

FEMALE GENITAL MUTILATION AMONG CANADIAN-SOMALIS

BREAKING WITH TRADITION:  
FEMALE GENITAL MUTILATION OR FEMALE CIRCUMCISION  
AMONG CANADIAN-SOMALIS IN SOUTHERN ONTARIO

By  
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## ABSTRACT

Allegations by the Canadian media that the Canadian-Somali population has been continuing its traditional practice of Female Circumcision (FC) or Female Genital Mutilation (FGM) in Canada despite its illegality was questioned in this thesis. Through qualitative interviews undertaken with fourteen members of the Somali community in Southern Ontario, it was discovered that the respondents do not believe the practice is being continued in Canada. Their views concur with those of the Ministry of Health - Canada which claims that to date, not a single case of FC/FGM being performed in Canada has been substantiated. The respondents credit their voluntary abandonment of the practice primarily to anti-FGM campaigns that were supported in the urban regions of Somalia from the 1970s until the onset of the Somali civil war in the late 1980s. A secondary deterrent is the fact that the practice is illegal in Canada. Present anti-FGM programs in Canada were deemed necessary by the respondents to reach the minority of individuals who might seek to continue the practice in Canada. Such programs, however, also serve to provide support to circumcised women living in Canada, as well as to provide education about health care in general. Non-FC/FGM related health concerns were deemed more pressing to the Canadian-Somali community, namely, lack of employment, overcrowded living conditions, and inability to access proper health care. Consequently, the respondents were critical of the Canadian media's approach to FC/FGM since the media has neglected to consider other, and in their view, more immediate health concerns faced by the Canadian-Somali community.

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## **CHAPTER ONE: Introduction**

Over the past several years, the Somali community in Canada has received popular media attention. This is due to alleged controversial decisions of some African immigrants to continue their cultural tradition of practising female ‘circumcision’ (FC) or female genital mutilation (FGM) on their daughters (Steed 1994) despite the fact that it violates Canadian law (Mosley 1992). Overwhelmingly, the media has highlighted FC as a harmful practice. Moreover, as numbers of immigrants from countries that traditionally support the practice rise in Canada,<sup>1</sup> government interest in the practice has similarly increased. Such interest has sparked the development of an interdepartmental committee, including the Ministry of Health and the Department of Justice, to examine the situation. Further, this attention has recently instigated major changes within the Canadian Ministry of Justice which, prior to 1996, felt that despite anti-FGM groups’ demands to the contrary, a specific law against FGM was unnecessary because it was currently deemed illegal under existing laws. However, as of March 26, 1997, a specific law was passed under Bill C27 that specifically defines and cites FGM as an illegal activity (Department of Justice: 1997).

What is remarkable, however, is how the voice of the Somali community is, with few exceptions, largely absent from such reports. As well, these reports do not take into account

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<sup>1</sup> Some 25,000 to 70,000 Somali refugees have immigrated to Canada over the past decade, with the majority settling in the Metropolitan Toronto region (Opoku-Dapaah 1995).



the fact that anti-FGM programs had been supported in Somalia's urban centres for over 20 years prior to its recent civil war. This raises the question as to whether or not such a portrayal by the media is truly representative of what is actually occurring within the Canadian-Somali community. Is there truly a need for these government interventions? Are Somalis still practising, or desiring to practice FC in Canada? If not, how have these men and women come to abandon a practice that traditionally contains so much cultural significance and for centuries has comprised part of Somali individual and group identity? Moreover, if the media is misrepresenting the Somali community, what key issues important to Canadian-Somalis are being ignored?

Based on open-ended interviews with members of the Somali community in southern Ontario, my thesis seeks to answer these questions. By developing an understanding of changing attitudes of recent Somali immigrants to Canada towards the practice, my aims are to determine whether or not FC/FGM will be a future issue of concern for the Canadian-Somali community. Consequently, this thesis will seek to understand both traditional and current meanings of FC to Somali immigrants in Canada; why changes, if any, have occurred; determine the Somali community's vision of the future of the practice; and present an opportunity for the respondents to voice concerns that they believe are being over-shadowed due to an arguably disproportionate amount of attention paid to FC/FGM at the expense of other health concern issues.

The thesis comprises seven chapters. The first part of the thesis will place FC/FGM in a historical context, followed by an outline of its methodology. The second part of the

thesis presents, in narrative form, the data gathered from the respondents. Next, an examination of issues of female and male Somali identity in relation to how the respondents struggled with removing FC/FGM from their culturally learned concepts of womanhood and manhood will be undertaken. Finally, the last chapters will critically examine health-related areas of concern that the respondents feel are overshadowed by or even deemed more pressing than FC/FGM and address the responsibility of the media in its portrayal of health concerns in Canada.

## **CHAPTER TWO: Background Issues**

In an effort to understand the complex issues surrounding present Canadian-Somali realities of FC/FGM in Canada, a general overview of the practice first needs to be addressed. As FC/FGM has strong historical roots and is culturally ingrained in Somalia, we will begin with a discussion of the practice's terminology and history.

### **Terminology**

Estimates claim that 98-100% of Somali women undergo FC/FGM in some form (Abdalla 1982: 12; Dorkenoo 1994: 88; Gallo & Abdisamed 1985: 311). There are three types of FC/FGM which vary in the severity of damage done to the female genitalia. The mildest form - *sunna* - consists of the removal of the clitoral prepuce only, a procedure akin to the removal of the foreskin in male circumcision (Abdalla 1982: 8). Commonly, however, the term *sunna* is also given to the second type of FC/FGM which is referred to as *clitoridectomy* or *excision* (Hailu 1994: 5). Excision involves the partial to full removal of the clitoris and part or all of the labia minora (Lightfoot-Klein 1989: 4). The third type, *infibulation*, involves the complete removal of the clitoris, labia minora and parts of the labia majora. The remnants of the labia majora are then sutured together, leaving only a tiny opening for the passage of urine and menstrual fluids (Slack 1988: 441-442). In Somalia, most female children typically undergo infibulation between the ages of four and eight (Abdalla 1982: 11). Infibulation is practised by both urban and rural Somalis. In rural areas, and among the urban poor, the procedure is usually performed by a midwife, who uses razor

blades or knives as cutting instruments without anaesthesia. The young girl is usually held down by several women, usually her close female relatives, while the midwife performs the procedure. Once the operation is complete, the girl's legs are then tied together for several days to promote healing of the infibulation scar. Shock, infection and haemorrhage are not uncommon side effects due to the lack of use of anaesthesia and antibiotics. Death has also been reported as a result of complications arising from the procedure. Only among the wealthier urban Somalis, particularly in the capital Mogadishu, is the practice performed in hospitals with sterilized equipment and painkillers (Hosken 1993:114). There, a young girl is given anaesthesia, and the doctor usually decides with the parents which type of FC will be performed on their daughter.

A further subtype of infibulation is referred to as *reinfibulation*. During childbirth, the infibulation scar is torn open. Afterwards, the woman's female relatives may insist that the midwife reinfibulate, or resuture, the vaginal opening to again give the woman the appearance of virginity. Depending on the wishes of the relatives present, the reinfibulation can be as tight or tighter than before. The woman then must repeat the healing process that she had previously undergone as a young girl. Reinfibulation may be repeated after the birth of every child. In contrast, *deinfibulation* refers to the process of surgically opening the infibulation scar in an attempt to return the vagina to a more natural state.

In discussing such sensitive terminology, semantics inevitably plays a large role. Several terms or phrases have therefore been used in the literature in reference to the practice. Depending on one's position as either an advocate for or against the procedure, or even as

a neutral observer, different terminologies are favoured. Each term carries different, and not uncommonly opposing political nuances. Deciding on which term to use in this thesis therefore became quite problematic. The controversy stems from attempts to develop a term encompassing all forms of the practice, namely between the phrases “female circumcision” and “female genital mutilation.” References to the practice as FC have been criticized by some activists against the practice as not acknowledging the extensive forms the practice can take. Unlike male circumcision that removes only the foreskin of the penis, removal of the clitoral prepuce or *summa*, is only one form of the practice, as addressed above. Such critics have therefore advocated the term “mutilation” instead, claiming that not only does it more accurately include varying forms of the practice, but that it also describes the practice for what they perceive it to be - a mutilation of women’s genitals. Use of “mutilation” therefore clearly denotes one’s position against the practice.

The term FGM, however, is not without its critics. Using “mutilation” is a clear statement of negative judgement, whereas “circumcision” is not. In effect, use of “circumcision” relates the practice to the already accepted practice of male circumcision, thus bringing the practice through semantics into a socially acceptable realm of discourse. Moreover, use of “circumcision” has been argued as being more culturally sensitive. Calling a traditional and cultural practice “mutilation” denotes a negative judgement on that tradition which transcends the practice to also judge the culture that supports it. Wally (1997) also outlines the connection between FGM and a neo- or post-colonial legacy. During colonial times in Africa, traditional customs such as “female genital operations,” as per Walley’s

terminology, were labelled as “barbaric” by colonial powers. Because such traditions were “...understood by the colonizers as both intrinsic to the character of the colonized and the embodiment of their inferiority” (Walley 1997: 426), criticisms of traditional practices served as a justification for colonial powers to dominate the followers of such practices. Critical references to the practice as “mutilation” can therefore be construed as a neo-colonial continuation of previous colonial attitudes. This point becomes even more powerful when one considers that the majority of criticisms of the practice have stemmed from the West or so-called First World.

Abandoning FGM, however, may undermine the efforts of organizations such as FORWARD International that are fuelled by African women (Walley 1997). Such women work towards the eradication of the practice and refer to it as “mutilation” as well as an “oppression” of women. Both FC and FGM, therefore, pose problems for the researcher attempting to portray a theoretically bias-free position. Moreover, when attempting to decide on a phrase for the practice, I was confronted by respondents who attempted to persuade me to use one term over the other. For example, one respondent, an anti-FGM advocate, insisted that I use the term “mutilation” because, as she expressed, “it *is* mutilation.” In contrast, some Somali respondents referred to the practice as circumcision, particularly when they expressed sentiments in support of the procedure. Other Somali respondents, when asked about the conflict in terminology, dismissed it saying “they are both the same thing” and did not consider the implications of using one term over the other.

In an effort to retain cultural sensitivity, but portray the various positions of my

respondents, both supporters and advocates against the practice, I have decided to use FGM when discussing anti-FGM advocates and their activities. Likewise, when discussing cultural realities surrounding the practice as well as its supporters, I have elected to use FC. The use of these terms will also vary depending on reference materials used when discussing and citing other sources in the thesis. The term FC/FGM will occur when either term has been used by relevant sources. However, I have also included a third “gloss” term for the practice, *gun-nin*<sup>2</sup>, which, according to the respondents, is the Somali term for circumcision.

### History

FC/FGM is presently found in over 27 countries, and is most prevalent in Northern Africa. Reports of African immigrants continuing to practice FC/FGM in their host countries have now spread worldwide, however, there are other non-African indigenous populations who support the practice *i.e.* some populations in Indonesia and Pakistan. In another example, indigenous peoples in Brazil, Peru and Columbia have also been reported to practice clitoridectomy. However, prevalence rates of the practice, particularly infibulation, are most concentrated in the Horn of Africa including Sudan, Somalia, Eritrea and parts of Ethiopia (Dorkenoo 1994: viii-x).

The origins of FC/FGM are unclear. Some authors believe that infibulation was originally practised in Egypt and spread across the Horn to other regions. For example, there is evidence that some Egyptian mummies were infibulated. Consequently, infibulation is also

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<sup>2</sup> Although Talle (1993) spells this Somali terms as *gudniin*, because my respondents who used the term spelled it as *gun-nin*, I elected to honour their choice of spelling.

referred to as “pharaonic circumcision” because of its believed connection to Pharaonic Egyptian culture. The milder form, *sunna*, may have a different origin. References to *sunna* as a religious ordinance for women appear in the Muslim *hadith* scriptures, or “the sayings of the Prophet”(Hansen 1972: 19). However, *sunna* is only an optional requirement and originally involved simply the removal of the clitoral prepuce, a procedure akin to the practice of male circumcision. Presently in Somalia, however, practitioners and laypeople may use the term *sunna* to describe any form of FC that is not infibulation.

Why infibulation began to be adopted by North African Muslim cultures instead of *sunna* to fulfill the optional Islamic requirement, which later became interpreted as an ordinance, is a mystery. One argument is that infibulation spread with the slave trade as a means to prevent pregnancy among slaves (Mackie 1996: 1003). Nevertheless, at some point, infibulation seems to have been adopted by the general populace in Sudan and Somalia in lieu of *sunna* and came to be popularly considered an Islamic commandment. Since infibulation is seen in regions where Black African and Arab cultures meet in Northern Africa (Dorkenoo 1994: 33), it is likely that some African traditions began to merge with the incoming Islamic practices and eventually there was a blurring of cultural lines. Infibulation was probably assimilated as a form of *sunna* and eventually it became the dominant form of FC practised in North Africa. Nevertheless, even if another explanation for the marriage between infibulation and Islam exists, as Islam spread through the region, infibulation began to spread with it. In Somalia, records of infibulation are mentioned in historical accounts of Somali culture by foreigners (Hosken 1993: 114) such as Dos Santos’ observations in Mogadishu



in 1609. He noted that the practice was performed on Somali women, and particularly on slaves which increased their value (Mackie 1996: 1003).

Regional differences exist in terms of the extent of the procedure performed. The Northern Somalis who are primarily nomadic, practice infibulation almost exclusively. In the Southern coastal regions, where the majority of Somalia's cities and farming communities lie, mixed forms of the practice are supported. *Sunna* is believed to be practised more frequently in urban areas. Arguments for why this regional difference occurs has been credited to education. The majority of Somalia's schools are in the south where more people have access to higher learning. Studies have shown that as education levels increase, the severity of the type of FC performed decreases (Gallo & Absidamed 1985). Moreover, Somalia's cities have provided the locus for anti-FC or FGM movements. Since the majority of Somali cities lie in the South, more southerners would have had exposure to anti-FC ideas and therefore would have been more likely than northerners to adopt the milder forms of the practice. As well, some urban people have reportedly abandoned the practice altogether. However, the majority of Somalis continue to support the practice and, despite some urban movement towards less severe forms, most Somalis continue to support the more extreme form, infibulation.

#### Cultural Motivations and Consequences of the Practice

It is important to realize that Somalis highly value their children (Hezekiah 1995: 1) and do not subject them to FC out of any sense of maliciousness. On the contrary, FC is supported by Somalis because of all the perceived benefits that the procedure culturally

offers<sup>3</sup>. For example, Somali boys and girls undergo genital modification of some form in order to be accepted into adult society. Both men and women must be circumcised in order to marry. Non-circumcised women are not eligible for marriage because without infibulation there is no method of telling, according to Somali belief, whether or not the woman is a virgin. For Somali women, infibulation is a rite of passage that socially turns female children into potential and respectable marriage partners. Infibulation is also necessary to protect the woman's family honour (Ntiri 1992: 223) in that without it, she is thought of as no better than a prostitute and her family is socially condemned for not raising a 'proper' daughter. Consequently, infibulation:

...is seen as having a positive function with respect to other components of the patriarchal Somali familial practices (such as marriage, the modesty code, family honour, women's social roles and life patterns, and the patrilineage) which are fundamental in Somali society (Abdalla 1982: 41).

In particular, FC has shaped the way in which Somali women are traditionally viewed by society because, for the Somalis: "...one's identity as a woman is so strongly linked to the changes in the external genitalia caused by this operation, [therefore] it is difficult for the woman to imagine that it might not be a necessary part of womanhood" (Dirie & Lindmark 1991: 584).

Moreover, the association of FC/FGM with Islam is widespread in Somalia despite the fact that the practice is not mentioned as a religious requirement in any Islamic text (Dirie

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<sup>3</sup> See chapter five for a more in-depth analysis of the cultural motivations for the practice.

& Lindmark 1991: 584). Nevertheless, it has been associated with Islam because of two main factors: first, the word *sunna* refers to an Islamic requirement that unquestionably must be performed. Because the non-infibulation types of FC are commonly called *sunna*, Muslim Somalis believe that FC is a religious necessity and are unaware that it is not practised by all Muslims (El Dareer 1982: 71). Second, Mohammed is reported to have said: “Circumcision is an ordinance in men and an embellishment in women.” He also is recorded to have spoken to a woman who performed FC on young girls. He apparently told her: “Do not go deep. It is more illuminating to the face and more enjoyable to the husband” (El Dareer 1982: 72). These passages have been interpreted by Muslim FC supporters to mean that the Prophet supported the milder forms of FC and therefore was in favour of the practice.

Somalis also support FC on a religious basis because it is believed to promote Islamic norms and Koranic ethics, especially in relation to women’s behaviour. Such ideology creates expectations for Somali women to remain virgins before marriage, be faithful afterwards, exemplify purity and modesty values, not divorce, accept polygamy, and ensure the legitimacy of their husband’s children. Women’s behaviour and expectations are further shaped in Somalia by the Koranic based *Shari’a* laws that the Islamic faithful follow (Abdalla 1982: 30). FC is believed to support these Islamic expectations of women because it controls women’s sexual behaviour by reducing their sexual drive (Ntiri 1993: 215). Consequently, FC ensures that there will be no question regarding the paternity of the husband’s offspring.

Some studies of supporters of FC in Somalia have also found that the practice is believed to be ‘good for the man’ because men’s “sexual sensations seemingly are increased

by the artificially contracted genital organs of the woman” during intercourse due to her infibulation scar (Abdalla 1982: 50). A related argument put forward by Somalis in support of FC is that the infibulated genital region is viewed as more visually appealing, as well as “cleaner.” As one Somali woman reported to Boddy (1994):

That part of a Somali woman is covered and it looks better. I have brothers, cousins, and friends who have dated European women, or women who have a clitoris, and they say we have the best one - they say it's smaller, hard, it's clean and it's less wet. I know myself we smell better and are less dirty than women who are uncircumcised (Boddy 1994: 280).

Moreover, in Somalia the natural female “protuberances are viewed as ugly, the unchaste accoutrements of prostitutes” (Gregory 1994: 52).

Despite such perceived benefits that FC/FGM offers to supporters of the practice, it has been internationally condemned by such agencies as the World Health Organization (WHO), the United Nations Commission on Human Rights (UNCHR), and various non-government organizations (NGOs) due to the documented negative physical, mental, social, psychological and sexual complications that it causes (Slack 1988: 451; Gordon 1991: 5; Dorkenoo 1994). Opponents have argued that the practice is a form of female oppression (Walker & Parmar 1993) as well as a violation of human rights (Dorkenoo 1994).

Health problems, particularly with infibulation, range from short-term complications such as haemorrhage, sepsis (the ‘poisoning’ of the bloodstream by absorbed pathogenic microorganisms), septicaemia (a disease caused by the presence of toxins in the blood), and tetanus (Black & Debelles 1995: 1590); to long-term complications which can include keloid formation, cysts, recurrent urinary tract infections, dyspareunia (painful or difficult

intercourse), recurrent vaginitis (inflammation of the vagina), chronic pelvic infection, infertility, prolonged labour which may lead to infant/maternal mortality; and difficulty in gynaecological examinations, due to the artificially small vaginal opening. This makes the detection and treatment of gynaecological problems difficult or nearly impossible (Baker et al. 1993: 1617).

FGM also directly causes psychological problems including sexual dysfunction. Not only can the infibulated woman become permanently sexually disabled by the removal of her clitoris, but she may also undergo pain during intercourse due to the inflexibility of her infibulation scar, resulting in “anxiety, depression and frustration” (Mackie 1996: 1003). Gordon’s (1991) studies comparing circumcised verses uncircumcised women’s sexual satisfaction found higher percentages of circumcised women incapable of reaching orgasm, or of having decreased sexual experience. However, the debate as to whether or not excised or infibulated women are capable of fully experiencing orgasm continues. Although female orgasms:

...originate in the clitoris, it is very difficult to correlate female circumcision with a lack of orgasm or sexual gratification. This is because there is great difficulty in obtaining accurate research data on the sexual experiences of circumcised women as the majority of them are reluctant to speak on the subject (Hailu 1994: 27).

Psychological fear of pain during intercourse may cause the woman to suffer from *vaginismus*, the tightening of the vagina. This can be caused by post-traumatic stress from previous sexual interactions and can make penetration impossible (Dorkenoo 1994: 24). Due to the tiny vaginal opening of an infibulated woman, initial penetration by the husband may

take weeks before the opening becomes large enough to permit intercourse. During this process, the infibulation scar is torn open and the husband must continue to have intercourse with his wife while the wound heals in order to prevent the opening from resealing. Sometimes the scar is impenetrable and the husband must hire a midwife to open the scar for him with a knife, or the husband uses the knife himself. According to a respondent, in Southern Somalia, usually the husband opens the scar on his own and a midwife is only summoned if necessary and in great secret. The ability to open one's wife using only the penis is considered to be a rite of manhood in Somali culture. However, in the Northern regions, more Somalis are taking the opportunity to have their wives opened in the hospital, although secrecy is still maintained. After the birth of a child, the vaginal opening is often reinfibulated and the process of intercourse must begin again. Consequently, Somali women may fear intercourse and can be psychologically traumatized by it.

FC/FGM can also place women at risk of contracting AIDS or other diseases transmitted through blood. As groups of girls are sometimes infibulated at the same time, the operator and infected girls can pass infected blood to each other because the operator may use the same unsterilized knife on all the girls in the group (Walker & Parmar 1993: 297-298).

#### FC/FGM Eradication Programs in Somalia

After independence was gained in 1960 and prior to its recent civil war, Somali culture was in the process of transition. Urban cities began to develop and urbanized groups experienced rapid changes due to western influences. Rural groups, however, distant from the influences of the city, more strictly adhered to cultural traditions. Religious leaders were

divided on the change - some believed change was necessary while others believed that their customs were being destroyed. Supporters of traditional customs, such as infibulation, considered modernization and western influences threatening to Muslim order and authority (Abdalla 1982: 41). On the other hand, supporters of change 'modernized' infibulation by finding medical practitioners to perform it in hospitals (Hosken 1993: 116). As a result of such influences, some Somalis altered their views on FC. Although the practice is still supported by the majority of Somalis, as awareness of the consequences of the practice grew, less severe forms of the practice seem to have become a trend among the innovators, educated and urban elite, despite the pressure some may feel from older female family members to support infibulation (Somali Women's Health Group 1991: 15-16).

In Somalia, as in other countries where FC is of concern, the first supporters of anti-FGM movements were the women's organizations (Dirie & Lindmark: 1991: 37). Official anti-FGM programs began in 1977 through the efforts of the Somali Women's Democratic Organization (SWDO). After obtaining government permission to publicly speak out against infibulation, a representative of SWDO presented her arguments against FGM to an open forum. She was well received and this marked the beginning of a government supported anti-FGM movement in Somalia. The government developed an official policy of only "pricking the clitoris to release a drop of blood" as a ritual instead of full infibulation. A health education campaign ensued and called for FGM to be banned from all hospitals. The campaign "...centered on proving that there was no rational reason for mutilation - that it was not healthy, not clean, not Islamic and that it did not even guarantee virginity" (Dorkenoo

1994: 118). However, no law was passed which prohibited hospitals and other health service offices from performing FGM. The procedure, therefore, could still "...be performed by health personnel on public health service premises" (Dirie & Lindmark 1991: 584). This was confirmed in 1978 when the ambassador of Somalia to the UN reported that infibulation was still being performed in government hospitals (Hosken 1993: 117).

In 1979, the World Health Organization held a seminar on FGM in Khartoum, the capital of Sudan. During the seminar, two representatives of SWDO outlined steps viewed as a necessary complement to anti-FGM government legislation in order for it to be effective:

1. Any law must be supported by a day-to-day action campaign, throughout the country, in order to inform women and men of medical facts and encourage them to re-examine their attitude.
2. Religious leaders should speak out publicly against infibulation.
3. Discussion groups should be organized among women, workers and young people.
4. Statistical information on irrefutable data gathered by doctors should be collected.
5. The mass media should be widely used to inform the population so that the idea of change can be accepted and a new relationship between the sexes established (Dorkenoo 1994: 119).

These recommendations called for positive community-based action. Nevertheless, despite these recommendations, the government did not implement any anti-FGM legislation. Moreover, hospitals continued to perform the procedure except for Benadir Hospital in Mogadishu whose director was a strong anti-FGM activist. One of my key informants, a pediatrician who practised in Somalia, noted that Benadir was a pediatric hospital. It was the only children's hospital in Mogadishu that served both the urban region and surrounding rural areas as well. In her opinion, this hospital was easier for the government to control in regards to FGM because it was the only one of its kind in the area.



Despite efforts made in Benadir Hospital, there was a general lack of government and hospital commitment against FGM during the 1970s to early 1980s. One theory explains the deficiency during this time as the result of a health report sponsored by the US Agency for International Development (US/AID) in 1979. As part of the process of providing developmental assistance to Somalia, the US/AID funded a health expert team to report on the state of Somali health. It reported high maternal and infant mortality but did not, however, cite infibulation as a health problem. This omission is believed to have caused the Somali government to continue supporting FGM "...since all other adverse health conditions were specifically cited in the US project papers except genital mutilations" (Hosken 1993: 117, 119-120). After receiving criticism from an anti-FGM group, a follow-up report on FGM was conducted by US/AID which finally acknowledged health problems caused by the practice. It noted:

A commission composed of the Ministers of Health, Education and Religion and the Somali Women Democratic Organization (SWDO) is studying the issues. The position of the SWDO is that passing a law against the custom is premature at the moment. They feel that a massive educational campaign against the practice is required before a law will be accepted and confirm already changed attitudes...(US/AID/Somali in Hosken 1993: 121).

By this time, plans for education programs for the mass public, developed by SWDO, were underway. Efforts by SWDO apparently had some effect because by the late seventies, there is evidence that some urban Somalis in Mogadishu were beginning to abandon the procedure. Moreover, a support organization was developed which offered support to parents opposed to FGM and their children. The group brought their daughters in contact

with other girls who were not circumcised and taught them how to respond to teasing by other children (Hosken 1993: 123).

By the early 1980's, a center was established by the Swedish agency 'SAREC' in the Somalia Academy of Arts and Sciences to "conduct studies on the health, psychological and social aspects of FGM" (Dorkenoo 1994: 119). In 1987, the Italian Association for Women and Development (AIDoS) collaborated with SWDO. They jointly founded a project with the following objectives: "To launch and implement a campaign to eradicate infibulation" and: "To strengthen and support SWDO structures in conducting the above campaign" (Dorkenoo 1994: 119). AIDoS provided technical support while SWDO was solely responsible for the content of the program. The project produced five information packages "which included audio-visuals for women, young people, religious leaders, medical and paramedical personnel, in the Somali language" (Dorkenoo 1994: 120). By the end of 1987, these materials were used in workshops to train individuals to teach others in the Somali community as part of their "Information Campaign to Eradicate Infibulation" (Hosken 1993: 124). Seminars for women were then organized, as well as a national poetry contest on FGM. By 1989, the government power of the time - the Somali Revolutionary Party - supported an international conference held in Mogadishu entitled "Female Circumcision: Strategies to Bring about Change" (Dorkenoo 1994: 120). By 1988, much of the SWDO/AIDoS program "was being integrated into various existing programs by different ministries and especially by all schools and information programs," with plans to eradicate infibulation from Somalia by the year 2,000 (Hosken 1993: 125). A strong base for the eradication of FGM had been established.

Beginning in 1988, however, the Somali civil war, fuelled by an escalating power struggle between clans, started in the North. Coupled with a severe drought that resulted in mass starvation, law and order deteriorated (Hosken 1993: 126). By 1991, the Somali Revolutionary Party was overthrown and the country was enveloped in civil war, ripped apart by inter-clan warfare. Government institutions were destroyed, including the base establishments of the government supported anti-FGM programs (Dorkenoo 1994: 120). Presently, attempts to implement organized anti-FGM efforts are nearly impossible. Until the civil war ends, the only productive anti-FGM programs will be those attempting to eradicate the procedure among immigrant or refugee Somalis outside of Somalia.

#### FC/FGM in Western Countries including Canada

As immigrants from countries which practice FC/FGM immigrate to Western countries, a second generation of "...black girls are growing up in a Western environment where the definition of womanhood is not linked to mutilation of the erogenous zones of the female sexual organs" (Dorkenoo 1994: 124). Moreover, some authors claim that FC/FGM continues to be performed in Western countries despite its illegality (Calder et al. 1993: 232) as some immigrant parents in countries such as France and England have been found to continue the practice in their new country. As well, media reports often claim that the "problem" of FC/FGM in western countries among certain immigrant populations is likely more prevalent than is realized.

The response of western countries to the realization, or suggestion, that some of its immigrants may continue to support FC/FGM has been varied. Despite the various

organizations and publications that point out the harmful consequences of the procedure, because the practice is culturally motivated, many western legislators and social services have not always been in agreement as to how to address the issue. Nevertheless, FGM in western countries usually falls under laws of child abuse (Dorkenoo 1994: 125) and are consequently punishable by law, even if a specific law against the practice does not exist. It is difficult to determine the extent of FC/FGM in western countries since:

Systematic studies on the incidence of FGM in Western countries have not been conducted. Such studies are very difficult as the communities which are likely to practise FGM are marginalized and closed. Also, there are scattered individuals who could live in any part of the country. The practice of FGM within communities which practise it is often a closely guarded secret (ibid: 127).

Although in-depth studies outlining the extent of FC in western countries has yet to be compiled, evidence that some immigrants are continuing to support the practice has been discovered in some western countries, including France, Britain and the United States. Recently, a young Togolese woman sought political asylum in the US “in an effort to escape a forced clitoridectomy and a forced marriage” (Walley 1997: 405). Similarly, a Nigerian woman sought “cultural asylum” for both herself and her two daughters in order to escape being circumcised (Gregory 1994: 52). Burstyn’s (1995) article indicates that some immigrants are continuing their cultural tradition in the United States either by secretly circumcising them in the States or by sending their children back to their country of origin (Burstyn 1995: 30). In France, over a dozen cases of FGM has been brought to court and at least one parent has been jailed for circumising her daughters (Simmons 1993). Such

reports have been documented there since 1979 (Winter 1994: 944). Dorkenoo (1994) similarly reports at least four babies who have died as a result of being circumcised in France after immigration, and in the United Kingdom, reports of social workers discovering cases of suspected circumcision after immigration also exist (Dorkenoo 1994: 128).

Due to international condemnation of the practice, western countries with immigrants from concerned communities have leaned towards condemnation of the practice, if not outright legislation. Because the practice is culturally sanctioned by some immigrant communities, however, confusion has often emerged on the part of the western legislators in deciding whether or not the practice should be allowed despite the fact that it is usually recognized as a form of abuse. The confusion stems from debates over whether or not a culturally sanctioned practice can be defined as abuse from western standards. Moreover, because the practice is usually not specifically cited as a criminal offense in legislation, this can translate into non-action on the part of law enforcers. For example, in the majority of the United States, young girls have limited legal protection from the practice. This is not only due to the fact that it is “difficult to uncover” but also:

...because, absent a *specific* law against the practice, courts are unsure how to punish it. One effort at prosecuting a woman in Georgia who cut off her niece’s clitoris failed in part because of the legal confusion surrounding the problem (Burstyn 1995: 33, emphasis mine).

Other countries, in contrast, were quicker to legislate against the practice and formally recognize it as abuse. Such a stance became evident in France during the early 1990s when “African immigrant parents and a circumciser were charged with child abuse and assault for

“African immigrant parents and a circumciser were charged with child abuse and assault for performing clitoridectomies” (Walley 1997: 405). In the United Kingdom, FORWARD (Foundation for Women’s Health Research and Development) International has long worked on promoting both awareness and prevention of the issue. For example, in 1992, it “organized the First Study Conference on Genital Mutilation of Girls in Europe and the Western World” (Dorkenoo 1994: 128). Such efforts against FGM in the United Kingdom, coupled with court cases questioning the legality of the procedure, culminated with the *“Prohibition of Female Circumcision Act 1985*, that specifically makes the practice of FGM an offense” (Ferguson & Ellis 1995: 25). Similar awareness initiatives and public interest exist in the United States. Although there is no research indicating the extent of the practice in the US, efforts have been made to legislate against the practice. Minnesota made all forms of the practice illegal in 1994, unless deemed necessary for health reasons by a licensed physician. Similar proposed legislation in New York State in 1994 and 1995 has been put before the New York Assembly and Senate (ibid: 27).

In Canada, prior to 1997, the Criminal Code did not specifically contain a reference to FGM as a criminal offense because the Minister of Justice felt that FGM would fall under existing sections of the criminal code, including: “assault causing bodily harm (s.267), unlawfully causing bodily harm (s.269), and aggravated assault (s.268)” (Rock 1994: 1). Moreover, “Parents could be charged as parties to the offense under section 21” (ibid). However, as a result of many years of work by anti-FGM lobbyists in Canada who argued that leaving a specific reference to FGM out of current legislation would not deter supporters

of the practice, a law specifically outlining FGM as a criminal offense has been included in the Canadian criminal code as of May 26, 1997 with the passing of Bill C-27. According to a press release by the Department of Justice (1997), “this amendment will serve as a useful tool in our efforts to clarify that the practice is illegal and to educate Canadians regarding the health risks associated with this practice” (Department of Health 1997).

Despite Canada’s anti-FGM laws, however, no concrete evidence exists of the practice being performed by concerned communities in Canada. Moreover, there are no confirmed cases of parents taking their daughters out of the country to have the procedure performed (Ferguson & Ellis 1995: 29). Nonetheless, considerable interest in the practice remains. For example, as concern with the *possibility* of the practice being performed in Canada grew, physicians were faced with decisions regarding how to respond to parents requests to circumcise their daughters, or to re-infibulate after childbirth. As a result, Ontario physicians were advised in 1992 that the performance of FC, excision and/or infibulation “by a physician licensed in Ontario would be regarded as professional misconduct” (Member’s Dialogue 1993: 15). Interestingly, it is now the position of the Canadian Ministry of Health that all forms of circumcision are no longer officially advocated by the government, including male circumcision which until recently was a routine operation in Canada. Although the government does not outlaw male circumcision, its present stance indicates that the government no longer supports the practice. Male circumcision must now be asked and paid for directly by the parents, whereas previously it was automatically performed and financially covered under government health care [personal communication, Ministry of Health Canada].

The government has also developed the *Federal Interdepartmental Working Group on Female Genital Mutilation* as a response to growing concern regarding the issue in Canada. The purpose of this group, “chaired by Health Canada, with representatives from the Department of Justice, Canadian Heritage, Citizenship and Immigration Canada, Status of Women Canada, and Human Resources Development Canada” (Ferguson & Ellis 1995: 29), is to address the issue of FGM in Canada and devise ways of ensuring that FGM is not being practised here. For example, this working group sponsored a study of FGM involving consultations with members of concerned communities that were held in Ottawa and Montreal in 1995 (Hussein & Shermarke 1995: vii). These consultations found that the practice is believed to be dying out as the majority of members of concerned communities are aware it is not accepted in Canada. Nevertheless, the consultations addressed FGM related issues within the community as well as proposed suggestions regarding how culturally sensitive anti-FGM efforts might proceed (ibid: viii-ix).

Hussein & Shermarke (1995) also summarize government-supported efforts made in Ottawa regarding FGM. These include, among others, the founding of the *Horn of Africa Resource and Research Group* in 1991 who, at the time of the article, had focused on improving access to resources in the Somali community, particularly in regards to FGM. In 1992, the *Ontario Women's Directorate* funded several discussions with groups of Somali women regarding FGM in Ottawa and Carleton.<sup>4</sup> Primarily since 1991, anti-FGM Canadian

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<sup>4</sup> See Hussein & Shermarke 1995: 4-6 for a more complete listing of government sponsored FGM-related activities.



government policies have increased, as well as the funding of various FGM related efforts.

The media response to the growing awareness of the practice in Canada has been varied. Articles encompassing the issue of FGM in Canada have ranged from acknowledging the possibility that the practice is occurring here (Conseil du Statut de la Femme 1995), identifying women and young girls at risk of the procedure, providing information to health care providers about culturally sensitive care of patients who have undergone FGM, to general information about the issue. Hussein & Shermarke (1995) list fifteen Canadian newspapers and magazines which have published articles on FGM, noting that the coverage of the topic in Canada has centered primarily around four main periods since 1991:

(1) in 1991 when the College of Physicians and Surgeons of Ontario prepared to release its policy statement regarding FGM; (2) in March 1994 with the release of recommendations by the Canadian Advisory Council on the Status of Women calling on all levels of government and health/legal professionals to take action against FGM...; (3) in July 1994 when Canada granted Khadra Hassan Farah and her children refugee status after they fled the ritual practice in their native Somalia; and (4) during the United Nations Population Conference in Cairo [1995]... (Hussein & Shermarke 1995: 36).

Several articles allege that the practice is being performed in Canada and seek to make health care professionals, social workers, educators and others aware of potential “warning signs” indicating young girls and women “at risk.” For example, one article outlining “warning signs” that professionals need to be able to identify in order to be aware of potential risk individuals for FGM, cites the following:

- \* they come across a girl/woman who has undergone FGM
- \* they become aware that a girl goes on holidays for between 6 weeks to 6 months and shows behavioural changes on return
- \* they become aware that girls are frequently away from school with bladder

or severe menstrual problems

- \* they hear reference to “circumcision” in conversation, for example, a girl may request help from an adult or teacher

- \* in the case of midwives, nurses or doctors, they will see that the girl/woman they are treating has undergone FGM

- \* health professionals involved in childbirth may be asked to reinfibulate

- \* delivering a woman who has undergone FGM may trigger off concern for the baby if she is female

- \* the family comes from a community which is known to practise FGM (Hedley & Dorkenoo 1992, in Omer-Hashi & Entwistle 1995: 142).

Other articles allege that the practice is being continued in Canada in secret, *i.e.* Steed’s (1994) article which is titled “Mission to stop female genital mutilation: Health workers fear girls could die because of practices done in secret” (Steed 1994).

Further articles, as found in western countries other than Canada, seek on a general level to build awareness of the need for culturally sensitive care for individuals who have undergone the practice and seek to familiarize health care professionals “with the practice and its ramifications for their patients” (Toubia 1994: 712). For example, one study by Calder et al. (1993) surveyed women in Somalia in order to determine which health care facilities or methods in Canada would be more accepted by circumcised Somali women in order that Canadian “health care providers can offer more comprehensive and culturally sensitive care” (Calder et al. 1993: 227). Several articles have also been written by a former Somali midwife and nurse now working against the practice in Canada. In these articles, she seeks to educate health care professionals about culturally sensitive care, particularly of Somali patients, highlighting issues surrounding infibulated patients (*i.e.* Omer-Hashi 1993, 1994). Similarly, Pellizzari (1994) in her discussion of the need of health care professionals to be aware of the

challenges of treating a culturally diverse population, addressed a case where one of her patients, a Somali woman who had been de-infibulated after childbirth, needed counselling and special care (Pellizzari 1994).

### Conclusions

In Somalia, individuals are socialized to accept FC/FGM as a necessary rite of passage, from which stems many social and psychological benefits. Nevertheless, growing awareness of the negative consequences of FC/FGM led to the development of anti-FGM programs. Centered in urban regions of Somalia, before the war, these programs arguably have had some impact on the Somali population. For example, these programs assisted in shaping the views of some educated urban Somalis, and appeared to be increasing in scope until the Somali civil war decimated the country's infrastructure. As a result, many Somali immigrants to Canada may have been exposed to anti-FGM ideas before arrival, particularly if they were former urban dwellers and were educated. As Canadian legislation concurs with current international condemnation of FC/FGM, those who would continue to defend their practice are faced with a harsh environment in Canada whose government has made FC/FGM illegal and whose media overwhelmingly portrays the practice negatively.

### **CHAPTER THREE: Methodology**

Several methodological issues emerged during the development of the thesis. Because of the sensitive nature of the subject, finding Canadian-Somalis willing to be interviewed was a difficult task. During the interviews, two groups of respondents were contacted. The first group comprised Canadian-Somalis and the second professionals who, although not Somali, were familiar with the issue of FC/FGM and Somalis in Canada. Somali respondents were contacted initially in Hamilton, Ontario, through contacts with social service groups who referred me to Somalis active in the Hamilton-Somali community. Eventually, one telephone conversation led me to Dr. Saida Ahmed, who became both my key informant and later, a good friend. A former pediatrician and anti-FGM activist from Somalia, Saida was a knowledgeable and supportive colleague. Through Saida, I was able to gain introductions to other Somalis in Hamilton, Kitchener and Toronto. Contacts with respondents from the Ottawa area were initially made through a non-Somali respondent working for the Ministry of Health. Individuals in both Somali and non-Somali groups were reached by word of mouth and through mutual acquaintances. A commitment from a potential respondent to participate in the study depended on a combination of his or her availability and/or interest in discussing FC/FGM. Several Somali contacts declined to be interviewed but were able to put me in contact with other Somalis who were interested in my thesis. Several non-Somalis I wished to interview either did not respond to my initial inquires or were unavailable at time

of the interview. Ultimately, however, thirteen female and one male Somalis, as well as two non-Somalis, were formally interviewed. Several more informal contacts were made, but not included in this study as formal interviews were not undertaken, or permission to use information gleaned from the interview was not confirmed.

In terms of the methodology employed during data collection, the use of questionnaires was initially rejected as being too impersonal and unlikely to generate complete and/or sufficiently detailed responses. However, a further reconsideration of the approach culminated in an experimentation with questionnaires. Failure of the experiment proved that my initial assertion that questionnaires would not be a useful approach was correct. A Somali respondent well-connected with her community offered to distribute a questionnaire to colleagues in order to assist in the data generation of the thesis, but no questionnaires were returned. An attempted follow-up to ascertain the reasons why the targeted respondents did not participate in the survey was unanswered.

Ultimately, the open-ended semi-structured qualitative interview method was chosen as the data collection method. This allowed for a more personal approach to the topic. In preparation for the interview, respondents were free to choose a location most comfortable for them. The Somali respondents invariably chose to be interviewed either in their homes, a community center through which they were affiliated or a quiet, public location such as the local public library. Non-Somalis were either interviewed at their place of employment, or over the telephone. All interviews were conducted by myself, with Saida interjecting as the need arose when she was present during interviews with Somali respondents.

Because many respondents were initially reluctant to speak about their personal experiences with the practice, the interview questions were divided into three areas. The first area related to general questions regarding the practice in Somalia. This allowed the respondents to speak about the practice in a non-personal manner and would hopefully encourage them to relax and not feel threatened by my questions. The second section asked the respondents to comment on changes in attitudes towards FC/FGM in Somalia, particularly during the late 1970s and early 1980s when the effects of anti-FGM programs in Somalia's urban centres apparently began to be felt. The third section of the interviews asked the respondents about how they perceived the practice in Canada today, and particularly queried as to whether or not they were aware of the practice being performed in Canada. This third section was placed last primarily because of legal implications. If, for example, the respondents knew of someone who was performing the practice in Canada, they would be divulging potentially incriminating evidence against their friends, family and/or colleagues. Therefore, to put the most sensitive issues last was an attempt to allow the respondents time during the interview to develop trust and confidence in the interviewer in order that they might provide more complete answers to the third section of the interview questions.

The respondents were informed before the interview that they were allowed to make their responses as personal or impersonal as they wished, that their identities would remain anonymous, and that they were free to withdraw from the study at any time. Moreover, the respondents who had difficulty with English were interviewed with Saida acting as interpreter. As well, respondents who felt more at ease being interviewed as part of a group were

accommodated. Because the respondents were given complete control as to how they wished to answer any question (or not answer if they chose), many respondents ultimately volunteered personal narrative experiences.

Data recording methods varied during the interviews depending on the respondent. Respondents were asked to give permission to be tape-recorded, with the understanding that no one but myself would have access to the tapes. One group of respondents agreed to be recorded under the condition that the tapes were destroyed once the thesis was written which I readily complied with. The respondents were also allowed to shut off the tape at any time, or erase any part of the interview they did not wish to be used in the study. Respondents who were uncomfortable with being tape-recorded alternatively allowed me to take hand-written notes during the interviews. One non-Somali respondent was interviewed over the phone which I recorded using hand-notes. In order to distinguish tape-recorded data from handwritten and subsequently paraphrased data, in the thesis direct quotes will be written in italics. In contrast, interview discussions recreated in the text from notes will be written in normal text.

#### **CHAPTER FOUR: The Respondents and Their Voices**

Respondents included both Somalis and non-Somalis, therefore, general descriptions overviewing the characteristics of the respondents are based on divisions of them into either of these two categories. In order to preserve the anonymity of the Somali respondents, non-identifying information regarding age, education and types of circumcisions are tabled to provide an overall description of the group. As not all Somali respondents volunteered personal information, tables include an “unknown” category in order to distinguish between the respondents who provided personal information from those who did not. In the age tabulations, when ages were not made known, approximate age for some respondents is postulated based on other information provided (*e.g.* age at time of first birth cross-referenced with known age of oldest child). In the narrative section following the respondent description section, individual Somali respondents are each assigned an identifying “letter,” *e.g.* respondent A, B, C, *etc.* The exception are references to Saida, my key informant, as she gave permission for her name to be used. References to each letter/respondent pair will remain consistent throughout the thesis.

The second group of respondents was comprised of two non-Somalis familiar with the issue of FC or FGM among Canadian-Somalis. Both respondents were interviewed with the condition that their identities remain anonymous, therefore, a brief but non-identifying description of these respondents will be provided.



### *Canadian-Somali Respondents*

The first group comprised fourteen Canadian-Somalis, thirteen women and one man, who are recent immigrants to Canada. The majority are middle aged women between the ages of 30 and 50.

**Table 1 - Respondent's Ages**

	26 - 35	36 - 45	46 - 55
Female (age known)	1	1	1
Female (age approximate)	1	9	-
Male (age approximate)	-	1	-

Most respondents had one child and at least five of the respondents had daughters. Several were single parents. This was largely a result of forced separation due to the Somali war. When fleeing Somalia, many husbands, wives and children were separated. Consequently, several respondents had immigrated alone or with one or two of their children, but without their husbands.

Most of the respondents can be assumed to have lived in Canada for less than six years. Not all respondents directly volunteered this personal information, but in some cases I have been able to approximate the length of time they have lived in Canada based on other factors, *e.g.* knowing how long and when they have attended ESL classes or other schooling since immigration. All respondents also reported having left Somalia because of the war which began in 1989 - 1990. It can be assumed that the respondents left Somalia no earlier than 1990, and most would have taken at least a year before immigrating to Canada.

Therefore, the respondents earliest entry into Canada would be 1991 or later.

Nearly all of the respondents reported attendance and/or completion of high school in Somalia. Several had also attended post-secondary institutions or completed graduate or professional school. Some had completed their education in European countries such as Italy or Britain. One completed her accounting degree in Saudi Arabia. My lone male respondent completed high school in Somalia, but decided to open a business instead of pursuing post-secondary studies. However, in Canada he has since returned to school since he is considered unqualified by professional employers and cannot find employment. Moreover, at least five of the respondents are presently pursuing post-secondary studies or are enrolled in recertification programs.

**Table 2 - Education Levels Prior to Immigration**

<b>Level</b>	<b>MALE</b>	<b>FEMALE</b>
< Secondary School	-	1
Completed Secondary School	1	1
Completed University/Professional	-	9
Unknown	-	2

In terms of employment and/or work experience, this sample of respondents contained a number of individuals with professional designations. Several were in the medical field, *e.g.* one was an obstetrician, another a pediatrician and a third a nurse. Others were in the education field, and yet another was an accountant. Most of the women who spoke about their work experience reported continuing to work after marriage while in Somalia.

All of the respondents underwent some form of circumcision. The single male respondent was circumcised when he was a child as required by Islamic tradition in Somalia. From our discussion, Somali male circumcision seems akin to the practice of male circumcision in western culture where the foreskin of the penis is removed, leaving the glans of the penis exposed. Among female respondents, the type of circumcisions performed varied. The percentages of Somali women that traditionally underwent infibulation began to change only in the 1970s. Therefore, since the majority of respondents were older than age 30, one can assume that all or nearly all of the women have undergone circumcision in some form, with the majority having undergone infibulation.

**Table 3 - Type of Circumcisions**

<b>TYPE</b>	<b>FEMALE</b>	<b>MALE</b>
“sunna” including partial clitoridectomy/partial labia minora removal	3	N/A
infibulation	6	N/A
male circumcision	N/A	1
unknown	4	N/A

Among the five respondents with known female daughters, two did not have any type of circumcision performed on their daughters. The remaining three had their daughters undergo *sunna*. However, upon further discussion, it became clear that for them *sunna* encompassed both partial clitoridectomy to the removal of the labia minora. One respondent had only a tiny portion of the clitoris removed from their daughters; another had approximately one-third to one-half of their daughters’ clitoris removed, and the third had a

partial clitoridectomy and removal of the labia minora but no suturing of the labia majora. All of these daughters in question are presently between the ages of approximately age eight and 22. None of their daughters' circumcisions were performed in Canada. Of these five respondents, all presently regret having had their daughters circumcised and would reverse their decision. I only met one respondent who continues to support the practice. Although she presently has only sons, if she does have a daughter, she would want her to be circumcised. The remaining respondents, although they often acknowledged that the practice contained positive attributes, believed that the practice should be abandoned, or modified to only "true" *sunna*.<sup>5</sup>

#### *Non-Somali Respondents*

The two non-Somali respondents are Caucasian, middle to late aged women who have had contact with the Somali community regarding issues of FGM. Both are advocates against the practice and have worked in varying ways towards the eradication of the practice among immigrants of concerned communities in Canada, including Somalis. Both had worked on or through government projects aimed at building awareness of FGM in Canada as well as anti-FGM education and eradication. One was principally involved in a national study on FGM in Canada and works through the Ministry of Health - Women's Health Bureau in Ottawa. As outsiders, their input was valuable for several reasons. First, as Caucasian women, they

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<sup>5</sup> Although *sunna* has come to be popularly associated with a variety of circumcision forms, religious scholars have argued that the original Islamic form of *sunna* was to remove the clitoral prepuce only, and/or to prick the clitoris to symbolically release a drop of blood.

were able to provide me with insights about how my interests and research in the practice would be received by the Somali community based on their experiences. They were also able to provide me with information about FGM in Canada that I would not otherwise have been able to access. They also educated me about government supported anti-FGM projects as well as the history of the evolution of government interest in the issue.

I have decided, however, not to summarize the interview findings with the non-Somali respondents for two reasons. First, these interviews are not representative of non-Somalis involved with FGM as a group. Moreover, these respondents served more as resource persons either for my experiences as a non-Somali outsider, or as information providers *e.g.* in terms of laws regarding FC in Canada.

First, however, it must be addressed that the respondents in this study may not be representative of the Canadian-Somali population and as a consequence, their views of the prevalence of FC/FGM in Canada may not adequately represent what is actually occurring in the Canadian-Somali community. Should one assume that the Canadian government has simply not yet been made aware of secret cases of circumcisions in Canada, if the respondents are not representative of their community, this study may not be accurate in its findings that, according to the respondents, FC/FGM generally seem to have been abandoned by Canadian-Somalis. For example, the respondents in this study appear biased in this sense because nearly all of them had abandoned FC/FGM before immigration to Canada and consequently might not be closely acquainted with anyone who would admit to performing FC/FGM in secret. A large majority of the respondents were also highly educated, as well as were urban dwellers

in Somalia - other factors predisposing them against the practice. A colleague suggested that perhaps the respondents were sincere in their assertions that they did not know of anyone who practised FC in Canada, but were themselves not able to speak for the community because perhaps others in the Canadian-Somali community that supported the practice hid it from those who did not in order to avoid risking being reported to authorities.

I agree that the respondents are certainly not representative of all Somalis. However, my respondents may be more representative of the *Canadian*-Somali community if it is true that more educated and former urban dwellers from Somalia have immigrated to Canada than previously rural dwellers. Specific research in this area would have to be undertaken in order to attempt to substantiate this claim. Nevertheless, these respondents, although predisposed to abandoning the practice because of their former education and exposure to anti-FGM ideas in Somalia, in another way were ideal to ask about the prevalence of the practice among Canadian-Somalis. The reason for this is that at least half of the respondents were involved in anti-FGM education in Canada and have personally spoken with hundreds of Canadian-Somalis about the issue. Since these respondents have worked within the community on this issue, they are in an advantaged position to know more about the present ideals and vision Canadian-Somalis hold for FC/FGM than perhaps others would have been. Moreover, because the opinions of these community involved respondents was substantiated by nearly all the other respondents who were not involved in such community affairs, the views of the respondents in general are certainly part of a much larger voice than the fourteen I had originally interviewed. Therefore, the respondents' views cannot be so easily dismissed, even

if one were to argue that the Canadian government cannot substantiate the respondents' claims.

*How did gun-nin originate in Somalia?*

The respondents believed that the practice of *gun-nin* has been part of Somali culture for centuries, but they were unsure as to how the practice originally came to be accepted by Somalis. Of those that postulated an answer, it was believed that the practice had spread into Somalia from Egypt through Arab traders:

*D: I do know that historically it originated with the Arab traders to Somalia. It's definitely been brought in from Egypt and Arab traders that used to come into Somali centuries and centuries ago. And that's how also the name pharaonic circumcision which is the one that is predominant in Somalia, that used to be predominant in Somalia, has come around.*

*I: You mean infibulation?*

*T: Nobody really has a clue of how it originated. We believe that it came to Somalia through the Arabian traders as [D] mentioned. How it came to the Arabian Arabs is unknown to us.*

Another respondent expanded on why Somalis adopted the practice from Arab traders:

*A: It came to Egypt, this whole thing came to us from there, from the Arab side. And of the Arabs, all of them, believe in the religion anyway. We thought, a kind of competition between clans and people at the time, kind of a - my daughter has not been so easy for the man to have sex with my daughter, it took him three, four weeks to break it.*

According to this respondent, infibulation was adopted because it provided a method of measuring status between clans since the tightness of a woman's infibulation was a symbol of the morality of her family. The tighter the daughter's infibulation, the more difficult it would be for her husband to "open" her. Easy access would imply the strength of the groom's lineage, whereas difficult access would imply the virtue of the bride's. None of the

other respondents, however, alluded to this reason for the adoption of infibulation.

*Sunna*, in contrast, was considered a requirement of Islam by all the respondents. Although the majority of the respondents have learned *sunna* is only popularly believed to be part of Islam and is not commanded by the Koran or related Islamic texts, they noted that the majority of Somalis do not know this. Therefore, most Somalis identify *sunna* with Islam, although it is not clear whether *sunna* came with the original proselytizers of Islam, or was adopted and later attributed to Islam.

#### *Types of FGM found in Somalia*

The respondents differentiated between only two types of *gun-nin* that are practised in Somalia: infibulation and *sunna*. One respondent's comparison of infibulation to *sunna* was typical of the descriptions provided by the group:

*I: What are the main differences between the types?*

*D: Infibulation is basically when the two sides of the labia majora are stitched together, no matter how much cutting has been done. It doesn't matter, but it's the stitching. I understand the infibulation by the stitching of the labia. The sunna type is very less drastic. There isn't much cutting done, or even when it is done to very small cutting, it is only the pricking of the clitoris, it is not even any cutting in some cases. The excision is not popular in Somalia.*

Sometimes, however, descriptions of *sunna* seemed to be descriptions of what the FC/FGM literature has termed excision. For example, I spoke with individuals who claimed to have undergone *sunna*, but their description of their *gun-nin* was more akin to descriptions of excision, *i.e.* partial to full removal of the clitoris and parts or all of the labia minora. In these cases, excision was not conceived of as a separate type on its own, but was included as a form



of *sunna*. One woman claimed that she had the *sunna* type because her “large folds” were not cut. Her inner labia, however, had undergone some modification and part of her clitoris was excised. Although she identified her *gun-nin* to be *sunna*, the procedure she underwent is typically referred to as excision in the FGM/FC literature.

Infibulation was found to be common in the cities, but because of the anti-circumcision movements in the urban areas since the 1970s, nearly all respondents noted an urban trend leaning towards less intensive forms of the practice. Only one respondent was not aware of any such movements when she lived in Somalia, even though she was from Mogadishu. The respondents also alluded to differences in the practice according to region. Despite the fact that most Somalis favour infibulation, the respondents noted a general difference in practice between the northern and southern regions. The northern nomadic peoples are seen as almost exclusively supporting infibulation, however, the respondents noted that traditionally, some southern coastal peoples have practised less intensive forms of the procedure. For example, Saida recalls these coastal people to be non-nomadic and therefore were less apt to adopt nomadic practices such as infibulation. She also believes they were more familiar with religion and consequently knew that *gun-nin* was not a religious commandment. Furthermore, she believes that these people were urban dwellers who lived with other immigrants who settled on the coast, causing the peoples of this region to experience a “melting pot” of cultures. Such interaction with others allowed for integration of foreign ideas, including an openness towards different methods of *gun-nin*.

The association of less intensive forms of the practice with urban peoples was

common among the respondents. Whether one underwent infibulation or not, however, depended on the residency of the practitioner. Regardless of where you lived, if your practitioner was an urban dweller, the odds of s/he supporting *sunna* were greater than if your practitioner was from a rural area. For example, one respondent reported that her family was educated and lived in the city, but when the time came for her eldest sister's infibulation, they paid for a traditional circumciser from the country to come to their home and perform infibulation. Nevertheless, the respondents expressed the belief that "city people" were more likely to be educated about the arguments against the practice because of exposure to anti-FC arguments and therefore more likely to favour less severe forms than the rural dwellers. For example, in one of the small focus groups I held, a woman commented:

*D: ...In larger cities, people from different parts of the country live, where - this is my own opinion, I could be wrong - so there are a mixture of many different groups of people in bigger towns, where in smaller rural areas, the same communities have lived for a long time, so there's more...the smaller the community knows each other, so change ways takes longer in rural areas. Because there is no outside influence, there's no people coming from other corners of the country and moving in that rural area, but where are some bigger towns, people are coming from all over the country. So your neighbours will be from who knows where, and they might have other ideas so people with different backgrounds are coming together and that's what created the change in the bigger towns and cities.*

Even when infibulation is practised in the city, usually the methodology employed is different from that used in the country. "M" and "A", a married couple I interviewed, noted the following differences between rural and urban infibulations:

*I: Would it [infibulation] be as severe in the hospital?*

*A: It should have been less, because in the hospitals they have a practitioner, or someone qualified, they do that.*

*M: Sterilized these things, or something anaesthesia they use.*

*A: [In rural areas] Here is a piece of knife...*

*M: Without anaesthesia...*

*A: Razor blade is normally what they use. Razor blades.*

*M: And they make egg.*

*A: Other things, they do a lot of other things after to try and ease the pain. This is something they believe, and egg is one thing.*

*I: They put the egg on top of the circumcision?*

*M: Yes, egg and...*

*A: Usually they cover the whole bloody area with egg and they sit with it and they have to tie the legs like that...for several weeks like that in order for this to be completely sealed.*

*I: Who cleans the girl?*

*M: Nobody cleans, they just use the hot water. I remember I had to do something like that.*

*I: You saw this happen to somebody?*

*M: Yes, because my aunt, they did this.*

In another example, one respondent, an anti-FGM activist who was infibulated in a Somali city as a child, commented on the differences between her infibulation and that of her cousin whose infibulation was performed in a rural area:

*S: I interviewed almost 100 women last year and what we found out is the people in the rural, the procedure is very hard and so different than the people in the city, because for me I remember, I don't remember but my mom told me for me it took 15 to 20 minutes in the hospital, but in the rural area it takes maybe 2 hours, 3 hours because they don't have the medicine to stitch, they do all the herbal, homeopathic medicine to stop the bleeding and many people die. I remember one of my relatives died for that complication when she was 11 years old.*

*I: How did your family explain her death to you?*

*S: Someone explained to me because when my cousin was very sick, they took her in the hospital and they found out, they found out that, not her vagina, but her bleeding, because...her, how do you say? Period flow was not flowing, for almost a year. And it built up, built it, built it, until it caused infection. And she did, she died from infection.*

In contrast, "S" did not recall any serious complications with her hospital operation.

Somalia is also home to a small, anomalous community who do not practice any form of *gun-nin*. Different from urban dwellers exposed to anti-FC arguments, or from coastal peoples who often modify their practice of *gun-nin*, this non-practising community never adopted the practice in the first place. This group of Somalis, however, seems to have paid a price for their lack of adoption of *gun-nin*. A respondent recalled such people to be isolated from the rest of Somali culture as they “kept to themselves” and were not supposed to intermarry with other Somalis:

*K: Usually those people who doesn't perform, they are a distinct society, I mean, another community.*

*I: So they wouldn't marry into your community?*

*K: No, they used to marry to the community, and they usually used to marry, I don't know how to say...for example, two sisters, their children, I mean if I had a boy and [my sister] had a girl, they used to get married. How do they call that?*

*I: Oh, cousins.*

*K: Yes, between cousins.*

*I: So what would happen if one of them wanted to marry outside?*

*K: They, it happens, but you will be, I mean, you are not a part of that community if you do that.*

K's recollection of this non-practising community shows the importance of *gun-nin* in Somali society. This community was traditionally a minority in Somalia who were separated socially because of their decision not to practice *gun-nin*.

### *Generational differences*

Variations in the type of circumcision performed were reported between generations. Usually, respondents who spoke about their own circumcision recalled their mothers and older female relatives having undergone a more intensive form of the procedure than they had.

This was probably due to the fact that the majority of respondents were from a major city and would have been born in the 1960s. This was during the period when the value of infibulation began to be questioned. Therefore, the chances of their parents supporting a milder form of the practice were greater. Even when the respondent herself was infibulated, references were made to how much “worse” it had been for her mother. The main reason accounting for this difference was that the mother was infibulated “in the bush” away from hospitals and without anaesthesia. Respondents also felt that the practitioners of traditional “bush” circumcisions cut more flesh away than did doctors or practitioners in hospitals. For example, during one interview, a respondent commented about the differences between her mother’s and her own circumcision:<sup>6</sup>

*I: You didn't suffer this?*

*M: No, didn't suffer it.*

*I: But your mother did?*

*M: My mother did. My mother is a nurse at that time, she knows what is bad and what is wrong, and also my father was doctor, my mother, and he was manager of big hospital in Mogadishu...And I wasn't suffer because our family was civilized, and my mother said 'I was suffered, but I don't want to suffer my daughters.' She was suffered, they did in like disaster things, she was suffering a lot. But I wasn't suffering, seven days they did with anaesthesia, I don't know what they did the doctor, but I wasn't suffered at all, no.*

Several respondents also spoke of conflict in terms of which procedure was to be

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<sup>6</sup> Note that prior to this narrative section, the respondent herself spontaneously referred to female circumcision as something one “suffers.” My use of the term “suffer” in this narrative segment was because of the respondent’s choice of wording, not due to my leading her into thinking that FC is a “sufferance.”

performed. Often one parent would want *sunna* and the other would insist on infibulation. For example, K was infibulated as a child. Because she recalled dissention between her father and mother on the issue, when it came time to circumcise her own daughters years later, she was unsure which form to choose:

*K: ...I remember, because there was a conflict between my father and my mother, when I was six or eight or something, because my mother wanted that I be performed in the old system and my father said no. That's why when my children grew, I wasn't even sure what to do, and my husband, I remember my older daughter was circumcised while I was away...my husband with my mother, they did this in the hospital and they performed the sunna.*

*I: So they made the decision for you?*

*K: Yes.*

Another respondent, R, recalled similar dissention between her parents in terms of what type of *gun-nin* she should have.

When R was younger, she remembered wanting to be circumcised. She was nine years old at the time and it was during summer vacation when circumcisions were usually performed. Her father, however, was trying to delay the operation and every year until then had kept saying to her mother "wait until next year - they are young." R felt that he was probably against the practice, however, R wanted to be circumcised and "cried to have it." She felt different from the other children and was teased by them for not being circumcised. One time, a young girl neighbour told R that her clitoris was long and growing because it was not cut off. Her parents finally had her infibulated in a hospital by a doctor where they used anaesthesia and antibiotics to avoid infection.

Even if the parents were in agreement about whether or not they wanted their daughter to be "circumcised" and what type should be performed, often the parents wishes would be ignored. For example, T recalled a situation with her cousin:

Her cousin did not want to have her baby daughter infibulated and told her family so. The grandmother was unhappy about this, and one day when her

cousin went to work for three or four hours, the grandmother called a midwife and had the baby infibulated, even though the baby was only six months old. T recalled they left an opening so tiny that it was only the size of a grain of maize, significantly smaller than the size of Canadian corn. The hole was too small to pass urine and the cousin had to get a doctor to get the hole enlarged. Although T's cousin was angry, she felt there was nothing she could do about it anymore and, as a result, never expressed her anger to her mother because she felt she could not talk to her mother in such a way. In Somalia, according to T, people learn to obey their parents, even when they are wrong, and do not express themselves when they do not agree with their parents' decisions or actions.

Some of the respondents also recalled having arguments with their parents over the circumcision of their younger siblings. As these respondents learned about the function of their sexual organs, especially if they were enrolled in a medical program or had attended university in Europe, they began to question the practice and outwardly confront their mothers. R remembered such a situation:

Her younger sister was eight years old and was being prepared to be circumcised. R told her mother that there was no reason to do this to her sister. R was in her late teens or early twenties and had just returned on holiday from studying abroad in Italy. Her mother was eventually persuaded, but because R's grandmother was alive and tradition in general was strong, the grandmother pressured R's mother into having R's sister infibulated anyway. R's mother then sent the sister away to a great-aunt's house where she would be infibulated without R knowing about it. Afterwards, when R discovered what had happened, she was upset but she did not confront her mother because at that point, there was nothing that could be done.

One couple who had their daughters circumcised before immigration to Canada also experienced conflict over which type of FC their daughters should undergo. In their case, however, although pressure to perform *gun-nin* on their daughters came from a sister on the husband's side of the family, they related the cause of their conflict as stemming from

expectations of society:

*A: Her mother did not want circumcision. With our family, our mother and father, the father I don't know what he said, but the mother didn't want circumcision. She was also from the medical field, she was...*

*M: Nursing.*

*A: Working in the ministry of health for a long time. So she knew more of that, and she saw the pain like that, so we had no pressure from that.*

*M: And also my sister...*

*A: We had more pressure from society, especially my side my sister was there and she was one of them. And once she knew, we let her know, it would have been bad, it would have been hard for us to let her know they weren't circumcised, the word goes around and that would be something like the girls would not be able to live in that kind of society.*

*I: Couldn't you have lied?*

*M: We lied already.*

*A: We have lied already, yes, because of the way we circumcised them.*

*M: Yes, we have secret, my husband and I, we said don't tell other people and we have to say...*

*A: We spoke to the man, the doctor, privately.*

*I: Did you have to pay him extra?*

*A: We gave him money, yes. Well, normally they don't tell anyway, they spoil their own business.*

Since A and M wanted their daughters to be able to be accepted into Somali society and eligible to marry Somali men, they had *sunna* performed on their girls. They chose the least intensive form where their daughters' clitorises were only slightly nicked. Despite having fulfilled their ritual obligation, however, they still felt pressure that *sunna* would not be considered "good enough" by others. Therefore, they felt obliged to lie to their friends and family and claim that the girls underwent a more intensive form. This was despite both of their upbringing in families that questioned the necessity of the practice, particularly in light of the medical complications M's family had seen as medical workers.



*What are the positive motivations for gun-nin?*

Tradition was cited almost universally by the respondents as one of the leading motivations of the practice. Because nearly every Somali woman has been infibulated, or at least had *sunna*, most Somali girls look forward to having the practice done. This desire was heightened by the teasing of other children, particularly by older ones who had already undergone *gun-nin*. Even when some of the respondents reported fear of the operation, most of them did not think that there was any alternative. Several respondents reported begging their parents to let them have the operation. It was only much later, after they were educated about the negative consequences of the practice, did they come to regret their circumcision. One respondent, however, remembers crying because she was not circumcised:

*M: My mother said when we were nine years old said 'you leave it, you leave it,' but my old friends did this thing and I was crying all the night. 'I have to do this thing,' I said. I wanted to do, I like this, because all the people they were proud of them who did this, it's our culture. And I say my grandmother, I was living with my grandmother, my mother was working in another province and my grandfather was the manger, director general in the hospital, and he applied the circum- this thing....I said I have to do this thing, I want it, I cry.*

*I: So you were eight years old and you wanted..*

*M: Ya! I did.*

Other respondents cited psychological motivations of *gun-nin*. They contrasted growing up in a culture that supports the practice to psychological problems one would face growing up with *gun-nin* in a country such as Canada that condemns it:

*I: Do you think there is a psychological cost of the practice?*

*T: I don't think there are any psychological effects on the negative side because it is an acceptable practice. That's the tradition. There's nothing bad about it. In the community sense, I mean, it is something that is looked*

*forward to, it's something that's for the benefit of the child, so nobody looks at it negatively in that way, in psychological point of view. So, I have never seen any psychological effects it has created.*

*D: I agree completely with what [T] said. Because the practice is done in a way that is acceptable for the communities that practice it. It's something that's not done in secret, that people are not ashamed of, so it doesn't have negative aspects for them. So people accept it from early on that they are going to do it. For example, the early generations who had the procedure done in Somalia come here at the ages of 10 or 8 would grow up in a community that completely, sort of, are terrified even at the mention of it. That can have negative side effects, and we've come across here, a number of years ago when Somalis started coming to Canada, they were sort of in the papers, I'd never seen that but it was before I came I think, it was all over the papers that circumcision, and young teenaged girls were really terrified by people calling them names in school and you know how schools, how cruel children can be, and schools and terrible and teenage years are always a difficult stage... I heard that they were really very troublesome for young women going to school, especially in the Toronto areas where there is a big community, a Somali community. But apart from that, I can imagine how that affects their...*

*T: Their image.*

*D: Image, and their well being because they want to fit in so bad, and because people call them names. You know, it's just as bad as calling people ugly names whether they are fair or not.*

According to the respondents, *gun-nin* was one of the most important events one could go through in order to 'fit in' with Somali society. Girls that were not *gun-nin* ran the risk of being called names, but also were feared to have unmanageable sexual drives. This fear was epitomized in the "myth", as some respondents termed it, that an uncut clitoris would grow as long as a penis:

*I: Were there any health reasons that were given in support of the practice that you were aware of?*

*D: Not in Somalia, not as far as I know. Except that some people think that the clitoris is going to be larger if they don't circumcise the girls. That has been...*

*T: That the clitoris would get enlarged and grow, so it would be uncontrolled*

*after awhile. Some mothers would say 'oh, I don't circumcise my kids but how am I going to manage? How is she going to manage a clitoris that is going to grow?*

Infibulation or *sunna* was also deemed necessary because it was believed that men would never be able to satisfy a woman whose clitoris was uncut. It was thought that such women would be uncontrollable, unsatiable, and consequently, unfaithful. When I asked a Somali couple what uncircumcised women were thought of in Somalia, I received the following response:

*A: ...there is also a belief, whether it is true or not, I don't know, but if the girl is not circumcised, she is going to be so sexual, that nobody can stop her. She will be sexually more overactive. For sure she will commit adultery.*

*M: They believe it, I don't.*

*A: I don't know whether it is true or not!...The desire in the woman for sexual contact in women who is circumcised, compared to women who are uncircumcised, there is a degree of difference as far as they are telling us. I cannot prove this, this can only be proven by the ladies themselves, the ladies that have not been circumcised, but they say there is no desire what so...and in fact the Somalis themselves - I'm just going to be frank with you. Somalis who have had contact with European ladies have been telling me the same thing, they were telling me they [European women] were so active "I couldn't even satisfy her."*

Virginity is highly valued in Somalia and is one of the largest motivational forces behind the practice, according to the respondents. Because virginity is a requirement of women before marriage, infibulation in particular was a method of ensuring the woman's sexual drive would be reduced. It also sewed a woman shut "just in case," making premarital relations difficult. Although some respondents have since come to understand that virginity is "on the inside" and occurs when the hymen is broken, they stated that most Somalis are

unaware of this. Even if they were, infibulation provides the appearance of virginity, something that can be readily determined by simply looking on the outside. Some respondents acknowledged that infibulation is not 100% effective, as they knew of people who had premarital relations or had been raped and then resealed. Nevertheless, upon inspection before marriage, families of the prospective groom accept the infibulation scar as “proof” that the bride-to-be had never known another man. Without such proof, finding a groom would be nearly impossible because she would be forever branded a prostitute, or a loose woman. One respondent recalled a girl who had to have her infibulation opened as a young teenager because her vaginal opening had been sewn so tightly, her menstrual blood was not being passed. Her mother, however, was reluctant to have the operation performed because she feared her daughter would lose her “virginity.” The mother was only convinced to have her daughter opened on the condition the doctor would provide a paper for her future husband’s family to “prove” she was a virgin and was opened before marriage for medical emergency purposes only.

Some respondents also thought that infibulation was a form of protection against rape. However, the respondents did not personally believe that infibulation would protect you against a man if he truly wanted to rape you. This was poignant considering these respondents have lived in Somali during the war, as well as in refugee camps outside Somalia. Many women, separated from their families, were vulnerable during this period and two of the respondents remembered stories of other women getting raped. Their infibulations did not help them.

My male informant, A, provided a fascinating insight about why a Somali man had to marry an infibulated woman. When I asked him if deinfibulation was common on one's wedding night to assist with penetration, A and I had the following discussion:

*A: Men have to do. It was a challenge, it was a challenge for the men. If the man cannot do, he is weak.*

*I: Can I ask you a frank question?*

*A: Go ahead.*

*I: Wouldn't a man feel upset that he was causing this much pain to his wife?*

*A: Well, it depends on the individuals, from case to case. It didn't happen to me<sup>7</sup> but I would feel, yes, I would feel sorry, but if I was married to a woman like that, what could I do? I want to have sex with her. I have to do what is being done before, I have to cut it, and it helps.*

*I: Did men cut it themselves?*

*A: No, in cases in city life we have information, it can be done in hospitals, so instead you taking three, four weeks to do it, suffering...so it was a new technique to take to the hospital, but that itself was a secret, it was being done secretly because it shouldn't be known to anybody, it would be bad for the man. In the culture...for the society, it is a shame for the man, he couldn't do it, he is weak.*

One of the most important motivations behind the practice was Islam. All the respondents talked about the perceived relationship between Islam and *gun-nin*. The following is a typical exchange I had with the respondents about this issue. The speaker is a Somali woman who was raised to think that the reason women were infibulated in Somalia was because it was an Islamic requirement:

*K: Somalis, I don't know why but, first we believe that it was a requirement from the religion, first of all. And they say it keeps you clean, but I was believing before that it was a [religious] requirement. That was the only reason why I did this to my children. But then we realized that we didn't*

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<sup>7</sup>A was married to a woman who had not undergone infibulation. Both he and his wife reported no problems with their intimate relations on their wedding night.

*know nothing about the religion, and only lately when we went to the religion and studied in deep, we realized that it wasn't so.... There are two kinds of people, those who don't study the Koran but they know all these things by heart, I mean, they memorize the Koran but they are not able to read it or write it, and those are the ones who believe in the complete removal of the circumcision, while those who study [the Koran] later, they are called the extremists, those are the ones who studied and they can explain to you all the process and they don't believe in circumcision.*

Like many other respondents, K distinguished between laypeople's knowledge of what the Koran demands from those who have actually studied it. The majority of Somalis have not studied the book and a popular sense of what it contains has evolved. This lay knowledge includes the belief that infibulation is a requirement. Most respondents felt that once people study the Koran, they learn it is not required and can make the decision not to circumcise their daughters. However, they felt that despite growing religious knowledge, the vast majority of Somalis continue to support *gun-nin* on a religious basis. Only two of the respondents believed that *gun-nin* was a religious requirement. One even acknowledged that the practice was not in the Koran, but continued to support the practice in a religious sense regardless because it is what everyone else in her family believes.

Another religiously related motivating factor for *gun-nin* was the issue of cleanliness.

Because one must be ritually clean to pray in Islam, infibulation was supported because it was believed to make women "cleaner" and thus eligible for prayer:

*T: Previously, I think it was something that little girls were talking about often, and those who were previously circumcised would always tease others and say 'oh, you are not clean. You are unclean, unless you get circumcised. Don't play with me or come near me because...' but I think nowadays that doesn't happen anymore. At least to my knowledge.*

*I: What do you mean by unclean?*

*T: For example, it was believed that in many cases that the prayers we do, we pray - Muslims pray. So, previously it was believed that unless girls were circumcised at the age of 6 or 7, we can't pray. But it was never sort of substantiated in any way, but it was a belief that girls should not pray until they are circumcised.*

*I: But is that in the Koran?*

*T: (laughs) No, no!*

The respondents themselves did not believe that *gun-nin* made you cleaner, either in a ritual or physical sense. As one respondent noted: “most of the urban people they found out that if you have water and everything, you will be clean too without sewing and cutting this organ.”

#### *Problems Associated with FC*

As all but one of the respondents were against the continuance of the practice, several problems with *gun-nin* were discussed. The term “suffering” was often used in connection with the practice. One respondent who worked with anti-FGM education workshops in Canada remembered talking to three elderly women during a workshop on FC. One of them said: “We suffer when I was five years old, I suffer when I get married, and I’m still suffering when I’m having children.” Infibulation was thought by several respondents to cause one to suffer in all life stages. One “suffers” through the operation as a child which places one at risk for both immediate complications as well as long-term complications such as chronic life infections. Once married, infibulation also causes you to go through tremendous pain during intercourse, childbirth, re-infibulation after birth, and subsequently, more pain during intercourse.

Pain associated with intercourse was a “suffering” that was frequently discussed with

several of the respondents:

*R: A lot of girls go through menstrual pains...*

*S: And marriage, when they get married.*

*R: That also. A girl will be so happy to get married, but even for ordinary girls from any country, you know the first night is always a trauma. But, imagine for someone who knows that an opening has to take place. In some areas, I think a doctor opens, but from S's part, it has to be done by the man.*

*S: In the southern part, the man has to open, but I don't agree with that because we did dilating. They did dilating or sometimes they de-infibulate...*

*R: Yes, but for us was always done so that when the girl [on her wedding night] would be taken to the doctor and an opening would be done and anaesthesia and all that. So less trauma. But still there is a wound, and then a man comes and forces himself and most times that man is not something she knows because most of them is arranged marriages. She's afraid of the man, she's afraid of the thing [penis]...And that one she lives with the husband and never liking him because she knows he was the cause of that pain.*

Other sexual problems were spoken of during the interviews. Not only did one potentially fear intercourse, but some respondents noted that female circumcision caused a loss of female sexual sensation. S, a woman who campaigned against the practice in Somalia, spoke on this issue:

*S: [Anti-circumcision advocates] explained the women at that time. They said circumcision for the male is difference than women. I took my book. Because men they just do the foreskin and the women they take all the organ which is different.*

*I: If they did the same thing to a man, he would not be left with anything.*

*S: Yes, and they don't want that. But what they doing [to women] is cutting out all the organ and all the sensitivity the people will lose.*

Two other respondents, who only had a partial clitoridectomy, or a ritual *sunna*, disagreed. They felt that, despite having a small part of their clitoris removed, they were not sexually impaired in any way. Moreover, they thought that infibulated women, although they may



have had their sexual organs removed, still felt sexual desire in their minds. For example, S believes that it is possible for infibulated women to reach orgasm, although she has met many in her work as an anti-FGM activist who could not:

*S: If your partner knows you are this way, and most of our husbands have also dated women who were not FGM, not circumcised, so they can compare how they react and the husband or boyfriend or whatever, it is nice to understand that. He can stimulate the person because sometimes it is not only the organ, also it comes from the brain. We need also to stimulate the brain, you know, not to do it directly, maybe, intercourse, but he can do stimulate other ways around. And when then woman becomes stimulated, then maybe she can reach orgasm. Because I remember, I know all the women I asked, they said none of them reached that. I was amazed, and most of them have six, eight children.*

Despite the possibility that women with *gun-nin* could reach sexual fulfilment, most of the respondents agreed that a circumcised woman's sexual drive was nevertheless affected in some way.

Because of the pain associated with the operation itself, one could also develop a fear of doctors or health practitioners that might impede an individual from seeking medical help or traditional healing for the rest of one's life:

*I: What do you think are the positive and negative effects of the practice?*

*T: Personally, I don't see any positive. Personally, to be truthful, I don't see any positive effects in female circumcision. When I'm speaking in view of the person, that the practice has happened to...*

*I: The individual?*

*T: The individual, it has no positive attitudes at all...It creates fear.*

*I: Fear of...?*

*T: Of all operations. For example, a young girl of age seven has seen this practice, she will always be frightened of nurses and traditional birth assistants. I mean, it has that effect to a young girl.*

D, a medical doctor, added to the above conversation by discussing physiological

medical problems associated with the practice with T:

*T: And then they have difficulty in passing urine, so she will always be afraid of urinating. And there were cases where little girls would stop urinating for two, three days.*

*D: And medically speaking, research shows that women that have gone the practice have more urinary tract infections than generally. I don't know if we have any statistics or data supporting that but it is general knowledge and it's known that they have more urinary tract - not all of them, but a percentage of the women that have.*

*T: And sometimes they experience shock, in the earlier stage.*

*D: Yeah, there are cases that, it's been reported cases that young girls actually died during the operation, so that's also very negative...*

*T: Aspect. ...And there are longer term difficulties that maybe [D] can talk about medically.*

*D: I don't know, it has never been proven because nobody actually did research on what it does but it's believed that it also, sterility and infertility is one issue that women can, a possibility of infertility because of the scar tissue being formed on the ovaries or whatever. Or repeated infection. That would be another thing.*

A former obstetrician named F personally saw one girl die from the procedure in Somalia as a result of contracting tetanus during her operation. I asked her if circumcision related deaths were rare occurrences and she said "yes and no." She said that most girls in rural Somalia have the operation at home, and few of them go to the hospitals. Rural Somalis were afraid of hospitals because they knew that most doctors were against infibulation. Therefore, most who die from complications are never seen in the hospitals and are not reported. According to some respondents, autopsies are not performed in Somalia,<sup>8</sup> and people generally do not ask questions when someone dies. Statistics are also difficult to keep

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<sup>8</sup> According to Islamic tradition, bodies need to be buried as soon as possible after the death of a person, usually within 24 hours.

on these types of deaths because deaths are not reported in Somalia to the government. Therefore, F assumes that for every girl they see die in the hospital, there are many more in the rural regions who also die.

*Who is in charge of having gun-nin performed?*

I was curious as to who decided what form of *gun-nin* should be chosen. When I asked this question during one of the focus groups, I gathered a rather lengthy and complex response:

*T: The mothers, the mother most of the time. And in some cases the grandmothers.*

*I: Who holds the biggest influence, do you think?*

*D: I think the decision is the mother's.*

*I: I've often read in the literature about how the older relatives are the ones who tell the younger relatives what they are supposed to do with their children. Do you think that is true?*

*D: No, not anymore. I don't think anybody tells us what to do.*

*Group: [laughs]*

*D: And our age group, we are older [laughs], things have changed so dramatically and nobody ever told me what to do with mine [her daughters]. It was my decision. So I think more and more, and it's always been the women's decision because the men - they knew what was going on - but the men never used to get involved.*

*I: So it's women's business?*

*D and T: Yes.*

*D: It was women's business.*

*T: It's purely a woman's business.*

*D: And decided by women. Definitely at the time of marriage if the girl's found out not to be circumcised. The men would have a problem with that but in Somali culture, the men have absolutely nothing - they try...even when we talk in groups and we talk about circumcision with men. And we did sort of community workshops where we spoke about...and we did one here in Toronto and one in Ottawa and in Toronto there were more men, that was about two, three years ago, more men in the group. And some of them had never heard about it and younger men would, I truly honestly believed that they had absolutely nothing to do with it, but not because they had nothing*

*to say about it, but because they distanced themselves. So it's women's business, women doing it, women doing it to girls, and to other women, and they [the men] would distance themselves, but if they wanted to make the decision and stop the practice, you'd have more, they would have had better chance than women were trying to do.*

*I: Why do you say that?*

*D: Because Somali culture is basically, predominantly, the man, the father is the head of the family. And it has always been like that. And many decisions of the family, you cannot decide on many things if the father disagrees. So, but because they didn't want anything to do with circumcision, they stayed out of the question and discussion.*

This discussion highlights problems inherent in trying to understand who, and if, the power behind a particular cultural tradition can be attributed to one segment of society only, *i.e.* women. In the case of FC, it is truly difficult to determine who is “in charge.” Although on the one hand the respondents feel that the women are in control, and traditionally female midwives were responsible for performing the operation, on the other hand several of them claimed that men have the power to stop the practice if they so desired. Certainly as individuals began discussing whether or not the practice should be continued, power issues come into play. For example, Saida told me:

When she first went into rural areas to teach people about the negative side of circumcision, the men did not know what to make of her because she was a working woman in a position of power. Consequently, she was afraid that the men would not let her talk to their wives about circumcision. She thought they would be afraid that their wives would look at her and want to be independent also, and go live in the city, instead of being content as rural housewives raising children. She feels that women need to fight the patriarchy inherent in Somalia's social system and become economically independent in order to be able to make their own decisions and not be dependent on men. Once they have achieved such independence, they will be able to choose against circumcision instead of being told what to do with themselves and their daughters. As it stands presently, Saida believes that most Somali wo-

men have been raised with “the mentality to accept” the way they are treated, including expectations of circumcision.

Other respondents, although having stated that women are “completely” in charge of the practice, nevertheless believed that if all men suddenly decided to marry uncircumcised women, the practice would cease. This dichotomy was commonly expressed. What became apparent during the interviews is that both men and women support and influence the continuation of the practice. Moreover, both husbands and wives have some influence over whether or not their daughters will be circumcised and what type they will have. This holds true for practitioners as well. Although traditionally practitioners were female midwives, the respondents noted that presently, as more families start to take their daughters to hospitals, male doctors are increasingly becoming involved in the practice.

#### *Why Did Gun-nin Start to be Questioned in Somalia?*

The respondents, with the exception of one who was not aware of such efforts, recalled the 1970s as the decade when Somalis began to question the validity of the practice. During this time, religious leaders began to speak out against the practice, saying it was not required by the Koran. The government began supporting anti-FGM efforts and educational campaigns were developed to promote the eradication of the practice. However, some respondents believed that the campaigns were sparked because of the few people who initially spoke out against circumcision, whereas others thought the campaigns developed because many people had already been discussing the issue amongst themselves which lent support to these campaigns. The following discussion outlines the development of the movement in

Somalia, with these differing views in mind:

*I: When do you think this movement was started?*

*D: About 25, 30 years ago.*

*I: Who were the initial leaders in this movement?*

*T: A group of people, educated women, who were educators and nurses who had the courage to bring it about and then there was the women's, the Democratic Women's Organization that also had given them support.*

*D: Also doctors and religious leaders...I don't know how it started.*

*T: It all had something to do with education, people are doing this because they believe that it's something that's obligated by our religion...A lot of women were talking about it, a lot of religious leaders were talking about it, for example, my father was not really a religious man as title, but he was educated in religion, and he knew a lot about religion that other people didn't know, and he used to say, even to my mother "this is not Islamic." There's no need that you should do this. But nobody was taking that from him then...*

*D: Yes, absolutely, but that was long before the campaign, actually the government tried to own the campaign and make it its own policy, but I think the issue was like N was saying, there were many men who were religious who were leaders in the community who questioned the validity of the practice. So when N and the others in the campaign started, the ground was already fertile. People had questioned the validity of this because the religious men spoke up and said "you guys, what are you doing? It doesn't really make sense, it is not religious." So I think that the ground was already fertile when the actual campaign got started.*

*T: When these women decided that this, it's time for us to do something about it, so let's take it to the authorities who can help us with this.*

*I: So then the government got involved?*

*T: Yes...The Ministry of Justice used to advocate the sunna, he used to say "OK, let's not stop the practice completely because it is a sunna" and by sunna he used to mean just by pricking the clitoris.*

Other respondents thought that as people began studying the Koran, questioning of the practice was instigated. Nevertheless, the respondents noted that movement gained momentum from a variety of factors: discussion of the practice among the urban populace, male religious leaders publicly speaking against the practice, the mobilization of women's

groups, and government support of the anti-FGM movement. Moreover, the involvement of the medical establishment brought to light the negative physiological effects of the practice, which were utilized in anti-FGM education programs. Several of the respondents were personally involved in such programs in Somalia.

*How did the anti-circumcision program affect Somali attitudes of gun-nin?*

The program was relatively successful in urban areas where the movements were located. Most respondents claim that the urban areas were largely affected and that many urbanite Somalis totally abandoned the practice, or adopted *sunna* instead. However, the onset of the Somali civil war was credited as a major factor inhibiting the spread of the movement into rural areas. The respondents believed that the movement would have expanded into rural regions over time, although one respondent acknowledged the difficulties that such a task would ensue. Since Somalia's rural, nomadic people frequently move, it is difficult for anti-FGM activists to travel to these groups. Nevertheless, most respondents believed that the practice, or at least infibulation, was dying out in Somalia and that it was only a matter of time before it was abandoned altogether. The war was thought by some only to delay this eventuality.

One respondent, however, noted that the movement was quite limited, even in the cities. Although the initial feminist movement in the 1970s was relatively productive, government involvement in the 1980s was believed to have set back the movement. She believed that because the Somali government in the 1980s was comprised of uneducated military personnel, the government, of which SWDO [see chapter two] was part, in reality did

little to improve the situation for women. She believed that the government only used money from outside organizations to put up a front that they were working against the practice. Such activity weakened the movement. In her opinion, once the movement, initially spurred by feminists, was taken over by the predominantly male government, the movement was finished.

Overall, most respondents did state the movement was productive. Several were even adamant I make clear that attitudes towards FC had been changing in Somalia for a long time, and that most Somali immigrants to Canada were already convinced of the negative aspects of the practice before immigration. For example, several respondents recalled changing attitudes in their own families. Although older siblings were infibulated, often younger ones would only have *sunna*:

*M: It depends on the people only, because sometimes you see in the same family some kids they have sunna, and some kids they have infibulated. The same family, two sisters maybe it's different.*

*I: Why, do you think?*

*M: It depends, you know, sometimes it depends on the mother and the way they tell her to do the things and it depends on the grandmother also sometimes she will tell OK don't do this time this one or do this kind, and it doesn't mean they hate the first child and love the second child, no, it depends on the time that she came, that child. For example, if I was born in 1950 or something, they make all the kids infibulated. Like 1960 or 1970, it changed the situation. They may see the parents that the girl she had more difficulties than that so they may make less but at the same time you know always if anything she make mistake, the second girl, the second daughter, they will tell always was better to make infibulated, otherwise she won't react like this way or she won't talk the sex and the sex also we have taboo.*

Despite changing attitudes, however, the above passage shows that such changes take time.

Daughters with *sunna* may be watched more closely for “mistakes.” Should she do something



“wrong”, *i.e.* have a premarital relationship, the fact that she was not infibulated would be cited as the cause of her behaviour.

### *Gun-nin in Canada*

All the respondents believed that the majority of Somalis in Canada had either voluntarily abandoned the practice before immigration, or had refrained from doing so because of the illegality of the practice in Canada. Even the lone respondent who wants to continue the practice acknowledges that she is in the minority as most Somalis do not support the practice here. None of the respondents claimed to personally know of any Somalis who had secretly infibulated or had *sunna* performed on their daughters after immigration. As well, none personally knew of anyone who had taken their daughter out of Canada to have *gun-nin* performed. The majority of respondents believed that the practice was dead or dying in Canada. Although some had heard rumours of isolated incidents, they themselves never found any proof of this.

Several explanations were given for why the majority of Canadian-Somalis had already abandoned the practice. As Saida explained to me, because there are laws against it in Canada, this supports families' decisions against the practice and not having to 'give into' social pressure. Moreover, Saida believes that if people are doing it, it is being done very secretly because if complications occur and they are forced to go to a hospital, they will be discovered. Therefore, Saida feels that even if these laws are difficult to enforce, the fact remains that they are helpful to many families. Her answer was typical of the majority of respondents who cited Canadian law as a major deterrent against continuing the practice. As

T stated: "The service is not available here. So they can't be able to get it here and if they want to do it, they have to take their children out of the country and that costs a lot."

Other respondents believe that when uneducated immigrants come to Canada, they learn that women have rights in this country that they may not have had in Somalia, *i.e.* freedom to make decisions over their own bodies and/or the chance to support themselves financially instead of depending on a husband. Thus empowered, these women are able to take responsibility for their and their daughters' bodies and turn away from the practice. For example, according to A, women in Canada do not have to worry about being circumcised in order to find a husband. Since women in Canada are not circumcised, if men want to find a wife, they will have to accept uncircumcised women. Only one woman I interviewed named M, who was infibulated as a child in Somalia and complained about the side effects of being sewn so tightly, feared not finding a Somali husband if she were deinfibulated. Moreover, none feared that their daughters would be unmarriageable without *gun-nin*.

I asked respondents what they thought about media allegations, *i.e.* in newspapers and on television, that Somalis were practising FGM in Canada. A few were not aware of these, and of those who had seen them on television or had read about them did not believe them. For example, A said: "If they were doing that, we would have heard." Some respondents, however, were upset that FC had become a media circus. According to these respondents, the media portrayal of FC, as well as the decision of some anti-FGM Somalis to openly publicize the issue, has made many Canadian-Somalis defensive of their tradition, even though they claim to be abandoning it as a community. The media was a very sensitive issue with

these respondents, as many of them felt that the media, as S expressed, “negatively labelled things and we felt this was not fair.”

They were particularly displeased with anti-FGM television programs that depicted Somali girls being circumcised. According to two of the respondents, R and S, the Somali community was upset by such works because although the practice is found in many countries, it seems to them that only the Somalis are being singled out, leading the audience to think that FC/FGM was primarily a Somali affair. Several of the respondents readily could recite statistics of prevalence rates among many other populations, such as Ethiopians, Kenyans, and other peoples. They would have preferred that people refrain from centering on the Somalis as if they were the only ones who performed FGM in order to provide a more accurate presentation of the prevalence of the practice. These respondents feared that only centering out the Somalis would create negative stereotypes about them in Canada, making their assimilation into Canadian culture more difficult.

Moreover, the graphic portrayal by the media also has negative psychological and social effects on many Canadian-Somalis. In reference to one particular film shown on TV that filmed a young Somali girl being infibulated, two respondents said:

*S: Why they just pick on Somalis? That's why then many Somali communities, they didn't like the program. And many women they don't like because they saw and it reminded them back the trauma. And I remember a lady who came here, she said she felt sick when she saw and she say "I never realized my anatomy was like that" so she felt bad. Me too, it was scary when we saw. And you know what happened? A man called me at home and he said, he was talking to my husband and I just, you know, I just picked up the other side of the phone, and the man was saying "oh, you see what they do to Somali women on TV? Disgusting!!"*

*R: Even it was bad for the students who were attending [school]...other students were saying "are you like that?"*

*S: "Are you FGM?" I remember I told you that day I was crossing the road over the other side of the market and a man, he said "Hi African! Are you circumcised?" No, not circumcised. "Are you FGM?" Just like that, brutal, and they victimized us. And I said "How we expect the children at the school?" So many Somalis they complain and they call us and said "Why they do this to us?"*

Some respondents who run anti-FC/FGM workshops in Canada found that the media is detrimental to their efforts. They claim that the negative portrayal of FGM by the media inhibits people from attending FGM workshops because they do not want to be attacked for their beliefs. When I asked one activist how she advertises her anti-FGM sessions to her community, she replied: "We don't want to include the media, we don't want to publicize our workshops, we don't want to see anyone, we just want to sit down together and talk."

Another media-related point came across with R. She felt that it is acceptable to discuss and educate against FC as long as it is done properly. I asked her what she thought a negative approach would be. She answered it would be one that imposes someone's view on you, and saying that you are totally wrong. To her, and to the majority of respondents, the topic needs to be approached in a sensitive manner, which most outsiders, and apparently some Canadian-Somalis, so far have not proven themselves capable of doing. Therefore, the respondents felt that education initiatives in Canada would likely be more productive should they come from and stay within the community itself.

Several of the respondents were involved in such anti-FC/FGM efforts in Canada. These involved leading small workshops with members of the Somali community to discuss

the issue.<sup>9</sup> These respondents found that an indirect approach was best because there continues to be traditional reluctance to talk about sexuality in the community. Therefore, in order to promote discussion in a non-threatening manner, these activists held informal sessions about a general topic, such as women's health, and included FC in the discussion. For example, two respondents found that among more senior Somalis, the desire to continue the practice is relatively strong. Therefore, they invited seniors to attend focus groups on a more general topic, and then worked in a method of discussing FC during the session. When I asked how they convince people to change their minds about FC, one respondent replied that they brainstorm. They get the group to come up with a list of why they used to do the practice, and another as to why the practice is not good anymore. Then they discuss the pros and cons. They have always found the con list to be longer, and more convincing, because the reasons they used to practice FC are not seen as applicable anymore.

A final critique of the media's portrayal of the practice was that it was only interested in profiting from exaggerating or creating hysteria about the prevalence of the practice in Canada. In fact, one group of Somali women I interviewed allowed me to interview them on the condition I did not use the information to publish anything other than my thesis unless they gave me permission beforehand. They said this because they did not want any other people "making a living" from what they consider to be a sensitive issue that should be handled by Somalis. Furthermore, the media's portrayal of FC was thought to only "sell

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<sup>9</sup> See *Female Genital Mutilation - Workshop Manual* (1996) for descriptions and examples of specific strategies that may be advocated in FC/FGM workshops.

papers,” as one respondent so poignantly phrased, at the expense of “real” concerns and problems that the Canadian-Somali community face on an everyday basis. For example:

*R: You know, ours is a new community. How we are being excluded from employment and advancement. Many other pressing things. Because what we are facing, FGM is the least important thing right now.*

*S: Well, I think it's good to do [FGM research] just for the health aspects but what we want more is employment, we want education, we want other things to be subsidized - housing - and we want a lot of other things.*

*R: There was one project that we tried, to have our own co-op [housing] and after spending so much money on it, how much was it?*

*S: We received eight million dollars.*

*R: It was just about to take off, really! Soil analysis was done...layout, architecture work, everything!*

*I: So you were going to build a housing complex for...*

*R: Yes, that's what we needed because the existing houses were not meant for families with ten children, twelve children. And the average for families is eight, seven children, so what type of housing is available for that? Because we have large families and no one...*

*S: No one will, you know now most of landlords, if you say you have three children, four children, they won't rent. So we have to hide them [the children]. I have to say two when I have nine.*

The anti-FC/FGM activists I spoke to were aware of these other concerns to the community and attempted to incorporate them into their efforts. Not only do they try and teach individuals not to perform *gun-nin* on their daughters, but they also try to teach families about holistic health care. This includes building awareness of proper health care as well as providing support for people having to visit doctors. When I asked what problems Somali women face when they seek medical assistance in Canada, I was told that Somali women are treated poorly by health care workers because of their circumcisions:

*R: Young mothers, one thing they said is that they need help. They said already they are circumcised. They saw we are ready to help them. They are having their first child and people are sneering at them when they go for Pap*

*tests, they go and see a doctor, and the doctor and the nurse around them is so insensitive - these are the issues where we are needed. They tell us the areas where they need help. Whether it is interpretation, or whether it is, you know...*

*S: Support.*

*R: Support...and going with them.*

*S: Because R and I, we go every month to the hospital...*

*R: "Seeing doctor", she said, "I don't want." The woman is most vulnerable when she visits the doctor and she has to put her legs here and there...and then he gets other people...*

*S: A showcase.*

Several respondents told me stories about how they or friends of theirs had gone to the doctor for treatment and were treated as if they were barbarians because they were circumcised. They related similar stories of insensitivity by the medical establishment. For example, a woman would go to her family doctor or gynaecologist, whom she never met before, for an examination. Within minutes and without a word of explanation, the doctor left her alone in the room with her feet in the stirrups of the examining table and her genital region exposed. He or she would then return with other nurses or doctors to stare at the woman who was ashamed that these strangers were staring at her private parts.

Another problem noted with the medical system in Canada is that Canadian doctors do not know how to deliver babies from women that are circumcised. As S discovered:

*S: We sent a questionnaire and found 90% of the Somalian women of childbearing age are all having caesarian, C-sections...which was unnecessary. Because when this Somali doctor went to there<sup>10</sup>...because we*

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<sup>10</sup> S and R helped to organize a workshop for health care workers in their home city in southern Ontario which this particular doctor attended. He tried to address the specific concerns that pregnant Somali women have and how their treatment could be improved.

*have an audience of 100, 150 health professionals, educators and social workers, and when he was speaking he said "I deliver yearly 1,000 babies and my success ratio was 99%." And his [number of] C-sections was 5% of deliveries that year. Can you imagine? ...And he said, how come you are doing 99% here? He said it is not cost - or you just wanting the money? Because some doctors when they perform [C-sections] they get more money. So he said it's not fair. First you do episiotomy - they have techniques to do! To deliver, open everything. He said "if you don't know, I can help you" But still they didn't accept our doctor to do that.*

### *Why is Canada Different?*

Despite the assurances of the respondents that the practice was dying out in Canada, I continued to wrestle with a disturbing thought: why are Canadian-Somalis not practising FC when African immigrants from concerned communities in countries such as England, France and the US have been documented as secretly performing it? What made Canada different?

One group of respondents postulated an interesting demographic explanation:

*D: ...we know from literature that it's been done in France, West Africa, where immigrants have imported, in a sense, midwives, and it has been going on for years or until they are found out. But, the difference between there and here [Canada], are because immigrants that have lived in France have lived there for centuries, for a very long time. But the new, the people coming from parts of Africa, Middle East or whatever to here develop new communities. So they don't have the networks, the don't have developed that [to practice FC]. It's not an impossibility, it could happen, it's quite logical that people come from rural areas and they have a midwife among themselves. But it doesn't happen because we have never seen it happen. And the community as I said do not have the networks of, for example, immigrants in France have.*

Canada was an exception because immigrants to these other countries, especially in Europe, have been settling there for decades. Because it was not against the law to practice circumcision when the first Somalis arrived in other Western countries, the respondents



thought that these immigrants were able to establish circumcision networks, *i.e.* import circumcisers, and were not disturbed by the authorities in doing so. In their opinion, this was the main difference between these other countries and Canada. Perhaps, they mused, the rates of new cases of circumcision were so low in Canada because Somalis have only been immigrating to Canada *en masse* since the late 1980s to the early 1990s. Because FC or FGM has been an international issue since that time, Canadian authorities were more aware of it and it was made illegal, or at least was considered so under existing laws, not long after the initial waves of Somalis came to Canada. As a result, Canadian-Somalis did not have the same opportunity as their counterparts in the UK, for example, to establish circumcision networks. Other respondents, when questioned about this possibility, concurred that this was a logical reason attributing to the abandonment of the practice in Canada as compared to other countries.

Another demographic factor which some of the respondents thought may have contributed to the lower rates of FC in Canada was related to the fact that most Somalis arrived in Canada as refugees from the Somali war. These respondents noted that in Somalia, the rural or nomadic peoples held on more tightly to traditions, whereas urban peoples were more likely to be influenced by changing ideas. They believed that most urban people were beginning to change their views on FC before the war. When the war struck, many Somalis were forced out of cities and into the countryside, often having to leave the country altogether and enter a refugee camp, *i.e.* in Kenya. The respondents postulated that it is more likely that urban Somalis would have left Somalia, whereas rural or nomadic peoples were more likely

to maintain their traditional lifestyle in the countryside, even if they had to move away from war areas. Rural or nomadic peoples were consequently less likely to immigrate. Moreover, immigration often requires one to have some money to be able to travel. Therefore, the respondents thought that a higher percentage of urban peoples would have immigrated because either they had the means or they were forced out of the cities and so a higher proportion of urbanites as opposed to rural peoples left Somalia in the first place. Because Somali immigrants to Canada were likely from the city, the respondents thought, Canadian-Somalis were more likely to be educated, or come from educated families, and/or been exposed to anti-FGM ideas. As a result, Canadian-Somalis as a whole may be predisposed towards abandoning the practice because a larger number of them were urban dwellers.

If one were to attempt to validate this argument, one would have to determine the percentage of Canadian-Somalis who were either urban dwellers before immigration or who had received secondary or higher education, or at least came from families where this was the case. Education would be a key factor because usually only urban dwellers would have had access to school systems other than religious, or Koranic schools. Religious schools are primarily the only form of education found in rural areas as nomadic Somalis, even after Independence, tended to view western styles of education as both unnecessary and contradictory to their traditional Koranic schools (Nelson 1982: 117). Consequently, rural “regions with larger concentration of nomads...[were] poorest in terms of education”

(Haaland & Keddemann 1984: 849)<sup>11</sup>. Education levels would be important to know since higher levels of education has been credited as a factor which influences Somalis to abandon the practice. Knowing the education levels of Somalis in Canada would, in a crude sense, indicate whether or not they could have been exposed to anti-FGM campaigns in Somalia and were therefore predisposed to abandoning the practice. Attempts to substantiate the respondents' demographic argument, however, was beyond the scope of this paper. A review of Statistics Canada's census structure found that the census does not have a place for respondents to classify themselves as being of Somali descent. Somalis must check their ethnic descent as part of the "other" category (1991 Census Handbook Reference 1992: 48). Therefore, attempts to cross-tabulate education levels with Somalis in Canada at present are impossible. However, Opoku-Dapaah's (1995) recent survey of 375 Canadian-Somalis from the Greater Toronto area found that, of his respondents' educational background, 52% had completed high school, 10% vocational or technical school, and 18% university. Only 4% "had no formal education at all" (Opoku-Dapaah 1995: 113). His findings suggest that the Canadian-Somali population may indeed have, as a group, higher levels of education. If Opoku-Dapaah's findings are correct, these higher education levels could at least partly account for the apparent willingness most Canadian-Somalis have come to abandon FGM. Future research in this area, however, should be undertaken.

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<sup>11</sup> In this sense, education refers to western styles of schools which were developed in urban centres in Somalia. Historically, Koranic schools, geared to educating Somali boys, have been the primary form of Somali education, prior to western influences, for the last twelve centuries (Kaplan et al. 1969: 128; Ntiri 1991: 79).

In light of their beliefs that FC is dying out in Canada among Canadian-Somalis, I asked D and N about how they felt about reports saying that Somalis are performing the practice in secret. They recalled the following story:

*N: I think it is vanishing, no? The practice is not done here. Although some people say it is done, we never saw it and nobody, it's never documented that it's been done in Canada.*

*D: I've never heard it, but in the beginning the women who were doing work in our community were suspicious. People kept on saying "you know, it's happening here and it's happening there" but we sort of challenged most people in the community and said "well, show us one case that's been done in Canada"...But until this day, I've never seen anything.*

*N: No proof...They'll say there was a case, but when you say "where, who did it to who..."?"*

D, T and N then recalled one case where a male social worker claimed that four Somali girls told him they had been circumcised in Canada. The Children's Aid was alerted, and one of the above women went as an interpreter for one of the girls and her family during an investigation. Apparently nothing was proven and the case was dropped.

Only three respondents knew secondhand of individuals rumoured to have circumcised their daughters in Canada. M and A, the couple I interviewed, heard of a woman who was determined to circumcise her infant daughter and take her out of the country to do so. At the time of the interview, this person had not yet followed through on her desire. M and A said that other Somalis had been trying to talk her out of her decision. The other admission that Canadian-Somalis were practising FC was by M, who claimed that in 1996, a Somali community in Toronto imported a circumciser from the United States. This former midwife allegedly circumcised dozens of young Somali girls in Toronto before one girl suffered

complications and had to be taken to a hospital. The police became involved and the circumciser fled back to the US before she could be arrested. The respondent could not personally verify this story, but claims a relative in Toronto was friends with a Somali who lived in the building where the circumcisions took place.

Nevertheless, the respondents continued to maintain that overall, the practice is dying in Canada. Moreover, several of my respondents were adamant about pointing out that this is not a product of coming to Canada and learning the 'enlightened ways of the West.' Their attitudes were already changed before they came here. As D expressed:

*D: Many people have reached the decision not to do it to their children long before they came to Canada. So it's not something that's just suddenly, you know, woke up one day and "I'm in Canada, I have to stop." It's a process, that has taken years and years to develop...so most people are ready to take that action, and ready to accept the fact that it's not really part of my life - it wasn't when I was in Somalia, it wasn't part of my life. I decided long ago that for my children. That's why most people say "we don't want to talk about it, it's not an issue now"...People are really angry because FGM has been brought to the forefront, and journalists...there are so many people who are not interested in the community and their needs and their problems and issues of settlement, or issues of language, but people were interested in Somalis because of FGM. And people want to dissociate themselves with that because it is not a problem for me anymore. So although the community and other communities - Somalia is not the only country that practices, over what? 27, 29 cultures in the world?...So that's the process that brought us today because most people hear about FGM and say "it has nothing to do with me anymore."*

## **CHAPTER FIVE: “You Cannot Escape, You Cannot Leave” - Transformations of Self and Social Identities**

...often persons, male and female who speak against FGM are accused of being anti-tradition, anti-family, anti-religion, anti-national or of rejecting their own people and culture. [Mak (1993) in La Ferne Clark 1995: 16].

Although the majority of the respondents have come to abandon FGM, what was remarkable about their present conceptions of the practice was the process through which they came to make their culture-challenging decision. When one considers the numerous culturally sanctioned motivations for the procedure, particularly those relating to identity and acceptance into adult Somali society, how one comes to redefine one's conceptions of self and society in order to make the decision to change such a culturally significant practice is almost awe-striking. Despite the fact that nearly all my female respondents had been circumcised and raised with the understanding that their genital operations were necessary in order to make them 'complete' women able to enter Somali society, at some point these women (and man) have come to reject this tradition for their daughters, despite one respondent's assertion "...you are culturally within a society, you cannot escape, you cannot leave."

What was found during the interviews was that the respondents were able to make this personal 'transformation' with certain shared experiences. Nearly all had been raised believing in the positive aspects of the practice. The majority, however, also underwent experiences that enabled them to embark on their transformation of self and social identities

in respect to *gun-nin*. Most had completed secondary school, with over half having completed post-secondary or professional degrees; many had travelled and lived in other countries as young adults before the war and subsequent immigration to Canada; and nearly all were formerly urban dwellers, mainly from Mogadishu, who were exposed to and/or involved in anti-FGM campaigns in Somalia. Ultimately, with one exception, all had either decided to leave their daughters uncircumcised, regretted circumcising their daughters in the past, or were not planning to circumcise any future daughters. These preceding commonalities were those that arguably enabled the majority of respondents to change their ideas of traditional Somali concepts of female identity. Consequently, the majority of the respondents had come to accept that their uncircumcised daughters could be ‘complete’ women of their own accord, and did not adhere to traditional beliefs that uncircumcised women were ‘unclean’ or ‘immoral’. Moreover, they felt that their daughters, as could other → uncircumcised Somali women, retain their cultural identity *as* Somalis without the procedure.

In considering the effects of abandoning the practice on concepts of self and Somali identity, a comparison of the respondents’ experiences to the findings by Boddy (1989) in the Sudan, as well as Talle’s (1993) observations in Somalia, on infibulation and identity will be made. This will include an analysis of various factors that contribute to the development of traditional female identity in Somali culture. As well, an examination of factors held in common by the respondents which may have contributed to their ability or willingness to abandon the practice and alter their concepts of self and social identity will be undertaken. Potential negative consequences as a result of their decision will also be explored.

*Infibulation and Concepts of Selfhood and Identity*

One cannot refer to the relationship between infibulation and identity in Somali culture without recognizing the social construction of the body and its relationship to Somali female identity. As Boddy (1994) noted in her study of Hofriyat in the Sudan, the act of infibulation shapes a child's body to a particular gendered image. This causes the child to internalize the image in the process of being properly socialized into adulthood (Boddy 1994: 59). This socialization takes many forms which includes the act of infibulation itself, followed by reinforcement of the new identity through various social concepts *i.e.* new awareness of one's sexuality, potential fertility and marriageability, relative position in the kinship system, and peer acceptance. These are further reinforced through various language metaphors which serve to impress on the growing female child what being female means in society, as well as what it does not. Traditionally, the rite of infibulation and subsequent related ideology permeate and intertwine with concepts of female identity and cannot be separated.

As Broch-Due (1993) noted in her study of the Turkana people of Kenya:

Gender is not a fixed property locked into sexual bodies, but rather a bundle of attributes that are open to contextual transformations which people themselves engage in continuously through their acts, communicating the effects in a series of signs inscribed on their 'social skin.' In their dynamic gender models the Turkana construct, 'maleness' and 'femaleness' depend on culturally definable acts and not unchangeable essences (Broch-Due 1993: 81-82).

Similarly in Somalia, gender is socially constructed. Although one may be born with genitalia defining a child as either 'male' or 'female,' it is through the act of circumcision that a boy or girl begins to be formed into a potentially acceptable woman or man. As among the



Turkana, Somali newborns are believed to be comprised of both male and female parts. In order to turn young girls into 'true' females, their 'masculine' parts need to be removed through *gun-nin*. As "hardness" is "associated with maleness," some Somalis believe that this is the reason the "hard" parts of the female *i.e.* the clitoris, needs to be excised. As a result, this operation "propagates 'gender identity'" because it "...manipulates and strikes at the very part of the body where the anatomical difference between women and men is apparently most prominent" (Talle 1993: 84). Such attitudes are reinforced through metaphors *e.g.* some of the respondents' recollections that leaving the clitoris uncut would allow it to grow as long as a penis. Talle also found that Somalis have a derogatory term for women or girls with clitorises which means "with (or having) father" insinuating that the girl's clitoris is "like the penis" (ibid: 86).

Boddy found similar belief systems in Hofriyat. Because the young child's gender is ambiguous, young boys and girls are similarly socialized *e.g.* they are allowed to play together. At the point of circumcision, a child's sex becomes defined as either male or female through the removal of physical traits that are deemed opposite to one's socially construed gender. This is achieved through the removal of the prepuce in boys and the removal of the external genitalia in girls. Afterwards, relationships between young boys and girls begin to change as a "polarization of the sexes" occurs. They are no longer allowed to play together and sexual segregation ensues. This socialization continues into adulthood where men and women live seemingly separated lives *e.g.* seldom even do men and women eat together (Boddy 1989: 57-59). Similarly in Somalia, once infibulated, young girls are expected to

begin to behave like “small women”(Talle 1993: 87) and limit their relationships with boys until marriage.

As discussed in chapter two, excision of the female genitalia is believed to be necessary in order to curb the ‘unmanageable’ sexual impulses of women. However, Boddy believes that FGM is less about the management of sexuality and protection of virginity than it is about the promotion of fertility. The reduction of the female genitalia, at the same time as curbing her sexuality, promotes a woman’s child-bearing potential. In Hofriyat, virginity “is a social construct, not a physical condition.” Because virginity is perceived by the intactness of one’s infibulation scar, infibulation gives the appearance of virginity which more importantly allows women the right to marry and consequently the right to bear legitimate offspring. One is able to advance one’s social position as a woman by giving birth to sons (Boddy 1989: 53-55). Consequently, circumcision is a vehicle that enhances one’s femininity by emphasizing one’s reproductive potential, ultimately giving women the opportunity to gain status and prestige as women through the birth of children.

Similarly in Somalia, infibulation is a means of preventing premarital affairs, thus ensuring that a young girl is eligible for marriage and that the paternity of her offspring can be guaranteed. It is also a means of allowing fertility rights of a woman to be transferred from her patrilineage to the lineage of her husband’s. A similar transference, in this case to the breast rather than the infibulation scar, is evident among the Turkana where:

...gendered persons are the outcomes of interaction. Everybody is a composite of different identities; bodies do not ‘belong’ to persons, but are composed of social relations of which the ‘person’ is a part. A woman’s

breasts are conceptually turned into artefacts appropriated by a man through the bridewealth, the beasts he gave for her as a wife. Since it is the woman who is conceived of as moving in marriage, the breast becomes a symbol for the fertility given by her clan to be consumed by the husband on behalf of hers (Broch-Due 1993: 69).

Similarly, in Somalia a young woman learns to identify herself with her fertility, the rites to which are controlled by either her or her husband's patrilineage, as her sexual self is de-emphasized through infibulation.

This is not to say that sexual aspects of identity are ignored in the developing self-awareness of a young Somali girl. As Abdalla (1981) noted: "the principal effect of the operation is to create in young girls an intense awareness of [their] sexuality and anxiety concerning its meaning, its social significance" (Abdalla (1981) cited in Boddy: 1994: 322).

Somali girls are taught to fear their sexuality as they are socialized to believe that sexual experience before marriage "is a source of shame and a symbol of degradation" (Boddy 1994: 322). Thus they learn to disassociate themselves from their sexuality, particularly since they are reinforced from an early age to believe that female sexuality is something to be feared and removed. Such attitudes are reinforced through perceptions of non-infibulated woman as "prostitutes," as recounted by the respondents, as well as fears of not being able to manage the sexual drives of their daughters if they were left uncut.

Fear of one's sexuality can also potentially affect one's relationship with one's kin, a very important aspect of Somali identity, thus further legitimizing the need for infibulation. As Lewis, cited in Boddy, writes:

As Somalis themselves put it, what a person's address is in Europe, his genealogy is in Somaliland. By virtue of his [or her] birth, each individual has an exact place in society and within a very wide range of agnatic [patrilineal] kinship it is possible for each person to trace his [or her] precise connection with everyone else (Lewis in Boddy 1994: 299).

Doing what is required in order to maintain solidarity with one's kinship group is vital in Somalia where one's identity is shaped by his or her position in the clan, or for a woman, marriage into her husband's clan. Moreover, marriages are alliances between a woman's patrilineal lineage and the lineage of her husband. Interestingly, Talle (1993) noticed that the word "tol" is used to refer to patrilineal agnatic kinship ties means "to 'sew' or 'bind' together." "Tol" is also used in reference to an infibulated girl. Talle argues that marriage in Somalia is a union between two groups of agnates where an intact infibulated girl becomes a symbol of "the unity and credential of her lineage group" (Talle 1993: 96) reinforced through semantics in language such as the use of the word "tol." However, Talle goes further to suggest that the shape of the infibulation scar, being elongated with the vaginal orifice shaped into a small hole at one end, resembles a penis, thus making a woman "into a 'man,' a pure agnate" (ibid: 99). Consequently, infibulation is used to shape a woman's genitalia into a male image, thus further identifying her with her agnates. Whether or not one agrees with this interpretation, Talle does note that "the ritual act of enclosing the girls into a male-based collective by inscribing the insignia of agnation on to their bodies, also separates sisters and brothers, women and men, into two laterally segregated gender categories" (ibid: 98). As a result, in terms of identity, women must be "created" through infibulation, where part of one's identity is belonging to an agnatic group.

Becoming a symbol of one's agnatic group requires young Somali girls to internalize a gendered image of themselves that incorporates the values of her patrilineage. As a result, Somali girls learn to internalize ideologies of women as being chaste and pure through refraining from premarital relations. These ideals become part of their own morality, thus shaping their identity as socially respectable women. These morals are reinforced through various metaphors which, according to Boddy, also reinforce morally appropriate fertility. Such metaphors, some of which were recalled by the respondents, include viewing the infibulated region as "pure" or "clean" and "smooth" (Boddy 1989: 60).

Certainly the development of the female self in Somalia involves the socialization of male dominance. As the symbol of the honour and respectability of her patrilineage (Boddy 1994: 323), infibulation turns women into vessels through which men can prove their status. A woman knows she must remain chaste before marriage and embody related characteristics in order to promote both her respectability and that of her father's line. The tighter infibulation scar symbolizes the chastity of the girl as well as gives increased honour to her patrilineage. Paradoxically, however, the scar is also an opportunity for proving both the self-worth and the strength of the groom's lineage. Being able to break open the infibulation scar with the penis is a source of pride: not just for the groom, but for his patrilineage. This act serves as an opportunity not only for one lineage to prove its superiority over the other (the bride's lineage will take pride if the groom cannot penetrate the scar; similarly, the groom's lineage will be proud of the groom for gaining entry), but also for males to prove their superiority over women. The penis, or a knife if the penis cannot penetrate the scar, is a

symbol “of male selfhood and power over women” (Talle 1993: 99). This theory was confirmed by the one male respondent who noted that being able to break open the infibulation “was a challenge for men.” Not only does breaking open the infibulation serve as a test of manhood, but it also serves to reinforce the role of womanhood in the woman being ‘opened.’

Considerations of abandoning the practice are often met with much fear and resistance because it is so ingrained in Somali culture. Respondents reiterated fears held by many in their community that they would be ‘turning their backs’ on their tradition if they abandoned the practice. However, I argue that it is not the loss of tradition to be feared as much as the loss of identity. This loss of identity is on several levels. As my sole respondent who continued to advocate the practice noted, she would be uncomfortable if her daughter was not circumcised in some way because her daughter would not “look like” her. The identification with infibulated or excised female genitals as the norm would be difficult for most to abandon. How does one identify with an image of femaleness that previously was associated with such words as “unclean” or such occupations as “prostitute”? Moreover, there are other issues relating to identity that should be considered. As Boddy summarizes, being infibulated is a matter of pride for most women that demonstrates her honour and self-worth to her patrilineage. There is also the strength of social norms to be considered, including the risk of peer rejection if these norms are not followed. As a result, “this web of implicit knowledge holds the individual, shapes her sense of self and social reality; it is seldom resisted or contested without cost” (Boddy 1994: 324).

### *Commonalities in the Respondents Experiences*

All of the Somali respondents recounted aspects of their culture which reinforced the importance of infibulation for Somali women. More than just following tradition, these social pressures shaped Somali female identity in that without the practice, an uninfibulated woman would not be able to take her place as a normal member of her society. However, all but one of the respondents, while aware of these pressures in their culture, had experiences in common which altered their perceptions of what a 'normal' Somali woman should be. This perception did not include infibulation. What was found during the interviews was that the respondents were able to transcend traditional directives and begin to envision Somali 'womanhood' in a different way, not only where a woman would be uninfibulated, but also where a woman's position in society would ultimately change.

Education was undoubtedly the key factor for such change among the respondents. Nearly all had completed secondary school and most had some post-secondary. The role of education as a correlation factor reducing the rate or severity of infibulation was discussed in chapter two. The respondents substantiate these findings because of their own high levels of education and their decision to abandon the practice. The reasons provided as to why education is such a successful mechanism allowing one to abandon the practice was because of the passing of knowledge. The respondents felt that most people traditionally accepted infibulation because they thought it was normal. They felt most Somalis were not aware of the complications that the practice caused, and often did not realize that suffering *e.g.* from chronic bladder infections, was a direct result of the operation. As well, most were not aware

of the function of the clitoris and only through education did they realize what was being removed. Although some respondents believed that one could still retain a strong sexual drive after infibulation, others indicated that *gun-nin* caused sexual impairment and most agreed the sexual drive was affected in some way after the operation. Moreover, the respondents felt that as Somalis began to read the Koran for themselves, they realized that infibulation was not a religious requirement, and *sunna* was only optional. Such knowledge allowed the respondents to re-evaluate traditional views of women. They questioned the value of a practice that caused women so much ‘suffering’ and began to envision women in a new light. Although the forces of tradition were very strong, these respondents indicated that they began to reject this traditional view of women as their new image of ‘women’ began gathering force among the educated community of which they were a part.

It appears that the respondents, through living in educated circles during a period where a new image of Somali woman began to evolve, began to internalize this new image. This is not to say that the respondents were ‘automatically’ able to ‘turn their backs’ on this tradition and triumphantly hold up their daughters as models of the ‘new’ Somali woman. Many difficulties, doubts, and pressures continued to be felt by some respondents, even after intellectually deciding that they did not want to continue the practice, as was experienced by the couple I interviewed who lied to their families about only having *sunna* performed on their daughters.

Fears that their children would be viewed as immoral and rejected by the larger Somali society would certainly be a consideration for most parents seeking to end the practice.



Paradoxically, even if parents do not agree with the practice, often they may feel pressure to continue the practice, (or like the couple above, pretend to), in order to avoid ostracism. Young women who are not infibulated probably undergo identity conflicts - on one hand, their parents have decided that the practice is, in effect, detrimental for them and actually takes away from their experience as 'complete' women *e.g.* because it causes undue suffering, limits sexual experience, *etc.* At the same time, however, these young women are faced with the reality that the majority of Somalis view uncircumcised women as immoral and unclean, both in a social and religious sense. For example, one respondent recalled a friend who confided that she was not infibulated but begged her not to tell anyone in order to avoid ridicule by others. Future research targeted at such women would be interesting in order to discern more succinctly the identity conflicts they undergo.

Another interesting commonality found among the respondents was that most had travelled to other countries and some even resided in them for a period of time. This contact with other cultures, as well as non-infibulated women, also could have contributed to the realization that infibulation is not necessarily a 'normal' state for women as previously believed. Such contact with other cultures also could provide these women with experiences with non-Somali health care professionals who may have influenced some of the respondents' understanding of the practice. For example, one respondent went to a gynaecologist who, upon seeing her infibulation scar, lectured her about the barbaric practices of her society. Although not an effective method of conveying information, such negative reactions from others would perhaps have caused the respondents to consider the practice in a different light.

Despite this influence from other cultures, however, the respondents wished to make absolutely clear that it was not western interference that caused them to abandon the practice. The most influential factor was the emergence of anti-FGM programs, mainly in Mogadishu. These programs, outlined in chapter two, were supported by the growing number of educated, urban Somalis who were beginning to reconsider what being a Somali woman meant. Religious leaders and women's groups, backed by the government, began to speak about the negative consequences of the practice and how their daughters could retain their morality simply by having morals reinforced at home. They spoke of how infibulation does not necessarily stop a young woman from having premarital relations because she can be simply sewn up again to give the appearance of virginity. They attempted to show how the 'new' Somali woman, uninfibulated, could retain traditional morals and ideals, which shape traditional ideas of Somali female identity, through her behaviour. In effect, they tried to convince the Somali public that a non-infibulated woman could equally be valued as a member of society.

Another interesting commonality between the respondents was that nearly all were, for lack of a better word, 'modern' women. As ideas surrounding infibulation emerged, some women, particularly among educated, urban dwellers, were beginning to enter non-traditional roles in society. Instead of remaining house-wives and raising children while their husbands worked, many of the respondents were highly educated professionals themselves. As these women began making non-traditional lifestyle choices for themselves, it is not surprising that at the same time such women began questioning traditional expectations of women, including

infibulation. As these women began to be accepted in the innovative part of society, ideals for women among this group must have begun to change, leading to other challenges of traditional ideals.

### *Conclusions*

The respondents certainly exhibited non-traditional beliefs. Although they recognize the worth of many traditional values such as the preservation of virginity, they believe that infibulation will not necessarily prevent their daughters from engaging in pre-marital activities. Nor do they believe that their daughters will automatically be immoral because they have not had *gun-nin*. Moreover, they believe that their daughters are more *complete* rather than lesser women as a result of having their genitals intact. For the respondents who were infibulated, at least now their daughters will not have to undergo the same 'suffering' as they and their generation experienced as a result of their infibulation. As well, now that they are residing in a new culture, and are becoming influenced by it, the traditional ideals for women, highly valued in Somalia, do not hold the same significance in Canada. As the respondents and their daughters become acculturated into Canadian society, most of the respondents recognized that their children will internalize Canadian values and begin to identify themselves with them. The struggle for identity, similar to the struggle between weighing traditional and modern Somali values, will become one of balancing Somali values taught at home with new values and ideals that the respondents and their children will face through their integration with Canadian society.

## **CHAPTER SIX: “I thought they killed that subject to death!” Non-FC/FGM Health Concerns of the Canadian-Somali Community**

What has emerged from the last chapters is the belief that the practice of FC, at least for the majority of the respondents, has become a non-issue in Canada and thus appears to contradict fears expressed by the media. This was an unexpected result of the interviews, particularly since the initial focus of my Master’s dissertation has been to discover the alleged “secret” networks that I had been alerted to by the media. More surprising, however, was when nearly half of the respondents voluntarily and spontaneously referred to FC/FGM as one of their *least* important health concerns. This caused me to become aware of two larger issues within the realm of FC/FGM discourse. The first is a problem within the media itself; that of sensationalism. A number of the respondents expressed frustration and anger with the media’s portrayal of their cultural tradition. They felt that the media was merely profiting from the sensational and exotic elements of FC, particularly of African women’s genitals, and that the media was not truly concerned with the health and welfare of the Canadian-Somali community.

This brings us to the second issue: as nearly all the respondents have abandoned the practice, it was not surprising to discover that most of the respondents are concerned with other issues that specifically affect their health and welfare. Moreover, the respondents were upset that the media continued to focus on FGM but neglected to address issues that were of more immediate importance to their community’s health and welfare, and overall quality

of life. This was best summarized by a respondent who, when first told about the subject of my study said “I thought they killed that subject to death!” She, as well as several other respondents, were concerned with other issues, namely improper health care, inability to find suitable housing for their often large (by Canadian standards) families, separation from spouses due to the war resulting in single-headed families with less income; poor job prospects regardless of former education, qualifications and/or experience; and difficulty in accessing funds for retraining or further education. Although not all respondents were questioned on this topic, the fact that it was spontaneously expressed in several interviews without prompting shows that at least some respondents feel that their health and standard of living in Canada is threatened, but not because of FC/FGM. Furthermore, this topic is also worthy of mention because the respondents’ concerns can be related to a growing body of literature regarding health concerns relating to Somalis in Canada. This literature indicates similar areas that need to be addressed when considering improvements to the quality of Canadian-Somali life. The consequences of focusing only on FC/FGM as a primary health concern of the Canadian-Somali community, therefore, is not reflective of the multidimensional reality of Canadian-Somali health and well-being. The implications of this must be addressed and cannot be underestimated.

#### *Female Circumcision, the Media, and the Medical Establishment*

As indicated throughout the thesis, the respondents believe that the majority of Canadian-Somalis are not practising circumcision in Canada. This, therefore, raises the question regarding the validity and necessity of current media exposure of the practice. Is the

media's portrayal of FC necessary in Canada for improving Canadian-Somali health, or is it simply an economic ploy by the media to sensationalise and exoticize African women for the sake of profit? The answer I received was two-parted. On one hand, the respondents acknowledged the importance of keeping the issue of FC/FGM in the open. However, what they criticized was the way in which the media did so and the respondents argued for a more sensitive portrayal, preferably by concerned communities themselves. Foreigners to their culture, they explained, as outsiders simply do not understand the complexities of the practice. They felt that anti-FGM initiatives should be left in the hands of their own communities.

The reason why the media or other FC/FGM awareness initiatives may remain necessary relates to efforts being made by the Somalis themselves to promote awareness of the practice. Several of the respondents are involved with or run workshops and have published manuals that include the topic of FC/FGM. For example, one respondent was involved in the publication of the "Female Genital Mutilation Workshop Manual" (National Organization of Immigrant and Visible Minority Women of Canada 1996). This manual is divided into units to help facilitators run workshops in an effort to promote awareness of FGM as well as the reasons as to why it should be abandoned by concerned communities. At least five of the respondents were also involved in promoting anti-FGM ideas in their community through incorporating the topic into larger health schema. For example, they would advertise a workshop that would discuss women's health, and include FC/FGM as one topic for discussion among others in order not to discourage attendance.

The respondents' involvement in such activities caused me to ask the questions: Why

do you continue talking about the practice if it has largely been abandoned? Would not the fact that members of the Canadian-Somali community continue to discuss FC be a justification for the media's interest in the practice in Canada? I also inquired as to why they would have to "hide" the fact that they would be talking about FC by giving the workshops a general heading. Surely that would imply that people are continuing to defend their tradition in Canada and do not want to be exposed to ideas to the contrary? The answer I received was multi-faceted.

The workshop organizers realized that although most had abandoned the practice, as discussed in previous chapters, some Canadian-Somalis would want to continue the practice but are not allowed to by law. As a consequence, the organizers want such fellow Somalis to come to understand the negative consequences of the practice, and come to voluntarily agree with its abandonment, not just because they are presently forced to by law.

The reason as to why the practice must be "hidden" in a larger workshop theme is because the discussion of sexuality is considered taboo by Somalis. Traditionally, in Somalia, sexually related matters were euphemized in terms of another problem. Doctors seeking to treat gynaecologically oriented problems often had to decipher the true ailment from vague descriptions provided by the sufferers. Even among family members, such issues are not discussed. Moreover, it has been found that problems relating to one's circumcision are often not perceived as a problem and just accepted as a reality of being female. Therefore, the respondents expressed the belief that if they are trying to reach women who are traditional minded, openly advertising the fact that they are going to be discussing FC/FGM might deter

them from attending in the first place. As well, the workshop organizers noted that often younger mothers want to leave their daughters uncircumcised, but do not know how to face criticisms and demands from older, more traditional relatives. By obscuring FC/FGM from the advertised workshop theme, older, more traditional women are not deterred from attending and hopefully learning from the workshop.

Finally, the respondents reported that workshops are necessary not only to prevent future circumcisions in Canada, but also to assist women who are already circumcised. The reason for this is, according to the respondents, that there is a need to provide health and emotional support for circumcised women. These women, as I was told, are often afraid to seek medical treatment, particularly if their problem is gynaecologically oriented, because they feel that Canadian doctors treat them disrespectfully, as if they were “a showcase.” Workshops can provide a space through which Somali women can support each other in the face of dealing with health care professionals who do not know how to deal with circumcised women. As one respondent noted:

*...because FGM in my country...is more taboo - we don't discuss that. We think that sexuality is something more personal and private and I don't have to discuss with anyone. But some of them they face a lot of difficulties with their medical doctors and also to the professional health providers because since these things are new, and the doctors will just see like, a showcase. So some women came to complain to me and they said 'I'm not doing a pap smear, I'm not doing this because I'm scared that the doctor, when I show him [my infibulation], is going to call all the nurses and all other people.*

Not only have some Somalis' experiences with doctors sparked fear of treatment, according to some respondents, but Somali women may also fear being shamed by their doctors. This



shame can stem from either the exposure of their genitals to a stranger itself, or be complicated through criticism and prejudice from the doctors' attitudes towards them because of their circumcision. Moreover, this shame is made even more complex by the fact that most Somali women traditionally do not discuss issues of sexuality, even with their doctors and especially if the doctor is male (Somali Women's Health Group 1991: 10).

A related health concern for several of the respondents that is addressed in their FGM/health workshops is that the Canadian birthing system has made many Somali women afraid of childbirth in Canada. For example, they may feel forced into having a caesarian rather than a vaginal birth which some respondents claimed is preferred by Somalis. Moreover, the respondents indicated that many Somalis fear the manner in which episiotomies are performed in Canada. Some respondents feared having a vertical episiotomy because the horizontal is apparently preferred. Workshops can serve the function of preparing Somali women for the way in which they will be treated when giving birth as well as to provide support to each other. It also serves to draw attention to problems in the system that the Somali women may face in relation to childbirth.

A related health problem some of the Somali respondents perceive from the medical establishment is a communication barrier. The language difference itself is a major problem for many new Canadian-Somalis. They may have difficulty understanding the doctor and may need to bring a translator. Workshop organizers that I interviewed said they often serve as a translator for other Somalis who have difficulty speaking English. These organizers accompany Somali women to the hospital in order to ensure that they and the doctor

communicate effectively with each other. This is necessary also because of the style of language and mannerisms employed by the doctors themselves. Several respondents expressed concern that doctors do not explain anything to them. They may not understand the doctor's diagnosis and method of treatment, and feel that the doctor does not want to take the time to explain things to them. This caused many Somalis to be frustrated with the Canadian health care system. My findings are comparable to those found by Hezekiah (1995). In her workshops of Canadian-Somalis, similar frustration with the Canadian medical establishment was also expressed. In her study of health care concerns held by Canadian-Somalis in the Hamilton, Ontario area, Hezekiah noted that her respondents felt that Canadian doctors "don't care" *i.e.* take the time to explain things to patients, or show empathy to patients. Examples of other related themes she discovered were that Canadian doctors do not understand specific Canadian-Somali health problems because the doctors are unfamiliar with circumcision, are insensitive to their Somali patients, and that the Canadian system of treatment is more impersonal than in Somalia (Hezekiah 1995: 5-8). Because of this problem, at least five of my respondents were actively working towards educating Canadian health care professionals about improving their treatment of Somali patients, and they continue to see a need for further growth in this area.

Therefore, the consequences of these seemingly frequent negative experiences with Canadian doctors has made, according to the respondents, many Somali women afraid of seeing doctors. The potential risk of ridicule and maltreatment, coupled with language barriers and the Somali tradition of not publicly discussing one's genital region, especially

with males, puts Somali women at a greater risk of health problems. If the Somalis are afraid of how they will be treated by their doctor, they will feel inhibited to seek preventative health care or even treatment for ailments. Moreover, they may put their unborn children at risk during pregnancy and childbirth if they are too uncomfortable with the doctors to seek prenatal care as well as generally fearing the birthing process in Canada.

Because of these health-related issues surrounding FC/FGM among Canadian-Somalis, *e.g.* the need to reach the perceived minority of potential supporters of the practice, as well as the need to support infibulated women seeking treatment in the seemingly hostile Canadian medical establishment, the respondents felt that awareness about the practice should continue to be advocated. However, they questioned the way in which the media has portrayed them. The overwhelming majority of the media has been negative towards the practice itself, but has not adequately address other issues, such as the negative treatment the respondents feel they receive from the medical establishment because of their circumcisions. The perceived insensitivity of the media towards the issue has made many respondents feel ashamed and in some ways has produced the opposite effect. For example, one respondent stated that she was not in favour of the practice, but when she hears of the negative things said about her culture in the media, it makes her want to defend FGM. Moreover, the respondents expressed the sentiment, with apologies to me as an investigator in this subject, that most people are only interested in sensationalising or making money from the topic to either sell papers or personally gain somehow. Even in the case of an outsider honestly wishing to help the community abandon the practice, they feel that outsiders will not be taken

seriously by the community. The told me that the community will not accept someone like myself telling them what to do about FGM, even if they agree with me, because they know that I have not gone through it and cannot identify with their culture. Therefore, in terms of FGM awareness initiatives, they would prefer to be in charge of such issues themselves and bring awareness to their communities in their own ways, usually through more subtle forms such as community workshops, rather than through the shamefully public displays that one sees in the media.

#### *Other Health-Related Concerns*

The previous media and health care concerns that the respondents expressed were at least partially, if not fully, related to their circumcisions. Note, however, that these issues were not related to any desire to continue the practice with their daughters, nor to ask for reinfibulation after childbirth. Although the respondents felt their treatment by the medical establishment because of their infibulations was a potential health problem because it would discourage some Somalis from seeking treatment, for some of my respondents, their major health concerns had nothing to do with FC/FGM. In fact, these non-FGM concerns were of primary, not secondary importance to their overall health and well-being. Such issues related to difficulties in finding adequate housing, lack of employment and retraining opportunities, and separation from spouses during the war leading to single parents being burdened with the responsibility of raising families on their own.

Improper housing in Canada appears to be a major issue of concern for Somalis particularly since it is normal for Somali families to be substantially larger than the average

family in Canada. For example, several respondents said they came from a family with five siblings or greater. Four of the respondents had four children or more. Moreover, several of the respondents also lived with extended family, such as aunts, nieces and cousins. Consequently, sometimes ten or more people would be living in a two or three bedroom apartment. Overall, inadequate housing poses a large problem for Somali immigrants since apartments in Canada are usually designed for families with only two children with a three bedroom maximum. Accommodation for a large family in Canada can be very expensive, which adds additional hardship to Somalis whose families are often run by a single mother living on Social Assistance while waiting for her refugee status to be approved or while looking for work. In Opoku-Dapaah's (1995) study of 385 Somalis from the greater Toronto region, he found that:

The majority of Somalis live in overcrowded conditions. In most cases, 1- to 2-bedroom apartments rented by Somalis tend to have two or three times the usual number of occupants. Somalis who occupy 3- to 5- room residential units also show signs of overcrowding; a significant portion (43 percent) or such units are occupied by twice the usual number of residents...a typical Somali household comprises offspring and other extended relations; there are also many reconstituted families, in other words, extended family grouping of survivors from the Somali conflict. The standard Canadian apartments that have 1, 2, or 3 bedrooms are therefore unsuitable for large or extended families of Somalis (Opoku-Dapaah 1995: 5).

Two of the respondents expressed that Canadian landlords are prejudiced against large families and often will refuse potential renters if they have more than two or three children. Opoku-Dapaah (1995) notes that this inability of the Canadian government to accommodate diverse living arrangements, such as larger numbers of children, or extended families, shows

the government's failure in keeping "pace with the growing sociocultural diversity of newcomers to Canada" (ibid). Several of the respondents expressed this sentiment themselves and would like to see the government assist them in building affordable accommodations that have the facilities to accommodate their larger and extended family living arrangements. One respondent from Kitchener-Waterloo was very frustrated because prior to the Conservative government's election in Ontario, she was involved in a community program that was awarded a large sum of money to assist her community in building accommodations able to accommodate larger families. However, once the Conservative party was elected, the promised money from the previous government was not honoured by the new one. This was very distressing to this respondent because she is a worker within the Somali community and she sees how frustrating it is for many families living in such crowded conditions. Even if larger accommodations were available, the limited incomes of many Somali families, particularly since many are relatively recent immigrants or refugees, makes such housing impossible to afford.

Another major problem that lowered the respondents' quality of life was not having adequate financial means. Several of my respondents expressed difficulty and frustration with finding employment despite the fact that the majority of them had received some professional designation, most from European schools and institutions. I met doctors, health care workers, teachers, an accountant and a Master's degree holder in economics unable to find employment in their fields. Even though they have searched for employment outside their fields, the majority of the respondents were presently unemployed. Only three of the

respondents had steady, full-time employment. Some of the respondents believed that they are having difficulty in finding work because either there are limited opportunities in their fields because the Canadian market is flooded, such as in the medical and teaching fields, or because their qualifications are not acknowledged. The respondents in this study mirrored findings by Opoku-Dapaah (1995). Of his 385 Somali respondents, 71% were unemployed. The respondents, similar to the findings in my study, believed that their high rates of unemployment were due:

...to the following factors: lack of job opportunities, layoffs, preoccupation with family obligations, decisions to embark on educational preparation prior to entering the labour market, nonrecognition of qualifications, and employers' insistence on Canadian experience as a prerequisite for employment (Opoku-Dapaah 1995: 7).

The Somali Women's Health Group (1991) similarly found in their study of Somalis in Ottawa that many of their respondents were also unemployed due to a lack of Canadian experience, and non-recognition of previous qualifications even if from a European or American university. As a result, many of their respondents were "humiliated and frustrated at being on social assistance" (Somali Women's Health Group 1991: 4).

Those Somalis who had not yet received refugee status faced particular hardships after their immigration to Canada in terms of employment opportunities. In Canada, refugees are "not permitted to work until after their first hearing, which can take months" (ibid). My respondents were similarly frustrated. For example, Saida recalled that while she was waiting for her status to be finalized, she had to wait for over eight months before she was funded to attend ESL classes. The only reason she learned any English during this waiting period was

due to the fact she was fluent in Italian, so she taught herself basic English through reading Italian-English translation books. Another woman expressed her frustration over the fact that for over six months after her arrival to Canada, the government would not provide support for her to attend ESL classes. The government only did so once her refugee claim was accepted. Therefore, this particular respondent was isolated and reduced to dependency on her English speaking friends to help her seek medical care, fill out appropriate paperwork, *etc.* for a much longer period of time than she would have if she had been allowed to begin learning English much sooner after her initial arrival. Such a delay also increased the amount of time it would take her to become fluent enough in English to look for employment. Other respondents also noted that difficulty with English was a barrier that impeded finding employment.

Re-education and/or retraining to improve chances of obtaining employment were also difficult for many of the respondents. Many of the respondents were unable to find employment in their fields because their qualifications are not recognized in Canada. Moreover, two of the respondents did not have their full transcripts and/or degrees because they were lost during the war. Since their qualifications were from Somalia, and many of the government buildings and records were destroyed during the war, it is impossible for them to reproduce them. At least two of the respondents are in the process of getting recertified, one is studying to be recertified as a medical doctor and the other as an accountant. At least three others are attending secondary school, both to improve their English and to have a secondary school designation in order to permit them to attend post-secondary in the future.



Nevertheless, one respondent expressed concern that her recertification would be useless. She said that even if she received her recertification as a medical doctor that would allow her to practice medicine in Canada, her chances of finding employment here are slim because of the overflow of doctors in Canada. She believes ultimately she will have to immigrate to another country in order to practice medicine. Moreover, some respondents were further frustrated by the fact that they could not afford recertification courses since they were on assistance or because they were awaiting landed immigrant status. The respondents informed me that refugees do not qualify for student loans, and that many of them have had to postpone their re-education several years in some cases while they await their landed immigrant status. Only then are they eligible to apply for loans to return to school. Moreover, when they fled their home country, they left most of their possessions behind and do not now have the resources to fund their own educational enterprises. Again, these findings concur with Opoku-Dapaah's findings. He discovered that 69% of his respondents:

...had to delay their education in Canada for various reasons. For some people, education has been put on hold for a few months or a few years; for others, it has been put on hold indefinitely. The most frequent reason cited by respondents for having to delay educational pursuits is "waiting for the outcome of refugee application," or "finalizing immigration status" (Opoku-Dapaah 1995: 5).

The final major concern that some of the respondents drew my attention to was the difficulties that occur due to separation from other family members because the war. In particular, separation from spouses caused considerable emotional and financial hardships. For example, one respondent who has resided in Canada for the last four years, with her four

children, continues to wait for her husband's immigration papers to be approved. Presently, he is waiting in a refugee camp in Kenya for his paperwork to be accepted which will allow him to join his family in Canada. The results of such separation is that many of the respondents, after immigration, have found themselves in the role of the single head of their household, with all the financial responsibility of their families solely squared upon their shoulders. Not only are they constrained financially with a single income to support both their immediate and often extended family, but should they need to pay for extras, such as legal fees to assist in either finalizing their landed immigrant status or to sponsor other family members to join them in Canada, they could find themselves in a terribly compromising financial situation. The Somali Women's Health Group (1991) also found similar conditions of poverty among their Ottawa respondents. They expressed their belief that:

Many Somalis in Canada are poor...The lack of money makes it impossible to help family in Somalia or in refugee camps. This is compounded by lack of landed immigrant status, which makes those in Canada ineligible to sponsor family members to join them (Somali Women's Health Group 1991: 4).

Opoku-Dapaah also noted that it is not uncommon for families to be separated because of the war. Although the majority of his respondents from the greater Toronto area maintained "the overall structure of nuclear and extended family members," approximately one-quarter of the families in his study did not. These families arrived in Canada:

...with an assortment of fragments of nuclear and extended families. They are mainly female-headed single parents with "reconstituted family members," in other words, extended family groupings of survivors. The female heads were accompanied by their own children as well as younger siblings, nephews, and nieces. In one such family, the woman had responsibility for seven children.

The parents of the children died either during the conflicts or while fleeing from Somalia (Opoku-Dapaah 1995: 64).

Therefore, because of separation from spouses, many Somali women may find themselves overburdened with not only their own children, but with other relatives. Some of my respondents were also overburdened with the responsibility of caring for older relatives. For example, one respondent's two-bedroom, four room apartment was home to her, her son, a niece, two cousins, her mother, and a great-aunt. Moreover, other relatives would often come and spend days or weeks at a time as needed. With only social assistance to help provide the necessities of life, particularly in single-headed families, several of the respondents, as well as many of their friends and family, were living well below the poverty line and felt that their health and welfare were severely compromised.

## **CHAPTER EIGHT: Conclusions**

Changes in cultural practices, particularly those that comprise integral parts of both individual and social identities, require long and involved processes. Although condemnation of FC/FGM may arguably be justified, particularly by anti-FGM activists in light of the health and sexual complications that the practice can cause, the complexities surrounding the practice within the cultures that support it are vast. This reality makes impossible quick approaches to eradicating FC/FGM from a culture, as is evidenced by the situation in Somalia where even after twenty years of active anti-FGM campaigning, the majority of Somalis continue to support the practice in some form. Nevertheless, cultural changes can occur, given sustained campaigns advocated by members of the community involved, as the respondents in this study have shown. Most importantly, such changes can occur when alternatives to the practice in question can be incorporated as part of that culture's identity. Calls for the imposition of cultural changes, such as the eradication of FC/FGM, without taking such cultural sensitivities into account, invariably are met with resistance.

Certainly, the social responsibility of the Canadian media in its call to eradicate the practice needs to be addressed. Throughout the interviews, the respondents greatest frustration was that although the media will publish articles about the health consequences of FGM and its alleged continuance by Canadian-Somalis which puts their daughters at risk of health problems, never does one find articles about other health-related concerns that the

Canadian-Somali community faces. As some of the respondents so adamantly pointed out, never do you find an article focusing on other important issues, such as the negative perceptions of the Canadian health care system which can lead to unwillingness or fear of seeking treatment or preventative care. Neither do we hear about Somali families living in poverty in Canada due to difficulties in finding employment or retraining opportunities. Nor we do not hear about single mothers shouldered with the burden of raising large families on their own, separated from their spouses during the war.

Moreover, the media's portrayal of FGM in Canada also has the potential of causing defence mechanisms to come into play. As the Somali culture is condemned for its traditional advocacy of FGM, Canadian-Somalis may feel defensive about their cultural tradition which comprises part of Somali, and particularly Somali women's, identity. A more sensitive analysis and portrayal of the issue is necessary in order not to alienate the people who are most affected. Awareness of FC/FGM is deemed necessary even by the respondents in order to reach the few who are determined to continue the practice, or who still believe in its positive characteristics. It is also necessary in order to provide support to women who are living with the consequences of their genital operations in a country which condemns those cultures who traditionally support it, as well as to educate health care professionals about cultural sensitivity when dealing with circumcised clients. However, the portrayal of FGM as a health care concern in the media is limited when it does not take into consideration other health and welfare issues. Health care initiatives are not unidimensional. Focusing on FGM as a primary health concern of the Canadian-Somali community is irresponsible when it

neglects to address other issues, such as poverty, which afflict a large number of Canadian-Somalis. The inability of the Canadian government to assist in alleviating the multitude of problems Canadian-Somalis face must also be addressed. Although the respondents do not necessarily believe that anti-FGM programs should be abandoned in Canada, they do feel that less focus on FGM, and more focus and financial support towards problems with the health care system, adequate housing, employment/retraining, and financial assistance, particularly for overburdened single mothers, should be given.

Focusing only on the exotic practices of others does little to assist those whose health and well-being is determined by a variety of needs and concerns. Both responsible analysis and responsible health initiatives must address this multitude of concerns in order to avoid being rendered useless or too limited to those most adversely affected.

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