what she is able to do; what constitutes sexual competence; what constitutes normal and abnormal genitals; what constitutes cosmetic surgery; what constitutes genital mutilation; what is moral; what is immoral; what should be legal and what should be illegal; what is

natural; what is unnatural and what this means; what constitutes a religion; what constitutes a cult (cf. Carabine 2001:269).

An important aspect to think about in regard to discourse is its relationship with knowledge and power. Carabine (2001:275) suggests seeing discourse as “intermeshed with power/knowledge where knowledge both constitutes and is constituted through discourse as an effect of power” (cf. Foucault 1990, 1991). Discourses use and sometimes transform existing knowledge to produce new knowledge and new power effects in the sense that they specify which objects, practices and social relations are possible and valued in specific institutional contexts (Carabine 2001:274; Schirato and Yell 2000:59). Put differently, discourses function as powerful sets of socially and historically constructed rules which designate ‘what is’ and ‘what is not’ (Carabine 2001:275). Some of the values produced by discourses might be implicit rather than explicit. However, they still control, in a powerful way, which practices and meanings are likely to be acceptable within the institution by specifying what is morally, socially and legally acceptable and unacceptable at any given moment in a culture. This makes power an important element in the construction of knowledge and what counts as knowledge (Schirato and Yell 2000:59; Carabine 2001:274-275). Even so, while discourses have regulatory intentions, they do not necessarily ultimately have regulatory outcomes. This is because individuals are active agents and discourses themselves are in a state of constant reconstitution and contestation (Carabine 2001:279).

One domain in which the role of discourse in creating knowledges and ‘truths’ is evident is that of sexuality. In *The History of Sexuality*, Foucault (1990, cited in Carabine 2001:275) investigates the ways in which sexuality has come to be seen and spoken of, that is, “the development of knowledges about sex, as a means of understanding the operations of power”. By employing dominant discourses, knowledges or ‘truths’ about sexuality tell us what is ‘normal’ and ‘natural’ whilst establishing the boundaries of what is acceptable and appropriate” (Carabine 2001:275). In his analysis, Foucault (1990, cited in Carabine 2001:275) challenges the universal understanding of sexuality as being “‘natural’, fixed and/or biologically determined” and instead shows it to be socially and culturally constructed.

When talking about sexuality in this thesis, I am using Carabine’s (2001:278) definition which describes sexuality as embodying “identity, behaviour, acts, desires, relations and

relationships”. She takes it to refer to a category of a person (for example, heterosexual, homosexual or lesbian), the focus of their desire (for example, same-sex, opposite sex) and as embracing all sexual behaviours, acts and relationships, as well as the meanings attached to those acts and behaviours. This knowledge has been historically, socially and culturally constructed and passes as the ‘truth’ about sexuality at this particular moment (cf. Carabine 2001:278).

There is a relationship between discourse and normalisation in that discourses convey messages about what is the norm and what is not; they “establish the norm” (Carabine 2001:277). Through normalisation, individuals are compared and differentiated according to a desired norm (Carabine 2001:278, citing Foucault 1990). Normalisation establishes a measure by which all individuals are judged and deemed to conform or not. This process produces homogeneity through processes of comparison and differentiation (Carabine 2001:278). Rather than just being a way of comparing individuals in a binary way, normalising judgement is also a ‘norm’ towards which all “individuals should aim, work towards, seek to achieve, and against which all are measured – ‘good’ *and* ‘bad’, sick *and* healthy, ‘mad’ *and* ‘sane’, heterosexual *and* homosexual” (ibid.). Just like discourses, normalising strategies are not uncontested, nor do they lead to successful and complete regulation or outcomes. Rather, they are “a continual, if not uneven, and contradictory process” where individuals are in a constant process of reassessing, establishing and negotiating their position in relation to the norm (Carabine 2001:278).

I briefly mention Foucault’s concept of bio-power and its implication in the production of discourse. Bio-power refers to the “technologies, knowledges and discourses that that are used to bring about the regulation and management of populations” (Schirato and Yell 2000:49). Bio-power works to analyse, control and define the human subject, its body and behaviour (ibid.). In many ways, it is similar to Bourdieu’s concept of habitus – defined as “a set of dispositions gained from our cultural history that stays with us across contexts” (Schirato and Yell 2000:189) – in the sense that they both work as some kind of “writing of the body and the soul” which starts soon after an individual’s birth and continues throughout the person’s life (Schirato and Yell 2000:49.). This is effected using institutions and fields which shape people’s values and behaviour and orient their trajectories. Significantly, once people’s ideas, values and bodies have thus formed, they become self-regulating (ibid.).

Even so, bio-power does not completely dominate people's lives and thinking (Schirato and Yell 2000:50). Since it is productive, through its technologies, institutions and discourses, bio-power produces a variety of people and behaviour. That is to say, by producing categories of what is normal, healthy and good inevitably bio-power also produces other categories: "the pervert, the deviant, the troublemaker, the problem child... the hysteric, the kleptomaniac, the pyromaniac, the psychotic" (ibid.). In that sense, power produces its own opposition. That is to say, as well as dominating and regulating people's lives, it also creates and provides spaces where people work and think against it (ibid.). Just as Bourdieu's habitus is "challenged and transformed as subjects move across different cultural fields", in Foucault's theory, even though bio-power functions to regulate and 'normalise' subjects, the many different competing 'authorities' and discourses engender a sense of scepticism in people, which helps to distance them from the control of bio-power (Schirato and Yell 2000:51). Furthermore, by creating categories of "unnatural and unhealthy subjectivities", bio-power produces subjects who are 'naturally' inclined to think and act against it (Schirato and Yell 2000:51).

In my application of discourse analysis, I take ideas from Taylor (2001:6) who describes this activity as the act of looking closely at language in use with a view to noticing and highlighting patterns. Taylor (2001:7) proposes four approaches that can be used in discourse analysis. The first one focuses on language in use so as to discover how it varies, and then relates this variation to different social situations, environments or users. The second approach focuses on the activity of the language in use, rather than the language itself. That is to say, the analyst studies language use as a process while investigating the interactions between two parties and looking for patterns in the language users' actions. My interest in discourse analysis relates Taylor's third and fourth approaches. In the third approach, the analyst

looks for patterns in the language associated with a particular topic or activity, such as the family of special terms and meanings around it.... And a fourth possible approach to discourse analysis is to look for patterns within much larger contexts, such as those referred to as 'society' or 'culture'.... For example, the analyst might investigate patterns in the labelling and classification of people or activities within a society. The language of categorization will be implicated with, on the one hand, the values underlying it (for example, beliefs that certain people are 'good' or 'bad) and associated philosophies or logics (such as when an activity is evaluated negatively because it is believed to have negative consequences),

and on the other, the consequences and social effects of the classification (Taylor 2001:7).

The third approach to discourse analysis understands language as situated within a particular social and cultural context. On the other hand, an analyst following the fourth approach identifies patterns of language and related practices and shows how these constitute aspects of society and the people within it (Taylor 2001:8-9). This approach lends itself to controversy because it involves “the study of power and resistance, contests and struggles”. It also proceeds from the assumption that the language available to people “enables and constrains not only their expression of certain ideas but also what they do” (ibid.). This fourth approach to discourse analysis also highlights the all-encompassing nature of discourse as a fluid medium through which meaning is created but also contested. In this context, the language user is neither a detached communicator nor a free agent, but is always located or immersed in this medium and always constrained in his or her choice of language and action in line with his or her own social and cultural positioning (Taylor 2001:9-10).

I draw from these two approaches to discourse analysis to undertake a qualitative analysis of my fieldwork data. That is to say, I take an open-ended and iterative approach in searching for and identifying patterns in the data (Taylor 2001:38-39). The insights obtained through this process are necessarily partial, situated (that is, specific to the practice of circumcision and reconstructive surgery in Burkina Faso) and relative (that is, interpreted from an anthropological worldview) (Taylor 2001:12). I do not claim to exhaust all avenues to which the available body of data could lead, but I do explore in detail the patterns I focus on and highlight those that would benefit from further exploration (Taylor 2001:39, cf. Seale 1999:102-105).

I also borrow from and implicitly use the socio-semiotic model for analysing text-context relations proposed by Schirato and Yell (2000:112), drawing from Halliday (1985). This model proposes that there is an interdependent relationship between particular social contexts and the kind of textual practices that take place in these contexts. (Schirato and Yell [2000:109-110] define contexts as the particular environments in which communication, texts and meaning-making occur and function as meaningful, or the the situation in which people make sense of a text or a meaningful practice). This model, which I employ tacitly, involves separating context into three dimensions: field (What is happening? What is the communication about?), tenor (Who

is taking part? What is their interaction? What position are they taking?) and mode (How is the text structured? What part is the code or language playing?) (Halliday 1985, cited in Schirato and Yell 2000:112).

Conclusion

In considering and explaining the construction of my identity and the choices I made in positioning myself in Burkina Faso, I find useful Voloder's concept of 'the diversity of insider experience'. I was in overdrive trying to identify with the Burkinabe people as an African, while at the same time desperately clinging to that which made me different. Although we were similar in some ways, through our origins and experiences we also differed in many other aspects which were not necessarily relevant to the fieldwork experience and thus not up for scrutiny. It was within this difference that my researcher self was situated. This sense of individuality and otherness also helped me remain vigilant and kept me from being too complacent lest I forget that actually I was not 'one of them'.

I went into Burkina Faso to conduct research for my PhD thesis and, to a large extent, I felt I succeeded in bringing back a body of data that would enable me to complete my research project satisfactorily. My stay undoubtedly enabled me to understand the practices of female circumcision and reconstructive surgery in more detail. It also gave me a deeper understanding of the urban Burkinabe society even though I clearly did not stay long enough to understand all its aspects in great depth.

The fieldwork experience also marked me in other ways that I had not anticipated. I did not realise until I left the country how much of a toll the constant feeling of insecurity and various difficulties I had faced as a single female foreigner trying to make my way in Burkina Faso had had on me. When I went to Kenya to see my family before returning to New Zealand, I felt an immense sense of relief, familiarity and security even though the country was in the midst of an uncertain election period. On my return to New Zealand, I was acutely aware that I was different from the people with whom I travelled into the country. I started being more aware, and less accepting, of instances when I felt I was treated differently, particularly if I thought that that happened because of my ethnicity or nationality. Conversely, I developed a deeper appreciation for people who were accepting of me. My identity as an African had become more concrete and I had become more protective and appreciative of it. In noticing these changes, I would

like to think that the fieldwork experience deepened my self-awareness and, perhaps more significantly, increased my appreciation and respect for other people and their way of life.

CHAPTER 3

THEORETICAL FRAMEWORK: FEMINISM AND CULTURAL RELATIVISM

Introduction

In this chapter, I explore the implication of the theoretical perspectives of feminism and cultural relativism in discussions about female circumcision and other surgeries performed on the female body. This discussion is prompted by the observation that most of the scholars I cite in the subsequent chapters of my thesis situate their interpretations of these procedures within feminist discourses dealing with the limited nature of women's autonomy, the role of patriarchy in maintaining these practices and the various notions of femininity which are invoked in the performance of these procedures. In the chapters ahead, I explore the ways in which discourses informed by these ideas influence women's decisions to conform to existing ways of being or to adapt to 'modern' ones for social and economic gains. In specific regard to my research, I interrogate how ideas from these two schools of thought are implicated in the decisions of some Burkinabe women to embrace genital reconstructive surgery as necessary to the expression of their femininity and wellbeing while others reject it as an absurdity.

Genital reconstructive surgery differs from both female circumcision and cosmetic surgery as practised by some people in the West in that the latter practices entail "the removal of or damage to healthy, normal genital tissue" (WHO et al. 2008:1) while reconstructive surgery arguably proceeds from a perspective of repairing damaged bodies. Even so, all these procedures implicate notions of femininity, attractiveness and normality, and the ways in which these concepts underlie the decisions that women make or are forced to make in remaking their bodies. The literature explored here and in the chapters ahead is by no means exhaustive nor are the ideas clear-cut as there is a great deal of contention on most, if not all, of the themes that have to do with the practices under consideration.

The concepts explored include a brief overview of the forms and prevalence of the practices termed female circumcision, ideas of some feminists who point to these practices as a violation of women's and girls' rights and those of postcolonial and third world feminists who suggest that some Western feminists wrongly perceive women as a

homogenous group, seeking to impose on them a feminist framework conceived by, and for, a white, middle-class, Western minority. In addition, I explore the ideas of some cultural relativists who point out that many Western feminists do not pay adequate attention to the cultural context in which female circumcision is practised and, as such, err in their blanket condemnation of various practices and in their quest to ‘emancipate’ ‘oppressed’ women. Finally, I discuss the views of various scholars who address the notions of ‘choice’ and ‘agency’, and who point out that although Western cultural contexts differ from those of communities that practise female circumcision, there are parallels in Western contexts in terms of societal expectations and practices that are oppressive to women, even though the particularity of these expectations and practices differ. They therefore suggest that feminists should address these gender-related issues across the board instead of adopting a binary ‘saviour-victim’ approach, and only doing so when considering the cultural practices of the ‘Other’.

Female circumcision: an introduction

While there is no consensus about the origin of female circumcision, some historians have traced the practice to the fifth century BC; the earliest known source that records it is traced to Herodotus (484-424 BC) who indicates that excision was practised by the Phoenicians, Hittites, Ethiopians and Egyptians (Lockhat 2004:9). It has also been suggested that this procedure was practised by early Romans and Arabs, and that in some groups it appears to have been a mark of distinction while in others it was a mark of enslavement and subjugation (Lightfoot-Klein 1989:27-28). There is no clear indication concerning where, how and why these practices began, or even how they spread to their present areas of prevalence. However, various writers (Prolongeau 2006:79-80; Cook et al. 2002:284; Lockhat 2004:81-83; Lightfoot-Klein 1989:179-181; Huelsman 1976:127, cited in Boddy 1998b:91) point out that in addition to existing in some parts of Africa, the Middle East and Asia, female circumcision, mainly clitoridectomy, was also performed by some American and European doctors particularly in the United States of America, France, Britain and Germany during the nineteenth century (but also even as late as 1948) as a form of treatment for nymphomania, masturbation, hysteria, epilepsy, melancholia and insanity. The practice of introcision (making cuts into the vagina) was also observed and described during the British incursion into Australia as part of a complex ritual among some Aboriginal groups (Toubia and Izett 1998:4).

In current times, female circumcision is reported to be most prevalent in the western, eastern and north-eastern regions of Africa, although it is also practised in some countries in Asia and the Middle East and among certain immigrant communities in North America and Europe (WHO et al. 2008:1). As I explain in the latter sections of this chapter, some scholars have rightly highlighted the fact that in listing countries where the practice sometimes termed ‘female genital mutilation’ is practised, often little or no mention is made of Westerners who have these procedures done to their bodies in their countries. Therefore, when, for example, United Nations agencies indicate that there are currently between 100 and 140 million girls and women in the world who have undergone some form of female circumcision, and that these practices are mostly carried out on girls aged between 0 and 15 years but, occasionally, also on adult and married women (WHO et al. 2008:1, 4), these statistics do not take into account women from Western countries. Clitoridectomy and excision (Types I and II) are said to be the most common forms of the practice, while infibulation (Type III) is the principal form in Somalia, Djibouti, Eritrea and central and northern Sudan. It is also practised to some extent in eastern Chad, southern Egypt, parts of Mali, the lowlands of Ethiopia, by Somalis living in north-eastern Kenya and by some groups in northern Nigeria and Senegal (Boddy 1998b:81-82; Lightfoot Klein 1989:31; Hosken 1982, cited in Lightfoot-Klein 1989:31; Gruenbaum 2001:8; Shell-Duncan and Hernlund 2000:9). Countries with recorded national estimates of percentages of girls and women who have undergone various forms of female circumcision – classified as Types I, II, III and IV female genital mutilation by the World Health Organisation (WHO et al. 2008:4) – include Benin, Burkina Faso, Cameroon, the Central African Republic, Chad, Côte d’Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, the Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Northern Sudan, Togo, Uganda, the United Republic of Tanzania and Yemen (WHO et al. 2008: 5, 29).

The list cited above is by no means complete as some researchers mention a number of other countries – for instance, Botswana, Lesotho and Mozambique – where “reliable figures on prevalence are not available, and reports of the existence of the practice are based on anecdotal information” (Shell-Duncan and Hernlund 2000:9, citing Koso-Thomas 1987). Some studies have also documented cases of female circumcision in Colombia, the Democratic Republic of Congo, India, Indonesia, Iraq, Israel, Malaysia,

Oman, Peru, Sri Lanka, the United Arab Emirates and among certain ethnic groups in Central and South America (Ghadially 1992; Budiharsana 2004; Strobel and Van der Osten-Sacken 2006; Asali et al. 1995; Isa et al. 1999; and Kvello and Sayed 2002, cited in WHO et al. 2008:4, 30). Recent estimates indicate that around 90% of female circumcision cases include Types I, II and IV, and about 10% are Type III (Yoder and Khan 2007, cited in WHO et al. 2008:5). In looking at the literature explored on various themes relating to female circumcision, one of my primary observations (which will be demonstrated in this chapter and in Chapters 5 and 6) is that in spite of being practised on a much smaller scale than other forms of female circumcision, there is a lot of concentration on the practice of infibulation particularly as practised in Sudan. There is also some literature referring to the practices of excision and clitoridectomy in some of the countries mentioned above (particularly in Chad, the Gambia, Kenya and Nigeria) but there is hardly any literature on Type IV female circumcision. As I will explain in Chapter 6, the abundance of findings from studies based on infibulation influences the perception of the impact of the negative effects associated with these practices in Burkina Faso.

It is fundamental to underline the fact that it is extremely difficult, if not impossible, to give a complete and clear picture about the prevalence of female circumcision, the age at which it is carried out or even the form carried out in a particular region. In general terms, these practices vary according to local traditions and circumstances which seem to be associated with regional and most especially ethnic differences (UNICEF 2005a, cited in WHO et al. 2008:4; Obermeyer 1999:88; Gruenbaum 2001:9). In addition, these practices seem to be evolving over time so that now it is not possible to identify with all certainty the particular form of the practice that is performed even within a single region or ethnic group. For instance, Boddy (1998:82) points out that in Sudan “a modified and somewhat medicalised form of pharaonic circumcision” introduced in the 1920s and 1930s by British medical personnel in their attempts to put a stop to infibulation has gained ground over the years, and now a compromise between *sunna* (removal or incision of the clitoral hood or prepuce) and infibulation is practised in urban Sudan.

Female circumcision is often portrayed as a practice that is performed without anaesthesia, in unsanitary conditions and with unsterilised surgical instruments which may include knives, razor blades or even pieces of broken bottles, by people – elderly women in the community specially designated for the task, women from the blacksmith

caste particularly in Mali and Senegal, traditional birth attendants, traditional healers and barbers – who often have no medical training and little anatomical knowledge (Abusharaf 1998:23-25, 2001:118; Toubia and Izett 1998:6; Lockhat 2004:9, 14). However, this is not always the case as in some instances health professionals such as nurses, trained midwives and physicians also perform these procedures in hospitals and private clinics particularly among affluent clients (ibid.). Indeed, Astrid Christoffersen-Deb, a gynaecologist who has researched the subject, points to the ‘medicalisation’ of female circumcision – the practice of carrying out these procedures either by a health worker or under medical conditions – as being advocated “throughout this past century by local health, religious, government, and development practitioners as a pragmatic solution to fatal tetanus infections and haemorrhage” (2005:403).¹⁹

Western feminists and ‘female genital mutilation’

In considering and presenting the manner in which some Western feminists have theorised about female circumcision, it is important to take into account one of the initial political aims of feminist theorists as seeking to make understood women’s subordination and exclusion from, or marginalisation within, cultural and social arenas (Jackson and Jones 1998:1; cf. Grosz 2010:49). Of course, feminist theory has not remained constant since its inception, and indeed there are now multiple feminisms. As calls for gender equality began to emerge in the middle of the twentieth century, white feminists of the nineteenth and early twentieth century were rediscovered by activists in the early days of second-wave feminism (Aulette and Wittner 2012:13). In the American context, early second-wave feminism took the form of two conjoined movements. The first, which was spearheaded by the National Organization for Women, focussed on reform of the political and economic system, and was founded in 1966 by a group of lawyers, academics, writers, business executives, and government employees to work for the elimination of legal barriers to women in government, the work force, educational institutions, and labour unions (Aulette and Wittner 2012:14). The second

¹⁹ I discuss in more detail the proposed reasons underlying these practices in Chapter 5. In Chapter 6, I discuss some of the negative effects these procedures are said to have on the people who undergo them.

arm of second-wave feminism, often called the women's liberation movement, was made up of young women, many of whom identified themselves as socialist feminists. They were former civil rights activists, Vietnam War protesters, community advocates, and student militants (ibid.).

Black and white socialist feminists arose from the civil rights, antiwar and new left movements, and sought to build a new society in which neither sexism nor racism divided women and men, or people of colour and whites (Aulette and Wittner 2012:14-16). However, second-wave feminism became dominated by white feminism, which led to the splitting of this community of activists into separate movements, often based on their singular sexual or racial identities. When feminists entered universities as students and young faculty members in the early 1970s, they opened up new areas for study and theorising (Aulette and Wittner 2012:16), and “tensions and contradictions emerged as a plurality of perspectives was developed” (Coleman 2009:4). As a result, many different feminist theories have been added to the original three – liberal, socialist and radical feminism – including postcolonial feminism, black feminism, ecofeminism, psychoanalytic feminism, standpoint feminism, multiracial/multiethnic feminism, feminist studies of men, social construction feminism, postmodern feminism or queer theory and third-wave feminism (Lorber 2009, cited in Aulette and Wittner 2012:16).

The feminists of colour movement gained momentum in the 1980s as black, Asian and women-of-colour feminists and literature began to emerge and to criticise Western feminists for perceiving all women as a homogenous group, and, consequently, ignoring basic differences between women of different cultures (Kalev 2004:345; cf. Mohanty 1991; Johnson-Odim 1991; Obiora 1997a; Maparyan 2012; Amadiume 1997; Nnamuchi 2012). According to Kalev (2004:345), feminists of colour view cultural differences among women as equal causes of discrimination and connect the oppression of women to imperialist and colonialist oppression of non-Western cultures, while preserving the link with class oppression which is already claimed by earlier wave feminists. Feminists of colour therefore give voice to the women of other cultures which are not understood or represented by Western feminists.

One of these feminists, Chandra Talpade Mohanty, decries some Western feminists' “strategic location of the category ‘women’ vis-à-vis the context of analysis” (1991:55). According to her, “the assumption of women as an already constituted, coherent group

with identical interests and desires, regardless of class, ethnic or racial location, or contradictions, implies a notion of gender or sexual difference or even patriarchy which can be applied universally and cross-culturally”, and which, ultimately, begets “a homogenous notion of the oppression of women” (ibid.). Yet, as Jackson and Jones (1998:1-2) rightly point out, women are not a homogenous group; they are “differently located within global and local social contexts and differently represented in art, literature and other media ...[with] distinctions of nationality, ethnicity, education, language, family, class, employment, ability/disability and sexuality”.

The female body and women’s sexuality have been important areas of focus for Western and non-Western feminists alike. Interest in these sites of oppression and empowerment continues to engender productively diverse and conflicting, as well as often conflicted, responses by feminist scholars as they reflect upon and attempt to conceptualise women’s sexual bodies within the cultural and political landscapes of the twenty-first century (Muller and Llewellyn 2011:315). Since second-wave feminism’s embracing of female desire and bodily pleasures, feminist understandings of the body as a means of experiencing and expressing sex and sexuality have become increasingly varied and complex (ibid.). The variety and complexity of these understandings is reflected in various contexts including in the perception of some feminists of colour that Western feminists have often portrayed women of non-Western cultures in racist and demeaning ways by condemning their practices and implying that they are passive and submissive victims of oppressive cultural practices. These practices include veiling as practised by some Muslim women, polygamy and female circumcision (Kalev 2004:345). Such practices seem particularly oppressive and unacceptable from Western perspectives when they are juxtaposed with portrayals of the notions of sex and sexuality in Western contexts where there is an increasing presence of sex and sexual connotations in the public sphere and in many areas of consumer culture (McNair 2002:12; Attwood 2009:xiii, both cited in Muller and Llewellyn 2011:315).

It is in view of such a juxtaposition that Mohanty (1991) suggests that some of the writers whose works are used in Western feminist discourse on women in the third world (for example, Fran Hosken 1981; Maria Cutrufelli 1983; Juliette Minces 1980; Beverley Lindsay 1983; Patricia Jeffery 1979, all cited in Mohanty 1991:57) portray third world women as victims of male violence, the colonial process, the Arab familial system, the economic development process and the Islamic Code. She suggests that

such feminist writers “discursively colonize the material and historical heterogeneities of the lives of women in the third world, thereby producing/re-presenting a composite, singular ‘third world woman’ – an image which appears arbitrarily constructed, but nevertheless carries with it the authorizing signature of Western humanist discourse” (Mohanty 1991:53). This ‘average third world woman’ “leads an essentially truncated life based on her feminine gender (read: sexually constrained) and her being ‘third world’ (read: ignorant, poor, uneducated, tradition-bound, domestic, family-oriented, victimized, etc.)”, which is in contrast to the (implicit) self-representation of Western women as educated, modern and having control over their bodies and sexualities, and the freedom to make their own decisions (p.56).

Female circumcision has been perceived and presented by some Western feminists as a violation of women’s rights, and the fact that it persists is attributed to “far-reaching male domination of women within traditional communities” (Kalev 2004:340). Early second-wave feminists who spoke out against the practice and presented it as being rooted in patriarchy include Fran Hosken (1976a, 1976b, 1981), Mary Daly (1978) and Hanny Lightfoot-Klein (1989). These feminists raised international awareness about these practices, but they also presented them as being sadistic tools of “a global patriarchal conspiracy” and symbols of women’s subordination (Boyle 2002:45-46). For instance, Hosken (1981:14, cited in Mohanty 1991:58) grouped excision and infibulation together with rape and sexual assault as forms of violence which were a marker of the “male sexual politics” carried out “with astonishing consensus among men in the world” to assure female dependence and subservience. Similarly, Daly (1978, cited in Leonard 2000b:172-173) portrayed these procedures as being “violent, cruel and oppressive”, catalogued “‘African genital mutilations’ alongside Indian suttee, Chinese foot-binding, European witch burnings, and U.S. gynecology in her list of ‘Sado-Rituals’”, and used such descriptors as ‘mutilated’, ‘barbaric’, ‘unspeakable atrocity’, ‘massacre’, and ‘inflicted’ to speak about them and the context of their practice.

These early second-wave Western feminists did not portray the victims of patriarchy as being only those who underwent female circumcision in the ‘third world’. Indeed, it would appear that from the perspective of Hosken and Daly above, female circumcision is just one of many practices that oppress women that have gone on in various parts of the world at different junctures. What these and some other Western feminists did,

however, and which some feminists of colour and cultural relativists took issue with, was to judge these practices as oppressive and unacceptable from a Western perspective, and to portray women in societies that practise female circumcision as passive victims of “a ‘phallocracy’ in which women are expected (or, in this case, physically forced) to be silent, subservient, virtuous, faithful, and pure” (Daly 1978, cited in Leonard 2000b:173; cf. Mohanty 1991:71). In other words, they failed to understand the importance of these practices in the contexts in which they were practised and the role of women in perpetuating them.

The portrayal of female circumcision as an oppressive practice rooted in patriarchy has not been a preserve of Western feminists. As sociologist Lisa Wade (2012:37) points out, although the ‘cultural inferiority frame’ is primarily made by American and European writers (see, for example, Annas 1996:325, 353; Hayter 1984:326; Hosken 1976a, 1976b, 1981; James 1994; Levin 1980:201; Lowenstein 1978:421; McGarrah 1991:269; Simms 1993:1954; Slack 1988:440, 466; White 2001:132,192, all cited in Wade 2012:37-38) and does deserve critique, there are some African scholars such as Awa Thiam (1983) and Olayinka Koso-Thomas (1987), born in Senegal and Nigeria respectively, who have taken this perspective in their writing.²⁰ Some writers using the cultural inferiority perspective also erroneously imply that these practices only occur in Africa and among all Africans.²¹

Scholarship on female circumcision started turning against “culturally imperialist narratives” so that by the mid-1990s, the postcolonial critique of Western engagement with these practices dominated the literature (Wade 2012:32). Some writers sought to deconstruct these narratives by explaining their bases and assumptions, for example, regarding sexuality and the ‘natural’ body, and the double standards applied when

²⁰ Wade (2012 [2011]) gives a detailed analysis of the different perspectives that various researchers in the social sciences and humanities took between 1976 and 2005 in regard to female circumcision and to other writers’ portrayals of these practices.

²¹ Examples of these include essays, articles and books with such titles as: *African genital mutilation* (Daly 1978); *Female circumcision in Africa: an overview* (Kouba and Muasher 1985); *Genital mutilation of women in Africa* (Hosken 1976a); *Female circumcision and fertility in Africa* (Hosken 1976b); *Prisoners of ritual: an odyssey into female genital mutilation in Africa* (Lightfoot-Klein 1989).

considering bodily alterations.²² Other writers seemed to conflate Western opposition to female circumcision with cultural imperialism or used a few examples from Western academic literature to label the literature as a whole ethnocentric, neo-imperialist, neo-colonialist, universalist, racist, arrogant and salvationist (Wade 2012:34-35).²³

In specific regard to the use of the ‘cultural inferiority frame’, Wade (2012:40-41) shows that by the mid-1980s, many Western scholars – particularly European and American anthropologists – were responding negatively to their peers’ use of this perspective. Some of these scholars, Western and non-Western alike (see, for example, Assaad 1980: 3; Boddy 1991; Gruenbaum 1982; Leonard 1996; Morgan and Steinem 1983 [1980]; Van der Kwaak 1992, all cited in Wade 2012:40), contest ethnocentric reactions towards these practices and argue in favour of a “difference frame for FGCs” (Wade 2012:40). While they do not support these practices, they nevertheless argue that within certain cultural contexts, these procedures are viewed by the people who practise them as meaningful and even loving, and not as oppressive or cruel.

Cultural relativists, feminists of difference and ‘female circumcision’

In supporting the views of feminists of colour or difference, some scholars argue that the practices under consideration should be considered from a cultural relativist angle – that is, understanding each culture within its own context rather than judging it by the values of others (Gruenbaum 2001:26) – and not a universalist one (Kalev 2004:340). Speaking from such a position Wairimu Njambi, a feminist of Kenyan descent living in the United States, uses the context of her own circumcision at the age of sixteen in the Gikuyu community to argue that “much of the ‘anti-FGM discourse’ as currently

²² See, for example, Morsy (1991); Njambi (2004a); Shweder (2002 [2000]); Boddy (1998); Hetherington (1997); Lane and Rubinstein (1996); Lyons (1981); Parker (1995); Bell (2005); Chase (2002 [1998]); Sheldon and Wilkinson (1998); Silverman (2004); Wilson (2002), all cited in Wade (2012:33).

²³ See, for example, Abusharaf (2001a:112); Ajayi-Soyinka (2005:49); Akudinobi (2005:154); Brière (2005: 166-167); Chase (2002 [1998]:126, 145); Hale (2005 [1994]:33); Hetherington (1997:7); Korieh (2005:111-112, 115, 118, 122); Lane and Rubinstein (1996:35); Leonard (2000b:158); Njambi (2004a:286); Nnaemeka (2005a:14, 2005b:14, 2005c [2001]:29, 35); Nwankwo (2005:220, 223, 237); Obiora (2005:183, 186); Parker (1995:513); Shweder (2002 [2000]:235), all cited in Wade (2012:34-35).

formulated, overly homogenizes diverse practices, is locked in a colonial discourse that replicates the ‘civilizing’ presumptions of the past, and presents a universalized image of female bodies that relies upon particularized assumptions of what constitutes ‘naturalness’ and ‘normality’” (2004: 282, 294). Njambi is right to argue that such an ‘anti’FGM discourse’ carries with it legacies of colonial representations of ‘third world’ societies as ‘savage’ and ‘barbaric’, even while claiming to be pursuing their collective well-being (p.283).

Even so, such scholars as Njambi (cited above) and Fuambai Ahmadu (2000), who use the examples of their own circumcision to argue against the representation of these practices by some Western scholars, cannot be said to be representative of all the girls and women who undergo these practices, but whose voices are not prominently represented in the literature and who might experience these practices as oppressive and unnecessary. Davis (2004:305), while reacting to Njambi’s (2004) stance, acknowledges that the ‘moral outrage’ position adopted by some Western feminists depicts the practice of female genital cutting as “an instance of female oppression and barbaric relic of traditional societies”, a position which reduces girls and women who undergo these practices to passive and ignorant victims of ‘culture’, while Western women situate themselves as the enlightened defenders of universal ‘human’ rights. Nevertheless, Davis (2004:306) also urges caution on taking a cultural relativist position which assumes that this practice has relevance and value within a specific culture and that outsiders should be tolerant and wary about making judgement about, let alone interventions in, practices outside their own culture. This position, according to her, “encourages an indifference to the suffering experienced by women and girls who undergo genital cutting and a reluctance to engage with issues outside one’s own cultural domain” (p.305). Similarly, Kalev (2004:247) criticises feminists of colour who argue from a cultural relativist position for often failing to recognise that there are some women who do feel oppressed by the norms of their communities and who do want cultural changes. She suggests that these feminists are in danger of unwittingly supporting the continued oppression of women on the grounds of cultural norms.

Some arguments proposed by cultural relativists oppose the portrayal of female circumcision procedures by Western feminists and activists as inevitably causing harm to girls’ and women’s health. Scholars advancing such arguments seem to call for a consideration of the specific procedure in question before condemning it. For example,

Amede Obiora, a Western-educated lawyer of Nigerian descent, takes this position even while giving credit to feminism for making the world more sensitive to problems of particular concern to women (1997a:48, 52).²⁴ She takes a particularly vehement position regarding what she considers a “nihilistic and ethnocentric radical campaign” against these practices. According to her:

[t]hese campaigns are engineered by activists who indulge in inexcusable exaggeration, denigrate other legitimate points of view, and co-opt or insist on controversial postures... in order to portray [the practice] as indefensible, the bulk of these campaigners resort to decontextualized depictions that fail to illuminate the social dimensions of the practice....The various forms of circumcision and their gradations of harm are conflated as ‘mutilation’: the entire continent of Africa, despite its complex heterogeneity, is reduced to a single research site....Typically, the anecdotes only capture the worst case scenario; they also blur various forms and motives for the practice (Obiora 1997a:52-53).

It is in line with this idea of gradation, which seems to suggest that there are relatively harmless forms of these procedures which should not necessarily be condemned and harmful ones which should be opposed, that the World Health Organisation (WHO et al. 2008:26) seeks to clarify the inclusion of “pricking, piercing, incising and scraping” under ‘Type IV female genital mutilation’. These procedures are carried out as either a traditional form of female circumcision or as a replacement for more severe forms of the practice (WHO et al. 2008:26, citing Budiharsana 2004; Yoder et al. 2001; Njue and Askew 2004). While some scholars (for example, Obiora 1997b; Shweder 2003; Catania and Hussen 2005, cited in WHO et al. 2008:26) argue that these practices should be removed from the World Health Organisation’s typology because they are considered significantly less harmful than other forms of female circumcision, others point out that they should be retained in this typology either to enable documentation of changes from more severe procedures or to ensure that they are not used as a cover up for more extensive procedures (WHO Somalia 2002; Elmusharaf et al. 2006a, both cited in WHO et al. 2008:26).

²⁴ Other scholars who argue that the “negative health consequences and effects on sexuality are overstated or, at least, unproven” (Wade 2012:28) include Ahmadu (2000), Kratz (1994), Lewis (1995) Obermeyer (1999, 2003) and Shell-Duncan (2001). This idea is further explored in Chapter 6 and Chapter 7.

While they do not necessarily argue from a cultural relativist position in relation to female circumcision, other ‘third world’ feminists and scholars of other disciplines criticise the overstatement and distortion of this issue both in scholarship and activism. Although they do not support these practices, they point to other priorities, including the rebuilding of democratic and economic systems in the wake of colonialism, which they consider more important to ‘third world’ women, and which, once fulfilled, would enable the affected people to effectively deal with harmful cultural practices (see, for example, Johnson-Odim 1991:322; Walley 2002:33; Abusharaf 1998:27; Maparyan 2012:26). For example, anthropologist Christine Walley (2002:33) points to the events of the international women’s conference in Copenhagen in 1980 when some African and other ‘third world’ women took issue with the presentation of ‘female genital operations’ by first world feminists in a way that did little to address “troubling power dynamics that exist between first and third worlds as well as between first- and third-world women”. These women along with other women of color, working class women, lesbian and many third-world women challenged mainstream Euro-American feminists because they felt that their experiences and understandings had been excluded by white, middle-class formulations of feminism.

Conceptions of power and the ‘value’ of female circumcision

There are diverse perspectives on the conception and exercise of power and control that come into play when considering female circumcision in researched communities.

These perspectives are not only expressed by ‘outsiders’ such as scholars and researchers, but also by some of the women who have been subject to these practices.

As already indicated, it is a widely held (and contested) view that female circumcision is a quest for control by male-dominated communities of girls’ and women’s sexuality, in societies where this sexuality is seen as a threat to social order and virtue (Cook et al. 2002:284; cf. Prolongeau 2006:153). However, other scholars point to the need to widen the scope of understanding of these practices beyond the single issue of sexuality and consider them as representing prevalent gender ideologies, politics and values regarding femininity and sexuality (Abusharaf 2001:127). Abusharaf, an anthropologist of Sudanese descent, points out that mothers who have their daughters circumcised believe they are doing the right thing as they believe that their children would likely become social outcasts if they do not have the procedure done (1998:23). In this context, the focus of female circumcision is not primarily on the manipulation of a girl’s or

woman's sexual organs but rather on raising the status of the girl or woman as a future wife, or even initiating her into a 'powerful' secret society (Finke 2006:13). As Boddy (1998:95) points out, "[w]omen circumcise their daughters, not because they wish to do them harm, but because they love them and desire the best for them. Thus, tackling the practice in terms of 'child abuse' is a doubtful strategy even in Western countries, for a mother who permits the operation is neither incompetent nor mindlessly following tradition, but making an astute and contextually appropriate judgement about the future welfare of the child". In this regard, the practice is not inhumane or degrading, nor is it done to exploit or damage health and well-being, but is done with due regard to the girl's future well-being in mind – by equipping her with an "appropriately gendered body" (Meyers 2000:486) – so that she is considered eligible for marriage, is accepted in her community and the wider society, and is socially and economically secure (Lockhat 2004:25).

The perpetuation of these practices and the reason women seem to be their custodians, is closely linked to and regulated by the institution of marriage. Marriage on its part is linked to social and economic security. Referring to the context of Sudan, Abusharaf (1998:27) suggests that getting married and having children is a survival strategy, and the socioeconomic dependence of women on men colours their attitude towards these practices. Although in this context the perpetuation of these practices can be said to still serve the interest of patriarchy, these procedures should be understood as a loving act aimed at protecting the propriety, morality and marriageability of girls and young women in a society where there is little economic viability for women outside marriage (Abusharaf 2001:131; Toubia and Izett 1998:2). Consequently, the most impassioned, ardent advocates of the ritual are women seeking to safeguard their daughters' reputations and future livelihood. Underlining this important link between virginity, marriage and security, Gruenbaum (2001:45-46) points out that where female virginity at marriage is considered vitally important, as in Sudan, even rumours that question a girl's morality may be sufficient to harm a family's honour and effectiveness in marriage, and failure to get married honourably would be ruinous in this society where women must derive their social status and economic security from their roles as wives and mothers. In this context then, "clitoridectomy and infibulation serve a clear and compelling purpose: they guarantee virginity, morality, marriageability, and the hope of

old age security, all in one decisive action taken when [a girl] is too young to object” (Gruenbaum 2001:46).

Nevertheless, there is a kind of irony raised in the literature when considering female circumcision and its desired outcome of granting a woman a place in society as a mother and a wife. Some researchers (see, for example, Abusharaf 1998:27; Boddy 1998:86, citing Shandall 1967) suggest that these procedures which are aimed at making a woman socially and sexually acceptable and guaranteeing her a secure marriage might in reality deprive her of this position. The theme of men being dissatisfied when in relationships with circumcised women is prevalent in the literature and, as I show in the chapters ahead, is also implicated in some Burkinabe women’s decisions to have genital reconstructive surgery. A number of other scholars cite studies which they or other researchers have conducted in Sudan, Somalia and Egypt (Abdel Magied and Musa 2004:18-19, 26-27; Lightfoot-Klein 1989:95-96; Boddy 1998b:87; Dirie and Lindmark 1992, Kere and Tapsoba 1994, and Karim 1994, cited in Toubia and Izett 1998:36), Burkina Faso (Toubia 1995, cited in Toubia and Izett 1998:35-36) and Kenya (Christoffersen-Deb 2005:411-412) which point to various difficulties, dissatisfaction and even injury to body and valour that men claim to experience when having sex with women who have undergone various forms of female circumcision, and these men’s preference of women who have not undergone these procedures. It is in this context that Christoffersen-Deb (2005:411-412), for example, points out that among the Gusii of Kenya, “the optimal choice appear[s] to be marrying a circumcised woman while engaging in sexual relations with uncircumcised women ... or taking a second wife who [is] uncircumcised” (p.412). As a result, young women are caught in a moral dilemma; on the one hand, they are expected to be sexually passive while on the other, their passivity is implicated in their husband’s acquisition of second wives or extramarital girlfriends (ibid.).

However, even within this realm of seemingly compromised sexuality, one needs to be cautious about assuming that these women are helpless victims of patriarchy. Speaking in specific regard to the women of the Douroshab community in Sudan, Abusharaf (2001:121-122) suggests that these women have the upper hand in determining when, how and where girls undergo the procedures in question, making these practices an important affirmation of the authority of one generation of women over another. Further, she points out that within the complex symbolic and social context of

circumcision practices, these women see their participation as voluntary. Moreover, some of these women in Douroshab believe that infibulation endows them with a remarkable ability to exert self-control and power, to take charge of their 'natural' desires and to display restraint over their sexuality (Abusharaf 2001:129-131).²⁵ Self-mastery, a disposition seen as a virtue, enables them to "drive hard bargains and have a say in household politics and decision-making processes" in the face of scarce resources, hardship and constrained socioeconomic circumstances (ibid.). Hadi (2006:122) explores a similar line of thought among some of her respondents in Deir El Barsha in Egypt but points to it as a pattern of women attempting to "convert a form of bodily harm and emotional violence into a form of empowerment". Moruzzi (2005:13) widens the scope by pointing out that among the Gikuyu of Kenya, the cultural emphasis on physical self-discipline inculcated during initiation rituals and ceremonies continued through adulthood. It definitely included sexual self-discipline, a quality that was useful for birth-control, and in creating a balance between the number of mouths to feed, the number of hands to work the land and the productive capability of the land. For Moruzzi, this was a culture that emphasised necessary sexual control, but this control was not necessarily tantamount to repression (ibid.). In other words, while some researchers point to the control of women's sexuality as repression, it is conceivable that the indigenous people in question did not necessarily perceive these practices as being repressive to women.

Another way to look at this would be that in societies that practise (or practised) female circumcision, people are conditioned not only to accept the practice within the indigenous social definitions of womanhood and identity, which leads them to perpetuate the practice, but that the roots of the practice also run deeply into the individual's psychology, sense of loyalty to family and value system. This perspective, presented by Toubia and Izett (1998:2, 33) who write from an activist position, also proposes that in this context, pain and trauma, concepts of morally appropriate fertility and repudiation of sexuality become central in defining the appropriate feminine disposition and prescribed gender identity. Furthermore, they suggest that women's sexuality is affected just as much by the processes of social conditioning that

²⁵ The contentious issue of the impact of female circumcision on sexual pleasure will be explored in more detail in Chapters 4-9.

accompany genital mutilation as the trauma and physical damage that results from it, and, as such, the state of their mutilation becomes such a part of women's bodily image that any alteration to that state threatens their sense of security. The implied assumption here seems to be that women in communities that practise female circumcision have been conditioned to accept the repudiation of their sexuality, as well as pain and mutilation, and would be negatively affected by the withdrawal of these elements. This would be very similar to the often-criticised portrayal of these women by Lightfoot-Klein in the title of her ethnography *Prisoners of Ritual* (1989), which condescendingly casts these women as victims who need saving.

One therefore needs to consider that the necessity of "buying maturity with pain" (Davison 1996, cited in Moruzzi 2005:212) or the "unmaking and remaking" of girls through a painful experience (Christoffersen-Deb 2005:410) is not blindly embraced as a by-product of female circumcision, together with "some bleeding" and "some limited risks of infection and other health problems" (Sulkin 2009:17) as this perspective seems to suggest. As Christoffersen-Deb (2001:410) points out, among the Gusii of Kenya, for instance, it was tied to the testing of the values of courage, strength and self-sacrifice seen as necessary for women who would face the hardships of working on the land, bearing children, coping with periods of famine and drought and living away from their husbands. In this view, womanhood was "not so much constituted by an assertion of sexuality as an ability to withstand the hardships of life" (ibid.). In the same way, Moruzzi (2005:212, citing Davison 1996:42,56,117) points out that among the Gikuyu of Kenya, learning to cope with pain – during initiation, labour, childbirth or illness – was part of the process of maturing in this traditional life which "required enormous physical endurance" (ibid.). Similarly, for the Rendille, enduring pain "is a constitutive experience in preparing a woman for her role as wife and mother, her central role in Rendille society" (Shell-Duncan et al. 2000:117). In these contexts, female circumcision seems to be a considered response to the demands of the practical aspects of these girls' and women's life rather than a blind conditioning to trauma and physical damage to their bodies.

The perception of female circumcision as a conscious and deliberate response to social, economic and environmental circumstances is observed in societies where female circumcision has been adopted in the late twentieth century. These procedures have been recently adopted in some societies in Sudan (Lightfoot-Klein 1989; Gruenbaum

2001; El Bashir 2006) and Chad (Leonard 2000a), where they are attributed to local understandings of the concepts of modernity and progress. In these cases, some people in communities that have not previously practised female circumcision have taken up these practices seemingly to attain social acceptance by practising groups and/or gain access to better economic opportunities. For instance, El Dareer (1982, cited in Gruenbaum 2001:105-106) and Lightfoot-Klein (1989:48) point to the spread of female circumcision in the 1970s and 1980s from northern and central parts of Sudan into some groups in southern and western Sudan where it was not previously practised by the indigenous population. Lightfoot-Klein (1989:48) points to the adoption of these “modern and hygienic” practices by a “less socially and economically advantaged indigenous population in order to make their daughters more marriageable”. In the same way, El-Bashir (2006:161-164) explores the adoption of these procedures by migrant groups from West Africa (mostly Hausa and Fulani), now living in Mayerno in Sudan, whose history of migration into Sudan dates back to the late nineteenth century but who only started practising infibulation during the last thirty years or so. Based on these trends, Gruenbaum (2001:107) suggests that “female circumcision is not merely a residual traditional practice, but is in certain situations an important marker of privileged ethnic group status, used ideologically to exclude aspiring lower status groups, who are in turn tempted to adopt it as part of the cultural assimilation necessary to upward mobility”.

This development whereby the prevalence of female circumcision is rising steadily among younger women (El Bashir 2006:162), has also been observed by Leonard (2000a:176-181) among the Sara ethnic groups in south-central Chad who did not previously practise these procedures. Speaking in specific reference to Myabe village inhabited by the Sara Kaba ethnic subgroup, Leonard points out that the adoption of clitoridectomy is quite recent, dating around 1980. According to her:

[w]ith very few exceptions, mothers, grandmothers, parents, and religious and spiritual leaders in the village are not advocates of female ‘circumcision’ and do not organize or carry out the ‘circumcision’ ceremonies. In fact, most of them express strong opposition to female genital operations, and some have actively sought to block infiltration of the practice. The impetus for the adoption of this innovation comes instead from adolescent girls.... The narratives of these girls as well as those of other village residents suggest that female ‘circumcision’ in Myabe is anything but a ‘traditional’ practice forced upon passive young victims as a result of patriarchy, century-old custom, or religious doctrine. Instead, genital cutting

is more like a fashion statement; it is a thoroughly 'modern' thing to do (2000a:181).

This association of female circumcision with modernity is also highlighted by Lightfoot-Klein (1989:98) who points out that the phenomenon of reinfibulation (the re-suturing of women's genitals to pin-hole size after each birth) "was unknown in Sudan only 50 years ago... [but] is now practised by a majority of women, and even more curiously, it is a phenomenon that begins with educated urban dwellers, and spreads to the uneducated in the villages". She suggests that the intent of this practice is cosmetic and is aimed at making the women "like virgins once more" since it is thought that making the vaginal opening small after each birth increases the husbands' pleasure and keeps them from being tempted to marry other wives (pp. 99-100). El Bashir (2006:165) echoes this idea indicating that reinfibulation is usually associated with valuable gifts of cloth, gold and money from husbands. According to him, "[t]he wife who is repeatedly recircumcised after childbirth in order to keep herself tight hopes that the practice provides a sense of security against her husband's taking another wife, which she fears would result in her being neglected or abandoned". In these contexts, it would seem women are consciously adopting female circumcision for social and economic gain even as these practices are being abandoned in other places.

It is important to emphasise the fluid position female circumcision in the various places that have been discussed here (and those that will be cited in the chapters ahead). In some places these practices are portrayed as being in the past, in other places, it is stated or implied that they are currently being practised and have been practised for a long time albeit with various alterations to their forms, while in other places still, they are just getting embraced. Even within the same ethnic group and/or region it is not possible to portray female circumcision as being firmly in the past or the present. This is in line with the fact that the cultural contexts in which these practices take (or took) place have been and continue to be irreversibly altered. Moruzzi (2005:217), for instance, points out that the traditional Gikuyu culture and community have been eroded by a combination of wage employment, Christian conversion, education and cash crop agriculture, and the local cultural context of subsistence agriculture, age-mate groupings and bodily self-discipline have changed so that the initiation rituals that included female circumcision no longer seem relevant. In view of this, although older women mourn the lost cultural context in which the practice was located, they express little interest in

continuing a practice that, without that context, is no longer meaningful (p.218). In the same way, Christoffersen-Deb (2005:410) points out that the present-day medicalised practice taking place on girls as young as six years of age among the Gusii, and which is devoid of any celebratory aspect, is described by many as a useless practice. According to her, grandparents in particular are apt to point out that the perceived painlessness of the procedure today conflicts with past meanings associated with the practice.

In these two communities, elderly members of the society – particularly women – are at the forefront in recognising that these practices are now obsolete and need to be stopped. However, their reasons – that having lost their cultural context, these practices have also lost their intended meaning – may be different from those espoused by younger people who are abandoning these practices, and they are most definitely different from those of governmental and non-governmental agencies working to stop these practices. Activism against female circumcision is centred on negative health consequences associated with the procedures, and children and women’s rights.²⁶

Perhaps, it is here, in the recognition by some people in indigenous communities that these cultural practices have lost their intended meanings and purposes as they no longer exist within the cultural contexts for which they were conceived, that the ‘battle against female genital mutilation’ will be won. Perhaps it will also be won as people address what Gruenbaum (2001:21) calls the “lengthy agenda of life struggles” facing the people of the societies in question, and not in what Boddy (1998:95) deems “Western assumptions of the person as a self-contained locus of rights and obligations,

²⁶ The various approaches and impact of these efforts are too detailed to explore here. Suffice to say that there is evidence in the literature to show that in such diverse places as Senegal, Uganda, Egypt, Sudan, Djibouti, Mali, Kenya and many others, there has been, since the 1950s, movement towards the abandonment of female circumcision or a shift towards less extreme forms of the practice. Some of the literature detailing eradication efforts and their impact includes: Abusharaf (1998:26, 2001:118-119, 135-136, 2006:10); CRLP (2002:69-80, cited in Abusharaf 2006:10); Boddy (1998b:96); Boyle (2002:101, 110); El Bashir (2006:142); El Guindi (2006:39-46); Gruenbaum (2001:21, 176-197, 208); Hadi (2006:104-105, 115, 119-122); Johnsdotter and Essén (2010:32); Kouba and Muasher (1985:108); Leye (2005:80); Leye and Deblonde (2004, cited in Shell-Duncan and Hernlund 2007:41); Lockhat (2004:49-80); Mohamud et al. (2006:75-103); Shell-Duncan and Hernlund (2007:40); Rahman and Toubia (2000:9-13); Toubia and Izett (1998:56-57); Prolongeau (2006:80-81, 94-97, 130); WHO et al (2008:22). I discuss these concepts as they relate to the Burkina Faso case in more detail in Chapters 5 and 6.

possessed of a social identity increasingly vested in the appetites and private... pleasures of a singular body, [which] clash with African and Middle Eastern notions of self in which the person is unthinkable except in relational terms”.

Genital cosmetic surgery, female genital mutilation and the construction of femininity

While some cultural practices in some ‘third world’ countries are considered female genital mutilation by some Western and non-Western scholars, governments and health- and human rights-oriented organisations, there are analogous practices carried out in Western countries which do not often attract this negative label. In an article that was part of a WHO multi-country research project on gender, sexuality and vaginal practices and which drew from ethnographic data gathered in 2005 in Tete Province, Mozambique, southern African anthropologists Brigitte Bagnol and Esmeralda Mariano point to the ethnocentrism of discourses that stigmatise practices of African and Asian ‘Others’ while staying silent on analogous or more invasive practices in the West (2008:42, 49). Procedures going on in some Western countries where women are having their genitals altered through surgery, and their resemblance to those termed ‘female genital mutilation’, have been discussed by various scholars (see, for example, Johnsdotter and Essén 2010; Braun 2005, 2009; Shell-Duncan and Hernlund 2000; Boddy 1998b; Green 2005; Renganathan et al. 2009; Lih and Creighton 2007). According to Braun (2009:233-234), procedures performed on genitalia that are anatomically ‘normal’ include:

those designed to reduce and make symmetrical the labia minora (known variously as labiaplasty, labioplasty, and nymphectomy); those designed to ‘augment’ the labia majora through fat grafting, removal of loose skin or liposuction (vulvar lipoplasty), which is also applied to the mons pubis (pubic mound); those designed to tighten the vagina (so called ‘vaginal rejuvenation’ or vaginoplasty) through muscle realignment or fat grafting; perineum ‘rejuvenation’ (perineoplasty); hymen ‘reconstruction’ (hymenoplasty); clitoral ‘unhooding’ (hoodectomy); and the so called G-shot, a collagen injection into the anterior wall of the vagina which increases the size of that patch of tissue (the ‘G-spot’).

Other cosmetic procedures which are widely accepted in Western countries, and whose motivations and effects can be considered alongside those of practices which alter genitals, include face lifts, rhinoplasty and breast augmentation (Johnsdotter and Essén (2010:32). Lockhat (2004:26) rightly suggests considering that cosmetic surgical operations such as breast enlargement or reduction, face-lifts and operations to remove

ribs in order to achieve a slimmer form might be regarded by some people – particularly those in non-white cultures – as immoral, barbaric and potentially damaging physically or psychologically. Indeed, Smith (2008:55) presents a study she carried out about procedures of ‘female genital cutting’ in Senegal and breast implantation in the United States to show the ways in which patriarchal social forces embed themselves in the physical existences of women, and to determine whether people in these societies are able to recognise the mechanisms of social control that regulate women’s bodies. According to her, it is clear that although women have diverse experiences with their bodies, they all go to lengths – albeit different lengths – to conform to ‘normalised sex roles’ and beauty norms. Significantly, in what Smith (2008:61) terms “non-verbal and re-colonizing responses”, when asked what they thought of breast augmentation surgery as practised in Northern America, some of Smith’s Senegalese respondents exposed their breasts in a deliberate and unsolicited attempt to show what a ‘true’ breast, representing a ‘true’ woman, is. They expressed disbelief that “people would travel across the globe to fight female genital cutting while the unnatural and ungodly practice of breast implantation exists in their own communities”, and indicated that if they had adequate resources, they would consider going to the United States to sensitise American women about the dangers of breast implants (ibid.).

Similarly, Boddy (1998:105-106) presents parallels between practices which bring the female body into accord with an elusive ideal of womanhood in Hofriyat in Sudan and the normalising practices of Western femininity, which, according to her, both work to instil in women a desire to conform, to become what they ‘ought’ to be. Seeking to expose as equally subordinating and productive these practices in the West, she points out:

Western body techniques at their most extreme have included surgeries and other physical interventions: in Victorian times, clitoridectomy to reduce ‘excessive female sexual appetite’ and removal of the bottom ribs – revived in 1990s Argentina and Hollywood – to ensure a tiny waist, plus corsets that displace the internal organs causing violent indigestion, uterine prolapse, perpetual weakness, immobility, and shortness of breath; in the contemporary West, cosmetic surgeries of all types – liposuction, lip enlargement, breast reductions and implants, tummy tucks, face lifts – in which the risks of disfigurement, discomfort, infection, and impairment of social and physical functioning are clear (Bordo 1993; Ehrenreich and English 1979; Morgan 1991, all cited in Boddy 1998b:105-106).

Another contentious form of ‘female genital mutilation’ in the West involves surgery

performed on intersex individuals. Intersexuality is a “fairly common phenomenon” (Fausto-Sterling 2000:31) and was culturally accepted in many societies in the past. However, in the present day, it disappears from view soon after the birth of intersex individual because doctors ‘correct’ intersex genitalia right away (ibid.). Feminist theorist and philosopher, Diana Tietjens Meyers (2000:472, citing Diamond and Kipnis 1998, and Fausto-Sterling 2000) points out that parents of children with ‘ambiguous genitalia’ generally presume that left ‘untreated’, an elongated clitoris will have deleterious effects on a girl’s psychological development and will prove socially disabling; without ‘corrective’ surgery to remove the masculine aspects, it is thought that a genetic female endowed with ‘ambiguous’ genitalia will be unable to attain a feminine identity.²⁷

Surgical ‘correction’ of intersexuality often arises from a genuine and compassionate desire to help intersex children to fit into their environment and function physically and psychologically as healthy individuals. Even so, this desire is motivated by three flawed assumptions: there should be only two sexes, heterosexuality is normal and particular gender roles define the psychologically healthy man or woman (Fausto-Sterling 2000:44). As Laqueur (1992:6) points out, the “dominant, though by no means universal, view since the eighteenth century has been that there are two stable, incommensurable, opposite sexes and that the political, economic, and cultural lives of men and women, their gender roles, are somehow based on these ‘facts’”. Similarly, American anthropologist and bioethicist Katrina Karkazis (2008:180) rightly explains that even though public awareness of intersexuality is relatively new, “the fears it invokes about gender difference and deviance from the norm are old and embedded in our culture and social structures”.

Increasingly, there are divergent views about the management of intersexuality. Some common discussions include those about bodies, gender and genitals, their implication in the creation of men and women and the assignment and understanding of the categories male and female (Karkazis 2008:14). Consequently, more and more people are approaching intersexuality not only as a medical matter, but also as a complex

²⁷ It is notable that removing masculine traits and enhancing feminine ones is one of the reasons underlying female circumcision as explained in Chapter 5.

sociocultural issue implicating individual wellbeing and social stability (Karkazis 2008:180). Among the more prominent voices in discussions about intersexuality are those of adult intersex people who criticise the current handling of intersexuality and propose new ways of considering the phenomenon. For example, Cheryl Chase, the founder and director of the Intersex Society of North America (2002:163), refers to ‘corrective’ surgeries done on intersex individuals as “American medicalized female genital mutilation” which is “yet to attract significant support or even notice from feminists and journalists who express outrage over African genital cutting” (2002:128). This is because many first world activists seemingly consider Africans to have “harmful cultural or traditional practices” whereas they themselves have science which is linked to enlightenment, progress and truth and used to “normalize the deviant”. As such, according to Chase, genital cutting performed on intersex people is condoned to the extent that it supports these cultural self-conceptions (2002:142-143)

This critical view of ‘corrective’ or ‘normalising’ surgery which likens it to ‘female genital mutilation’ is also observed in the writings of some gender and sexuality scholars. For example, American researcher Anne Fausto-Sterling (2000:79-80) asserts that this surgery has cosmetic intentions as it is “performed to achieve a social result reshaping a sexually ambiguous body so that it conforms to our two-sex system”. She points out that this social imperative is “so strong that doctors have come to accept it as a medical imperative, despite strong evidence that early genital surgery doesn’t work; it causes extensive scarring, requires multiple surgeries, and often obliterates the possibility of orgasm” (2000:80).²⁸

Even so, it is worth noting that a lot of the parents who put their children through the surgery do not set out to ‘mutilate’ them and indeed condone the surgery while troubled by conflicting views. As Karkazis (2008:215) points out, the pervading influence of the binary model of sex, which is often communicated in well-intentioned opinions of medical personnel, friends and relatives, may strengthen parents’ own convictions (or weaken their reluctance) and compel many of them to opt for surgery to “help their children fit into a culture that expects that everyone be unambiguously male or female”. Furthermore, because of the well-established protocol on rapid gender assignment and

²⁸ I briefly revisit this issue of the impact of the surgery in Chapter 8.

early surgical interventions, such parents are forced to make those decisions quickly (Karkazis 2008:180). Many of them are also keen to act speedily so as to protect their children from being perceived as abnormal. However, since there are scarce long-term studies regarding treatment outcomes for this kind of surgery, parents have to undertake complex moral and often irreversible decisions about what is best for their children amidst their own views of what is (or should be) male or female and amidst pressure from clinicians who want to proceed with the surgery(Karkazis 2008:180) .

The question of agency

In general terms and in various contexts, shaping and sometimes forcing sex to conform to its culturally appointed gender appears to be more marked in females than males even though, of course, men do also undergo procedures to shape their sexuality. For instance, exploring the practice of cosmetic surgery in Brazil, Edmonds (2010:183) points out that not only are the majority of patients female, but that the surgery is also intertwined with major milestones in the female life course including puberty, pregnancy, breastfeeding and menopause. In addition, the surgery can mark rites of passage including initiation into adulthood, marriage and divorce. Laqueur (1992:22) points to the perception of the female body as problematic and unstable which “is either a version of or wholly different from a generally unproblematic, stable male body”. As such, women’s sexuality is seen as an empty category which is always being constituted. This might create the view that woman alone has gender since “the category itself is defined as that aspect of social relations based on difference between sexes in which the standard has always been man” (ibid).

This observation highlights the relevance of discussions in the literature about the notion of choice among women who undergo body-altering practices. There are suggestions that in cases of procedures done in Western contexts, it is normally individuals who have attained the age of consent who willingly make the decision to undergo them, whereas in most cases of female circumcision the affected girls are too young to make autonomous decisions about it (Lockhat 2004:26; Johnsdotter and Essén 2010:32).²⁹ Addressing the reality of individual autonomy or choice, Boddy suggests

²⁹ The veracity of this idea is contested by such scholars as Njambi (2004:283) who argues that the “decision to avoid as well as to opt for female circumcision is ... within the realm of cultural possibility”.

that similar to the context of infibulation in northern Sudan where the material constraints on women's lives give them no realistic option other than to play by the cultural rules, the question of choice regarding cosmetic surgery in Western contexts is illusory (1998:96, 106). She points out that if women in Western countries "fail to meet minimum but ever-shifting standards of feminine 'normality' – in slenderness, skin color, facial features, even age – [their] social and economic chances including marriageability, may be sharply curtailed" (Boddy 1998b:106, citing Morgan 1991). Furthermore, just like Sudanese girls, these Western women are schooled to accept prevalent images of femininity from an early age. In spite of relying on this 'myth of choice' which stems in part from the Western ideology of autonomous individualism, all these women can do is pick from an array of treatments all of which are directed towards normalisation (Boddy 1998b:106; cf. Smith 2008:55).

The rhetoric of choice, individual agency and consent which is employed in regard to practices termed cosmetic surgery serves to portray Western women's choices as empowered and individual acts performed by women who have the agency to choose how to act based on their desire (Braun 2009: 243, 249; see also Braun 2005). However, Braun, whose research is located within feminist and critical psychology (2009:233, 243-244), argues that clusters of cultural logics lead to particular desires, options and choices, as well as rationales and justifications for actions. She therefore suggests that instead of being framed in terms of individual choice and agency, women's 'choice' around female genital cosmetic surgery could be understood as a logical conclusion to female subjecthood in the West at this particular time. Hence one needs to look beyond the individual as the analytic frame when considering agency. It is in light of this that Johnsdotter and Essén (2010:32) suggest that women who are choosing to 'fix' their bodies in various ways may be seen as victims of patriarchy, the beauty industry, the pressuring ideals of today or their own inner insecurities.

The question that arises then – and which is raised by a number of scholars (Bagnol and Mariano 2008; Johnsdotter and Essén 2010; Smith 2008; Braun 2005, 2009) – is why cultural practices being carried out in some 'third world' countries are termed 'mutilation' and 'oppressive' and consequently outlawed, while analogous practices in the West are not. Braun (2009:233) suggests that the use of the 'choice rhetoric' in relation to Western women's bodies and genital cutting practices is "necessary to discursively (and politically, and practically)" separate female genital cosmetic surgery

from ‘female genital mutilation’. I agree with Braun and would further argue that it is this distancing which facilitates the discriminatory nature of laws against ‘female genital mutilation’ in many Western countries. These laws are applied to people from immigrant communities while turning a blind eye to procedures being carried out on Western women even though they are also illegal under these laws.³⁰ Johnsdotter and Essén (2010:33-34) rightly point out that

[i]f child protection is the major concern in the legal and medical fields, then legislation banning female genital cutting needs to state that all adult women – irrespective of ethnic background or colour of skin – have a right to make decisions about their own bodies. The only alternative is to state that genitals are inherently different from noses and breasts, and to forbid all modifications to the female genitals –again, irrespective of ethnic background and skin colour.

Indeed, it is interesting to note that according to the World Health Organisation (WHO et al. 2008:28), “[s]ome practices, such as genital cosmetic surgery and hymen repair, which are legally accepted in many countries and not generally considered to constitute female genital mutilation, actually fall under the definition used here”. This conclusion reached by the World Health Organisation and its partner agencies is important because it resonates with the suggestions made by the scholars cited above that the reason some Western feminists come across as patronising and one-sided when dealing with the issue of female circumcision is because they fail to acknowledge and address numerous practices going on in their own countries which can also be classified as mutilation. Perhaps if more researchers and scholars were seen to reach and acknowledge this conclusion, it would take the debate beyond the shortcomings of the ethnocentric perspective of some Western feminists (and the discriminatory application of the law in some Western countries) into a discussion about what, if anything, should be done about ‘oppressive’ cultural practices going on not just in ‘third world’ countries, but in Western ones as well.

³⁰ For laws and provisions in the penal codes of some Western countries – Austria, Australia, Belgium, Canada, Denmark, Finland, Germany, Greece, France, Ireland, Italy, Luxemburg, the Netherlands, Norway, New Zealand, Portugal, Sweden, Switzerland, Spain, the United Kingdom and the United States of America – relating to ‘female genital mutilation’, please refer to Toubia and Izett (1998:56-57); Johnsdotter and Essén (2010: 32); Lockhat (2004:44-48); Gruenbaum (2001:208); Leye (2005:80, 82); Hernlund and Shell-Duncan (2007:40); Boyle (2002:101, 110); Prolongeau (2006:132); Leye and Deblonde (2004).

Of course, as already shown, many scholars have already recognised the existence of these practices in Western and non-Western contexts, the various applications of the notions of choice and individual agency, and the problems that these notions pose in relation to practices that are considered oppressive or harmful. Significantly, for example, Muller and Llewellyn (2011:315) raise the question of whether women's 'voluntary' involvement in potentially oppressive structures and practices renders them complicit in their own and other women's objectification or it provides a legitimate space of subversion, liberation and personal fulfilment. While one envisions the conception of this question with a Western context in mind, it would also be important to explore the suggestion put forward by Njambi (2004), Obiora (1997a, 1997b), Nnamuchi (2012) and Yaa Asantewaa Reed (2001:175, cited in Chilisa and Ntseane 2010:618) that it is entirely possible, even preferable, to conceptualise questions of choice and agency from non-Western perspectives and to seek home-grown solutions to local 'problems'. In looking at the Burkina Faso context, in the chapters ahead I consider how some Burkinabe women consider the reconstruction of their bodies as happening within this 'space of subversion, liberation and fulfillment', and how they craft roles for themselves or modify existing ones in the creation of this space.

The themes explored above provide a theoretical background to the issues I discuss in the chapters ahead. While a few of the scholars cited here seem to present the practices in question as being oppressive traditions which have been kept in place by patriarchy and ignorance, many others present more insightful considerations which shed a lot of light on these procedures as practised in various societies and what they mean to the people who do them. I will draw on more literature relating to these themes in some of the following chapters, particularly in Chapter 5, to indicate how some of the views people have about female circumcision influence the manner in which they perceive genital reconstructive surgery. In Chapters 7 and 8, I get into some of the scarce literature available on genital reconstructive surgery after circumcision, and relate it to my findings.

CHAPTER 4

THE WOMEN REMAKING THEMSELVES

Introduction

In this chapter I present the stories of five circumcised women living in the cities of Ouagadougou and Bobo-Dioulasso. Two of them have had reconstructive surgery and two others are awaiting the operation upon the completion of the Raëlian hospital in Bobo-Dioulasso. The five narratives are drawn from my conversations with the women based on questions contained in the semi-structured interview schedules I used during fieldwork (see Appendix IV A and B). These questions focused on the women's direct experiences with female circumcision and reconstructive surgery. I have taken their answers, translated them from French into English and used them to construct these stories.

I have strived to keep the narratives as close as possible to their original form. However, I have removed details which would compromise the anonymity of the research participants. In some places, I have reorganised sections of speech to ensure coherence and deleted hesitation markers, filler words and repetitions (except where these repetitions are markers of emphasis). Where I judge them significant, I have included brief notations of actions to indicate the demeanour of the speaker.³¹

I have chosen this format to address the challenge of talking about women who have undergone procedures which they refer to as 'female genital mutilation' or 'circumcision' and 'restoration'. My aim is to present this material in such a way that these women are able to tell their stories the way they know them and want them to be understood. In including details of the contexts in which these procedures happened, I hope to focus attention on these women not as disembodied statistics but as whole human beings, whose lives consist of different facets – physical, social, psychological,

³¹ In quoting my research participants in this and the subsequent chapters, I have used the following styles and punctuation marks as follows: italics = emphasis; three suspension points = the speaker trailed off and then started speaking again; three suspension points in square brackets = I have omitted a section of speech; words in square brackets = I have added a word or phrase to ensure coherence; words in braces = a notation of the speaker's demeanour or action.

spiritual, economic – and not just as sexual or reproductive entities solely defined by what has happened to parts of their bodies. As Simpson (2011: 377, 383-384) rightly points out, bodies come with persons attached just as persons come with bodies attached. Although the focus of this chapter limits the extent to which I can dwell on these other aspects of the research participants' lives, I have tried to offer a glimpse, albeit a narrow one, into their implication in these women's experience of female circumcision and their choice and/or ability to have reconstructive surgery.

* * *

Leila Abdi, 60s, Ouagadougou

I first contacted Leila Abdi in December 2012 (the month prior to leaving New Zealand for Burkina Faso) and she indicated that she would be willing to talk to me. I stayed in touch with her and once I got to Burkina Faso and obtained my research permit, I was able to set up an interview with her. Her collaboration and assistance endured throughout the fieldwork period.

Leila was a plump and elegantly dressed Muslim woman who was business-like but friendly in her manner. She appeared extremely knowledgeable on local and global discussions on female circumcision and reconstructive surgery probably because she had previously worked as a senior government official implementing programmes against female circumcision. At the time of our interview she was still actively involved in similar activities at national and international levels.

For this interview, I went to Leila's house which was located in an affluent part of Ouagadougou. She received me well, and I saw that she had been working on a laptop computer in the carpeted veranda of her very big house in a walled-off and gated compound. That cool and sheltered space provided a welcome respite from the rest of noisy and dusty Ouagadougou on that hot Thursday morning. There was a young boy, perhaps two years old, asleep beside Leila. There were also sights and sounds of activity around us as people moved in and out of the house, occasionally calling out to each other. Leila spoke animatedly and assertively as she told me her story.

* * *

My name is Madame Leila Abdi. I'm the president of a non-governmental organisation involved in the promotion and protection of women's rights. We have integrated in

that vast domain the issue of violence against women under which we focus on female genital mutilation. I became involved in this struggle through my personal experience. I was circumcised at the age of seven. There were three of us: my elder sister who was perhaps 12 or 15 years old and a cousin of mine who was the same age as me.

It happened very early in the morning, at around 3am. My elder sister [was circumcised] first and when she was leaving she called me and told me that it was very painful. I tried to run away [but] arrangements had been made because our mothers had imagined that we might flee. We lived above... it wasn't a storey house but it was one of those houses built during the colonial era. The foundations were very high so there were a lot of stairs to climb. They had brought two young men to sleep at the foot of the stairs to catch us if we tried to escape.

It was very painful [but] it was forbidden to cry. Crying meant that you were not brave and that you were going to dishonour your family, so we had to internalise all the pain. So when I went I didn't cry but I talked a lot, and for a while people laughed at me. Keita is my maiden name, so I was telling those women who were holding me down, I said, "I'll not cry, I'm a Keita. Am I not a Keita?" and they answered, "Yes, you're a Keita!" {laughs}. I said that so as not to cry.

But when I asked my mother, "Why was this done to us?" she wasn't able to give me an explanation because she didn't have one. She told me, "That's how it is. It's the tradition, we must respect it. We were also cut, so that's just how it is. We must perpetuate this tradition." I thought, "How can a tradition have no explanation?" And when I asked my father, it was the same thing. I said, "But why hurt someone?" [My cousin] had even had problems because our circumciser couldn't see very well. So I thought, "Why expose the lives of children to such risk?" I was appalled by my parents' silence, by the lack of explanation from my mother regarding that act. So during my adolescence I tried to educate my mother so she doesn't do it to my younger sisters. But as you know, in Africa women don't have a voice, let alone little girls.

It hurt me a lot. It's a painful operation. I said, "But how can there be no response in relation to such a painful operation which can create problems for people, where someone can even die?" At the time I was aware of the dangers because I...when you're a baby and you get circumcised you feel pain but you don't remember. With me, I remember my operation up to now as though it was yesterday. That's why I'm

telling it to you in such clear detail. Because it remained in ... I was traumatised. I was very scared and whenever I see a needle, a blade, I start to shake. I had psychological consequences which were not detected. I wasn't able to see a psychologist. Had I been able to see a psychologist {laughs} perhaps I'd have been able to control the effects of that pain.

So it's because of that. It was through my personal experience that I became involved in the fight [against female genital mutilation]. It was not easy, eh. [But] I had to have the courage to oppose my parents, to stand up to them.

When I had my first daughter I was a student. My parents offered... it was in 1973 and I was in France. When I came on holiday with my daughter my parents told me, "If you leave for school again with your daughter it will be complicated. You should leave your child here. That way you'll study well." I thought about what had...they didn't have any ulterior motives. It was a service they were offering, she was their granddaughter.

So I asked my father to organise a family meeting, because I wanted to talk to them. He called all the people who were concerned. I thanked them and then went straight to my objective. I said that I'd leave my child behind, but that if someone ever has her circumcised... all the people who will be involved in the operation, the ones who will go to fetch [the circumciser], even the one who will allow it to happen in his house, that I'll have them all dealt with. I even pronounced a curse! I said, "May the child die immediately in the course of the operation." I said that to frighten them. My father said, "But is that why you brought us together, to tell us such things?" He said if I wanted, my child could stay with her clitoris, that it didn't bother him. That's how my daughter stayed.

Unfortunately, some of her cousins, the daughters of my elder sisters, got circumcised. They used to make fun of my daughter when she was little. She was about six years old so the others would make fun of her because she was in an environment where girls her age were circumcised. One day she told me, "Mum, I also want to be circumcised like the others." I told her, "No, one day you'll thank me when you're older, that your mother saved your life." And when she had her first baby at Yalgado Hospital, the midwives, the whole team which was there...when the other women who had been circumcised were suffering and screaming, with her, the child came out just

like that, like a fish in water, and people applauded. It was a moment of great pride for me.

* * *

Amina, 41, Ouagadougou

I had read about Amina and her experience with reconstructive surgery prior to leaving for fieldwork but had been unable to obtain her contact details.³² Once I got to Ouagadougou, I telephoned Samira (whose story I tell below) who was in Bobo-Dioulasso to organise our meeting later the following month. After that discussion, Samira sent me the contact details of three women living in Ouagadougou – among them Amina and Antoinette (see next account) – and implied that they too might be willing to talk to me. When I called Amina to ask whether I could go see her, she was noncommittal. I feared that she was weary of talking to strangers about her private life. However, she called me a few days later and asked me to go to her house during an upcoming public holiday.³³

Amina was a tall, sturdy woman who appeared to be pregnant. She wore a black weave on her head and maroon polish on her nails. She was affable, thoughtful and soft-spoken. During the interview, she spoke clearly, confidently and with great candour. Although she had done a number of interviews with national and regional media, she did not seem to present a rehearsed story or to have got tired of explaining herself, and I felt humbled when she expressed gratitude at having a place in my thesis to share her story. What struck me most about Amina (and, to some extent, Antoinette) was her solicitous nature and generosity of spirit, and the patience and openness with which she shared her thoughts and the details of her life in the firm belief that these would benefit

³² To maintain Amina's anonymity, I do not reveal the particular sources in which I read this information.

³³ She later explained that she rarely had free time as she had a full time job and was regularly involved in AVFE activities.

other women in similar circumstances. That first impression of her continued to be manifest in our subsequent dealings.³⁴

The material below was collected on a hot Friday morning during an interview conducted at Amina's residence which also served as the Raëlian centre in Ouagadougou. We sat in a spacious living room with a TV set one side and a number of seats on the other three sides. On one of the walls there was a big cloth painting of a picture of a man who I later learnt was the Prophet Raël. There was also a symbol – the insignia of the Raëlian Movement – above the dining table on the wall adjacent to the main door (see Figure 4.1). From where I was seated, I could see a curtain concealing a corridor which led to other rooms in the house.

The homestead was a hive of activity as a number of young men and women did chores and talked to each other outside the house. From time to time someone would come into the house to pick up something and then leave. At one point a man came into the living room from one of the rooms behind the curtain. Amina introduced him to me as her partner and invited him to sit with us but he declined.³⁵ Although the setting was not entirely conducive for our interview (given the sustained noise and lack of privacy), it gave me a glimpse into what seemed to be a warm, communal existence.

³⁴ It is worth mentioning, however, that in a subsequent social call with Antoinette, Amina told me that while Raëlians generally ignore negative things which are said about them, they sometimes sue people if they “go too far”. I did not know whether to take that as an indirect warning about the way I presented them in my thesis.

³⁵ After my interview with Antoinette, I briefly spoke with Amina's partner about his work as a university lecturer in Bobo-Dioulasso and his professional trips to Kenya. He then asked his brother to take me back to my residence on his motorcycle after promising to grant me an interview once I was in Bobo-Dioulasso. Given my precipitated departure from the second city, that interview did not take place.



Figure 4.1 The insignia of the Raëlian Movement on the wall

* * *

I don't know [much about my circumcision] because I was a baby when it happened. Even so, I later saw what happened with my sisters when I was older. I believe I was 10 years old when I saw it. I must have undergone the same thing. Because I came from an Islamic family, it happened on the seventh day. On the seventh day they shave your head and baptise you. At the same time they circumcise you. That's what happened with my younger sisters. That's what I saw and so I suppose that it's what happened with me.

It happened in Bobo-Dioulasso. I was born in Bobo and grew up there. I'm Bobo. It's true that it was done routinely; when I was young it was considered normal. In any case I didn't have any information [about why it was done] because I was a baby when it was done. I didn't feel it. It was afterwards when I saw it that I couldn't stand it. I don't remember the point at which I knew... well, being with others, girlfriends who were not circumcised, that's when I realised that there was something missing in me. In school we became aware, they told us that circumcision is not good. We became aware of that while mixing with others. You become aware that there's something missing in you, so you begin to question yourself. I asked my mother but she didn't

know either. She was born and found [circumcision happening] and I didn't blame her for it because she was just following what society said.

It's true that when they do sensitisation campaigns, if you've been circumcised when you see the consequences you feel somewhat diminished. With me it was during meetings among women [when] I was perhaps 22, 23 years old that I watched a film on the harm caused by circumcision. The CNLPE [staff] have a video which they use to sensitise people. It was that video...when I watched it, there's a scene in it where they are circumcising a child which *really* affected me and disgusted me. I felt it in my flesh because it was a baby. It's as they say, psychologically you remain somewhat affected.

Afterwards there were other occasions among women where we were shown the sexual organs of a woman who has not undergone that. I looked at that and said, "There's something which is not alright with me. But what is missing in me?" So I started to enquire and then I said to myself, "There's something precious which was cut from me and I'd like to find it again." I didn't have any information. It was these enquiries that led me to get interested in sensitisation campaigns against circumcision, starting with my family and then my relatives. If there's a chance at a professional level, I also talk about it. I wasn't a complete woman but that didn't prevent me, it didn't block me. But I still felt that there was something, a part of myself, which had been removed and which I wanted to recover. That was it until I got information about restoration.

I felt [the impact] physically when I had sex. I don't know what the first sexual experience is like for women who have not been circumcised, but for me I couldn't do it for at least a year. I delayed with my boyfriend because I couldn't stand it. When someone touched me, I felt disgusted. I couldn't feel any pleasure. I was also *afraid* that he might hurt me. It took a long time, it took a long time. It *really* took a long time before I did it. I got more information that it wasn't only the sex organ that procured pleasure. One must seek something else...one must find other pleasurable points in the body. So I started developing in myself, looking for what else could be interesting, what could give me pleasure. It was in that context that I met someone who was very mature and who helped me in that sense. And there, I can *truly* say I didn't have a problem with sex anymore because I developed in me the capacity to feel pleasure.

At the beginning the problem was when I tried having sex I felt pain so I stopped. Afterwards it was okay, but I didn't feel any pleasure. I did it for the other person; it wasn't for me. But when I met my partner he helped me and it was in that sense I didn't have any...well, I felt well in regard to sex. But there was still the thought that I didn't have that organ.

It was in 2003, I think, when one of our sisters who was studying in the United States saw an interview with Foldès on the Internet and sent it to us.³⁶ We were really excited about it and passed it around. We copied the interview into double-sided fliers and distributed them everywhere. It was on the occasion of 8 March celebrations where there are a lot of women.³⁷ We distributed the fliers and gave broadcasts on the radio in order to inform women that this surgery existed. It was with the aim of mobilising women. At the time [the surgery] was done in France. So we said to ourselves that we needed to prepare ourselves so that one of us could go, but there was still the problem of obtaining a visa. But at the same time we were disseminating information every year when the opportunity arose.

It was in 2006 when we had information that it was happening here in Burkina Faso. It was on the day before 6 February.³⁸ We saw that on TV. It was a broadcast about circumcision and afterwards there were gynaecologists who told us that there was this possibility of being restored. And there, oh really {laughs}, we didn't...I didn't sleep because I had been waiting for that. So the following day we looked for...no, actually it was the eve of 8 March. The previous day was 7 March so the following day I took the doctor's number and called him. He said that they did the operations here, there was no problem. That he had just completed an operation on someone.

³⁶ Here Amina was referring to members of the Raëlian community in Burkina Faso. She also assumed from the outset that I already knew that she had had reconstructive surgery with Samira – which I did not know.

³⁷ In Burkina Faso 8 March, International Women's Day, is marked with a public holiday and an information campaign to highlight a particular priority issue (<http://capacity4dev.ec.europa.eu/article/taking-international-womens-day-seriously-burkina-faso#sthash.mQnADI7Y.dpuf>).

³⁸ 6 February is designated by the United Nations as the 'International day of zero tolerance for female genital mutilation' (United Nations. n.d.). In Burkina Faso it is officially marked with sensitisation activities by the CNLPE and other activist groups including AVFE.

One week later we were in Ouagadougou to have the operation. I believe it was 18 March, but I don't remember. On TV they had told us it cost 100,000 [CFA francs], and I and Samira had prepared 100,000 each.³⁹ Then we realised that there was an examination before the operation, so it went up to 150,000 and then the doctor's fees...but we took credit, we took loans and then we left. They examined us and told us to return that night to be admitted into the ward. We arrived in the evening and were admitted and then the following morning they started with Samira and then after a while, 40 minutes maximum, [she came back]. Afterwards I went. There were medical students there and the doctor was explaining to them. I was also listening, because he used local anaesthesia. So I was listening as he explained that I had been circumcised in the second type, the second degree, that's to say they had removed the clitoris and the labia minora. Even I didn't know that before then! Afterwards I fell asleep and sometime later I woke up in my room.

It was during the weekend and we needed to return to Bobo on Sunday. We were admitted on Friday evening, [the operation] happened on Saturday and we returned here in the evening, and then the following morning on Sunday we were in Bobo. We were given an appointment, we had to return every two weeks. So we left with pills, things...it's true after the local anaesthesia wears off it hurts. It must be said that it hurts because that's normal, it's a wound. And one must nurse the wound. So we cleaned it with the necessary products and took the pills we were given. Sometimes it felt tight which is normal because it's a nerve that's there so it itches. But it means that it may be dry and you should wet it. Honestly they gave us everything, they helped us. Every second week we went back [to see the doctor] and then after a month and then after two months.

{Sighs} I really wanted them to do it for pleasure {chuckles}. I had never had surgery before. It was my first surgery and it was for my well-being, for my pleasure. Sincerely I became a very different person. I used to be shy, very shy, very, very shy, very repressed and...I don't know whether it's related to that but afterwards I'd say I became more comfortable, more open, and so more fulfilled. Not [just] sexually, but I

³⁹ The West African CFA (*Communauté Financière Africaine* or African Financial Community) franc is the medium of exchange in eight West African countries including Burkina Faso. Since 1999, its value in relation to the euro has been fixed at 1 euro = 655.957 CFA francs. One hundred thousand CFA francs would currently be worth about 220.74 New Zealand dollars (CoinMill.com 2015).

had got more comfortable and I told...I challenged women who were not circumcised. I said, "I'm more sensitive than you." Yes, because before the restoration I had developed other points in me which were...it wasn't that, it was my integrity above all else. I also realised that sexually it was different too. It was much more, it was much more. Yes, because first of all...I think it's...we used to be told that we should masturbate but I couldn't do it because I'd tell myself, "How am I going to masturbate?" But after the restoration {sighs} naturally.... I'd like to say after two weeks I felt sensations I had never felt before. And even without touching myself, and this happens to me very rarely. I can sit and suddenly I...I had got to a point where I get this sensation for a few seconds and then it passes. I wasn't psychologically prepared for that, but I know that it's related [to the restoration], and it gives me intense pleasure and I can now masturbate without any problems. I'm very satisfied. Also, of course, with my partner. Truly it's very, very different. It's very different.

I hadn't had a child [by then because] I had been really traumatised seeing the consequences [of circumcision] at birth. It terrorised... I didn't want to have children. It was a year after 2006, so in 2007 when I became pregnant and had the little one that you saw. Here normally people have children early, but I was 35 years old. Normally people have difficulties but I didn't have any difficulties. So I gave birth normally without undergoing caesarean section. The child was three and a half kilograms and everything went well. But before [restoration] I was afraid because people used to tell me, "You're going to get torn, they are going to do this or that to you." I didn't want to do it.

I was confident [about] the restoration. I was really confident because it's true that I'm not in the medical profession, but when they explained to me what the clitoris is like, that it's more than 10 centimetres long underneath what is cut, it was so simple that I saw, I knew that it was just minor surgery. Sincerely I had no fear at all! I was in such a hurry {laughs}, very excited. But we had discussions with the doctor before, so I knew that there would be pain and that I'd have to deal with that. I was ready for that. Truly I told myself that if it happened, I'd do it without any doubt.

My partner [knew that I was going to do it]. It's even he who paid for it {laughs}. He encouraged us and was at our side. He's part of Clitoraid because they are the ones who are in the process of constructing the hospital. My family...I informed my mother and my sisters. With my brothers, well, it's a story of...I informed my sisters. I told

them to arouse their interest, but none of them was interested. I'm the last among my sisters, so they thought they were too old {laughs}. Before doing it I informed my mother. I was very, very touched because she told me...because she was blaming herself for having [had me circumcised]... she regretted it. But she was also still happy that in spite of that, there was the possibility for repair. She was very satisfied. She supported me a lot [...]. She was the one who told me to talk to my sisters about it.

It doesn't bother me [to be identified as a woman who has been restored]. It doesn't bother me at all because it's a decision I took. I think that the message spreads better when there's a living witness who says, "I did it. See what it has brought me. I can testify. I can tell you. I can help you." So I don't hide it at all and it doesn't bother me.

I'm an administrative assistant by profession, but it's true I talk a lot about [circumcision and restoration]. I've been a Raëlian for 14 years. And I'm sure that even if I wasn't Raëlian, I'd have still done the restoration because... it has nothing to do with it.

* * *

Antoinette, 36, Ouagadougou

I first met Antoinette at Amina's residence. I had contacted her earlier and she had said she would get back to me. She got in touch that Friday morning as I was headed to Amina's house and said she was willing to meet me then. I told her I would call her later in the day as I had another engagement at that time. When I finished talking to Amina, I was getting ready to leave and telephone Antoinette when Amina told me that there were other women I could talk to and that one had just come into the compound.⁴⁰ It turned out to be Antoinette!

Antoinette was a petite woman in a smart, patterned outfit of the type locally referred to as *pagne*. Her hair was in cornrows and she had painted nails and wore conspicuous jewellery. She had a powerful voice and a methodical manner of expression. Antoinette

⁴⁰ Antoinette had arrived at the residence earlier but had stayed outside the house. Amina must have heard her talking to the people working there.

seemed to be heavily committed to activism against female circumcision, and a strong advocate of the Raëlian Movement and its involvement in reconstructive surgery.

During the interview, we sat in the same room that I had been in with Amina but apart from two instances – when a young woman came to clean the floor and when Amina brought us a drink of water – we were left alone. Even so, I got the impression that Antoinette was keen and proud to tell her story without caring whether or not she was overheard.

* * *

My name is Antoinette. I'm a Raëlian. We also have a women's organisation which we call Angels of Raël. Raël is our prophet who saw the difficulties which African women have and decided to set up a hospital in Burkina Faso to help victims of circumcision. That hospital aims to repair the negative effects of circumcision and to restore the clitoris which was cut. [It will] also teach sex techniques to those who want [to learn] because after repair or restoration, women need to be taught how to take pleasure in that organ. In our association AVFE – Association of the Feminine Path to Fulfilment – we carry out [sensitisation] activities. We talk about that. Otherwise, [I'm] a customs clearing and forwarding agent.

I'm 36 years old, single, with no children. I come from an Islamic family; my father and mother are both Muslims. In 2001 I got baptised as a Christian, a Catholic. In 2006 I had a decline in faith because I was always asking myself questions as a Christian [...]. I've known the Raëlian Movement since 2006. That's when I became a Raëlian. I learnt about that and came to know that there was Clitoraid. The representative of Clitoraid in Burkina Faso is AVFE. I'm a member of that organisation. I told myself, "You were looking for something to do. Here it is, get involved!"

I'm Burkinabe, but I was born in Ivory Coast. I was circumcised in Ivory Coast. I don't have a precise date, but it was between the age of four and five. I remember [the experience] very well because I know that one evening we received a visitor. It was a woman who used to come to our home, so she came as usual and being children we were not aware of anything. But the following day we, the little girls, were told that there was going to be a party. So you see we didn't know what it was about. Afterwards there was a lady who told us that actually we were going to be circumcised. I'd never heard of circumcision and so I asked her what it was and she said, "You'll know once you get there."

The woman [who had come to our house] and two of our mothers went outside. We were undressed and then, one by one, we were taken behind the house. They were taking turns with us. There were two [girls] who went before me. When they came back they were in tears and were unable to walk properly. They were told, "Ah, well done, it's good." But seeing them in tears and unable to walk made me already realise that it was [not good].

When it was my turn, I arrived [behind the house] and sat down. They were doing it with razor blades without any anaesthetic. You arrive, you sit, they spread your legs and then paf! They cut your clitoris and bury it right next to you. That's how it happened. They cut off my clitoris and labia minora.

For treatment, in the evening they would heat water. You sit and they put hot water between your legs so that the wound can heal. It was very painful {chuckles}. It was very painful, especially when you wanted to urinate. It was truly hell. It was excruciatingly painful. Every time you wanted to urinate you went with a kettle full of water and when you felt pain, you poured water on it, little by little, so the urine came out until you finished urinating. Every evening the women made dressings like that with hot water and they also put Shea butter [on the wound]. The following morning they did the same thing. It took one to two months for it to heal properly.

There was no explanation. You know in Africa matters of sex are taboo, so people don't talk about them. So they couldn't explain why they did that to us. Even our mothers didn't talk to us about it.

What impact has being circumcised had on me? The clitoris is the centre. It's a woman's sensitive organ. It's from it that a woman begins to feel that she desires sex. If one removes it, your sensitivity diminishes. It's like removing a man's penis because he needs it to have an erection. So first there's that and also I was lucky; I could say I was lucky because I don't have problems during sex except that I don't get wet. When I have sex...there are women, you just touch them and they begin to get wet. Unfortunately, I don't get that. I don't get wet and it also depends on my partners. There are partners with whom when you have sex you don't feel anything because they don't know the sensitive points which you have been able to develop. On the other hand, there are others who when you have them they know, they are able to look for your sensitive points. So when I'm with a man who knows my sensitive points, I

don't have any problems, just that I don't get wet. And I also don't have my clitoris to have fun with {chuckles}. So there's all that.

The first time I heard about [restoration] was with the Raélians. They are the ones who've really engaged themselves in it. I could even say that they are the pioneers of that in Burkina Faso. They are the ones who began to talk about the restoration of the clitoris. It's true at the beginning it was very expensive and one had to go to France. There are Raélians who did that. They went to have themselves restored.

I haven't been restored yet. I'm waiting. Of course I have the possibility of doing it and with all the places I know, I can have myself restored. But I prefer to wait to have myself restored at our hospital in Bobo-Dioulasso. It's a personal choice. I want to be a part of the women who are going to be restored there and who are also going to testify about it, that they were restored at that hospital. I have the possibility to have it done here [in Ouagadougou], but I prefer to wait for our hospital.

I don't have problems relating to sexual intercourse but I want to [be restored] because it's a part of my body. I call the clitoris a woman's jewel. It's a part of me that my parents tore off without my permission. Today I have the possibility of regaining that part which was torn off, so I'm going to do it. Also, the more women get restored, the more circumcisers will be discouraged. I think it's the best way to stop circumcision. When circumcisers realise that that which they are cutting, these children are later going to grow up and have it returned, that will block them and they will no longer do it. That's why I say to women, "Go on, go and have yourselves restored. If you really want circumcision to end in Burkina Faso, go and put back the clitoris!"

When I decide to have myself restored, I'll not need anybody's opinion. I'm not going to ask for anybody's permission to go and do it. I'll just do it because it's mine. It's for me and it's something that belongs to me. I don't need anybody's permission for that. It doesn't matter to me if [people have a problem with my decision]. If I have myself restored and people reject me because I'm not a circumcised woman, I couldn't care less about it because my life is my own, because I'm the one who knows what I live with. Nobody else feels what I feel. So I couldn't care less about what people are going to think of me. [But] at the same time I take myself as a poster child for this issue. Women are going to think, "Ah, she's fulfilled." It will be an example for those women to have themselves restored.

I've never thought that [the procedure could go wrong]. It has never come to my mind. I tell myself that I want my clitoris because in life I've always told people that they should be positive. If you want something, be positive. If you think negatively, negative things will happen. But for me the most important thing is that I want my clitoris. Whether things go wrong or not, in life everything is a risk. It's a risk. I also know that today our doctors are sufficiently motivated to do that. The last time I went to see Dr Nikiema [with the girl I told you about] he said that he had got to a stage where he now asks women, "How do you want your clitoris? Do you want it big or small?" Then he models it according to what you want. That means that [the doctors] cannot have such errors where it fails because they are sufficiently motivated in doing it. It's their profession so... I think that there's nothing that's hidden in it. If they even ask what you want your clitoris to be like, that means that they have mastered that perfectly. I've never thought that it could go wrong.

* * *

Maimouna, 32, Bobo-Dioulasso

I conducted this interview with Maimouna at the Clitoraid hospital in Bobo-Dioulasso on a hot and dusty Saturday afternoon. I had earlier met her with Samira and six other Raëlian women at a roadside restaurant.⁴¹ Samira introduced the women to me one by one using the formulation: "This is Maimouna. She is a victim of circumcision who is awaiting restoration at the Pleasure Hospital." The women were in their 20s and 30s but there was one in her 60s who was cradling her grandson. Samira introduced me to the other people in the compound and then suggested that we go to talk at the hospital because it would be much quieter there. Five of us – Samira, Maimouna, Sophie, another young woman and myself – went there in Samira's car, but the rest of the women went home.

Maimouna was a tall, heavy-set and outspoken young woman. She was considerate in her interaction with me, and seemed mature and frank in the way she handled questions particularly those to do with personal feelings and opinions. Since she sometimes came

⁴¹ The restaurant was located in a homestead belonging to a Raëlian man and his 23-year old partner, Sophie.

across as anguished and rather defensive, during our interview I did not ask her as many follow-up questions as I did with the other research participants.⁴² Instead, I relied heavily on the information she felt comfortable divulging without much probing on my part.

The interview with Maimouna was conducted under strained circumstances not least because we had not interacted much beforehand. The location, mode of transport and even duration of the interview were controlled by Samira who indicated, soon after I started conducting the interviews, that we needed to leave. At one stage during my conversation with Maimouna, Samira came into the room and stayed for a minute or so, ostensibly clearing cobwebs from one of the windows not too far from where we were seated.

* * *

My name is Maimouna. I've lived in Bobo since adolescence. At the moment I'm a cook at a guest house. My partner and I have a guest house so I cook for the clients. I'll soon be 32 years old. I'm from the Samo ethnic group which is of Malian origin. I was born in an Islamic family. I don't talk much about religion. I don't like getting into it as I'm a Raëlian. Since people don't understand it much, they don't seek to understand it. As soon as you say you're a Raëlian they begin judging you, so I don't talk much about my religion.

We had gone to my grandmother's place, my father's mother, for our holidays. My father was a policeman, so we lived in Ivory Coast. At the end of each school year we had holidays and went to Ouagadougou to spend them at my grandmother's place. It was my grandmother who had us circumcised. She did that without my father's consent. He was never okay with it. There were two of us: my sister and myself. I was

⁴² It appeared that Maimouna felt that in being circumcised a great injustice had been done to her, an injustice which could only begin to be rectified by clitoral reconstruction. She was also quite defensive when I asked questions about the Raëlian Movement perhaps because she thought that being an outsider, I would be judgemental towards the group.

12 years old [and] she was 11 years old, no, 10 because there's a two-year gap between us.

My mother didn't know about it. You know, in a big family, in an African family like that, your grandfather and grandmother...it's as though they are the masters of the house. Even if your mother is there, they are the ones who make the big decisions, so they made the decision without the consent of my parents. Even if my mother was there, she didn't have the right to decide or to impose herself.

I could say I remember everything about it. It's something that really hurts. You can never forget it; it's between life and death. That's my opinion about it. My grandmother called a female circumciser who was accompanied by six really hefty women. Those six women are the ones who held us – two here, two there, two others by the legs, so you couldn't even move. That's when they almost killed me {chuckles}. I can say that they almost killed me, because as I grew up...for others it's even worse than that. There are others who are circumcised when they are just babies. But we were lucky enough to know what the clitoris was. Truly there... the scars that formed were really painful. Afterwards there were sequelae. We felt pain as we recovered, as the scars formed.

I asked why they did that, because we were still children, and we didn't understand why they had done that to us. [My grandmother] said if a woman has a clitoris, as she grows it will also grow and that's not beautiful to look at, that it's ugly. You see things like that which don't stand up. It really doesn't stand up. She also told me that there's another explanation – that when a woman has it, she cannot stay calmly in her house. That if you're with your husband you'll always want to go out, to go and see elsewhere because you...you don't stay faithful to your husband and that's not good. She also told me that in addition to that if you have it, when you make love to a man, if your clitoris touches his sex organ in a bizarre manner, that your man can catch a cold like that – I mean some sort of a chill and the person can die. So you can lose your man. I can say that that can make some sense if it were to happen, but I think those are lies. So there were three or four explanations which didn't really convince me as to why I was hurt in such a way.

I forgive [my grandmother] because she didn't know; for her it was normal. It's the custom. It's what is supposed to be done. My relationship with her didn't change, but I was seeking to understand why, so she gave me those reasons and explained that for

her also when it happened it was in a group and all that. That for her it's normal that a woman should be circumcised, that it's all normal that we got circumcised. We were her first grandchildren. The first ones are circumcised but afterwards, now, she will begin to understand that really it isn't good, so the last ones in the family [will be] saved. She has stopped doing it because she lives in Ouagadougou and is afraid that she's going to be locked up.

Circumcision has caused problems for me. I never felt at ease when having sex with my partner. I've had partners in my life [and] when I'm with a man, when I'm having sex...actually at the beginning when I was circumcised during my adolescence, I had sequelae. When I went to the toilet to urinate, blood came out afterwards. When I explained that to my mother, she said that it was the effects of circumcision. They put me on some treatment, some traditional things and afterwards it went away. The second thing that happened to me was during sexual intercourse. When I had sex, instead of having pleasure I felt pain. I was always afraid of having sex with men. Later when I got involved with the Raëlian Movement, they explained to me and I started learning. Before the Movement I had men who...men now seek women who have their clitoris. When you don't have it, they blame you for that. You feel embarrassed because you don't know what to do. You want to get it back. You're not comfortable having sex, you're embarrassed instead of being happy. Every time you're being blamed because you don't have the clitoris. It's embarrassing. It's sad.

Now Samira and her entire team have helped me to re-educate myself sexually. When I have sex, I experience pleasure but I'd like to get my clitoris in order to have more pleasure when making love instead of feeling pain. Even though I already feel pleasure when making love without my clitoris, my partner's criticism of me when he says, "If you had your clitoris and so on and so on" upsets me. So I'm in a hurry to recover my clitoris {laughs}.

I heard [about restoration] from the Raëlian Movement, when they started the hospital project. That's when they said that they can do that. There was also a doctor in a TV broadcast. It was a doctor who had restored a circumcised woman because she couldn't give birth if I understood it correctly. But it was a long time ago.

I want to have pleasure when having sex, that's why I want to be restored. When I make love, it's to have pleasure and to really find myself. So I want to get my clitoris back. I came into the world with that, so I want to find it again and be the way I was

when I came into the world. Why did they take that away from me? If it wasn't good, I wouldn't have come into the world with it. I came with it. In addition to that, when I make love I want to have pleasure and there are...well, actually I have two children and during the deliveries I had problems because I was circumcised. Now I've decided to stop having children because I have two already, but having the operation is going to enable other women to give birth without problems.

Of course I've already informed a lot of people [about my intention to get restored]. My sister agrees with it, the one who was circumcised at the same time as me. She has agreed to get restored. There's another one...well, all the people I can inform, I inform them every time. I want all women to have their clitoris!

I think that all women have the same pain that I do, but they don't dare say it because of social pressure [...]. There are others who say that they are afraid because they fear that the pain will be similar to the one they experienced when they were circumcised. So I reassure them and tell them that I haven't had [restoration], but I reassure them and refer them to Samira who has already had it, and she reassures them.

I'm in a rush [to have restorative surgery], but at the same time I'm afraid. I'm a little afraid because I don't know how it will go, but by listening to the advice of those who have already done it like Samira, I'm reassured. So I have confidence in myself. I have confidence that it will go well, so the fear which is in me is not too much as such.

* * *

Samira, 58, Bobo-Dioulasso

I had been in touch with Samira for several months on email and telephone before I met her in Bobo-Dioulasso. She was in charge of the 'pleasure hospital' project, and on my second day in town she took me to see the site.⁴³ The hospital, located six kilometres from Bobo-Dioulasso town, was in a two-hectare compound demarcated by a perimeter wall under construction. There were two men making blocks near the building (see Figure 4.2). Samira showed me around the hospital and talked to me extensively about

⁴³ I explore the controversy around the naming of this hospital in Chapter 9.

it, and later also about herself. The structure, which looked quite well-constructed, was all but complete, as were other buildings in the compound.

It was extremely hot and dusty but the atmosphere was conducive for talking as it was quiet but for the clucking of chickens and the occasional arrival of a vehicle. Samira was a tall and robust woman with a gregarious nature and an expressive manner. She was also generous, helpful and friendly. Even so, I sometimes got the impression that there was a rehearsed element to parts our conversation. Our discussion appeared to be just one of the many interviews she had done on the subject and for which she seemed to adopt some sort of performance role. Samira was a captivating narrator who varied the intensity, tone and volume of her voice, and extensively used facial expressions and hand gestures to accentuate her story. Her engaging manner may have been the result of her family background (her father performed a public role as a muezzin) and/or her position as a Raëlian bishop who no doubt instructed the other adherents.⁴⁴



Figure 4.2 The ‘pleasure hospital’

⁴⁴ Samira said she had relinquished the AVFE presidency to the younger generation. However, the other Raëlians with whom I spoke still referred to her as the president of the association. She was also clearly the leader of the Raëlian group I met in Bobo-Dioulasso.

* * *

My name is Samira. I'm Turka. I'm a widow [and] I have two children. I'm an accountant by profession. I've worked for 27 years and I'm 58 years old. I'll soon be retiring. I'm a Raëlian bishop guide, the first woman...we are two Africans but the other one, Monique Diawara, lives in the United States. I was a Muslim at first; my parents were prominent Muslims. My father was the neighbourhood muezzin.

I was in Cote d'Ivoire with my elder sister, and, as it was the tradition, when you got to a certain age, they circumcised all the girls in that generation. I was old personally. They used to circumcise girls at seven days, seven years, ten years and I was thirteen years old. That's to say, I arrived there when they had already circumcised girls and so I had to wait for the following year.

That day my sister woke up very early and put [a pot of] water on the wood fire outside. I got up and was ventilating the fire, blowing on it so that the water gets hot. Afterwards in the early morning four women arrived. There was one who was older than the others. The others were as old as I am today. When they arrived my elder sister took stools and went to give them. There was a mango tree near the bathrooms. My elder sister went and put the stools there. They sat down there. She put water in a pail to go and put there. I didn't know that anything was happening and afterwards she remained in the house. She called, "Samira, here take this soap dish and give it to the old lady who is seated there." I took the soap and left, and she turned her back.

When I got there I went to give the soap dish to the woman. Two women caught me like this. I was tall and thin. I was as you see me, thin. I'm not fat. They caught me like this and I was asking myself what was happening to me. I looked at her. I looked at her without crying, without screaming. They carted me into the bathroom where there was water and everything else. They put me on the floor. One sat down like this {demonstrates} straddling me like this. She put my head there and put her knees on the ground and she caught my two hands. She pressed them firmly like this {demonstrates that the woman seized her wrists and pressed them firmly downwards}. Another one who seized one foot and another took the other foot, and the old woman was in the middle. {The following sentences were said softly, in contrast to more animated description above.} She's the one who circumcised me. I screamed. I screamed. I screamed. I screamed. I shouted calling mother, father, my

elder sister. I called. I screamed. I cried. Nobody came. {Very softly} They circumcised me. They circumcised me.⁴⁵

After me there was my niece, my elder sister's daughter. She was about one or two years old. She was circumcised as well. When they finished, the circumciser took me to her house. She lived a bit far. I stayed there for two months to get healed. My elder sister stayed with her daughter at home.

{Rising voice} Every morning she took black soap. She put a little stool in a basin and I sat there. One person got hold of me here and the old woman [made] foam. When the foam from the black soap was made in hot water, she put the hot water with foam on the wound. {Rising voice} Every morning. I was even afraid of sunrise because every morning I had to undergo that. It really hurt. Little by little I healed. The wound didn't heal quickly. It took two months.

My elder sister said she did it, her mother did it, her grandmother did it, why not me? Everybody did it, so it had to be done. It was fashionable. It was the tradition. When I looked at myself later, I saw that they had removed the prepuce and then that old woman went on to scrape even a part of the labia majora at the top. She knew that the clitoris is on the inside. After the prepuce, there's the clitoris which is on the inside, so she went to scrape that off. So I can say that it was at a primary level; it's just the clitoris [that they removed]. I have the labia minora, I have the labia majora.

My first experience...first of all, my elder sister said that it was painful. Because she was circumcised and when we spoke about it she told me, "Um having sex, being with a boy *hurts*. It hurts." I had a boyfriend and I still wanted to try, [but] in my head it hurt, so I had to prepare myself in my head to experience that. When we got together I was tense [...]. I was tense and at the smallest gesture I became clenched, stiff. And the first time I was penetrated by a man I had a shock. I felt pain. It was difficult. I felt pain. I even got a tear. Yes, because it wasn't supple. I was still young. I was an adolescent and so what immediately came into my head was it hurts. I was about 18 years old and so it was a bit hard.

⁴⁵ Samira later said, "I didn't want to look you in the eye when telling you that story because I feel it in my head all the time."

I must say I [got] luckier in my sexual relations. I met a man who understood me. I met my partner when I was 22 years old. He was jovial and interesting. I told him everything as he was open towards me. I told him that my sister had said it would hurt and that when I had some fun with my boyfriend I had a tear, that indeed it hurt. And he prepared me, he didn't penetrate me just like that. He prepared me bit by bit – either it was with his finger...anyway I can say that we took almost 6 months. We just had fun until he was able to penetrate me little by little, little by little so that I could feel good.

And he taught me to discover myself. He did it in such a way that sexual pleasure wasn't only felt in my sexual organs, that I could experience pleasure in other parts of my body. He made me feel that my breasts were very sensitive. I felt good when he touched my breasts and I realised that they were very sensitive, even my feet [...]. He made me discover my whole body. It's through that that I began to have confidence in myself and to love myself as I am and to have pleasure when with him.

That's how I was able to have two children with him, but with difficulty because at each delivery they made an incision so that the head of the child could come out. They put staples in me because the hard part prevented the child's head from coming out. So that's what happened, and then he left. Today I know that wherever he is, he is very happy because he must be in paradise. He died in 1995 in Ouagadougou and I continued to live. Honestly I thank him all the time. I constantly thank him because I would still be there in the process of seeking pleasure with men.

[I heard about restoration] on TV. [But] already Monique Diawara [had seen] the interview of Pierre Foldes, the initiator of clitoral restoration. When she saw the interview she knew that we had problems, that we were circumcised, so she sent us the interview on the Internet. We read it, printed and photocopied it and distributed it on 8 March. We distributed it everywhere in order to inform people so that they could go to France to get restored. We ourselves were in the process of getting contributions and saving money in order to go to France to have ourselves restored.

One day we were seated in front of the TV, there's a programme called Santé Marque. They were talking about clitoral restoration...they were talking about circumcision. There was Dr Kerekou who said that restoration was being done in Burkina Faso.

They had been trained to restore circumcised women and that it cost 5,000 [francs].⁴⁶ As we had been able to save a little money, we called so that they could give us the [doctor's] telephone number. They gave us the number of his place of work and we went there the following weekend.

The two of us, Amina and I, went. We went...it was interesting. We arrived and made an appointment. We learnt that if it was at the Yalgado National Hospital it was [FCFA] 5,000, but if it was in a clinic it was 250,000. We needed to get an appointment at the hospital and the list was long. So we had to go to a clinic, Prof Camara's clinic. We went to get information and he gave us the total. Ah, the money wasn't enough! So we went to all the Raélians who were there, the guides, and said, "Help us, help us. We came for this but our money is not enough." So they got together and helped us. They gave us a loan.

We went the following day. It was Friday. We paid and they admitted us at around 8pm at the clinic. The following morning at 8am the doctor came and said, "Who will start, who will be first?" I got up {laughs}. As I'm cowardly, I didn't want the other one to go before me. I got up and I went. It took 20 minutes with local anaesthesia. He restored me, and 20 minutes later they came to return me to my bed. [Amina] left and 20 minutes afterwards she came. The following day on Saturday at 4pm after the anaesthesia had passed, he came and asked us, "How do you feel? Where do you feel pain? Are you okay?" There were no problems so he discharged us. He gave us a prescription and said, "Go and continue with the treatment."

On Saturday we slept in Ouagadougou, the following morning on Sunday we took the bus and came to Bobo. The following day we went to work {laughs}. We took our motorcycles and went to work, and in a week or two weeks the wound scarred over and we were healed. He had advised us to return weekly so that he could see [our progress]. And so we went every time.

We had ourselves restored and we saw a difference. There was a change. I, in any case, felt a difference because I felt that I was getting stirred there. There were sensations there. I had sensations at the site of the clitoris. Pleasant sensations. Every time during my baths I touched myself in that place which had become very sensitive. And all the sides around had become very sensitive around the labia majora, all of it had

⁴⁶ Approximately NZD 11.04 (CoinMill.com 2015).

become very sensitive compared to before. So I got myself a boyfriend and I enjoyed it when he touched that place. He enjoyed it and it gave me a great deal of pleasure. We enjoyed ourselves a lot. Actually we enjoy ourselves a lot {laughs}.

It's very good. You don't need a man to give you pleasure because just with your finger, you can get an orgasm [...]. Here I must underline an aspect I felt in myself which I didn't have before. You see when a girl is not circumcised, when she has sexual relations, there's a liquid which comes out which flows between the labia minora and the labia majora. That liquid comes from the clitoris. The clitoris has pockets since it's long; it's eight to ten centimetres long. Those pockets are like testicles but they are on the inside. They produce secretions which show that you're aroused [...]. I didn't know that, but restoration is so effective. With restoration it's as though the doctor opens that pocket so the liquid can start flowing. I had that sensation [...]. I can understand it today when people say that a woman urinates or that she ejaculates during sex. It's those pockets which secrete [...] that liquid which passes through the clitoris and spills out. It produces a pleasant sensation. It also allows the male sex organ to penetrate easily [...]. It's very good and it's a part of restoration which must be emphasised. It's very, very important. Yes, people must know because a circumcised woman can *never* feel that.

I didn't think about [something going wrong] for even a moment. For me it was about discovery. I didn't think about that for even an instant [...]. I'd always wanted it...I must do that to see what happens. Because they removed my eye, I must put it back to see whether it... I had to. When I was having myself restored I was 53 years old [but] I swore to myself... when I learnt that restoration existed, I said, "I'm also going to taste that sexual pleasure."

* * *

The issues highlighted in the experiences above form the foundation of the thematic analyses in the chapters ahead. These include the context of the practice of female circumcision in Burkina Faso, its purpose and the harm it is thought to cause, and the research participants' understanding of reconstructive surgery and its benefits. My discussion of these issues will be informed by the views presented above, other voices from the field as well as those in the literature speaking in similar vein or in response to these matters.

These five stories seem to be located in a transitional moment in the history of female circumcision in Burkina Faso where the traditional context of these practices has been already largely altered. That setting has in itself created problems for the women in question. In addition, these practices are now dying out, and although the majority of women in the country have undergone them, there are others who have not. As I show in Chapters 5 and 6, consciousness has been raised about the negative impact of these practices but these messages are framed in a way which creates even more problems for the women who have undergone these procedures. These women then become not just ‘victims’ of female circumcision – as these sensitisation messages portray them and as they come to see themselves – but ‘victims’ of a time of transition as well.

As recounted in these stories, female circumcision was done under conditions of deception and secrecy, and the girls affected did not often know why it was done except that it was the custom. In speaking about their experiences, these women also made reference to the traditional way of life, a rigid system of hierarchy in the family and taboos which were not to be broken. Even so, there came a moment when these women started to act differently from their peers in questioning tradition, breaking taboos by talking about and combating these practices and even seeking to reverse their effects. Their questioning was reinforced by exposure to other modes of thought mainly through education and religion. For these women then, the social reference group was no longer just the village and the family steeped in customary practice. While Leila Abdi situated her understanding and response to female circumcision in local and international discourses and policies regarding these practices, for the Raëlian women the social reference group seemed to be other Raélians.

It is with this in mind that I explore, in Chapter 9, the place of the teachings of the Raëlian Movement in these women’s conception and attainment of a new identity as ‘complete’ women. I discuss the implication of the Raëlian doctrine in their reactions to female circumcision and their embracing of what they term ‘restoration’. In other words, I enquire into the role of the group in moulding these women’s beliefs about the body, indeed their bodies, to enable them to attain their desired form and function.

Other research participants

Apart from the research participants cited above, others I quote extensively in the following chapters include Sylvie, Gabrielle, Etienne, Albert and Nafissatou. I met

Sylvie at a medical and advocacy centre run by Leila, located about a 20-minute drive from central Ouagadougou. With its modern build, the centre stood out in the rather dusty and dilapidated neighbourhood and reminded me of the private medical clinics I had visited in Ouagadougou. The centre offered free reproductive health services to women in the neighbourhood. Those services were offered by a nurse, a midwife and a gynaecologist. The other staff members at the centre included social workers involved in community activities aimed at eliminating female circumcision, a psychologist, a lawyer, an administrator, an accountant and a manager. The first time I went there, Leila (and her driver) collected me from my neighbourhood on her way from a meeting with Chantal Compaoré, the First Lady. When we arrived at the centre, Leila introduced me to all the staff members who were inside the building. She asked the administrator to set up meetings for me with the personnel that I wished to interview. However, in the end it was Sylvie, the midwife, a tall, cheerful and pleasant woman in her 50s, who through her personable nature facilitated my access to the other staff members including Gabrielle, Monique, Etienne and Dr Diallo.

My access to Albert and Nafissatou was also facilitated by other people in Burkina Faso. The officer granting my research permit in Ouagadougou had indicated that there were social scientists at a research centre nearby and encouraged me to go and meet them. The research centre was a big three-storey building that stood in a large, dusty fenced-off field. One of the scholars I met at this centre was Albert, a 46-year old anthropological researcher. He was a Catholic from the Samo ethnic group who was married and had two children. Albert had conducted studies on the attitudes, perceptions and behaviour of people in regard to female circumcision for two organisations in the Est (East) and the Plateau Central regions. He was very friendly right from our first meeting and made a lot of helpful suggestions about my stay and travel in Burkina Faso and about other potential research participants. He agreed to grant me an interview to talk about the research he had done and, although he indicated that he did not know much about reconstructive surgery, he was willing to give his opinion about it. I conducted the interview on Friday, 1 February 2013 on one of my visits to the research centre. During the interview, Albert answered my questions thoughtfully and comprehensively.

I interviewed Nafissatou on Monday, 28 January 2013 at the CNLPE headquarters located in the Kamsonghin suburb of Ouagadougou, about a 10-minute drive from the

city centre. The offices were housed in a densely-populated area in a big, modern-looking building (see Figure 4.3). There was a big sign board near the gate displaying the name of the organisation, the contact telephone number and a telephone number people could call free of charge to report cases of female circumcision (see Figure 4.4.). Most of the CNLPE offices were located on the second floor. On the walls and doors along the second-floor corridor were slogans and posters denouncing female circumcision (see, for example, Figure 4.5).

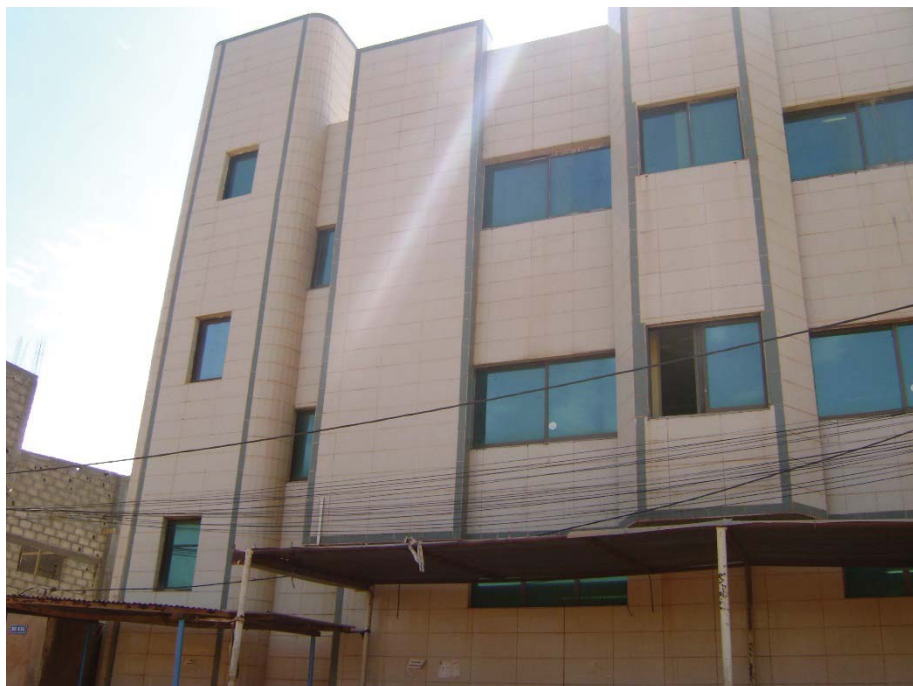


Figure 4.3 The CNLPE offices in Kamsonghin, Ouagadougou



Figure 4.4 The CNLPE sign board with the free-to-call telephone number, 80 00 11 12



Figure 4.5 A poster in CNLPE offices

My meeting with Nafissatou was facilitated by an associate of my landlady in Ouagadougou. As I explain in Chapter 2, I had earlier visited the CNLPE offices and although I had met one helpful staff member, she had not been willing to speak

officially on behalf of the organisation. When my landlady learnt about my research, she requested her friend, Madame Alamissa, who was a former permanent secretary, to introduce me to the CNLPE permanent secretary. On the day we went, the permanent secretary was in a meeting but we were introduced to Nafissatou who worked in the training department. At first Nafissatou indicated that it would be better to wait to see the permanent secretary, but since nobody knew when she would be free or indeed whether she would be willing to talk to me, Madame Alamissa and Nafissatou finally decided that it might be better if Nafissatou granted me an interview.

Nafissatou was a social worker who looked much younger than her 50 years. She was from the Mossi ethnic group and was a mother of four children, two of whom were university students. Although we had not established a relationship beforehand, I found Nafissatou friendly and helpful. She answered my questions comprehensively and provided me with information about upcoming advocacy events. She granted me permission to attend two of those events: a bicycle race held on 6 February (International Day of Zero Tolerance for Female Genital Mutilation) and a workshop which brought together members of the CNLPE and Burkinabe musicians. In addition, she lent me a sample of the resources used during sensitisation activities and gave me contact details of some of the doctors who performed reconstructive surgery in Ouagadougou.

There are other research participants whom I do not quote extensively but whose details and opinions I mention in the chapters ahead. I also draw material from six medical doctors whose profiles I present in more detail in Chapters 7 and 8. The ideas raised in my conversations with all these people form the basis of the key discussions in this thesis.

CHAPTER 5

CONTEXTUALISING FEMALE CIRCUMCISION IN BURKINA FASO

Introduction

In this chapter I explore the context of female circumcision in Burkina Faso. I discuss the prevalence of the practice, the forms of the procedure carried out, the age at which girls undergo or previously underwent it and the reasons motivating or justifying its continued existence. I also look at the efforts which have been made by the government to end the practice and the impact that these efforts have had. I consider these issues from the perspective of my research participants but also from that of other researchers who write about these practices in Burkina Faso. In some instances, I also refer to other places where various forms of female circumcision are carried out to draw parallels with the Burkinabe case.

The secondary material explored here is drawn from researchers from various disciplines who have contributed to literature on the practice of female circumcision. These writers include anthropologists Rogaia Mustafa Abusharaf, Janice Boddy, Ellen Gruenbaum, Ylva Hernlund and Bettina Shell-Duncan, medical practitioners Haseena Lockhat and Nahid Toubia, and advocacy personnel in non-governmental organisations such as Susan Izett and Anika Rahman. I also refer to reports commissioned by research and advocacy organisations in Burkina Faso and those produced by independent researchers such as social psychologist Hanny Lightfoot-Klein and French author and journalist Hubert Prolongeau. These writers do not fit into well-defined spaces or positions on this matter and indeed a number of them transcend their disciplines and/or professions so that, for example, a number of doctors are also avowed activists, as are some of the scholars.

An introduction to female circumcision in Burkina Faso

Female circumcision is very widespread in Burkina Faso and has long been practised in most of the country's 63 ethnic groups.⁴⁷ The vast majority of adult females in the country have undergone some form of the procedure in their childhood, adolescence or even adulthood. Leila Abdi, a prominent activist against the practice (whose personal

⁴⁷ As I show below and in Chapter 3, it is well-nigh impossible to say with precision when these practices began.

experience is recounted in Chapter 4), emphasises that these practices are prevalent in the whole geographical territory of the country and that the areas where they are not done are extremely few. According to her, “apart from a few ethnic groups and families, practically everybody circumcises”. This reality is also portrayed by the results obtained in the fourth Demographic and Health Survey and Multiple Cluster Indicator (hereafter, EDSBF-MICS IV) conducted in Burkina Faso between May 2010 and January 2011. In that study, 76% of the interviewed women aged between 15 and 49 indicated that they had undergone the procedure (INSD and ICF International 2012:ii, 291).

Determining the forms of female circumcision done in Burkina Faso is difficult. When talking about the procedures that they underwent, the women whose experiences are detailed in Chapter 4 described to varying degrees the removal of a section of the clitoris and the labia minora which would fit into what the World Health Organisation classifies as Types I and II female genital mutilation, that is, clitoridectomy and excision respectively (see Figure 5.1, Column 1). Other researchers (cf. INSD and ICF International 2012:289, 297; Lockhat 2004:63; Toubia and Izett 1998:11-12) also propose that the most commonly practised forms in the country are the removal of the clitoral hood or a section of the clitoris (clitoridectomy) and the partial or total removal of the clitoris and the labia minora (excision). These procedures are said to be mainly carried out by traditional practitioners.

Even so, there are challenges in determining with certainty the nature of these procedures, and indeed this is one of the issues I encountered during my study. In their study, INSD and ICF International (2012:292) also acknowledge difficulties in obtaining reliable information to determine the type of procedure done in Burkina Faso.⁴⁸ Self-reporting is not a reliable method in determining these procedures because the girls or women involved may not know the form of the procedure they underwent. For example, as Amina recounts in Chapter 4, she did not know that she had undergone Type II female circumcision until the doctor pointed it out to medical students when Amina was undergoing reconstructive surgery at the age of 36.

⁴⁸ The researchers asked women whether the procedure had consisted of a simple cut or whether some flesh had been removed from their genital area. They also asked them whether their vaginal opening had been closed off to determine whether or not it was a case of infibulation.

Difficulties in determining and describing with certainty the procedures in question become more evident when considering the responses of experts, in this context medical doctors and activists, in Burkina Faso. Even though in speaking about these practices they base their categorisation on the classification proposed by the World Health Organisation and adapted by the CNLPE (see Figure 5.1, Column 2), they often do not align their typology with that of these two publications, making it difficult to understand the specific procedures that they have in mind. This specificity is important because, as I discuss in Chapter 6, understanding the type of procedure women have undergone would help contextualise some of the problems associated with these practices and explain why they may necessitate reconstructive surgery.

There were a variety of responses from my research participants regarding which form of circumcision is done in Burkina Faso. For example, Leila, explained:

The first form is where they cut the clitoris. The second form is where they cut the clitoris and the labia minora. In Africa we talk about ‘excision’ but ‘excision’ is actually [just one] element of female genital mutilation [...]. Type III is removing the clitoris, the labia minora and the labia majora and then they sew it up. Type IV is all the other forms which exist. [...] there are those who don’t cut, who pull and stretch the clitoris like that until it becomes flat.

Leila’s typology is very similar to the current World Health Organisation’s classification of these practices and probably attests to her close engagement with advocacy work both in Burkina Faso and on the international scene. On the other hand, Dr Diallo, a female gynaecologist practising reconstructive surgery in Ouagadougou, seemed to draw her classification from the CNLPE’s manual albeit with a bit of confusion between Type III and Type IV female circumcision. She said:

In general circumcision is divided into four large types. Type I is where they just remove the clitoris. It goes without saying that removing just the clitoris causes, perhaps I’d say, fewer problems, I think because [...] the area of circumcision is not expanded. So we could say that we expect fewer complications than with other types, for example, Type II where they remove the clitoris and the labia minora and Type III where they remove the clitoris, the labia minora and the labia majora. So one has a higher chance of getting complications be it in the short term or the long term. And then Type IV where they practically remove everything and then sew it up and close it. That’s infibulation. In Burkina Faso [...] we have types I, II and III. We don’t have infibulation here. Even if it’s there, it’s very rare. I’ve personally never seen a case of infibulation; I’ve just heard it talked about.

The World Health Organisation et al. (2008:4)	<i>Conseil National de Lutte contre la Pratique de l'Excision (CNLPE) (n.d: 5-6)⁴⁹</i>
Definition: Female genital mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons (WHO et al. 1997, cited in WHO et al. 2008:4).	Definition: Circumcision is the act of cutting the external genitalia of a woman or a girl.
Type I – partial or total removal of the clitoris and/or the prepuce (clitoridectomy);	Type 1: partial or total cutting of the clitoris;
Type II – partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision);	Type 2: the cutting of the clitoris and the labia minora;
Type III – narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation);	Type 3: the cutting of the clitoris, the labia minora and the labia majora; This form can be accompanied by the closure of the vaginal opening using sutures making it infibulation. Infibulation is not practised in Burkina Faso. Only in some studies (EDS) is the adhesion of labia misunderstood and confused with infibulation.
Type IV– all other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterisation.	Type 4: other unclassified forms of female genital mutilation (FGM): numbing, pricking, lengthening/stretching. In Burkina Faso Types 1 and 2 are the most practised forms.

Figure 5.1 Defining circumcision and its various forms

On his part, Hassan, another gynaecologist practising in Ouagadougou, explained:

⁴⁹ I have translated information from this source from French to English, as I have done for all the other sources used in this study which are written in French.

All types of circumcision are practised in Burkina Faso, but the most frequent types which we find here are mainly Types II and III.

Here, I was at first inclined to think that Hassan was following the CNLPE typology above where Type III female circumcision is defined as the removal of the clitoris, the labia minora and the labia majora. Even so, when I asked him whether infibulation is done in Burkina Faso (because I was not sure whether he was following the CNLPE or WHO typology) he responded, “Yes, yes infibulation is done here”. Furthermore, Hassan and another doctor based in Bobo-Dioulasso named Karim indicated that they had personally conducted surgical operations on women who had undergone infibulation to reopen or widen the vaginal opening to allow for sexual intercourse upon marriage.⁵⁰ INSD and ICF International (2012:292) also point to minimal cases of infibulation in Burkina Faso (1% of the women interviewed in their study) which goes against the CNLPE’s assertion above that infibulation is not practised in Burkina Faso.

The difficulties encountered in identifying these procedures may have to do with the fact that some people follow the WHO classification – which changes from time to time (see, for example, WHO et al. 1997:3 vs WHO et al. 2008:4) – while others follow the CNLPE one. However, it is also clear that while it makes sense to classify these procedures for ease of understanding and discussion, in practice these procedures vary from place to place and the people who carry them out do not do them in a precise manner drawing from these fixed categories. That is to say, practitioners of female circumcision do not base their procedures on the classification method proposed by these organisations and indeed it is members of these institutions who take an array of procedures and try to fit them into fixed categories for purposes of coherence. It is in light of this that Sylvie said:

[The form of circumcision done] here is not controlled. If it was controlled we could say, yes, it’s the tip of the clitoris and part of the labia minora that are removed. If it was controlled it would be just removing the tip of the clitoris which would not reduce the [vaginal] orifice. But [for example] in a baby everything is together and sometimes they confuse the clitoris with the labia minora so they cut everything.

⁵⁰ In Chapter 6, I discuss complications where less severe forms of the practice can lead to pseudo-infibulation. In Chapter 8, I explore in greater detail the doctors’ involvement with reconstructive surgery.

Fluidity regarding the practice of female circumcision in Burkina Faso is not only observed in the form of the procedure done but also in its timing. In regard to this, INSD and ICF International (2012:293) indicate that these practices are carried out before the age of five for 60% of the women interviewed, between 5 and 9 years for 28% of the women interviewed and after the age of 10 for 11% of them. Even so, that does not mean that in practice these ages are followed systematically. A common expression used by my research participants to indicate this is that “these practices have no age”. According to Leila, these practices can occur any time between birth and death with some families even putting their womenfolk through them in death, in order to be able to accord them a proper burial which will enable them enter the afterlife.

The timing of these practices seems to vary depending on the ethnicity and religion of the people involved. For example, Amina pointed out that girls in her family underwent female circumcision on the seventh day because her parents were Muslims. However, all the other research participants who tell their stories in Chapter 4 were born in Islamic families but the age at which they were circumcised varied considerably: Antoinette at four or five; Samira at 13; Maimouna at 12; and Leila at seven. These women all come from different ethnic groups and one may be inclined to think that the timing of these procedures is influenced by ethnicity and what these practices mean in those different groups. However, even then, there is little evidence to suggest that these practices happen consistently or that they did before they were banned by law in 1996. For example, Leila Ali said:

Now with the impact of the effects of sensitisation, with the law age has declined because people think that if they wait... in my region it was a prelude to marriage. When one gets to the age of marriage. Before, there was an initiation ceremony but now it's no longer there. They would do the *kene-kene* [circumcision ceremony] and as soon as the wound healed, they would send the young girls into marriage. But now that's disappearing and circumcision is no longer practised universally here. There are isolated acts, acts done in the family where children of the same family are united or else friends come together, or it's just the family which decides to circumcise its children. That means there's no age. But now the age is in the process of dropping and it's now from birth till five years – in early childhood. It's now generally on small children that they do it.

Although Leila largely attributed these changes to the impact of sensitisation activities and the introduction of the law banning the practices, it is still notable that she herself was aged seven when she underwent the practice in the late 1950s together with her

sister who was 12 or 15 and her cousin who was also seven. In that case, the procedure was not done as an initiation ceremony which was a run-up to marriage. That tends to suggest that even by that time, these practices were already being done outside the socio-cultural context in which they had previously occurred in her community. That context seemed to have been eroded gradually over time so that these practices started to be carried out more haphazardly.⁵¹ As I explain below, this current unsystematic manner is the result of changes in the way of life of the Burkinabe people (influenced mainly by Western education and Christianity), but more so of fears created by sensitisation efforts and the passing of laws criminalising these procedures. Even so, regardless of the loss of the traditional socio-cultural context of these practices, some people in present-day Burkinabe society still consider these procedures important and indispensable.

Although female circumcision is widespread in many parts of Burkina Faso, there are evident disparities in its distribution which are linked to region and ethnicity. In terms of regions (see Figure 5.2), INSD and ICF International (2012: 291) point out that the Centre-Ouest region is characterised by the lowest proportion of women who have been circumcised (55%). The proportion is much higher in the other regions: Centre (66%), Boucle du Mouhoun (70%), Cascades (82%), Centre-Est (90%), Centre-Nord (87%), Centre-Sud (68%), Est (70%), Hauts Bassins (82%), Nord (88%), Plateau Central (88%), Sahel (78%) and Sud-Ouest (79%). This regional disparity could be explained by the fact that ethnicity has great influence on the prevalence of the practice. Female circumcision is practised most notably among the Sénoufo (87% of the women interviewed), Peulh (84%), Lobi (83%), Bissa (83%), Mossi (78%), Dioula (73%), Dagara (69%), Bobo (68%), Gourmantché (64%) and Gourounsi (60%), and less frequently among the Touareg/Bella (22%) (INSD and ICF International 2012:292).

⁵¹ Similar cases are discussed in more detail in Chapter 3 as observed in two Kenyan communities: the Gusii (Christoffersen-Deb 2005:410) and the Gikuyu (Moruzzi 2005:217-218). A similar trend is also observed in the Gambia by Ylva Hernlund (2000:235).

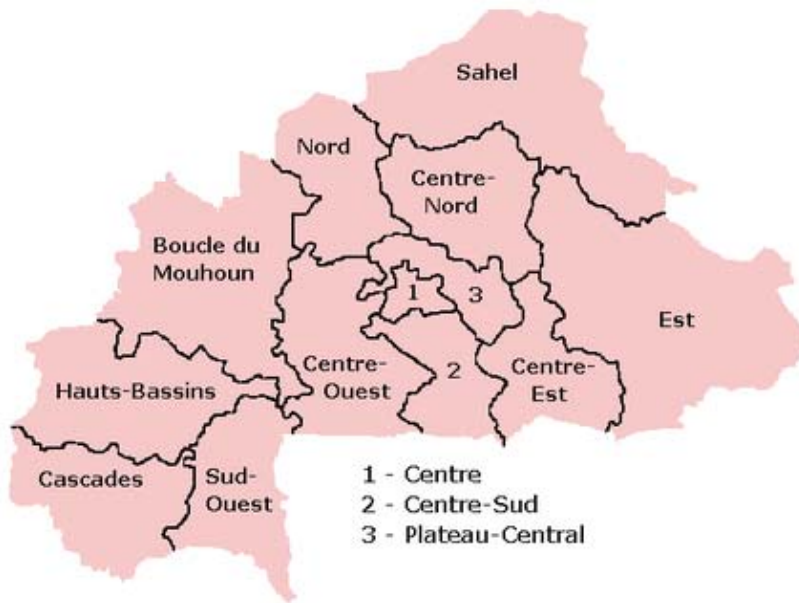


Figure 5.2 Burkina Faso's 13 regions

(Source: http://en.wikipedia.org/wiki/Regions_of_Burkina_Faso).

However, even within these regions and ethnic groups, the occurrence of the practice is not always straightforward. For example, citing an unspecified 2001 World Health Organisation report, Prolongeau (2006:111) points out that certain social groups such as the griots (storytellers, praise singers, poets and musicians) and the Mossi 'masks' do not practise female circumcision, and among the Gourounsi, those from Réo do not practise it whereas those from Léo and Tiébélé do. Even within the same ethnic group, some clans (for example, the Thiombiano clan of the Gourmantché ethnic group) do not practise it. This variation in the prevalence of the practice even within ethnic groups may perhaps explain why, for example, contrary to my findings and those of the EDSBF-MICS IV (INSD and ICF International 2012: 292), Toubia and Izett (1998:12) claim that the "Gourounsi, Leo and Tiebele do not practise female genital mutilation". The unpredictability characterising these practices was pointed to by Antoinette who comes from the Lélé ethnic group which falls under the larger Gourounsi group. She said:

Yes, yes, indeed, among the Gourounsi there are those who do not circumcise and those who circumcise. If you go to Réo, for example, at Réo there is no circumcision and when you go to Didir, there is a section which circumcises and another which does not. I'm from that section of Didir [which circumcises].

There is a trend observed especially since the passing of the law prohibiting female circumcision, where people put younger children, even babies, through the practice to avoid the risk of being found out and denounced to the authorities. People are said to sometimes plan female circumcision to coincide with other events such as vaccination after which a child may cry persistently without raising suspicion. This tendency was pointed out by Leila and Sylvie (cited above) but also by practically all my other research participants. Dr Diallo of the S noufo ethnic group linked this drop in the age at which girls undergo the procedure with fear of denunciation, but also with the mitigation of risks associated with it. She said:

I know that in some areas, [female] circumcision is a rite just like male circumcision which [marks] the passage into adulthood. For example, in my region it was at the time of marriage, in the rituals performed during the ceremony of marriage, that is when circumcision took place. Since marriage took one month, after the ceremonies, the woman would stay in the house for a month ... so that the wound heals [...]. But increasingly with the problem of the fight against circumcision and, well, I'd say people who are a bit more educated think that performing [circumcision] in adulthood has a lot more risk. Women bleed a lot. So they are increasingly doing it at a lower age.

In this case, the sensitisation messages about the negative consequences of female circumcision and the introduction of a law under which offenders are punished are both directly leading to younger and younger children being circumcised, which, as Sylvie points out above, leads to an increased risk of long term complications. A similar move towards circumcising younger children is also observed by anthropologist Ylva Hernlund among the Mandinka of the Gambia (2000:243, 252). She cites representatives of Gambian women's groups who suggest that this tendency is as a result of the fear that a law will be passed making the practice illegal (hence the need to carry out the procedures before it is too late) and the view that younger girls are less capable of resisting the practice. However, Burkinabe practitioners of these procedures find ways of silencing even older children using threats and deception. In regard to this, Albert explained:

There was a woman who testified to me. She used to circumcise young girls or adolescents. She would ask the child if she loved her father. The child says yes. "Do you love your mother?" She says yes. [Then she would say], "Well, now we are going to circumcise you, but if you scream, it's your mother your father who is going to die." So the child was able to keep the secret.

It is not only children who are silenced in regard to these procedures. For example, Pauline, a student at the University of Ouagadougou, explained to me that even when people know about these procedures happening in their communities, some of them are afraid to report them to the authorities as they fear that the circumcisers will bewitch them. These silences underpin the challenges met when trying to determine the current incidence of female circumcision in Burkina Faso. The EDSBF-MICS IV results show a sharp reduction in the percentage of younger girls who have been circumcised compared to that of women from the older generation (INSD and ICF International 2012:291, 294). However, the researchers in this study acknowledge that while this apparent reduction in prevalence from one generation to another may be a result of efforts to eradicate the practice, it may also be a result of underreporting by mothers who may fear prosecution (INSD and ICF International 2012:294).

The rationale for female circumcision

In this section, I explore some of the reasons behind the practice of female circumcision in Burkina Faso and juxtapose these with explanations from other societies where these practices are carried out. Understanding these reasons is important as they present the context of female circumcision in Burkina Faso and the cultural backdrop against which decisions about genital reconstructive surgery are made. Abusharaf (2000:152), who has done much of her anthropological research in her native Sudan, proposes that the motivations behind these practices rest “on an opulent repertoire of diverse cultural themes regarding notions of femininity, beauty, tradition, gender, sexuality, and religiosity”. As I show below, some of these themes are observed in the Burkina Faso case, particularly tradition, the control of women’s sexuality while protecting male virility, ensuring the perpetuation of life and the bid to practise one’s religion correctly.

A primary observation to make from the narratives in Chapter 4 is that in Burkina Faso female circumcision is often carried out in an atmosphere of deception and secrecy, and the girls involved do not know what is going to happen to them, let alone why it is happening. The explanations, if any, come afterwards. As already pointed out, the traditional context and understanding in which circumcision happened previously has been gradually lost and by the time these women were circumcised, it seemed random and without meaning. When the women sought explanations, they were told that this was a tradition which should be followed as it had always been. Those who were given reasons, such as Maimouna, found them unconvincing or unsatisfactory. Indeed, my

research participants pointed out that explanations proposed to rationalise these practices do not have any basis and are merely used to validate an unjustifiable practice. For example, Nafissatou said:

There are very many reasons which are put forward but which have no foundation. But it's simply because it's anchored in people's minds. They think if you don't circumcise your daughter, she will be the first one [who is not circumcised], that she will not get a husband [...]. So it's that fear that people have regarding abandoning the practice.

One of the main reasons cited to explain the practice of female circumcision in Burkina Faso is the upholding of local traditions or customs which, together with other beliefs and practices, form part of one's cultural identity. Indeed, a common way in which research participants expressed the futility of trying to find out the origin and purpose of the practices is that their parents and grandparents before them were born and found them going on. As such, for some people, these practices are traditions which should not be questioned. This reason is also cited by Hernlund (2000:237) who explains that in the Gambia female circumcision is practised nearly universally among the Mandinka, Serahule, Bamana, Fula and Jola. According to her, "[t]he reason for practising female 'circumcision' most strongly stated by Gambians ... is respect for tradition and conventional norms of behaviour" (pp.238-239). Even so, in Burkina Faso activists opposing female circumcision point out that when they try to trace its origin, they find that originally it was not part of the customs observed in Burkinabe societies. They underline the fact that it is a foreign custom, quite possibly imported from Arab societies, which took root and thrived for many centuries in Burkinabe societies.

It is also in the context of tradition that female circumcision is seen in some societies as a rite of passage marking the transition from girlhood into womanhood. It is part of a set of practices deeply embedded in local customs and beliefs, and necessary in the training of girls in preparation for their eventual entry, acceptance and integration into society as adult women capable of handling marriage, husbands and children (Prolongeau 2006:160; Lockhat 2004:15; Abusharaf 1998:23; Rahman and Toubia 2000:5). Albert pointed out that initially, in Burkinabe societies where these practices were carried out during initiation ceremonies, female circumcision was integrated in the transmission of social values such as the upkeep of the household and management of child care. However, now people neglect the aspect of initiating a woman into life in the household and teaching her about child care, married life and how to conduct herself in the society.

They have only retained the removal of sections of female genitalia. By so doing, they have taken the practice out of its original setting within a set of other social values and practices. This is seen in Leila's and Diallo's communities where these procedures, originally carried out in an initiation ceremony just before or during marriage, are now done as isolated acts within individual families before girls attain the age of marriage.

The alteration of the context of these procedures is observed in other societies which are coping with socio-cultural changes. For instance, Shell-Duncan et al. (2000:120-121) point out that in some previously nomadic Rendille communities in Kenya which are now living a settled existence, the tradition of arranged marriage is being eroded as a rising number of girls (who are now increasingly attending school) elope and initiate childbearing without undergoing these rites. As a result, men and women alike are expressing deep concern because "[a] woman of any age is regarded as a 'girl' if uncircumcised and as unable to legitimately bear children" (Shell-Duncan et al. 2000:121). The solution to this trend among the Rendille has been to uncouple excision and marriage, and to circumcise schoolgirls early. Such a trend is also observed among the Gusii of Kenya explored by Christoffersen-Deb (2005), where there has been a gradual shift from performing the procedures as part of an initiation ceremony so that now there are highly individualised forms of the practice carried out among prepubescent girls. It can therefore be argued that lowering the age at which these procedures are done is an adaptation aimed at trying to preserve some of the purposes they were meant to serve. Even so, it is also plausible to argue that in a number of cases including the Burkinabe case, these practices seem to have lost their meaning as markers of the transition from childhood into adulthood as they are now devoid of ritual, the transfer of knowledge from one generation to another and the communal celebrations that marked these rites in the past (Kouba and Muasher 1985:103; Prolongeau 2006:160-161).

It is not in all Burkinabe societies that female circumcision was or is a rite of passage from childhood to adulthood. In some cases, these procedures may be a way of clearly marking femininity on children's or adolescents' bodies in order to integrate them into the 'female' category. For example, Maimouna, who hails from the Samo ethnic group, pointed out that in having her circumcised, her grandmother explained that "if a woman has a clitoris, as she grows it will also grow and that's not beautiful to look at, that it's ugly". There are beliefs in Burkina Faso that such an unchecked clitoris increases the

degree of masculinity in a woman and in some cases creates a permanent state of sickness in her (Diop et al. 2008:5). In this context, removing the clitoris ensures that a woman is not only beautiful and healthy, but is also appropriately marked as female. The association of the removal of the clitoris with enhanced beauty and femininity is observed in other societies such as Sudan (Abusharaf 2001:114,122-123, 1998:24; Lightfoot-Klein 1989:39), Mali (Prolongeau 2006:159-160) and Egypt (Lockhat 2004:16-17), where these operations serve to complete the social and spiritual definition of a child's sex by removing visual traces of anatomical ambiguity (Boddy 1998b:90).

Female circumcision has also been linked in Burkina Faso with the understanding and practice of Islam. Leila pointed out that even though it is not mentioned in the Quran, some Muslims in the country consider the removal of the clitoris an act of religion which enables them to practise their faith correctly. Such people believe that an uncircumcised woman is not clean. Neither her ablutions nor her prayers are accepted and she will not go to paradise upon her death. The clitoris is therefore considered a bad organ whose presence makes a woman impure. In the same way, Johnson (2000:219) points out that among the Mandinga of Guinea-Bissau, clitoridectomy is presented as “a cleansing rite that defines a woman as a Muslim and enables her to pray in the proper fashion”. Even so, it is important to point out that it is not only Muslims who practise female circumcision in Burkina Faso; the vast majority of girls are put through them regardless of their parents' religious affiliation. Similarly, beyond Burkina Faso, the practice is observed in communities from all sorts of religious confessions: Coptic Christians, Ethiopian (Falasha) Jews, Catholics, Protestants and followers of indigenous religions (Prolongeau 2006:161; Moruzzi 2005:208). The difference is that some Muslims in Burkina Faso (and elsewhere) link these procedures with the practice of their religion whereas adherents of other religions do not. It is perhaps because of that association that the proportion of women who have undergone the practice is highest among Muslim women in Burkina Faso: 81% compared to 66% of Catholics, 60% of Protestants, 75% of those who follow indigenous religions and 62% of those who do not declare a particular religion (INSD and ICF International 2012:291).

Some of my research participants in Burkina Faso were keen to explain that the practice is not justifiable by Islam and should not be linked to it because it is not sanctioned in the Quran. Moreover, as Nafissatou pointed out, Muslims in some Arab countries do not practise circumcision but that does not hinder them from practising their religion.

Moruzzi (2005:208) suggests that those Islamic communities that practise female circumcision usually define it as a recommended religious practice which is preferable but not required. She points out that a reference made by Prophet Mohammed to the practice recorded in a *hadith* (a collection of sayings and practices attributed to the Prophet) is ambiguous; it can be interpreted as an Islamic justification of the practice or as the Prophet's attempt to minimise a problematic pre-Islamic practice (cf. Hadi 2006:107-108). However, in Burkina Faso some people believe that this is a required religious practice, not just a recommended one.

There are also suggestions in the literature that the association of these practices with Islam can be explained by similarities between some Islamic values and pre-Islamic ones found in societies where these procedures happen. For instance, Abusharaf (1998:25-26), who posits that this practice is virtually unknown in some predominantly Islamic countries such as Saudi Arabia and Iraq, suggests that it is likely that when Islam was introduced in African societies, its emphasis on purity became associated with the practice of female circumcision which already had these connotations. Boddy (1998:81) echoes this idea by pointing out that "African Muslims account for a sizeable number of those affected" and suggests that the practice supports the preservation of premarital chastity that is strongly associated with Islam. Such suggestions imply that female circumcision pre-dated Islam in these communities.⁵² Even so, as already pointed out, some Muslims in Burkina Faso do not view these practices as being independent of their faith, and some research participants suggested that it is likely these procedures came into Burkina Faso with the Islamic religion.

The need to control the sexuality of girls and women is another common reason put forward to explain female circumcision. Womenfolk are circumcised in a bid to control them by making them less sexually sensitive or responsive which is then thought to make them desire or seek sex less frequently than their uncircumcised counterparts. People thus link the presence of the clitoris with compromised morality saying that an

⁵² Antoinette pointed out that the Gourounsi only started practising male circumcision recently under the influence of Islam, and that indeed none of her brothers are circumcised. A similar trend was also pointed to by Doctor Condeh of the Bobo ethnic group. In these two communities, female circumcision preceded male circumcision and the latter is more readily associated with Islam than the former.

uncircumcised woman is promiscuous. Citing Françoise Couchard (2003), Prolongeau (2006:155) suggests that the need for men to suppress women's sexuality stems from ancient myths which portray women as having boundless sexual energy. As such, female circumcision is used to "calm the passions of girls" to ensure that they remain virgins until they are married, and that once married, they remain faithful to their husbands. Leila explained to me that this is the main reason why people continue to practise female circumcision in Burkina Faso, a country where polygamy is common and men want to keep their wives faithful.⁵³ Indeed, Maimouna's grandmother told her that a woman who has her clitoris cannot stay calmly in her house or be faithful to her husband. This idea is echoed by Jirovsky (2010:88-89) who, in her research detailing how these procedures are viewed by women and men in the region of Bobo-Dioulasso, points out that the need to control female sexuality is the main reason given for why the practice is considered necessary. Some of the young men she interviewed considered the practice good as it enabled women "to stay calm" (2010:89), and it was these 'calm' women that they wished to marry.⁵⁴ Indeed, in the Bobo-Dioulasso area situated within the Hauts Bassins region where the prevalence rate is 82% (INSD and ICF International 2012:291), the cultural and social need for the practice had not changed, and many of Jirovsky's (2010:88) respondents indicated that they wished for the procedures to be done in a way that avoids the negative health consequences currently associated with circumcision.

The connection of female circumcision with premarital chastity and fidelity in marriage is not unique to Burkina Faso. It is observed in other societies, particularly in Sudan, Somalia and Egypt (cf. Cook et al. 2002:284; Rahman and Toubia 2000:5-6). There is debate in the literature over whether the sexual control of women is the main goal of

⁵³ Even though this would suggest a harsh view of extramarital sex, I had discussions with various people, particularly university students, which led me to think that premarital sex is fairly common and tolerated in Burkina Faso. Still, given the scope of my study, I do not have adequate information to make an informed comment about the scale of this phenomenon or societal attitudes towards it.

⁵⁴ My research participants, particularly the Raélians, dispute the veracity of this reasoning arguing that it is one's upbringing that determines moral conduct. Some of them suggest that if anything the procedure leads to girls and women becoming more promiscuous. I discuss this idea in more detail in Chapter 7.

these practices or it is a by-product of a different end – that of ensuring family honour and a girl’s beauty, purity, chastity, fertility, respectability and marriageability (cf. Obermeyer 1999:84; Abusharaf 1998:23, 2001:127; Boddy 1982:685-687, 1998:95; Gruenbaum 2001:40). This discussion seems more applicable to societies in Sudan, Egypt and Somali where the emic perspective associates these practices with symbolic purity which goes beyond physical cleanliness. This symbolic cleanliness is observed where these practices are linked to Islam even in Burkina Faso. However, Burkinabe insiders do also link these practices directly to the need to lower women’s sexual sensitivity in order to make them desire sex less frequently thus keeping them from being promiscuous.⁵⁵

In Burkina Faso, there are also direct links of female circumcision with fertility among some people who consider the clitoris dangerous to the perpetuation of life. In this context, the clitoris is removed not only to curb a woman’s potential promiscuity but also to protect male potency and even life during sexual intercourse. It is in regard to this that Maimouna talked about her grandmother’s belief that if a man comes into contact with the clitoris during sexual intercourse, he can catch a chill and die. Gabrielle, a 28-year old Catholic from the Gourounsi ethnic group working as a

⁵⁵ Another contentious theme among researchers is the one that associates female circumcision practices, particularly infibulation, with increased sexual pleasure for men (cf. Toubia and Izett 1998:36; Gruenbaum 2001:154; Assaad 1980:13; Ammar 1954:120; Boddy 1982:685). Although none of my Burkinabe research participants mentioned this justification, it is mentioned in an earlier survey (EDSBF-III) carried out in 2003. Other justifications associated with the practice in that survey include: social acceptance, good hygiene and better prospects for marriage (INSD and ORC Macro 2004:214-217).

Regarding the association of female circumcision with the cleanliness of female genitalia, Prolongeau (2006:158, 160) points out that some people in Burkina Faso believe that female genitalia have a lot of folds and crevices which harbour a lot of dirt (and in some cases worms) which causes bad odour. Getting rid of these folds thus eliminates these problems once and for all. This belief was also observed in Sudan by Lightfoot-Klein (1989:6, 9). Lockhat (2004:17) points to the irony of this rationale given that female circumcision is linked to an increased predisposition to infections and subsequent odours.

community support technician in Leila's centre while completing her doctoral degree in sociology, also pointed to such reasoning among some people. She explained that some believe that if a man has sexual relations with a woman who is not circumcised, he can become impotent. Yet, she explained, there are men who are married to and have sired children with uncircumcised women. There are also beliefs expressing concern for the life of the next generation. As Sylvie explained:

We don't know why but people lie and say that if during birth the clitoris touches the head of the child, the child will die. We asked people, for example, when I was in maternity. They said that [the clitoris] should be cut, otherwise the child will die and if he doesn't die, then he will be a dimwit, retarded, with delayed mental development because the clitoris shouldn't touch his head. These are bizarre beliefs.

Leila also countered such beliefs by saying that it has been proven scientifically that during birth the clitoris is dilated, and it is not possible for the baby's head to touch it. Likewise, there are beliefs that the clitoris absorbs the blood of the foetus and in some cases can prevent a woman from bearing children (Diop et al. 2008:5). These beliefs are not unique to Burkina Faso; Orubuloye et al. (2000:73-74) cite their 1994-1995 study in Nigeria to point out that "the Yoruba have had only one specific explanation for the need for female 'circumcision' and that is to preserve the lives of the next generation, for the tip of the clitoris touching a baby's head during birth is thought to result in the baby's death".

Whatever the reason for carrying out female circumcision in Burkina Faso, it is thought that exposure to Western education influences the decisions that parents make about circumcising their daughters. For example, although Amina who is Bobo largely attributed her circumcision to her parents' Islamic faith, she also underlined their lack of formal education and the role that that probably played in the matter. She said:

Well, we realised that in my case, for example, I came from an Islamic family and so almost all the girls were circumcised. In contrast one of my friends who was my age mate but from a different religion was not circumcised. But [it's also because] her parents were educated, they were intellectuals because her father taught at high school and her mother was... she sold in a pharmacy. I believe that with their level of education and sensitisation at that time, that helped. There is circumcision among animists, Catholics, Muslims.... So I would put it down to the level of education of her parents. And also their awareness because, especially the woman worked in the medical field, so she knew how to justify herself since she had information that it wasn't good. But with me, my parents were not... they were illiterate so I can understand that they did not have information.

This correlation between the level of education of parents and the decisions that they make regarding having their daughters circumcised is also made by INSD and ICF International (2012:295) who conclude that mothers with no formal education are more likely to put their children through the practice while those with formal education, particularly secondary school education and higher, are less likely to do so. Even so, Amina pointed out (as did Leila) that there are some educated people who still have their daughters circumcised because the practice is deeply rooted in their mentality through their religious and cultural beliefs. Moreover, it needs to be emphasised that in the Burkinabe context, the decision-makers are not always the parents of the girl in question as people often live with other relatives in an extended family set-up. For example, Samira's circumcision was organised by her sister, with whose family she lived in Ivory Coast. On her part, Maimouna indicated that although her parents, particularly her father, were against the practice, her grandmother had her circumcised during a visit. In that context, it was only Maimouna's father who could have stopped the procedure as her mother did not have the power to go against that decision because of her lower rank within the extended family.

Efforts to stop female circumcision in Burkina Faso

The first objections to the practice of female circumcision in Burkina Faso can be traced to the beginning of the twentieth century when Catholic missionaries threatened to excommunicate circumcised women (Prolongeau 2006:108). They considered circumcision as damaging to women's physical integrity, thus deserving of condemnation. However, while a few people tried to follow the teaching of the church, the trend was rapidly stopped because women who did not get circumcised found it extremely difficult to find husbands, and when they did, their spouses had them circumcised after marriage (ibid.).

After independence, in the 1960s, the new president, Maurice Yameogo, tried to mount a campaign of information against the practice, but social opposition proved too much and he was accused of being a "white man in black skin" (Prolongeau 2006:108-109). Female circumcision continued to be opposed marginally until 1975, International Women's Year, when, in an increasingly noticeable manner, some women began to speak against the practice on public radio, often provoking violent reactions. It took another ten years during the National Women's Week instituted in 1985 by the president of the day, Thomas Sankara, for proper mobilisation to take place and for a

number of united women's groups to call upon the authorities to prohibit the practice (ibid.). Leila explained that she was involved with these early efforts which were facilitated by a Swiss non-governmental organisation. She met with other people in a group of about 10 to talk about ways of curbing circumcision. Those talks culminated in a national conference in May 1988.

The May 1988 conference brought together three hundred representatives from various organisations and led to the creation, in October of the same year, of a provisional committee to look into efforts to end the practice. On 18 May 1990, the *comité national de lutte contre la pratique de l'excision* (the national committee for the fight against the practice of circumcision, CNLPE) was set up with its honorary president as Chantal Compaoré, the wife of the new President, Blaise Compaoré (Prolongeau 2006:108-109).⁵⁶ Leila held a key leadership position in the committee.

Since then, the political will of the Burkinabe government to fight against female circumcision has been translated into several initiatives: the creation, in 1996, of a permanent secretariat to function as a coordination organ for the CNLPE; the adoption, in 1996, of a law forbidding female circumcision; the declaration of 18 May as a national day of fighting against the practice to be marked annually with official ceremonies throughout the country; the setting up of a free telephone line permitting people to call the authorities anonymously when a case of female circumcision is planned or has already taken place; and the institution at national level of measures to ensure management of the consequences of these procedures through reconstructive surgery. On 27 May 2009 the Burkinabe Council of Ministers adopted the 2009-2013 National Action Plan aimed at completely eliminating these practices in Burkina Faso by 2015 (INSD and ORC Macro 2004:203; INSD and ICF International 2012:289; Jirovsky 2010:85; Lockhat 2004:63-64; Diop et al. 2008:2). The country has also over the years ratified or adopted a number of international conventions in favour of women's and children's rights which are used to formulate arguments against female circumcision (Diop et al. 2008:16).

In its constitution of 2 June 1991 Burkina Faso guarantees the fundamental human rights of everyone living in the country (see Articles 2 and 26). In its Penal Code, law

⁵⁶ The word 'comité' has since been replaced with 'conseil' (council).

number 043/96/ADP of 13 November 1996 spells out punishment for perpetrators of and accomplices in acts of female circumcision. Law number 049-2005/4N on Reproductive Health in Burkina Faso prohibits, in Article 7, Paragraph 5, harmful traditional practices, including female circumcision (INSD and ICF International 2012:289). Instituted under these laws are fines of between 150,000 and 900,000 West African francs (approximately between 367.34 and 2,204.02 New Zealand dollars),⁵⁷ prison sentences of between six months and three years for perpetrators of female circumcision and sentences of between five and ten years in case of the death of the victim. Doctors discovered carrying out these procedures receive the maximum sentence and are barred from practising for five years, while people who fail to denounce practitioners are liable to pay fines of between 50,000 and 100,000 West African francs (Karmaker et al. 2011:8, Jirovsky 2010:85, Prolongeau 2006:109-110).

The CNLPE is made up of sixty members representing government ministries, non-governmental organisations, women's associations, professional associations, human rights groups, traditional and religious leaders, and persons of good will. It operates under the auspices of the Ministry of Social Action and National Solidarity whose minister is also the president of the CNLPE. Its activities are coordinated by a permanent secretary who is supervised by the ministry. Through its permanent secretariat located in Ouagadougou, the CNLPE organises sensitisation activities, human resource education programmes, as well as advocacy activities targeting political authorities, administrators and development partners. These activities are going on currently and are increasing in intensity through provincial committees (INSD and ORC Macro 2004:203; CNLPE n.d.:17-18).

Sensitisation activities coordinated by the CNLPE include informing people about serious medical problems associated with female circumcision and the social problems emerging from these health consequences. Campaigns target different audiences including schools, youth associations, community leaders, women's associations, religious leaders, political leaders, security forces, the judiciary, healthcare providers, journalists and practitioners of female circumcision (Jirovsky 2010:85; Diop et al. 2008:2; WHO et al. 1999:65). Different media are employed to spread the message, for

⁵⁷ Exchange rate obtained from CoinMill.com on 18 April 2014.

example, traditional communicators, local radio, facilitated group discussions, theatre and television (Jirovsky 2010:85). Nafissatou explained that CNLPE staff go to supervise and coordinate such activities in communes, provinces and villages. They also prepare documents to ask for funding so that there can be activities in these sites.

These efforts have not been without difficulty. Leila recounted that when programmes were first put in place to end female circumcision there was opposition. She said:

When we started officially, it was not easy. We had to oppose... we had to stand up to the national opinion which was not favourable. Because people would say we had come with ideas imposed by the West, we are manipulated by Europeans, we are in the pornography industry, we are paid [...]. But we continued. We did not listen. We continued until today people are in agreement with us. Even if there is a small minority which thinks that... today the great majority is in agreement. Now how do we find a strategy to stop [circumcision] completely? That's the big problem.

Difficulties in getting everyone to end the practice have to do with convincing both circumcisers and people who have their daughters circumcised that the procedures are harmful. Albert suggests that the continued practice of female circumcision is due to the fact that circumcisers view these practices as a heritage which they are obliged to maintain, otherwise they will need to account for their failure to the ancestors who conferred that responsibility. There are also practical difficulties in transmitting information in a country where up to 85% of the inhabitants live in the countryside, in scattered villages, where paved roads are rare and the rainy season renders certain regions impassable for several months (Prolongeau 2006:110-111). Even once these people have been reached, there are fears that because some of them are not convinced about the need to stop circumcision, the practice is driven underground and done earlier on even younger children as discussed above. Furthermore, some urban dwellers take their girls to the countryside, or even out of the country, to Mali or Ghana, to be circumcised. Other people resort to performing these procedures during the rainy season or at night when they can be more easily concealed (Prolongeau 2006:127-128; Diop et al. 2008:5).

In spite of these difficulties, which were underlined by some of my research participants including Leila and Nafissatou, there are indications that the campaign coordinated by the CNLPE is getting positive results as it is reported that cases of female circumcision are now much fewer in the country than they used to be. It is also clear that the message of the negative effects of female circumcision is reaching the people. The people I

interviewed in Ouagadougou and Bobo-Dioulasso, even those who were not activists and those who were not circumcised, seemed to know quite a lot about this practice and its perceived negative impact.⁵⁸ In confirming that the sensitisation campaign about the negative effects of female circumcision has been largely successful, Gabrielle said:

Yes, we can say that a majority of the population have got that information even in the remotest villages. Even though circumcision still persists it's not because people don't have information but because they still haven't decided to change their behaviour [...]. The customary chiefs, the municipal councillors and the various district delegates, everybody is with us in that sense [...]. We trained men who went and spoke to their peers in society, their fellow men. That is to say that if you take anyone at the moment, he can talk to you about circumcision. So the information has truly passed. In any case, we haven't yet had any information on a new case of circumcision in this sector since this centre was put here in 2007 or 2008.

Several factors are said to have contributed to the abandonment of female circumcision in Burkina Faso. These include the publicising of the law prohibiting these practices, a free of charge phone number enabling people to report perpetrators of the practice, the involvement of traditional leaders in campaigns to end the practice and people's contact with the outside world with alternative values which has led to the embracing of new ideas and facilitated giving up old practices. There are also suggestions that living with and seeing the consequences of these procedures in one's family or neighbourhood has enabled some people to change their outlook (Diop et al. 2008:4-5).

Conclusion

Practices of female circumcision in Burkina Faso are characterised by a great deal of inconsistency. Modifications to the context and nature of these practices seem more noticeable in the present day and are said to be influenced by government efforts to end these procedures. However, from the stories told by my research participants in Chapter 4, it is clear that the contexts of these practices started changing considerably from at least the 1950s, but probably even around the beginning of the colonial period. The unpredictability observed affects the form of the practices done, the times when they are done and who undergoes them. Even within single ethnic groups, these practices carry a

⁵⁸ Conversely, as I explain in Chapter 7, very few people outside advocacy and medical circles seemed to know much about reconstructive surgery because the CNLPE strategy lays more emphasis on convincing people about the negative effects of female circumcision and getting them to stop the practice.

great deal of unpredictability making it difficult to generalise about them. It is therefore more plausible to consider these practices as they happen to individuals rather than to groups of people. How and when they happen seem to depend on a combination of factors which include ethnicity, religion, place of residence, parents' or guardians' level of awareness and/or education, and even convenience.

When discussing why female circumcision is done, some of my research participants drew from their experiences in their families and ethnic groups, but some also made reference to a multiplicity of settings quite often without addressing specific cases. They used such phrases as 'in some groups in Burkina Faso' and 'some people in this country'. That could be because my research participants were all located in the two cosmopolitan areas of Ouagadougou and Bobo-Dioulasso where understandings of female circumcision procedures and their context may be drawn from multiple ethnic and religious groups. However, it is more likely that it is because some of my research participants were directly or indirectly involved in efforts to end female circumcision. They therefore often did not speak about it from the standpoint of their ethnic groups but from their position as activists and medical personnel looking at these practices as a whole. As such, there was a tendency to speak about the context of circumcision with reference to Burkina Faso as a whole without clear identification of the specific ethnic or other groups concerned. Even so, some research participants did make reference to their own ethnic group and religious affiliations making it possible, in some cases, to discuss these issues in those contexts.

It is notable that even the research participants who did not work in activist or medical domains employed a generalised and condemnatory discourse associated with activism against female circumcision when discussing these issues. This demonstrates the permeation of activist messages in the general population. It is particularly observable that research participants rarely presented reasons proposed to justify the continued practice of female circumcision without taking time to debunk them.⁵⁹ Taken individually, these reasons might have arisen from many different ethnic groups but they are now often cited together as though each is considered relevant in all of Burkina Faso's 63 ethnic groups. Moreover, although I met people from ethnic groups where

⁵⁹ The success of the CNLPE messages is even more noticeable, as I explain in the next chapter, when people talk about the impact of female circumcision.

these practices are not carried out, I was hard pressed to find a conclusive list of these groups as it is generally stated that they happen in ‘almost all’ of Burkina Faso’s ethnic groups.

Research participants demonstrated a deep awareness of possible origins of female circumcision, its nature, why it is carried out and the problems it is thought to cause. In general terms, given the prevalence of female circumcision in Burkina Faso, few people do not know about these practices and what they mean for the people who do them. However, if there were some who did not know much about them before (perhaps men or even girls and women who have not been circumcised), today few people in Ouagadougou and Bobo-Dioulasso have not heard the CNLPE’s message regarding the nature of these practices, who undergoes them, how they are changing and why the reasons proposed to justify them do not stand up to scrutiny.

CHAPTER 6

THE REPRESENTATION OF CONSEQUENCES OF FEMALE CIRCUMCISION IN BURKINA FASO

Introduction

In this chapter I explore the framing of the discourse opposing female circumcision in Burkina Faso. I demonstrate that the Burkinabe government (through the Ministry of Social Action and National Solidarity, and the CNLPE), healthcare workers and other activists portray female circumcision as inevitably causing grave problems for women. I present the language used to express the negative consequences associated with these practices and to formulate the material used in sensitisation activities. In this material, Burkinabe women who have undergone circumcision are presented as victims who are undoubtedly suffering and who need a remedy even as efforts are redoubled to end female circumcision. The women's distress is presented as occurring at a physical level – causing severe health and sexual problems – but also at a psychological level. I further show that members of the general public have embraced this discourse and portray the procedures in question as deadly.

I also refer to some researchers and activists outside Burkina Faso who discuss the perceived negative consequences of female circumcision and their portrayal. Some of them link these practices to harmful physical and psycho-sexual effects, while others suggest that the evidence cited is often drawn from research fraught with methodological errors and is thus questionable. In Burkina Faso, this debate is much less noticeable with an almost universal view among those exposed to the official discourse that female circumcision inevitably causes problems for women as individuals, but also as relational beings.

The propositions that are made in this context are important to consider as they provide an insight into the Burkinabe people's understanding of female circumcision. More importantly, they show how this understanding is implicated in the need for women to have reconstructive surgery. Perceptions about the negative consequences of female circumcision inform the ideas of incompleteness and loss of integrity that circumcised women have about their bodies and influence how these women receive information about reconstructive surgery. This ultimately underlies the decisions they make regarding this surgery. As I demonstrate in Chapter 7, reconstructive surgery is

presented as a solution to these problems as it offers these ‘victims’ a chance to rebuild their bodily integrity and create new identities as normal, healthy and complete women.

Perceptions of the consequences of female circumcision

In urban Burkina Faso, practices of female circumcision are almost always understood and presented as inevitably causing negative health consequences. This is perceptible in information given by medical personnel who treat women with reproductive health problems and by activists working to eliminate these practices. It is also noticeable in conversations with members of the general public who have been exposed to the activists’ messages. There is an assumption that wherever these procedures are done, there are attendant negative health consequences. For example, in a 2009 report detailing research carried out by the CNLPE on the management of the consequences of female circumcision in the communes of Ziniaré and Kombissiri, Ouédraogo and Ouédraogo (2009: summary) state: “The significant prevalence rates cited above necessarily imply the existence of sequelae in victims of circumcision, hence our interest in the action research”.

To determine my research participants’ understanding of the effects of the practices under consideration, I asked: “In your understanding, what is the impact of circumcision on girls or women in Burkina Faso?” In their answers, research participants tended to give a detailed list of problems associated with these practices, depicting them as though they routinely occur in all types of female circumcision and in everyone who has been circumcised. Rarely did they point to the conditions or contexts under which the problems cited can or do occur. This stance runs counter to Dr Diallo’s acknowledgement (quoted in Chapter 5) that different types of female circumcision are bound to cause varying degrees of complication. In the section below, I quote extensive passages from my conversations with some research participants to demonstrate the manner in which they depict these issues with little attention to specificity.

One of my first respondents was Professor Kerekou, a medical doctor renowned in Burkina Faso for his work in reconstructive surgery. He said:

But you know the consequences...⁶⁰ which ones are you asking about? Medical or psychological or what? No, the medical consequences, you know that the clitoris is a vascular organ which is highly innervated. So that is to say there are a lot of nerves in it, because it is the ultimate organ of sensation for a woman. So when one is circumcised, immediately during the act or soon afterwards, there can be haemorrhage. There is pain first of all, there is haemorrhage, and haemorrhage is very serious; it can lead to a drop in blood pressure, thus to shock, and the woman can die. And pain also can cause shock and the woman can die. There is also urine retention because it hurts when she urinates. When urine touches the wound it hurts. So you have immediate consequences.

Later in the coming days, what dominates is infection, because it is a wound which is not treated medically, which is not treated in an aseptic way. So what happens? The woman can get an infection. And the most serious infection is tetanus. I forgot that at the moment of circumcision, because it's a mass circumcision, if one of the circumcised girls has a hepatitis B or HIV virus, these two viruses can be transmitted to the others. So a few days later there is infection. So it is infection that dominates.

And later, when the wound is healed, the girl can have keloids. She can have cysts in the vulva. She can have pain during sexual intercourse. She can have urine retention. She can have retention of menstrual blood. She can have urine incontinence where urine flows all the time. And later, if she can have intercourse – it might be that she cannot have sexual intercourse – even if she can have sexual intercourse, she can have pain.

It's from there, from that act where all the psychological problems arise because she feels diminished in comparison with others by an act which was imposed on her without her consent. It revolts her. She is not in agreement. She revolts against society. Some of them decide not to get married as a revolt against the whole society. Or else they run away from sexual relations which leads to the disorganisation of the couple and causes a lot of divorce. So circumcision has nothing that is beneficial. It just has disadvantages.

Kerekou sometimes prefaces his presentation of these negative consequences with the phrase 'can cause', but the same is not observed in activist material used to create

⁶⁰ Kerekou's implication here that the negative consequences of female circumcision are obvious to everybody seems to be a common view in forums where discussions about these procedures take place in Burkina Faso. I observed this, for example, when I attended a meeting held in Ouagadougou on 5 February 2013 between the CNLPE staff members and musicians. One of the aims of the event was to ensure that the musicians understood the negative effects of female circumcision (from the CNLPE's point of view) and disseminated accurate messages in their compositions and performances. One of musicians asked, "What are the negative effects of circumcision?" There were audible groans of incredulity from the rest of the participants as though to say that everybody knew the answer to that question and that asking it was a waste of time.

awareness. For example, the last section of a leaflet distributed by members of AVFE entitled 'No to Female Genital Mutilation/Circumcision' contains the following statement:

Consequences of female genital mutilation or circumcision which are harmful to health: non-cicatrization; abscess formation; cysts; excessive growth of scar tissue; urinary tract infections; painful intercourse; increased susceptibility to HIV/AIDS, hepatitis and other blood-borne diseases; infections of the reproductive system; pelvic inflammatory disease; sterility; painful menstruation; chronic urinary obstruction/bladder stones; urinary incontinence; obstructed labour; increased risk of haemorrhage and infection during childbirth.

A booklet prepared by the CNLPE, *Je n'exciserai pas ma fille*, presents these practices as though they are performed in a uniform manner, causing very severe problems in most, if not all, cases.

Circumcision is practised by a woman who is not qualified, who is sometimes visually impaired and who works without any [regard to] hygiene or anaesthesia. The complications are, therefore, numerous.

Immediate complications can occur during the operation or immediately afterwards. These complications are: pain; bleeding that can drain all the blood of the circumcised person who then dies; transmission of the AIDS or hepatitis B virus; urinary retention; urinary incontinence; breakage of the bones of the arms, legs or ribs.

Subsequent complications can occur: tetanus when the girl is not vaccinated; AIDS; pain during sexual intercourse, which may be impossible because the vaginal opening is closed or reduced; lack of pleasure during sexual intercourse; impossibility for menstrual blood to flow out; the formation of an opening between the bladder and vagina (vesico-vaginal fistula) or between the end of the large intestine and the vagina (recto-vaginal fistula); thickening and swelling of the scar after the healing of the wound (keloid); difficult childbirth; tearing of the vaginal opening; the death at birth of a baby who remains stuck in the birth canal for long; impossibility for a woman to get pregnant because sex is impossible or because her genitals have been damaged by infection; mental disorders caused by frustration; economic consequences – multiple prescriptions to buy because of infections and infertility; social consequences – infidelity, marital turmoil, divorce (CNLPE n.d:14-16).⁶¹

⁶¹ CNLPE (n.d). *Je n'exciserai pas ma fille, et toi?* (I will not circumcise my daughter, what about you?) I have effected some changes in the layout of the material.

Some of the circumcised women I interviewed also framed these consequences in the same manner. In the extract below, Samira's understanding and presentation of these consequences came in an angry diatribe against people who consider clitoral reconstruction to be cosmetic surgery.⁶² (During this explanation, Samira's voice rose as she became increasingly angry so that by the end of this excerpt she was practically shouting).

Do you realise a girl of 13 who wakes up one morning and finds four women coming into her yard? And her elder sister in all simplicity, in all ignorance, gives her over to these women who get hold of her and circumcise her? At 13 years, is it possible to forget such pain? One is already old then. One cannot forget. That is what happened to me. That is what happened to me, and today I forgive. I forgive those old women, I forgive my elder sister *but I cannot forget*. It's in my head. When I think about it I have goose bumps. Every time. Once circumcised, every morning they come and get you and use soap, black soap, to wash your wound. Every morning! You cry for two months before you get healed. You understand that. You cannot forget.

You manage to get healed, you grow up and have a boyfriend and start having sex. Your friends tell you, "Oh, sex is good. It is like this, like that." But you, when you go with your man, instead of having pleasure you feel pain. Is it your man's fault or is it your fault? You don't know. You don't know but your colleagues take pleasure in it. You talk to them and they tell you, "No, you, you know nothing. Maybe it's your man's [fault]." And you continue. You change men, you change men and afterwards you are made aware that it's because of your circumcision that that happens.

And it so happens that you get pregnant. In spite of the pain you are pregnant. You go to give birth, you have difficulties. At every birth they have to make an incision. They have to make the opening bigger so that the child's head can pass. Because the scarred part becomes hard. The skin is hard it cannot... because ordinarily the skin is elastic. But because it is scarred, it becomes hard. It breaks if the birth attendant is not careful. If she does not help you with pain relief. You break, you get torn. When you get torn what happens? The child struggles inside and makes a hole between the bladder and the clitoris. And that's how fistulae are formed. You are torn, they put staples in you and you heal. You have finished everything, you have given birth but it so happens that when you sit, urine comes out on its own. You smell bad and your husband rejects you. He no longer wants you because you smell bad. That you are possessed by spirits. Your co-wives, your colleagues, flee you because you smell bad.

In Samira's portrayal of the effects of these procedures, there is a slippage between her own experience (which she talks about in Chapter 4) and the dire consequences outlined

⁶² I discuss this issue in Chapter 7.

in sensitisation literature. This trend was observed among other women, particularly Maimouna and Antoinette, who, when requested to talk about the impact of circumcision on their lives, also went on to talk about general problems affecting other specified and unspecified women. By so doing, they seemed keen to emphasise that these procedures are extremely harmful, and that even though they themselves may not be suffering from these problems, there are other women who unquestionably do. For example, Antoinette, who said that the only problem she had had as a result of being circumcised was that she did “not get wet during sex”, also said:

It's also just that I have friends who approach me and say [...]. For example there's one who approached me and said [...] she has sex for the sake of it, but she does not feel anything. She does not know what it is to really enjoy sexual relations. So it really is a problem for some women. There are others, for example, who are in such a situation that for them having sex is really a nightmare because they just have small openings for letting urine through. So when a man has to penetrate them, it's rape. I think it's a case of rape. Even with the husband it's rape. It is rape because they are like victims, they are...they were circumcised to a very advanced degree.

Most of my other research participants – even those not in the medical or activist domains – also portrayed female circumcision as inevitably causing problems for all women who undergo it. This understanding seemed to be derived from the manner in which negative consequences had been presented to them by activists and medical personnel. During fieldwork, it was increasingly difficult for me to extricate the research participants' actual lived experience from hypothetical problems or activist rhetoric. To get a clearer picture, I began asking medical practitioners whether they, in fact, came across these problems in their work. For research participants who were neither medical practitioners nor activists, I asked whether they knew people or had heard about people who suffered these complications. The problems raised then became fewer. For example, Dr Diallo said:

What we often have, well, increasingly we have less and less of it because [circumcision] is now prohibited. We have fewer immediate complications, that's a type of haemorrhage which can even cause death. A type of septicaemia because, afterwards, if it's not well treated, it's infected. And then what we see now are those who were circumcised since... the sequelae, that is to say, delayed complications. A type of narrowing of the vulva. If they scraped your labia minora and the labia majora, and they did not care for it well, there is often an adhesion of the vagina which makes one have a narrowing of the vulva. That's what we have most often as a complication.

Dr Salif Hassan explained that most of the consequences seen arise from the ‘disastrous’ secret conditions under which circumcision occurs:

The first consequence that I believe we often see here is infection which occurs after circumcision. And also the second consequence that we can find which has sequelae is injury to the other organs, for example, injury to the urethra. And we have also rarely seen cases of death occurring from haemorrhage but it’s mainly infection. But what is frightening above all are the consequences occurring during childbirth. And during the consummation of marriage through sexual intercourse. Because, especially in cases where there is infibulation, sexual intercourse becomes very, very difficult. And so it needs to be repaired so that sexual intercourse is possible. But the most difficult is during childbirth. Circumcised women have a vulval opening that is greatly narrowed, and so during childbirth that creates a lot of problems.

The generalisation and bulk presentation of problems associated with female circumcision without linking them to specific cases is by no means unique to Burkina Faso. It is observable elsewhere in activist and academic literature. For example, in a book commissioned by the World Health Organisation, Nahid Toubia, a surgeon of Sudanese descent, and fellow women’s rights activist Susan Izett discuss immediate health complications linked to all forms of female circumcision and the long-term complications of what the WHO classifies as Types I, II and III female genital mutilation (1998:25-31). They contextualise their discussion by explaining the functional anatomy of the external female genitalia and point out that the occurrence of physical complications depends on such factors as the extent of cutting, the skill of the operator, the cleanliness of the tools used and the physical condition of the child or woman undergoing the procedure (1998:24-25). In some cases, the two writers refer to some media articles and other literature in which various authors discuss these problems in the context of scientific research and the documentation of anecdotal cases. These are drawn from several countries including Sudan, Somalia, Cote d’Ivoire, Nigeria and Kenya (see, for example, Aziz 1980; Dirie and Lindmark 1992; Asuen 1977; Warsame [1988] 1989; El Dareer 1982, 1983; Silberstein 1977; Fleischer 1975; Sami 1986; Hathout 1963; Post 1995; Maendeleo ya Wanawake Organisation 1991; WHO et al. 1997; Rushwan 1980; Shandall 1967; Mustafa 1966; Brown et al. 1989; Agugua and Egwuatu 1982; van der Kwaak 1992; Onuigbo and Twomey 1974; DeSilva 1989; McCaffrey 1995; WHO and IFGO 1992; United Press International

1996, all cited in Toubia and Izett 1998:25-31).⁶³ However, in other cases Toubia and Izett (1998) list and discuss complications without showing the source from which they draw them. That is to suggest, some of the complications they present are not drawn from any actual published source and are thus discussed as potential problems. In the same way, in the introductory chapter of her book, anthropologist Gruenbaum (2001:4-5) indicates:

All the forms of female circumcision share certain risks. First, the unhygienic circumstances in which circumcision operations are often carried out, together with the minimal training of many circumcisers, pose serious risks. Infection of the wound is common when unsterilized instruments are used or if cleanliness is not meticulously attended to. Hemorrhage (uncontrolled bleeding) is sometimes difficult to stop if the circumciser has cut too deep. Shock can occur, and septicemia (blood poisoning) can also result. In the days after the surgery, some girls experience retention of urine because of pain, swelling, fear of pain, or obstruction of the urethral opening. Problems such as adhesions of labial tissue (where not entirely removed), vaginal stones, and vaginal stenosis (narrowing) are also reported.

Here, Gruenbaum follows the pattern of offering generalised and neatly packaged negative consequences of female circumcision which are attributed to all forms of these practices. In subsequent paragraphs, Gruenbaum (2001:5-6) goes on to discuss problems associated with infibulation. In doing this, she cites some writers (for example, El Dareer 1982:37-38; Shandall 1967; Verzin 1975; Inhorn 1994, 1996; Abdalla 1982:26; Mudawi 1977; Boddy 1998a:53) who highlight such problems in their research and in some cases discuss them in reference to specific scientific studies. Still, in other cases, Gruenbaum discusses these problems at a conjectural level. The presentation of such a list by an otherwise meticulous writer (who, in the subsequent

⁶³ Other researchers discussing long-term complications of female circumcision include Okonofua et al. (2002:1092) and Almroth et al (2005:118) who draw their evidence from studies they conducted in Nigeria and Sudan respectively. Infibulation has been singled out as the form that causes the most adverse physical complications. These have been discussed by many scholars (cf. Toubia and Izett 1998:8, 28-31; Boddy 1982:686, 1998:85; Abusharaf 1998:23, 25; Lightfoot-Klein 1989:52-62). Conversely, there is not much discussion in the literature about Type IV 'female genital mutilation'. Bagnol and Mariano (2008) explore some practices in Mozambique and insist that they should not be classified as female genital mutilation, even though under the WHO's typology they would qualify as Type IV. These writers do not necessarily discuss these issues in the manner highlighted in my discussion, that is, in a generalised and decontextualised manner not linked to specific research.

pages of her book, gives a considered analysis of infibulation in Sudan) lends credibility to such a list and makes it amenable to copying and pasting in other academic or activist literature regardless of the fact that there are no studies backing up some of the assertions made.

Divergent views and the birth connection

The presentation of practices of female circumcision as though they inevitably cause problems reinforces the perception that some authors and activists present lists of complications with no effort to contextualise or substantiate them. The bone of contention is not so much whether the practices in question can cause (or do cause) negative effects, but the extent to which the available data is credible and applicable to all cases of female circumcision. It is in light of this that Obermeyer, for example, suggests that research on the consequences of these procedures on reproductive health and sexuality is clearly insufficient and that the “powerful discourse that depicts female genital surgeries as inevitably causing death and serious ill health is not sufficiently supported by the evidence” (1999:97). In the same way, Shell-Duncan (2008:226) suggests that closer scrutiny of scientific evidence on health problems associated with female circumcision shows that it is difficult to establish the sources of what is presented as medical fact, and that even once located, these sources prove to be individual case studies or small, poorly designed studies.⁶⁴ This idea is echoed by Shell-Duncan and Hernlund (2000:15) who propose that in reproducing the often repeated ‘laundry list’ of adverse health outcomes of these procedures,

little attention is devoted to considering the original source of this information... or the incidence of various complications arising from different types of genital cutting.... Instead, noteworthy case studies on infibulation are generalized to describe the health risks of *all* forms of genital cutting and to support the view that genital mutilations should be treated as a public health problem (emphasis in original).

I asked my research participants to react to suggestions that the discussion of problems associated with these procedures is rather indiscriminate, in that some problems which

⁶⁴ Some researchers who highlight these problems also acknowledge that there are difficulties in accessing reliable information concerning these complications (cf. Boddy 1998b:84; Kouba and Muasher 1985:95; Almroth et al 2005:123; El Dareer 1982, cited in Shell-Duncan and Hernlund 2000:15; Toubia 1993, cited in Shell-Duncan and Hernlund 2000:15).

might be caused by infibulation are attributed to all forms of these procedures, particularly clitoridectomy and excision which are said to be most common in Burkina Faso and which are not as severe as infibulation. The vast majority of them were of the view that female circumcision in all its form causes problems, and did not seem keen to be drawn on gradations of severity. For example, Gabrielle, a community support technician, said:

Be it scraping everything or removing just a little, it's still mutilation [...], and it can always cause problems. Even just removing the clitoris can cause problems because it has nerve endings. There are a lot of membranes found there. It can also cause haemorrhage and lead to death. And also during childbirth, it can cause problems. It may not be infibulation, it may be that they did not remove everything, but it still causes problems during childbirth.

I also asked my research participants to respond to suggestions that there may be women who have been circumcised who indicate that they have not had any ensuing problems. I drew their attention to suggestions that the gravity of these problems is an idea propagated by some ethnocentric Western writers who find these practices a shocking and repulsive form of patriarchal oppression, or even cultural inferiority, and tend to exaggerate the harms associated with them.⁶⁵ A minority of research participants suggested that this might be the case. For example, Aziza, a PhD researcher in maternal and infant health who said she was not circumcised, suggested that the reproductive health problems afflicting Burkinabe women are not necessarily a result of circumcision. Her view was similar to some findings from research that female circumcision may not be wholly or always to blame for reproductive health problems. For example, Johndotter and Essén (2010:33) cite a study conducted by Morison et al. (2001:643-653) which shows that medical problems often cited as consequences of female circumcision such as “damage to the perineum, vulvar tumours, painful sex, infertility, prolapse, and reproductive tract infections” were not more frequent among circumcised women than in a control group of uncircumcised women in the Gambia. Sylvie indicated that there are many women who were circumcised as children but who

⁶⁵ See, for example, discussions by Boyle (2002:45-46); Leonard (2000b:172-173); Wade (2012:37); Mohanty (1991); Njambi (2004); Obiora (1997a); Johnson-Odim (1991:322); and Walley (2002:33) in reaction to some early Western feminists such as Fran Hosken (1976a, 1976b, 1981); Mary Daly (1978) and Hanny Lightfoot-Klein (1989) among others.

do not even realise it because they do not have any problems. Explaining that the people who carry out circumcision in the present day are not as experienced as those who did it in the past, Sylvie attributed problems to procedures which are “so badly done”, emphasising that there was a time circumcision was were done properly by experienced practitioners and women who underwent it did not have problems as a result.

Other research participants suggested that when circumcision was performed in its proper traditional context, no problems ensued because it was linked to other rites including healing rituals. However, since these traditional contexts have been increasingly eroded over time, it is now not possible to curtail these harms and, as such, they are now more prominent. It is in regard to this that Pauline, who until our conversation knew only of clitoridectomy (or Type I in the WHO typology), explained that if circumcision is situated in its traditional Burkinabe context, it does not cause problems since the rite is associated with other customs and practices, and accompanied by rituals drawn from African beliefs and practices which prevent complications. However, according to her:

If you take circumcision nowadays, with the arrival of white people and their religion, their culture, people have started gradually abandoning what they had in favour of the West. And so when you start having one leg here and the other on the other side, it becomes difficult to walk. So at this time we cannot combine the two. One cannot perform circumcision while being a Catholic, for example, [...] because you will be obliged to perform those rites which enable the woman to be healthy in spite of circumcision. But if you refuse to do them because of your faith, that can create complications and the woman will die [...]. There isn't even someone who can do [circumcision] in the original manner. The practice has deteriorated over time to the point where it can no longer hold. Yes, if it is done, it will bring problems, complications.

Still, the vast majority of my research participants were not in agreement with these views. Some pointed out that women who say they do not have health problems resulting from these procedures are merely lucky and very few. Others were adamant that all circumcised women inevitably have problems but might not talk about them for various reasons. For example, Danielle, a research assistant and Master's student in economics whom I met through Albert and who did not indicate whether or not she was circumcised, suggested that in the past women probably suffered in silence and did not dare speak out about these problems (as they did not have a voice within the community) lest they be deemed disrespectful to their husbands or the customary

leaders. Evoking economic and other problems in Burkina Faso, Amina suggested that “when you are living in misery, you push these problems to the background”. Other research participants suggested that those who say that they have no problems are simply not making the connection between these procedures and the problems they cause. It is in relation to this that Dr Diallo, who took a contrary view to Pauline’s above, explained that such complications had always existed but instead of associating them with circumcision, people linked them to supernatural reasons. She said:

As they say, ignorance is an affliction, ignorance can kill [...]. So it’s not that the Whites came to open our eyes [...] but I would perhaps say that it’s because people went to the white man’s school, they detached themselves a little from their culture in order to see with a more analytical eye.

Similarly, Leila suggested that initially healthcare workers and “the women who were dying, who have episiotomies, who get torn during childbirth” did not make a connection between the procedures in question and the problems they caused. The solution was to train health personnel to systematically give information about the consequences engendered by female circumcision. Nafissatou echoed this assertion and explained that circumcised women who say they have no problems simply do not know the experiences of other women as the subject is taboo. She explained that circumcised women do not experience pleasure during sexual intercourse and are sometimes not able to have sex at all because of the problems they have. Citing her own experience, she stated:

Every woman who has been circumcised has a problem. Even we who were circumcised, we know the problems with which we live. My first deliveries were very painful but while feeling all that, one does not know that it’s a problem linked to circumcision. During childbirth you find that the clitoris and the labia minora which are supposed to spread out so that the child comes out easily, it’s not the case. You have to get torn so that the child comes out. All that is linked to circumcision. But how can you experience all these problems and then say that you don’t have any problems?

The frequency with which problems during childbirth are mentioned in Burkina Faso as a consequence of female circumcision is noteworthy. The matter was raised again and again by almost all my research participants including medical personnel. This issue aroused some scepticism in a minority of research participants, such as Aziza, who argued that since it is mostly clitoridectomy and excision, not infibulation, done in Burkina Faso, it is difficult to understand why

these practices would create so many problems in childbirth. In Aziza's view, consequences of female circumcision are not as dramatic and numerous as they are made to sound, and maternal deaths in Burkina Faso are not necessarily linked to these procedures.

It is conceivable that in some cases ordinary pain and difficulties associated with this natural event are erroneously attributed to female circumcision. Still, it is difficult to dismiss the issue of female circumcision causing problems at birth without a closer look. Some of the women who raised this matter spoke in relation to themselves whereas others referred to other people. For example, in speaking about her daughter (who was not circumcised), Leila said:

[W]hen the other women who had been circumcised were suffering and screaming, with her, the child came out just like that, like a fish in water.

Amina also suggested that she was able to give birth without having a caesarean section because she underwent reconstructive surgery before getting pregnant. Conversely, Maimouna said:

I have two children and during the deliveries I had problems because I was circumcised.

Antoinette also said:

Personally, I have my younger sister, when she became pregnant, when she was giving birth, she had problems because she was circumcised.

While some of these women did not explain the nature of the problems they alluded to, a few of them such as Samira and Nafissatou cited a loss of elasticity caused by scarring which prevents the vaginal opening from widening during childbirth. Further information collected particularly from medical practitioners (see, for example, Hassan and Diallo above), points to a coalescing of the labia which sometimes causes a pseudo-infibulation, hence creating a very narrow vaginal opening in circumcised women. This necessitates an episiotomy during childbirth if these problems are not discovered before the onset of labour. In addition, Dr Condeh mentioned keloids which further block the vaginal opening and create problems during childbirth. Sylvie, a midwife, explained that she saw these complications when she worked in the maternity section of a hospital saying:

If the head of the child cannot get out, they are sometimes obliged to make an upward incision, which we call a 'circumcision incision' in order to open

up the woman [...]. So most often there are two [incisions], we cut upwards, the 'circumcision cut', plus an episiotomy so that truly the head can come out. Or the woman can even have a downright caesarean section.... It can also happen that she is in the bus and she is not near a health centre. Perhaps the baby's head keeps bumping but cannot come out. If she doesn't get to the hospital in time, afterwards when the child eventually comes out, he will be handicapped as he will have received too much shock. People can try to reanimate him in vain and he dies or else he can be reanimated but have sequelae, and so afterwards you find that he is handicapped.

The 'circumcision cut' to which Sylvie refers is described by Gruenbaum who, in reference to the experience of infibulated women, says, "During childbirth, a midwife must be present to cut the inelastic scar tissue across the vaginal opening when the baby is in position for delivery. This cut is basically an episiotomy which is cut upward (anterior) rather than downward (posterior). Lateral or bilateral episiotomy to widen the vagina is also sometimes necessary" (Gruenbaum 2001:5, citing Abdalla 1982:26). However, it is not clear to what extent pseudo-infibulations resulting from clitoridectomy and excision occur in Burkina Faso necessitating multiple episiotomies or even caesarean sections.

Increased focus on problems associated with female circumcision in recent years might also be giving them prominence making them appear colossal. However, there is a need to consider that the discourse linking female circumcision with increased problems for Burkinabe women during delivery might not be without foundation. Some researchers (cf. Prolongeau 2006:84, 89-90; Handa et al. 2008) suggest that African women have a narrow pelvis which predisposes them to difficulties in childbirth. Problems caused by this anatomical configuration might be compounded by physiological effects of female circumcision such as keloids and rigid scars; people of black ancestry are also said to be more predisposed to keloid formation following trauma to parts of the body (cf. Allah et al. 2013:115-122; Kieran et al. 2014:326-333; Edmonds 2010:12).

Changes in the timing of circumcision in Burkina Faso might also be causing more long-term consequences. As explained in Chapter 5, the negative portrayal of these practices, but more especially their criminalisation, means that the people who practise them do so clandestinely and on very young children. Such people might be more reluctant to seek medical aid when these procedures go wrong for fear of prosecution, and untreated complications may lead to more long-term problems. However, the biggest impact of performing these procedures on young children, particularly babies,

is that there is more extensive cutting which leads to increased negative health consequences. As Sylvie pointed out:

[I]n a baby everything is together and sometimes they confuse the clitoris with the labia minora so they cut everything. And now if someone has a bad skin, it can form keloids. It sticks together and reduces the [vaginal] opening [...]. We have noticed that it's now difficult during childbirth. Otherwise, before, there were many people who were circumcised but who did not have problems during childbirth. Because I believe that at the time they used to remove the little tip at the end. But now they take everything.

Sylvie explained that problems related to female circumcision, particularly those affecting childbirth, have been on the rise in the past 20 years. According to her, these problems are mainly observed in girls aged 17-20 who, upon marriage, are forced by their husbands to seek medical help so that they can have sexual intercourse and bear children. The period during which Sylvie situates the rise in these problems corresponds to that marking the campaign to dissuade people from carrying out female circumcision which officially began in its present form in 1990 and culminated in the 1996 law prohibiting it. It can therefore be argued that efforts to end these practices have inadvertently led to even more serious health consequences for girls and women, some of which are prominent in childbirth.

Furthermore, some older girls who have been exposed to campaigns depicting these procedures as harmful and/or illegal try to resist them. Struggling during circumcision increases the risk of extensive injury to genitalia which may lead to more long-term problems later on. (However, it can also be argued that passive girls or women may also undergo more extensive forms of the practice because in such cases it is up to the person performing the operation to decide when to stop cutting). Ylva Hernlund (2000:243-244) points to such realities in the Gambia saying:

Nowadays, many believe that the younger the girl is, the "easier" the procedure will be for both her and the circumciser. One circumciser I interviewed told me that she herself will no longer "circumcise" older girls because it is "too difficult" for them.... Now that there is so much talk about the dangers of female "circumcision," she said, older girls try to fight back, and it is "just too painful," for both her and the girls.

The difficulties and pain cited above are also evident in the film I describe below where an adolescent girl who struggles during the procedure is warned that she will "hurt herself". Additionally, the cutting portrayed in the film sometimes appears somewhat arbitrary; in one instance one of the assisting women tells the circumciser that she is

taking too much flesh. Such haphazard and extensive cutting is likely to cause more problems later, perhaps even at childbirth.

Fear mongering or a burden of care?

The strategy of trying to eliminate female circumcision through a top-down approach which highlights problems hitherto overlooked and encourages, nay, forces people to accept imposed solutions has not been without difficulty. Leila Abdi explained that at the beginning of their campaign, they privileged the ‘compromised health’ discourse and told people that, for example, using the same razor blade to cut girls “transmits AIDS”. In response, the circumcisers started buying individual blades for the girls, sterilised them before use, wore gloves and provided clean sheets for the girls to sit on.

These solutions were not taken into account by campaign activists who instead sought more effective ways of making people abandon female circumcision. Training of personnel was intensified and new arguments were developed to oppose these practices. Sylvie explained that the information disseminated to the public now is multi-pronged: healthcare workers address medical problems such as difficulties with childbirth and sexual intercourse, while community agents say that these practices are not indigenous to Burkina Faso and are a form of violence done to women and children. The law criminalising them serves as further motivation to make people stop them. In this way, the Burkinabe government ignores the fact that some people still consider the procedures in question to be central to their socio-cultural fabric and, instead, imposes ideas from the top down privileging the discourse of one group while denying the legitimacy of the other.

Many research participants, including Gabrielle and Albert, were convinced that these practices need to be eliminated even when the people who embrace them consider them to be normal and culturally necessary. Leila explained how activists have tried to get people to accept the discourse highlighting human rights and loss of integrity saying:

We had to go through health. It’s now that we are talking about rights, about integrity. Otherwise at the beginning people did not care. In a village environment women do not think about rights. Before thinking about women’s rights, women think about their health, they think about the education of their children, they think about potable water, they think about transport, they think about grain mills. And we explain to them that all those packages – water, mills, the road – all those are rights for them [...]. We had to start with health problems so that people could accept that circumcision is a problem.

The paternalistic approach used to convince people in Burkina Faso that female circumcision is harmful to them seems to replicate the one used on the international scene particularly in the 1980s and 1990s when some Western feminists highlighted the issue in a decontextualised and sensationalised manner. Indeed, the preoccupations observed among local Burkinabe women in Leila's quote above have been pointed to by some scholars (cf. Johnson-Odim 1991:322; Abusharaf 1998:27, 2000:158; Walley 2002:33; Maparyan 2012:26) who criticise the treatment of this issue as though it concerns all women in the same way and as though it is their sole preoccupation. The difference now is that while in the past it was some Western feminists who seemed to be formulating solutions and dictating them to women from 'third world' countries, in the Burkinabe context, it is the governing class and those schooled in Western education who are determining and enforcing what they deem healthy and good for the rest of the population. Nafissatou confirmed this when she said that instead of looking at problems associated with circumcision as being inspired by Western ideas about femininity and normality, people should consider that the West "came to help us [...] to become aware, to be enlightened in order to abandon harmful practices".

A few of my research participants were firm that this is not the right approach to take. For example, Aziza found the approach ineffective and attributed increased activism around the issue to feminist movements which have gained momentum in the country. It can be argued here that the blanket presentation of problems associated with female circumcision runs the risk of being dismissed as activist propaganda particularly by people who have undergone it and who have not experienced the problems cited. Such people might continue to practise these procedures, and, as I show in Chapter 7, they are also likely to stigmatise those who admit to suffering problems. This ardent activism in Burkina Faso may in some ways, therefore, be in fact hindering efforts to end female circumcision. It is in line with this that Aziza said:

But the idea of talking about sequelae, the idea that they have difficulties in giving birth whereas there are no difficulties really, I think that they should review [that]. I think that really by wanting to create fear, on the contrary it's ridiculous because the public does not see those cases. Even if there are cases which are... I don't want to say isolated, but cases which are not massive... I'm not saying it's not legitimate, but I say the manner of presenting the problem, I don't think it's a good way. It's not by saying, "Yes you have sequelae!" whereas women cannot see the sequelae that they are going to change.

Interestingly, Nafissatou also pointed out that there are people who “are ready to cite the consequences which are in the practice of circumcision” but who are not willing to change. This implies that in spite of this apparent success in making these messages accepted, some pay lip service to the activists’ messages but continue to practise these procedures. This was also highlighted by Pauline who said that sometimes even people involved in activism against circumcision have their daughters circumcised secretly. As explained in Chapter 5, some people still see circumcision as an effective means of curbing girls’ and women’s sexual desire making them chaste and/or faithful, and would thus have their daughters circumcised to ensure that they grow up to be respectable women.

The importance of understanding and respecting the beliefs underlying female circumcision, instead of just pointing out its potential problems and criminalising it, is also highlighted. For example, Etienne, a psychologist working at Leila’s centre, suggested using an approach which allows people to evaluate for themselves the risks associated with female circumcision. In his view, that will perhaps lead them to choose to stop doing it and be at peace with that decision. Calling it a case of judicial and medical imperialism, Etienne suggested that forcing people to stop circumcising leaves them feeling guilty because they are made to abandon their beliefs and practices, and the intergenerational reproduction of the values which underlie them. Indeed, as explained in Chapter 5, when the reasons underlying these practices are mentioned by activists and even members of the general public who have embraced the activist discourse, it is to mock them or to show that they do not stand up to scrutiny and hence should not be taken seriously. Not much effort is put into trying to understand the reasons from the perspective of the people who subscribe to them.

Catastrophic language

The persistence of the Burkinabe government through ‘soft’ approaches such as sensitisation efforts by activist organisations but also through punitive measures is increasingly convincing people that female circumcision is harmful and should be abandoned. Perhaps the most successful strategy has been to present these procedures in horrifying and catastrophic language and images, and as a matter of life or death. (This is not to deny that in some cases they can lead to death. In fact, Kerekou and Sylvie both recounted instances where deaths attributed to female circumcision have occurred in recent times near Ouagadougou). This mode of depiction has been

embraced by members of the general public. Many research participants used terms which conjure images of death (when one undergoes circumcision) versus those of life (when one escapes it or has reconstructive surgery). For example, in explaining how she dissuaded her daughter from undergoing the procedure, Leila said:

I told her, “No, one day you’ll thank me when you’re older, that your mother saved your life.”

In the same way, when recounting her circumcision, Maimouna said:

That’s when they almost killed me.

In speaking about her work coordinating the building of the ‘pleasure hospital’ and telling people about clitoral reconstruction, Samira said:

I am ready to leave my job to sacrifice myself for that because it is a noble mission. It’s noble, it’s to save humanity [...]. There are a lot of women who are in that condition [...]. They are suffering in their bodies, they are suffering in their spirit. So it would be good that someone is committed to sacrificing herself for them.

When not using life and death imagery, research participants employed terms which evoke torture, anguish and perpetual oppression. For example, when asked to react to suggestions that the scale of the harm associated with female circumcision is inspired by overstated ideas of some Western feminists, Nafissatou said:

Actually does the West even know this practice? They do not know this practice. We are the ones who do this butchery to our children!

Albert said:

And even the pain associated with the practice of circumcision is a way of controlling the person. When you are tortured it remains as a consequence. And now reminding you of that torture stigmatises you in some way. It puts you in a state where you are dominated. It creates some form of fear in the person.

Hassan talked of ‘disastrous’ conditions and ‘terrifying’ consequences. Dr Condeh expressed this more forcefully saying:

[Regarding] the gravity of the scourge [...], it’s the visible sequelae which make a lot of families to decide to no longer circumcise their children [...]. First of all, in the immediate, it can be haemorrhage which can take the young girl. And afterwards it’s the vicious scars. You know that darker skin has more keloids, so the scars can occur. In my practice I have met women where the sequelae, the keloids after circumcision, are totally monstrous that they close the whole vulva. So in these conditions, it goes without saying

that the sexual life is compromised [...]. Because she has this scar, this tumour between her legs, she can decide to not even have a sexual life. There are scars which narrow the vulva, which cause it, in terms of the degree of circumcision where they remove all the labia, where there is only a small opening, there's urethral stenosis, where the [opening] is even totally closed and she cannot urinate.

There is also use of correspondingly alarming slogans and images in sensitisation material, such as brochures, posters, picture boxes and films, to underscore the grave consequences associated with female circumcision. For example, in the first part of their brochure cited earlier, the AVFE indicate:

Every 10 seconds, somewhere in the world, a little girl is a victim of genital mutilation. Three million girls are circumcised every year. Together we should succeed in ending this human tragedy.

The CNLPE presents these ideas even more graphically compiling pictures of possibly the worst outcomes of practices done in various countries, but presenting them as likely consequences of the procedures done in Burkina Faso. For example, on page 22 of the booklet *Je n'exciserai pas ma fille* is the picture of a child whose vulva is totally closed off making it difficult for her to urinate (see Figure 6.1). This is presented as a severe consequence arising from infibulation. It is notable that the CNLPE staff use this image even though they also say that infibulation is not practised in Burkina Faso (CNLPE n.d.:5). The image would be shocking to people who do not consider this to be the normal appearance of female genitalia. Unless told that this is a case of infibulation, such people might also assume that this is a possible consequence of female circumcision procedures in general. There are other even more horrifying photos depicting labial fusion, cysts, keloids, a woman in late labour who cannot release the baby because her vaginal opening is too narrow and a mangled dead baby following such a difficult delivery (CNLPE n.d: 22-26).

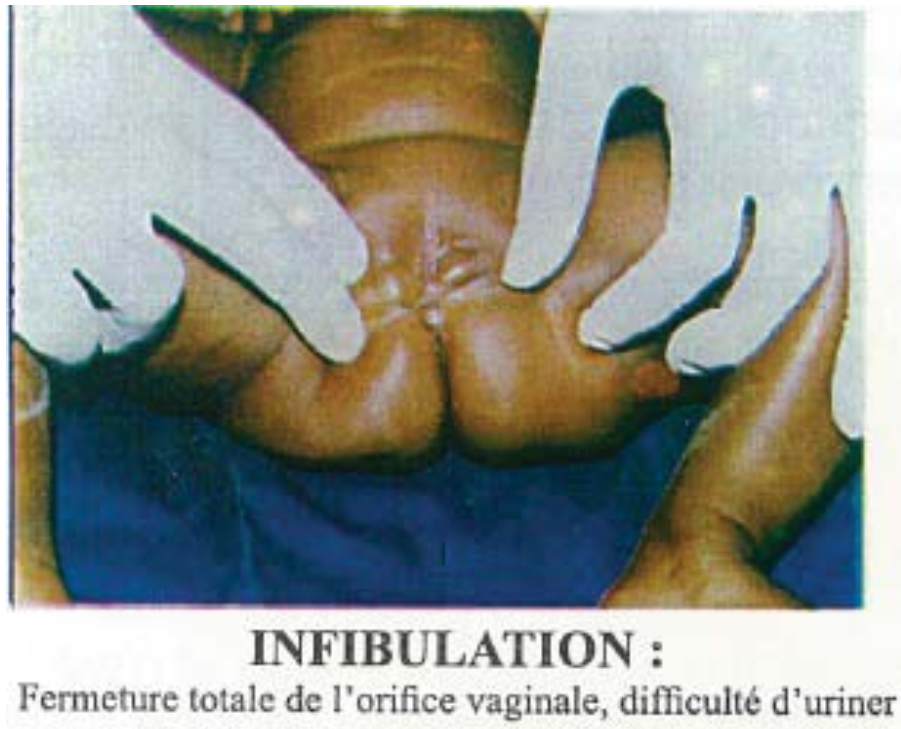


Figure 6.1 A CNLPE depiction of one of the effects of female circumcision

Films and picture boxes used to educate people about these procedures and their impact are equally replete with raw and shocking images. Some of them depict the procedures as they occur whereas others explore the delayed physical and social impact. Below I describe in detail one segment of a 15-minute film depicting four girls undergoing various forms of female circumcision.⁶⁶

The excerpt is entitled *Excision d'une Adolescente au Mali* (the circumcision of an adolescent in Mali) and comes after two clips showing a baby and a young girl being circumcised.⁶⁷ This particular film sequence takes about four minutes with the actual genital cutting taking slightly over one minute. The clip opens with the image of a girl aged about 13 disrobing in what seems to be an outdoor bathroom. The adolescent's face is blurred making it difficult to observe her facial expressions. (It is not clear

⁶⁶ OIBF-Respect (n.d.) *Images d'une pratique néfaste pour la santé* (Images of a practice that is harmful to health).

⁶⁷ There is a fourth clip addressing the practice of infibulation.

whether or not this blurring is for ethical reasons – for example, confidentiality – given that neither the faces of the two younger girls nor those of all the other people involved in these procedures are hidden). Even so, her bodily movements suggest that she is extremely agitated. A woman (whose words are sub-titled in French) repeatedly tells her to calm down. At the beginning there are three women on camera but as the film progresses, it is clear that there are a lot of people around. One woman tells the others to bring water and to call more people. Another calls out that she cannot hold the girl down on her own. One of them tells the girl, “One can never be too careful! We have to stop you.” Yet another tells her to stop crying saying, “Stop getting agitated. It doesn’t hurt. Calm down.”

The now naked girl (except for a white band around her waist) is made to sit down. She starts crying. One of the women says, “This child is already mature. She is going to tire us!” Two women try to pry the girl’s thighs apart but she resists. They hit her. All around there is a cacophony of voices shouting at her: “Calm down! Be still! You are going to hurt yourself! Have you no shame? Be quiet! We are going to set men upon you! You stupid bastard!” By now the girl is screaming. The women then address each other saying, “Cut the tip of her sexual organ well! Raise her head! Hold her leg! Keep her still! Hurry up!” It is a very chaotic scene with the girl screaming and struggling, the women shouting orders and the camera shifting haphazardly. And they have not even started cutting yet!

The circumciser is a woman, perhaps in her fifties, wearing a stylish purple and white garment (Figure 6.2).⁶⁸ She gets hold of the clitoris and someone says, “Woman, the portion you have seized is too big!” Some of the yells which can be heard at this point include: “You must immobilise her completely! She is going to bite us if you don’t hold her thighs firmly! Hurry up!” The girl screams, “I am dead!”

⁶⁸ On one of the sleeves of the dress is an image of the map of Africa and the signage of the Pan African Women Organisation (PAWO) with the following words around it: *Journée Panafricaine des Femmes pour l’Afrique de l’Ouest* (Pan African Women's Day for West Africa). On the upper front and back side of the garment is a partially obscured slogan which reads: *Accès des femmes aux postes électifs: défis, enjeux et perspectives* (Women's access to elective positions: challenges, issues and prospects).



Figure 6.2 The circumciser (OIBF-Respect n.d.)

The circumciser lifts her bloodied hands and knife to expose the girl's gory genitals and says, "Verify that it's well done." But then she does not stop cutting. She goes back and cuts again and again, completely removing the external clitoris and the labia minora. The girl continues screaming. Someone yells, "Be quiet, girl! Don't expose me to shame before the whole society. A blacksmith's daughter who is conducting herself this way!"

A man says in English off camera, "Stop, stop, stop." Still, the cutting does not stop. Instead the cutter seems to go deeper and deeper as though looking for the very root of the clitoris. She says, "Gag her with your hand. Her clitoris was well formed. Shut her mouth! Hit her on the mouth! Make her quiet!" It is not clear what the others do but the girl's screaming ceases momentarily. One of the women says, "In God's name, is it good that you are crying like that?" The girl answers, "It is enough! Are you going to kill me like this?" Someone else says "She is already a young woman, with well-formed breasts."

By the time they are done with the now seemingly exhausted girl, her genital area is a gaping, raw wound. She says, “I am dead,” and the women answer, “Calm down, calm down, it’s finished.” The camera shifts and it is not clear what the women do immediately afterwards. (With the two little girls who preceded her, the women put some black powder from a bottle on a piece of cloth and put into onto their bleeding genitals provoking more agonised screaming). Eventually they bind the girl up in a blue and white piece of cloth and make her stand up. Their parting words as she totters away are: “A big girl like you crying that way! If you thought that we were going to leave you uncircumcised, that you would be rotten while still in our hands.... Go! Nothing happened! If you thought you were going to stay impure beside us.”

Although this film is shot in Mali, I describe it here because it is used as a sensitisation tool in Burkina Faso.⁶⁹ Moreover, the procedures depicted in the first three clips – cutting off sections of the clitoris and the labia – are similar to those said to occur in Burkina Faso. There do not seem to be any other rituals surrounding these procedures in this setting and it is not clear what happens afterwards. The words spoken to the adolescent imply that the procedure is meant to keep her from being ‘corrupt’ or ‘polluted’. It also appears that the circumciser believes that the more she cuts, the ‘better’ the girl becomes.

There is some incongruity in having some trappings of modernity, such as the mobile phones used by some of the women and the video camera used for recording, alongside

⁶⁹ This film was made by Respect For Change (R4C), a Belgian not-for-profit organisation reportedly working for the abandonment of female circumcision and early marriage in sub-Saharan Africa in a bid to foster women’s empowerment. The organisation aims to contribute, through information and public debate, to the promotion and affirmation of women’s rights, human rights and respect for fundamental freedoms. Its members have worked in several African countries including Mali, Senegal, Djibouti and Burkina Faso since 2006 where they publicise these issues through films, advertisements, music videos, trailers, television and radio programmes, conversations and social networking on the organisation’s website and also Facebook, Vimeo and YouTube. The organisation is primarily funded by an unnamed philanthropist who, touched by the suffering of ‘the mutilated child’, decided to devote the bulk of his revenues to develop the means to inform and educate the people affected by these issues, with a view to changing attitudes and social behaviour (personal communication with Christine Delginiesse, staff member, R4C, 25 July 2014; Respect for Change n.d.).

this age-old ritual. However, the circumciser is undoubtedly the biggest representation of the collision, perhaps coexistence, of the traditional and modern elements in this setting. She is performing a traditional rite meant to fulfil certain cultural obligations but which is now condemned as harmful. Meanwhile, she wears a garment with messages addressing the challenges hindering women's participation in the country's politics. Inadvertently or not, she is advocating for increased women's representation in the Malian parliament, an act which would presumably put more focus on ending condemned procedures such as the one she is performing.

These images are intended to shock and horrify and indeed they do. The warning that the images in the film are "terribly shocking" is apt but does little to prepare the viewer for the true extent of the horror depicted. Nafissatou explained that the picture boxes and films used by the CNLPE for sensitisation are intended to shock people – particularly those who do not know about the practice because they underwent it when they were young or those who have never seen a circumcision scene – and to show them the immediate consequences such as haemorrhage, pain, shock and infections which cannot be measured or be reproduced verbally during campaigns. This shock is meant to accelerate awareness and cement people's belief that these practices cause negative consequences. As a dissuasion tool, these films are highly successful. Indeed, Amina, who does not remember the events of her own circumcision said she was greatly affected and disgusted when she saw the clip showing a child being put through the procedure. Further, as I explain in Chapter 7, it is also after being shown such material that women like Amina begin to believe that there is something wrong with them.

These images are a powerful way of demonstrating that female circumcision is injurious in the short term and probably also in the long term. The procedures depicted in this film are not done in an aseptic environment; they are performed on the floor of what seems to be a dusty outdoor bathroom. The circumciser appears to use the same knife on all three girls. It is not clear what the black powder used to stem the bleeding is and the pieces of cloth used to bind up the girls after the procedure do not seem any cleaner than those subjected to day to day use. Nor does the circumciser seem to sterilise her hands beyond rinsing them in not-so-clear water. However, perhaps the most convincing element of these films is the uncensored depiction of the undoubtedly traumatic and painful procedure which is performed without anaesthesia. It is possible to imagine immediate problems, particularly shock and infection, developing from these

operations. One can also envisage secondary problems arising from the repeated extensive cutting which is done on the adolescent girl.

Conclusion

The depiction of female circumcision procedures as inherently harmful has been largely successful in urban Ouagadougou and Bobo-Dioulasso. The effectiveness of the strategies associating female circumcision with grave consequences is seen in the discourse of people who repeat the words of medical practitioners and activists almost verbatim: the practices in question cause a lot of problems and need to be stopped. The fact that it is powerful and influential people propagating these messages, with the backing of the State, has lent this information great weight if not legitimacy and acceptance.

The trend of putting younger and younger children in danger is an unintended by-product of the campaign to end female circumcision in Burkina Faso. In some cases, this trend is also associated with increased health problems, particularly those occurring during labour and childbirth. The other effect, which I explain in more detail in Chapter 7, is that this campaign convinces women that all their sexual and reproductive health problems are caused by these procedures. This in turn creates psychological consequences which are hardly addressed in Burkina Faso. In the next chapter, I argue that some of the sexual and psychological problems affecting some women in Burkina Faso are not so much the result of female circumcision procedures as they are effects of the discourse opposing the practices examined in this chapter. I also show how reconstructive surgery, which is not accessible to everyone, is presented as a one-stop solution to these problems further compounding the issue.

CHAPTER 7

CIRCUMCISING THE MIND, RECONSTRUCTING THE BODY

Introduction

In this chapter I argue that embracing the discourse explored in Chapter 6 regarding the damaging effects of female circumcision is adding other layers of victimhood to circumcised women. It is creating psychosexual problems arising from the new understanding that these women have regarding the manner in which their bodies have been changed and the deficiencies these changes have caused. I revisit the experiences of circumcised women, explored in Chapter 4, to show how they perceive themselves and why some of them are seeking reconstructive surgery. I also address the manner in which reconstructive surgery is understood and practised in Burkina Faso. I explore the ways in which both experts – medical personnel and activists – and members of the general public define this surgery. In Chapter 8, I delve more deeply into issues around reconstructive surgery, including people's opinions regarding this surgery and the women who undergo it.

As a solution offered by the Burkinabe government, reconstructive surgery at first glance seems to be a reasonable response to addressing the physical problems associated with female circumcision. However, as I will show in Chapter 8, little help is offered for the psychological problems created not only by female circumcision but also by the discourse that is turning hitherto 'normal' women into victims. Instead, reconstructive surgery is offered as a panacea for these problems. The presentation of female circumcision as a stand-alone cause for reproductive health problems reinforces the view that reconstructive surgery is a stand-alone solution to these problems. The ideals of health, completeness, normality and sexual attractiveness propagated by activists remain elusive for women who need reconstructive surgery, or think they need it, but cannot access it.

Creating psychosexual victims

In my discussion below I do not mean to imply that the psychosexual problems associated with female circumcision in Burkina Faso are all generated by the campaign against female circumcision. Rather, I wish to show how the salience of the discourse against female circumcision further compounds the problems that some circumcised women might be experiencing and, in some cases, engenders these problems. Female

circumcision is associated with psychological problems. Some of my research participants pointed out that the trauma of circumcision remains with circumcised women for the rest of their lives and that it can even alter one's personality.⁷⁰ For example, Pauline, a university student from the Mossi ethnic group where female circumcision has been widespread, explained:

Circumcision has harmful [physical] consequences but it also creates other frustrations. When one [circumcises you] when you are around 4 or 5 years old, until the day you die, you will always remember that day. You see it all the time. You even see the people who did that to you, and those people represent enemies for you. So it is a frustration in oneself. And that can create problems in the long term. The person can live and be strange and people can spend all their time castigating her and yet it's not her fault.

There is similar mention in the literature of psychological problems such as anxiety, depression and post-traumatic stress disorder arising from the trauma of the circumcision act (cf. Gruenbaum 2001:7, citing El Saadawi 1980, Abdalla 1982; Behrendt and Moritz 2005; Toubia and Izett 1998). However, in several other cases psychological problems are more associated with the physical problems and other inadequacies associated with female circumcision than with the trauma of circumcision itself. These psychological effects are mostly documented as anecdotal cases in anthropological and other literature and are drawn from countries where infibulation is practised, particularly Sudan (Abusharaf 1998; Lightfoot-Klein 1989), or from immigrant communities in Western countries (Momoh 2005; Barber 2010; Lockhat 2004). Abusharaf (1998:25) suggests that depression and anxiety are frequent consequences of infibulation and are spurred by health problems, fears of infertility or the loss of a husband because of penetration difficulties. Lightfoot-Klein (1989:76) similarly points to cases in which women in Sudan "expressed the fear that they may not be sexually adequate for their husbands' needs, and many, paradoxically, suffer from feelings of guilt because they are not able to function better sexually". Analogous feelings are evoked among young French women of African descent who seek genital reconstructive surgery and who are said to experience shame and fear of rejection, and whose main reasons for seeking reconstructive surgery seem to be so that can feel 'complete' and have 'normal' sexual relations (Prolongeau 2006:179-181). The

⁷⁰ I revisit this issue when I address the notion of *épanouissement* (fulfilment) in Chapter 9.

experiences of these French women are comparable to those of the Burkinabe women discussed below.

As explained in Chapter 6, the success of messages opposing female circumcision in Burkina Faso is seen in the reproduction of the official discourse by members of the general public. It is also seen in the manner in which circumcised women view themselves and are viewed by others in their communities. The notion of what constitutes a woman who is normal, desirable, sexually attractive and complete has been redefined by activists so that now most people in urban Burkina Faso, particularly in Ouagadougou, associate these attributes with the state of having sexual organs which have not been altered by cultural practices. As a result, circumcised women are led to believe that something undesirable and debilitating has happened to them. They are turned into victims who believe they are suffering (and/or are thought to be suffering) and are in need of a solution.

A lot of my research participants from the four categories of people that I interviewed used the term 'victim' to refer to circumcised women. For example, when introducing me to a group of Raëlian women in Bobo-Dioulasso, Samira referred to them as "victims of circumcision". In the same way Antoinette indicated that the Clitoraid hospital in Burkina Faso is to help "victims of circumcision". Nafissatou and Leila also used the term liberally. For example, at one point Nafissatou said: "There are already a lot of victims of the practice of circumcision and those victims suffer from the consequences of circumcision". From the manner in which they spoke about themselves and their experiences (see Chapters 4 and 6), it is clear that such women as Amina, Samira, Antoinette, Maimouna, Nafissatou, Leila and others have come to believe that there is something wrong with them – they are missing something, they cannot enjoy sexual relations as other women do, they anticipate problems during sexual intercourse and childbirth. As I demonstrate below, they attribute any sexual or reproductive health problems to the procedures they underwent as children or adolescents. In short, these women consider themselves victims who are no longer healthy, normal or complete. This change of status has occurred because these concepts have been redefined by the activist discourse.

The victimisation of circumcised women in Burkina Faso occurs at three levels: physically, psychologically and socially. They have been circumcised and some of them

suffer negative health consequences as a result. They therefore feel that they are victims of this practice at a physical or bodily level and refer to themselves as such. Secondly, during sensitisation campaigns these women are marked psychologically and convinced that they are victims of a horrible cultural practice termed ‘female genital mutilation’. The strategy of using raw and shocking images, explored in Chapter 6, has worked to convince people that the practices in question are brutal and harmful. However, its other unwitting effect has been to turn hitherto ‘normal’ women into victims who no longer feel complete within their bodies. For example, Amina, who said she did not remember the procedure she underwent as a baby, pointed to feeling “somewhat diminished” during sensitisation campaigns. When shown models of genitals of women who had not been circumcised, she felt that there was something “not alright” with her and that she “wasn’t a complete woman”.

Circumcised women are also marked at a societal level and institutionally. The society in Ouagadougou and Bobo-Dioulasso has been conditioned as to what the new ‘normal’ is. As a result, as I explain below, these women are regarded as being more prone to health problems which can prevent them from finding their place and fulfilling their roles as mature women in the society. They are stigmatised and live in the fear of being shunned by others in the society. At an institutional level, these women are also ‘marked’ which further reinforces the view that there is something wrong with them. For example, Sylvie explained that when she first examines a pregnant woman at the medical and advocacy centre where she works, she indicates in the patient’s record file whether the woman is circumcised or not. She said that this is done largely for statistical purposes, but that if during the examination she realises that the woman might experience problems during delivery, she refers her to a bigger medical facility for surgical intervention. Doctor Hassan also explained:

We do a routine screening during consultations and when we realise that a woman is circumcised, we make her understand that there is a possibility of surgical repair to give her the chance to have less painful relations. And also to give her the opportunity to give birth without problems.

While this is done with the aim of assisting these women avoid problems during delivery, this screening could also further entrench the view that these women are different from those who are not circumcised and should be treated as such.

In Burkina Faso female circumcision is closely associated with problems during sexual intercourse.⁷¹ This may be because of long-term complications caused by these practices such as pseudo-infibulation, keloids and other scar tissue which obstruct the vaginal opening. Some of my research participants cited in Chapter 6, particularly Dr Condeh and Dr Hassan, refer to cases where women with these problems are unable to have intercourse and have to undergo some form of surgery to enable them to do so. However, there also seems to be a view about the manner in which sexual intercourse should be experienced and the idea that circumcised women cannot experience it that way.⁷² Such women expect to experience pain, not pleasure, during sexual intercourse. This pain is described in a way that seems to transcend the discomfort associated with the breaking of the hymen during some women's first sexual experience. For example, Amina said that she could not bring herself to have sex for at least a year when she first had a boyfriend; she could not stand him touching her as she felt disgusted, could not feel any pleasure and was afraid that he might hurt her.

This expectation that sexual intercourse would be painful because one has been circumcised is also observed in Samira's case. In her case, it was created by the information she had got from her elder sister that sex would be painful. Regarding her first sexual experience, Samira said: "[I]n my head it hurt, so I had to prepare myself in my head to experience that". As she described in Chapter 4, during her first sexual encounter she was tense and at the smallest gesture from her partner she became clenched and stiff. Unsurprisingly, the experience was painful and difficult. Even though Amina and Samira attributed the pain and lack of pleasure that they experienced to circumcision, it is clear that they had also been prepared psychologically to expect that sexual intercourse would be painful. It is therefore plausible to argue that the difficulties they experienced could have been a function not only of the practices they underwent as children but also the result of the salient discourse about the problems that circumcision causes. As I show presently, they were also probably a function of other prevailing circumstances during these sexual encounters.

⁷¹ It is also associated with an inability to *s'épanouir* (to develop, blossom or be fulfilled), a concept which I explore in more detail in Chapter 9.

⁷² I explore this in more detail in Chapter 9 particularly from the Raëlian perspective.

I discussed the matter of sexual and psychological consequences of female circumcision with Etienne, a clinical psychologist working in the centre headed by Leila. He pointed out that some of the women who are referred to him with psychosexual problems have internalised the anxiety caused by the frightening and distressing information disseminated by activists and gone on to ‘create’ sequelae. In his view, young women in particular go as far as to confuse the problems of their first experience – penetration difficulties and the pain of the hymen being broken – with sexual trauma caused by circumcision. He explained:

Yes, there are women who come. But very often women come pushed by the anxious preoccupations communicated by precisely these publicity issues, these issues of the fight against circumcision led by non-governmental organisations but also the voyeurism of certain doctors [who say], “Let’s see, don’t you have problems linked to circumcision?” These women even create symptoms. There are women who have no problems but as soon as people discuss [problems] or ask about them, they will somatise, because of fear. That is anxiety. It’s psychogenic [...]. When I was a child, a woman and a man did not sleep in the same hut [...]. How did they manage to have a child? [...] When someone describes to you how coitus was done, it was fast, without preparation. It *hurt*. Especially when it was the first time. And all that becomes medicalised because of this obsession with finding sequelae.

Informed by such views at Etienne’s, one can suggest that the manner in which sexual intercourse happens or happened in the past – quickly and without preparation – is different from the expectations or the representations which people have been given about it in modern-day Burkina Faso. This leads people to have inaccurate expectations particularly of their first sexual encounter and makes them attribute the pain and lack of pleasure that they experience to female circumcision. Moreover, from Samira’s and Amina’s accounts, it appears that what one experiences during a sexual encounter depends greatly on the patience and expertise of one’s partner. It is also influenced by one’s (and one’s partner’s) awareness of her body and the parts of it which can procure her pleasure. Significantly, both Amina and Samira indicated that even before they underwent reconstructive surgery, once they learnt more about sex and met mature and patient men, they were able to experience pleasure and did not have problems with sex anymore. Likewise, Maimouna indicated that since meeting Samira and her team, she had learnt how to experience sexual pleasure even though her partner castigated her for being a circumcised woman. Antoinette, on her part, explained the importance of finding partners who were able to find sensitive points in her body in her quest for

sexual pleasure. Some of the descriptions that these Raëlian women gave when explaining their interaction with sexual partners sounded like what is commonly referred to as foreplay, without which sexual relations could be painful or at least uncomfortable even for uncircumcised women.⁷³

Regarding the manner in which circumcision affects female sexuality, virtually all my research participants suggested that the procedure does little to ensure that girls and women are chaste or faithful. That is to say, it does not prevent girls or women from desiring or seeking sex. This is contrary to one of the motivations keeping this practice in place, discussed in Chapter 5, where sexual desire and pleasure are conflated. My research participants pointed out that it is a child's upbringing which determines whether one grows up to be a promiscuous person or a virtuous one. They emphasised that instead of damaging the bodies of girls and creating long-term complications in the process, parents should put taboo aside and talk to children about sex and sexuality.

The Raëlian women particularly were keen to point out that instead of dampening sexual desire (as it is intended to in some cases) circumcision leads women to become more promiscuous as they seek men who can enable them to attain sexual pleasure. In other words, they suggested that female circumcision interferes with sexual pleasure but not with desire. For example, Samira alluded to this in her own experience indicating that had she not met her partner, she would still be going from one man to another seeking sexual pleasure. More generally, she said that there are girls who are obliged to change men because they do not experience sexual satisfaction. As already pointed out above, the Raëlian women also indicated that upon exploration they discovered that they were able to attain pleasure through different parts of their bodies. This reporting of other pleasure points aside from the clitoris finds resonance with a study carried out by Okonofua et al. (2005:1092, 1094) in Nigeria whose findings indicate that genital cutting did not reduce the level of sexual activity in women. However, such women

⁷³ Even so, as I explain in Chapter 9, these Raëlian women pay more attention to the question of pleasure than do other people in Burkina Faso. It is significant, for example, that even though Antoinette and Maimouna have learnt to experience pleasure notwithstanding their circumcision, they still feel the need to undergo reconstructive surgery in order to attain maximum pleasure, but probably also as a religious and political statement.

“were significantly less likely to report that the clitoris was the most sexually sensitive part of their body”, reporting instead that the “breasts were the most sexually sensitive parts of their body” (2005:1094).

Aside from the Raëlian women, other people in Burkina Faso also closely associated female circumcision with a loss of sexual pleasure. For instance, Madeleine, a retired Catholic nurse I interviewed at Leila’s centre, told me that she suffered frigidity as a result of circumcision and wished she had become a nun instead of getting married. Nafissatou of the CNLPE, also a Catholic, said that a circumcised woman does not share in sexual pleasure with her husband. On her part, Aziza, an uncircumcised Muslim, hypothesised that the consequences of these procedures are mostly to do with frigidity and that circumcised women do not experience sexual pleasure in the same way as uncircumcised ones. Pauline also suggested that circumcised women are not as sensitive as they would naturally be without circumcision, while Gabrielle cited painful intercourse for such women.

Nevertheless, there are also women in Burkina Faso who indicate that circumcision has not affected their attainment of sexual pleasure. For example, Sylvie pointed out that there are many women who were circumcised but who do not even know it because they do not experience any problems. More directly, Leila said:

[During sensitisation] we made allusion to sexual intercourse. We would say, “Yes, a circumcised woman does not feel pleasure during sexual intercourse.” There are women who interrupted and said, “No, I am circumcised but when I have intercourse with my husband, I have pleasure.” What can you say in the face of that? Because there are several forms of [orgasm]: there is the clitoral form, there is the vaginal form and so on.

The idea that circumcision does not affect women uniformly, and that some circumcised women do experience both sexual desire and pleasure, can also be found in the literature on these practices. Such researchers as Boddy (1982, 1998), Gruenbaum (2001), Lightfoot-Klein (1989), Toubia and Izett (1998) and Obermeyer (1999) point out that the effects of these practices on sexuality cannot in any way be said to be experienced in a uniform manner among all women even in countries where one form of the procedure is practised. For example, Shell-Duncan et al. (2000:115-118) report that among the Rendille of Kenya, a community in which girls undergo excision during the marriage ceremony and where it is acceptable for girls to be sexually active before marriage, some women indicate that they desire and/or enjoy sex while others say they do not. It

is also important to underline the powerful role that culture plays in structuring the acquisition of knowledge about sex, the expression of sexuality and sexual response, and even the associations made with the notions of pleasure and pain (cf. Obermeyer 1999:96; Gruenbaum 2001:139). Some of the authors exploring these issues (for example, Obermeyer 1999:94-95; Toubia and Izett 1998:35; Paterson et al. 2012:6) rightly point out that more research and better designed studies are needed in order to assess and fully understand them.

Still, there are fervent discussions in the literature on the impact of female circumcision on sexual response and function. Some of these are centred on the clitoris and its necessity for sexual pleasure with, for example, Abusharaf (1998:24) arguing that removing part of the clitoris makes orgasm practically impossible. Others suggest that while they might not necessarily completely abolish the possibility of sexual pleasure, these procedures interfere with the physical receptivity of sexual stimulation in women (Toubia and Izett 1998:24, 35), and may dampen sexual desire and arousal but also impair sexual pleasure, satisfaction and orgasmic functioning (Paterson et al. 2012:3-4).

There are also counter arguments in the literature to the effect that the available evidence does not support the notion that circumcision prevents sexual desire and pleasure, and that in some cases it can even ameliorate the sexual experience (cf. Obermeyer 1999, 2005; Sulkin 2009; Ahmadu 2000, 2009). For example, Obermeyer cites studies conducted in Sudan by Lightfoot-Klein (1989), El Dareer (1982) and Boddy (1996), and in Egypt by Assad (1980) and Khattab (1996) to argue that they do not categorically show that these practices “are fundamentally antithetical to women's sexuality and incompatible with sexual enjoyment” (Obermeyer 1999:95-96).

Moreover, in her view, the link between an intact clitoris and orgasm which is “presented as an indisputable physiological reality may ... be socially constructed” (ibid.). Ahmadu (2000:283-312), an anthropologist raised in the United States but who underwent excision as part of her initiation into womanhood in the Kono society of Sierra Leone, disputes the notion that “a woman can be physiologically or psychologically *incapable* of sexual enjoyment and desire” (2009:16-17, emphasis in original). She explains that as practised by the Kono, excision improves sexual pleasure by emphasising orgasms reached through stimulation of the ‘G-spot’. Sulkin, another anthropologist, also considers a myth the notion of sexual dysfunction in circumcised women. According to him, such discourses as the one purporting that ‘mutilated’

women do not achieve orgasm “can function as persuasive, self-fulfilling prophecies, and it is not surprising that many circumcised women in diaspora come to think of themselves as mutilated and their circumcision rituals as necessarily traumatising violations, and to blame sexual troubles on their modifications” (Sulkin 2009:19; cf. Johnsdotter and Essén 2004; Abdulcadir et al. 2012, cited in Boynton 2013:232).

Some of the authors referred to above, particularly Sulkin (2009), Johnsdotter and Essén (2004) and Abdulcadir et al. (2012) refer to the experiences of some women and girls from circumcising societies who are now living in Western countries. However, this conflict between cultural values is also observed in Burkina Faso where these women have not moved into other countries but live in areas like Ouagadougou and Bobo-Dioulasso where the discourse against female circumcision is prominent and new values are increasingly being amalgamated with local ones (cf. Boddy 1998b:86). While there are conflicting views observed in the literature regarding the impact of female circumcision on sexuality, I found that in Burkina Faso more and more people are subscribing to the view that circumcision causes grave sexual (and other) problems for women. The Raëlian women in particular insist that no circumcised woman can fully blossom in her life or be fulfilled sexually without undergoing reconstructive surgery even though, as already explained, they also say that by learning more about sex and getting involved with mature and patient sexual partners they are able to experience pleasure. When I suggested to Samira that there may be circumcised women who feel that they do not have problems and would not seek reconstructive surgery, she answered that such women do not know the full measure of the pleasure that they are capable of experiencing. According to her:

They don't have information. They don't know what pleasure is. When you say, for example, that honey is good, is there anything that is better than honey? You don't know. But on the other hand if someone tells you, “That thing is better than honey,” but you say, “Well, I only know honey, so I'm going to limit myself to honey. You girls go and taste that, but me....” That's how it is!

In her response, Samira supports the dominant discourse which privileges the view that female circumcision inevitably causes problems which need a solution. Her reaction is similar to those seen from other research participants in Chapter 6 in relation to women who say that they do not have any problems arising from female circumcision. The proposed solution, as will be shown below, is presented in terms of reconstructive

surgery even though this procedure is not accessible to all who are made to believe that they need it. Moreover, as will be demonstrated below and additionally in Chapter 8, the Burkinabe government, through the CNLPE, acts as a gatekeeper to accessing these remedies and even information about them.

Genital reconstructive surgery in Burkina Faso

During the past ten years there has been a gradual increase in the amount of information in academic literature and the media about reconstructive surgery after female circumcision (cf. Thabet and Thabet 2003; Aziz 2004, 2005; Momoh 2005; Prolongeau 2006; Nour et al. 2006; Johnson and Nour 2007; Mansour-Hugues 2007, cited in Ouédraogo et al. 2013; Henry 2009, cited in Ouédraogo et al. 2013; Villani 2009; Jivrosky 2010; Madzou et al. 2010; Krause et al. 2011; Quilichini et al. 2011; Foldès et al. 2012; Paterson et al. 2012; Ouédraogo et al. 2013; Ogodo 2007; Irin News 2009; Kamara 2009; Ouédraogo 2009; Thomas 2009; Tsai 2010; BBC Radio 4 2013a, 2013b; Pressly 2013; BBC Radio 4 2014; Lloyd-Roberts 2014).⁷⁴ Some of these writers deal with the procedure I describe in this section but focus on its practice in France, and more recently in Spain and the United States, while a few others explore its practice in Burkina Faso. Others document more established procedures carried out on infibulated women particularly those living in Western countries.

In general terms, there are two main forms of reconstructive surgery relating to female circumcision. The first one consists of procedures referred to as defibulation or deinfibulation carried out on infibulated women to facilitate sexual intercourse or a vaginal delivery. Paterson et al. (2012:7, citing Johnson and Nour 2007 and Nour et al. 2006, who are based in the United States) explain that these procedures involve releasing the vulvae scar tissue, exposing the introitus and creating new labia majora (cf. Krause et al. 2011, writing from Switzerland). Momoh (2005:24), a prominent healthcare professional based in the United Kingdom, explains:

The reversal procedure can be done under local or general anaesthesia and involves a vertical incision dividing the previously sutured labia. After dividing the labia, clitoral tissue may be felt or revealed interiorly, if the

⁷⁴ There is mention in the literature of clitoral reconstruction in transgender reassignment (see, for example, Dabernig et al 2007) which falls outside the scope of my study.

original operation had not involved partial or complete removal of the clitoris.

The second type of surgery involves procedures carried out on women who have undergone other forms of circumcision notably clitoridectomy and excision. For example, Thabet and Thabet (2003:13, 17) writing about their medical studies conducted in Egypt point to reconstruction procedures (which they refer to as clitoroplasty or clitoro-labial reconstruction) which are “usually needed for the restoration of sexuality in most cases of mutilated circumcision or postcircumcision clitoral cysts”:

The clitoris [is] reconstructed by freeing the available part from any adhesion, cutting the suspensory ligament and its reattachment in a more backward position after pulling the available part of the clitoris forward to create a reasonable clitoral part, then the skin wounds are repaired. Repair of labia minora is usually done using the labial remnants to reform continuous labium attached to the clitoris base, referring to the known rules of plastic surgery (2003:13).

This procedure has some similarities with the surgical procedure developed and used by Pierre Foldès which I explore in this section, and around which my research is based. Foldès (cited in Prolongeau 2006:90-91) explains that circumcision procedures detach the clitoris from the skin triggering bleeding and infection. This pushes back the stump, causing it to be displaced and to take up a new position which is two to three centimetres higher than normal. The stump is then covered by a scar. It is this scar and this position which are thought to curtail pleasure. With the understanding that excision is rarely very deep, coupled with knowledge gained by examining the techniques employed by Bernard-Jean Paniel in treating clitoral cancer and Bowen’s disease, analysing techniques used in penile reconstruction and carrying out anatomical experiments on cadavers, Foldès came to the conclusion that by preserving nerve endings and capitalising on the length of the clitoris, which is about 11 centimetres, it would be possible to repair the organ (Prolongeau 2006:98-101).

In an illustrated article in *The Journal of Sexual Medicine*, Foldès (2006:1091) explains the procedure which he developed in Africa and continues to practise in Saint Germain-en-Laye, France, and which is used by the doctors he has trained.⁷⁵ He explains that he

⁷⁵ This procedure has not remained static since its inception. While I was in Burkina Faso, Professor Kerekou informed me that Foldès was scheduled to visit the country

“focused on the sexual problems following female genital circumcision and developed a surgical procedure aimed at restoration of both clitoral anatomy and clitoral function in afflicted women” (2006:1091). Explaining the workings of his four-step procedure, Foldès says:

The female genital circumcision leaves women with varying degrees of absent glans clitoris, prepuce, right and left frenulae, and right and left labia minora. One key surgical principle is that the residual clitoral shaft remains attached to the suspensory ligament.... The skin covering the distal stump of the clitoris is resected sharply with scissors, taking care to stay close to the clitoral stump, and proceeding upward to include the upper extremity of the clitoral stump. Once exposed, the residual clitoris shaft is easily palpated in the midline.... Sharp dissection around the clitoris is performed with scissors laterally, inferiorly, and at the junction of the suspensory ligament with the pubic bone.... The superior extremity of the clitoral stump is detached from the pubic bone. The suspensory ligament is progressively transected close to the bone and as deep as necessary, to allow sufficient downward mobilization of the clitoris to bring it to the glans' normal location. Any lateral fibrous tissue is then carefully removed from the neo-clitoral shaft extremity until the tunica albuginea is identified. In the plane of the tunica albuginea, most of the residual fibrous tissue is carefully removed, preserving only a thin layer, especially over the dorsal region of the neo-clitoral shaft extremity. Careful inspection of the dorsal region reveals an intact neurovascular bundle, and this bundle is cautiously preserved in this state. The area is closed in two layers. The first layer involves fixing the neo-clitoral shaft extremity in place to prevent retraction.... Above the clitoris, the vestibular skin is closed.... (Foldès 2006: 1091-1094).

As practised in Burkina Faso, genital reconstructive surgery is divided into two distinct surgical procedures. Medical personnel, CNLPE staff and other activists refer to these procedures using two phrases: *réparation des séquelles de l'excision*, which I have translated as ‘surgical repair for circumcision sequelae’, and *reconstruction du clitoris*, which I refer to as ‘clitoral reconstruction’. The Raëlian women I interviewed refer to clitoral reconstruction as *restauration*, that is, ‘restoration’.

Surgical repair for circumcision sequelae involves various procedures of varying complexity. In some cases, it entails removing keloids which may develop on the genitals of some circumcised women. It may also involve widening the vaginal opening

from 10 February 2013 to teach the Burkinabe doctors his updated technique. However, that visit was postponed.

in cases where the labia have fused to create a pseudo-infibulation (cf. Jirovsky 2010:86). Dr Hassan explained:

The simplest form is where there is just a little narrowing due to the fact that the clitoris or the labia minora were affected, so we do repair. But there are complicated forms where it's very narrow, and it's just a small opening which is there. In such a case we have to open. There it's truly a case of surgical repair in order to enable the person to have a sexual and maternal life which is of a better quality.

Dr Diallo also explained this surgery saying:

There is the correction of the sequelae of circumcision. That is to say, it's very often linked to long term complications such as the narrowing of the vulva. One can have a narrowing of the vulva so we do surgery to enable the woman to have normal sexual intercourse. Narrowing of the vulva can even be the cause of... it closes the vaginal opening of the woman and menstrual blood cannot get out, so we do it to correct that. Or at the level of the urethra, it closes it which means that urine cannot come out. That is surgery on the sequelae of circumcision.

Clitoral reconstruction, on the other hand, involves removing the scar tissue resulting from clitoridectomy or excision, exposing the residual clitoral shaft and reconstructing it into an external clitoris. Hassan explained this saying:

Now there are also repairs which resemble plastic surgery which is clitoral reconstruction where we try to go and look for the piece of the clitoris which is inside in order to reconstruct it.

About clitoral reconstruction, Diallo explained:

There is another surgery which appeared recently [...]. Now we actually talk of clitoral reconstruction, which is a separate sort of surgery [...]. That is to say, the clitoris which was cut, the core that remains, we try to bring it out, to make it more superficial, to make the woman more sensitive.

Leila also said:

The second form of the surgery is the reconstruction of the clitoris. And that I think with Professor Foldès, who is a French urologist, he trained... he is the expert in that domain. He is the one who trained some African, and particularly Burkinabe, gynaecologists who do it.

While the invention of clitoral reconstructive surgery is attributed to Pierre Foldès, it is not entirely clear when and how surgical repair for circumcision sequelae began.

Without giving a precise date, Prolongeau (2006:84-88) explains that Foldès's procedure to repair problems caused by circumcision proceeded from an initial interest in and engagement with the development of procedures to repair fistulae in Morocco

and Burkina Faso while on a humanitarian mission with *Médecins du Monde*. After consultations with a colleague, Jean-Antoine Robein, Foldès developed a technique that went beyond repairing fistulae to include repairing the damage occasioned by female circumcision (Prolongeau 2006:89-90). It is from this initial procedure meant to alleviate pain and prevent secondary complications of female circumcision that Foldès developed a procedure that has also come to be associated with the reconstruction of the clitoris and the restoration of sexual pleasure. Christine Aziz, a freelance journalist reporting for *The Scotsman* in 2004, also seems to suggest that Foldès developed a surgical procedure to treat negative consequences of female circumcision before moving on to clitoral reconstruction.⁷⁶ She writes:

Dr Fordes [sic] first encountered the traumatic effects of excision 25 years ago while he was working as a humanitarian doctor in Burkina Faso, West Africa. “Some women came to me complaining of scarring which was very painful for them every time they moved,” he recalls. “A special type of scar tissue called a keloid can develop on black skin and in these cases it grows hard and thick and attaches itself to the pubic bone. The women asked me if I could do something about it. While I was operating I began to do some reconstruction surgery on the vagina and labia as well as clearing scar tissue.” ... When, 15 years ago, Dr Fordes [sic] embarked on his mission to develop surgical techniques to restore the clitoris he was shocked to find that the only organ in the human body devoted to pleasure had been metaphorically excised by the male-dominated medical fraternity.

The periods given by Aziz situate Foldès’s development of the first form of the surgery in 1979 and the second form around 1989. Regarding the Burkinabe context, Leila explained to me that initially children who had major problems linked to circumcision were sent to France for treatment because Burkinabe doctors had neither the expertise nor the equipment to treat them. As Burkinabe doctors became increasingly aware of problems caused by female circumcision, they went to France to get training on how to treat those problems surgically.

However, while crediting Foldès with pioneering clitoral reconstruction, Professor Kerekou disputed the idea that it was Foldès who began the first type of surgery (surgical repair for circumcision sequelae) in Burkina Faso. Kerekou told me that he had started performing this surgery in 1991 and had taught it to other doctors. When I asked him how that came about he explained:

⁷⁶ <http://uk.linkedin.com/pub/christine-aziz/14/48a/a16>, accessed 15 August 2014.

When I went for studies, I was at the Yalgado Hospital, the biggest university hospital. I saw a lot of girls who came with problems of circumcision sequelae. Finally few were operated on because we had to put them to sleep so they had to buy an infusion kit, bandages, Betadine [and other things]. All that was very expensive for them. So I said to myself, if we can manage to circumcise boys with Xylocaine at a reduced cost, why can't we repair those girls with Xylocaine?⁷⁷ I tried it and it worked, and that's how it started. And until now I have trained more than 250 Burkinabe medical practitioners and even foreigners. Yes, in November we had some training for two doctors from every country in the West African Economic and Monetary Union. Two years ago, we trained 16 others, so that is 32 that we have trained from foreign countries.

My research participants were not able to say with certainty when these surgeries began in Burkina Faso. I therefore asked the medical doctors I interviewed to tell me when they began performing these procedures in the country. Apart from Kerekou who began to do surgical repair in 1991 and Hassan who began in 1995, all the other medical doctors began performing these procedures in the 2000s: Condeh in 2009, Diallo in 2006 or 2007 and Nikiema in 2006. While most of these doctors learnt the procedure from Kerekou, Nikiema told me that he learnt the procedure from a medical doctor practising in Angers, France. Hassan indicated that as a gynaecologist, he had the training to do surgical repair for circumcision sequelae, and had been doing it before the training organised by the CNLPE which, according to Nafissatou, began in 2000. Dr Condeh, a surgeon, also indicated that he had been doing other forms of surgical repair (not related to circumcision) before 2009.

Other research participants' understanding of reconstructive surgery

Knowledge about genital reconstructive surgery in Burkina Faso is mainly held by the medical doctors who perform these procedures and some activists against female circumcision. While medical doctors, CNLPE staff and other activists, and the Raëlian women are clear that there are two forms of reconstructive surgery and know what they entail, other research participants do not display this uniform understanding of these procedures (cf. Jirovsky 2010:86). I asked my research participants what they understood by the term 'reconstructive surgery' in the context of female circumcision or what they knew about these procedures. In response to this, Pauline said: "Well, I in

⁷⁷ Xylocaine is a brand of topical anaesthetic.

particular have never heard of [reconstructive surgery]”. Seeming to refer to cosmetic surgery done in France, Aïcha, a university student, said:

What I know, once I was reading an article on the Internet and it was on the issue of repairing cells or...I'm not sure. It was something scientific so I did not understand it properly [...]. There were women who were going, for example, to have a part of their organ removed [...]. I read that it was happening in France, on French women.

Some research participants had some information about these procedures, particularly surgical repair for circumcision sequelae. For example, Aziza, whose sister is a gynaecologist trained to perform reconstructive surgery, said:

I think that in the practice of circumcision there are really [problems] with scarring. Perhaps there can be keloids or there can be some small problems which make the sexual organs not beautiful to look at. That perhaps means that with reconstructive surgery, they try to reconstitute the parts which were affected, which were removed, so that the sexual organs look a little bit better [...]. I don't know whether it is subsidised or not or whether it is free for women. I also don't know women who have undergone that surgery. So really I don't know what it can change in their life.

On his part, Albert, an anthropologist who has researched female circumcision practices in parts of Burkina Faso, said:

I don't know much about reconstructive surgery. Well, I know that there are services, clinics which specialise in that [...]. People have talked about them in the newspapers. The other thing I know is that there are gynaecologists who intervene and perform surgery in case of problems with reproductive health, childbirth or circumcision sequelae.

Madeleine, a retired nurse filling in for the regular nurse at Leila's medical and advocacy centre, said:

Yes, there are a lot of women who come for repair. And that, it's the gynaecologist who does that [...]. No, no, no. I have not heard of clitoral reconstruction.

Sylvie (who worked closely with the gynaecologist that Madeleine referred to) knew about both types of reconstructive surgery, but said:

I have not even seen [a case] of clitoral reconstruction. I haven't yet seen that, but surgical repair, I have seen that with our gynaecologist, because often I'm the one who hold the clamps and thread and then she does it.

Other research participants seemed to have understandings which can be applied to both procedures but they themselves did not make a distinction between surgical repair and

clitoral reconstruction. For example, Danielle pointed to her understanding of reconstructive surgery after female circumcision as surgery that is performed on women's genitalia to alleviate problems that may tamper with reproductive and sexual health. She said:

Yes, yes, yes. I have heard of reconstructive surgery which is done by Professor Kerekou. He is a gynaecologist who is in that domain. And he is very well known here [...]. He works at the Dominion Clinic and Yalgado [Hospital] I believe. It was from him that I first heard about it. But it was on TV that I saw it [...].

According to me, after circumcision, there are problems. There are sequelae which prevent the normal functioning of a woman at a sexual level. So these are treated so that she regains her health, that she has no problems. For example, I have a childhood friend, after [circumcision] she had problems urinating. She underwent an operation to correct that a little bit. And afterwards she was able to... she has even given birth now. But before that, her problem was because of the sequelae of circumcision. I [also] saw a report on TV about a woman who had undergone some form of repair after circumcision.

The understanding that members of the general public have about reconstructive surgery seems to be linked to their professional proximity to medical practice and activism against female circumcision, and their access to media tools particularly television, newspapers and the Internet. The Raëlian women had heard about these procedures from their overseas associates, fellow Raëlians in Burkina Faso who had had reconstructive surgery and media reports. Few of my non-Raëlian research participants seemed to have deliberately sought information about these procedures or knew women who had had reconstructive surgery. One of the exceptions was Gabrielle. When I asked her what she knew about reconstructive surgery, she straight away began to talk about clitoral reconstruction saying:

I know that reconstructive surgery is practised here in Burkina Faso. Personally, I know some people who have sought reconstructive surgery. It's not everybody who has this idea of reconstructive surgery because some find that it's something mundane because if your clitoris was removed [...] why is it necessary to reconstruct it? That's to say, it's not accepted by everybody. But there are some people who do it all the same.

Gabrielle was also one of the few research participants to try and locate the beginnings of both surgical repair and clitoral reconstruction. She said that she had known about clitoral reconstruction for at least ten years but said that surgical repair began much

earlier than that. When I asked how she had heard about it, she was silent for a while and then said good-naturedly:

Well, it's a question in which I'm interested. So that means I'm always in search of information, new developments. That makes me to always seek information relating to circumcision [...]. So I can't tell you whether it is by reading that I discovered that or on the Internet, radio or TV.

Conversely, other research participants pointed out that they did not know much about reconstructive surgery either because they had not purposefully sought information about solutions to the problems of female circumcision or because they did not come across such information in their work or study. For example, Pauline put down her lack of knowledge to the fact that she was not personally affected by circumcision sequelae. She also indicated that as a language and literature student she was unlikely to come across such information in her studies. On her part, Madeleine said that since she had been retired for six years, she did not have current information about health matters.

The observations I made about the lack of uniformity or detail in the understanding that Burkinabe people have about reconstructive surgery led me to ask activists and medical doctors whether this information is made available to the general public. Some of them indicated that there is adequate information provided to people regarding the availability of these procedures, particularly surgical repair for circumcision sequelae. For example, Leila explained that women are given this information during sensitisation campaigns which include counselling sessions specifically designed for women. According to her, during these sessions some women openly admit to having problems and are given appointments for consultation. Others surreptitiously ask where the medical centres are located. Nafissatou also explained that the CNLPE staff train people from various provinces and villages, and those people in turn go to inform others in their locales about what they have learnt. According to her:

Afterwards, if there are women who are victims, they see their facilitators who refer them to the CMA [medical centre with a surgical outpost] or refer them directly here [to the CNLPE].

However, some of my research participants pointed out that while members of the general public are given information about the problems caused by female circumcision, they are not told about the possibility of reconstructive surgery. Even when such information is broadcast, the media used do not always reach the target audience. For example, Dr Condeh of Bobo-Dioulasso explained:

This offer of care doesn't get to the villages. People don't have this information [...]. In the villages people don't know that it exists. And since it's not part of the [sensitisation] programme to say that we are going to repair the clitoris and all that...they only say, here are the complications to which you are exposing your child by having her circumcised: narrowing of the vulva, haemorrhage and so on. And as a consequence, difficulties for her to have children. And when you say that, the message passes. They are not told, "Look, if in any case this happens we are going to repair." Basically, the possibility of repair is not part of those messages.

If you do something on the radio, it's not everyone who has a radio set. It's not everywhere that they can capture the broadcast because the waves are, actually they don't get there. There's no television in the villages.

Gabrielle, who was of a similar view, said:

It's because most of the time they train people on sensitisation, on the consequences of circumcision. They make people aware that there is a law, that there is punishment. But they forget to also tell people that those who are circumcised, that we can do repair if they have problems [...]. That aspect is practically forgotten. So a lot of people don't have information about that. If someone feels unwell, she goes to a health facility and people realise that it's because of a problem of that nature. They refer the person to a facility which deals with repair. But if you don't go to a health centre or if one does not know that you are feeling unwell in that manner, you are not given that information.

In certain situations, disseminating information about the consequences of female circumcision but not about reconstructive surgery, particularly clitoral reconstruction, seems to be a deliberate strategy on the part of the CNLPE to safeguard and accelerate the fight against circumcision. I delve into this further in Chapters 8 and 9. I also discuss the issue of the cost of reconstructive surgery in Burkina Faso in Chapter 8.

Taboo, shame and stigma

Even though it is clear that genital reconstructive surgery has been going on in Burkina Faso since at least 1991, it was difficult for me to find women, apart from the Raélians, willing to tell me about their experiences with this surgery. I also noticed that although the vast majority of adult women in Burkina Faso are said to be circumcised (INSD and ICF International 2012:ii, 291), it was mainly the Raélians and prominent activists and medical personnel such as Leila, Nafissatou and Madeleine who spontaneously said that they were circumcised. On the other hand, apart from Sophie (a Raélian), only Aziza told me that she was not circumcised.

I began to ask my research participants why women seemed to be so reticent to talk about their experiences with circumcision and/or reconstructive surgery. They told me about taboos surrounding sexual matters in Burkina Faso as well as the shame and stigma associated with problems caused by female circumcision. A number of my respondents pointed out that it is taboo to speak openly about sex and sexuality even within the confines of the family, and that such matters may only be discussed in restricted circles among friends. As such, it was unrealistic to expect women to openly share with me, a stranger, their experiences with circumcision and any problems associated with it, much less discuss the need or desire to have genital reconstructive surgery. Perhaps had I stayed longer in Burkina Faso, I might have gradually encountered more openness. However, the responses I explore below make it plausible to argue that a lot of women would have still been reluctant to talk to me about their experiences. It is notable, for example, that Aziza who was born and mostly raised in Burkina Faso, and who at the time of our conversation was a PhD researcher in maternal and infant health, said that for a long time she did not know that female circumcision was widespread in the country. She said that in recent years the CNLPE had started having public debates about it, but that still people did not talk about it even amongst their peers. She explained:

I think that because sex itself is taboo, it's a taboo subject. To discuss that just like that, even though it's true it's talked about on TV, people find that it's... there's a certain bashfulness in talking about it like that. There's...it's like some shame. There's shame in saying, "I'm circumcised or I'm not circumcised." Because there's that too. I admit that I personally don't say it. It's really something that we don't talk about [...]. It's really in restricted circles that it's discussed. Not even with our mothers [...]. Those are sexual things and we are quite modest on the question. It's perhaps because of that that women are ashamed of declaring that they are circumcised or not.

Samira also said:

Since sex is a taboo subject, people don't talk about it like that. Talking about sexuality is taboo here in Burkina Faso. You will not see a woman tell her daughter, her own daughter, "Ah, you are 13 years old or 14 years old now, soon you will have your period. Here is what you need to do." Or, "Well, you have just had your period, be careful with men. This is what you need to do." You will never hear that from the mother or the father because sex is a taboo subject. Because of that, even restoration, even among friends, they have to be really close friends, otherwise they wouldn't talk about it.

Similarly, Danielle said:

Perhaps it is because it is linked to sex [...]. People don't talk about sexual organs everywhere. It's their privacy. One cannot start talking about sexual organs or one's sex life to just anybody. No, no [...] a woman who is going to have herself repaired, it is not likely that she will agree to tell people, "Listen, I'm going to do that." No, one has to be courageous. That woman who testified [on TV] was alone. Others, perhaps, would testify with veiled faces.

Taboo in talking about sexual matters and practices which change female genitalia makes salient the activist discourse against female circumcision. Some women who accept this discourse embrace with it a sense of victimhood and start thinking of themselves as diminished in the eyes of men and of uncircumcised women. This in turn leads to shame which further reinforces their reluctance to talk about their circumcision, any problems it has caused them or even reconstructive surgery. This shame associated with circumcision was cited by a number of my research participants. For example, when I asked Dr Nikiema why I seemed to be having difficulties meeting women willing to talk to me about their experience of reconstructive surgery, he said:

Because, first of all, these women... no adult woman wants people to know that she is circumcised. Saying that she is circumcised is like saying she is inferior to other women. So it is difficult to know. It would be embarrassing for a woman to say that she is having reconstructive surgery [...]. But already people don't like talking about sex. Sex among adults is not talked about. Whether one is circumcised or not, at a cultural level, people don't like talking about sex. They don't talk about it. That's simple and clear. Several journalists have come. There were even people from a television station who came to film what we were going to do [in reconstructive surgery] and who were looking for patients to interview. They have come to Burkina Faso for years without succeeding in finding a woman willing to talk about it. It's a cultural issue.

When I asked Monique, an accountant at Leila's centre, why it appeared women were reluctant to talk to me about their experience with reconstructive surgery, she said:

I think it's because of embarrassment, shame. Well, so that not everyone will know that they were circumcised because, well, they feel somewhat diminished. I think it's perhaps because of that they refuse to identify themselves, to testify openly or publicly. Yes, it's shame and embarrassment.

When I asked her why women would be ashamed of being circumcised in a country where it appeared that the vast majority of adult women were circumcised, at first she said she did not know why women were ashamed but then added:

Although you say that you want to meet people, *it would be very rare* to find women who were circumcised who will sit with unveiled faces to talk about their being circumcised. No, they can do it while hiding a little so that people don't know that they are circumcised, because, well, they know that... they themselves know that circumcision is not good. The woman knows that. It's because often they were forced to undergo it when they were young. They were not aware. But when they grow up, they know that it's not good. So they don't want people to know that they were circumcised. I think that's the reason for the fear. But those are really women who are educated. They know that it's not good. They don't want to show themselves.

In her response, Monique attributed women's shame about their circumcision to the information they receive as they grow older and more educated that circumcision is not good. They therefore fear being stigmatised if they are identified as circumcised women. Pauline also addressed this inferiority and the discourse inspiring it which she saw as coming from the West. She said:

Because people often think that if you have undergone circumcision, you are in some way inferior to those who have not undergone it [...]. There are those who are really embarrassed about being circumcised when they are among people who are not circumcised. But, first of all, it's not the person's fault. When they circumcised you, you were not... I can say you were not there, you are innocent in fact. It's not your fault. It's something you are innocent of. There's no reason to be ashamed of that. So I think that this mentality of inferiority doesn't come from anywhere else; it comes from the women themselves. They are the ones who have made this idea for themselves simply because they think that whatever comes from the West is better. So they have to conform to it.

From the responses cited above, it is clear that there is a pre-existing cultural tendency in Burkina Faso not to talk about sex and sexuality; these are taboo subjects. However, the discourse emphasising the problems associated with circumcision has added a layer of shame to the pre-existing modesty or taboo associated with sex and genitalia. This discourse has caused circumcised women to feel inferior and so they now have an additional reason to avoid talking about circumcision. This means that people who have had exposure to Western ideas and might otherwise be more liberated to talk about sex and genitalia are once again silenced because they have been turned into shamed victims of 'genital mutilation'.

Taboo and shame in talking about sexuality and practices which affect genitalia seem to be so widespread that they override even health concerns. Some of my research participants, such as Monique, indicated that women with problems associated with

circumcision find it difficult to seek help because they are ashamed of being circumcised and do not want people to know that they are circumcised. This was confirmed by some of the doctors that I interviewed. For example, Professor Karim, a Muslim doctor working in Bobo-Dioulasso, indicated that even when they have problems, women do not often seek reconstructive surgery because of the shame associated with intimate body parts. He explained that in the past he had only dealt with women who had been unable to have sexual intercourse upon marriage. Even then, they did not tell him directly what the problem was and most often said, “My stomach hurts.” It was only after a gynaecological examination that he was able to discover and treat these women’s problems. In the same way, when I asked him the approximate number of women who had approached him for reconstructive surgery, Dr Hassan said:

You see at the beginning women did not come because they were embarrassed. They are embarrassed to come and say, “I have a fistula. I have a sequelae of circumcision and I need to have it repaired.” They are embarrassed about that. And most often also, because of the organisation of our customs here, a woman does not tend to go like that towards a health centre without the authorisation of her husband. So I could say here we do about five repairs per month. But often these are repairs of women who have been referred to us by other consultants.

At the beginning of his answer Hassan seemed to situate women’s reluctance to seek help in the past. However, as he progressed, he implied that women still have trouble presenting themselves to healthcare personnel. Conversely, Dr Diallo suggested that women are increasingly seeking consultation without embarrassment. However, Gabrielle, who works at the same centre as Diallo, explained that even when they go to seek treatment, rarely do women indicate that they have problems related to circumcision and directly seek help from the gynaecologist. Instead, such problems are diagnosed following much probing by people working in the different sections of the centre and then referred to the gynaecologist. Nafissatou also acknowledged that some people who have problems which could be resolved through reconstructive surgery do not come forward, but she attributed this to the fear that people have following the passing of the law prohibiting female circumcision. According to her, people think that if they go to seek help, instead of being helped, they will be arrested.

In addition to the shame associated with being circumcised and the social conventions and taboos which prevent some people from discussing female circumcision and

reconstructive surgery, there is also stigma attached to problems linked to female circumcision. Revealing that one is circumcised and is experiencing problems as a result could lead to rejection. For example, Albert explained that if publicly known, these problems may lead to a woman being shunned by prospective marriage partners because of the assumption that a woman with constant gynaecological problems will need regular medical attention, and hence would bring a lot of expenses to the household. As a result of the prominence given to problems associated with female circumcision by activists, some men also fear that such women would not be able to bear children. This has added a social layer of victimhood to circumcised women in that it has turned these circumcised women (who were previously desirable as they were thought to make faithful wives) into unhealthy victims who are no longer as desirable for marriage as their uncircumcised counterparts. Some young women therefore hide any problems that they have from their parents (mainly because of taboo) and from medical personnel and their peers (because of shame and the dread of social stigma and rejection). As a result, in some cases problems linked to female circumcision are not discovered until the girls get married. Regarding this, Sylvie explained:

When they are young they do not say anything. For example, there was one who was sent here by her husband. She had never told the mother that she was not getting her periods. That the blood was not flowing and that urine came out in drops. Because when she came, the opening was like this {indicating the tip of a biro pen}. Even the tip of this Bic could not get in. But she had not told her mother. It's the husband who sent her here because he could not see anything for sexual relations [...]. Sometimes it even happens that if the husband is seeing nothing, [he says], "I'm going to send away my wife." So because of that, [girls] do everything to keep it quiet [...]. They are afraid because if you say that, sometimes it can prevent you from getting a husband. Because [the man] doesn't know, even if they say that you can give birth normally and all that, he will say, "But will this one be able to give me a child."

Etienne underlined the importance of marriage in Burkina Faso and the difficult position women with reproductive health problems face saying:

Yes, there are circumcised women who have psychological problems because they have real sexual problems, circumcision sequelae which hinder [marital life]. Yet being married is very important until the present day. And when they have these problems of sequelae, they hide. They reduce themselves to...they withdraw. So they don't assert themselves. They lack self-esteem. And because of that, since talking about the subject of sex is shameful in the culture, they don't communicate. The woman does not get

out of her silence. She is there, she can perhaps become phobic towards sexual relations.

Even when compelled to seek medical help, these women still fear that they might draw negative attention, and ultimately rejection, to themselves. This is especially so in cases where they live in the same communities as the people who work in health centres.

Some of the affected women are apprehensive that through these people, knowledge about their problems will become public and attract social stigma. Sylvie explained that it is important for these women to be assured that information about them is kept confidential. Echoing Dr Nikiema's explanation above regarding women's reluctance to talk about their experiences with reconstructive surgery, she said:

When people need repair, it's done anonymously because otherwise if somebody knows, he or she will talk about it. There are people who came from Mali, from all over. They worked here for a week. And they tried to see these girls [who had had repair]. A lot of the girls refused. When they came to see the doctor they did not want to talk. They were told, "You can speak, you are going to speak into a recorder and we will broadcast that without giving your name." They said, "No. What if someone recognises my voice?" So really people must... it's not easy. It's not that open because it has an impact in the environment, in the neighbourhood, family members and even other relatives. People are going to look at you...you will be somehow stigmatised. They will ask, "Really, is it now well repaired?"

Sometimes the person experiencing problems is blamed (particularly by other circumcised women who have no problems) because it is assumed that she must have done something to cause them. In other cases, these complications are associated with witchcraft because, as Etienne observed, there is a common belief that "one is never sick except by the hand of another". As a result of all these factors, a lot of circumcised women live with the impact of their circumcision or even their experiences with reconstructive surgery in silence.

Conclusion

The strategies used by the Burkinabe government to end female circumcision are inadvertently causing psychological, sexual and social problems for circumcised women. A lot of circumcised women in Burkina Faso refer to themselves and are referred to by others as victims. Some of these women might already have physical and psychosexual problems associated with their circumcision. Activists' representation of these women as victims of mutilation who are inevitably suffering risks provoking further psychological, sexual and social problems for these women thus compounding

their layers of victimhood. As demonstrated above, some women now inevitably attribute their sexual and reproductive health problems to circumcision, and some people in the country now assume that circumcised women inevitably have reproductive health problems. These multiple layers of victimhood have a direct impact on the silencing of circumcised women which also occurs at several levels. Firstly, these women are silenced in regard to their experiences with circumcision and reconstructive surgery by their cultural norms of modesty which consider such subjects taboo. These women are further silenced by the shame associated with their circumcised condition and the fear of social stigma and rejection in cases where they are thought to be unhealthy and thus unfit for marriage and motherhood.

The stigmatisation of women who have problems linked to circumcision might appear puzzling in a country where the majority of adult women are circumcised and where, presumably, some of these problems are common. However, as already observed in the previous chapters, these hitherto relevant cultural practices have been condemned and criminalised. Moreover, as explained in Chapter 6, the nature of these practices has changed so that they are thought to cause more problems now than they did in the past. That leaves people grappling with the challenges of handling these changes and new ideas amid the established beliefs and social conventions. In the next two chapters, I further demonstrate that the presentation of reconstructive surgery as the primary solution for problems linked to female circumcision is further complicating the situation particularly for women who have been made aware about this surgery but are unable to access it. Exacerbating these issues is the fact that the people involved in this process of creating victims – that is, the government through the CNLPE, non-governmental organisations and even some medical doctors – have not put in place adequate structures to address the emotional and psychological problems aroused by the portrayal of female circumcision as inevitably harmful.

CHAPTER 8

THE CLITORIS: FROM DIABOLISATION TO COMMERCIALISATION?

Introduction

I explained in Chapter 5 that one of the main reasons parts of women's genitalia, particularly the clitoris, are removed is the belief that this will ensure that girls are chaste before marriage, and that once married, women are faithful to their husbands. In this understanding, a good, marriageable woman is one who has been circumcised. However, as detailed in Chapters 6 and 7, new information about the problems associated with female circumcision has changed the perspective of many people in urban Burkina Faso so that now healthy, desirable and marriageable women are portrayed as those who have not been circumcised. The development and increased publicising of genital reconstructive surgery has led some women to seek this surgery in order to address their perceived deficiencies.

In this chapter, I show in greater detail the issues around accessing reconstructive surgery based on the manner in which these procedures are classified. I explore the perceptions and concerns of some members of the Burkinabe public regarding these procedures. In addition, I focus on the practice of some medical doctors who attempt to turn 'victims of female genital mutilation' into healthy, desirable and sexually competent women once again. I also highlight the scepticism of some Burkinabe people regarding the motivations of these doctors and of the activists opposing female circumcision, in view of the inadequate psychological care available to women who have been turned into victims. I conclude the chapter by briefly paralleling some 'normalising' surgeries.

The cost of genital reconstructive surgery

To learn about the practice of reconstructive surgery in Burkina Faso, I interviewed six doctors – Kerekou, Condeh, Hassan, Diallo, Nikiema and Karim. I interviewed Kerekou and Hassan at their private clinics in Ouagadougou, Condeh and Karim at the teaching and referral hospital in Bobo Dioulasso (*Centre Hospitalier Universitaire Souro Sanou*), Diallo at a medical centre in Ouagadougou and Nikiema at the teaching and referral hospital in Ouagadougou (*Centre Hospitalier Universitaire Yalgado Ouédraogo*). These

doctors are only a small fraction of the people who have been trained to perform genital reconstructive surgery. Nafissatou told me that since 2000, the CNLPE has had Prof Kerekou train up to 232 people – doctors, gynaecologists, health care assistants, midwives and birth attendants – from various parts of Burkina Faso to carry out surgical repair for circumcision sequelae. As cited in Chapter 7, Kerekou himself indicated that he has trained over 250 Burkinabe and foreign medical personnel in the procedure.

Leila explained to me that this training programme is facilitated by the Burkinabe government and UNICEF. She said that at the beginning the surgery was carried out by Kerekou at the Yalgado Hospital and at a mini-block in the First Lady's Dominion Clinic. However, because more and more women began to seek the surgery as they got information about it, UNICEF began to fund training for more healthcare personnel in the surgical technique in order to increase and decentralise the places where it was offered. Presently, UNICEF provides equipment for the surgery and the Burkinabe government pays the doctors who perform the procedures. All medical centres with a surgical outpost (CMA) have the necessary surgical material and at least one staff member trained in the technique of surgical repair for circumcision sequelae.

It was not entirely clear to me whether surgical repair for circumcision sequelae is provided free of charge as was suggested by most of my research participants particularly the medical doctors and Leila. When I enquired further, a number of people including Nafissatou, Amina and Antoinette indicated that this surgery could not be said to be completely free of charge as there were some charges (for example, the cost of transporting surgical equipment, the cost of some disposable materials used during the surgery and that of prescriptions given to the patient after surgery) borne by the patient. They indicated that at best, the cost of these services is subsidised. About this, Antoinette said:

They say free but is it really free? Yes, they say free but when you go, there are certain costs that you are going to shoulder. They can do the operation and all that but you have to pay for the medication. That's at your cost. Today if you go, for example, to the Dominion Clinic where it is done by Prof Kerekou and others who were trained there, you will not have less than 200,000 francs. Because in 2012, there was an Ivorian, a young student who left Ivory Coast to come to Burkina Faso. I was put in touch with her. I took it upon myself to go with her [...]. So when we evaluated the funds she needed, because there you go with your own money, you don't have less than 200,000 [...]. There are times when there are campaigns for that and

they do it for 10,000 francs, 10,000 francs and then you pay for your medication.

Two hundred thousand West African francs (approximately 508.27 New Zealand dollars) is a significant amount of money given that the average monthly salary in the country is about 150 US dollars or approximately 229.64 New Zealand dollars (BBC News 2015).⁷⁸ In her response above, Antoinette conflates surgical repair for circumcision sequelae with clitoral reconstruction which the CNLPE does not address in its funding policies, and which is not provided free of charge by healthcare workers in Burkina Faso. Moreover, she seems to overlook the fact that the free-of-charge care is limited to public hospitals; at the Dominion Clinic, which is a private establishment, free surgery is only provided on Wednesdays (as explained below) for referral patients. Self-referred patients attending this and other private clinics are expected to cover the full cost of the procedure. Antoinette's response suggests that the primary concern for circumcised women who feel they need this surgery is their ability to access it easily and affordably (or freely) without being encumbered by the differentiation made of the private and public establishments, or of surgical repair for circumcision sequelae and clitoral reconstruction.

The differences in the portrayal and provision of surgical repair for circumcision sequelae, on one hand, and clitoral reconstruction, on the other, became clearer as I spoke with other research participants. For example, Leila explained that clitoral reconstruction (which is not as common as surgical repair) can be considered a luxury only accessible to women with financial means. She said that although about 10 gynaecologists have been trained to do it, it is mainly two of them – Prof Kerekou and Prof Camara – who are most commonly associated with it, and that they do it in private clinics. The cost of the procedure puts it out the reach of most women. The medical doctors I interviewed were also clear about the difference in the perception, costing and provision of these two procedures. (I explore the significance of this differentiation in the next section below). For example, Dr Diallo who worked both at the Dominion Clinic and in the centre run by Leila said:

We do the two [surgeries] but what we do most often is surgical repair for circumcision sequelae, narrowing and the other complications linked to

⁷⁸ Exchange rate obtained from CoinMill.com on 20 July 2015.

circumcision because that is paid for [by the government]. The [surgical] kit is provided free of charge, the surgery is not paid for [by the patient]. But until now, clitoral reconstruction, that is considered as...well, it's like you are adding something to the woman. That is paid for by the patient. But that is rare, we do it but it's rare because it's not everybody who can afford it.

In the same way, Dr Hasssan said:

[We do] both types of surgery. I was trained in both the repair... because as I said there are two types. There is the repair for complications but there is also plastic surgery. That one is more... it's really plastic surgery. It's not mandatory. It's the women who want it done but one has to pay. The women who want it have to pay. It's reconstituting the clitoris.

I asked my research participants about the uptake of genital reconstructive surgery. Although they did not give definitive numbers, most of the doctors indicated that there are more women seeking surgical repair for circumcision sequelae than those seeking clitoral reconstruction. For example, Dr Diallo, who began practising this surgery in 2006 or 2007, said that on average she sees five patients per month needing surgical repair for circumcision sequelae. The same number of patients per month is cited by Dr Hassan who has done the surgery since 1995. On the other hand, Dr Nikiema, who has worked as a gynaecologist and obstetrician since 1991, and who is also a university lecturer, explained that he has mainly done clitoral reconstruction since 2006, and has operated on about 100 women. About the prevalence and cost of this surgery, he said:

[The prevalence] is very low because we have just started doing it and we don't have time. We have so many obstetrical complications to deal with that we cannot give you a figure [...]. The surgery is only done in Ouagadougou. And even in Ouagadougou, there are not many people who know about it. But there is no one who dedicates all his time to do that. That's why every year we have two campaigns that we consecrate to that. After that we just do a little bit because we have other things to do. It's not free. [During these campaigns] it's subsidised because we give a lot of products and the women pay for that. I think it's 10,000 francs. Otherwise it's expensive, and we have to give the women prescriptions. It can reach 115,000 francs. And in private it's 250,000 francs. It's more expensive.

From the responses above, one deduces that some costs relating to surgical repair for circumcision sequelae (the surgical kit and the doctors' fees) are borne by the government, but that the patient still bears some costs particularly for prescriptions. On the other hand, clitoral reconstruction, which is quite expensive, is solely at the cost of the patient (except during special campaigns when it is significantly subsidised) making it unattainable for most Burkinabe women. However, there is reason to believe that even

surgical repair for circumcision sequelae is not readily available to the women who need it. Some of my research participants suggested that some doctors trained to perform surgical repair for circumcision sequelae are unwilling to dedicate their time to a procedure for which neither they nor the health centres they work for receive payment.⁷⁹ Nafissatou pointed to a lack of motivation among some doctors saying that women needing surgical repair are not automatically received and offered the surgery in the health centres and hospitals which are supposed to offer the procedure free of charge. She said:

We asked at the Dominion clinic, for example, it's free of charge. Currently with Prof Kerekou it's free of charge there [but] it is not all doctors who accept to do it routinely because of the issue of it being free of charge. You will see that the majority of cases, even from the professor himself, are referred here.⁸⁰ So we see that [the doctors] don't all do surgical repair once they have been trained.

The idea that some doctors trained to perform genital reconstructive surgery do not do it was confirmed by the two doctors from Bobo-Dioulasso whose location and circumstances do not facilitate this surgery. Dr Condeh indicated that since being trained in 2009 he has only operated on four women in a private clinic, that is, not in the public hospital where he works and where these procedures are supposed to be done free of charge. He explained that as a general surgeon, it is difficult for him to broach the subject of reconstructive surgery with patients because he does not conduct gynaecological examinations and patients do not approach him with problems related to their sexual organs. On his part, Prof Karim explained that he has performed fifteen operations but no longer does so for various reasons: he has hurt his hand and needs time to recover, he is very busy teaching at the university, he travels a great deal and a lot of women are too ashamed to seek surgical intervention for their reproductive health problems. He therefore pointed out that some of the material provided by the Global Fund for Women for reconstructive surgery is lying idle at the teaching hospital in Bobo-Dioulasso. Even though Prof Karim referred to two of his colleagues in Bobo-Dioulasso who have also been trained to perform reconstructive surgery, both he and Dr

⁷⁹ In addition to working in government hospitals or health centres, virtually all the doctors I interviewed also ran or worked in private clinics and/or taught at university.

⁸⁰ The CNLPE staff are then supposed to refer such patients to health centres where they can get treated.

Condeh indicated that Ouagadougou was a better place for me to conduct my research as there was not much reconstructive surgery done in Bobo-Dioulasso, particularly in public health centres. Specifically, he suggested that I talk to Dr Nikiema who was very well known for clitoral reconstruction and also to Prof Kerekou, “the godfather of all things circumcision in Burkina Faso”.⁸¹

Even when surgical repair for circumcision sequelae is provided free of charge (or at subsidised rates), lack of information about it, the status of the people who offer it and the places in which it is offered can deter women from accessing it. In Ouagadougou, Nafissatou, Amina and Antoinette pointed to these services being offered mainly at the Yalgado Teaching and Referral Hospital, the CMA 30 (a medical centre with a surgical outpost) and the Dominion Clinic. (Apart from Nafissatou, my other research participants did not mention the clinic run by Leila which also offers these services perhaps suggesting a lack of information in the general public about it). Given that these places are not solely dedicated to reconstructive surgery, these services are not offered every day. For example, at the Dominion Clinic, this free consultation is only done on Wednesdays. Moreover, some of these places evoke certain perceptions in the public which could prevent them from seeking help there. For example, Aziza was of the view that situating the surgery in the Dominion Clinic (owned by Chantal Compaoré) might deter many women from going there because they might assume it is only accessible to rich people. She said:

And the Dominion Clinic, according to what they say, people have a certain perception about this clinic which makes it not accessible to everybody. In fact, even from its name ‘clinic’ one sees that it’s private [...]. ‘Clinic’ equals payment, equals expensive [...]. We know that, first of all, the clinic belongs to the First Lady, it’s the First Lady who is [the proprietor]. When I say the First Lady, that’s the president’s wife.⁸² So, well, already at that level, people think that it’s a certain category of the population which can go there. So with all that, very few people really are ready to go there [...]. Also, it’s located on the other side of town. For me, it’s the other end of town. So even the geographical access is not that simple. And when you go, it’s cars that you find in the parking lot and perhaps motorcycles. Well, if I

⁸¹ Dr Condeh also referred to Prof Kerekou as “the Mister Circumcision of Burkina Faso”.

⁸² The president in question, Blaise Compaoré, was ousted in a popular and violent uprising on 31 October 2014.

arrive on my bicycle.... So I think those things are an obstacle to the uptake of this surgery.

It is clear that even though surgical reconstructive surgery is available in Burkina Faso, it is only accessible to a small group of women. These are mainly those who know about its existence, those who can afford to pay for it (in the case of clitoral reconstruction) and those who are able and comfortable enough to go to the places where it is offered to find out when and under what circumstances they can benefit from it.

Cosmetic, plastic or reconstructive?

The clear distinction made between surgical repair for circumcision sequelae and clitoral reconstruction is not only based on the varying complexity of these procedures and their cost. It also has to do with the perception that while surgical repair for circumcision sequelae is necessary for good health, clitoral reconstruction is a cosmetic procedure. For most of my research participants, once one starts talking about the clitoris, he/she has crossed over from talking about restoring good health (which is considered necessary) to talking about aesthetics and sexual pleasure (which are considered a luxury). When I asked Nafissatou why the CNLPE focusses on surgical repair and not on clitoral reconstruction, she explained:

It's true with the repair of sequelae, it's for those women who are already victims to regain their health so that they can enjoy their sexuality like others. But regarding clitoral reconstruction, that is not in the framework of our strategies. That is cosmetic surgery. That is for something which was cut and which they need... that there's the remaining bit of that clitoris which is buried inside that they have to bring out [...]. That is at your cost if you have money because it's expensive, almost 300,000 francs. In any case it's not in our strategy. Ours is above all to help women who have adhesion, who have sequelae which prevent them from enjoying their femininity, that is what we do [...]. The act of reconstructing the clitoris even if... with reconstruction it cannot play the same role that it was supposed to play. Because it was cut, it's something, the nucleus, that they bring out. I don't know whether it can still play that role [...]. But in regard to problems of pleasure, as some women say, in fact it's a problem of sex education. People need sex education. Those people, when they approach us, we tell them that it's not only through the clitoris that a woman can have pleasure. If her husband or her partner is adequately informed, he can enable her to attain pleasure even though that organ is absent. There are other erogenous zones which he can explore to help his partner to have the same pleasure.

Nafissatou also gave me a booklet published by the CNLPE in which Ouédraogo and Ouédraogo (2009: summary) state:

It should also be noted that increasingly clitoral reconstruction is a current issue and people confuse surgical repair for circumcision sequelae, which is a health requirement and one of the CNLPE's strategies, with clitoral reconstruction which is not part of CNLPE strategies but a form of cosmetic surgery. Both actions need to be clarified within the population to guide people's choices and priorities.

Other research participants including Prof Kerekou, Dr Condeh and Prof Karim also referred to clitoral reconstruction as a cosmetic procedure. I asked the doctors to explain the distinction made between two procedures. I explained to them that some circumcised women in Burkina Faso might be of the view that the procedure is not cosmetic, and that even though they do not have physical problems, they have psychological ones which they feel could be addressed by having their bodies reconstructed. Such women would therefore benefit from free or subsidised clitoral reconstruction. To this, Condeh responded:

Yes, well, it's important but since it's necessary to go in stages, it's certain that there is a generation of women who are not going to benefit from this surgery [...]. It remains as sequelae but since it has no impact on childbirth and does not jeopardise the life of the mother nor that of the baby, it's not an urgent problem for the Ministry of Health.

On her part, Doctor Diallo explained that it would not be practical to expect the CNLPE to pay for clitoral reconstruction because:

We cannot say it's a complication. I don't know...that is like, it's to some extent something that is luxurious. It's for sensitivity. It's for something else. It's not a major problem which is there.

When I asked Dr Hassan to explain his use of the term *chirurgie plastique* (plastic surgery) to refer to the procedure, he said:

If it's just to be able to have sexual relations or to be able to give birth, we can do a simple repair without reconstructing the clitoris. Now if we have to reconstruct the clitoris, we talk about plastic surgery. When we are required to reconstitute an organ, that is the definition of plastic surgery. Plastic does not necessarily mean beautiful. No, plastic means we took some tissue to reconstruct. For example, if you want, we could reduce the size of your nose or reduce the size of your mouth or do some lifting on your eyelids. All that is plastic because you are reconstituting an organ. It is the same thing as when you are reconstructing the clitoris. We take the nucleus which is inside, bring it out and put the skin around it. It's plastic surgery [...]. When we take the policies here, what matters is having a functional organ, an organ which does not cause complications that can lead to death. But if we do a simple repair, that is enough. It is evaluated and deemed to be functional. The woman can have an orgasm, she can have sex, she can give

birth. Now, if she wants to recover her clitoris, because she finds that without her clitoris she is blocked, it becomes plastic. We cannot try to advocate [funding] that. It would be difficult to get it approved.

The terming of clitoral reconstruction as cosmetic surgery is a major point of contention between some women who have had clitoral reconstruction (or those seeking it), on one hand, and some doctors and members of the CNLPE on the other hand. Although Dr Hassan clearly indicated why the right term to use to refer to the process of recreating a body organ that has been damaged is *chirurgie plastique* (plastic surgery), he also referred to other procedures which involve modifying healthy body parts, for example rhinoplasty, to illustrate such surgery. While from a technical point of view this is accurate, such associations have led other medical doctors and other members of Burkinabe society to refer to clitoral reconstruction as *chirurgie esthétique* (cosmetic surgery). For them, plastic surgery is synonymous with cosmetic surgery. It is perhaps because of these associations and their connotations that Dr Nikiema prefers to term the surgery reconstructive, not cosmetic or even plastic.⁸³ He said:

For me, it is reconstructive surgery. Reconstructive surgery, if someone cuts your finger and there's a technique to restore your finger, what would you call that? Is it cosmetic? It's reconstruction. That is what I call it. But if you say you have a nose, you want your nose to be like Michael Jackson's nose, that is cosmetic surgery. Because your nose is not damaged, it's a normal nose, it's your nose but you want it to be pointed. That is cosmetic surgery. But if someone cuts your nose by accident and there is a hole, you want to be repaired. It's no longer cosmetic; it's reconstructive surgery. Terminology is important.

Although Nikiema singled out and castigated CNLPE staff for “talking haphazardly” and terming clitoral reconstruction as cosmetic, he nevertheless said that he understood the complex financial situation of the organisation. He said:

Actually, I understand them, I excuse them. They have never come to us to know what clitoral repair is. But it will happen. That is to say, the Committee will be compelled at a given time to [take it up]. For the time being, it's perhaps elementary for them because, already, the fight against circumcision, they haven't been able to manage that correctly. And then simple sequelae, they haven't been able to manage those correctly. And so adding reconstruction on top of that, while they do not have enough funds, they can have problems. So that sort of language that they use, I understand it. It is underpinned by economic issues. But it will be imposed on them.

⁸³ Cf. Ouédraogo et al. (2013:215): “It is a case of reconstructive surgery, not cosmetic surgery”.

Before, [clitoral reconstruction] was not reimbursed in France, it was considered cosmetic surgery. But since a few years ago, the social security system reimburses it because it's reconstructive surgery.⁸⁴ You see? So [the CNLPE] are at an embryonic stage. That is why you hear things like that. It will be a debate that ends with time.

Women seeking to have clitoral reconstructive surgery, and those who have had it, speak more vehemently about this surgery being a way of restoring their bodily integrity and alleviating the problems resulting from circumcision. They therefore do not entertain any suggestion that this surgery is cosmetic in any sense. For example, Amina criticised the media and “Prof Kerekou and his ilk” for perpetrating the view that clitoral reconstruction is a cosmetic procedure. She said:

It's the communication, it's the media which always wants to transmit information which is.... When that broadcast was done, I remember very well that the doctor who had done the surgery said that it was... the term that he used was 'cosmetic surgery'. Yes, that it's cosmetic. That with fistula it's free of charge but that [clitoral reconstruction] is cosmetic. Really *it's that* which affected people's mentality. It's as though if my breast is small, I'm going to make it bigger or if my breast is too big, or my face... it has nothing to do with that! We reproached them for that because it has nothing to do with that sort of project. It's the integrity of the person which is in question here. You have cut something from someone who did not want that to happen. And the person has this possibility of having herself repaired, yet you say it's [cosmetic]. So that is what is always in the minds of these associations [...]. It's a right for women, and that is why I believe that with information, with our campaigns, the cost has gone down [...]. There is something new which is there to save these women. Why don't we talk about it? That's it.

On her part, Samira reacted very angrily when asked to respond to the fact that some people in Burkina Faso consider clitoral reconstruction to be a form of cosmetic surgery. She said emphatically:

It really is a pity because people do not know their clitoris. They don't know what it is. When people don't know what it is then they can classify it as they wish. The clitoris has its role [...]. Removing the clitoris is like removing a man's sexual organ [...]. The clitoris has almost 8,000 nerve endings. Imagine the sensory nerve endings which are there. Eight thousand sensory nerve endings which are gathered there and you cut them, you sever each of them. Imagine the haemorrhage which will occur. All the blood will

⁸⁴ Foldès et al. (2012:134) point out: “In France, reconstructive surgery has been available on the French national health service since 2004. Surgery was initially offered to women with pain sequelae, but has since been extended to women wishing to improve their sex lives or their physical appearance”.

be drained. Imagine! When one doesn't know what it is, he/she can say it's a luxury but when one knows what the clitoris is, he/she cannot talk about a luxury [...]. It's as though you...as soon as a child is born someone says, "Ah that tongue, we must remove it because he shouldn't have a tongue. We must sever it." The clitoris is an organ which is part of the human body and which is important. It has its role to play too [...]. It's ignorance. I classify that as ignorance.

It is worth pointing out that some circumcised women such as Samira, Amina and Antoinette are reclaiming the term 'victim' and their representation as victims and using this to counter the official position on funding for clitoral reconstruction. For example, Antoinette said that a staff member at the CMA 30 told her that women have asked for the procedure not to be termed clitoral repair or reconstruction. Apparently, using the word 'clitoris' makes insurance companies refuse to pay for the procedure as they deem it to be cosmetic. Amina said that women need to be brave and stand up to the insurers (as she said she did) and insist that there is nothing cosmetic about the procedure. According to her, women need to present themselves as victims who have been made to suffer without their own choosing, especially since they cannot ask their parents (who had them circumcised) to make financial reparation.

For other research participants, particularly those outside the medical profession, the focus seems to be less about whether clitoral reconstruction is a cosmetic procedure and more about whether it is safe. Some also wonder whether once reconstructed, the new clitoris can function in the same way as a 'natural' clitoris. For example, Pauline said:

Well, in my view the clitoris is something which is natural. And if one wants to reconstruct it, I think that will be something artificial. I'm very concerned that there would be problems in the long-term [...]. You can do that and then [...] if the woman is not able to take care of it as she should, it can cause other problems. So I'm greatly concerned. If they can really manage to reconstruct the clitoris, well, I think it's good but can it be like that? Can it be like a natural clitoris? Can it have the same characteristics? I'm also asking myself, would it not create other problems? In cases where it is not well done, or it's not well cared for, will it not create other problems still?

Others have the impression that clitoral reconstruction involves adding a foreign body to a woman's body which arouses further concerns, particularly as they do not see the procedure as necessary. For example, Madeleine said:

I don't think there is any need to reconstruct that. The fact that they took it away, it's over. They took it away and it's over! Why would people reconstruct that? It concerns me whether it will have the same efficiency as a

true clitoris. Will it really play the same role as a natural clitoris? Because there it's some plastic thing that they are going to do, a graft perhaps.

When I clarified that, as explained to me, the procedure does not involve grafting but pulling out and reconstructing the remaining part of the clitoris, she said, "It would be a good thing if there are no problems, if there are no risks during the procedure".

However, there are other research participants who consider clitoral reconstruction a cosmetic procedure even as they voice concerns about the safety and effectiveness of the procedure. For example, Aziza deemed the procedure a luxury and, just like Madeleine, suggested that once the clitoris is cut, it is not possible to restore its anatomy or function. She explained:

Well, for the clitoris, I think, for me, once it has been removed, it's finished. Because it's a nerve. I don't know whether it's true, but that's what I think. That once it's cut, that's it. It's finished. So whatever one does, in reality she cannot return the sensitivity to that level. So it would just be make-believe but it does not add anything anywhere. She will not feel any more pleasure [...]. So indeed I think that it's cosmetic. And cosmetic, well, really I think that it's also a luxury.

Sylvie also suggested that this is a cosmetic procedure saying:

It's cosmetic because it's for the clitoris. There are those [women], for example, who want to make men believe that they haven't been touched down there [that is, circumcised]. But is it...I don't know how...I once asked Prof Kerekou, "But can it...how can it be...how can it go back to what it was before?" Well, it cannot go back as it was before but at least there is some sensitivity. I think that, it's not...it's no longer as it was before [...]. It's for cosmetic reasons. When you look, you think that nothing was taken away. But I don't know as I haven't yet seen [clitoral reconstruction]. If I had seen it, I would know what they do. In order to do that there, isn't it really constraining for the woman? Doesn't it traumatise too much because at that place the skin is fragile and thin?

Gabrielle also considered clitoral reconstruction to be cosmetic surgery and explained her understanding of the distinction made between this surgery and surgical repair of circumcision sequelae as follows:

Well, I think that with repair, it's because there is a hurt which is there, the person is not healthy. It's only the physical, the physiological, that they are trying to treat. Because they shouldn't let the person die during childbirth because she was circumcised. They can do repair to help her avoid that, whereas reconstruction is more at a psychological level in relation to the person herself. That is to say, the person does not necessarily have a physical problem, a physical illness. The person is not sick. The person can have sexual relations like everybody else, it will not hurt her. She will not have a

problem giving birth but, on the other hand, in her head, she will not be peaceful and perhaps she cannot attain as much sexual pleasure as others during sexual relations. Perhaps that is what makes the difference between repair and reconstruction.

Gabrielle therefore indicated that she understood why the government considers surgical repair for circumcision sequelae to be vital and funds it. On her part, Danielle did not support the differentiation of these two forms of surgery indicating that since it is circumcision which underlies both of them and which damages the clitoris, both procedures should be provided free of charge. When I explained to her that it appears the first form of surgery is funded because it is considered necessary for good health whereas the other one is considered a luxury done for cosmetic and perhaps sexual reasons, she interjected emphatically, almost incredulously, saying, “But it’s necessary! Yes, in my view it’s necessary. Otherwise I don’t know what [the woman] is going to do. It will be suffering for her, I think”. Nevertheless, she also raised the issue of the safety of the procedure saying:

For such a practice, I will first ask myself the question, will it not have health consequences? I don’t know much about how it happens, I’m not a doctor. But I would seek to know, in the long term, would it not cause me health problems? If doctors reassure me that it will not have health consequences, those who can do it, let them do it. If they want to improve their sex life, it’s their life. They can do it.

I also asked these research participants why, in their view, some Burkinabe women sought clitoral reconstruction. Gabrielle proposed that women who are socially integrated – who are convinced that circumcision is a good or normal practice – do not have a problem and do not seek this surgery. On the other hand, she highlighted the possible frustration experienced by circumcised women who have been convinced they are incomplete or inferior to uncircumcised women, who believe they need reconstructive surgery to alleviate this inferiority, but are unable to afford or access the procedure. She said:

However, if within yourself you know that the fact that you were circumcised took something away from you, and that you must have it, you cannot live your life. So you will necessarily have yourself repaired or reconstructed if you have the means to do that. But if you don’t have the means, perhaps you are going to live a frustrated life because you cannot have yourself reconstructed.

In this perspective, the need to have clitoral reconstruction, is predicated on how women interpret the circumcision of their bodies, and how much their thinking has been influenced by the discourse condemning and criminalising female circumcision.

The other possible reasons suggested to explain women's seeking reconstructive surgery include: so that they can be like uncircumcised women, to ensure their partners remain attached to them and to attain sexual pleasure. For example, Pauline suggested that women who seek clitoral reconstruction want to be like other women who have not undergone circumcision, and attributed this inferiority to ideas from the West which inspire the discourse against female circumcision in Burkina Faso. Aziza, who said that she was not circumcised, was also of the view that by undergoing clitoral reconstruction, circumcised women are seeking to be like their uncircumcised counterparts because they may think unaltered genitalia are more attractive especially if the men in their lives comment on these women's circumcision. Echoing both Gabrielle and Pauline regarding the effect that other people's opinions (particularly significant others) can have on the manner in which circumcised women view themselves, she said:

Perhaps men have said something to them, and they have thought that perhaps by doing that they will be more attached to them or something like that. I think that it's perhaps in that sense, otherwise, I don't see why a woman who has lived that way.... because when one is in an environment where she thinks that [circumcision] is normal, perhaps when around her people have [been circumcised], it doesn't pose a problem. But when someone makes a remark to you or you have seen that elsewhere, it can change. And you can think, "It means that they did that to me and [even though] in my environment a lot of women [are circumcised], well, it is not as normal as I thought it was."

Monique also suggested that the women might be seeking to feel better by regaining what they feel they lost and to be like uncircumcised women. She said that women should be encouraged to have clitoral reconstruction in order to improve their life. Conversely, Albert was of the view that, "once the clitoris is gone, it's gone, there is no reason to have it reconstituted". He pointed out that it is not just the clitoris which enables one to have a fulfilled sex life and that people should be made to understand that they can still enjoy their sexuality without it. Nafissatou said women go for clitoral reconstruction because they think it will enable them to attain orgasm and, in a statement that seemed to contradict her earlier views regarding the impact of circumcision on sexual expression, asserted that the absence of the clitoris does not necessarily preclude pleasure.

Some research participants, particularly the older ones, made a clear association between clitoral reconstruction and the quest for sexual pleasure, and suggested that it would be acceptable for young unmarried women to seek reconstructive surgery but not mature women who are already married. They found absurd the thought that married women, especially those who already have children, would be interested in seeking clitoral reconstruction and suggested that such women might be thought to be intending to cheat on their husbands. For example, Madeleine, the retired nurse filling in at Leila's centre at the time of my fieldwork, said:

Well, the fact that they removed [the clitoris], it's over. They removed it and it's over. Why would they go to reconstruct it? I don't understand that reconstruction. Well, it depends, perhaps young [women] can go but women of a certain age, I don't know. Young people who have undergone [circumcision] can go and have themselves reconstructed.

Sylvie, a midwife in her fifties, said:

Yes, I think that...well, perhaps there are a lot of young people who will go there. But for those who have already had children, what would you go to look for there? Young people perhaps...young people who are yet to discover sex because they, they have been...well, they were not asked for their opinion, their clitoris was removed, perhaps they want to know the kind of sensation they can have. But women who have had two children, one child, what would you go to look for there again?

I remarked that even such married women might seek clitoral reconstruction to attain sexual pleasure to which Sylvie replied:

When you have already had children? Most often here sexual intercourse is for procreation. When you are married, your in-laws and everybody looks at you to see whether there are children coming. But now, it's the young people, with them it would be pleasure. But a married woman who already has two children, what would you go to do there? You perhaps need to work first of all on your husband's mind so that he doesn't think that you are going to cheat on him, because they have it in their head that [the clitoris] turns women into nymphomaniacs. That's what they say. So if it's for pleasure, one needs to really have the consent of the husband [...] otherwise it risks causing another problem.

In this perspective, sexual enjoyment and satisfaction appear unimportant since women are viewed primarily as reproductive beings, not sexual ones. However, as I explain in Chapter 9, this is very different from the view held by the Raélians for whom people of both/various genders, young and old alike, are expected to engage in and enjoy sexual intercourse.

Some of the reasons suggested above to explain why some women might seek clitoral reconstruction – for example, because they feel incomplete, to attain sexual pleasure and as a response to remarks made by male partners – rhyme with those given in Chapter 4 by the women who have undergone or are seeking clitoral reconstruction. However, it is important to recognise that most of the views conveyed above are made from a conjectural position as some of these research participants cited do not have much information about reconstructive surgery, particularly, clitoral reconstruction. It is only the medical doctors and activists and community workers such as Leila, Nafissatou and Gabrielle, who have information about this surgery and are able to give an informed opinion about it. These views can also be said to be informed by ideas that people in Burkina Faso have about the secondary place that sexuality and, as I explain below, psychological issues hold in relation to other basic needs such as physical health. As I explain in Chapter 9, sexuality in particular is considered something that should be privately lived and which respectable women are not supposed to be overly interested in or outspoken about.

Interrogating the motivations of the men remaking women

There is some scepticism in Burkina Faso regarding the emphasis put on efforts to end female circumcision and the necessity of reconstructive surgery. This is particularly so because while a lot of effort is being made to inform people about the ills of female circumcision and to provide relief for women suffering from physical problems associated with these practices, little is done to address the negative psychological consequences arising out of female circumcision or its portrayal. When I asked Nafissatou of the CNLPE whether there is care provided to women who have psychological problems which they attribute to female circumcision, she said, “Yes, for example, at the centre run by Madame Abdi, there is a psychologist who deals with cases like that”. According to her, this care is provided so that ‘victims’ can be lifted up to enable them to accept what happened to them and enjoy their femininity. However, this view is not shared by other research participants (who also hold credible knowledge about issues relating to female circumcision) who indicate that there are limited structures in place to diagnose and treat psychological problems. For example, Albert said:

Regarding the psychological aspects, I don't think that there are management facilities. If there is violence done to women in a general

manner, domestic violence... it is true that in some health facilities there is an aspect of social or psychological support for the woman. But taking circumcision as causing psychological problems, the management of that, personally I don't have any knowledge of it. But those who are involved in sensitisation, they try to see whether the woman has psychological problems and then they try to console her. But for psychological problems, doing typical therapy, it's complicated. I am not sure that.... I don't believe that there are specialists in Burkina Faso in any case who do that. Even if people do that, it's not really in a very, very professional, very, very systematic, very, very structured manner.

Dr Condeh also said that he did not know of specialised facilities where psychological problems associated with female circumcision are addressed. Etienne, the psychologist referred to by Nafissatou, was even more emphatic about the inadequate care for women with psychological problems. He said:

I personally don't know psychologists in Burkina Faso who do that. I know that there are just doctors who say that they do repair [...]. I don't know *a single* psychologist who specifically does that. Because, first of all, already in Burkina Faso there is a deficit of mental health psychologists. Mental health psychologists if we count in Burkina Faso, at the level of perhaps Professional Masters, if it's too many, it's nine. Doctorates, if it's too many, it's three. Yes. So very often it's people with Masters 1, who have not defended and who go out [to practise]. So very often it's what we call students in psychology who call themselves psychologists and do it [...]. It's not just anyone who can bring himself to do that. With which tools? And you know that one needs to distinguish between psychological practice and advice. Everybody advises.

The scarcity of care for psychological problems associated with female circumcision is conspicuous particularly given that, as shown in Chapter 7, the Burkinabe government is, unwittingly or otherwise, heavily invested in creating 'victims of female genital mutilation'. Instead, emphasis is put on reconstructive surgery which addresses physical problems. This leaves women who do not have physical consequences of female circumcision but who may have psychological ones without solutions. This includes those plagued by feelings of incompleteness, as described in Chapter 4 and Chapter 6, who believe that clitoral reconstruction will enable them to regain a sense of wholeness, but who cannot afford the procedure. Gabrielle suggested that the reason for the lack of psychological care is two-fold. Firstly, the government of Burkina Faso does not have adequate funds to cater for all needs and prioritises physical problems over psychological or emotional ones. Secondly, she said that in Burkina Faso (and in Africa generally) psychological issues are not talked about much and, as such, leaders do not take them into account when formulating health strategies.

However, some of my research participants were more critical of what they saw as a system propped up by activists and doctors with selfish motives. While they did not point to a conspiracy between the government and activists or healthcare workers, some people proposed that activists and healthcare personnel are not interested in finding solutions for women with psychological problems. Instead, they are contributing to the fervent discourse about the negative consequences of female circumcision and the need for reconstructive surgery, and using it to enhance their personal and professional standing and to get funding from the Burkinabe government and overseas donors. They are thus seen as fomenting and taking advantage of some women's insecurities for personal gain. For example, when I asked Aziza why activism against female circumcision seems to be so intense in Burkina Faso, she responded matter-of-factly:

Well, it's a question of money. Yes, because, very often, these are NGOs which receive funding from elsewhere. So they mobilise partners, external partners. If we take a look [...] what the State invests in that fight can't be, it's not the same as what the external partners invest in it. I'm sure that the partners invest much more than the State. What do NGOs live on? They live on projects. Projects which are financed by external sources. So long as they have money to do these sorts of projects... yes, we know that in Burkina Faso the statistics indicate that we have a lot of circumcision. So what do we do? We will start a project of intervention, even if it has no effect we say, yes, perhaps these practices can harm, they should be changed. So there is money like that. I think it's really a question of money.

Etienne was also quite critical of the doctors who perform reconstructive surgery and the activists who compound the problems that women have in the manner in which they carry out their sensitisation. In his view, such people are more concerned with citing statistics and enumerating the number of surgical procedures they have done than with addressing the psychological harms they create. He said:

People never talk about psychological repercussions. Of what use are they to them? It's economic statistics. It's statistics which facilitate funding. But has that intervention resolved the presentation, the internal construction of the person? No! They are not interested in that. There is no support. There is no psychological care. They don't look for psychologists. Here the doctor...there's a confusion of roles. So it's a problem which is first of all institutional, organisational and functional. If the doctor, instead of the doctor dealing with his work, he says he will do everything. He will do everything. They confuse psychological care with advice. The Ministry of Social Action comes and says that it will give advice. They confuse psychological care with community mobilisation [...]. So the psychological dimension is not understood [...]. They need to work on a group, on a

personalised population, on a clinical population, with a clinical approach [...]. They don't do it! Nothing is done!

Given these views, I sought to understand the motivations of the doctors who practise reconstructive surgery and asked them how and why they got into it. Dr Condeh explained that he had been identified as a resource person by the CNLPE staff, who wanted to popularise the surgery outside Ouagadougou. He was trained to perform the surgery but also to train other doctors in the procedure. Dr Diallo also explained that being a gynaecologist, she was offered the training as were other doctors and medical personnel such as nurses and midwives. Therefore, these two doctors did not cite any special reason, beyond their position, that led to their getting involved in this surgery. These doctors and Dr Hassan see their training in surgical repair for circumcision sequelae as evidence of the Burkinabe government's initiative to help suffering women. Dr Hassan explained this saying:

[Leaders] got interested in the scourge simply because they realised that among traditional practices, those were the most harmful, simply because they hampered the sexual functioning of a woman but also because of the drama that occurs during childbirth. Drama which can end in increased maternal mortality or a woman who gives birth and remains with sequelae like fistulae. She has no control over urine, she leaks stool from the vagina [...]. There was a development of advocacy in the sense of containing that pathology.

Other doctors indicated that they have a more personal commitment to reconstructive surgery which is underpinned by their opposition to female circumcision and other oppressive practices done to women. For example, Prof Kerekou explained:

I was in the Committee for the Fight against Circumcision from the very first day. From the time the National Committee was formed, I was there with Madame Abdi. Because I have always refused violence done to women. Yes, yes, even my clinic is named after my mother. She is a woman. So all women are in the image of my mother and I would not accept that one does that to my mother. So that is the idea that underlies my determination to fight against this practice.

Dr Nikiema (who mainly does clitoral reconstruction) explained that he got into this surgery:

Because there was demand from patients. Women who were asking whether there was a way of recovering the clitoris which had been cut. That they did not feel good in themselves, they no longer felt like women. So they need their clitoris. So we were responding to their demands.

Etienne's and Aziza's views above suggest there is a need to interrogate the origin of this demand and to examine the position of these doctors, especially Prof Kerekou and Dr Nikiema, who are renowned in Burkina Faso as the two leading practitioners of clitoral reconstruction, the more expensive and unsubsidised form of the procedure. Such specialisation exists in a new and profitable niche which is partly (or even perhaps largely) created by the discourse turning previously 'normal' circumcised women into deficient victims of genital mutilation. As pointed out in Chapters 6 and 7, it can be argued that the needs that women exhibit in having their bodies reconstructed are as a result of the successful campaign about the harms of female circumcision. Furthermore, it is clear that during consultations, some doctors promote reconstructive surgery even when women do not go to see them for problems related with circumcision. Both Dr Condeh and Dr Hassan informed me that during consultation with gynaecologists, circumcised women are made aware that they can benefit from such surgery. There are also periodic campaigns during which circumcised women are recruited to undergo clitoral reconstruction in Ouagadougou. Indeed, when I was in Burkina Faso, Kerekou was registering women to undergo reconstructive surgery during Foldès's visit in early March. Dr Nikiema was also publicising a campaign scheduled for 4 to 16 March 2013 during which he and Dr Diop from France would offer clitoral reconstruction, as well as repairs to the perineum and treatment for urinary incontinence. It could therefore be argued that rather than just the state of being circumcised, it is these suggestions made to circumcised women during consultations with doctors and public medical campaigns, together with the influence of activists' messages, which largely contribute to the demand for clitoral reconstruction.

However, the doctors involved see things differently. When I suggested to them that some people argue that African women have a lot of needs – such as access to clean water, basic healthcare and education – which should be addressed first before sexual pleasure which is considered a luxury, they both disagreed vehemently. According to Kerekou, the high number of women registering for the surgery shows that there is demand. He said:

It's not true to say that [sexual pleasure] is not a problem for African women. I can tell you that we have not yet [announced Foldès's coming] but there are a lot of... I have more than 40 women who have registered themselves to be repaired by Foldès. If there is a psychological problem, the woman feels as though she is lacking something, and if she feels that way, it

can cause a problem. No, no, one cannot say that. People are spinning you yarns.

Nikiema on his part found such statements uninformed and even racist. Conflating the sexual experiences of people from different societies as well as those of men and women, he said:

No! Sexual pleasure is not a luxury for women. It's for every human being. You know that sexuality is the only thing which doesn't stop regardless of the situation of disaster. Even when there is war, sex continues. When it is raining, sex continues. When there are floods, sex continues. Sex is the only thing that continues. People can stop eating but they can never stop having sex. So sex is at the centre of people's lives. It's not an issue of developed countries or undeveloped ones. If an African woman has sexual intercourse, she has the same orgasm as Obama who has sex with his wife [...]. It has nothing to do with economic development. Those who say that are people who have a bad connotation of Africa. And that's a pity, because even in developed countries, there are homeless people on the streets. And they must have sex [...]. Don't they have a right to orgasm? No, those who say that are racists. People who have no regard for Africans, who think that Africans are an inferior race.

Nikiema therefore saw the biannual campaigns, about which information is disseminated on the radio in different languages and during which clitoral reconstruction costs 10,000 francs, as an affordable way of availing the surgery to affected women. Furthermore, he suggested that doctors do address the psychological issues that these women have and do not blindly perform clitoral reconstruction for any woman who desires it. As he explained:

When the woman comes and says she had no orgasm, she does not have pleasure during sex, and she wants her clitoris, we don't just reconstruct her straightaway. We do a review of the problems which can be at the root of her orgasmic problems before reconstructing her, because we explain to her that there are women who are not circumcised but who don't have orgasm. And so, even if we restore her clitoris, if we haven't sorted out her other problems, she can still be in that situation. So women who come and say that they no longer feel like women, that they want to have their organs restored, we reconstruct them without any problems.

In terms of this psychological evaluation, Burkinabe doctors such as Nikiema seem to be borrowing from models developed in France to determine who qualifies for reconstructive surgery. In a 2009 article, Villani explores decisions around the 'rehabilitation journey' of 55 women who sought clitoral reconstruction in France. By analysing the medical files of these women, Villani (2009:260) explains that the medical team considers that the repair does not take place only from an anatomical point

of view, but also symbolically, aesthetically and culturally. Discussions between physicians show that they consider a woman's degree of 'maturity' to be an essential factor in ensuring the efficacy of the surgery. Villani explains the different types of 'maturity' sought, as follows:

For the medical team, it is important that the women express the feeling of "being different from others", and "wanting to be a whole woman", and that they should recognize that their body has been damaged and their genitals mutilated.... The sexologist and the psychologist place much more importance on the woman's traumatic experience, and agree that "maturity" is acquired by means of rejecting the culture of origin. Some women are "mature by crying", for example, and will express arguments relating to the pain, whereas others are "mature by anger", and their denial will be more combative.... The patient's "maturity" also consists in awareness, and being able to integrate the opinion of the specialists, showing that she rejects "all the cultural claims that go with excision" (2009:260-261).

It is notable that in this context just as most girls and women do not freely choose to be circumcised, the decision to have reconstructive surgery is also not wholly in their hands. Even if they want the surgery, it is ultimately other people who decide whether the women are 'mature' enough to have it. However, whereas in the cases studied by Villani, a woman's readiness to undergo reconstructive surgery is determined by a team consisting of different experts – physicians, a sexologist and a psychologist – in Burkina Faso, as Etienne rightly argues, it is the surgeon who takes on all these roles and makes the decision. But perhaps the most troubling issue in this context is the requirement for women to renounce not just the practice of circumcision but also the cultural claims underlying it in order to qualify for reconstructive surgery. While women of foreign descent living in France might be able to renounce their original way of life and embrace mainstream French culture, this would be extremely difficult in Burkina Faso where these women, even while rejecting circumcision, still live in the dominant culture and arguably still subscribe to many of the societal views associated with the correct management of sexuality.⁸⁵

These models which underlie reconstructive surgery, and which are implicated in the portrayal of female circumcision in Burkina Faso, are not considered helpful by everyone. For example, Etienne admitted that some women might have sexual problems

⁸⁵ I revisit this issue in Chapter 9 where I explore the place of the Raëlian Movement in Burkina Faso.

linked to female circumcision which create feelings of deficiency, leave women unfulfilled in their pursuit of pleasure and ultimately make them frustrated. However, according to him, the framing of the debate against female circumcision in Burkina Faso does not help these women and instead compounds their sense of victimhood. He suggested that activists against female circumcision and some medical practitioners promoting reconstructive surgery create a form of persecutory paranoia in the general public and in the process victimise and traumatise circumcised women. Regarding women experiencing “real problems” arising from circumcision, he said:

Otherwise, those who really have problems with [physical] sequelae just seek treatment. They are not as dramatic. They don't seek to find that old woman who...in the heart of the village, with perspectives which are perhaps outdated today. They are no longer in the attitude of victimisation.

Some of the doctors who carry out clitoral reconstruction in Burkina Faso and in France are increasingly admitting that psychological care should accompany reconstructive surgery. For example, in talking about clitoral reconstruction, Ouédraogo et al. (2013:215) point out that “psychological care and sessions with sexologists appear to be very necessary”. Foldès et al. (2012:140) also explain that “although clitoral reconstruction is extremely important, we believe that women should be offered a multidisciplinary care package, including sexual therapy, if this is acceptable to them”. While still offering reconstructive surgery in Burkina Faso, Dr Hassan also seemed to suggest that psychological issues are best dealt with from a psychological perspective. However, perhaps given the limited resources in Burkina Faso, he did not point to conventional psychotherapy as offering the solution and, instead, proposed that affected women acknowledge that their rights have been violated and take a stand against circumcision in order to protect future generations from the practice.

Expectations and outcomes of clitoral reconstruction from the doctors' perspective

I asked the doctors I interviewed why women seek genital reconstructive surgery and what the women's expectations are. In regard to clitoral reconstruction, the main reason that the doctors cited is regaining bodily integrity and feeling complete. Nikiema also suggested that some women go for the surgery in order to be able to experience orgasm, while Kerekou pointed out that for some women clitoral reconstruction is a form of revolt against society or what Villani (2009:260-261) would call “rejecting the culture of origin”. I also asked these doctors what the outcome of the surgery is in regard to these expectations. In answer to this, Kerekou said that he has had “80% good results”

whereas Nikiema, who has operated on about 100 women from such diverse countries as Burkina Faso, France, Haiti, Ethiopia, Benin, Ivory Coast and Mali, placed his success rate at more than 95%. When I asked Nikiema whether the less than 5% of women whose surgeries do not succeed find themselves in a worse position than they were at the beginning he explained:

No, it's not worse. No, we haven't been able... that is to say, we restored her clitoris. Either the clitoris was small, the circumcisers really took a lot and there is not much left, and once healed, she has the impression that she cannot see the clitoris. That it's as it was in the beginning. That's what we call failure [...]. Or where a woman thought that she would have an *intense* orgasm, and when it's done, she goes and has no orgasm and thinks that it failed.

Kerekou also pointed out that for the 20% whose operations are deemed to have been unsuccessful, "it might be because they don't have pleasure during sex, yet the absence of sexual pleasure can be psychological, not necessarily because of the absence of the clitoris". Kerekou's observation is important because, as pointed out in Chapter 7 and in the discussion above, some sexual and reproductive health problems might be being erroneously attributed to female circumcision. Indeed, Amina and Antoinette told me of a young woman who travelled from Ivory Coast to Burkina Faso to seek reconstructive surgery because she said that during sexual intercourse she felt pain and that she did not experience any pleasure. Antoinette accompanied her to the Dominion Clinic to see Prof Kerekou. Upon examination, the doctor discovered that the woman had not undergone any form of female circumcision and diagnosed her as being frigid.⁸⁶

It is impossible, in the scope of this study, to ascertain the reliability of the success rates cited by Nikiema and Kerekou without interviewing the women that these doctors have operated on, and on whom they base these figures, in order to determine whether their views correspond with those of these doctors in regard to these outcomes. As I show below, in some cases, women express dissatisfaction regarding the outcome of their reconstruction even when from the doctors' perspective the procedure has been successful. The women whose stories are told in Chapter 4 express satisfaction with the outcome of their operations – they have gained a sense of completeness, experience sexual pleasure and orgasm, and have increased self-confidence. However, some of

⁸⁶ Antoinette also told me that she personally examined the young woman and verified that she had not been circumcised.

them (and other research participants) also refer to other cases where there have been complications in the wake of genital reconstructive surgery. These complications are not necessarily just those to do with women's unrealistic expectations, underlying psychological issues or the severity of the original circumcision. For example, Leila pointed to cases of necrosis at the inception of clitoral reconstruction in Burkina Faso, and Amina said:

There were some women who had the operation but who were not satisfied. But it is also related to the management and care. That care is very important. But if it gets infected, it becomes something else and it cannot bring you pleasure.

Dr Nikiema also conceded that there can be complications where women have infections which need treatment after surgery.

In the recent past there have been a few academic publications about clitoral reconstruction, its success rates and the complications experienced in its wake (cf. Foldès 2004; Foldès and Louis-Sylvestre 2006; Sawadogo 2007; Madzou et al. 2010; Foldès et al. 2012; Ouédraogo et al. 2013). Madzou et al.'s findings (2010:62) are based on about 100 operations done in France and Burkina Faso since 2006, Foldès et al. (2012:137) give results based surgery done on 2,938 women between 1 January 1998 and 31 December 2009 in France, while Ouédraogo et al. (2013:209) report on a retrospective study of 94 patients who underwent clitoral reconstruction from 2007 to 2010 in Bogodogo, Ouagadougou. Ouédraogo et al. (2013:210) explain that in this procedure, healing is rapid as swelling subsides within a week, and the reacquisition of sensation occurs between the fourth and the eighth week. Temporary incapacity to work is between one day and 60 days (Ouédraogo et al. 2013:212). Some of the common complications cited in these three studies include haematoma, suture failure, infection, fever and persistent pain.

Most women in Foldès's study reported an improvement, or at least no worsening, in pain and clitoral pleasure after reconstruction. However, 20 patients in total cited a worsening of clitoral pleasure and nine patients without pain before surgery reported discomfort or pain (Foldès et al. 2012:137). In Ouédraogo's study, 67 (71.3%) women were satisfied with the aesthetic appearance of the new clitoris while 27 (28.7%) remained unsatisfied. For those who were not satisfied, the clitoris was deemed to be too big or too small, even though the surgeon was only dissatisfied with four cases

where there was a palpable but invisible clitoral projection (Ouédraogo et al. 2013:213-214). In terms of functional results, some women reported improved sexual desire and others said they acquired new clitoral sensations. Even so, these researchers still point out that the improved sexual desire and function could be explained by the fact that after reconstruction, women would be more in harmony with their bodies and feel complete, free and confident rather than being frustrated and full of self-doubt (Ouédraogo et al. 2013:214-215).

Some parallels of ‘normalising’ surgeries

As I explained in Chapter 1, in my thesis I only focus on genital reconstructive surgery after female circumcision. This is because the nature and contexts of various forms of surgeries or modifications done to the body differ a great deal depending on their context, making them difficult to explore here in any significant depth. This, regardless of the fact that these modifications might be done as a response to comparable cultural and social norms. As shown above, genital reconstructive surgery is necessitated by the fact that a body part was initially changed to fit certain constructions and expectations of normalcy and femininity. Newer discourses have changed that definition, and now some circumcised women in Burkina Faso are having their bodies reconstructed to fit into newer constructions of the feminine identity. In cases of cosmetic surgery, people have hitherto unchanged parts of their bodies constructed to fit certain perceptions of beauty or attractiveness (cf. Edmonds 2010; Johnsdotter and Essén 2010; Braun 2005, 2009; Shell-Duncan and Hernlund 2000; Boddy 1998b; Green 2005; Renganathan et al. 2009; Lih and Creighton 2007; Lockhat 2004; Smith 2008). In cases where intersex individuals have surgery, this is meant to align their bodies with prevailing constructions of either masculinity or femininity (Karkazis 2008; Fausto-Sterling 2000; Meyers 2000; Chase 2002:163). In that sense, this surgery originates from a perception that these individuals are not normal and need to be ‘normalised’ to fit expected standards.

Despite their differences, there are some thematic parallels between genital reconstructive surgery and other forms of surgery which are worth pointing out. These parallels have to do with the beginnings and progression of these surgeries, the motivations of those who undergo them or commission them, perceptions about them and their impact on the body and the psyche. In this section, I briefly parallel four forms of interventions done to ‘normalise’ bodies in different contexts: female circumcision as

practised in Burkina Faso; genital reconstructive surgery done in Burkina Faso reportedly to alleviate problems caused by female circumcision; Edmonds's (2010) exploration of cosmetic surgery procedures done on the abdomen, breasts, buttocks, face, nose, thighs and arms in Brazil; and Karkazis's (2008) and Fausto-Sterling's (2000) exploration of 'corrective' surgery on intersex people in America. It is, however, important to reiterate that whatever parallels are drawn here are necessarily partial or incomplete at best because, as already pointed out, these modifying techniques differ a great deal in context.

Different kinds of plastic surgery appear to sometimes have less controversial beginnings before taking on more contested forms. Specifically, they appear to start from humanitarian concerns before branching out into forms that are deemed cosmetic. Foldès's clitoral reconstruction is said to have started from his early efforts, as a humanitarian worker, to treat some circumcised women with reproductive health problems (Prolongeau 2006:89-90; Aziz 2004, 2005). On the other hand, Brazilian plastic surgeon Ivo Pitanguy, who in his prime owned a pristine island off the coast of Rio de Janeiro and commuted by helicopter to his exclusive private clinic (Edmonds 2010:14), had as his first patients "hundreds of children burned in a horrific circus fire" in Santa Casa. Although doctors who carry out these newer and more contested forms of surgery go on to build a sizable clientele base among people with ample means, they also offer these surgeries to people with limited economic resources, perhaps as a recognition that people's motivations to have these surgeries are not necessarily determined by economic capability. This is the case in Burkina Faso where doctors like Nikiema and Kerekou now offer genital reconstructive surgery at subsidised rates during special campaigns in Ouagadougou. On his part, Pitanguy offered cosmetic surgery at 'bargain prices' to poor patients in Santa Casa because, in his view, just as rich people, "[t]he poor have the right to be beautiful" (Edmonds 2010:14).

There are also some similarities in the motivations underlying women's decisions to have plastic surgery. Burkinabe women who have genital reconstructive surgery point to good health and sexual and psychological wellbeing as the main motivators behind their decisions. Some of Edmonds's (2010:21, 46) research participants point to having cosmetic surgery to relieve psychological discomfort. One of them explains that having 'defects' "messes with [one's] interior" (Edmonds 2010:46), so she has had cosmetic surgery to feel better and improve her self-esteem. This is similar to the thoughts

expressed by circumcised women such as Samira, Amina and Maimouna, who find that circumcision robs them of their ‘interior’ and their ability to *s’épanouir* which I will explore further in Chapter 9. There is a case to be made here that perhaps what robs both groups of women of their self-esteem or access to *épanouissement* are the perceptions that (they think) their bodies attract rather than the actual state of their bodies themselves.

One might readily understand the application of cosmetic surgery to alleviate negative feelings brought about by the defects attributed to ‘mutilation’ as in the case of injured First World War soldiers on whom plastic surgeons honed their burgeoning techniques (Edmonds 2010:78), or that of circumcised Burkinabe women whose private ‘deficiencies’ have been rendered open to public scrutiny by the fervent discourse against ‘female genital mutilation’. Medical interventions to treat the natural deterioration of the body might be more contentious. The debate highlighted above over which types of surgery should be termed reconstructive, as opposed to cosmetic, becomes relevant here. Edmonds (2010:48-49) rightly asserts that this distinction rests on a broader moral judgement about what constitutes legitimate medicine (which is a response to legitimate suffering) and what does not. This distinction drives decisions in many countries about what can be covered under the public health system or even by insurance companies and what should not.

For a good number of my Burkinabe research participants, the criteria to distinguish between reconstructive and cosmetic procedures appear to be whether one’s focus is on physical health (in which case it plastic surgery is termed reconstructive) or sexual pleasure (in which case they consider it cosmetic). In Brazil, the debate seems to be more focused on the intent and impact of the surgery. Such doctors as Pitanguy argue that both reconstructive and cosmetic procedures “operate not on pathologies or defects, but on a suffering psyche” (Edmonds 2010:14). In this view, the plastic surgeon considers himself a very effective “psychologist with a scalpel in hand” (Pitanguy 1976:125, cited in Edmonds 2010:14).

The notion that perceived ‘defects’ in appearance greatly affect the wellbeing of people who are otherwise ‘normal’ is not new. Edmonds (2010:56) argues that plastic surgeons in Brazil are just following a historical trend in democratic societies toward the idea that appearance is essential to mental health, economic wellbeing and social and sexual

competence. According to him, to be able to apply plastic surgery procedures for purely cosmetic ends, surgeons borrowed innovations of psychoanalysis and psychology, particularly the concept of the 'inferiority complex' to explain that "deviations from norms of appearance could disturb mental health" (2010:78). With time, this concept developed into the "more flexible and encompassing notion of self-esteem", eventually becoming accepted as "normal knowledge" (Edmonds 2010:78, citing Ward 1996:7; Cruikshank 1996:232). Consequently, plastic surgeons are able to argue that they are using cosmetic procedures to heal a psychological complaint (Edmonds 2010:78).

Moreover, in some cases, 'normal' unattractiveness and older age can cause stigma and people deemed to be below average in appearance can suffer real social and economic penalties (Hammermesh and Biddle 1994, cited in Edmonds 2010:49). In such cases where appearance has repercussions for mental health, economic wellbeing and social functioning, it becomes difficult to strictly separate cosmetic and reconstructive surgery. It is in view of this that some plastic surgeons in Brazil invoke the World Health Organisation's assertion that "health is a state of physical, social, and mental well-being, not simply the absence of illness" (Edmonds 2010:55) to make cosmetic surgery available on the public health system. This is one striking difference with the Burkinabe case; the Burkinabe government deems clitoral reconstruction cosmetic surgery and does not fund it, whereas in Brazil cosmetic surgery procedures are provided "within an ailing public health system" for those who cannot afford to have them in private establishments (Edmonds 2010:14).

There are technical aspects which also muddle up the distinction between reconstructive procedures and cosmetic ones. In this regard, Edmonds (2010:49) points out that the same techniques used in cosmetic surgery are used in reconstructive procedures. In some cases, reconstructive procedures restore functionality and also improve appearance. Moreover, cosmetic procedures such as the reduction of large breasts can have functional justifications such as reducing back pain (ibid.).

Even so, some doctors in Brazil do recognise a grey area in the overlap of cosmetic and reconstructive procedures. As a result, some clinics in Brazil rely on psychologists to "screen out unsuitable patients" (Edmonds 2010:81). This screening appears important in a context where the patients themselves perform a kind of "aesthetic triage" to rank their defects by their severity and decide on which operations are most 'necessary'

(Edmonds 2010:98). Others simply choose the operation with the shortest waiting list at the hospital. However, in some cases, a consultation with a psychologist or even an obstetrician/gynaecologist can get patients referred to a plastic surgeon (Edmonds 2010:81). As explained, in Burkina Faso, in most cases, the doctors who offer reconstructive surgery take on the role of the psychologist to determine the circumstances under which women should have clitoral reconstruction.

Notwithstanding the motive behind these surgeries or even the manner in which they are perceived, there are some striking similarities on the impact that different kinds of bodily interventions are said to leave in their wake, the awareness or lack thereof that some women have regarding the impact of these surgeries on their bodies and their psyche, as well as in the handling of the side effects arising from these surgeries. I have pointed out that in some instances where women are not satisfied with the outcomes of clitoral reconstruction, some doctors appear to blame this on the women themselves: they have unrealistic expectations regarding clitoral size, the degree of circumcision was extremely extensive to begin with, or their sexual problems are not necessarily related to circumcision. This would be similar to some cases in Brazil where, when complications occur following cosmetic surgery, some surgeons blame the patient's response to the surgery or the patients blame themselves (2010:95). In the same way, just as many doctors and proponents of clitoral reconstruction do not seem to talk much about possible negative side effects arising from clitoral reconstruction (except perhaps in private consultations with patients which I did not access), Edmonds (2010:95) – who did access such consultations – observed that public hospitals in Brazil offer very short consultations before plastic surgery procedures, and that “some patients were uninformed about the possibility of complications, some even unaware that operations would leave a scar”.

Aside from the fact that it is a form of plastic surgery, ‘corrective’ surgery for intersex people is very difficult to compare with both cosmetic surgeries in Brazil and genital reconstruction in Burkina Faso. Infact, ‘corrective’ surgery for intersex people is more comparable to female circumcision than it is to the other surgeries cited here. The main difference would be that while consequences attributed to female circumcision are highly contested by a number of reputable scholars as shown in my thesis, there is not (yet) a big body of literature in research on intersexuality to observe that degree of contestation.

The secrecy, silence and deception which marks the circumcision of many of my Burkinabe research participants echoes experiences of some intersex people described by Karkazis. Karkazis (2008:227) points out that such individuals might feel anger towards their parents which is based on a violation of trust: “they believe their parents betrayed them by withholding the truth about their condition or failing to protect them from pain and humiliation”. Furthermore, for many of her research participants, this erosion of trust extends to the clinicians who treated them. They are left with a lasting distrust and fear of doctors and might avoid any medical, but more so gynaecological and pelvic, examinations (Karkazis 2008:228).

Some of the negative physical, sexual, social and psychological consequences that ‘corrective’ surgery on intersex people is said leave in its wake are comparable to those highlighted by various scholars in Chapters 6 and 7. As pointed out in Chapter 3, some researchers liken this surgery to ‘genital mutilation’ because it causes extensive scarring, affects orgasmic functioning and necessitates further surgery (Fausto-Sterling 2000:79-80; cf. Chase 2002; Meyers 2000:472, citing Diamond and Kipnis 1998). Although the two procedures cannot be said to be fully comparable, just as some Burkinabe learn to feel ashamed and defective as a result of the circumcision of their bodies because of the discourse surrounding circumcision in the present day, the experiences of some intersex people leave them feel like there’s “something about their body was wrong or shameful” and gives them a sense of deep bodily vulnerability and of a loss of control over their bodies” (Karkazis 2000:223). According to Karkazis, “this loss of control can lead to depression, anger, a sense of disconnection from their bodies and a disinterest in taking care of them, and a retreat from their family members and friends” (ibid.). Moreover, even though doctors place a great deal of importance on a good cosmetic result, some of the people who have had ‘corrective’ in the United States consider their bodies ugly and disfigured (Fausto-Sterling 2000:80; Karkazis 2008:229). Follow-up treatment and medications can cause pain and, as adults, some of these intersex people recall feeling a sense of discomfort, vulnerability and humiliation from repeated medical and genital examinations as well as the trauma of the unexplained surgeries (Karkazis 2008:222-223). Just as it is increasingly difficult for some Burkinabe women to admit to being circumcised for fear of rejection and stigmatisation, intersex people also face difficult choices around disclosing their needs to their friends and potential sex partners because of the desire not to be viewed as different and the

unpredictability of others' reactions (ibid.).

That is not to say, however, that parents are unaffected by the decisions they make in putting their intersex children through clinical treatment; Karkazis (2008:180) speaks of medical, but also complex sociocultural concerns, which “often meld sadness, phobia, shame, worry, frustration, anger, and fear, create unique stressors for parents”.

According to her, parents are motivated by an overwhelming need to ‘normalise’ their children, and this need supersedes questions about the other possible effects of this intervention for children such as pain, future problems with sexual activity and lasting psychological trauma (Karkazis 2008:215). This is comparable to parents who circumcise their children, not out of a desire to harm them, but so that they can function within the norms of their societies, the potential future negative impact of these procedures notwithstanding.

There are also similarities in the ways in which individuals respond to the circumcision of their bodies and to ‘corrective surgery’. Some Burkinabe women have embraced activism against circumcision, and Raélian women in particular are reconstructing their identity as complete and competent women. Similarly, some of the adults in Karkazis’s (2008:234-235) study have reframed the experiences they have had with intersexuality as individuals and begun to consider them as a social or political issue. Informed by personal experience and social movements concerned with health issues, they see their experiences as being tied to cultural ideas about the body, gender and sexuality. They have thus opened intersexuality and clinical procedures used to treat it to contestation by “recasting what doctors understand as medical treatment as, instead, a gender battle waged on the bodies of small children” (Karkazis 2008:2-3). Just like my Burkinabe research participants who advocate for parents to talk to their children about sex and sexuality, some of Karkazis’s (2008:234) research participants suggest that parents and clinicians need to be more honest with intersex children and tell them about their diagnosis. Others suggest that there should be more counselling and support provided to intersex people and that surgery should be deferred until adolescence or later when these individuals can better appreciate the full implications of the surgery (Fausto-Sterling 2000:81; Karkazis 2008:234).

Conclusion

Genital reconstructive surgery is gradually becoming common in Burkina Faso. However, even though the CNLPE has trained more than 200 people to perform this procedure, its practice seems to be mostly limited to Burkina Faso's capital city, Ouagadougou. Surgical repair for circumcision sequelae seems to be a fairly uncomplicated procedure both in the manner in which it is done but also in its acceptability to the public who deem it necessary. Still, there are a few logistical and institutional issues which make it difficult for some women to access it, in addition to the shame and fear of social scrutiny cited in Chapter 7. On the other hand, clitoral reconstruction is a more complex procedure, the understanding of which differs depending on where one is positioned in Burkina Faso in relation to issues around female circumcision. This procedure also attracts much more comment and even disapproval from members of the general public and even activists. A few people consider it as necessary as surgical repair for circumcision sequelae. Some see it as a luxury predicated on sexual pleasure which women are free to pursue if they can afford to pay for it. Others deem it an unnecessary quest for pleasure which could lead to health problems or even social ones particularly for married women.

In general terms, the psychological issues around female circumcision in Burkina Faso are neither clearly elucidated nor addressed. In some ways, clitoral reconstruction surgery seems to be done in lieu of psychotherapy for women who feel diminished by the manner in which their bodies have been changed. This makes the intentions of the doctors who conduct that surgery come under scrutiny and reproach; they are deemed not as focused on getting help for the 'victims of female genital mutilation' as they are on convincing these women that they are suffering and need this surgery, and showing outsiders that there are 'victims' in Burkina Faso in need of aid. Even so, some doctors in Burkina Faso and France are increasingly acknowledging that it is important for psychotherapy and sex therapy to be available to women seeking reconstructive surgery. However, in Burkina Faso clitoral reconstruction – which the doctors say helps women attain sexual pleasure, bodily integrity and a sense completeness while acting as a form of social revolt for some women – is still being offered without this additional or alternative care.

CHAPTER 9

CONSTRUCTING IDENTITY AND RESTORING BODILY INTEGRITY THROUGH RELIGION

Introduction

The condemnation and criminalisation of female circumcision in Burkina Faso has disrupted the conception of identity of some circumcised women in the country, particularly those exposed to activist messages regarding this practice. As I have explained in the previous chapters, as a result of undergoing circumcision, some women who were previously considered mature and respectable are now cast as unhealthy, unattractive, incomplete and undesirable. These women have gone from celebrating their identity as formerly conceptualised in their communities, to sifting through the universal values being advanced in urban Burkina Faso in order to create a more acceptable form of identity. This new identity is precariously hinged on clitoral reconstruction. Even after they undergo reconstructive surgery in a bid to address their perceived deficiencies, these women are not supposed to overtly display their restored health and sexuality, and, as explained in Chapter 7, some people in the society are still likely to continue believing that there is something wrong with them.

In this chapter I explore the experiences of the Raëlian women in Burkina Faso who have had or are seeking genital reconstructive surgery. I discuss the role the Raëlian worldview plays in the attitudes they display towards this surgery and in the manner in which they express their sexuality. I also show how these attitudes differ from those held by other people in the country. Moreover, I explore the understanding and attitudes that people in the general population have towards members of the Raëlian Movement and their ‘pleasure hospital’.

When I began this research project, and even at the initial stages of fieldwork, I did not realise that religious belief played a very big role in the lives of some of the women who had undergone reconstructive surgery or were contemplating it. Nor did I expect that Raëlian women would make up the bulk of my research sample and would be the only ones who would tell me about their experiences with the surgery. That turned out to be the reality on the ground and, because of that, the ideas explored here about having genital reconstructive surgery are not representative of the experiences of all Burkinabe women who have had the surgery but just of Raëlian women who have had it.

Moreover, because of the confronting nature of the Raëlian worldview vis-à-vis the mainstream culture in Burkina Faso, the reactions of some non-Raëlian research participants are aimed as much at the Raëlian women who have had the surgery as at the surgery itself.

As I indicate in Chapter 7 and 8, there are no definitive statistics regarding the number of women who have had reconstructive surgery in Burkina Faso. However, from my interviews I was able to gather that both Raëlians and non-Raëlians have had and continue to have it. The apparent skewedness of my research sample has to do with the fact that, as I explain in Chapter 7, there is a lot of taboo surrounding sexual matters in Burkina Faso, and non-Raëlian women who have undergone circumcision and reconstructive surgery do not talk openly about these procedures. It is, therefore, these silences on one hand, and outspokenness on the other, which are reflected in my data rather than the idea that it is only Raëlian women who undergo genital reconstructive surgery.

The notion of *épanouissement* and the promises of ‘the pleasure hospital’

In Chapters 6 to 8 I explained the physical, sexual and psychological problems circumcised women in Burkina Faso are said to endure and how these are handled. The circumcised women I interviewed repeatedly spoke of the notion of *épanouissement* (fulfilment, development, thriving, flourishing or blossoming) and the manner in which problems arising from circumcision lead to an inability to attain this ideal. They used this term to refer to sexual fulfilment, but also more generally to the overall development and maturity of a woman and the attainment of her full socioeconomic potential within the community.⁸⁷ For example, Samira explained the condition of such women as follows:

These women are suffering. They are not fulfilled. When a woman is not fulfilled in a society, she is... it's like she has lost all her interior. She is not herself. She cannot be happy [...]. And if she feels diminished, she cannot be happy, she cannot be fulfilled.

Amina also explained:

⁸⁷ As I show below, this notion of fulfilment or blossoming is a central tenet in the Raëlian Movement.

When one gives birth to a child, she wants that child's wellbeing. For the child to grow and to develop. But it's the contrary when you deprive her of this organ [...]. For one to be fulfilled she has to feel good in herself. But the first problem is at a psychological level. If one is affected psychologically it means that be it in school, be it in our relations, be it anywhere, one has a handicap which makes her not develop.

As shown in Chapters 6 and 7, the problems that circumcised women experience, and thus their inability to *s'épanouir* (to develop, blossom or be fulfilled), can be a function of the discomforts they suffer in their bodies but also of the beliefs that they have acquired regarding the impact of circumcision on the capabilities of their bodies. Raëlian women such as Samira, Amina, Antoinette and Maimouna, and even non-Raëlian ones such as Danielle and Gabrielle, claim that circumcised women need to have reconstructive surgery in order to fully function socially and physically as uncircumcised women do. They see this surgery as a way of restoring physical, sexual, emotional and psychological health thus enabling women to *s'épanouir*. At a physical level, this need for reconstructive surgery seems to be modelled on the idea of a 'correct' female body and what that body is capable of doing. It is in a bid to recreate this body that Raël, the founder of the Raëlian Movement (see discussion below), commissioned the non-governmental organisation Clitoraid to raise funds and build a hospital in Bobo-Dioulasso to provide clitoral reconstruction for circumcised women.

Amina and Samira separately explained to me how the hospital project was conceptualised. Amina said it all came about because the Raëlians have a philosophy in which "a woman is *really* respected [and] equal to a man". She explained that the idea of the construction of a 'pleasure hospital' in Africa arose from the proceedings of a Raëlian workshop held in Accra, Ghana, in 2004. In the course of a discussion about circumcision, Raël apparently pointed to a girl who was about 15 or 16 years old and asked whether the girl was also circumcised. Amina replied in the affirmative. Raël was shocked to hear that and tasked a Raëlian scientist called Brigitte Boisselier to find a solution for such girls. As Boisselier was doing research on the issue, Amina and Samira underwent reconstructive surgery in 2006 in Ouagadougou. They wrote a report detailing their experience with the surgery and said that they were very happy with the results. When Raël saw the report, he instructed Boisselier to form an organisation with Raëlian and non-Raëlian volunteers to collect funds in order to construct a hospital "to help those women in Africa".

Samira's version of events echoed Amina's even though she did not mention the proceedings in Accra, Ghana. She indicated that Clitoraid was formed in 2006 and, like Amina, she was keen to emphasise that even though the organisation is based in the United States and was founded by Raélians, all religions and ethnicities are represented in it. According to her, "they go out in the snow, the rain and the sun, they go from door to door to look for money to send here". Samira explained that members of Clitoraid mainly collect money from Canada, Europe and the United States and put it in a bank account in the United States. She suggested that although they are involved in collecting money, Raélians do not give money for this project. She said:

And he who initiated the project, Prophet Raël, said that no Raëlian should get money out of his or her pocket to put in the project. That the public must know what is happening. It's a genocide. It's a crime which is happening. The public must repair what it's in the process of destroying. So that it can put to a stop to it.

Meanwhile, the Raëlian women in Burkina Faso also formed an organisation called *Association Voie Féminine de l'Épanouissement* (Association of the Feminine Path to Fulfilment) which is responsible for receiving and using the money collected by Clitoraid. Members of AVFE looked for land and prepared the administrative files required by the Burkinabe State in order to construct a hospital offering reconstructive surgery free of charge. Samira told me that when they explained the project to the customary chiefs in Bobo-Dioulasso, the chiefs gave them two hectares of land free of charge. I asked Samira to clarify the original ownership of the land, and asked her how the customary chiefs, who presumably supported female circumcision, were able to give them the land. She explained that the land belonged to the community or the autochthons, the inhabitants of Bobo, who lived around it. She said that when they explained their project to the customary chiefs, "they were very happy and very touched at the same time", and so the chiefs gave them the land.⁸⁸

The Clitoraid hospital is located about six kilometres from the town of Bobo-Dioulasso on the Bobo-Abidjan road. Samira explained that they chose to situate the Clitoraid hospital in Bobo-Dioulasso because both she and Amina were based in the town at the time, so it would be easier for them to oversee the administrative details and the

⁸⁸ I was not able to independently verify this account of events.

construction of the hospital. Clitoraid was launched in 2006 and AVFE members spent most of 2007 looking for land and getting the relevant papers from the government. The construction of the hospital began in earnest in late 2007. During our conversation in February 2013, Samira said that 85% of the project was complete since the building had been constructed, the perimeter fence set up and electricity connected. What was left was connecting a water supply to the building and furnishing the hospital with medical and other equipment. She explained that the surgical material would be shipped from Australia and transported by road to Bobo-Dioulasso in a process that would take three to four months. She foresaw the hospital opening in eight to ten months.⁸⁹ Samira gave me a tour of the building and indeed the entire project grounds, and explained that in constructing, the contractor had followed architectural plans sent by Clitoraid.

Following Samira's angry reaction to the suggestion that some people in Burkina Faso consider clitoral reconstruction to be cosmetic surgery (as detailed in Chapters 6 and 8), I asked her to explain to me what exactly the hospital was intended to do. She said:

The main job is repair of circumcision sequelae. That is one, and secondly, sensitisation. Those who want to have themselves restored will have themselves restored. Those who don't want to get restored can live in harmony with themselves. That is what is important. So we are going to do a lot of sensitisation because there are a lot of girls who are not circumcised but who don't even know what the clitoris is, who don't know how to use their clitoris [...]. A lot of women are going to come, a lot of men are going to come. We have to teach them how to use their clitoris, to love their clitoris [...]. And after restoration... it's as though you broke your foot or arm by accident, once the plaster is removed, it's done, you are healed. You need to retrain your arm. So after restoration we need to retrain the clitoris. It has to be taught because it has stayed inert for years, so retraining must be done. So at the pleasure hospital we are going to also do retraining. We are going to teach that. There will be [doctors], psychologists, there will be sexologists. There are people who have learnt to really enable women to be fulfilled and above all to know themselves. To know themselves and to love themselves. To be fulfilled.

Samira, who said that she was in fulltime employment and volunteered her free time in the evenings and weekends to oversee the construction of the hospital, appeared to be up to date with all the processes that were going on with the construction and even those that would happen once it was completed. She was confident that once the hospital was

⁸⁹ As I explain in the next chapter, although the hospital was eventually completed and equipped in 2014, it is not yet open for surgery.

inaugurated, its services would be much sought after because there were many women who got in touch on a daily basis after finding the site www.clitoraid.org to have themselves registered for the surgery. Still, she indicated that there were many people who did not know about the surgery and because of that, AVFE members carried out sensitisation activities in Burkina Faso to inform some of those women. These included distributing fliers at demonstrations or even door to door, and having radio and television broadcasts about their hospital. She explained that during the broadcasts, there is a short broadcast in French and a more extensive one in Dioula, one of the local languages. She said:

We talk about the harm caused by circumcision and we also talk about the hospital. Because we say no to circumcision, which is fine, but what about those who are already circumcised? Is it over for them? So we tell them there's hope. Thanks to science today, they can recover their clitoris [...]. We tell them to always take heart, that the hospital will soon open and that they will be able to recover their clitoris and sexual pleasure [...]. We tell them that with clitoral restoration at Kamkasso they will be saved.

Samira's use of the name 'Kamkasso' in talking about the broadcasts that they do for the general public is notable because elsewhere she and the other Raëlian women I interviewed consistently referred to the entity in question as 'the pleasure hospital'. As I explained in chapter 1, I was aware prior to fieldwork that the Raélians and their philosophy regarding sexuality were not entirely accepted in Bobo-Dioulasso (Jirovsky 2010:86), and that the name 'Kamkasso' was starting to replace 'the pleasure hospital' on their site www.clitoraid.org. I therefore asked the Raëlian women I met to explain these changes to me. Amina informed me that it was Prophet Raël who had come up with the idea of a pleasure hospital. According to her, Raélians talk about issues of sexuality and pleasure without any taboo, but the administrators in Burkina Faso did not agree with this Raëlian view of naming things as they saw them and forced the Raélians to change the hospital's name. The Raélians subsequently chose the name 'Kamkasso', which means 'the house of (black) women'. Amina further pointed out that the term 'Clitoraid' also bothered a lot of people in the country. She said:

With Clitoraid we said, well, let's name it after the thing that it repairs, the clitoris. It's a word, because... people should say words as they are. 'Clitoris' is like my foot, my finger, it's like... there's no taboo. It's like my nose. And we are... we say it like that so that people understand.

Antoinette also pointed to her preference for the two terms and the problems that people had with them saying:

Yes, it's a pleasure hospital. It's a pleasure hospital simply because women who were circumcised, mutilated, they are going to have themselves restored. They are going to learn how to use their organs in terms of pleasure. Hence, Clitoraid, hence, the pleasure hospital. People thought that Clitoraid, that saying 'clitoris' is vulgar, that Raélians are vulgar. The pleasure hospital, they think it's vulgar so we needed to change the name to Kamkasso. They accepted Kamkasso. It was because people found the name vulgar, that it was not respectful, that it doesn't respect the end of suffering for women.

When I asked Antoinette whether it was the administrators or the community members in Bobo-Dioulasso who had a problem with the name, she said it was the administrators, particularly those in the Ministry of Health. She also suggested that the real problem that the administrators had with the hospital was that it was going to offer restoration completely free of charge. Samira, who said she had taken the files to the administrators, explained this matter and the renaming of the hospital – which links black women's ethnicity, their oppression through circumcision and their need for emancipation (which she repeatedly termed salvation) – as follows:

I deposited the files with [the name] 'the pleasure hospital' in 2007 [...]. And because the name had come from Clitoraid, I put 'A Medical Centre Called the Pleasure Hospital'. The word 'pleasure' raised... in front of me, the regional director of health who is in Bobo, before me, he said to me, "How can you call a hospital, where people are suffering, how can you call that pleasure?" He said that that is not possible. That in the whole planet that he had never seen that. He had never heard of that. So he said no. Because it was the [Ministry of] Social Action which was supposed to sign, he instructed [them] not to sign unless we changed the name. So we could not... the file could not progress [...]. I sent correspondence abroad. And [Clitoraid] told us that it's not because of the issue of a name that we should stop our wonderful project. Because us, we want to save people [...]. So we said we would comply. So we chose a local name. A name which truly everyone knows. We said it will be 'the House of the Kamité Woman'. Obviously these are the women who will come to be restored. Kamité ... Kama is a word which means 'black' [...]. In the local languages, all that has to do with black begins with 'Kam'... So we said that is the authentic name of the African woman. And also that it is the black woman who is circumcised. I haven't yet seen a white woman who is circumcised. Since it is the black woman who is circumcised, we said that it is 'the house of the black woman'. That's it. Kamkasso.⁹⁰

⁹⁰ The Raëlian women with whom I spoke, and indeed most of my research participants, often made statements implying that only African women underwent/undergo circumcision. As I explain in Chapters 1 and 3, this is the manner in which the issue is

Samira was adamant too when I asked whether the name had been opposed by the community perhaps because sex is taboo in the country. She was emphatic that the community did not have a problem with it saying:

It's not the community. The community did not care. The important thing was the act... what would happen with the finished product. For the community that was it. But it's a pity that at the top, there are people who don't want things and it's reflected everywhere. It's enough that at the top [someone] says, "I don't want that thing," and it's as though it was the whole of Burkina Faso which did not want it. You see, it's very sensitive. *A single regional director*. It was not even the minister. It was not even the national director. He said no. And that reverberated on everything. So that we could not have the papers.

When talking about clitoral reconstruction, the Raëlian women use the term *restauration* (restoration) which connotes a return to an earlier state of being. For example, Samira said that in sending a group email to the other Raëlians, she and Amina wrote of the differences they felt in the present day compared to the time when they were circumcised, emphasising the fact that they were no longer circumcised, but restored, women. They also use the term *temoigner* (to witness or testify) to denote the act of talking about their experience with reconstructive surgery, making it sound akin to a religious act (for example, recounting spiritual rebirth or salvation) or a legal one. Moreover, just like other people exposed to or involved in the campaign against circumcision in Burkina Faso, they also used the term *sequelles* (sequelae) to talk about the negative consequences or effects of these procedures.

It is also notable that my Raëlian research participants spoke very candidly about masturbation, genitalia, sexual intercourse and having multiple, and sometimes concurrent, sexual partners. They did so much more freely and in greater detail than my other research participants. Their perception of these issues was also arguably quite likely different from that of other people in Burkina Faso. For example, Samira perceived as a sign of respect the fact that her partner (who introduced her to the Movement) did not tell her of the other women he had sexual relations with. Later she got comfortable with it and even started wooing other girls for him. About this she said:

sometimes portrayed in some academic and activist literature giving the impression that the issue affects all African women or only African women.

In order to avoid shocking me, to be prejudiced against him...he respected me in such a way that even when he went with other girls, I didn't know it. Until he was able to prepare me ...until I was even able to accept it. I'd even tell him, "Mm that girl over there is beautiful," and he would go with her. I'd even woo the girl myself and then give her to him. And when he returned, he would tell me, "Mm she's like this, like that. She's not circumcised but you're much better, you're better because you have other parts which are more sensitive."

These views about celebrating, and not merely tolerating or accepting, open sexual expression and practice were not discernible in my conversations with non-Raëlian research participants. Even though some of them such as Leila and Sylvie made reference to polygamy in the country, they portrayed it as a negative practice rather than as something to embrace and celebrate. For example, they both suggested that because some women have problems caused by circumcision, their husbands take second wives. It is also noteworthy that in the statement above, Samira uses a discourse invoking women's rights in relation to their bodies and the empowerment of women, but, at the same time, she (and arguably other Raëlian women) also accept what many women, especially those in Western countries where this discourse originates, would regard as being completely contrary to respecting and empowering women. In this way, it can be argued that these Raëlian women have picked up some ideas about feminism and empowerment from the West and mixed them up with Raëlian ideas (which I discuss below) to come up with their own interpretations of women's rights.

As already observed, some of the ideas portrayed by the Raëlian women about the female body and its capabilities are rooted in the discourse against female circumcision. However, a lot of their ideas are also inspired by the teachings of their Movement, some of which are at odds with the values of mainstream Burkinabe society. It is therefore important to situate the views of the Raëlian women cited here and in the previous chapters – particularly those pertaining to sexuality, pleasure and the human body, as well as those relating to social institutions such as marriage and family – in the context of their religious beliefs. In view of this, in the section below, I give a brief overview of Raëlian Movement as presented by various scholars of anthropology, sociology and religious studies, highlighting some of the beliefs and practices that underlie the attitudes of my Raëlian research participants in Burkina Faso.

The International Raëlian Movement: an overview

The precursor to the International Raëlian Movement, *le Mouvement pour l'Accueil des Elohim Créateurs de l'Humanité* (the Movement to Welcome the Elohim Creators of Humanity, MADECH), was founded in 1974 by Claude Vorilhon (b.1946) (Gregg 2014:567; Palmer and Sentes 2012:167, 173). Vorilhon, a former racing car test driver, journalist and pop musician, claims to have seen a saucer-shaped UFO land in the Clermont-Ferrand mountains of the Massif Central, France, on 13 December 1973. An extra-terrestrial piloting the craft, and who was representative of a species of people called the Elohim, inducted him into new scientific and religious truths on which he based his movement (Gregg 2014:567; Palmer and Sentes 2012:167-168; Palmer 1995:106). In his book *The Message Given to Me by Extraterrestrials: They Took Me to Their Planet* (1978), Raël explains that the Elohim, or 'those who come from the sky', are not supernatural beings, but rather an advanced race of extra-terrestrials, somewhat smaller than humans, with pale green skin and almond eyes, but in no other way different from humans except in their superior scientific knowledge (Brodd et al. 2013:539-540; Palmer 1994:159; Raël 1989:2; 1998:19-20, 75, cited in Östling 2014:369; Hammer and Rothstein 2012:8).

The Elohim revealed to Raël that they created human beings some 13,000 years ago from their DNA. They gave Vorilhon the honorific title 'Raël', which means 'light of the Elohim'. They also appointed him the prophet of the 'Age of Apocalypse', an era that began with the detonation of the atomic bomb at Hiroshima (Palmer and Sentes 2012:169; Raël 1998:84, cited in Östling 2014:379; Raël 1989:133; 1998:19ff., cited in Östling 2014:370; Palmer 1994:159). Today Raël's followers consider him to be the personification of such figures as the awaited Messiah of Judaism, the Islamic Mahdi and the Buddhist Maitreya, and refer to him as 'his holiness'.⁹¹ Raël presents his Movement as being an atheist religion or a religion of science, and Raëlians reject the notion of the eternal soul, explaining that it is our genetic code "which gives us ego, insight and personality" (Östling 2014:371, 375, citing Raël 1989:143; 2001:159; Gregg 2014:569). The two immediate goals of the International Raëlian Movement are to

⁹¹ In some of the Movement's more recent writings, Raël is portrayed as having been born of a sexual relationship between Yahweh, the Elohim's leader, and Raël's human mother (Chryssides 2003:53).

spread the message of humanity's true origins and to build an embassy in order to welcome the Elohim upon their return. The Elohim are expected to return to earth accompanied by thirty-nine immortal prophets (including Jesus, Buddha and Muhammad) before the year 2035. At that time they will share their knowledge of science and technology, which is 25,000 years in advance of our own, and thereby usher in a utopian world (Palmer and Sentes 2012:169-170; Chryssides 2003:53).

The International Raëlian Movement claims to have about 60,000 members in 52 countries (Palmer and Sentes 2012:167, 182; Chryssides 2003:45, 60-61). There are two ranks of membership in the Raëlian Movement: the 'Structure' and the 'rank and file' members. The latter make up the majority who have embraced the messages, are baptised, pay their annual dues and receive the newsletter, *Apocalypse*. The 'Structure' is comprised of six descending levels of leadership which represent degrees of responsibility, self-awareness and proximity to the aliens: first is Raël – the Guide of Guides, the Planetary Guide or the Last Prophet – followed by the Bishop Guides, the Priest Guides, the Animators, the Assistant Animators and the Probationers (Palmer and Sentes 2012:173, 175-176; Palmer 1994:158; Palmer 1995:132). Brigitte Boisselier (b. 1956) is one of the top female Raëlian Bishops. She was formerly a director of research at Air Liquide, a French chemical company, and Raël has appointed her as his successor (Palmer and Sentes 2012:179-180). According to Palmer (2004:122), the Raëlian Movement's 1999 international survey of international leaders shows that there are 467 active leaders in Europe, 370 active leaders in the Americas, 539 leaders in Asia and 45 leaders in Oceania. Africa has 67 leaders 40 of whom are located in Burkina Faso while 20 others are in Ivory Coast. Among my research participants, Samira is a Bishop Guide while Antoinette belongs to the Order of the Angels of Raël. The others Raëlians with whom I spoke did not reveal their membership rank.

The Order of Raël's Angels is a group of female members of the Movement who are chosen by the Prophet Raël himself to 'feminise' humanity and prepare the way for the Elohim when they return to earth (Gregg 2014:570). These women will be the only ones allowed to enter the embassy and will act as hostesses, companions and lovers to the alien visitors, and liaison officers between the Elohim and the world's media, scientists and politicians (Palmer 2004:134). To qualify to join this order, women have to be aged eighteen or over, test negative for sexually transmitted disease and should be beautiful and feminine. This is because, according to Raël, the male Elohim are extremely gentle,

delicate and sensitive, to the extent that “the most feminine woman on earth is only 10% as feminine as the Elohim” (Palmer and Sentes 2012:170, citing Palmer 2004:140; cf. Palmer 2004:151). Palmer explains that before the creation of this Order in 1998, women were considered equal to men and endowed with identical emotional needs and intellectual abilities. However, the creation of this Order changed the Raélians’ view of gender by placing an emphasis on women’s unique qualities and creating a millenarian role for them. It also elevated women, particularly those considered feminine and beautiful, to a superior position in relation to men, giving them greater access to Raël and situating them closer to the Elohim (Palmer 2004:139-140, 151).

Raël chose the first six ‘angels’ – in whom he found “religiosity, discipline, serenity, harmony, purity, humility, charisma, inner and outer beauty” (Palmer 2004:140, citing Raël 1998) – but other aspiring ‘angels’ have to fill in a questionnaire, attach a photo and explain their reasons for wanting to join the mission. Meanwhile, as they prepare for the return of the Elohim, these women attend to Raël’s wellbeing: they cook for him, supply him with glasses of pure mineral water, massage him, decorate UFOland’s halls for his parties, welcome him when he returns from his world tours at the airport and accompany him to his races, where they dress seductively and cheer him on. They cultivate close friendships and, occasionally, lesbian relationships among themselves and are regarded with high esteem by male Raélians (Palmer 2004:135, 150).

In the Raëlian Movement sexual pleasure with many partners of either sex is seen as a way of generating new brain cells, improving neural pathways and, ultimately, increasing an individual’s intelligence (Palmer and Sentes 2012:174, 177; Palmer 1995:133). In fact, Raël advocates free love and advises his followers to “commune with the wonder of the universe by exploring their sexuality with the opposite sex, the same sex, and any other life-forms – even robots and extraterrestrials” (Palmer 1994:162). Sexual activity and a more general cultivation of sensuality are perceived as a path to mystical awareness of, or oneness with, the universe and telepathic communication with the Elohim (Palmer and Sentes 2012:174, citing Raël 1980; Gregg 2014:568, 573; Palmer 1995:133; Östling 2014:378).

Raélians openly endorse masturbation and nudism arguing that since humans are created in the image of the Elohim, they should embrace their beauty and not look down upon their naked bodies (Östling 2014:378). They also participate annually in a sensual

meditation workshop in a rural setting which features fasting, nudity, sensory deprivation and awareness exercises and sexual experimentation. The final part of this meditation is the physical union of two beings in order to achieve what is referred to as a cosmic orgasm, a state achieved when the participants put themselves in harmony with the infinitely small parts from which they are composed and the infinitely large ones that they themselves are a part of (Palmer 1994:162; Östling 2014:378, citing Raël 1989:8; 1998:171, 185-186; 2002:72ff., 112ff). Raélians are also advised to engage in the ritual of sensual meditation daily, using an instruction tape, in order to transmit love to and telepathic links with the Elohim and to achieve harmony with infinity (Palmer 1995:129-130; Palmer and Sentes 2012:174).

These ideas about the beliefs and practices in the Raëlian Movement, particularly those to do with sexuality and sensuality, help explain why it is so important for the circumcised Raëlian women in Burkina Faso to find a way to experience sex and sexuality as fully as they imagine uncircumcised women do. In regard to this, these women are informed by two systems of thought. There is the official campaign against female circumcision which, among other things, tells them that there is something wrong with their bodies, they are not complete and they cannot attain orgasm. Secondly, there is the Raëlian philosophy which requires them to explore their sexuality abundantly and which labels some instances of orgasm a religious act. That makes clitoral reconstruction, and the Clitoraid project, extremely important for these women as they believe that it is only by restoring the parts of their bodies which were removed during circumcision that they will be able to attain this Raëlian ideal. In that way, genital reconstructive surgery, which is an issue of health and bodily integrity from the perspective of the medical doctors, the CNLPE and other advocates, is a religious matter for Raëlian activists.

Raélians in other parts of the world where female circumcision has not been practised as consistently as in Burkina Faso – but more so those like Amina and Samira who have had themselves ‘restored’ – take it upon themselves to ‘save’ circumcised women who, in their view, have been condemned to a life where they cannot attain orgasm and are thus unable to attain the pinnacle of one of their religious services (cf. Gregg 2014:575). In a quote printed in Raël’s book *Sensual Meditation*, one woman states:

When I discovered Sensual Meditation at twenty-four years of age, I had my first orgasm.... I express one wish, and that is for every woman to be able to

discover this, especially as I have learned that 70% of women have never experienced an orgasm” (Palmer 1994:187, citing Raël 1986:146).⁹²

It is notable that although this woman is not necessarily referring to circumcised women, the Raëlian women in Burkina Faso associate female circumcision so closely with a lack of sexual pleasure and/or orgasm that they do not consider that just as there are women who do not attain orgasm even if they are not circumcised – as Amina and Antoinette acknowledge – there are circumcised women who lead fulfilling sexual lives and who perhaps do not need this ‘saving’ project.

Clitoral reconstruction not only enables the Burkinabe women who adhere to the Raëlian Movement to engage in fulfilling sexual intercourse but it also enables them to regain the feminine qualities and desirability they feel they lost as a consequence of circumcision. (Ironically, as explained in Chapter 5, one of the reasons underlying female circumcision in some Burkinabe communities is removing masculine traits, especially the clitoris, from girls and women. The two worldviews which some circumcised Raëlian women straddle therefore have polar opposite ideas about the clitoris and its role in determining gender identity). Femininity is an ideal required by the Raëlian philosophy which requires women and men to cultivate feminine qualities (and stifle masculine ones) to prepare themselves for the return of the Elohim. Palmer explains that this quality, in both men and women, is seen as urgent and necessary for the ‘Age of the Apocalypse’ (Palmer 1994:157; 2004:151).⁹³

If, for Raëlian women, part of being feminine, beautiful and desirable is dependent on having all their genital parts, then genital reconstructive surgery, or restoration, as they term it, is very important. Luckily for them, the Raëlian Movement is very favourable towards plastic surgery. Even though, as pointed out in Chapter 8, my Raëlian research participants are adamant that genital reconstructive surgery is not a form of cosmetic surgery, in general terms, Raëlians embrace plastic surgery and cosmetic surgery, and other practices such as body building and hair bleaching (Palmer 1994:187). Based on the observations she made in Quebec, Palmer points out that many Raëlians undergo

⁹² The source of this statistic is not indicated.

⁹³ Cf. Östling (2014:378, 380), citing ‘Clitocracy’, <http://www.thereisnogod.info/English/Clitocracy.html>.

plastic surgery and love to talk about it. According to her, “Many of the older women in the structure are deceptively youthful in appearance, due to cosmetic surgery, strict diet, exercise, and perhaps the destressing effects of sensual meditation” (Palmer 2004:122).⁹⁴

The issue of Clitoraid and the ‘pleasure hospital’ also need to be understood in the wider context of Raëlian activism and the manner in which they handle publicity. Raélians engage in political and social activism, and hold that everything should be permitted, so long as it does not harm anyone or impede scientific and technological advance. Their causes include women’s rights, gay rights, anti-racism, support for genetically modified foods, a ban on nuclear testing and the promotion of human and animal cloning (Palmer and Sentes 2012:177; Chryssides 2003:54, 56; Gregg 2014:573; Palmer 1994:164, citing Raël 1986:237). Palmer (2005:372ff, cited in Östling 2014:378) suggests that rather than shying away from controversy, Raélians keep a steady, low level of controversy in relation to the surrounding society, and use the media to promote their worldview and values and to secure social acceptance. On his part, Gregg (2014:573, 582, citing Gregg 2012) suggests that the Raëlian causes should be understood as a performance of a ‘ritual of protest’ which seeks to present the Raëlian worldview as ‘other’ to mainstream conservative religious views. In specific regard to Clitoraid, Gregg (2014:575) posits that this project has “a two-fold aim to raise the profile of Raëlian philosophy and worldviews via the internet and to create a world (however idealistic) of increased female sexuality which is compatible with Raëlian cosmology”.

Sacrificing belonging to gain integrity?

It is important to point to the difficulties some Raëlian women encounter while constructing an alternative identity in an African society which esteems family and kinship, which until recently endorsed female circumcision and which still expects women to act in a ‘respectable’ manner in regard to their sexuality. These values are in direct opposition to some of those held in the Raëlian Movement. In the Raëlian

⁹⁴ Raélians also have dietary rules which ban alcohol, coffee, tea and recreational drugs as these substances are seen as damaging to the genetic code. However, these rules are not always followed or strictly enforced (Palmer 2012:173; 1995:132).

worldview, marriage and childbearing are seen as curtailing the ability of individuals to blossom and be fulfilled. Because of this, Raël advises that conceiving a child should be delayed until the individual is fulfilled in body, which in turn leads to the blossoming of the mind. He therefore advises his followers to use birth control devices and, if necessary, abortion. Moreover, he advises that if people have a child but then later no longer desire him or her, they should hand the child over to society in order that both they and the child can find fulfilment. Because of these teachings, women in the Raëlian Movement postpone or eschew childbearing, are open to expressing their sensuality with other women and live on an impermanent basis with their lovers (Palmer 1994:157, 163-164, citing Raël 1986:236-238; Palmer and Sentes 2012:177; Chryssides 2003:54). Furthermore, Raël advises couples against trying to maintain long-term relationships by working out their problems or pursuing monogamy. In his view, these notions, coupled with marriage, represent a proclamation of ownership or possession of a person and lead to an atrophy of our higher consciousness and awareness of the infinite (Palmer 2004:136, 157, citing Raël 1978:285; Palmer and Sentes 2012:177; Gregg 2014:569).

It can be argued that these Raëlian teachings about the importance of individual gratification, and the restrictive nature of family and society, make it easier for women who have chosen to be Raëlian in Burkina Faso to cope with being in a marginal Movement which, as I show below, is considered a cult. Palmer (2004:150) points out that “[t]he Raëlian religion exalts the atomized individual, who cuts his or her ties with ancestors and the biological family and is self-made in the image of the extraterrestrials”. She quotes a Canadian ‘angel’ who says, “I consider my real family are the Raëlians with whom I share the same philosophy” (Palmer (2004:144).

In the section below, I reproduce some excerpts from the conversations I had with my Raëlian research participants regarding their conversion into the Movement, and the manner in which this has been received by their families and others in the society. There is a varying degree of conflict in their experiences. The older Raëlians such as Samira and Amina seem to have put behind them whatever problems or estrangement they suffered when they converted and have found a new form of acceptance in their families of origin. On the other hand, the younger Raëlians, particularly Maimouna and Sophie, appear greatly conflicted by this decision and have not told their families about

it mainly because they are afraid of their families' reaction. Regardless of this, the Raëlian identity is extremely important for these women.

Amina, who has been a Raëlian for fourteen years, said:

Yes [changing religions] caused me problems at family level because I was a student when I did it. I'm from an Islamic family, so, yes. With my mother there were no problems and my father, well, he had died much earlier. My elder brother, yes, but what was interesting... what was good was that there was no violence. I just listened to what they had to say, and then, as time passed, they realised that I was enjoying myself. I was flourishing and so they respected me. Moreover, I have now become a reference person in my family [...] there is no problem.

At a professional level, well, one cannot say for sure if it is because of that but I have changed jobs a lot. I have lost a lot of jobs. Officially I cannot know if it is because of that, but it may be related to that. But I've been open about it at work. Wherever I am in associations [...] I have always been open about being a Raëlian.

Antoinette, who was born into a Muslim family and later got baptised into Catholicism in 2001, said she lost her Christian faith in 2006 and eventually became a Raëlian. She said:

I was always asking the question: if God exists as they say in church why is there so much suffering? God, who is everywhere at the same time, who sees us suffering, why is that right? So I was always asking myself these questions until one day I met a Raëlian. A man who was wearing a medallion. It's through that medallion that I knew that he was Raëlian. That's how it started. That's how I left the Christian religion to become a Raëlian because I got a response from the Raëlians to the questions I was asking myself. That's when I became a Raëlian and became really committed in [fighting] circumcision.

As I said, I left my parents early. But even when I was with them, I used to do catechism classes. Because my parents are Muslims but they are not fanatics. So they did not impose their religion on their children. In our family I am Raëlian, I have Catholic brothers, one who is a Protestant, one who is in the Assemblies of God and another one who does not pray. So there's everything in my family.

As I explained in Chapter 4, I decided not to ask Maimouna many follow-up questions because she repeatedly declared that she did not want to talk about her faith as it was misunderstood by a lot of people. Nevertheless, she answered some of my initial questions giving an insight into her conversion into the Raëlian Movement. She explained:

My first partner was a Raëlian. It was because of him that I heard about the Raëlian Movement. He is the one who led me to the Raëlians. I just listened. I don't judge religions, I just listen and understand. I see that I like their philosophy. It's true that there are things which are not really good, but I like a lot of other things in the Raëlian Movement because their religion is based on science. I like scientific things. So that has helped me a lot to grow through the advice that they give about life. Also, I've learnt a lot of things as a Raëlian.

You are taught a lot of things in [the Movement]. There's love above all [...]. You learn all the faces of love, not just sexual love. Love towards other people. It's really crucial, the principle of really being yourself, of having love for yourself and for others, all the faces of love. Every day they try to teach you all these things.

My grandmother was a Muslim, my grandfather was a Muslim, almost the entire family were Muslims but some of my aunts were married to Christian men, so they converted to Christianity [...]. It was my grandfather who was really integrated in [Islam] but since he is now dead, my father does not care about it; he follows his own way.

A lot of my family members do not know that I am Raëlian because I don't know how they will take it. It's not at all easy. They do not impose religion on you – if you want to be a Christian, you can be a Christian. If you want to be a Muslim, you can be a Muslim. But being Raëlian, maybe they can't imagine that. I have...well, one day my father learnt that my partner was Raëlian and he was upset about it. He was not happy and that caused a lot of problems afterwards. That is why I don't really like talking about my religion. I don't really like showing my Raëlian identity. Because they do not know at all that I'm a Raëlian. My family is really weird with that because if you are not really sure of yourself you can't do what you want. You have to be sure. When you are not sure you have to progress slowly.

Samira gave a much longer account of her conversion into the Raëlian Movement. Here are some of the things she said:

When I met my boyfriend, my partner, he was not yet Raëlian. He left to study in France [...]. When he returned he brought the messages. He was the first black person to bring the [Raëlian] messages back to Africa. He had read them there. He explained a bit how he read them. When he left work he was passing near a bookshop, and behind the glass he saw *The book which tells the truth* so he went in and bought it. He took it home and read it in one night. At the end of the book they explained that there was a second one. He returned the following day and took the second one. At the end of the book they said that there would be a meeting on the first Sunday of April [...]. He asked for permission and went to the gathering. Raël was there and [my partner] listened to all that he said. He asked Raël all sorts of questions. He said, "Is what you are saying true?" and Raël said, "Yes." He said, "In that case the whole African continent will be behind you, because we are all animists."

He came back and on his return, we met as usual. I was still in my dreams in my preparations for marriage. It was then that he took out the book of messages and gave me [...]. I took it and read it. I also read it in one night. And the second one, I took two days and I read it. I returned to it and read it again [...]. It was said that you are not going to sign a contract in order [...] to tell a person “I love you” in front of everyone. Ah, I said to myself, so there will be no marriage. I also agreed with the messages [...]. We stayed together and I learnt the [Raëlian] messages [...]. We started spreading the messages around us with everyone and that’s when I also had my Raëlian baptism. I followed the training, I can say that since we started training... we welcomed the prophet here in [19]82, and since then until now, I have perhaps missed just one single training session on the African continent.

[Leaving Islam to join the Raëlian Movement] um-huh...uuuu...pu pu pu pu pu...it was a big deal. Because already when I was doing catechism lessons [as a child] it was in secret. Not really in secret but I was in a nuns’ school so it was normal [...]. On the contrary, leaving Islam to become Raëlian was not easy. When [my partner] came back from Europe we had to go tell my parents that we were no longer getting married. We stayed together for a while until we had our first child. A girl. And then we had to go tell my parents that actually we were not going to get married. The two of us went before my father [...]. My partner spoke of the messages, he summarised the messages. He said that because we were Raëlians, it was not necessary to go before the mayor to sign some paper. That’s when my father got up and went into his room and took a gun [...]. He said that [my partner] had to leave. That he had impregnated his daughter and given her a child, and that’s where he wanted to stop, he didn’t want to marry her. He said my partner should just get up. So my friend, my partner, got up and left.

He left and I got up and went into my mother’s room, because my father had four wives. I went into my mother’s room. At my mother’s, we are 6 girls. All the girls were married except the last one. And I’m the fifth one. So all the girls were married and [my father] was the one who had got husbands for his daughters. So he was shocked to see his daughter...and I was the first to go to school, all those other daughters, none had gone to school. He had made them leave school very early. I was lucky to go to school because I lived with my elder sister in Ivory Coast. She sent me to school when she sent her children to school.

I got into my mother’s room, I was crying, I did not say anything. I loved my man and I had a child. Who was going to raise my child? So I calmly stayed at home for a week with no problem, no difficulty, no issue. I then went with my child [back to my partner] and we stayed, we lived there for a long time. When I left, [my father] banned me, he disinherited me. He said that I was no longer his child. I no longer went home. When I went home it was to see my mother and then leave in his absence.

In any case, I was always happy because my partner, as I explained to you, helped me. He always put up with me given all the difficulties I had with circumcision and all that. He is the one who enabled me to continue with my studies. He paid for my studies, so I continued. My partner was then transferred to Abidjan [Ivory Coast]. We stayed in Abidjan for a long time.

My father called me at the time of his death to ask for forgiveness and say he was sorry for having [banned me]. Before he died he called me and said that he was asking for forgiveness, it was over. And there it ended. It ended and he died. He died and I started coming home with my family with no problem. I get along well with my sisters, brothers, and even the other women, we get along well...there's no problem. It so happens that when there are problems at home [...] it's my point of view that is sought because we have our ideology which is logic, that is, the analysis of facts. We must see logically how things happen and how to reconcile two people and so on. So my point of view generally passes, and so in my family there are no problems up to now.

[Since publicly testifying about having reconstructive surgery] women approach me to know more about it. They approach me because with the association...all my neighbours are members of [AVFE]. And even in the office everybody knows... and there is a lot of respect. People approach me with respect. And those who want to know more about it come to me and congratulate me saying, "How can we...is [the hospital] finished yet?" There are those who have registered their wives. Yes, there is a university professor every time he sees me [he says], "Hey, isn't it yet open? My wife is there, eh. Hurry up!" Yes, it is with respect because there is no problem. I feel good within the community.

I have not had [any threats]. No, I haven't seen a look like that or any threatening phone calls [...]. But I know that during our radio broadcasts when the telephone is open there are those who come on the phone and say, "No, we don't agree. You are telling lies." They are not against me. It's to say that the activities which we are carrying out do not suit them. They support circumcision [...] and generally, it's men who telephone and say that.

Finally, I spoke with Sophie, a very friendly, cheerful and soft-spoken 23-year old woman who had lived with her Raëlian partner for three years. She had been raised in a Catholic household and had not informed her family that she was now a Raëlian. Sophie was not circumcised but she supported the fight against circumcision and the activities of Clitoraid. About her conversion and her support for the 'pleasure hospital', Sophie said:

I'm a Raëlian. I have been baptised. [Before] I was a Catholic. I heard about the Movement about four years ago. That is when I read the books and understood. Then I decided to be baptised.

My family is not yet aware. It's not easy. I don't know when I will inform them but I'm not ready to put myself [through that]. I don't know how to tell them. I don't know how they will react. Already they are saying that because my partner is a Raëlian ... that I shouldn't follow him. That he is a demon. That I shouldn't get lost and should instead return to the Bible. That is their reaction but I don't know if now, if I tell them that I am also a Raëlian, I don't know how they will react.

It's not easy to be a Raëlian here in Burkina Faso. There are women, girls, who have become Raëlians and have even been banished, even just for saying that God does not exist. It creates a problem. Yet there are very many who have understood that the word 'God' does not exist. That does not mean that we don't have creators. It's the word 'God' which doesn't exist, otherwise we have our creators.

When I heard about the construction of the pleasure hospital, it made me happy. I am very happy. I'm even impatient. I'm waiting with impatience so that other women who have lost this pleasure can find it quickly.

These women have joined a minority religion in a country where the majority of people are either Muslims or Christian Catholics (Ouédraogo 2010:393; INSD and ORC Macro 2004:3). All the women with whom I spoke – except Antoinette who made an enquiry when she saw a man wearing a Raëlian medallion⁹⁵ – were introduced to the Movement by their male partners. A number of them say that when they read the messages contained in Raël's books, they found them convincing and decided to join the Movement. Based on the research that she conducted with her students between 1988 and 1993 in Quebec, Palmer suggests that the typical Raëlian woman

is likely to be in her late twenties or early thirties, from a Catholic and working-class background but upwardly mobile in a white collar job; she has an undergraduate degree or is earning one; and she lives with her boyfriend with no intention of ever marrying. Also she is likely to be attractive, long-haired, and to wear flamboyant clothing (1994:168; cf. Palmer 1994:157).

Palmer and her students also met “a surprising number of strippers, both female and male, in the meetings”. She posits that this “conspicuous number of strippers and transvestites and highly expressive homosexuals among the congregation” suggests that the Movement is particularly attractive to people who define themselves as sexually marginal (1994:170,186). Palmer further points out that during Montreal Raëlian

⁹⁵ Raëlians wear large medallions of the swastika inside the Star of David. Palmer (1994:167) suggests that they believe this is an ancient symbol of the integrity of time and energy, while Chryssides (2003:53) explains that Raël claims to have seen the swastika on an Elohim spacecraft where it was associated with the ancient Aryan symbol of power, rather than Nazism. To ameliorate their chances of getting land from Israel to build an embassy for the Elohim, in 1990 the Raëlians modified this symbol rounding out the angles of the swastika and making it more like a swirling galaxy symbol to represent the cycle of infinity in time (Chryssides 2003:53; Palmer and Sentes 2012:174, citing Raëlians Information Pack 1992). In spite of this change, the original symbol is still on display at the Raëlian centre in Ouagadougou (see Figure 4.1).

meetings (held on the third Sunday of the month), women are as active as men; they make announcements, give speeches, caress their boyfriends and generally behave in an overtly sensual fashion (Palmer 1994:166).

It was not easy to determine, by just looking at them, that my research participants were Raélians. Granted, Samira had seemed overly informal in her correspondence with me, and, when we met, she and Amina were more demonstrative and affectionate in their greetings than were my non-Raëlian research participants. They also referred to their male companions as ‘partners’ rather than ‘husbands’ or ‘boyfriends’ as my other research participants did. Otherwise, until I interviewed them, they appeared to me like many of the other Burkinabe people that I had met. They were all employed or self-employed and participated in the mainstream society: Samira was an accountant at a Catholic establishment, Amina was an administrative assistant, Antoinette worked with a clearing and forwarding company, Maimouna operated a guest house with her partner and Sophie ran an eatery and reared poultry with her partner. It was not until I met them that I realised that they were much more concerned with issues of sexuality than other people in Burkina Faso. Moreover, although I observed Maimouna being fondled by a journalist at the Clitoraid hospital, I was not able to observe the displays of sensuality that Palmer refers to as I was not able to accompany my Raëlian research participants to their private gatherings.⁹⁶

It can be argued that these Raëlian women in Burkina Faso are jeopardising their position as fully accepted members of their families and communities in order to gain physical and emotional integrity through clitoral reconstruction and to have the freedom to exercise their sexuality beyond the boundaries dictated by the Burkinabe society. The Raëlian community provides some sort of substitute family for these women who have been raised to esteem kinship ties. They are therefore not simply rejecting this value altogether but reformulating and transferring it to some degree to this new ‘family’. Furthermore, as shown in the excerpts above, even though some of them fear and experience estrangement from their families because of their Raëlian affiliation, this separation is rarely complete or permanent, even though, of course, its impact should not be minimised. That is to say, those who are estranged such as Samira are only

⁹⁶ I explain the reasons behind this choice in Chapter 2.

rejected by some family members, not all of them, and with time, these relationships are restored or reformulated in new ways. It can therefore be argued that these women maintain some ties with their original families, albeit partial ones in some cases, while establishing new and perhaps stronger ones with their Raëlian kin. It is in this space where they are straddling two worldviews that some of them make the decision to have their bodies reconstructed and where they embrace ideas about sexuality some of which are in conflict with those of mainstream Burkinabe society.

Other people's views of the Raëlians and the Clitoraid hospital

My Raëlian research participants are proud of what they have attained both in their Movement, and also in their public campaign against circumcision and support for reconstructive surgery. Amina and Samira also point to the respect they have garnered in their families and communities because of their approach and outspokenness. They see themselves as rendering an important service not just to other Raëlian women but to all circumcised women. In talking about the hours she consecrates to the hospital project, Samira says she is ready to sacrifice herself to save humanity. However, as I show below, other people in Burkina Faso do not always see these women in such a positive light, and some people even associate them with satanic practices, if not a disgraceful obsession with sexual pleasure.

I asked my non-Raëlian research participants whether they knew of the Raëlian Movement. I also asked them whether they had heard about the Clitoraid project in Bobo-Dioulasso or about the Raëlians' activities in opposing female circumcision and promoting reconstructive surgery. There were a variety of responses about this, displaying varying levels of familiarity with the Movement. Some of my research participants had not heard of the Clitoraid hospital, and I therefore needed to explain the project to them before seeking their opinion about it.

Some people consider the Clitoraid initiative a positive venture which will enable women to access genital reconstructive surgery, particularly clitoral reconstruction, which is otherwise unattainable for most women. For example, Leila explained to me that when the 'pleasure hospital' project was launched, three representatives of the Raëlian Movement in Burkina Faso went to see her at home to present their initiative and seek her opinion and support. She said she congratulated them and acknowledged that since activists had denounced female circumcision, they had also aroused needs and

it was appropriate to provide solutions to those needs through reconstructive surgery. However, she told them that her problem with the initiative was the name ‘the pleasure hospital’ because it trivialised and jeopardised the advocacy work already done and opened it up to ridicule. According to her:

The fight is organised so that women in good health, who are enjoying their rights, can bring their contribution to the development process. That is the final objective of the fight. So it’s not only for pleasure. If it’s for pleasure people will not get involved.

Leila was satisfied when the Raélians changed the name of their hospital and welcomed their initiative. On her part, Gabrielle had not heard about the name ‘Clitoraid’ but she had heard about the Raélian Movement and the hospital that they were constructing in Bobo-Dioulasso. She said she had read about it in the press about two or three years previously. When I sought her opinion about it she said:

If they can do it, so much the better, because the State is not going to fund clitoral reconstruction [...]. It is not free and not everyone can access that. It’s true that [the Raélians] lay a particular emphasis on sexuality, sexual pleasure, but if they can do it, and if that enables people to enjoy their sexuality, so much the better.

Danielle, the economics researcher working in Ouagadougou, told me that sometime between 2002 and 2005 when she was at university, she had heard about the Raélian Movement because Raël had visited Burkina Faso. She had also had a few Raélian classmates, but she did not know much about their beliefs or practices. Danielle had also heard about the Clitoraid project as, according to her, Raël had come with a white woman called Brigitte who had spoken on TV about it. When I asked her opinion on the project, she said:

It’s good. Given that it is to help people regain their health, to be well, to be fulfilled, there is no problem. It doesn’t bother me.

On the other hand, some people in Burkina Faso see the Clitoraid initiative as a harmful one which will encourage female circumcision. For example, Nafissatou explained that the CNLPE did not support the Raélians’ project because, by offering clitoral reconstruction, the Raélians would create the impression that it was okay to continue circumcising girls since genitalia could be reconstructed. She explained that because the control of girls’ and women’s sexuality is at the centre of circumcision, reconstructing the clitoris and the labia and associating this procedure so closely with a recovery of sexual pleasure would create a fear in the population that these reconstructed women

would once again become ‘uncontrollable’, and that would make it difficult to convince people to stop circumcising their daughters. She therefore suggested that it was better to focus on telling people about the health and reproductive problems associated with circumcision. Albert, the medical anthropologist who has done research on female circumcision in parts of Burkina Faso, shared this view.

The Raélians see such criticism as hypocrisy. For example, Amina said that sexual pleasure is very important for women and not a week goes by without this surgery being done in clinics in Ouagadougou. Her argument was that women, be they Raëlian or not, are seeking to have reconstructive surgery to attain sexual pleasure and that such criticism is just a case of refusing to deal with the reality on the ground. Nafissatou argued that the CNLPE is trying to discourage people from removing the clitoris in the first place rather than removing it and having it returned through surgery, but Samira reckoned that it is this realisation that it can be ‘returned’ which will show people the futility of the practice and discourage them from circumcising girls in the first place. She said:

The circumcisers themselves will realise, if they are intelligent, they will think, “but we cut, they return it... we cut it, others return it, we cut it, others return it, so we should just stop cutting.” And if they are intelligent, they will stop.

Some research participants consider the Raëlian Movement a cult and see the Clitoraid project as a dangerous and deceptive ploy to get people into the Movement.⁹⁷ For example, when I asked Pauline, the English language student from the University of Ouagadougou, whether she had heard of the Raëlian Movement in Burkina Faso, she hesitantly said that she had heard about them and she knew them to be a religious cult which believes in the divinity of man. Pauline said she had not heard about Clitoraid, so I explained to her that it would provide reconstructive surgery for circumcised women who desired it and also teach people about enjoying their sexuality. Pauline, a Catholic, did not think that the Raëlian venture would find support in the country because “Burkina Faso is a religious country” (and clearly, for her, the Raëlian Movement is not a religion). Furthermore, she was suspicious of the Raélians’ intentions and wary of the

⁹⁷ Internationally, Raélians are also labelled a cult particularly in France and Belgium (Palmer and Sentes 2012:176, 179).

forces that facilitated clitoral reconstruction. Even though she had not heard of the Clitoraid hospital prior to our conversation, she said:

I think it's risky to go and have one's clitoris reconstructed by those people. They say that the act of removing a woman's clitoris is not good, but on what basis do they want to reconstruct [it]? They are people who are working with supernatural forces and even in their hospitals we find, we can find doctors, I apologise for the term, but witchdoctors. Real witchdoctors in the true sense of the word [...]. All that they want to do, they can. People who claim to be able to give and take life. It's really risky to go and expose oneself to those people because I think that being... going to reconstruct the clitoris in the long term, sooner or later, you will become a part of their group also. So, in my view, it's a way of integrating people in their group [...].

Monique, who worked in Leila's centre, said that she did not know much about Raélians but she had heard people say that they are a cult. She had not heard about the Clitoraid hospital in Bobo-Dioulasso, so I explained it to her. In regard to this, she said:

Isn't it dangerous if cults begin doing things like that? I don't know, but what will it amount to in the end? Isn't it a play for something afterwards? Won't it be something else? I don't know much about that. It's just that the Raélians, I don't know what they have in their minds. I just don't know.

Some people think that the idea of a hospital for reconstructive surgery is not wholly bad, but suggest that the Raélians should widen the scope of their hospital to offer more services. For example, Aziza said she had heard about the Raélians in Burkina Faso about three or four years previously. She had seen in the press that they were encouraging women to seek reconstructive surgery and were against circumcision because they thought that women should have a right to their physical integrity, and to pleasure. She further said that the Raélians did not have a good reputation in Burkina Faso as they were considered to be a cult practising Satanic practices. According to her, they were thought of as peculiar and strange, and that perception would hinder people from going to the Clitoraid hospital. Furthermore, Aziza was not sure the Clitoraid hospital would have much demand or even impact in the country given that

the consequences [of circumcision] do not prevent a woman from giving birth and that it's just a question of pleasure, whereas, for me, perhaps I'm wrong but I think that once the clitoris is cut, you cannot resurrect a dead nerve [...] it's for cosmetic purposes [...]. The fact that the consequences are not as disastrous, as dramatic as they are said to be, it will always be an obstacle to the use of that surgery.

Aziza suggested that instead of focusing on clitoral reconstruction and issues of pleasure, the hospital could look at providing other more relevant gynaecological services or family planning services. This view about the scope of the hospital was shared by Dr Hassan. He pointed out that while it was a good thing to help resolve circumcision sequelae, the focus of the hospital was too narrow. He anticipated that eventually circumcision would cease in Burkina Faso and, with time, the Clitoraid hospital would have no clients. He therefore suggested that it would be more useful to include in their repertoire other reproductive health services and even projects emphasising women's rights.

My interviews with the doctors regarding the Clitoraid hospital yielded a curious mix of responses. Some of the doctors I interviewed were keen to distance themselves from the Raélians and their activities, and some of them at first said they did not know anything about the Raélians before going on to tell me some of the things they had heard about them. For example, even though Dr Hassan gave me his opinion about the hospital, when I first asked him whether he knew about it, he said he was not aware of it. When I pursued the matter, he said he had vaguely heard about it "in the corridors". On her part, Dr Diallo said she had little knowledge of the project and, because of that, did not wish to give a personal opinion about it.

I had erroneously anticipated that Dr Condeh, who was living and working in Bobo-Dioulasso, would know much more about the Clitoraid hospital than the other doctors. He said he had seen the building and read some controversial exchanges in the press about it between the owners of the project and Raélians. Condeh seemed unaware that the hospital was itself a Raëlian project and suggested that it was the Raélians – whom he described as a cult – who were critical of the use of the term 'pleasure hospital' because it would pervert morals. He explained that he did not know who was financing the project, who the players were or whether they would call on local practitioners to work there. When I asked him about his personal opinion on the hospital he said:

Well, I don't know, since I don't have much information about it, and I don't know what their real objectives are, it's difficult to give an opinion. Otherwise, from what I learnt from their writings in the press, if it's to have a centre for clitoral repair and to go on to its eventual re-education over there, it's certain that [...] it's like a house of pleasure, a house of prostitution in the end. Because if a woman comes to have her clitoris repaired, if she must go on to practise to see whether it works or not [...] from an ethical point of view, it's not acceptable.

Other doctors, such as Prof Kerekou, were more forthright about their view of the Raélians and their hospital. Kerekou – who is renowned in Burkina Faso for clitoral reconstruction and who views this surgery as women’s expression of revolt against societal oppression – thought the Raélians’ use of the word ‘pleasure’ was in poor taste. He said:

We have distanced ourselves from them, because they say that it’s a pleasure hospital. For us in Africa, it’s in very bad light to say that one is constructing a hospital for pleasure.

My most challenging interviewee regarding the Clitoraid project was Dr Nikiema who seemed keen to emphasise that he did not know about the Raélians and did not want to be drawn into discussions about them or their activities. The more questions I asked about it, the more exasperated he seemed to get. When I asked him whether he knew about the Clitoraid hospital, at first he said:

I’ve heard about it but I’ve never seen it [...] so I can’t say anything about that. I have never spoken with a Raëlian about clitoral reconstruction. Never [...]. When they come to have the operation, they don’t say that they are Raélians. I see a lot of women. I don’t know, I’m not interested in the religion of the people who come.

As Nikiema specialises in clitoral reconstruction, I asked him whether he thought the Burkinabe public might increasingly assume that this procedure is a Raëlian practice given that they are the ones who are mainly outspoken in the community about their experiences with the surgery and the anticipated services of their hospital. Regarding this Nikiema said:

It does not concern me. I don’t seek to understand. The Raëlian religion is very minimal in relation to the needs of women in the context of reconstructive surgery [...]. Why didn’t you interview women? Because once people have had reconstruction, they don’t talk about it. They do that discreetly and then they are silent. It’s only the Raélians who talk about it a lot [...]. In fact, it’s not even my problem. Honestly, you’re asking a question which doesn’t interest me. Whether people confuse or don’t confuse, it’s of no interest to me. What interests me is that the person needing it comes to be reconstructed. It’s not an illegal practice, it’s not a hidden practice. For me, a woman who is in need comes and I reconstruct her. I don’t care about the rest [...]. I don’t know the Raélians. They don’t know me. I’m not a Raëlian. I am a Catholic [...]. They have collected funds internationally on their site Clitoraid and all that. That concerns them [...]. From time to time, if I have time, I do communiqués. Those who need to have their clitoris reconstructed just have to come. I [am interested] in those women.

Nikiema concluded his remarks by emphasising that he did not enter into discussions around reconstructive surgery with “people who have never been circumcised who want to speak in the place of others” and was only interested in talking to circumcised women who felt they needed the surgery. I was not sure to whom he was referring and, given the atmosphere of the interview, I decided not to pursue the issue. However, his remarks, the CNLPE’s view that clitoral reconstruction encourages circumcision and the events surrounding the opening ceremony of the Clitoraid hospital in 2014 (which I highlight in the next chapter) alluded to some acrimony around the issue of clitoral reconstruction and its practice in Burkina Faso.

Conclusion

Without doubt there are various reasons to explain why some Burkinabe people have embraced the teachings of the Raëlian Movement. Clearly, some women in this country have found the principles of this Movement – particularly those addressing love, personal freedom and the positive nature of sexual pleasure – extremely appealing and are using them to navigate the difficulties imposed by the changing public perception of female circumcision. Contradictions in the demands made of ‘respectable’ Burkinabe women and their bodies in this patriarchal society have made the Raëlian Movement attractive to these women and enabled them to construct an alternative, albeit marginal, identity through religion.

Being Raëlian heavily contributes to the identity of these women. Although they participate actively in the life of the overall society in which they live, their Raëlian identity also plays a big role in the manner in which they have reconfigured their femininity and sexual integrity, and puts them at odds with some aspects of mainstream Burkinabe society particularly in regard to respectability and sexual expression. They have embraced the Raëlian interpretation of values touching on sexuality, intimacy and partnership, and created a family of sorts with other Raëlians. By adopting this identity, some of them risk estrangement from their families and the wider community in order to have the freedom to express themselves as they wish. The fear of rejection expressed by some is well-founded as in some cases conversion into the Raëlian Movement has led to estrangement albeit impermanent. However, clearly, a lot of them still value the esteem and acceptance of their families of origin. Because of this, some of them have concealed their involvement with the Raëlian Movement from their families in order to preserve their reputation.

By joining this group and successfully taking part in the religious activities focused on sexuality and sensuality, these women are able to prove to themselves, and perhaps to others, that they are complete women capable of experiencing sexual pleasure. Possibly, this makes them feel more desirable as well. Some of them have embraced reconstructive surgery (or are seeking to have it) to ensure the complete restoration of their bodies, in order to exercise the pleasures that they feel – and have been told by their religion and by activists against circumcision – their bodies should be capable of.

CHAPTER 10

CONCLUSION

Summary of research findings

This thesis argues that circumcised women in Burkina Faso, particularly those living in urban areas, are caught in a transitional moment during which female circumcision, which was pervasive in some places in the past, is increasingly being stopped and perceptions about it are changing. In addition to traditional views about circumcision, which are now dismissed as unfounded by activists campaigning against the practice, there are also modern discourses about women's rights to health and physical integrity. Moreover, there are moral discourses about moderating the manner in which new identities around sexuality are created even after women reject circumcision. These discourses have contributed to gradual shifts in the meaning of the concepts of completeness, attractiveness, desirability, good health, respectability and normality as applied to Burkinabe women.

The government of Burkina Faso (through the Ministry of Health, the Ministry of Social Action and National Solidarity, and the CNLPE) is waging a two-pronged campaign against circumcision by criminalising the practice but also disseminating messages about the problems these procedures are thought to cause. The actors in this campaign use strong and horrifying language and images to represent the worst possible contexts and outcomes of these procedures. They also present them as inevitably causing problems for the women and girls who undergo them, ultimately causing family and social problems. This is in spite of the fact that in practice, the nature of the procedures done, the ways in which they are changing, who undergoes them, when they are done, where they are done and the motives behind them are so varied that it is very difficult to make general statements about female circumcision in Burkina Faso. The way messages against circumcision are framed (in generalised and condemnatory terms), the fact that not all women have undergone circumcision, and because these messages have been accepted by many members of the public, has led to a revictimisation of circumcised women who are in this threshold moment. Beyond the circumcision which they underwent and which might be causing them problems, these women are cast as inevitably having physical and sexual problems, and this ends up stigmatising them and

creating psychological problems for them. These psychological problems are not adequately addressed or resolved because there are inadequate resources in the country.

This research suggests that the victimisation of circumcised women is inadvertently reinforced by doctors offering genital reconstructive surgery and other medical workers and activists who come into contact with these women. These specialists mark women socially and institutionally by putting them on registers at hospitals and clinics as circumcised women who will probably need medical intervention during childbirth or the consummation of marriage. They communicate to these women during consultation that there is something wrong with them and that they may need to seek medical attention, and, specifically, genital reconstructive surgery, to be able to function optimally. By being cast as sick people in need of medical attention, these women who were once considered mature and marriageable are stigmatised in the society as doubt is created about their ability to make good marriage partners who can successfully have sexual relations and conceive and bear children. Because of this, even when they do need medical attention, some of these women are afraid of seeking it because they are apprehensive that people in their communities will find out about it and this will lead to their being shunned by others and, more especially, by potential marriage partners. They therefore fear that they will be unable to take their rightful place in their communities as mature and married women.

The campaign against circumcision has been successful and there are signs that many people are abandoning the practice. There appears to be a near-complete uniformity of voices regarding the harms done by circumcision in activist and medical circles and even among members of the general public. However, there are indications that some people pay lip service to the official discourse but still clandestinely have their daughters circumcised. This is due to the fact that the issue of morality and chastity is so closely associated with female circumcision that many people still believe that if they do not circumcise their daughters, these girls will not be able to control their sexual urges as they grow into women. Because of this, some people are having their children circumcised when they are younger than they would ordinarily have been and because of this, and perhaps the inexperience of some who perform these procedures, some young girls now suffer much more extensive injury than their counterparts in times past. The campaign against circumcision has therefore also inadvertently led to more harm being perpetrated on some girls.

There are also a few discordant voices which criticise the manner in which the fight against circumcision is waged and mediatised. A few of my research participants view the campaign as having a very narrow focus and liken it, as Etienne proposed, to a blind declaration of “the clitoris for all” (modelled after declarations of “marriage for all” going on in other parts of the world). This conception of a single global image of femininity and the quest to have Burkinabe women fit into this model fails to take into account the fact that female circumcision has been central to the construction of identity for some women in Burkina Faso. Publicly banning and criminalising these practices does harm to these women, particularly those who live in urban areas where these new discourses are rife, but who are not able to access reconstructive surgery which has been presented as the main antidote to female circumcision.

Some circumcised women in Burkina Faso have responded to the crisis of identity created by the current representation of female circumcision, and undoubtedly to the problems they suffer in their minds and bodies as a result of circumcision, by embracing activism against circumcision and undergoing genital reconstructive surgery. These women say they undergo this surgery to regain what they lost, thereby gaining a sense of completeness. They also seek the surgery to enjoy their sexuality as other women do and to eliminate reproductive health problems, particularly those associated with childbirth. Those who have had this surgery emphasise that they have experienced a great deal of difference in the quality of their lives and have gained a lot of confidence about themselves and their abilities. They feel they have regained a greater sense of health, completeness and femininity, and are able to enjoy sexual relations and to have children without difficulties. Those awaiting the surgery also point to these ideals as some of the things they want to gain from it. They also feel it is their right to have all their body parts intact.

While I have presented opinions regarding both circumcision and genital reconstructive surgery from a wide variety of people, the voices of the women who have undergone these practices are skewed as it was mainly activists, some of whom are members of the International Raëlian Movement, who were comfortable enough to talk to me about their experiences. This is because Burkinabe society, much like many other societies, does not encourage women to openly talk about their sexuality and intimate body parts. In addition to societal taboos around sex and sexuality, ‘ordinary’ Burkinabe women who have undergone circumcision, and who have been exposed to activist campaigns

condemning the practice, feel inferior and are embarrassed or ashamed to talk about their experiences. Because of that, the views I have presented from the perspective of women who have been affected by these practices are intertwined with ideas of activism and religion which have shaped the manner in which they have responded to the circumcision of their bodies, and indeed their willingness to talk about it.

My research has uncovered a wide range of attitudes towards genital reconstruction and the women who undergo it. Most people generally assume that women who seek surgical repair for circumcision sequelae do so to regain good health, alleviate pain during sexual intercourse and prevent problems during childbirth. On the other hand, there is a variety of views regarding why some women seek clitoral reconstruction. The doctors who perform the surgery see women who seek this procedure as trying to attain a better sex life, find a sense of completeness and revolt against society. Other members of Burkinabe society also evoke some of these ideas and consider this surgery to be a positive and helpful procedure for women. They suggest that these women have their genital parts reconstructed to gain a sense of completeness, have a better sex life and feel like other 'normal', that is uncircumcised, women in their society. Some research participants think women seeking reconstruction are motivated by a sense of inferiority fed by Western ideas about what 'normal' female bodies should look like. Others, particularly members of the CNLPE, find the promotion of clitoral reconstruction, which they view as solely focused on trying to augment sexual pleasure, as detrimental to the campaign against circumcision. They suggest that the procedure is also unnecessary as women are able to experience pleasure in other ways and in other parts of their bodies aside from their genitalia. Other people I spoke with consider the procedure downright dangerous, while some find the whole concept absurd and cannot fathom why grown women, particularly those who are already married and have children, would have this surgery.

While highlighting these diverse views (garnered both from people who already knew about the surgery and from those who were hearing about it for the first time), it is fundamental to underline that the vast majority of people in Burkina Faso do not seem to know about genital reconstructive surgery and particularly clitoral reconstruction. Furthermore, it is important to emphasise that, as it is currently presented in Burkina Faso, genital reconstructive surgery tends to come across as a one-stop solution for all the reproductive health problems and sexual problems circumcised women suffer. Even

though some of the people I interviewed, particularly doctors, did point out that not all such problems are caused by circumcision, this point is often omitted when people talk about genital reconstructive surgery. Moreover, the idea that the manner in which a woman's body 'performs' after this surgery is dependent on a lot of other factors external to the surgery itself is not really addressed. This then passes on the message that without genital reconstructive surgery (which is not accessible to all women) circumcised women (who are all deemed by most people to be suffering poor health and problems with sexual expression) are doomed to live unhealthy and unfulfilled lives. In cases where women who have undergone reconstructive surgery are dissatisfied with the results, some doctors who perform this procedure put this dissatisfaction down to the women's own unrealistic expectations regarding the size of the clitoris or orgasmic experience after the surgery. Other possible problems, some of which are documented in papers published by doctors who perform these procedures in Burkina Faso and in France (Madzou et al. 2010; Foldès et al. 2012; Ouédraogo et al. 2013), are not highlighted in the information given to the general Burkinabe public, further giving the impression that the reconstructive procedure is a near-perfect reversal of circumcision procedures.

The other issue which is not emphasised in conversations about reconstructive surgery is the possible emotional or psychological upheaval women who undergo clitoral reconstruction might be faced with, seeing as they are navigating multiple systems of cultural expectations and ideas. The necessity for these women to have access to other healthcare experts such as psychotherapists to enable them have a smoother transition even as they seek to remake their bodies was mentioned by some research participants (such as the Raélians and Etienne, the psychologist), but not by the doctors who perform this surgery. (However, even when the Raélians mentioned this, their emphasis seemed to be more in the context of maximising sexual pleasure rather than finding an even keel psychologically). In view of this Pierre Foldès and his colleagues say:

Clitoral reconstruction after female genital mutilation is feasible. It can certainly improve women's pleasure and lessen their pain. It also allows mutilated women to recover their identity.... The operation must be followed by an adaptation period, and can only ever restore a potential. The extent to which this potential is realised will depend on each individual woman's life course and the many complex factors known to be related to sexuality. Reparative surgery can be a liberating experience, but many women have to strike a difficult balance between their desire for this

liberation and the ordeal of calling family values and local traditions into question (Foldès et al. 2012:140).

In the Burkinabe context, the struggle that many women might face by turning their backs on the values associated with circumcision in their societies does not seem adequately explored in discourses castigating circumcision and extolling reconstructive surgery. There is a lot more emphasis on the procedures themselves – the harms of circumcision and the benefits of reconstructive surgery – and much less emphasis on the complex socio-cultural context of the women who undergo these procedures.

The Raélians who support clitoral reconstruction in Burkina Faso emphasise the idea that after the surgery, women need to learn to use their genitalia in order to attain their maximum sexual potential. They propose offering such lessons to the people who go through their hospital, and they themselves undertake sensual and sexual activities in their day to day practice of their religion. As pointed out in the preceding chapters, even those circumcised Raëlian women who have not already had reconstructive surgery say that thanks to their mentors in the Movement, they are able to enjoy sexual relations. They therefore present clitoral reconstruction as a political statement reifying their right to physical integrity. This in turn enables them to attain maximum sexual fulfilment which is a religious act for them. This sort of experimentation does not seem to be available to non-Raëlian Burkinabe women for whom sexual expression is a highly private activity about which discussions do not take place. It is therefore difficult to determine whether or not they do anything to maximise the potential of the surgery without the intervention of psychologists, sex therapists and other experts, or whether they find the surgery as successful as do the Raëlian women who have had it.

There also seem to be simmering tensions around the practice of clitoral reconstruction affecting the CNLPE, the doctors who charge substantial amounts of money to perform it and the Raélians who promote this surgery and are seeking to offer it free of charge. As already pointed out, the CNLPE's view is that this surgery gives the impression that circumcision is reversible and therefore encourages people to continue practising it. They take a particularly dim view of the Raélians who associate clitoral reconstruction with a recovery of pleasure. Members of the CNLPE (and other research participants such as Albert, an anthropologist) think that this will feed people's fears that uncircumcised women are unable to control their sexual urges, and will lead to such people continuing to practise circumcision in a bid to ensure their daughters are chaste.

While the CNLPE staff and members of the Raëlian Movement are outspoken about their views regarding clitoral reconstruction and the people who do it, some Burkinabe doctors seem more guarded with their views. Some declare that they do not know much about the Raëlians and want no association with them. Those who specialise in clitoral reconstruction, particularly Nikiema, are insistent that they do not engage in frivolous debates such as the one about the impact of the Raëlians' activities or even that by offering clitoral reconstruction they are hindering the fight against circumcision. Yet, in unguarded moments, these doctors make utterances which make one think there is much more acrimony among these three parties than they are letting on. The publications of some doctors who undertake this surgery suggest that this procedure is accepted by one and all. For example, Madzou et al. (2011:62-63) report:

The advent of the reconstruction of the clitoris [in Burkina Faso] is seen as a weapon in the arsenal of the fight against genital mutilation. During each campaign of clitoral reconstruction and repair for the sequelae of genital mutilation, many women come, from the youngest to the oldest. This reconstruction is well accepted by the woman, her family and the society since the doctors who do it are congratulated publicly and are not stigmatised.... The Ministry of Health approves of this technique because these campaigns are carried out in a public hospital.

My research shows, however, that the attitudes of the government of Burkina Faso and the ordinary Burkinabe people regarding genital reconstructive surgery, and especially clitoral reconstruction, are not as straightforward as they are presented here by Madzou and his colleagues. Indeed, the government, through the CNLPE and the Ministry of Health, collaborates with some doctors to facilitate surgical repair for circumcision sequelae and even organises the training of doctors. However, given the CNLPE's views about clitoral reconstruction, the fact that it engages some senior doctors such as Prof Kerekou (who, with Nikiema, is renowned for clitoral reconstruction) to train other doctors in genital reconstructive surgery may be testament to a collaboration born out of necessity rather than total agreement on the need to offer clitoral reconstruction.

New developments and recommendations for further research

Much has changed in Burkina Faso since my visit in early 2013, but there are two main occurrences that are implicated in the issues that I have discussed in this thesis: the ousting of the country's president, Blaise Compaoré, and the completion of the Clitoraid hospital. On 31 October 2014, President Compaoré, under whose rule most of the campaign against circumcision has been waged, was forced by a popular and violent

uprising to relinquish his 27-year grip on power (BBC News 2014a). Protesters in Ouagadougou stormed the state broadcasting facilities, set ablaze a section of parliament, destroyed cars and properties belonging to the government and burnt or looted the homes of the president's relatives and aides. There were similar protests in Bobo-Dioulasso and in the other smaller towns of Burkina Faso. The unrest sprang from a legislative proposal to remove presidential term limits from the constitution to enable Compaoré to extend his rule (BBC News 2014a; BBC News 2014b; Taoko and Cowell 2014). Compaoré was a young army officer when he seized power in 1987, and won four disputed presidential terms after that. He was a taciturn man nicknamed Beau Blaise (Handsome Blaise) but the name did not necessarily suggest he was popular. Many Burkinabe people blamed him for the death of his predecessor, the charismatic revolutionary Thomas Sankara, who had started extensive programmes for social and economic reform and the promotion of women's rights (BBC News 2014a; BBC News 2014b; Shuffield 2006; Wilkins 1989).

Compaoré was a controversial figure who retracted most of the reforms put in place by Sankara, and he was often accused of stoking rebellions around West Africa particularly in Liberia, Sierra Leone and Ivory Coast. However, over time, he was able to transform his image internationally and was increasingly relied upon by foreign governments to mediate in conflicts in the region. He largely followed the economic orthodoxy prescribed by international financial institutions even though this did not translate to economic gains for Burkina Faso which is considered one of the least developed countries in the world (BBC News 2014a; BBC News 2014c; Wilkins 1989; Ellis 1999; Pham 2005; Adebajo 2002). With growing Islamic extremism in West Africa, particularly in Mali and Nigeria, Compaoré's regime had become more and more important to Western countries such as the United States and France and their allies. Washington has a large embassy in Burkina Faso which is an important intelligence and military planning centre (BBC News 2014c).

The ousting of Blaise Compaoré will necessarily have some impact, albeit unknown at this stage, on the campaign against circumcision, but more especially on the practice of genital reconstructive surgery in Burkina Faso. As explained in Chapter 5, the CNLPE was established with Compaoré's support and, although it is under the Ministry of Social Action and National Solidarity, it has also been under the honorary tutelage of his wife, Chantal Compaoré. Madame Compaoré has been extremely prominent in the

campaign against circumcision both in Burkina Faso and on the international scene. Some of the doctors and activists I interviewed, particularly Prof Kerekou and Leila Abdi, consulted closely with her, and Prof Kerekou and Dr Diallo worked part-time in her clinic where they performed reconstructive surgery on circumcised women. It is unclear at this stage to what extent the operations of the clinic have been disrupted with Blaise and Chantal Compaoré having fled to Ivory Coast (RFI 2014; BBC News 2014d). It is also not certain whether the interim president – Michael Kafando – or the government which will succeed him will give as much support for the campaign against circumcision and for the continued provision of subsidised rates for surgical repair for circumcision sequelae as did the Compaoré regime. Follow-up research could be done to determine the manner in which this change of government in Burkina Faso, after 27 years of consistency, will affect the campaign against female circumcision and people's access to genital reconstructive surgery. It would be worth exploring, for example, the position that the new Burkinabe government will take regarding female circumcision, the subsidising of surgical repair for circumcision sequelae and even on the issue of clitoral reconstruction which has been hitherto considered cosmetic surgery and not eligible for government subsidies.

Another significant development has been the anti-climactic completion of the Clitoraid hospital in Bobo-Dioulasso. On 2 May 2013 *lefaso.net*, a web-based Burkinabe news outlet, published a statement by Brigitte Boisselier, the president of Clitoraid and spokesperson for the International Raëlian Movement. In her article, Boisselier explained that the Clitoraid team was launching an International Clitoris Awareness Week between 6 and 12 May 2013 during which they would celebrate the clitoris and create public awareness about its importance. She invited all women to mark the week by organising events in their communities to celebrate the clitoris through educational conferences, art exhibitions, songs and dances, and hen nights during which they could share experiences and knowledge. She also mentioned that the first hospital consecrated to clitoral restoration for circumcised women would be inaugurated in Bobo-Dioulasso in October 2013. This was the same date I had been given by the Raëlian women I interviewed. That event did not take place and the next time there was a flurry of activity on the Clitoraid website was in early 2014 when announcements were posted to the effect that the long-awaited pleasure hospital would be inaugurated on 7 March 2014. The then First Lady, Chantal Compaoré, would be the guest of honour at the

opening ceremony. However, the site later reported that Madame Compaoré had pulled out of the venture but that the inauguration would take place as planned.

It subsequently emerged from media reports that the Burkinabe government had refused to grant the hospital an operating licence. Clitoraid had flown in five volunteer doctors to perform the surgery in their hospital. This team was led by Dr Marci Bowers, a Chicago-based male to female transgender surgeon internationally renowned for sex reassignment or transgender surgery, who had also learnt to perform clitoral reconstruction from Foldès. Since the Clitoraid hospital was not allowed to operate, the Raélians in Burkina Faso made alternative arrangements so that the doctors could do the surgery at the Clinique Lorentia in Bobo-Dioulasso. However, the Burkinabe government soon withdrew the operating licences of the visiting doctors by which time they had operated on 29 of the 80 women who had presented themselves from Burkina Faso, Mali, Senegal, Sierra Leone and Kenya to have surgery scheduled for 3 to 14 March 2014 (Vibe Ghana 2014; Times LIVE 2014; Lloyd-Roberts 2014; BBC Newsnight 2014).

Different reasons were advanced for the refusal of the Burkinabe government to allow the Clitoraid hospital to operate. A BBC journalist, Lloyd-Roberts (2014), cites a local Clitoraid representative in Bobo-Dioulasso, Banemanie Traore, who said that the Raélian connection was the real reason behind the government's decision not to grant the licence, and that mainstream religions feared that the women who got the surgery might become Raélians out of gratitude. Boisselier also said that the real reason for the delay in the hospital opening was the fact that the hospital was initiated by Raël, the spiritual leader of the Raélian Movement (Vibe Ghana 2014; Times LIVE 2014). Lloyd-Roberts, who went to report on the inauguration of the Clitoraid hospital, underlines the fact that the five American volunteers were not Raélians and that she saw no attempt to convert the patients. She cites Dr Bowers who said, "I came because I believe that Female Genital Mutilation is a crime against humanity and I am on a humanitarian mission. I am not a Raelian but I think it is a wonderful thing that they are doing" (Lloyd-Roberts 2014). When Lloyd-Roberts enquired about the reason for withdrawing the Americans' permission at the regional health ministry in Bobo-Dioulasso, an official told her that it was because, "The hospital administrators failed to fill out the necessary forms to allow inspections to take place before opening". However, the Minister for Health, Lene Sebego, later told a journalist from the Thomson Reuters Foundation that

“medical organisations should be focused on saving lives and not advertising their religion in an attempt to convert vulnerable people” (Lloyd-Roberts 2014a, 2014b).

The Raélians also directly accused the Catholic Church in Burkina Faso of lobbying the government to refuse to grant the hospital an operating licence and to withdraw the licences granted to the Clitoraid doctors (Vibe Ghana 2014; Times Live 2014). As evidence of the pressure brought by the Catholic Church, Boisselier cited the following declaration made against the hospital by one “Professor R. Marie Charlemagne Ouédraogo, a Knight of the French Legion of Honor and Commander of the Sovereign Military Order of Malta, a well-known branch of the Catholic Church”. According to her, Prof Ouédraogo said: “This is a big campaign of fraud organized by the sect of Rael with the complicity of certain doctors of Burkina Faso! The health ministry and the governor are beseeched to stop this poisonous campaign! Also, the complicit doctors will have to appear before the medical board very soon!” (Vibe Ghana 2014). In response to this Boisselier said:

How can a doctor who performs these surgeries himself at very high cost to his patients accuse us of a fraudulent campaign when his rates are way too high for the poor women who planned to come to the Kamkaso hospital? What is the real fraud here? Clitoraid offers free surgeries performed by competent volunteer doctors, and they follow a procedure that has been published officially by its originator, Dr. Pierre Foldes of France. It has already been performed on thousands of women (Vibe Ghana 2014).

These statements seem to be underpinned by the acrimony I referred to above regarding clitoral reconstruction and the different players implicated in its practice in Burkina Faso. This is a matter worth exploring in more detail in further research.

Given these events, it is worth finding out the new government’s position regarding the Raélians and their hospital. It would also be important to interrogate the Raélians’ response to the government’s refusal to grant them a licence (that is, to follow up what has happened since March 2014) seeing as they had been working so determinedly for over seven years to complete the hospital and make clitoral reconstruction freely available in Burkina Faso. One wonders what has become of the majestic building they put up. It would be interesting to see whether the Raélians will eventually be able to put it into use as they intended and the manner in which the people of Bobo-Dioulasso, and Burkina Faso at large, will receive this initiative.

Even beyond these developments, more research is needed to illuminate Burkinabe people's attitudes towards reconstructive surgery, and particularly clitoral reconstruction, as they increasingly learn about it. Fundamentally, more research also needs to be done into more women's experiences with reconstructive surgery and the way it affects their lives. As already pointed out, it was very difficult for me to find women, other than activists and Raélians, who were willing to talk about their experiences because of the shame and taboo surrounding these procedures in Burkina Faso. Sylvie and Dr Nikiema told me of instances where other people, particularly journalists, had tried to interview such women assuring them that they would keep their identity confidential but the women still refused for fear that people would recognise them and that it would affect their standing in the community. As I have explained in Chapters 2 and 7, perhaps if I had managed to stay in Burkina Faso for a much longer period, and painstakingly shown that I was committed to safeguarding the identity of my research participants, some of the contacts I had made might have been able to persuade women who had had this surgery to at least meet me. I might then have been able to gradually build trusting relationships with those women and perhaps they would have eventually told me their stories. Even though such an endeavour would have been (and still would be) difficult, I suggest that it would be worth making this effort in an attempt to hear the stories of other women whose identities are not as shaped by activism and religion as are those of the Raëlian women whose stories I have presented here.

This thesis has explored the tensions occurring in the transitional moment marking the abandonment of female circumcision in Burkina Faso and the embracing, by some, of reconstructive surgery. It has presented a variety of perspectives from a variety of stakeholders including circumcised women, doctors, activists and 'ordinary' Burkinabe people. It has shown how women's decisions to seek reconstructive surgery are shaped by the evolving notions womanhood and femininity and how these are interpreted by various players in Burkina Faso. This study explores genital reconstructive surgery (and the underlying socio-cultural context of female circumcision) from an anthropological perspective which tries hard to go beyond the ethnocentric framing which often accompanies the depiction of cultural practices of the 'Other'. It would be a useful resource for social, cultural and medical anthropologists, and women's studies scholars. This research would also be important for government officials, medical personnel,

psychologists and social workers who deal with people who have undergone body-altering practices, and who may be experiencing physical, psychological or sexual problems as a result of these procedures and also the manner in which these practices are portrayed.

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1. Adèle
2. Aïcha
3. Albert Sarambe
4. Amina
5. Antoinette
6. Aziza
7. Danielle
8. David
9. Dr Christophe Nikiema
10. Dr Claudine Diallo
11. Dr Louis Condeh
12. Dr Salif Hassan
13. Eliza
14. Etienne
15. Gabrielle
16. Hannah
17. Leila Abdi
18. Madame Ouattara
19. Madame Sawadogo
20. Madeleine
21. Maimouna
22. Monique
23. Nafissatou
24. Pauline
25. Prof Karim

26. Prof Pascal Kerekou

27. Samira

Field notes/field diary kept between 10 January 2013 and 20 March 2013.

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APPENDICES

APPENDIX I A

INFORMATION SHEET

Researcher's Introduction

My name is Margaret Nyarango. I am a PhD student in Social Anthropology at Massey University, New Zealand. I am conducting research in Burkina Faso to find out about the impact of reconstructive surgery on women who have undergone circumcision. This research project is in partial fulfilment of the requirements of my programme of study.

Project Description and Invitation

I would like to speak to people in Burkina Faso who have information about genital reconstructive surgery. These include women who have undergone reconstructive surgery (or those planning to), doctors who perform reconstructive surgery, members of organisations working to eradicate circumcision or to offer reconstructive surgery and other members of the Burkinabe society. My aim is to learn more about this surgery and to gather views from the Burkinabe people about genital reconstructive surgery.

I would like to invite you to participate in this study and to share with me your views about this subject.

Participant Identification and Recruitment

Your participation in this project will involve talking with me about your experience with genital reconstructive surgery and/or your opinions on this subject. I request you to participate in this study if:

- you have had reconstructive surgery and would like to share your feelings and thoughts about why you decided to have it, and how this has changed your life;
- you are planning to have reconstructive surgery and would like to share your thoughts about why you want to have it and what your expectations are;
- you are a medical doctor or health worker involved in performing reconstructive surgery;
- you are affiliated with a non-governmental (or other) organisation working to discourage the practice of circumcision;
- you are affiliated with an organisation offering genital reconstructive surgery to women who have undergone circumcision;
- you have some knowledge about reconstructive surgery (or have heard about it) and would like to share your thoughts about it;

Please note that our conversations in this project will necessarily touch on matters relating to circumcision and genital reconstructive surgery. While this conversation may sometimes be uncomfortable, I assure you that I will be sensitive to your needs and will not force you to talk about issues that you are not comfortable addressing.

Please also note that this is an academic study, and since I am a student, I am unable to offer any monetary compensation for your time. However, I will be extremely grateful for your participation in this project.

Project Procedures

Should you accept to take part in this study, I would like to conduct an interview with you which will take approximately one hour. If for some reason we are unable to finish our conversation, I will request you to accord me more time, at your convenience, so that we can finish our conversation. Please note that I would like to record the discussion on a small audio recorder to enable me to accurately recall the information that you provide.

Data Management

I will use the information collected during this project to write my doctoral thesis in my programme of study in New Zealand. Once I get information from you, I will securely transfer it to my computer and store it there for the period of my study. I am the only person who will have access to the data stored there. Once I have finished writing my thesis and completed my studies, all this data will be destroyed.

If you would like me to do so, I will send you, via email, a summary of the project findings at the end of my study or send you a link that will lead you to that summary.

During the research process, I will at all times keep your identity confidential. In writing my thesis, I will not use your real name but will assign you an assumed name, and conceal or change other details that may enable people to identify you, so that your identity is protected. In addition, I will under no circumstances talk about our discussions with other research participants.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study by 31st July 2013;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded;
- ask for the recorder to be turned off at any time during the interview.

Project Contacts

If you have any questions about this project, please contact me by email or telephone using the contact details shown below.

Margaret Nyarango
Candidate, Doctor of Philosophy in Social Anthropology
Massey University, New Zealand
Email address: Margaret.Nyarango.1@uni.massey.ac.nz
Telephone number in Burkina Faso: 66398363

My research work will be supervised by Professor Kathryn Rountree whose contact details are provided below.

Social Anthropology Programme
School of People, Environment and Planning
Massey University, New Zealand
Email address: K.E. Rountree@massey.ac.nz
Tel. No. +64 (09) 414 0800 extn 9044

Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application MUHECN 12/066. If you have any concerns about the conduct of this research, please contact Dr Ralph Bathurst, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x9570, email humanethicsnorth@massey.ac.nz.

APPENDIX I B

FICHE D'INFORMATION

Présentation de l'Enquêtrice

Je m'appelle Margaret Nyarango. Je suis étudiante en doctorat en Anthropologie Sociale à l'Université Massey, en Nouvelle-Zélande. Je mène des recherches au Burkina Faso pour en savoir plus sur l'impact de la chirurgie réparatrice sur les femmes qui ont subi l'excision. Ce projet de recherche est en exécution partielle des exigences de mon programme d'étude.

Description du Projet et Invitation

Je voudrais me renseigner auprès des Burkinabés ayant des informations relatives à la chirurgie réparatrice des organes génitaux. Il s'agit notamment des femmes qui se sont fait faire la chirurgie réparatrice (ou celles qui envisagent de s'y soumettre), des médecins qui effectuent la chirurgie réparatrice, des membres des organisations qui luttent contre la pratique de l'excision et des organisations qui financent la chirurgie réparatrice, ainsi que d'autres membres de la société burkinabé. Mon but est de me renseigner d'avantage sur ce type de chirurgie et de recueillir les opinions des Burkinabés à propos de la chirurgie réparatrice.

Je voudrais vous inviter à participer à cette étude et à partager avec moi vos opinions à ce sujet.

Identification et Recrutement des Participants

Votre participation à ce projet consistera à me parler de votre expérience avec la chirurgie réparatrice des organes génitaux et/ou vos opinions à ce sujet. Je vous prie de participer à cette étude si:

- vous vous êtes fait faire la chirurgie réparatrice et vous souhaitez partager vos sentiments et pensées avec moi concernant pourquoi vous avez décidé de vous faire faire la chirurgie réparatrice et comment cela a changé votre vie;
- vous prévoyez de vous faire faire la chirurgie réparatrice et vous souhaitez partager vos réflexions à propos de la raison pour laquelle vous voulez le faire et de ce que vous attendez de cette chirurgie;
- vous êtes médecin ou agent de santé impliqué dans l'exercice de la chirurgie réparatrice;
- vous êtes affilié à une organisation non gouvernementale (ou autre organisation) qui lutte contre l'excision;
- vous êtes affilié à une organisation qui offre gratuitement la chirurgie réparatrice aux femmes qui ont subi l'excision;
- vous avez une certaine connaissance de la chirurgie réparatrice (ou en avez entendu parler) et vous souhaitez partager vos pensées à ce sujet;

Veillez noter que nos conversations dans ce projet auront nécessairement affaire aux questions relatives à l'excision et à la chirurgie réparatrice des organes génitaux. Même si ce sujet peut parfois être gênant, je vous assure que je serai sensible à vos besoins et ne vous forcerai pas à discuter des sujets qui vous rendent mal à l'aise.

Veillez également noter que ce projet est en relation avec une étude universitaire, et comme je suis étudiante, je suis incapable de vous récompenser pour votre temps. Cependant, je vous serai extrêmement reconnaissante de votre participation à ce projet.

Procédures du Projet

Si vous acceptez de participer à cette étude, j'aimerais vous poser quelques questions pendant une entrevue qui durera environ une heure. Si pour quelque raison nous sommes incapables de terminer notre conversation, il se peut que je vous prie de m'accorder plus de temps, quand cela vous convient, afin que nous puissions terminer notre conversation. Veuillez noter que je voudrais enregistrer notre discussion sur un petit enregistreur audio pour que je puisse me rappeler avec exactitude les informations que vous me donnez.

Gestion des Données

Je vais utiliser les données recueillies au cours de ce projet dans la rédaction de ma thèse de doctorat conformément à mon programme d'étude en Nouvelle-Zélande. Dès que vous me délivrerez des renseignements, je les transférerai en toute sécurité sur mon ordinateur et les y garderai pendant la période de mon étude. C'est moi seulement qui aurai accès aux données qui y sont stockées. Une fois que j'aurai fini d'écrire ma thèse et terminé mes études, toutes ces données seront détruites.

Si vous le souhaitez, je vous enverrai, par courriel, un résumé des résultats du projet à la fin de mon étude ou je vous enverrai un lien qui vous mènera à ce résumé.

Pendant le processus des recherches, je garderai confidentielle votre identité à tout moment. En rédigeant ma thèse, je n'utiliserai pas vos vrais nom et prénom, mais je vous attribuerai un nom d'emprunt, et dissimulerai ou modifierai d'autres détails qui pourraient permettre aux autres de vous identifier, afin que votre identité soit protégée. En outre, je ne dévoilerai nos discussions en aucun cas aux autres participants au projet.

Droits des Participants

Vous n'êtes en aucun cas obligé d'accepter cette invitation. Si vous décidez d'y participer, vous avez droit à:

- refuser de répondre à toute question particulière;
- vous retirer de l'étude avant le 31 juillet 2013;
- poser des questions relative à l'étude à tout moment lors de la participation;
- fournir des informations en sachant que votre nom ne sera pas utilisé à moins que vous ne l'autorisiez à l'enquêtrice;
- avoir accès à un résumé des résultats du projet quand celui-ci est conclu;
- demander que l'enregistreur soit éteint à tout moment pendant l'entrevue.

Coordonnées Relatives au Projet

Si vous avez des questions concernant ce projet, veuillez me rejoindre par courriel ou téléphone en utilisant les coordonnées indiquées ci-dessous.

Margaret Nyarango

Candidate, Doctor of Philosophy in Social Anthropology

Massey University, New Zealand

Adresse électronique: Margaret.Nyarango.1@uni.massey.ac.nz

Numéro de téléphone au Burkina Faso: 66398363

Mon projet de recherche sera supervisé par le Professeur Kathryn Rountree dont les coordonnées sont fournies ci-dessous.

Social Anthropology Programme
School of People, Environment and Planning
Massey University, New Zealand
Adresse électronique: K.E. Rountree@massey.ac.nz
Numéro de téléphone : +64 (09) 414 0800 extn 9044

Déclaration d'Approbation du Comité

Ce projet a été examiné et approuvé par le Comité d'Éthique Humaine de l'Université Massey: Nord, numéro de demande MUHECN 12/066. Si vous avez des préoccupations au sujet de la conduite de cette recherche, veuillez contacter le Dr Ralph Bathurst, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x9570, email humanethicsnorth@massey.ac.nz.

APPENDIX II A

PARTICIPANT CONSENT FORM - INDIVIDUAL

I have read the Information Sheet and have had the details of the study explained to me.
My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being sound recorded.

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

Signature: **Date:**

Full Name – printed

APPENDIX II B

FORMULAIRE DE CONSENTEMENT DU PARTICIPANT - INDIVIDUEL

J'ai lu et compris la Fiche d'Information et on m'a expliqué les détails de l'étude. On a répondu à mes questions à mon entière satisfaction, et je comprends que je peux poser des questions supplémentaires à n'importe quel moment.

J'accepte /Je n'accepte pas que l'on enregistre l'entretien.

J'accepte de participer à cette étude selon les conditions énoncées dans la Fiche d'Information.

Signature:

Date:

.....

**Nom et Prénom –
imprimés**

.....

APPENDIX III A

CONFIDENTIALITY AGREEMENT – INTERPRETER/RESEARCH ASSISTANT

I (Full Name - printed)
agree to keep confidential all information concerning this project.

I will not retain or copy any information involving the project.

Signature:

.....

Date:

.....

APPENDIX III B

**ACCORD DE CONFIDENTIALITÉ – INTERPRÈTE/ASSISTANT DE
RECHERCHE**

Je,, (Nom et Prénom - imprimés)
m'engage de tenir confidentiel tout renseignement concernant ce projet.

Je ne retiendrai ni ne copierai aucune information impliquant le projet.

Signature: **Date:**

APPENDIX IV A

Interview schedule for Burkinabe women who have undergone circumcision and reconstructive surgery (or those intending to undergo reconstructive surgery)

Thank you for accepting to meet me and talk with me about circumcision and genital reconstructive surgery.

The information you share with me will help me understand genital reconstructive surgery and its practice in Burkina Faso. I will use this information to write my thesis, an academic document required by the university which I attend.

I will keep all your identity private and will not discuss any of the information that you give me with other research participants. In using it to write my thesis, I will use a pseudonym (unless you do not want me to do that) so that nobody can identify you as the source of that information.

This conversation will take approximately one hour. I am going to record it but if at any point you wish that I turn off the recorder, or you do not wish to respond to a question, kindly let me know.

1. I would like to know more about circumcision in Burkina Faso. Could you please tell me about what you know about it?
 - Prevalence at present – decreasing or not?
 - Link with ethnicity/religion/level of education?
 - Age when girls undergo the procedure?
 - Reason(s)
2. What do you think is the impact of circumcision on women's lives?
 - Health, social, emotional, sexual?
3. Could you please tell me about what you remember about getting 'circumcised'
 - What age?
 - What happened?
 - Any discussion with parents (or others) about it?
 - Why was it done? Link with ethnic group identity?
4. What impact did this have on your life?
5. Some people say that circumcision does not have much negative effect on women's lives; that these are ideas that have come to Africa from the West. What do you think about that?
6. How did you hear about reconstructive surgery?
 - When did you hear about it? How?
 - How widespread is it?
 - Who perform it?
 - Cost?
7. Why did you decide to have it done?/Why do you want to have it done?
8. What was the reaction of your family and friends (husband, boyfriend, parents, brothers, sisters, other relatives)?/What do you think their reaction will be?

- Did you tell them?
 - Were you apprehensive about telling them?
 - What was their reaction?
 - How did you feel/react to that?
 - Did it matter how they reacted?
 - If participant did not tell family, why?
9. What why your feelings before going for reconstructive surgery
(Or what are participant's feelings if she is planning to go for reconstructive surgery?)
- Apprehensive? Excited? Pressured?
10. Could you please talk to me about that day?
- When? How long ago?
 - What happened?
 - Any preparation beforehand? What?
 - General/local anaesthesia? Did this matter?
 - How long did it take?
 - Feelings during (or just before)?
 - Feelings afterwards?
 - Pain? How long?
11. What were/are you hoping to gain from reconstructive surgery?
- Sexual? Social? Emotional? Physical integrity?
12. What do you feel you attained from it? How has your life changed since?
- In society – perception by others?
 - Health? Sexuality?
13. Some people say that women who have not undergone circumcision or who have had their sexual organs (clitoris, labia) reconstructed are unable to control their urges and cannot be faithful to their partners. What would you say to those people?
14. What do you feel now about reconstructive surgery?
- Regret? Happy? Satisfied?
 - Recommend it to others?

Thank you very much for taking time to share this information with me. Is there anything else you think would be helpful for me to understand reconstructive surgery?

APPENDIX IV B

Plan d'entrevue pour les femmes Burkinabés qui ont subi l'excision et qui se sont subséquemment fait faire la chirurgie réparatrice (ou celles qui envisagent se faire faire la chirurgie réparatrice)

Merci d'avoir accepté de me rencontrer et de me parler de l'excision et de la chirurgie réparatrice des organes génitaux.

Les informations que vous partagez avec moi vont m'aider à comprendre ce que c'est la chirurgie réparatrice des organes génitaux et sa pratique au Burkina Faso. J'utiliserai cette information pour rédiger ma thèse, un document académique requis par l'université que je fréquente.

Je vais garder tout votre identité privée et ne discuterai aucune information que vous me donnerez avec d'autres participants de la recherche. En utilisant ces informations dans la rédaction de ma thèse, je vais utiliser un pseudonyme (à moins que vous ne le vouliez) de sorte que personne ne peut vous identifier comme étant la source de cette information.

Cette conversation va durer environ une heure. Je vais l'enregistrer mais si, à n'importe quel moment, vous voulez que j'éteigne l'enregistreur, ou si vous ne souhaitez pas répondre à une certaine question, je vous prie de me le faire savoir.

1. Je voudrais en savoir plus sur l'excision au Burkina Faso. Pourriez-vous s'il vous plaît me dire ce que vous savez à ce sujet?
 - Prévalence au présent – cela diminue ou non ?
 - Lien avec l'appartenance ethnique / religion / niveau d'éducation?
 - Âge quand les filles sont soumises à la procédure?
 - Raison(s)/Justification(s)/Explication(s)
2. D'après-vous quel sont les conséquences de l'excision sur la vie des femmes?
 - Conséquences sur le plan de la santé, plan social, affectif, sexuel?
3. Pourriez-vous s'il vous plaît me parler de ce que vous vous rappelez de votre expérience personnelle de l'excision ?
 - A quel âge?
 - Comment est-ce que cela s'est passé ?
 - Vous en avez préalablement parlé avec vos parents (ou quelqu'un d'autre) ?
 - Pourquoi a-t-on fait cela? Lien avec l'identité du groupe ethnique?
4. Quel impact est-ce que cela a eu sur votre vie?
5. Il y a des gens qui disent que l'excision a peu de conséquences nocives sur la vie des femmes, que ces idées de sa gravité viennent en Afrique de l'Ouest. Qu'est-ce que vous en pensez?
6. Comment avez-vous entendu parler de la chirurgie réparatrice?
 - Quand en avez-vous entendu parler? Comment?

- Quelle est sa prévalence au Burkina Faso ?
 - Qui l'exécute?
 - Coût?
7. Pourquoi avez-vous décidé de vous faire faire la chirurgie réparatrice ? / Pourquoi voulez-vous vous le faire faire ?
 8. Quelle était la réaction de votre famille et vos amis (mari, ami, parents, frères, sœurs, autres parents)? / Comment pensez-vous qu'ils vont réagir ?
 - Est-ce que vous le leur avez dit ?
 - Aviez-vous peur de le leur dire ? Pourquoi ?
 - Quelle a été leur réaction?
 - Comment avez-vous réagi à cela?
 - Est-ce que leur réaction vous-était importante ?
 - Si la participante n'a pas informé sa famille, pourquoi?
 9. Comment est-ce que vous vous êtes senti avant la procédure de la chirurgie réparatrice ? / Comment est-ce que vous vous sentez (Pour les participantes qui envisagent se faire faire la chirurgie réparatrice?)
 - Appréhension? Enthousiasme? Sous pression?
 10. Pourriez-vous s'il vous plaît me parler de ce qui s'est passé le jour de la chirurgie réparatrice ?
 - Quand est-ce que cela s'est passé?
 - Qu'est-ce qui est arrivé?
 - Y a-t-il eu de la préparation préalable ? Quoi/Comment ?
 - Cela s'est fait sous anesthésie générale / locale? Est-ce que cela était important ?
 - Combien de temps a-t-il fallu pour la chirurgie?
 - Sentiments pendant (ou juste avant)?
 - Sentiments après?
 - Douleur? Combien de temps est-ce que la douleur a duré?
 11. Qu'est-ce que vous espériez gagner de la chirurgie réparatrice?
 - Plan sexuel ? Social? Affectif? Intégrité physique?
 12. D'après-vous qu'est-ce que vous avez gagné dès que vous avez eu cette chirurgie réparatrice ? Comment est que votre vie a changé?
 - Dans la société - la perception des autres?
 - La santé? La sexualité?
 13. Certains gens disent que les femmes qui ne sont pas soumises à l'excision ou celles qui se sont fait réparer leurs organes sexuels (le clitoris et les lèvres) sont incapables de maîtriser leurs désirs sexuels et qu'elles ne peuvent pas être fidèles à leurs partenaires. Que diriez-vous à ces gens?
 14. Quelles sont vos sentiments maintenant à propos de la chirurgie réparatrice?
 - Regret? Heureuse? Satisfaite?
 - La recommanderiez-vous à d'autres femmes?

Merci beaucoup d'avoir pris le temps de partager cette information avec moi. Voulez-vous me dire quelque chose d'autre pour m'aider à mieux comprendre la chirurgie réparatrice ?

APPENDIX V A

Interview schedule for doctors and other health workers involved in genital/clitoral reconstructive surgery

Thank you for accepting to meet me and talk with me about circumcision and genital reconstructive surgery.

The information you share with me will help me understand genital reconstructive surgery and its practice in Burkina Faso. I will use this information to write my thesis, an academic document required by the university which I attend.

I will keep all your identity private and will not discuss any of the information that you give me with other research participants. In using it to write my thesis, I will use a pseudonym (unless you do not want me to do that) so that nobody can identify you as the source of that information.

This conversation will take approximately one hour. I am going to record this conversation but if at any point you wish that I turn off the recorder, or you do not wish to respond to a question, kindly let me know.

1. I would like to know more about circumcision in Burkina Faso. Could you please tell me about what you know about it?
 - Prevalence at present – decreasing or not?
 - Age when girls undergo the procedure?
 - Link with ethnicity/religion/level of education?
 - Reason(s)
2. What do you think is the impact of circumcision on women's lives?
 - Health, social, emotional, sexual?
3. Some people say that circumcision does not have much negative effect on women's lives; that these are ideas that have come to Africa from the West. What do you think about that?
4. How did you learn about reconstructive surgery?
 - When did you hear about it? How?
 - When did you learn to perform it?
 - How widespread is it?
 - Cost?
5. Why did you decide to start performing reconstructive surgery?
6. Could you please describe to me what the surgical procedure entails?
7. In your opinion why do women seek reconstructive surgery?
 - What are they trying to gain?
 - Expressed feelings when seeking reconstructive surgery?
 - Expectations? Unrealistic expectations?

8. What feeling do the women express afterwards (after the surgery)?
 - Satisfaction?
 - Disappointment?
9. What has been the reaction of your colleagues towards your decision?
10. Some people say that women who have not undergone circumcision or who have had their sexual organs (clitoris, labia) reconstructed are unable to control their urges and cannot be faithful to their partners. What would you say to those people?
11. Some people in organisations fighting circumcision have publicly said that you are harming the fight against circumcision (that by offering reconstructive surgery you are creating the impression that circumcision can be reversed so there is no need to stop the practice). What's your opinion about this?
12. How would you react to people who say that you are importing decadent western values into the country by emphasising women's sexuality to the detriment of local values?
13. (Specifically to Burkinabé doctors) What are your feelings about the involvement of Clitoraid/the Raélians in genital reconstructive surgery?
 - Campaign/ proselytising
 - Focus on sexuality
 - Involvement of foreign doctors & other experts such as sex therapists

Thank you very much for taking time to share this information with me. Is there anything else you think would be helpful for me to understand reconstructive surgery.

APPENDIX V B

Plan d'entrevue pour les médecins et autres agents de santé impliqués dans la chirurgie réparatrice des organes génitaux/du clitoris

Merci d'avoir accepté de me rencontrer et de me parler de l'excision et de la chirurgie réparatrice des organes génitaux.

Les informations que vous partagez avec moi vont m'aider à comprendre ce que c'est la chirurgie réparatrice des organes génitaux et sa pratique au Burkina Faso. J'utiliserai cette information pour rédiger ma thèse, un document académique requis par l'université que je fréquente.

Je vais garder tout votre identité privée et ne discuterai aucune information que vous me donnerez avec d'autres participants de la recherche. En utilisant ces informations dans la rédaction de ma thèse, je vais utiliser un pseudonyme (à moins que vous ne le vouliez) de sorte que personne ne peut vous identifier comme étant la source de cette information.

Cette conversation va durer environ une heure. Je vais l'enregistrer mais si, à n'importe quel moment, vous voulez que j'éteigne l'enregistreur, ou si vous ne souhaitez pas répondre à une certaine question, je vous prie de me le faire savoir.

1. Je voudrais en savoir plus sur l'excision au Burkina Faso. Pourriez-vous s'il vous plaît me dire ce que vous savez à ce sujet?
 - Prévalence au présent – cela diminue ou non ?
 - Lien avec l'appartenance ethnique / religion / niveau d'éducation?
 - Âge quand les filles sont soumises à la procédure?
 - Raison(s)/Justification(s)/Explication(s)
2. D'après-vous quel sont les conséquences de l'excision sur la vie des femmes?
 - Conséquences sur le plan de la santé, plan social, affectif, sexuel?
3. Il y a des gens qui disent que l'excision a peu de conséquences nocives sur la vie des femmes, que ces idées de sa gravité viennent en Afrique de l'Ouest. Qu'est-ce que vous en pensez?
4. Comment avez-vous entendu parler de la chirurgie réparatrice?
 - Quand en avez-vous entendu parler? Comment?
 - Quand avez-vous appris à l'exécuter? Où
 - Quelle est sa prévalence au Burkina Faso ?
 - Cela coûte combien ?
5. Pourquoi avez-vous décidé de commencer à pratiquer la chirurgie réparatrice ?
6. Pourriez-vous s'il vous plaît me décrire ce que cette procédure chirurgicale implique?
7. A votre avis pourquoi les femmes cherchent-elles à se faire faire la chirurgie réparatrice?
 - Qu'est-ce qu'elles cherchent à atteindre ?
 - Quels sentiments est-ce qu'elles expriment quand elles viennent parler de la chirurgie réparatrice?
 - Est-ce qu'elles expriment des attentes? Des attentes irréalistes?
8. Quels sentiments est-ce que ces femmes expriment après la chirurgie?
 - Satisfaction?

- Déception?
9. Quelle a été la réaction de vos collègues envers votre décision de faire la chirurgie réparatrice?
 10. Certains gens disent que les femmes qui ne sont pas soumises à l'excision ou celles qui se sont fait réparer leurs organes sexuels (le clitoris et les lèvres) sont incapables de maîtriser leurs désirs sexuels et qu'elles ne peuvent pas être fidèles à leurs partenaires. Que diriez-vous à ces gens?
 11. Certains gens dans les organisations qui luttent contre l'excision ont déclaré que vous nuisez à la lutte contre l'excision (qu'en offrant la chirurgie réparatrice vous créez l'impression que l'excision peut être inversée, et ainsi il n'est pas nécessaire d'arrêter la pratique). Quelle est votre opinion à ce sujet?
 12. Comment réagiriez-vous aux gens qui disent que vous importez de mauvaises valeurs de l'Occident dans le pays en mettant l'accent sur la sexualité des femmes au détriment des valeurs locales? (comme la maîtrise de soi)
 13. (Plus précisément aux médecins burkinabés) Quels sont vos sentiments envers la participation de Clitoraid / des Raéliens dans la chirurgie réparatrice des organes génitaux?
 - Campagne / prosélytisme
 - Accent sur la sexualité
 - La participation des médecins étrangers et d'autres experts tels que des sexologues

Merci beaucoup d'avoir pris le temps de partager cette information avec moi. Voulez-vous me dire quelque chose d'autre pour m'aider à mieux comprendre la chirurgie réparatrice ?

APPENDIX VI A

Interview schedule for members/staff of organisations working to eradicate female circumcision in Burkina Faso.

Thank you for accepting to meet me and talk with me about circumcision and genital reconstructive surgery.

The information you share with me will help me understand the Burkinabe people's thoughts regarding genital reconstructive surgery. I will use this information to write my thesis, an academic document, required by my university.

I will keep all your identity private and will not discuss any of the information you share with me with other participants. In using it to write my thesis, I will use a pseudonym (unless you do not want me to do that) so that nobody can identify you as the source of that information.

This conversation will take approximately one hour. I am going to record this conversation but if at any point you wish that I turn off the recorder, or you do not wish to respond to a question, kindly let me know.

1. I would like to know more about circumcision in Burkina Faso. Could you please tell me about what you know about it?
 - Prevalence at present – decreasing or not?
 - Age when girls undergo the procedure?
 - Link with ethnicity/religion/level of education?
 - Reason(s)
2. What do you think is the impact of circumcision on women's lives?
 - Health, social, emotional, sexual?
3. Some people say that circumcision does not have much negative effect on women's lives; that these are ideas that have come to Africa from the West. What do you think about that?
4. What does your organisation do (in regard to circumcision)?
 - 'Fighting' against circumcision? How/Approaches?
5. Some people suggest that it would be important/ helpful to talk about women's right to sexual integrity and satisfaction in addition to talking about the negative consequences of circumcision. What do you think about this?
6. Could you please tell me what you know about genital reconstructive surgery?
 - How did you hear about it?
 - How widespread is it?
 - Who perform it?
 - Cost?
 - How long has it been performed in Burkina Faso?
 - Involvement of the organisation you work for?
 - Government involvement? Why? Why not? (in your opinion)

7. What is the position of the organisation that you work for regarding genital reconstructive surgery?
 - Is there an official position?
 - Is this likely to change soon?
8. Why do you think women go for reconstructive surgery?
 - What kind of women?
 - Do you think more would go for it if it was free of charge or cheaper?
9. How do you personally feel about reconstructive surgery/women who seek reconstructive surgery?
 - Gains/losses for your work? Why?
10. Some people say that women who have not undergone circumcision or who have had their sexual organs (clitoris, labia) reconstructed are unable to control their sexual urges and cannot be faithful to their partners. What would you say to those people?

Thank you very much for taking time to share this information with me. Is there anything else you think would be helpful for me to understand reconstructive surgery.

APPENDIX VI B

Plan d'entrevue pour les membres/le personnel des organisations qui luttent contre l'excision au Burkina Faso

Merci d'avoir accepté de me rencontrer et de me parler de l'excision et de la chirurgie réparatrice des organes génitaux.

Les informations que vous partagez avec moi vont m'aider à comprendre ce que c'est la chirurgie réparatrice des organes génitaux et sa pratique au Burkina Faso. J'utiliserai cette information pour rédiger ma thèse, un document académique requis par l'université que je fréquente.

Je vais garder tout votre identité privée et ne discuterai aucune information que vous me donnerez avec d'autres participants de la recherche. En utilisant ces informations dans la rédaction de ma thèse, je vais utiliser un pseudonyme (à moins que vous ne le vouliez) de sorte que personne ne peut vous identifier comme étant la source de cette information.

Cette conversation va durer environ une heure. Je vais l'enregistrer mais si, à n'importe quel moment, vous voulez que j'éteigne l'enregistreur, ou si vous ne souhaitez pas répondre à une certaine question, je vous prie de me le faire savoir.

1. Je voudrais en savoir plus sur l'excision au Burkina Faso. Pourriez-vous s'il vous plaît me dire ce que vous savez à ce sujet?
 - Prévalence au présent – cela diminue ou non ?
 - Lien avec l'appartenance ethnique / religion / niveau d'éducation?
 - Âge quand les filles sont soumises à la procédure?
 - Raison(s)/Justification(s)/Explication(s)
2. D'après-vous quel sont les conséquences de l'excision sur la vie des femmes?
 - Conséquences sur le plan de la santé, plan social, affectif, sexuel?
3. Il y a des gens qui disent que l'excision a peu de conséquences nocives sur la vie des femmes, que ces idées de sa gravité viennent en Afrique de l'Ouest. Qu'est-ce que vous en pensez?
4. Quel est le travail de votre organisation (en ce qui concerne l'excision)?
 - «Lutte » contre l'excision ? Comment/Approches?
5. Certains gens suggèrent qu'il serait important/utile de parler de droits des femmes à l'intégrité physique et au plaisir sexuel en plus d'expliquer les conséquences nocives de l'excision dans votre lutte contre l'excision. Que pensez-vous à cela?
6. Pourriez-vous s'il vous plaît me dire ce que vous savez au sujet de la chirurgie réparatrice des organes génitaux?
 - Comment en avez-vous entendu parler?
 - Quelle est sa prévalence au Burkina Faso ?
 - Qui l'exécute?
 - Coût?
 - Cela se fait au Burkina Faso depuis quand ?
 - Participation de l'organisation pour laquelle vous travaillez
 - Participation du gouvernement ? Pourquoi ? Pourquoi pas (à votre avis) ?

7. Quelle est la position (l'avis) de l'organisation pour laquelle vous travaillez concernant la chirurgie réparatrice des organes génitaux?
 - Y a-t-il une position officielle/un avis officiel?
 - Est-ce que cela est susceptible de changer prochainement?
8. D'après vous, pourquoi les femmes cherchent-elles à se faire faire la chirurgie réparatrice ?
 - Quel genre de femmes?
 - Pensez-vous qu'il y aurait plus de femmes à en chercher si c'était à titre gratuit ou moins cher?
9. Que ressentez-vous personnellement envers la chirurgie réparatrice / les femmes qui se font faire la chirurgie réparatrice ?
 - Gains/pertes pour votre travail? Comment ?/Pourquoi?
10. Certains gens disent que les femmes qui ne sont pas soumises à l'excision ou celles qui se sont fait réparer leurs organes sexuels (le clitoris et les lèvres) sont incapables de maîtriser leurs désirs sexuels et qu'elles ne peuvent pas être fidèles à leurs partenaires. Que diriez-vous à ces gens?

Merci beaucoup d'avoir pris le temps de partager cette information avec moi. Voulez-vous me dire quelque chose d'autre pour m'aider à mieux comprendre la chirurgie réparatrice ?

APPENDIX VII A

Interview schedule for ‘ordinary’ members of the Burkinabé society – men and women who are not necessarily affected by circumcision or genital reconstructive surgery but are aware of both phenomena.

Thank you for accepting to meet me and talk with me about circumcision and genital reconstructive surgery.

The information you share with me will help me understand genital reconstructive surgery and its practice in Burkina Faso. I will use this information to write my thesis, an academic document required by the university which I attend.

I will keep all your identity private and will not discuss any of the information that you give me with other research participants. In using it to write my thesis, I will use a pseudonym (unless you do not want me to do that) so that nobody can identify you as the source of that information. I will send you transcripts of our conversations so that you can check their accuracy before I use the information.

This conversation will take approximately one hour. I am going to record this conversation but if at any point you wish that I turn off the recorder, or you do not wish to respond to a question, kindly let me know.

1. I would like to know more about circumcision in Burkina Faso. Could you please tell me about what you know about it?
 - Prevalence at present – decreasing or not?
 - Age when girls undergo the procedure?
 - Link with ethnicity/religion/level of education?
 - Reason(s)
2. What do you think is the impact of circumcision on women’s lives?
 - Health, social, emotional, sexual?
3. Some people say that circumcision does not have much negative effect on women’s lives; that these are ideas that have come to Africa from the West. What do you think about that?
4. (If a single man) Would you marry a woman who has undergone circumcision?
 - Why? Why not?
5. Some people suggest that it would be important/ helpful to talk about women’s right to sexual integrity and satisfaction when talking about the negative consequences of circumcision. What do you think about this?
6. How did you hear about reconstructive surgery?
 - When did you hear about it? How?
 - How widespread is it?
 - Who perform it?
 - Cost?
7. In your opinion why do women seek reconstructive surgery?
 - What are they trying to gain?

8. How do you feel about reconstructive surgery/women who seek reconstructive surgery?
9. (If a single man) Would you marry a woman who has had genital reconstructive surgery?
 - Why? Why not?
10. How would you react if one of your family members (wife [if married], daughter, sister) decided to go for genital reconstructive surgery?
11. Some people say that women who have not undergone circumcision or who have had their sexual organs (clitoris, labia) reconstructed are unable to control their urges and cannot be faithful to their partners. What would you say to those people?
12. (If they know about Clitoraid/the Raélians)What are your feelings about the involvement of Clitoraid in genital reconstructive surgery?
 - Campaign/ proselytising
 - Focus on sexuality
 - Involvement of foreign doctors & other experts such as sex therapists

Thank you very much for taking time to share this information with me. Is there anything else you think would be helpful for me to understand reconstructive surgery.

APPENDIX VII B

Plan d’entrevue pour les Burkinabés ‘ordinaires’ - des hommes et femmes qui ne sont pas nécessairement touchés par l’excision ou la chirurgie réparatrice des organes génitaux mais qui sont conscients de ces deux phénomènes

Merci d'avoir accepté de me rencontrer et de me parler de l’excision et de la chirurgie réparatrice des organes génitaux.

Les informations que vous partagez avec moi vont m'aider à comprendre ce que c'est la chirurgie réparatrice des organes génitaux et sa pratique au Burkina Faso. J'utiliserai cette information pour rédiger ma thèse, un document académique requis par l'université que je fréquente.

Je vais garder tout votre identité privée et ne discuterai aucune information que vous me donnerez avec d'autres participants de la recherche. En utilisant ces informations dans la rédaction de ma thèse, je vais utiliser un pseudonyme (à moins que vous ne le vouliez) de sorte que personne ne peut vous identifier comme étant la source de cette information.

Cette conversation va durer environ une heure. Je vais l’enregistrer mais si, à n’importe quel moment, vous voulez que j’êteigne l'enregistreur, ou si vous ne souhaitez pas répondre à une certaine question, je vous prie de me le faire savoir.

1. Je voudrais en savoir plus sur l’excision au Burkina Faso. Pourriez-vous s'il vous plaît me dire ce que vous savez à ce sujet?
 - Prévalence au présent – cela diminue ou non ?
 - Lien avec l'appartenance ethnique / religion / niveau d'éducation?
 - Âge quand les filles sont soumises à la procédure?
 - Raison(s)/Justification(s)/Explication(s)
2. D’après-vous quel sont les conséquences de l’excision sur la vie des femmes?
 - Conséquences sur le plan de la santé, plan social, affectif, sexuel?
3. Il y a des gens qui disent que l’excision a peu de conséquences nocives sur la vie des femmes, que ces idées de sa gravité viennent en Afrique de l'Ouest. Qu’est-ce que vous en pensez?
4. Certains gens disent que les femmes qui ne sont pas soumises à l’excision ou celles qui se sont fait réparer leurs organes sexuels (le clitoris et les lèvres) sont incapables de maîtriser leurs désirs sexuels et qu’elles ne peuvent pas être fidèles à leurs partenaires. Que diriez-vous à ces gens?
5. (Si homme célibataire) Épouseriez-vous une femme qui a subi l’excision ?
 - Pourquoi ? Pourquoi pas ?
6. Certains gens suggèrent qu'il serait important/utile de parler de droits des femmes à l'intégrité physique et au plaisir sexuel en plus d'expliquer les conséquences nocives de l'excision dans votre lutte contre l'excision. Que pensez-vous à cela?
7. Comment avez-vous entendu parler de la chirurgie réparatrice?

- Quand en avez-vous entendu parler? Comment?
 - Quelle est sa prévalence au Burkina Faso ?
 - Qui l'exécute?
 - Coût?
8. D'après vous, pourquoi les femmes cherchent-elles à se faire faire la chirurgie réparatrice ?
 - Qu'est-ce qu'elles cherchent à atteindre ?
 9. Que ressentez-vous personnellement envers la chirurgie réparatrice / les femmes qui se font faire la chirurgie réparatrice ?
 10. (Si homme célibataire) Épouseriez-vous une femme qui s'est fait faire la chirurgie réparatrice des organes génitaux ?
 - Pourquoi ? Pourquoi pas
 11. Comment réagiriez-vous si un membre de votre famille (femme [si marié], fille, sœur) décide de se faire faire la chirurgie réparatrice des organes génitaux ?
 12. (S'ils sont au courant du travail de Clitoraid/des Raëliens) Quels sont vos sentiments envers la participation de Clitoraid / des Raëliens dans la chirurgie réparatrice des organes génitaux?
 - Campagne / prosélytisme
 - Accent sur la sexualité
 - La participation des médecins étrangers et d'autres experts tels que des sexologues

Merci beaucoup d'avoir pris le temps de partager cette information avec moi. Voulez-vous me dire quelque chose d'autre pour m'aider à mieux comprendre la chirurgie réparatrice ?