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THE PROCESS OF CHANGED MEANINGS

A STUDY OF THE CANADIAN EXPERIENCE OF SOMALI WOMEN IN THE KITCHENER-WATERLOO AREA IN REGARD TO FEMALE CIRCUMCISION

THE NARRATIVE RESEARCH METHOD

by

A. La Ferne Clarke

Thesis
Submitted to the Faculty of Social Work
In partial fulfilment
of the requirements of the degree of
Master of Social Work
Wilfrid Laurier University
1995

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ABSTRACT

This thesis tracks the process of changed meanings. My research tells the fictitious story of a Somali woman named Mary. She has been in Canada for less than five years, and she moved to the Kitchener-Waterloo area, almost immediately. The narrative tells of her transition and the issues she had to handle. Female circumcision is the central issue in the story. Mary's thought process as she moves from a country that supports female circumcision to a country that calls this practice female genital mutilation has to change if she decides not to circumcise her daughter.

This Canadian story should guide other women through this process of transition. It should also help Canadian social workers comprehend the issues Somali women, and all women who have this cultural practice experience. The story values the perspectives of women who have had to confront FGM. They encountered it in childhood in one context, and now have to manage this issue again as mothers in a different context. Their decisions will affect their daughters' lives in their new environment.

How does Mary handle situations? What feelings unfold within her? What coping strategies are formulated? These answers emerge when a composite of individual experiences create this fictitious narrative, which reflects an accurate Canadian-Somali story. This story was gleaned in a manner that was respectful and dignified and it provides us with an understanding of what occurs when the definition of female circumcision changes its meaning.

ACKNOWLEDGEMENTS

I would like to thank all my dear friends in the Somali community, who I will not mention by name to ensure that you are not stigmatized. You know who you are, thanks for the tea, recipes, food, jokes and laughter. In particular, a special thanks to 'our group' of women who participated in my research. Thank you for your belief in me and your courage to share. I would also like to thank my thesis committee for their leap of faith in allowing me to explore something new, Dr. Kenneth Banks, Dr. Anne Westhues and Dr. Juanne Clarke.

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INTRODUCTION

Female infibulation is also commonly called female circumcision (FC) and female genital mutilation (FGM)*[1]. FGM has a strong cultural tradition in parts of the Middle East and Africa. Immigration has caused this topic to become relevant globally. Today, globalization has transposed societal norms, mores and culture beyond geographic borders, therefore the interest in FGM has grown.

Essential to this debate within the Canadian context is whether FGM is a religious or a cultural practice. During my study in Africa, I discovered that FGM and other 'rites of passage' practices, and ceremonies are viewed as cultural not religious. I have adopted that perspective. My storytellers also believed that FC is a cultural and not a religious practice. Since this is a cultural practice, we need to examine what happens when African-Canadians change environments and make Canada their new home. By understanding FC from this perspective, social workers can predict the issues that may arise in the lives of Somali and other women. Knowledge and understanding will ensure that appropriate support is provided. A Somali woman reading the story will appreciate that her thoughts, experience and feelings are not unusual. Hopefully, this will be a source of strength for her.

---

[1] I will use female genital mutilation (FGM) and female circumcision interchangeably, unless specified, throughout this proposal. When communicating with Somalis I will use the term female circumcision.

At present the countries of the North*[2], are horrified at the practice and have aided the fight to rename the practice Female Genital Mutilation (FGM). The Ontario Women's Directorate has taken a firm stand on this issue. They demand that the federal government legislate against FGM in Canada. This direction is congruent to the current feeling of some women from the South*[3] How the changed terminology and its meaning affects Somali women has not been documented.

The focus of Canadian opposition is legally based as FGM is against the law in Canada. As social workers, however, we need to examine the policy and process perspective. The information gathered for this study aids policy makers to understand what FGM means to some Somali-Canadian women.

STATEMENT OF THE PROBLEM

My need to research this topic was driven by my desire to highlight, through stories, the Somali women's perspective. This suppository of information is useful in multicultural social work practice and policy. The current literature and research is 'Eurocentric' in focus, quantitative in approach, and is geared towards marshalling support for funding agencies to join in the cause of eradicating the custom. Research has not mapped a narrative that is recognizable and relevant to the lives of persons who have to cope with the two options - 1) to have their daughters circumcised or, 2) to disregard their cultural

---

North = formerly known as First world countries.

South = formerly known as Third world countries

practice. By ignoring the stories of immigrants and their process of 'Canadianization' we fail to understand the issues, circumstances and emotions to which female circumcision is tied.

Although FGM is widely practised by many cultures, the arrival of Somalis in Canada has highlighted this issue for Canadians. In the past five years, over twenty-five thousand Somalis have arrived in Canada (personal communication, Immigration Canada, May 1995), and approximately seventy percent of these immigrants are female. The largest Somali communities can be found in Toronto but within the past three years, the Somali community in Kitchener-Waterloo has been growing at the rate of two to three new families per week (personal conversation, May 2, 1995 K-W Somali Women's Coalition). Women's Health in Women's Hands, a Toronto based health centre for women, estimates that ninety-eight percent of the Somali women who now live in Canada have been infibulated. This makes the issue new to the K-W community, yet very relevant to the settlement and welcome of these new immigrants.

At present, members of the African community in Canada believe that this issue is not being handled sensitively. Due to distrust based on a legacy of colonization and the sensitive issue of sexuality, feelings and thoughts about FC are not easily shared. In many African societies sex and sexuality are not considered topics for open discussion, especially among non-family members. Therefore, relating a story helps the storyteller depersonalize her experience, which in turn makes the storyteller comfortable. Comfortable storytellers will interact naturally and give more realistic stories.

Narration is common within my Black experience. Within the African Diaspora, narration is used to promote learning This mode of learning is natural to us as we have used it to maintain our 'oral history' tradition. In most Black societies, narration is used in disciplining children, talking about sexual matters, imparting knowledge of life experiences and of course, telling our history. Narration is the nucleus to the telling of proverbs. It is felt that the story and its point will always be remembered. Memory is integral to reflection and learning and learning is necessary for behavioural change. Therefore, the Narrative Research Method was selected as it is consistent with the culture and oral traditions of the Black experience.

Some might conclude that because I am a Black West Indian social work researcher, my culture is congruent with that of Somalis and the acceptance of the Somalis would be a given. In my experience however, this was not necessarily true. Care in approaching the group was still needed. I feel Blacks of all cultures need to understand these practices. It was this lack of understanding, but an openness to learn, that aided my listening and kept me true to the storytellers' tale. My practicum in Zimbabwe added to my experience in handling sensitive cultural issues. This helped me read cultural cues correctly so that I gained acceptance.

One handicap was my inability to speak Swahili, Arabic, Italian, or, Somali. I planned to utilize women who were fluent in English, as well as interpreters and tape recordings to overcome this obstacle. This constraint forced me to focus on urban Somali women rather than rural women because their understanding of English might be limited. This meant

that I was unable to use women who had never been exposed to the FGM debate, and so might therefore be the greatest defenders of FC. However, to do this would have meant organizing another research project.

The transition from practising female circumcision to discontinuing the practice has been made in the past. Europeans, for example, practised FGM as a cure for certain diseases, for example, depression and epilepsy and yet it is not practised today (Koso-Thomas, 1987). Africans who became slaves and practised female circumcision may have found resolution to any cultural conflict they had, as female circumcision was not practised in the 'new world' by the slaves. In my personal experience and in verbal communication with members of the Caribbean community (February to August 1994), FGM is not currently practised in any Caribbean country. It is felt that FGM did not survive as a slave tradition, because of the prevalence of rape by plantation owners. It may also not have been the choice of North American or Caribbean Blacks to discontinue the practice, it may have been decided for them by slave owners. One hundred years after emancipation the resolution process has resurfaced.

FGM MEDICALLY DEFINED

FGM takes four basic forms: circumcision, excision, infibulation, and introcision Examination of the development of the genitals of the male and female fetus clarifies what is removed in circumcision and how it came to be viewed as the removal of similar structures in the male and in the female (Figure 1).

Circumcision, the first form, is also known as Sunna. Sunna, which means tradition, is the word used in Muslim countries. This involves cutting away the hood or, prepuce of the clitoris. The prepuce is the foreskin protecting the clitoris itself (Figure 2). This is often compared to male circumcision. It is the mildest form.

The second form, excision, is the removal of all parts of the clitoris and all, or portions of, the labia minora. However, it leaves the labia majora intact and the rest of the vulva unsutured (Figure 3).

Infibulation is the third form, and it involves the removal of the clitoris, and all of the labia minora and majora. The two sides of the vulva are then pinned, (usually with thorns), or stitched together; (suturing), leaving a very small orifice to permit the flow of urine and menstrual discharge (Figure 4). Scar tissue forming in the area is desirable as it is culturally thought to be aesthetic (Hosken, 1993; McLean & Graham, 1983; Koso-Thomas, 1987). This type of circumcision is most common in Somalia, although locally it is referred to as female circumcision.

My discussions, (personal communication with various African communities, August, 1994) revealed that FGM is performed on girls at different ages in different cultures. In Ethopia and Eriteria it occurs between four to nine days after birth. In parts of Arabia it takes place ten weeks after birth. In Northern Africa, FC is performed at any age between, three to eight years old, (before puberty) depending on the locality and ethnic group (AOHC Conference, 1994). In Kenya and Mali, FGM can also be performed at the age of 14 years

or older. In Mali, FGM is done shortly after marriage, and in Nigeria and Guinea it can be performed after bearing a child. It is important to note that the age limit depends on the ethnic group or clan thus, within one country a few age variations could co-exist. My research revealed (personal communication with the African community, August, 1995), that FGM is usually performed in Somalia between the ages of two to six years old. The desire was to have it done before the onset of puberty.

The fourth type of circumcision which is called introcision is not illustrated. Lyons, (1981) describes introcision and subincisions as having been practised by the Australian aborigines they "slit open the urethra as well as circumcise the penis", in the male (subincisions) and in females (introcision), the "vagina often being slit to conform to the contours of a male member widened by subincisions". This type of circumcision is rarely practised today and for that reason, I will not refer to this form again.

HEALTH PROBLEMS

Health problems associated with FGM depend on the degree of the operation, the hygienic conditions, the skill and eye sight of the operator and the struggles of the child. They occur more often in infibulated women than in sunna circumcised women, but this does not mean there are no complications in sunna. Health problems can be divided into seven areas:

Immediate: excruciating pain and terror at the moment of being seized or hearing other girls; haemorrhage from the cutting of the pudendal artery or the dorsal artery of the

clitoris; shock, bad eye sight of the operator or squirming of the child may cause cuts to other organs -- the urethra, bladder, anal sphincter, vaginal walls or Bartholin gland; instruments that have not been sterilized can cause acute urinary retention, urinary infection, septicaemia (blood poisoning), fever, tetanus; fractured clavicle femur or humerus (due to being restrained); and death.

Intermediate: delay in wound healing; dysmenorrhoea (pelvic infection); cysts and abscesses (dermoid cysts can become so large that they can be the size of a grapefruit); keloid scar (sometimes they are large enough to obstruct walking); dyspareunia (painful intercourse); chronic vaginal infections, (sometimes a large foreign body forms in the interior of the vagina as a result of mucous secretions); dysmenorrhoea (painful menstruation since menstrual blood cannot escape freely)

> Dr. Olliver, a military doctor in Djibouti describes this example in McLean & Graham (1983): "a sixteen year old girl brought to the hospital at one a.m. with unbearable abdominal pains. She had not menstruated for several months, and had not had intercourse, but her abdomen was swollen and sensitive, with the signs of a uterus in labour. She was infibulated, with a minuscule opening. Penetration would appear to have been impossible and there was no sign of a beating foetal heart. Dr. Olliver performed a disinfibulation (see figure # 5), opening of the scarred vulva, and released 3.4 litres of blackish foul-smelling blood" (p.5).

Late complications: Haematocolpos closure of vaginal opening; infertility (sometimes women become sterile due to infection which ascended into the reproductive organs); recurrent urinary tract infections; difficulty in urinating (because the opening is too small); calculus/stone formation; hyper-sensitivity to touching the genitals; anal incontinence; and fissure (rare, but this is due to rectal intercourse if vaginal intercourse is not feasible).

Consummation: Difficulty in penetration; dyspareunia (rigid scar tissue causes extreme pain during intercourse); false vagina (using another opening by mistake).

Sexual problems: lack of orgasm; frigidity; anxiety; depression; temporary impotence, and frustration, and extreme pain during intercourse.

At Delivery:

MOTHER: Prolonged and obstructed labour; unnecessary caesarian sections; perineal laceration (baby being pushed through perineum); uterine inertia (excessive blood loss and pain in second stage labour); obstetrical and gynaecological difficulties, for example pelvic examinations.

CHILD: stillborn; brain damaged; or mentally handicapped.

Post-natal Complications: fistulae - urinary and rectal (due to pressure of baby's head urine or faeces seeps through the cervix; prolapse of the uterus; fistula formation; causes incontinence later in life (that is constant dribbling of urine).

(Hosken, 1993; Koso-Thomas, 1987; Toubia, 1994)

POSSIBLE BENEFITS OF THE STUDY

This topic is timely to Canadians as the current literature suggests that FGM is being practised in Canada, probably to a greater extent than we know (Mak 1983; Canadian Advisory Council on the Status of Women [CACSW], 1994). Peg Robertson, in a CBC television interview said:

> "I think FGM is occurring in Ontario. I have no basis for that belief, other than this is a well-established tradition. And I have to believe that such a potent tradition is continued within the confines of Canada. "

When asked by the interviewer: "How would I get this surgery done? Where would I go?"

She replied:

> "Within the communities, I think there is access to people who will operate upon young girls in particular. And I also believe that there are surgeons, and I'm not talking necessarily about formally qualified surgeons, who are imported into the country, to operate on the girls" (CBC Radio Sunday Morning, Current Affairs program transcript, p.4, February 14, 1993)

This conclusion disturbs me, whether I believe Robertson or not. What is important is the reaction this statement got from the Canadian community. First, Robertson declared she had no basis for this belief but then she stated that women are being imported into the country to operate on girls. This reasoning without proof alarmed the Canadian population. It raised the topic of FGM to the forefront of the media and made Canadians angry, or horried that immigrants were continuing this practice. (personal communication with local K-W community May, 1995). High profile criticism, strong moral outcry, uncompromising legislation and unfavourable labelling of the practice have transformed this issue from a cultural to a medical, moral and legal one. This approach does not resolve any emotional conflict for the individual living with FGM or trying to decide what to do with her daughter.

Within this hostile context, the individual still has to decide whether she believes in the practice: the strength of her beliefs and whether she will communicate these beliefs to the next generation.

As a social worker, I believe it is imperative that we begin by examining our clients' stories. This will enable us to understand their affect, the way they think and their needs, in regard to FGM. Appropriate intervention methods and support are necessary to ensure that this population, usually first generation immigrants, are made to feel valued and understood. This is the essence of multicultural social work.

My research will be of value to other sectors of our society. Medical personnel need to have access to appropriate cultural information. The manner in which medical personnel react to a patient who has had this procedure is crucial. At present, these women are looked upon with curiosity, and thus feel stigmatized and embarrassed. Often, their genitalia are shown for educational purposes to medical students, nurses and other doctors, sometimes without their permission, and usually without any thought to their feelings. Photographing of the area and numerous examinations by a variety of personnel often embarrasses the women, fills them with shame and feelings of alienation. Very few of them are confident enough to refuse permission when asked, therefore their agreement should not be taken at face value. Often this experience will prohibit them from seeking medical attention in the future. How does this experience affect their thoughts on female circumcision? Future research needs to examine this question and this narrative research project begins the dialogue.

Learning about this practice also affects social-dating encounters between cultures, even within the Black race. Blacks, from the West and from Africa, find FC to be a difficult topic to talk about. Among Blacks from the West FC is an issue that is not understood. Within the Black-cultural context of sexuality, this issue needs to be understood. A narrative will aid this process of understanding and hopefully help to promote dialogue.

LITERATURE REVIEW

My literature review was ongoing throughout my research. I read and became conversant with relevant information as it related to the stories told by my storytellers I read any geographical, historical, religious, medical or psychological literature relevant to the story being told.

Mak (1993), estimated that over one hundred million girls and women alive today have scars and suffer the physical consequences of FGM. A 1993 study by the World Health Organization estimates that thirteen million girls in Egypt have undergone this operation (The Toronto Star, 1995). The United Nations estimates that two to three million girls under the age of eleven have this operation performed on them annually (McLean & Graham, 1983; Toubia, 1994).

The literature also identifies over twenty nations in Africa where this procedure is currently practised (McLean & Graham, 1983). It examines the medical facts and the emotional trauma that accompanies the practice always emphasizing the pain and helplessness of the victim (Mak, 1993; Whyte, 1990; Canadian Broadcasting Corporation, 1990). The Toronto Star (1995) quoted Egypt's Population Minister, Maher Mahran as saying:

> "adult patients in his own medical practice vividly recall their own suffering during circumcision".

FGM has been practised at different times in many cultures and countries. In ancient Europe and in the ninth to twelfth centuries in Britain, FGM was practised as a cure for nymphomania, hysteria, insanity, depression and epilepsy. Today circumcision is practised in parts of Africa; (Somalia, Djibouti, Ethiopia, Eriteria, Mali, Sudan, Sierra Leone, Burkina Faso, Gambia, Ivory Coast, Kenya, Senegal, Egypt, Guinea, Guinea Bissau, Nigeria, Mauritania, Central African Republic, Niger, Chad, Benin, Togo, Ghana, Tanzania, Uganda and Zaire); Asia, (Philippines, Malaysia, Pakistan and Indonesia, and the Bohra Moslems of India); the Middle East (Oman, South Yemen and the United Arab Emirates); and Latin & South America (Brazil, Peru and Eastern Mexico). Recently, reports suggest that FGM is performed among immigrant communities in France, UK, Australia and Germany and that many affluent Africans have the surgery done in European hospitals (AOHC Conference, 1994; CBC, 1990). Hospital conditions ensure greater safety due to accurate surgery; access to emergency care (in case there are complications); and a hygienic environment. The benefit for the hospital is the high profit to cost ratio. These operations are financially lucrative for doctors, therefore, they are often viewed as good business (Koso-Thomas, 1987; Whyte 1990).

Cultural variations account for some African countries practising FGM while neighbouring countries do not practise it. There was no information regarding a cultural link within the origin of the various forms of FGM. What is known is that it was practised in parts of Africa (Egypt or the Sudan) from before the time of the Pharaohs (Awake, 1993). Mak (1993) in her article says that mummies of ancient Egypt, dating back to 500 B.C. have been found

with signs of FC. Some speculate that it was used to distinguish aristocratic women from slaves.

The literature states that in many clans and ethnic groups in countries like Somalia, Sudan, Zambia, Nigeria and Ghana FGM is so wide-spread that although it is shrouded in secrecy, it is unquestionably accepted as part of everyday life (Mak, 1993) In these societies an uncircumcised woman is seen as shameful and unnatural, by both women and men (McLean & Graham, 1983).

FGM is practised by all religious and economic classes - Muslims, Catholics, Protestants, Copts and Animists (McLean & Graham, 1983). This has helped to formulate my opinion that this practice is cultural rather than religious. My opinion was confirmed by the Somali participants in my research who also the viewed FC as a cultural and not a religious practice. The World Health Organization's, (W.H.O.) official position is that FGM is a traditional and not religious practice (Communique, June 1992). However, this view in not held by all. A newspaper report on the Women's Conference being held in Beijing, China, states that some Muslims see the practice as religious (The Toronto Star, 1995). Dr. Thabet, an Egyptian physician, practising in Egypt and a supporter of FC says:

> "Female circumcision is purely Islamic, like male circumcision -- this is the word of our high religious authorities. Anyone who says it is illegal should be punished by the government ... Previously I was doing circumcision secretly, because I thought they were illegal" (The Toronto Star, August, 1995).

Subsequent discussions and Toubia's (1994) writings confirmed that there are two schools of thought: a) African Muslims believe it is part of Islam and originated in Islam, and the

truth, b) Historically, FGM preceded Islam in Africa, and newly converted African Muslims amalgamated the practice with Islam. This accounts for the belief of many African Muslims who cite it as a religious requirement. Whenever Islam spread from the Nile Valley in Africa FGM is thought to be a religious requirement. For example, the Daudi Bohras of India, their religious beliefs are derived from an Egyptian based sect of Islam. This also explains why some Muslims from countries like Saudi Arabia, Algeria, Iraq, the Gulf States and Kuwait do not practice FGM and find it difficult to believe that it is linked with Islam. Wherever Islam spread from the Arabian route it is not seen as a religious requirement (Toubia, 1994). Based on the above, future research needs to examine the extent that religion, class and/or education plays in perpetuating this practice in Africa and Canada.

In Africa the three forms of FGM are practised; circumcision, excision and infibulation (McLean & Graham, 1983). In Somalia the operations are performed by an old woman in the village known as "Gedda". My literature review done in Zimbabwe revealed other common practices. I found various 'rites of passage' for women in African society. The process of uncovering other sexual practices, such as elongating the labia and the hood of the clitoris.

The Kenyan newspaper "The Standard" (year unknown), and Mak (1993) noted that 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. In Zimbabwe and Kenya discussion on sexual matters especially with the opposite sex was greatly

frowned upon. In spite of this many are raising their voices and speaking out on sexual issues. These findings are supported in the literature (Mak, 1993; Toubia, 1994; Sisterlinks, 1989). This new attitude has led to voices being raised against the practice of FGM worldwide (Koso-Thomas, 1987). I have only been able to find one article, in my search of literature in Africa and Canada that speaks for the advocate of the practice of FGM (Toronto Star, 1995).

The literature relates the excruciating pain that is experienced when little girls are mutilated (McLean & Graham, 1983; Morgan & Steinem, 1983; Dorkenoo & Elworthy, 1992; Abella, 1983; Mak, 1993; Whyte, 1990; Hodge & Ndjamema, date unknown). They state that there is no medical justification whatsoever for the practice and state the belief that FGM accounts for many deaths (Awake, 1993; CACSW, 1994; Morgan & Steinem, 1983; Sisterlinks, 1989;). This procedure, like many incisions done with communal tools, plays a part in the transmission of AIDS in Africa (Awake, 1993; Sisterlinks, 1989). Tools have been jagged knives, razors and broken glass. The increased health risk has caused countries like Australia, Canada, Europe and the United States to view FC as a public health issue and these Euro-cultural regions are examining the cost to Western Health Care (CBC, February 1993).

Mohammed, (1992) discusses the impact FGM has had on a woman's life by turning our attention to poetry. In African poetry and literature there are three pains described as being female; circumcision, the wedding night and childbirth. She emphasizes the point that "nothing prepares a female child for the destruction of her female sexual organs". Toubia

(1994) encourages us to make a parallel between physical scars and psychological scars. She suggests that physical scars get bigger with age and subsequent childbirth. Using this reasoning, she says the invisible scars also grow. There is very little written research about this, but Toubia, (1994) suggests that anecdotal evidence is sufficient support;

> "After the circumcision and a month of confinement Oumi was returned home. Yassin, her mother noticed that Oumi behaved very strangely; she was easily irritated, her appetite had gone, and she often kept herself in isolation. She also noticed that she was not comfortable when she sat for lunch. She asked what was wrong and the answer was 'nothing'. Oumi was too embarrassed to mention her genitals in front of the other children. When Oumi's gloominess and discomfort got worse, and her visits to the toilet became frequent, her mother persuaded her to let her examine her genitals. There was inflammation and soreness at the site of the circumcision. It was three months after the operation. For a while Yassin tried the treatment Ngasimba (the traditional circumciser) gave her, but the wound got septic. She took her to the hospital where they dressed the wound and gave her antibiotics. The wound healed eventually but the infection keeps recurring. Oumi has to visit the hospital two to three times a year". (Toubia, 1994, p.40)

Despite the celebration, gifts and rivalry around the event, responses vary. Some adults remember the operation vividly, while others erase it from their memories; some women become angry and others deny the effects. The direct impact it has on shaping girls self-image is not known but research needs to uncover this fact. Central to the memory of the event is the method of administration. Often the literature describes, the pain and the feeling of helplessness, that occurs: One, the girl is forced to have the sensitive genital area cut often without anaesthetics; and two, the method required four to six women forcibly holding the girl down and restraining her physical movements by force as the girl writhes and tries to escape the pain and the confinement. The amount of bleeding caused by cutting the artery is also frightening for the child. In my readings I found various preparations, depending on the locality, were used to dress the wound, for example, salt and oil; herbs; eggs and sugar mixture; or ash. I surmise that this ointment, whatever is

its composition, would be painful when applied. The girls legs are bound together until the cut heals. It is said to take an average of three to four weeks. During this time urinating is very difficult (Toubia, 1994).

McLean and Graham (1993) describes the ceremony in Djibouti:

> "The little girl entirely nude is immobilized in the sitting position on a low stool by at least three women. One of them with her arms tightly around the little girl's chest, two others hold the child's thighs apart by force, in order to open wide the vulva The child's arms are tied behind her back, or immobilized by two other women guests. The traditional operator says a short prayer. :"Allah is great and Mahomet is his Prophet. May Allah keep away all evils." Then she spreads on the floor some offerings to Allah, split maize, or in urban areas, eggs. Then the old woman takes her razor and excises the clitoris. The infibulation follows: the operator cuts with her razor from top to bottom of the small lip and then scrapes the flesh from the inside of the large lip. The nymphectomy and scraping are repeated on the other side of the vulva. The little girl howls and writhes in pain, although strongly held down. The operator wipes the blood from the wound and the mother, as well as guests, 'verify' her work, sometimes putting their fingers in it. The amount of scraping of the large lips depends on the technical ability of the operator. The opening left for urine and menstrual blood is minuscule. The operator applies a paste and ensures the adhesion of the large lips by means of an acacia thorn, which pierces one lip and passes through into the other. She sticks three or four in this manner down the vulva. These thorns are then held in place by means of sewing thread or with horsehair. Paste is again put on the wound. But this is not sufficient to ensure the coalescence of the large lips; so the little girl is then tied up from her pelvis to her feet; strips of material rolled into a rope immobilize her legs entirely. Exhausted, the little girl is then dressed and put on the bed. The operation last fifteen to twenty minutes, depending on the operator and the resistance of the child" (p.3).

People question whether or not male circumcision is also a form of mutilation (Awake, 1993). Christian literature does not view [illegible] circumcision as comparable to FGM (Awake, 1993; Sisterlinks, 1989).

> "There is a principal difference between male circumcision and female circumcision (or rather excision). In the male circumcision no parts of the male sex organs are

> mutilated, only the foreskin -- the outer cover of the male sex organs -- is being removed, without touching the male sex organ itself. As for female circumcision the matter is different. Parts of the female genitalia are excised and removed from the girl's body. In female circumcision parts of the clitoris or all of it, the labia minora, and the labia majora are mutilated. No doubt such mutilation or excision of parts of the girl's sex organs is despised as it disfigures and deforms what God has created. God created human beings -- both males and females -- as complete persons. When "God saw everything that he had made, and behold, it was very good" (Sisterlinks , 1989, p.5).

Secular literature likens it to the 'amputation of the penis' (Toubia, 1993, p.593).

FC is advocated by Ethiopian Christians (AOHC Conference, 1994) and rejected by other Christians (Assad, 1989), whereas, secular literature shows the growing custom of not practising any form of circumcision (CBC, February 1993; Whyte, 1990).

Although circumcision is not openly advocated by all religions, it is indirectly sanctioned by some. When we examine male circumcision we see that the interplay between religion and culture is not clearly defined. Male circumcision is a religious requirement for Jews:

> "The Book of Genesis states that God ordered Abram to circumcise his male children and all the human males in his household. ... This is my covenant, which you shall keep between me and you and your descendants after you; You shall be circumcised in the flesh of your foreskins, and it shall be a sign of the covenant between me and you ... ' Genesis 17: 9-11. This covenant continued throughout the Hebrew Scriptures (Old Testament)" (Sisterlinks, p.4, 1989)

This is not the case for Christians, however:

> "Some Christian teachers, who were teaching at Antioch (Asia Minor), said to them: 'unless you are circumcised according to the custom of Moses, you cannot be saved.' (Acts 15:1) ... The first Christian council was held in Jerusalem to deal with this matter. ... 1 Corinthians 7:17-20 tells the outcome ... "Circumcision does not mean a thing, and uncircumcision means not a thing, but observance of God's commandments does. In whatever state each one was called let him remain in it". Hence, it is obvious that male circumcision, which was a religious practice in the Hebrew Scriptures (Old Testament) has no religious significance in Christianity." (Sisterlinks, p.5, 1989)

Although not required, the practice of male circumcision is not condemned by most Christian churches. Why is this? Could it be because of the ideological link between Judaism and Christianity? In fact, male circumcision is seen by some Christians as hygienic and is left to individual choice. What role does spirituality have in forming this choice? Spirituality forms the basis of Christian values and if there is no Christian church that condemns male circumcision, but instead tolerates and silently approves of this practice -- is this not sanctioning the practice? Do parishioners not assume that they have the church's blessing? If the answer is yes, then religious canonicity is not the only way that religious and moral mores are formed. If this is holds true for Christianity and male circumcision, why should FC and non-Christian religion be any different. I believe that there is some degree of sanction for circumcision by the Christian church and that there is this same link between FC and all of the religions which permit it in the countries in which it is practised. Principally these are Islamic countries but it is also practised by Christians, Copts and Animists.

Information from the Beijing women's conference in 1995 indicates that many Muslims believe that female circumcision is a religious requirement and yet others in the same country believe it is not - for example, Dr. Saeed Mohammed Ahmed Thabet and his wife.

> "Dr. Saeed Mohammed Ahmed Thabet ... an influential professor of obstetrics and gynaecology at Cairo University, has performed thousands of circumcisions on Egyptian girls during his 30-year career. Now he is training a new generation of medical students to carry out his mission. The doctor believes he has God, good hygiene and a girl's best interests at heart. ... There is good reason for its enduring popularity, according to Thabet. It remains a religious injunction. and is fully sanctioned by the state (Egypt). "Female circumcision is purely Islamic, like male circumcision -- this is the word of our high religious authorities." ... Thabet claims Egypt's Ministerial Decree, No. 61 issued in 1959, clearly authorized doctors to do

> it. ... he referred "to our Prophet and said the circumcision should be something called the 'khafd' -- a decrease in the size of the prominent structures, the clitoris and labia minora". Because of this, Thabet says: "... now he can perform them openly, particularly on religious holidays."

Interestingly, however, the same article reveals that Thabet's wife, also Muslim,

> "won't let him touch their own pre-pubescent daughter with a scalpel. The doctor says he can't understand why." (Toronto Star; 1995).

Another gap in the literature, not addressed in my research, is the role of the male and his perspective; especially as it relates to status, pride, self-esteem, headship, family relations, and the marriageable state of daughters and spouses. The belief is that FGM keeps women monogamous because their opening, after marriage consumation, is only tailorized to fit their spouse's penis (Koso-Thomas, 1987; The Toronto Star, 1995). Toubia (1994) also indicated that keeping women monogamous was seen as a benefit. Future research has to explore the medical veracity of such statement. If future research proves that the correlation between belief in polygamy and FGM is strong, inflibulation could have been used to ensure that wives would be indifferent to sex when their husbands were unavailable. It may have been that FGM was used as a method of social control and in a communal society ensured that friction around conjugal rights, adultery and relationships were kept to a minimum.

The only information I could uncover on sexual comfort following FGM was the Minority Rights Group (1983) article which states:

> "even in ... clitoridectomy a part of a woman's body containing nerves of vital importance to sexual enjoyment is amputated. The glans clitoridis with its specific sensory apparatus is a primary erogenic zone. When it has been reduced to an area of scar tissue, no orgasm can be released. The ... work of William Masters and

> Virginia Johnson, has conclusively proved that all orgasms in women originate in the clitoris, although they may be felt elsewhere. There remains confusion however, over the terms 'clitoral orgasm' and 'vaginal orgasm'." They continue..."The vestibular bulbs and circum vaginal plexus (a network of nerves, veins and arteries) constitute the major erectile bodies in women. These underlying structures are homologous to, and about the same size as, the penis of a man. They become engorged (swollen) in the same way that a penis does. When fully engorged, the clitoral system as a whole is roughly thirty times as large as the external clitoral glans and shaft, what we commonly know as the 'clitoris'. Women's sex organs, though internal and not easily visible as men's, expand during arousal to approximately the same volume as an erect penis. In short the only real difference between men's and women's erection is that men's are on the outside of their bodies, while women's are on the inside" (p.5, see also Figure 1 on the development of the male and female genitals).

Dr A. A. Shandall in the same article stated that many of the women he interviewed in the Sudan had no idea that there was such a thing as an orgasm. He also interviewed three hundred Sudanese husbands each with more than one wife, but at least one wife had been infibulated, and at least one wife sunna circumcised. Two hundred and sixty-six of the men in the study stated that they preferred sex with the sunna circumcised wives as they seemed to enjoy the desire, the act, and the pleasure of intercourse more (p.5). There was no definition in the study of what the male concept of female sexual pleasure was.

The first international forum to discuss FC was held in Khartoum, India in 1979. In 1987, the International African Committee for the Eradication of Harmful Traditional Practices held a forum, in Addis Abba, Ethiopia. At that forum the term for female circumcision was changed to female genital mutilation. Since then, the name has been associated with the movement to eradicate the custom. My literature review also uncovered a unanimous stance by the United Nations (WHO), the Organization of African Unit, the African organization "Women's Action Group on Female Excision and Infibulation" (WAGFEI),

FORWARD, in the UK, and Women's Health In Women's Hands, Canada. All these organizations are determined to help eradicate the practice of FGM and urge governments to formulate legislation to make FGM illegal. McLean and Graham (1983) recommend that health programs be amalgamated with socio-cultural pressures to eradicate the practice.

The first legal fight for the eradication of FGM began in Kenya in 1906 by the Church of Scotland missionaries who worked in Kikuyu hospitals (Lyons, 1981). By 1926, it became a political issue in Kenya when local action was taken to limit the operations to excision of the clitoris only. In 1946, the Legislative assembly of Sudan passed the law to prohibit infibulation or Pharaonic circumcision, but to permit Sunna circumcision (Sisterlinks, 1989). Officially, FGM has been banned in all government hospitals in Somalia. This measure has driven the operators underground (Ogiamien, 1989; Sisterlinks, 1989). The weakness of the law according to Koso-Thomas (1987) was that it only forbad one type of circumcision, and the law was passed before people were ready for it. (Ogiamien, 1989; Sisterlinks, 1989).

Somalia entered the FGM debate in 1977 when the Somali Woman's Democratic Organization was formed. It is the implementing agent for the Commission concerned with the Abolishment of the Operation, appointed by the government. Edna Adan Ismail, an experienced health worker spoke about infibulation, without the government's permission, at the launching of the organization. She says:

> "I was afraid that the great hall full of women might throw their shoes at me, instead they stood up and applauded. So many individuals then wanted to speak that the

> assembly broke into smaller meetings. At the end each group in turn called for abolition" (McLean & Graham, p.13, 1983).

Currently their strategy entails a day to day action campaign throughout the country in order to inform women and men with medical facts and encourage them to re-examine their attitudes. They have invited religious leaders to speak out about it. An intensive education campaign has been undertaken in hospitals. Discussion groups have been organized for young women and men. Statistics have been gathered by physicians. The media has been used to talk about change as an idea that can be accepted and about new relationships between the sexes (McLean & Graham, 1983).

Ismail believes that FGM must be spoken about as a health issue. She wrote that discussing FGM in the context of women's sexual freedom will doom it to failure. Her campaign is an education and action partnership between her organization and all government hospitals in Somalia. FGM operations have been banned, and health centres now promote the attitude that FGM is not healthy, not clean, not Islamic and does not guarantee virginity.

Reports from the population conference in Cairo (September 1994) and the meetings in Dakar of African Women for the Women's Conference in Beijing in 1995, indicate that the issue of FGM will continue to be at the forefront of women's issues and the legal debate around it has not abated:

> "Laws cannot change things, If you make it illegal, it will continue to be done, because both parties are interested; the patient wants the circumcision, and the doctor wants to make money." (Egyptian Population Minister Maher Mahran, (Toronto Star, p. F5, 1995)

The ineffectiveness of the law has caused the Egyptian government to now hold "circumcision days" as a public service. Health Minister Ali Abdel-Fatah justifies, it as preventative medicine.

> "... it's a way to bring FGM out of the closet and into the operating room. Under hygienic conditions, doctors can minimize the risk of infection and mutilation caused by untrained mid-wives and barbers. They can also explain the dangers of putting girls under the knife and dissuade parents from doing it. ... The Toronto Star article continues that: "This is a far cry from the total ban promised by the Egyptian government last year" (Ibid).

This means that the Egyptian government is sending mixed messages, one, asking people to stop the practice and two, offering it on request. This unique blend, the Egyptian government hopes will be both prohibitory and regulatory. Whether this will work, remains to be seen, however the Minister is hopeful as he says this approach takes into account ingrained traditions:

> "Egypt's ingrained traditions will take time to change and that is why he (Mahran) is lobbying for gradual reforms ... when adult patients were asked if they would submit their daughters to the same painful procedure, they almost invariably answer yes" (Ibid).

This dilemma in Egypt is not unique Sisterlinks in 1989 pointed to the example of women, who even after they had learned that FC was not required by the Koran and was therefore debatable and not obligatory, said:

> "As for me I do not believe in it. If I have any girl children, I will only perform 'sunna', (meaning the mildest form), ... That left the question ... if one does not believe in FC, why tamper with the girl at all!" (Sisterlinks, p. 18, 1989)

Koso-Thomas (1987) advocates that eradication must take an approach that looks at social, religious, and cultural transformation, rather than legal decrees, because this approach has proven unsuccessful in the past.

In 1982, two years after FGM entered the agenda of the 1980 World Conference of the United Nations Decade for Women held in Copenhagen, Sweden passed distinct prohibitive legislation around the practice of FGM. France now examines girls from countries where FGM is practised before they leave the country and after they return. If the girl has been circumcised while out of the country the parents are arrested and charged. (Rough Cuts, CBC, September, 1995) The U.K. has passed a bill known as the Prohibition of Female Circumcision Act 1985. Since then the World Health Organization (June 1992), issued the following communique:

> "WHO has consistently and unequivocally advised that female circumcision should not be practised by any health professionals in any setting - including hospitals or any other health establishments".

Federally, Canada has not yet taken a specific prohibitive legislative stand against FC although since 1994, women's organizations and the Ontario Government have been requesting that Ottawa write an explicit prohibition into Canada's Criminal Code. The College of Physicians and Surgeons of Ontario has however, banned the practice and deemed it unethical for a physician to perform it (Canadian Medical Association Journal, 1993).

Canada is one of the countries that has ratified the United Nations' Convention to Eliminate all forms of Discrimination Against Women (CEDAW), as well as Children's Rights Convention (CRC).

> My review of the document revealed that CRC is the most recent treaty and calls for countries to take action; Article 16, provides children with the right to privacy; Article 19, proscribes child abuse; Article 24 (3), requires that nations take appropriate measures to abolish traditional practices prejudicial to the health of children; Article 37, prohibits children from being subjected to torture or cruel, inhuman or degrading treatment (W.H.O. communique, 1992).

The international community, including Canada has yet to make the statement that identifies FGM as a specific violation of these articles.

The Department of Justice in Canada has, however, examined the issue. In a communique dated April 2, 1994, R. G. Mosley, Q.C., Chief Policy Counsel, Criminal and Social Policy Sector, stated that:

> "... No amendment to Canadian law is necessary in order to address this issue at this time, ... More specifically, in the event a person performed the procedure in Canada, he or she could be charged with assault causing bodily harm (up to ten years imprisonment) or aggravated assault (up to fourteen years imprisonment). The girl's parents could be charged with being parties to the offence (same potential penalty). After the procedure has been performed, if the parents did not seek medical treatment for the girl's wounds they could be considered not to have provided the necessaries of life. This could lead to a charge of criminal negligence causing bodily harm (up to ten years imprisonment). If the girl died as a result of her wounds, the person performing the procedure and the parents could be charged with criminal negligence causing death (up to life imprisonment). "

Information from the Beijing conference indicates that the supporters of FGM are adamant about maintaining this practice for the following benefits:

> " ... Religious requirements aside, there are sound medical grounds for putting girls through the procedure. Egypt is a hot, sub-equatorial country. People perspire more, their underarms become stained. "So you can imagine the sweat down there". The more creases in the vaginal lips, the more perspiration. For uncircumcised girls, the effect is "a cocktail of sweat and vaginal discharges," with a fourfold increase in ulcerations, vulval and venereal infections, he (Thabet) claims. ... removing these two structures decreases sexual desire, relegating sexual sensitivity deeper into the vagina. Translated, this means the circumcised girl will be a 'good girl'. ... she won't masturbate, or lose her virginity before marriage" (The Toronto Star, F5, 1995).

Lyons (1981) nevertheless points out that British anthropologists have been suspicious of interpretations that overemphasize hygiene and sexual motivation as the primary reason for circumcision.

She also speaks about the role of circumcision in the civilization debate. FC was used to place Blacks at the bottom of the evolutionary hierarchy; civilization versus savagery; or depravity versus virtue. The racial overtones were never complimentary and became indices to prove the licentiousness, debauchery and savagery of Blacks. It therefore became legitimate to cast negative aspersions on the social import of such a rite of passage, as well as Black sexual appetite, sexual motivations, virility, and the treatment and respect for their woman:

> "... male operations at least had Biblical precedent, and came as less of a shock to Europeans. Others saw the need to remove the clitorises of entire female populations as evidence of depravity; ironically the practice of clitoridectomy in Europe encouraged this viewpoint, for there it was used only for incorrigible cases, where punishment and threat had failed. ... What must be the moral condition of people who required such surgery for every female! Indeed, some who had imagined enlargement of the external female genitalia to be an innate peculiarity of African women saw clitoridectomy as a simple response to the unpleasing and inconvenient proportions which the clitoris might assume ..." (Lyons, p.507, 1981)

Since the practice is seen as barbaric and the people practising it like animals on the first rung of the ladder in the evolutionary chain, Durkeim, Freud and others were able to congratulate Europeans on their high status in the civilization chain. They were therefore able to use the practice to prove Black psychological dysfunction. I feel it helped to assuage the conscience of those who felt a twinge of guilt over their atrocious treatment of native cultures and Black slavery.

It is unfortunate that FGM has been used to stir up historical rivalry between the Euro/American Christian culture and the Afro/Arab Muslim civilization. Toubia (1994) notes:

> "Cultural slander and stereotyping only makes real change more difficult to achieve. Some Western media highlight the link between FGM and Islam and call the practice 'primitive and barbaric'. Some reactionary elements in the African and Arab media retaliate by highlighting the decadence and disintegration of Western society, pointing especially to liberated women who are considered to be sexually promiscuous. Moreover, when African and Arab women speak out against FGM, they are accused by conservatives of aligning with the West to undermine the traditional value of their societies. The battle is in fact about power and dominance..." (Toubia, p.35, 1994).

Today, the upsurge in feminist views via feminist theory and Masters and Johnson's recognition of the clitoris as central to female sexual response, has focused the FGM debate in the North to the examination of women's rights and the abuse thereof. This patriarchal story has to be told, but it also made me wonder if there are any other stories. To hear all women's stories, regardless of the perspective, will focus on a kaleidoscope of meanings. This variety is healthy and useful if we are to be effective social workers. Lyons (1981) advised that researchers need to look at FGM through 'clusters of meanings':

"With regard to genital mutilations and their sexual meanings, it is possible that 1/ genital mutilations in any individual case may combine sexual and non-sexual meanings; ... 2/ may have more sexual significance in some cases than in others; 3/ male and female operations, cross-culturally, may differ in the amount of sexual content which legitimately may be attributed to them" (Lyons, p.511, 1981)

SUMMARY

1. The appropriateness of FGM has become an issue in both the Western world and in some African and Arab countries.

2. The need to re-examine the attitudes toward FGM is exacerbated for women who immigrate to Canada, where they feel they are regarded as medical oddities and they have to decide which cultural practice to follow with their daughters - traditional Somali, or Canadian.

3. The focus of this paper will be on developing an understanding of how Somali women respond to this new definition of FGM, which they may have encountered in Somalia but which is more absolute and blatant in Canada because the practice is actually illegal.

MY BIAS

I instinctively agree with the Canadian Advisory Council on the Status of Women's view, and the United Nations initiative to eradicate the practice of FGM. However I wonder what my reaction would be if challenged strongly about my belief in male circumcision, a belief I inherited from my Jewish grandmother. I also reflect that my ancestors who were continuously subjected to rape in slavery must have suffered a fate worse than death when they, as infibulated women and girls, were raped. Although I find the subject painful to deal with, I am committed to understanding the issue. I sense a dilemma in me which makes a distinction between male and female circumcision. I watched the circumcision of my first born male but could not face the prospective pain or agony that inflicting it would do to my second male child. How I resolved the conflict between my inherited cultural values, and the modern view of unnecessary surgery was a useful resource for me when I listened to Mary, the Somali-Canadian woman in the narrative, in Episode 6 where she decides whether or not to circumcise her daughter.

The CBC television program Rough Cuts showed the operation on their program in September, 1995 and Oprah Winfrey, televised a panel discussion on the issue that same week. I was deluged with over twenty telephone calls from my friends. Some women were crying on the telephone or near to tears as they found FGM so disturbing. All the women were Canadian, many were from the visible minority community but they all needed

emotional support because they were so devastated. This made me think what the program must do to someone without emotional support. I then thought of the women who were circumcised if they watched the program, and wondered how many calls they received and what emotional support they had. I was disturbed when one friend indicated that she could never look again at another Somali without feeling sorry for them or wondering if they were circumcised I know that was not the point of the program but it evoked a strong negative response in the Canadian community.

This made me see the urgency for emotional support for all circumcised women. I felt their pain, the stigma was great.

ETHICAL PERSPECTIVE

The Canadian Association of Social Workers in the Code of Ethics states that the purpose of the code is to outline:

> "the professional attributes and conduct expected ... to provide a practical guide for professional behaviour and the maintenance of a reasonable standard of practice within a given cultural context. (p. 4)"

A code, although it is a part of all professional practices, presupposes that 'ethics' is something produced within a person's head -- a dialogue with their conscience which is influenced by a 'script'. In my reality, ethics is, partially at least, socially produced in dialogue with other people, history, social contexts, cultural values and religious traditions. Therefore my research will conform to the ethics of the Somali culture. I already know that due to the oral tradition my word is of the utmost value and it is more important than any written contract. However, to be true to both cultures I provided both an oral and written statement, and required that participants give their oral and written consent.

PLAN FOR OBTAINING INFORMED CONSENT

I am bound by the obligation to maintain confidentiality and stated this verbally and in writing to the individuals who participated in the research. These were the translators (Letter 1) and participants (Letter 2).

It is normal for Black society to trust the value of the verbal communication over the written record as we are an oral history based society. When I provided the

introductory letter and language request (Letter 2 and 3) I stated verbally my commitment to confidentially. These letters were sent out by the two community members identified, I, the researcher did not make direct contact with the potential participants until they agreed to be in the study. The consent letter (Letter 4) was obtained before the group sessions and I asked the interpreters to sign Letter 1.

CONSENT NOT OBTAINED BY PRESSURE

The translators agreed to make the initial contact. They were aware of the importance of not pressuring any woman to come to the sessions if she was not comfortable. The fact that women could withdraw from the group at any time was stressed and communicated to prospective storytellers.

RISKS

There was a natural reluctance to discuss the topic with strangers. Although I am Black I was still viewed as a stranger. To allay this fear, I did the following: I volunteered with the Black community on the issue of health, which involved. coordinating a health conference in June, 1995 through the K-W Chapter of the Congress of Black Women. My name and reputation gained acceptance within the African community through this initiative. I also used Somali interpreters who shared my aim to make the initial contacts. I ensured that the participants understood the purpose of the study and reinforced verbally that the information was to be shared. I also highlighted that the

findings could be used to benefit the community through educational work around the issue of female circumcision. I advised that free counselling sessions were available This would ensure that if any participant found the sessions evoked memories of traumatic experiences brought on by the war and relocation, they would get help to bring the matter to closure.

PRIVACY

The following was done to ensure confidentiality and anonymity. Storytellers were given fictitious names during the group sessions, although I knew the real names of the participants. Groups were conducted in pairs and so only the pair that was grouped together knew who they were; the other groups did not know. Storage of information was on discs in my home computer files. Any information on the hard drive was given pass-words for access and cassette tapes were accessed only by me. All back-up information was stored in a locked filing cabinet. The reporting of data was done as an aggregate story so individual idiosyncrasies were not exposed. Tapes and all other 'identifying' data will be destroyed after my thesis report has been completed.

RESEARCH ON OTHER CULTURES

Translators were available to translate verbal and written communication from English into Somali. However all participants understood and could communicate in English. The participants and I have a common racial heritage.

QUALITATIVE RESEARCH

WHY QUALITATIVE RESEARCH

A qualitative research approach was suitable for my study as it lent itself to enquiry dealing with process. When inquiring about process the research explored informal, unstructured linkages. It focused on the real and not on the ideal. It was the best approach for variables that were not yet identified and the ideal way to explore folk wisdom (Strauss & Corbin, 1990). Marshall and Rossman declares that this type of research is best when the research is "exploratory, as it stresses the importance of context, setting and the subjects' frame of reference" (p. 46). They advocate that the qualitative research approach enables researchers "to know how people define their situation" (p. 49). Thomas argues that "if men define their situation as real then they are real in their consequences" (p. 301). This philosophy is a perfect fit with my topic as I am trying to explore the issue from the storytellers' experience. I needed to answer the question, how much of my interpretation should there be of the data? I resolved this question by looking at what I wanted to do. My goal was to tell the participants' story accurately as they saw it, therefore, my task was to gather the data and present them so that the women spoke for themselves. My aim was to get a honest account that had very little interpretation. I saw my role as hearing and reporting. This was validated and congruent to thoughts articulated clearly in Strauss and Corbin (1990, p.21).

THE NARRATIVE RESEARCH METHOD

WHY THIS RESEARCH APPROACH

This study sought to tell the typical story of women who are affected by FGM within the Canadian environment. Doing the preparatory work for this study in Kitchener-Waterloo and Africa was a learning process for me. Before I left for Zimbabwe my approach was qualitative but very investigative in nature.

In Zimbabwe as I tried to get information on FGM and speak to women from the Tonga ethnic group (who I had heard practised FGM) I underwent a transformation in idea, attitude and research methodology. In my first four weeks in Zimbabwe I could not get anyone to talk about FGM. At a woman's conference I spoke (personal communication with conference delegates, September 1994) to delegates from Botswana, Kenya and the Sudan and was only told generalities. I was unable to get a direct answer from anyone. I was often told "FGM is not practised here"; or, "it used to be practised long ago in the ethnic groups from Zambia, but it has died out". No one would expand on the explanation or discuss the issue with me. I would only get monosyllabic replies to my questions

In my fifth week in Zimbabwe I discovered through other conversations that the direct approach with sexual matters was not deemed appropriate. It was then that I learned that a) sexual matters were handled by 'Sekuru' (grandfather or uncle) and 'Tete' (aunt); b) sexual matters are not discussed openly in a mixed group.

I then questioned a Jamaican physician, (personal communication, October 1994). She has been married to a Zimbabwean for twenty-four years and has lived in Zimbabwe for fourteen years. My questions to her were in her capacity as a medical doctor and I stumbled on other knowledge as well. She explained to me that my approach was too direct. In their society such questions should not be asked in such a manner. If I used the direct approach it made the other person very uncomfortable. She helped me to reframe my questions. She pointed out that the direct approach did not encourage dialogue, only monosyllables. She then told me about her use of stories and shared the method she used to discuss negative topics in her practice. Using this method and reading non-verbal cues was successful. I learned that FGM was not practised in Zimbabwe, but stretching of the genitalia was. I was able to discuss this topic in great detail with women thirty years and older but only after I had taken the time to observe and read on the African approach to sexuality.

This greater understanding of African traditional concepts of sexuality evoked greater sensitivity and respect in dealing with sexual topics like FGM. Sexuality in the traditional African context differs from the understanding of sexuality in a Western context (Koso-Thomas, 1987). African traditional lifestyles tend to suppress the personal gender role of the individual, whilst enhancing the social gender role. This emphasis arises out of the African custom of communal living and belief in the unity of the extended family (Johnson, 1991). Sexuality is regarded as a gift, to be used for the procreation of the human species, and any public display of sex-related feeling is seen as debasing this gift.

> "Traditional sexual relationships occur within a predominantly polygamous family structure. A relationship, however loose, is always interpreted as the making of a family. The boyfriend and girlfriend category, as it is known in Western societies, has no parallel in traditional African society. A relationship involving sexual intercourse is generally acceptable only between husband and wife/wives. In African societies ... where a high bride-price means prolonged courtship, pre-marital intercourse of the betrothed, usually resulting in offspring, is neither uncommon or socially disapproved of (except in the case of Muslims, who believe that virginity and chastity is a mandatory religious requirement). Such a relationship is accepted on the assumption that once the bride-price has been paid the marriage ceremony will take place.
>
> Love and appreciation of man and woman for each other do exist but are suppressed in public; it is un-African to display one's feelings in public, the community disapproves of such display. It is believed that emotional feelings between husband and wife/wives is a private matter and that under no circumstances should a wife attempt to exploit or provoke emotional situations to her advantage." (Koso-Thomas, 1987 p. 38).

Coming to this realization meant that I began to appreciate that the narrative research method conformed to the African way of approaching sexuality -- indirectly. I observed that in many old traditional ceremonies the sexes are separated. This traditional separation in public meant that sex-related communications may be conveyed only by subtle, covert means. Games were designed to attract the attention of women, although they may not directly participate, oral transmission within the group ensures that women were aware of the prowess of individual men and were thus indirectly involved. I therefore started to discuss sexuality not in open mixed forums. This enabled me to get more information on sexuality and FGM from my field placement supervisor.

After frank discussions with my field placement supervisor, (Dr. Perpetua Gumbo, direct communication, October and November 1994), she related how she used the narrative

research method and that she had seen it used with success in African studies that dealt with sexuality. She shared with me: a) the United Nations World Health Organization's 1992 Geneva Report; a study of the sexual experience of young people in eleven African countries using the narrative research method; and b) one of her case stories using the narrative method of participatory action research. Having read these two studies I thought this method would be a successful model for my research, as this approach tries to empower people in their own community by allowing them to study their own needs in their own way. This was a deliberate effort to 'de-professionalize' the outside investigator into a collaborative advisory role (WHO December 92 Report). The result is an easy to read and understand narrative. If English was the reader's second language it would make the research easy to understand. This method also complied to the African way of doing things and would therefore not offend the participant thereby keeping the data true to the real life experience. Strauss and Corbin (1990), Marshall and Rossman (1983), and Kirby and McKenna (1989) all encourage the researcher to keep true to the real life experience.

The advantage of this type of research is that it does not stifle story-telling. It allows for spontaneity, which is a natural part of explaining one's behaviour. It also allowed for the language of change to be documented. Without change there was no story, narration therefore linked 'before' with 'after' in discrete, coherent, tellable episodes (WHO December 1992 Report). Mishler (1986) and Johnson (1991) advocate using narratives to capture the context and situation-sensitive behaviour that would be destroyed by quantitative

questionnaires Therefore the type of information that was sought would specifically capture the way people organized and interpreted their lives.

> "Stories are cultural repositories of common sense or folk psychology, they portray human beings as intentional agents whose actions flow from their beliefs and goals. Stories explain the behaviour of characters in the common sense terms of individual motives and reasons for acting. ... because stories are about change, they have the potential to activate a community by giving it an historical awareness that its unquestioned traditions, customs and ways of life are not ageless and immutable" (WHO December 1992 Report, p 4).

My research sought to find the way Somali women in Kitchener-Waterloo explained their behaviour but in the manner that made sense to them and reflected their reality. It was their story and they were the experts (Strauss & Corbin, 1990).

The following elements were essential to build a proto-typical narrative tale (Johnson 1991):

a. Group sessions to make collective judgements on sequences in action, what was usual and what was believable and believed.

b. Insight into the state of mind, intentions and motivations of the characters, using the real life experiences of the storytellers to explain the possible courses of conduct and action.

c. Pretend play or projection was necessary for the participants to see the issues and weave a typical story of life.

This tale has episodes versus an ongoing story line. Gordon (1987) theorizes that projection is necessary and is done regularly by us "whenever we make inferences about the mental state of others." He suggested that the task would not difficult be if the participants had one culture. WHO December (1992) Report suggested that this adopts many of the characteristics of participatory action research.

> "Within a close-knit community, where people have a vast fund of 'facts', as well as shared norms and values, only a minimum of pretending would be called for ... What I would do and what the other will do would invariably coincide. A person transplanted into an alien culture might have to do a great deal of pretending to explain and predict the behaviour of those around him (p.142)."

The narrative tale produced a generalized case study, presented in a form which partially resembles the clinical case history of one individual (or couple or family) but is derived from aggregate data (Johnson, 1991). The generalized case study was a collaborative work in which participants converged upon the most typical or representative, rather than diverse. The aim was to produce many instances of the singular and unique (WHO December 1992 Report). This strategy matched the aim suggested in Marshall and Rossman (1983) who said researchers must use methods that aid them to suspend judgement based on their personal cultural context and values. This aggregate experience effectively excluded and prohibited any of my context and values in the data interpretation. As the storytellers discussed their story, they changed episodes to suit their reality, only when it felt comfortable to them, did they accept that it was typical. My values were not included in the story as I had no voice.

The approach emphasized general experience rather than personal revelation, and this distanced perspective offered a methodological advantage (Johnson, 1991). The research resulted in matter of fact descriptions of "what is", rather "than what ought to be". It shielded the participants from the discomfort of probes into sensitive areas of individual sexual

attitudes and judgements. This study of the standard cultural stories did not try to force personal confidences and self-disclosure from the participants. Corbin (1990) discusses how personal experience (p.43) gives sensitivity and yet allows us to step back from situations. By describing the generalized behaviour of others, respondents were not placed in the position of censoring or falsifying accounts of their own possibly 'non-Canadian' or 'immoral' stance on FGM. Therefore, they did not need to disclose according to the script they expected I wanted to hear.

METHODOLOGY

> "Human behaviour is significant by the setting in which it occurs; thus one must study the behaviour in situations. The physical settings - for example, schedules, space, pay and rewards -- and the internalized notions of norms, traditions, roles and values are crucial contextual variables. Research must be conducted in the setting where all the contextual variables are operating" (Marshall & Rossman 1989, p.49).

This primary source data obtained in this research was discussion by face to face communication. The women used the tools of role play to visualize their story. The participants came from the Kitchener-Waterloo environs. This area is home to 200 Somali families all of whom have been in Canada for under five years. A large number of family heads in this community are female one-parent households, their husbands are either still in Somalia or they are widows. This figure has been estimated at 51% by the K-W Somali Women's Coalition. The average family size is 6.3. I was able to approach the Somali community through friendship links.

The following is an outline of steps taken to complete the research process:

June to August, 1994

I spoke to Black Canadians and found readings on the subject of FGM. This helped me to gain a general overview of how Canadians view the subject. I also investigated whether FGM was practised in the Caribbean.

September 1994 to January 1995

a. I conducted a literature review when I was in Africa on the subject of FGM

b. Asked Africans to explain the many African meanings that FGM held for them I spent four months in Zimbabwe (September, 1994 to January, 1995), and used some of this time to explore this topic with Zimbabweans to ascertain their views on FGM. My rationale was to understand human behaviour by examining the environmental framework of how Africans interpret their thoughts, feelings and actions. This approach is encouraged by Marshall and Rossman (1989); and, Kirby and McKenna, (1989).

Being submerged in an African context afforded me the opportunity to see commonalities in culture between my Western background and my African heritage This was useful to me in my study as it gave me the self-confidence to trust my instincts. This idea is not unique and is supported by Marshall and Rossman (1989, p.51).

January to April 1995

a. I wrote my thesis proposal and submitted it for approval.

b. The FSW Ethics Committee reviewed and approved my research project.

May to August 1995

Formalized contact with the Somali community. I asked two respected Somali women to explain and dialogue with the community for me. The aim was to establish a relationship with them this would make it easy for them to verify my honesty and give an honest verbal appraisal of my character to their community. (I felt that they would be asked to verify my character by the community and they needed to know me to be able to act as references.) Having their confidence and trust also meant that I could get their perspective on cultural cues. I wanted to share the vision of an unscripted story, and my respect for their culture.

In personal communication with two Somali women, Tuesday, May 2, 1995, we discussed the idea and intent of the proposal and I got their verbal agreement to recruit participants for the study. They also signed the agreement (Letter 1); and agreed to do any interpretation written or oral that was needed.

The discussion revealed that there are two schools of thought on female circumcision in Somalia. Rural and older women tended to believe, support and practice female circumcision and urban women, who through the movement for eradication in Somali were exposed to the thought of breaking this cultural tradition. We discussed that these women would most likely be fluent in English and

multilingual; have been among the first to have arrived in Canada, due to easy access to resources, and viewed the practice as cultural and not religious.

To encourage older and rural women (group 1), to share would have been harder or impossible, based on the time frame for my research and therefore might not be practical for me at that time. My literature review revealed that in countries like Somalia and Sudan, FC was shrouded in secrecy and was unquestionably accepted as part of everyday life (Mak, 1993; McLean & Graham, 1983). This made me wonder if these women might view my inquiry as being too inquisitive and intrusive.

I decided that speaking with urban women, (group 2), would have more relevance to the Canadian reality. In personal communication with K-W Immigration, (May 3, 1995) I was advised that many refugees were from urban Somalia. I considered it prudent, however to have access to translation services. I also felt that rural women who came to Canada, would settle in an urban setting. Therefore, it would be reasonable to assume that after five years of living in Canada they would have received as much exposure, or more, to the issue of FGM as an urban Somali woman.

At our next Thesis Committee meeting on Tuesday, May 9, 1995, we reviewed and critiqued my outline (Appendix F). This outline was to be used to stimulate and

'guide' group discussions in the first session. This outline was to guide me, as I listened.

The plan was for three two-hour audio taped sessions which would focus on the group developing the episodes of significant events - transitional or formative - that shaped their view on female circumcision. These sessions would formulate the story line. To be included in the narrative, each event had to be common, or known, to many women in the group. If it was familiar and all women agreed, we would adopt it. The aim of our group discussions would be to create a believable storyline. Tools to be used include improvised dramatizations (role plays) to describe episodes and significant events in the lives of the urban Somali-Canadian woman. Musings or thoughts spoken allowed would also be included as scenes, the criteria for inclusion in the narrative would be consensus.

Details of formulating the narrative were: a) they would trace through different story lines which evolved from their interaction. b) role play, in which participants did impromptu enactment of some story scenes. This would help them formulate the story. The rationale was that seeing the action would help them judge if the scene was believable. The storytellers would be drawing upon their common experiences and so the stories would be rooted in their culture. They would also reflect their values and tacit, common sense assumptions. Stories true to culture and values

are among the aims of qualitative research (Strauss & Corbin, 1990; Lincoln & Guba, 1985). The storyline would, by their reflection, (Strauss & Corbin, 1990) help them discuss, enact and interpret events in their lives. My record of their experiences would be true to the storytellers tales. A subsequent review confirmed that they agreed to the scripted episodes.

The episodes from one session formed the starting agenda from which to build the story-line for the next session. A review of the previous episodes guaranteed that the women had time to reflect and change, or add versions to their story around themes. Throughout all the sessions the women created dialogue impromptu to explain their view. The series unfolded according to their agenda. My agenda would be:

a) Circumcision - an event in one's life. The reaction and feelings about it in Somalia.
b) What coming to Canada meant. The events that brought this realization and the feelings and emotions attached.
c) Daughter now needing to be circumcised. The issues and feelings.
d) What decision is made, and by whom.
e) How does she feel about the decision?
f) What support does she need from Canada?

The next stage was for the translators to ask women, who fit the criteria, to participate in the group. This was done by using the letters provided and discussing the information with them.

At the beginning of the first session I described the purpose of the study, explained that participation was voluntary and explained the criteria for selection a) language fluency; b) domiciled in urban Somalia; c) single- parent-head-of-household (I assumed that they were the decision makers); d) parent of a daughter; e) willingness to participate; and f) living in the Kitchener-Waterloo area. I allowed time for the women to ask questions to allay any fears that they were personally singled out for scrutiny, however I received no questions from my first two groups. I stressed that the typical and common events provided the story and so participants would be assured of their anonymity. I also assured the women that all tape recordings would be destroyed by December 1995.

Thirteen possible participants were recruited. I hoped to eventually have a group of eight storytellers. I anticipated that some participants would leave the group, and others would be replacements. However, my plans went awry.

The first group of eight met. It became apparent, that tape recording made the women uncomfortable. Having the session taped was going to be an unnerving experience for them. The women also spoke timidly. There voices were so soft they were hardly audible. I tried to encourage them to speak louder, but they did not. At the outset they were friendly but I used the term FGM and they became silent. I soon realized that my participants were resisting. After approximately thirty-

minutes four women from the group had ceased speaking. They were so quiet that I felt uncomfortable. This was my first indication that silence did not mean agreement. Silence has been used in the narrative to signal feelings of resistance. At the conclusion of that session all participants were too busy to schedule a second session.

A second group of six participants was arranged, as none from the first group returned. They however, were uncomfortable without a required and formal questionnaire. The women anticipated quantitative data collection techniques and were unhappy with the proposed format. I was encouraged to provide a draft questionnaire. The women indicated that they felt more content filling out a questionnaire and were ill at ease at the prospect of talking. They found it difficult to relax. This made me realize the enormous sensitivity of the issue to be examined. I wondered if they suspected me of having a hidden agenda. They often spoke to each other in Somali. I noticed that they had difficulty interacting with me. I reviewed the tape with my cultural interpreter and she advised that the setting was strained. The group was too large; and the proficiency in English for some for the women was low. The result was participants not feeling free to question me for clarification. She also suggested that breaks coincide with prayer times. Only two women indicated a willingness to return.

After some thought, I asked the interpreters to organize a third group of six women. This time the session would take place at a community centre. To highlight our similarities I wore comfortable African clothing. At the onset, I enquired if anyone had any specific time when they needed a break. I emphasized the importance of the unstructured format; that moreover there was no right or wrong answer; and how invaluable fictitious names were for ensuring anonymity in the tapes. I labelled each participant with an English name and asked that they refer to each other by that name. I was very nervous and vulnerable and articulated this fact. I ensured that all woman understood my accent, and that our communication was moderately fluent. Although we commenced hesitantly, I realised that the group was supportive. My efforts to ensure comfort had enhanced our interaction. Due to nervousness I did not record the session properly. Later we discovered what I had done, and we laughed. After that, I shared that my son was circumcised. I then asked if the group preferred the term female circumcision (FC) and male circumcision (MC) versus the terms female genital mutilation (FGM) and male circumcision (MC). The group agreed to use FC and MC rather than FGM and MC. After we adopted these terms, the group visibly relaxed. However, the participants were sharing but not equally. Some members were dominant and others quiet. I noticed that some women used eye contact to express and validate their friend's comments. I thought smaller groups would eliminate this problem. I decided to use their natural friendship links to pair women together. Their interaction in role plays

would be natural. I tried to schedule another session but I found that their schedules were conflicting.

My second successful session was arranged for a group of four women at the community centre. Two women however, cancelled their appointment so we decided to conduct the session at my home. This was the best session thus far, as we socialized comfortably. We prepared a light meal together and took breaks when we felt we needed it. We were the only ones at home therefore we were able to interact freely. I realised that the women welcomed the break from their normal routine. I discovered that visiting after lunch was a bonus as this is a common activity in Somalia. My home was conducive for prayer breaks when needed. In this atmosphere of trust, socializing and culture sharing, the tape recorder was not intrusive and we were able to honestly explore the meaning of FGM together.

The format changed to three small groups with two persons in each. We agreed to have three, three-hour-sessions with each group in a setting that was favourable to each pair, providing we could ensure that we had no interruptions. We used terminology that was comfortable, and discussed phrases that might unintentionally offend. For example, all three groups preferred FC to FGM. This word FGM visibly stirred something in hearts of the storytellers. It became apparent that this was an emotive issue. The women were open, honest and

sincere and because all the women spoke and understood English we were able to communicate well. From these discussions, we were able to look at - for example, Mary's feelings towards FC in Somalia. They openly discussed and debated the opinion, age and background information for Mary and came up with a consensus story line.

In role playing sessions, I agreed to participate in small parts. This was a deliberate effort to 'de-professionalize my role as outside investigator into a collaborative role (Strauss & Corbin, 1990). Becoming a participant put me in touch with the emotional context of the scene and submerged me in the context. It gave me permission to explore cultural context and to question what actions were appropriate or inappropriate for the 'script'. This enhanced my understanding, and education as the story unfolded. Realism was ensured by role play. Storytellers were able to see action, visualize, hear and reflect on cues. This verified the narrative's veracity. Improvisation and dialogue confirmed that the story was valid to observers, it was plausible and true to life. If it was not, counter examples and discussion soon corrected it. This gave the 'actors/storytellers' the opportunity to describe their emotions. Interaction was dynamic and responsive to feelings.

W.H.O.'s report (1992) states that role-playing was originally used as a technique in teaching and therapy. It has gained increasing acceptance among researchers as

one alternative to the social psychology laboratory experiment. Role-playing, properly executed, produced behaviour which mimicked what people do in real life. They advocated that this methodology enabled researchers to capture the complexity and spontaneity of naturalistic interaction.

I observed this to be true when I participated in a workshop at Chegutu in Zimbabwe, November 1994. This workshop was put on by the University of Zimbabwe's School of Social Work in partnership with Women and Law in Southern Africa Research Project . They used this method to communicate with chiefs and community trainers about the new laws around polygamy, a woman's right to inherit property, inheriting one's brother's wife and 'labola' (bride price). Objections to the disbanding of these traditions were vigorous, as the chiefs saw it as a usurpation of their power. Discussing this matter using discussion and impromptu role-play allowed for a rich and dynamic work shop. Even when discussing intimate matters, the many variations added diversity, acceptance and laughter to the topic. When tempers flared, chiefs were asked to be the actors and change the script, which was then criticised by the group. This diffused the anger and embarrassment, and allowed them to save face. Evaluations revealed that the enacted impromptu tales were a powerful aid.

The importance of using active listening skills in order to be able to clarify cultural nuances was highlighted by the example of the mother and child having similar surnames in Episode 3, Scene 4. The import of the surname to the mother escaped me until I discussed it. When the second pair of story tellers told me the same tale and enacted the scene I could share the emotion of the mother's distress. Examples like this built trust and understanding. The more knowledge I gained the more intimate details were shared because active listening built trust and diffused language barriers; for example, whenever cross cultural misunderstandings occurred, the process of examination sometimes revealed bias. It provided an opportunity for me to gain insight into their emotional process.

The research process lent itself to reciprocity. This contributed to the cohesiveness of the group. We left the sessions feeling gratified, we were all givers and takers, not just some always giving and others always taking, the sharing felt balanced.

I gleaned information about their informal supportive network through babysitting. It was soon apparent that some women, although they had declined to be a storyteller lent their support by babysitting the children of the storytellers. This was done without my knowledge and came to my attention by accident. It however formed the

basis for my understanding the informal network that would have been available for Mary if she had her baby in Somalia.

I valued this type of sharing. It is the hallmark of true community development as it is based on unselfishness, reciprocity and mutual aid, an integral part of traditional African culture. At first we shared at simple levels, for example, recipes or child-rearing stories. As time progressed however, we began to share activities and partnerships began to emerge. As our families began to be included and be supportive of our activities we began to build bridges of understanding between families. As our comfort level with each other grew, our interaction became more natural and open. Sharing and data collection became easier and richer as the friendships deepened. Our mutual understanding of issues and culture became clearer as time progressed. I came to understand that we all valued the traits of honesty, sharing and truth. They all had the goal of building a story that would typify a believable story for Mary. The women appreciated the avenue to get their collective story told; and I appreciated the responsibility and privilege of having been the vehicle used to share it.

August to September, 1995

Writing the report. This entailed accurately transcribing the women's narrative and double checking any language translations verbatim. Sharing the final narrative and

report with the participants. Defending my thesis and sharing the report with the community. This will provide the opportunity for the community and my colleagues to interact and ask questions on the research. After three months, (December, 1995) all tapes and data which have been secured in a locked cabinet will be destroyed.

THE NARRATIVE STORY

PROLOGUE

Interpretation of narrative data requires a different mind set than when one is examining tables and charts. Narrative story research depends on its own distinctive mode of thinking, it involves "searching for meanings from among a spectrum of possible meanings" (WHO Report, 1992 p.15).

The acquiring of this mind set was the single most important skill I learned. The process of qualitative research was not compartmentalized and it was complementary to the thinking process whereby words change meaning. My exploration into this exercise began when I realized that in dealing with FGM the discussions meandered through a varied collection of stories. These stories introduced various themes and true to qualitative research the storytellers did not compartmentalize the spectrum of their experience. This yielded a rich and diverse story.

I concluded that 'changed meanings' entailed examining old habits from new interpretations, and modifying behaviour according to new understandings. This process was dynamic and occurred at all levels. It is happening today in Africa and can take place in Canada. I became aware of three examples of 'changed meanings' that were respectful to African tradition and yet changed tradition to accommodate a new environment:

One, is a Nigerian story, 'The Ancestral Tree' by T. Obinkaram Echewa, it tells of a folktale that becomes modified, and the reader is encouraged to share it with children before discussing culture and tradition. The purpose of the story, according to the author, is for:

> "children everywhere who sometimes feel an urge to better a tradition they have received." Echewa believes that "Africans of this generation cannot be content with merely re-telling the folktales bequeathed to us by earlier generations, but must in turn add to the existing tradition, and produce newer stories for our children and grandchildren, ... teach and learn; custom and change."

A common African custom, which is still practised in the West Indies today, is the burial of the umbilical cord of a new born baby, under a seedling tree, called a 'Navel Tree'. The thought is that as the tree grows strong so will the child. In some African ethnic groups, when the person dies, this tree is cut down and another tree is planted in the 'Forest of the Ancestors' to signify that the person has passed on, and is now in a revered place of

honour. Planting is only done by the surviving children, it is never done by anyone else. In this story Obinkaram Echewa, points out that the local storyteller, Nna-nna, falls ill and dies, but Nna-nna, has no living children to plant his tree in the 'Forest of the Ancestors', yet the children of the village had promised him to keep his memory alive. They approach the village council and request permission to plant a tree, stating that by their love Nna-nna was their grandfather. The council convened and declared:

> "You children have taught us that customs have a beginning, customs can change, and sometimes customs come to an end. We have decided to end one custom and begin another. We will plant a tree for Nna-nna in the Forest of our Ancestors... ... we have decided that from this day onward, we will change the way we select which ancestors to honour. Beginning today, only those with honourable lives, whose spirit are noble, will have trees planted for them in the Forest of the Ancestors" (Echewa, 1994).

Although the story is a children's story the message is powerful, and opens the reader and their audience to the concept of change. It is written and told in the powerful African medium of story-telling.

Resolving cultural conflict was done in this second example as well. In my study in Zimbabwe I was told how many professional women were modifying customs and yet adhering to tradition. One was the traditional ceremony, one year after a woman was widowed. Many women show their celibacy, by observing the custom but refuse to to go further by choosing a second husband from the dead husband's relatives (personal communication with Sheila Matindike, Executive Director of the YWCA of Zimbabwe, November, 1994). The film and video 'Neria' is used as a teaching tool in Zimbabwe to discuss this issue. In it the grandmother states to Neria, her widowed daughter-in-law "You have shown me that at times we have to bend our tradition to the changing times. You are a strong woman!"

The third example relates to the topic of FC and how one mother in the African country of Chad resolved the issue. Khadidja, a Muslim mother was trying to find a way to shift some of the traditional ways her people had lived for centuries to the life she was exposed to while she attended university in Italy. Khadidja said she had sworn to herself never to circumcise her daughters. Her husband Ahmut, had been noncommittal and her mother had not requested that she do it. Her two children however, aged 7 and 9 wanted it done so they could fit into their peer group. Khadidja hired a the FC nurse and told her what she wanted. She wanted nothing cut off, she was about to invent a new method, instead, she wanted a small pinprick made in the clitoris. It would satisfy the traditional requirement for drawing blood and yet leave the girls intact. Some family members were annoyed, however, Khadidja arranged the traditional ceremony. All the trappings were observed and the girl's young friends were invited to the rite and accepted the pin-pricks as bona fide

circumcisions. The two girls were welcomed back into the community, their genitalia intact and their social status preserved (The Globe & Mail, 1993).

Process is the thread that knitted seemingly diverse experiences together. Unrelated stories were related by process, in each case the process led to changed meanings. By my research I hope to be able to communicate that environment can change meanings, either positively or negatively.

To preserve the narrative character of the study, the information is presented in a connected story line.

Script translation has been made as close to verbatim as possible without attempting to change the sentence structure of the dialogue. The structure is sometimes cumbersome. Often to persons for whom English is a second language the speech pattern may flow differently.

The storyline is divided into Episodes. These Episodes are divided into Scenes. Each Scene relates a different experience. The Commentary and Discussion sections which follow, provide analysis and supplemental data to foster further understanding for the reader.

EPISODE 1. - WHO IS MARY?

SCENE 1:

The Somali woman in this story is named Mary. She is 33 years old. She came to Canada pregnant, and this story covers the first four years of her experience. (The majority of Somali immigrants have been in Canada for less than five years.) Mary has six children; their ages range from 3 to 12 years. She lived in the city of Mogadishu in Somalia. She is coming from an area where there is clan violence.

Version 1: Mary was a housewife in Canada, as well as a housewife in Somali. She speaks Somali and Arabic. She understands English, but does not speak the language fluently.

Version 2: At present, Mary is a housewife in Canada. Mary worked as a professional in Somalia. She had finished high school and had gone to university. She understands English but is not fluent. She is fluent in Swahili, Italian (language used at university), Arabic (language used at primary and high school) and Somali (language spoken at home). She had no job after the children were born, as

she had to look after the children. She came to Canada pregnant with the seventh child.

Mary is comfortable with her self image. She is confident and self assured. She understands her values, way of life, religion, language, ethnic group and family. She anticipates that there will be problems when she immigrates to Canada but she is confident that in time she can adapt. She has chosen to come to Canada based on what she hears about Canada's multicultural philosophy.

SCENE 2:

Circumcision is not an issue Mary would think of in Somalia, unless it related to the circumcision of her child. She would have made a joint decision with her husband, and or family. She would be aware of the issues surrounding circumcision, but she would not be unduly worried about it. She would feel normal, going to the doctor or interacting with any in the health care system. She would most likely know some women that are circumcised and others who are not. Within her Somali network, she would not associate any

problems in childbirth with FC. Everyone is familiar with FC in Somalia and so coping with these problems is seen as a normal part of life. Mary's doctor was able to cope with any complications Mary had when she was giving birth. In her frame of reference -- FC has never contributed to any of her problems. She might view gynaecological complications as normal, for that setting; however, in Canada, those same symptoms might be seen as abnormal.

Although attitudes are slowly changing over the last two decades, Mary would not feel strange. In Somalia, some women are circumcised and others are not. It is not a big issue in the hospitals. The doctors and nurses are familiar so Mary would not spend hours talking or thinking about it -- both courses of action are acceptable.

SCENE 3:

When Mary came to here to Canada, she came to Toronto, because she has some relatives there. She decided to move to Kitchener because: 1) she felt it would be easier on her as a single mother with all these children. 2) She

wants to live at a place with her children where it is small as she will have easy access to services. 3) She feels it is easier to cope in small city, especially with a language barrier. 4) She has a family history of respiratory problems: for example, asthma. 5) There are two universities here so she feels there are better educational opportunities for her children. She felt like a stranger in Toronto, but she had familial support. This feeling of being alien surfaces in Kitchener-Waterloo and will not go away.

DISCUSSION & ANALYSIS:

The storytellers took a long time to determine the fictitious name of the Somali immigrant. At first, they wanted the name to be Somali, but they examined the repercussions of such a move on their community. A Somali name would alienate other Somalis and, furthermore this may cause Canadians to think that she was a real person. This could lead to embarrassing questions to all persons named 'X' by Somalis and Canadians. It was very apparent through these discussions that the only solution was to use a name not readily known in Somalia. Everyone must recognize that this is a story. This was the first sign that the community is careful not to stigmatize. These women when making choices tend to examine the meaning of everything, for example -- speaking and interacting with each other, they were careful not to decry or undervalue each other's viewpoint. They were supportive of each other, often shaking heads in agreement.

Most women coming from urban Somalia have had some high school education, as education is free until the college level. Most women speak at least two languages as schooling is taught in Arabic and Italian. It is not unusual for them to understand more than one language. Based on education and accessibility to resources, most refugees who crossed the Atlantic first, especially urban dwellers, have a college education.

Next, the group discussed the fact that although class distinction, (because of the Muslim philosophy), was not as pronounced as in the West, only those who had access to resources could cross the Atlantic. Therefore, it was most likely that Mary's husband had a good job. Based on this assumption, they probably lost all their money because of the war (clan fighting). Often, Somalis who had few resources settled in closer countries, eg. Kenya. Money and resources opened their options, and determined their route of escape.

In discussing Mary's feelings the group decided that " being a stranger" grows as events unfold, but finding a sense of belonging is important if Mary is to become a Canadian. Finding this sense is an important factor as it affects interpretations of events, the cultural assimilation, and is embryonic in changing meanings of Mary's life experiences. Mary came to Canada hoping to fulfil her self-actualization goals, but before this can occur she has to find a sense of belonging and fulfil her basic safety needs (Maslowvian hierarchy).

EPISODE 2: SATISFYING BASIC NEEDS

SCENE 1:

When Mary came to Kitchener she had many problems. For example; housing was an issue, as Mary has six children. Whenever she goes to look for housing, she is asked, "How many children do you have? Are you working?" Some people become unpleasant when they see her. It takes Mary time to figure out the barriers:

a) I have six children so there is no place for me with them. Canadians see this as too large a family and look down on the family size. b) I am not working and am on social assistance, but it just gets worse. c) My colour and my dress is different -- When she makes an appointment, as they see her, she hears the house is rented. She finds this embarrassing. Mary feels depressed, but not hopeless. However, it takes her three months to get housing. After some months, Mary figures out that she has to tell people that she has half the number of kids. Mary has a dilemma, on one hand, she needs at least three or four bedroom housing, and on the other hand, having so many children makes landlords reluctant to rent her housing. She figures it is like Somalia -- they will not throw me out with the children if she has no

where to go -- even if they discovered she lied, as long as she pays her rent she can stay. Mary says I have only two kids (laugh). Then they give her an apartment. Then for two days they watch her and then they come to her apartment and say there are so many children.

The landlord came to her and said, "Who are all these children?"

Mary: "They are my children!"

Landlord: "So why don't you tell us the truth about all these children?"

Mary: "I have been looking a place for me and my children for three months and I have no choice now it is winter time and I have not other place to go. This is the only choice I have."

Landlord: "I am going to take you to court. You lie to us."

Mary is afraid but cannot negotiate or reason with the landlord. He brings a paper that says she has six children and she wants to live here in a two-room apartment.

Welfare calls Mary: "You have all these children you must move out from this apartment as soon as possible and find housing that matches the age and sex of the children"

Mary: "I do not know what to do. I cannot search for another apartment. I have six children. The smallest one is two years old. I don't know anybody here, so how can I search for anywhere. I can not do it alone without babysitting. Can you help me?"

Welfare: "No, that is not my job. I am sorry but you have to look for yourself."

After one month, the superintendent comes to her and he says. "If you don't move by the end of this month we will go to the court."

Mary discovers she is different not only in dress but even in the way that she thinks. Coming from a homeland of war she is afraid of conflict and sees this as a step in the wrong direction. She had never heard of a lease agreement, or Landlord and Tenant Act. She does not know how to change this situation. She wants to negotiate but doesn't have the language. She wonders what she has done.

SCENE 2:

Mary came to K-W in the winter time so it was very hard for her to search for housing, because it was cold and she was improperly dressed. She had lots

of silk and cotton clothing. She felt she had suitable clothes, but she discovered she was wrong. She does not have the money to buy warm clothes! She does not know where to shop and what to buy. She buys the cheapest things that she thinks is warm, but they are warm for tropical Africa not temperate Canada. She has to seek advice, as she realises she doesn't know how to dress for this weather. She thinks this is a simple thing and yet she does not feel confident. The Multicultural Centre, the YWCA and the YMCA provide Mary with this new information. Before she learns of these places however, she suffers, she is always cold.

DISCUSSION & ANALYSIS:

This was the first lesson that Mary learned. She has to reach out, network and make mistakes to find out the social norms. She has no sense of connectedness until she meets other Somalis. She tries to reach out to others but does not communicate well enough in any other language but her own. The only people she understands are her Somali people, even if they are from a different clan they help and give advice. Clan problems do not surface here in K-W, any Somali is willing to help another. Often, the comment was made by the storytellers "she has to meet Somali people, as they understand, she will not feel stupid, strange or confused. They have had the same experiences and she can

communicate. Here there are so many simple things she needs to become accustomed to". For example the weather is new and difficult. Somalia is a dry semi-desert country with predictable rainy seasons, so unpredictable rain in Spring or unpredictable snow makes the weather hard to predict, and adjust. I was able to understand this, for in Zimbabwe, in areas where there is a rainy season, it rains every day during the season between 1:00 p.m. and 2:00 p.m., with no variation, and I found that to be amazing.

The second lesson is the matter of child care, as babysitting is an important issue for new immigrants. Networking means Somali friends will watch all her children, often for free. They are accustomed to large families and so her children do not become a burden. As these Somalis talk to her, they become her social network and a vehicle to share information. The storytellers felt that this made the difference between feeling isolated and lonely. Also, they felt that the degree of alienation is shaped by whether she has friends or relatives in her city. If she has no one, then the process of gaining friends is slow and the lesson of changed meanings takes on greater imoortance. For example: she would examine interactions with Canadians, especially as she does not know the language nor her basic human rights.

EPISODE 3 - ENCOUNTERING THE HEALTH SYSTEM

SCENE 1:

Remember Mary was a few months pregnant when she came to K-W. She is now nine months. Her top priority was searching somewhere to live. Now she discovers that one cannot just choose a doctor. She has to find out which doctor is taking patients. So then she starts searching for a doctor, not by phone, but in person, as she feels she will communicate better in person. It was very very difficult for her too because of her pregnancy and she has to take all the children. She goes to many doctors and is not successful. Her friends lead her to their family physician. She goes and asks if he has space, but he is not taking patients. At last, Somalis ask her if she has a list. She says she doesn't and they help her get the list. It is the last month of her pregnancy and she is just finding a doctor.

She is aware that she should have been going to the doctor regularly, but she feels she and the baby are fine. In Somalia, it was not like this where she has to be referred, so she never thinks of this. She doesn't know the system! She

goes through the family physician! When a woman is pregnant, she can go directly go to the gynaecologist. She does not have to be referred.

The family physician was shocked that Mary had not gone to the doctor before and had not done any tests. He was just able to see her once and give her a quick referral to a gynaecologist. She, therefore, did not have the time to build a rapport with the family doctor, and so she did not ask him what to expect. He took her late visit as tardiness and spent a lot of time admonishing her on basic health care.

SCENE 2

The gynaecologist was friendly to Mary. She felt nervous, but calm until he examined her. She told them she was nine months and this is her seventh child, she has already six children. After her examination, he was visibly shocked. He is shocked to see her genitalia and she feels so embarrassed that she keeps quiet. As he examines her, and he says in a shocked voice:

D: "What is all this? Are these scars from the previous labours?"

M: In a soft, low voice she says: "I am circumcised". (She feels embarrassed for the first time in her life about her circumcision.)

D: "Who did this to you? Did you do this to yourself? Your family? (He is trying to cover his shock.) I have never seen this... this circumcision! I am sorry but this makes me angry, it is so barbaric! It is the first time I have seen anything like this, or I have never heard of this. It is going to be difficult for me to know how to deliver you. (After some thought)... I am recommending that you have a Caesarian section."

Mary always thought she was normal so now she is scared. He thinks she is strange, he thinks she is abnormal? At first, she doesn't realize that he is horrified at the scar, she can't decide if the pregnancy or her genitalia is causing so much concern. She doesn't think her genitalia is that unusual. No doctor has ever commented on it before. She felt embarrassed for the first time about her circumcision. She was always proud of her scar. She interprets the situation that he is concerned about the baby and feels scared of her scar. She watches the expression on his face and he cannot hide his horror. She closes her eyes so as not to see his face. There is no time to seek

another doctor, she thinks. Would all doctors react like this? She is so embarrassed and scared. Then, she thinks 'Caesarian' -- "I don't need it, this is not an emergency." She concludes she and her fetus are in distress and the doctor is afraid to tell her. She starts to panic. She feels she has no choices and she has no time left. Mary says to the Doctor: "Tell me of any complications that I have?"

Doctor: "No complications, but I have no experience with this kind of thing, you have to have a caesarian section!"

Mary does not believe him she says: "Okay, I have no choice. I have no other doctor you are the only person that accept me so we will have to go ahead." She however feels that he will not tell her everything in a crisis, he is trying to protect her. She wants to hear the truth.

SCENE 3:

Mary expects something to go wrong from the time she enters the hospital. She is apprehensive, as she feels that the doctor has not yet told her what is wrong with the baby. She is, therefore, less talkative than she would normally be. She is careful to watch for all non-verbal cues.

She had the Caesarian and medically all went well, but socially her hospital visit was a disaster.

Health practitioners were always asking questions and at first she was not sure why. Then, she realizes that everyone knows about her and they are curious. At least ten doctors come to examine her. The personnel on the ward ask many questions. At first, she does not mind answering but the questions get too personal and she starts to keep silent. She is asked, "Where is your husband?" "Do you really have six children?" She hears expressions like "Oh my God!" very often. "Who did this to you?" "How can you manage with this?" Sometimes she is asked really stupid questions: "Are you willing to have other children?" She gets a reaction to her circumcision from all. Mary can tell some have come to her bed just to look at her. It is something that they have never experienced. It looks very strange, but they do not think of what this reaction must be like for her. They only think "let me satisfy my curiosity". Some are openly condemnatory of FGM but Mary sees it as condemning her. They ask without embarrassment -- "Are you sexually okay?" "Are you like the normal person?" "Do you feel like a normal person?" This

tells Mary, that she is not normal. She is a freak! This is embarrassing, -- because she is circumcised that doesn't mean that she does not have feelings. Mary thinks sexual feelings are also controlled by the brain ... they must understand that at least. She knows they feel that because she is circumcised she is not sexually active. "How do they think I have so a many children?" she wonders. The questions continue. They ask her so many questions Mary sometimes can't find the words to convince them that she is not a freak. She just keeps explaining. After a while she pretends she does not understand anything. What she really doesn't understand is why they are asking these questions. Mary is well aware that she is a topic of discussion on the ward. Hospital personnel talk about her even when she is present. They do not comprehend that although she understands English she does not speak it well. They conclude that she does not understand or speak English so they openly discuss her and often the things they say are not complimentary. When she is too embarrassed to speak, she turns her face to the wall. She feels depressed and alone. She misses her mother, husband and friends. She worries about the burden her six children must be

to her new Somali friend. She hopes her hospital stay will be short. She wants to go home.

SCENE 4:

At the hospital, Mary is given forms. She notices that the forms are filled and the surname of herself and her baby are the same. She says to herself, "the baby is not for my father, why does the baby have my last name?" They do not understand Mary's objections, they do not know that in Somalia, when a woman marries she does not change her name, she always retains her family name, it is an honour. She is told that in Canada if she is married the baby gets her surname. In order for the baby to be named differently the father has to sign the form. So now, the baby has a different surname from the rest of her children. All the other children have their father's family name and this child has Mary's family name. Mary worries that relatives will not understand and that this will cause problems in the future. This is unacceptable in Somali society. Mary says, "No! I want my child to have his father's family name" but the health personnel tells her that there is no father to sign. Mary alone is signing so the child gets her name. Mary signs the form, but she cries herself

to sleep that night. Mary is distressed! She can't fix it so she feels very bad, she doesn't know what to do. Now, she has to explain this to her husband and their relatives. She hopes they all understand. Also, the rest of her children will ask "How is it that we all brothers and sisters and yet he is not the same name as us?" This is something that will have to be explained all the child's life.

DISCUSSION & ANALYSIS:

The storytellers were quite adamant that receiving medical treatment was the most stressful experience, and they wanted this fact communicated clearly. They emphasized that this experience is typical. Often, Somali women experience medical personnel whispering and talking among themselves about circumcision, as though the patient cannot understand. Even, if Mary does not know what is being said she will soon be accustomed to the look. This type of treatment and negative attitude makes all women very embarrassed. Health care professionals must realize that all women have feelings. People must respect that a woman does not want to be discussed, especially if the topic is FC, in a certain context.

The group was very distressed that Mary's baby was named with the incorrect surname. They agreed that this was a common occurrence. They highlighted that for Mary to give

her child its proper name she needed to do it legally, and therefore, pay to have the name change done. It was noted by the storytellers that if Mary had been married, and then later divorced, this incorrect surname would cause custody, maintenance, inheritance and child support problems later on in the child's life. One storyteller pointed out that, if the child happened to be the only boy in the family, this uncorrected mistake would end the father's family name. This led to a discussion on customs. Traditionally, Somalis do not celebrate birthdays, although westernized Somalis do To some Somalis this causes confusion as birth dates are not used for governmental purposes in Somalia. Therefore many Somalis do not see the purpose or importance of completing forms using the same birth date each time, especially if they do not know the correct date. This results in confusion for Canadian services who are trying to use birthdates as identification.

When Mary was asked what her concerns were, at this part of the role play, she stated:

a) She did not have a relative locally and felt she was taking advantage of the woman who had offered to keep her children while she was in hospital. She lacks the money to pay for babysitting. Money is a big issue. Somalis feel humiliated and frustrated at being on social assistance. They suffer financial hardship, because rents are expensive. They often have very little money left for other living expenses.

b) When the doctor said she must have a caesarian her main concern was why a caesarian? Is something wrong with her or the child? Nobody sat with her and explained why such a procedure was chosen. As is common with many women, Mary thinks she is to blame and she wonders: "What have I done?" FORWARD (1989) in the U.K., listed "fear of being touched, fear of knives and razors, fear of operations" (p.5), as emotions they found prevalent among their circumcised clients.

c) Mary would prefer to have her child at home if she knew a mid-wife who could do the procedure for her. She would also be able to keep an eye on the children. It would have saved her from all the hospital problems she encountered. The story-tellers said many Somali women prefer to have deliveries at home as their hospital experience is so undignified for them. They felt that as Canadians we could explore alternatives, for example, midwives trained in Somali customs.

d) Mary was concerned that she had no one to assist her in labour, at the hospital. She needed psychological support. Traditionally, the main helper for a women in Somalia is her mother, although other women may do the cooking and housekeeping. Mary would have been accustomed to her mother sleeping in her room with her and her new baby. Her husband if he was here, would sleep in another room. Compared

to this experience, a new Somali-Canadian woman would feel that she has very little help, and might feel very overwhelmed without her traditional support.

Added to this, Mary would think about family and friends left behind. Lack of communication with those still in camps or elsewhere would make her worry more. She would be always thinking about them. Lack of stability in the region means that people move around a lot and so are hard to find. As family ties are so important to Somalis, Mary's loneliness during labour would be more acute.

e) In Somalia, when a woman is eight or nine months pregnant, it is the custom for Somali women to hold a special ceremony. Other women attend and special food is prepared. The expectant mother's friends anoint her with perfume, bless her, and pray for a safe delivery. She would also know about creams to be used to help the genitalia stretch. Back massages and baths are common remedies to relieve pain. Also for 40 days after birtn Mary would not go out socially, until after her friends had a party for her to celebrate the coming out of the new mother and baby. Mary could not find these supports or any of these remedies, instead she had to have a caesarian birth, which was a totally new experience. The storytellers told of women who stayed home until labour is advanced, in the hope of avoiding a caesarian section birth.

f) Customarily, Somali men are not in the delivery room so, asking Mary if she wants to have her husband present is an unusual question and contributed to the perception that something is dreadfully wrong. Usually husbands are only informed if anything is wrong. This is an example of, North American assumption-making and lack of cultural knowledge in the medical profession which unknowingly, stigmatizes and elicits fear.

Even this reference to her husband makes Mary long for her husband. The women explained that many men were separated from their families, some were in prison because of the war, some were killed, others were in the military, and others made the difficult decision to send the women and children out of the country for their safety, even when the men could not leave. Because Somali culture is very reliant on each family member carrying out their role, separations are extremely difficult.

g) The method of comfort is that all females in the family would converse with Mary especially her Mom. It helps if her Mom is there for her because she will not cry as much. Mary then takes comfort from her Mom and sisters. In Somalia, women are supposed to keep strong and not talk about their pain. If Mary expresses her pain, it is because it is extreme. To not have their support to help her bear the pain is very hard for Mary. She, therefore, feels lonely, depressed, and isolated.

h) Mary feels fear yet she does not discuss this fear with anyone. She is also sorry no one told her what to expect from a doctor's visit, for then she would have been prepared. She can't assess how dangerous a caesarian is. Added to the other pressures of adjusting, this experience seems too much. She feels depressed. She doesn't want to go to the doctor ever again. It is so embarrassing that she feels she could never experience this again. She thinks, "I already have six normal deliveries and never had any caesarian so what is the problem?"

i) Mary had no time to seek another doctor's opinion. If she had been in Toronto this could easily have been done. It was so hard for her to get her first doctor that she felt she would not get a second. She is afraid, but she just can't do anything. She feels helpless, powerless, strange, different, and alone. In Somalia, she knew everybody. Everybody was in the same situation, she was normal -- not different. She had choices. Unfortunately, here she feels she has none. Her feelings of loneliness do not disappear.

j) This frightening experience increased her pain as she had no emotional support. If she had asked the K-W hospital to call the multicultural centre then, she would not have felt so frightened, as community organizations such as this could have linked her with other Somalis. The centre could have provided translation for items on the menu. The hospital food was a big concern. Based on her religion, she could not

eat pork or its derivatives. Also, all meat eaten by Muslims should come from animals slaughtered according to Islamic practice. To ensure she maintains her religious diet, Mary has not eaten anything in twenty-four hours. She is not familiar with Canadian food and she cannot read the English menu. Often, health practitioners do not realize that Mary can't read the menu, therefore, when her tray returns with un-eaten food, they assume that she does not know about nutrition. A dietician is sent to inform Mary about the Canada Food Guide and explain the function of proteins. This makes Mary uncomfortable because she already knows this information, she studied it in high school.

k) The storytellers said that, "What made it especially hard for Mary, especially in the K-W area, is that she does not have a doctor, or gynaecologist, or obstetrician, who understands Somali female reproductive issues. "In Somalia, we are use to female doctors, nurses and attendants in gynaecology and most Somali women prefer to be attended by a female obstetrician and gynaecologist. So interacting with a male is difficult and in the K-W area, I think they have about two female gynaecologists."

l) Mary has difficultly with a long stay in the hospital. She does not want to stay for longer than 24 or 48 hours as she has her small children at home, but with a caesarian section this is not possible. She has many obstacles, including a lack of

transportation, the absence of her husband. Financially, she can't afford to bring her children to visit her in hospital everyday.

The discussion of what happens to Mary at the doctor, who had never seen a FC woman, was very spirited. The consensus of the storytellers is the following:

A. Mary would be apprehensive before she goes, as she does not know what the reaction of the doctor will be. She would therefore put off going to the doctor as much as she can until she must go. Examples were given of women being pregnant and for nine months never seeing a doctor because they are afraid. They fear becoming a 'show case'. She does not want to be viewed as an exhibit. She does not want to be victimized.

B. Frequently, health professionals feel that she, the Somali woman, has done this to herself. It is important that health providers in Canada be educated about FC. Somalis are infibulated, not circumcised, although FC is the local expression they use. FC is not something that Mary did to herself but that her culture did to her. It was through her tradition and it was acceptable.

C. The storytellers felt that health professionals view Mary as inferior. Too often, the attitude is conveyed that she is lucky she is here in Canada or else she would not

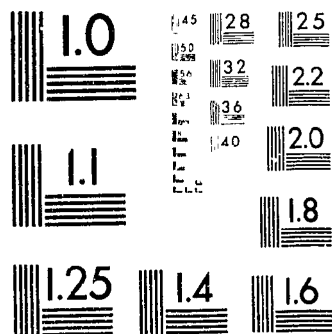
be exposed to modern life. "When one gets this sort of reaction they feel very hurt" "Mary would feel that they do not see her as an equal but as a sub-human being " "Sometimes, this will not be said but, actions speak louder than words." "You are human you can read the signs of modern language, especially if people say things like 'Oh my God!'." Mary might try not to show how this affects her. However, she will become silent and cease to cooperate. One only has to look at her body language. Many women close their eyes to avoid reading the body language and seeing the reaction as their discomfort is so great.

D. "Our parents, when exposed to the fact that FC is wrong, also feel very guilty Nobody takes this fact into account." Mary's mother felt that she did the right thing and was proud of FC in Somalia. Later, she heard the anti-FC information and became aware that FC was not acceptable in her religion. She no longer felt proud. "If she came to Canada, where FC is a crime she would feel worse." "Many mothers feel sorry for what they did. No mother wants her daughter to be deformed psychologically or physically. She did it innocently." Some Mothers might tell you they are sorry they did this to you. "Can you forgive me?" they often ask. It became apparent that this discussion causes a great deal of pain.

E. What Mary's mother wants is her to be strong now . She says to Mary, "Tell them, I did not do this to myself! This was done to me, so do not blame me. Our people

2 OF/DE 2

PM-1 3½"x4" PHOTOGRAPHIC MICROCOPY TARGET
NBS 1010a ANSI/ISO #2 EQUIVALENT



were not doing this to harm us or deform us, ... and we did not do this to ourselves."

F. Immigration to western countries, Canada or any other place, does not mean Somali are inferior or barbaric - physically or psychologically. Most immigrants encounter difficult barriers. The 'level of comfort' is a most difficult hurdle. This has caused some women, for example, to not have scheduled a pap test since they have been in Canada. (Three of the women in the group said they had not done the test in over two years, that is, 50%.) Women need pap tests annually, and Somalis know this, yet they risk cancer by not doing the pap test, because they are so scared - of the visit and the test. The women explained, "We feel victimized." "This may not be done intentionally, but we still feel victimized." "The only way to reduce this feeling is to educate the health care providers".

G. Somalis do not want specific topics to be openly talked about. "This does not mean that talking about it is taboo. It means that there are appropriate and inappropriate forums for discussion." Talking at inappropriate times brings alienation and embarrassment.

Consequently, this led to a discussion on cultural norms. It was agreed that there are a lot of misunderstandings between cultures.

Examples:

a. Sometimes, Somalis do not want to explain, therefore, they remain quiet. I feel, this is a protective mechanism. It is important that Canadian providers of service understand that. "Silence does not always mean yes, it may mean no, or, I do not want to pursue this further."

I, (the researcher), encountered this during discussion groups, often silence meant the session was now concluded. I had to learn to respect this and not press for discussion, after this point. I assumed that this was all they were willing to share at this time and I wanted to respect that decision.

b. In addition, Somali women feel odd when they are constantly questioned on the way they dress and why they dress this way. Questioners must remember that although one might ask the question for the first time, the informant has answered, that question numerous times. Reasonably, this may become aggravating after a while.

EPISODE 4 - MARY & THE MEDIA:

SCENE: 1

Our women do not like the publicity - media, it makes them feel different. Mary would feel this way. She would be angry about the publicity. FC was done

almost twenty years ago and most of the Somali mothers from the city are not doing this any more. Many urban Somalia are not practising FC anymore. At that time it served a purpose, back in Africa. One has to remember there is a war. Before Somalia was in war, there were other areas in war. FC protects a lot of girls and women from being raped. Everybody knows that there is no access and so it protects the girls. Remember one's reality is dependent on where they are from. Some Somali clans are nomadic; so it protects the girls. Mary would know the value placed on a virtuous girl, rape could destroy a girl's life. Dishonour is the worst thing that could happen to a family. Dishonour of Mary would destroy the family and the clan's life. Virginity is tied to honour and to destroy it without marriage is to disgrace the whole family. Mary would say, "let us not talk anymore about the rape during a war. It is different here." The women were silent for a few minutes at this point, the silence was poignant, their heads were bowed.

Mary is at home, she sees a TV program on FC. It is on national TV for all Canada to see! She was not prepared for it! She was shocked! If Mary was watching with her children, then she would have had to send them away

quickly. Somalis do not discuss this issue in this manner with their children. We do it privately and not in mixed genders. So there is no way that Mary would want her children to see this. The children also start wondering what is happening and are curious. If other children saw it on TV and asked Mary's children at school, then they would be embarrassed. Mary thinks it was inconsiderate for the station to show such a program on national TV, especially between the hours of 7:30-9:00 p.m. when children might not be in bed.

There is talk in the community. Everyone talks about how embarrassing it was.

A man calls Mary, "Did you see it," he says.

She says "yes", but while talking to him she is thinking ... "have they taken a photograph of me when I was at the hospital, and I did not know it!" She is afraid. She thinks, "I cannot go back to that hospital". "We do not show such things openly on TV", she is shocked and ashamed.

The male Somali says: "How on earth is it possible that these women are doing that?"

Mary says: "I am not the one who is doing this. They are Toronto people. If you want to object or advocate, then call them, do not speak to me, I had nothing to do with it. Call them, talk to them and tell them there are other issues and other problems bigger than this. This is facing us and nobody remembers that this is a problem for other communities. The focus is on us."

The man stops questioning Mary but she feels bad about it all the same. She speaks with her friends, and discovers that some men in the Somali community also think that their women are the ones who are publicizing this matter to embarrass them. Some cannot understand how this rite they were so proud of, is now such a big a disgrace. This brings stress to the community and sometimes to families. In Somalia even if you know about FGM you were not stigmatized, everyone knows about it, no one is horrified. Each gender wanting to know who did this to the community.

Mary feels if Canadians are so concerned about it, why have they not invited those concerned, for example, doctors, nurses and women, to a location, then show the film. After this private viewing, they could discuss strategies on how to address FC concerns. Deal with the issue in the community first, so that we are prepared for the publicity. What has been accomplished by shocking the whole nation? It has fed the negative image of the Somali refugee.

It also feeds the agenda of persons who are using the system. We hear stories of Canadians who were married to a Somali men. They separate and if they have girl babies they use this issue to gain custody. Women take advantage because of the FGM publicity and say -- my husband wants to do FC to my daughter. Nobody questions a) the age of the daughter. b) Nobody investigates if the husbands are urban Somalis, c) If he has other children, are they FC or any other details to prove the story true. They just believe. If one talks to the guys who are married to Westerns one wants to ask them, "How is it possible that you want to do FC to your child?" They would mostly likely say "No", because they have become accustomed to the uncircumcised. Many women use the issue as a tool to get custody. The fact

that he married her means he did not have a problem with an uncircumcised woman, but nobody thinks of these things. Only Somalis are barbaric. This type of incident when Canadian-Somalis hear it, brings fear, division and distrust.

Mary knows that most likely if the child was in urban Somalia, in a mixed marriage she would mostly likely not have been circumcised. Mary knows some girls as old as 20-25 years in Somali are not circumcised. Even a few girls age thirty years old are not circumcised She might have had a classmate who was not circumcised ... or even know a whole family.

No... No ... Mary thinks, circumcision is not practised here in Canada by us. She hears the rumour that people send abroad to have it done. She wonders who has that kind of money now? I do not know anyone that has done it.

DISCUSSION & ANALYSIS:

The groups were unanimous in their agreement that to understand how to approach the FC issue Mary would have to explain to Canadians the culture. For example:

> "Nomadic culture is strong. They are very proud. That is why many Somali women when they come here they never say hello. They just enter. Many think they are just rude. They are not rude, they are accustomed to asking no questions, just to go after what they want. They will not be rude, but they will not bow down to you either... that is our culture, never put your head down, keep your head up. This is nomadic people, who are concerned with their pride so you should not hurt them. If you do not respect me, I will not deal with you. Think ... Canada ... especially around the health services if they are not treated with respect, they feel put down. FC education will get nowhere. It may be different among other clans, I do not know, but Nomads, No. Education on FC must recognize this."

Programs targeting FC in Canada to this group must remember to keep these persons' self esteem intact. If you do not, you will not be able to reach them. They will not hear you.

This approach is an amalgamation of recommendations by the groups. They thought a FC education program should be based on a rational similar to this.

> "We know Mary's parents are back in Somalia. She cannot sponsor them if she is not working. Most of the parents do not know English or French so in Canada they would be in the home helping Mary with the children free of cost. For Mary to go to work, babysitting is a problem. She listens to the media and friends and hears that people are saying send the mothers to work - and she wonders, I do not know English very well, I should learn. Use this desire to learn English to educate. Educate in an environment where she does not have to pay babysitting and teach her to learn English through this issue of FC, parenting skills and other health issues. These are things she will understand. If it is done with respect, self-esteem, control and permission, it will work. Remember as a culture we do not talk about money, it is insulting, so if you are starting such a program do not start with that, stress the non-monetary benefits. Mary would learn about the issue, get a job to help support her family, learn English and then help others. That is community building - not advertising it on TV with no individual support."

The storytellers stressed that in the Somali culture one never speaks bad things about someone behind their back. It is against the religion. They are encouraged not to do it. When one is put in this position -- to discuss one another's problem without their

permission, Somalis do not like that. That is why public viewing of FC is stressful for Mary. For example:

> "For Mary to discuss "X" woman's experience of FC behind her back, to "Y" would not be right. So if Mary came into that sort of situation she would find it strange For our culture if she is being critical, she comes out and say it, but always with the person present, (preferably in a small group). It is a virtue in her religion to say what she means. If one does not do that, it is comparable to eating flesh ... and that is disgusting."

Before we educate Canadians about FC we have to educate them about basic things about Somalis. The following quotes, are good illustrations of experiences and thoughts that are representative of the community's experiences:

a) "She met with resistance because she was wearing the hejab. The hejab is the head covering. Many thought that because she is wearing this dress she is uneducated. Although Mary is a refuge, she could be a housewife of means. Only those who have resources could travel so far away. Other Somalis are in neighbouring countries, Ethiopia, Kenya, Djibouti, or areas surrounding, but for anyone who could cross the Atlantic means he/she had resources. It takes 'know-how' and money to come - one has to pay for airfares, visa fees. But when they see Mary's dress -- although she may know two or three other languages -- she does not speak English; then everyone assumes she is uneducated and looks down on her. If Mary had come from England it would be assumed that she was educated as she can mingle with the society easier. Mary is always seen as a stranger, no matter how long she will be here, five years or ten years. As long as Mary is a minority she is still seen as uneducated, add FC to that and she is subordinate. So being labelled as barbaric because of FC, is not helping us gain equity, it only helps racism and stereotypes. Immigrants lose their sense of kinship when they come to a strange country, they feel have to start from zero."

b) "For example when Mary is travelling in the elevator and a woman sees her, she automatically thinks, she does not even know which floor she wants to go. She wants to help, she is being kind, but she is assuming by just looking at Mary that she has no idea where she is going. Mary has not asked for help."

c) When Mary knows English some people will say slowly "WHAT ... IS ... YOUR ... NAME! ... loudly like she is deaf, as well as stupid. If Mary even wears glasses, she can't see ... but she can hear (laugh)."

d) "People ask did you have beds, bread, rice, or houses? Yet Canadians get annoyed when Americans ask them if everyone in Canada lives in igloos. Just as they are tempted to tell Americans, yes we all live in igloos, Mary is tempted to say yes, we all live in trees. People do not think - North Americans need to be educated geographically and culturally. It is narrow mindedness."

e) "Mary feels until she has a broad minded audience, it will be difficult -- yes hard, for her to talk about FC to someone who will not understand the issues ... take it out of context ... use it as a weapon against her ... blow it out of proportion and use it to make her life miserable She has so many other problems here, she would rather not help someone make a mess of her own life. Only a mad person would do this."

EPISODE 5: MARY'S CHILDREN

SCENE 1

FGM has affected Mary's children, as other teenagers ask them about FC at school. To talk about FC in a safe environment is okay but some children use it to make them feel inferior. Some teachers are aware so they monitor, but not all. School is already difficult for Mary's children:

a) Any between the age of 9 to 12 years old have missed schooling because of the war. They have to catch up.

b) Their biggest problem is they do not know the language. Gaining access to the language is the most important first step for all.

c) Mary wants them to fit in and so worries when she hears they are being teased. Her girls are very embarrassed when students ask them if they have been circumcised. Many do not even think that she might not be. Even if she was, whose business is it anyway, for her to discuss something like this with them.

d) Some of Mary's children might have the legacy of war, the psychological problems associated with war trauma and so many will be more aggressive in their behaviour and be hyperactive.

Mary has difficulty when she goes to parent-teacher meetings. She cannot understand, so she does not attend often. The teacher might think she is not interested in her child as she has not attended. In such a setting Mary would not feel safe to bring up teasing issues around FC to the teacher as simple discussions -- for example, why her child did not do his homework, can be misunderstood.

Mary's children also know what their mother went through during the war and they respect their mother so they do not want to worry her. They will often keep

bad news away from her. By doing this however problems escalate, and are not solved. The result might be other 'acting out' behavioural problems at school, but the root cause can be teasing on the play ground, the only interaction that the child truly understands and it is negative.

Difficulties also arise if Mary's children speak better English than she does. Mary's pride is affected when the child has to go to office to translate for the her. It does not help when teenagers say: "This is not 1950, this is modern times, I can handle it and you, (mother) can't". With this attitude Mary finds it difficult to dialogue, her daughter has no respect, so speaking together about sensitive issues like FC with her adolescent becomes difficult. She feels that when public education programs are being made for parents, young adults, and teens, these factors have to be considered.

DISCUSSION & ANALYSIS:

Often dealing with school highlights the changed role of children in Canada. Traditionally, the pride and honour of a family rests on the women in the family. A girl's behaviour is therefore very important. Children never become 'equal' to their parents in the Canadian sense. Adults, male and female, continue to obey and respect their parents all their lives.

Strong community partnerships that link the school and home and educate everybody at the same time (Canadian and Somali) without stigma is therefore a challenge When communication between the school and parent has to come through the child, because there is a language barrier, this complicates the issue. The storytellers said that the discomfort felt when parents interacted with school was also, tied to their change in roles A broader focus was necessary before parents and children could feel confident. The storytellers believed that teaching parents how to relate to their children in this environment and incorperating FC into that agenda was an important task their community could do They had varying degrees of resistance to schools dealing with the issue in health class The act of FC is seen as in the parent's past, though they may be dealing with the consequences at present. Although, all children needed this information, the storytellers felt that the priority was children who had been circumcised. The process of changed meanings was linked with becoming Canadian.

EPISODE 6: FACTORS THAT MIGHT INFLUENCE MARY'S DECISION TO CIRCUMCISE IN CANADA

SCENE 1:

Remember, now in most of urban Somalia, FC is a matter of family choice -- if you want you do it, if you do not want, you don't do it. Remember too that some mothers think that if they don't FC their daughter she will not get

married. They want to ensure virginity. Yet, some mothers apologize to their daughters for having circumcised them. Now-a-days a few Somali men marry, Russian, Canadian, and other women who are not circumcised and some are not virgins. Mary reasons, why abuse us, to be virgins? "If being a virgin is not an issue any more to some men, why circumcise?" She also feels that as a Muslim it very important. Mary wonders if FC is more for men than women. Is it done to satisfy men? "Yes", she reasons, "for the satisfaction of men". Some women after each delivery, for example, in the Sudan, are stitched again to make them tight after birth. She wonders, "Is this for men's satisfaction too?" She thinks of other cultures in Africa that have practices that are said to give men more sexual satisfaction. She muses, "Are all these practices for the men?"

Mary continues to think, "How does someone get access to a circumciser? There is no circumciser here. Is one available from another community/country that practices FC? I do not have the money to go to another country, or to pay to get it done! Here, in Canada, it is illegal. In my nomadic culture, they just stitch everything".

She thinks of seeing little girls in pain before they heal. She thinks of how hard penetration was for her after marriage. She thinks of childbirth which she hears is more difficult if one is circumcised. She thinks of experiences her friends tell her, for example, many did not consummate their marriage even after six months had passed. She thinks of the difficulty to have pap smears, urinate, doctor's examinations, and she thinks of how FC sometimes blocks the menstrual flow and the cysts that develop on some women's genitalia. She thinks of the pain of initial sex, she wonders if the pain is usual.

Mary thinks of FC within the Canadian context, ... personal questions by strangers ... visits to the doctor ... teen pregnancies ... abortions ... lack of control over her daughter's sexuality ... explicit sexual education in schools.

Yet despite all this, she decides she will not circumcise her daughter. It has not been an easy decision. She has thought about it for months. Especially as Mary is accustomed to discussing very important decisions with her husband. For her decision making on her own, on such an important matter was a difficult responsibility.

Mary realizes that her feeling towards FC has changed. First the word itself has changed, she can now call it female genital mutilation and not shudder. Second, now that she knows that some of the things she experiences are not common to all women, she does not want her daughter to have these experiences. She wants her daughter to have a new beginning.

Consequences ... She thinks about marriage and virginity. These factors are still very important to Mary but she knows Somali men who are married to women who are not circumcised, although this does not happen often. She wonders if circumcision will be an issue for her daughter if she returns to Somalia one day. Mary thinks that FC is being criticised there too. Mary reasons that if she knew a few uncircumcised girls before she left Somalia, by the time her daughter returns there will be even more girls not circumcised.

Mary tells her Somali friends:

> "I will not circumcise my girls. I see no health benefits. Maybe, if I was still living in Somalia it would be different, I might, but now, it is different. In this context the tradition has changed meaning for me."

Most of her new Canadian-Somali friends agree and say they are thinking like her, to avoid circumcision altogether. Somalis in Canada, do not expect to have their daughters infibulated circumcised. A few may accuse her of being anti-tradition, because they expected that she might have wanted 'sunna' done. Mary has changed and she realises that female circumcision will not be practised by the next generation.

DISCUSSION & ANALYSIS:

The groups pointed out the importance of getting women to discuss issues in context with their Canadian/Somalia experiences. They agreed that health, sexuality, the importance of virginity, the transition from girl to woman and male/female relationships were all topics that needed to be bridged. Discussion would help new mores to me formed. However, this will be a long and arduous process. Premarital and extramarital sex is forbidden in Islamic law, and so discussions around sexuality would first have to acknowledge this fact. Also, sexuality is not openly discussed, even between husband and wife, so even discussing it with doctors and nurses would be onerous. Sex is a private topic, many women would not even discuss it with female friends. The approach to sex education has to be carefully planned, for example, asking a single Somali female if she is sleeping with her boyfriend is an insult. This is completely unacceptable behaviour in her view and so would be offensive.

Traditionally virginity is stressed and highly valued. FC ensures that a woman's vaginal opening remains small until marriage. In times past, before marriage the groom's family inspected the bride to ensure that she was circumcised and a virgin. After the wedding, the vulva was opened by surgery or, the groom tried to open her by penial penetration. A cloth would be placed under the bride's genitalia and then displayed to the groom's family as proof that the bride was a virgin. Having too large an opening was grounds for divorce; small openings were said to tailor the vagina to the size of the penis and keep the woman monogamous. In the Canadian environment if anyone had this mind set they would change and so Mary's daughter, although a virgin would not need to go through this.

FC usually takes place when girls are between four to six years old. Boys are circumcised at four to nine days old. Circumcision is very relevant to Somali women having children in Canada, but it would be hard for the community to dialogue publicly on this. Dialogue had to begin within the community first, where the whole issue of virginity and its importance will be discussed.

Discussions on religion and circumcision revealed that because some Muslims thought FC was religious it was imperative that there be religious education on the practice. This was the first step. Step two, Canadian hospitals when requested, still circumcise baby boys this rationale had to explained. Male circumcision is not seen as mutilation. Questions that needed to be answered were:

"a) What is the ethical difference between the two forms of circumcision? b) Is the difference only 'Southern' culture and 'Northern' culture variables? c) If so, why is that? Christianity, and Judaism sees male circumcision as part of a health issue, and Muslims, if they believe it is a religious requirement also view all circumcision as related to health. Why is it not seen in the same light by those who view the issue secularly? d) Why do we never say the little boy has been mutilated?"

Discussions on religion and the pamphlet, "Female Genital Mutilation - A Call For Global Action" revealed that FC was "makrama"*[4] in Muslim doctrine. Storytellers felt that this should be communicated to African Muslims. All storytellers felt that there was no major Islamic citation that made FC a religious requirement. Neither the Quran*[5], nor the "Hadith"*[6] called for it directly. The pamphlet told that when Mohammed was asked what he thought of FC, his answer was "to circumcise, but not to destroy or (mutilate), for not destroying the clitoris would be better for the man and would make the woman's face glow." (Toubia, 1994). This quote is not found in the Quran. Many Muslims believe this describes circumcision where the prepuce is removed, with the object of making the clitoris even more sensitive to touch. Toubia (1994) also felt that this attitude was congruent to the Islamic attitude to sex;

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[4] Islam has different levels of religious requirements. The highest is mandatory - you have to practice them or you are not considered a Muslim. The second level are practices that are strongly recommended; one must strive to follow them or be punished. The third level is 'Makrama" -- things that are not essential, but if adopted one gets extra points but they are not required, nor are they punishable.

[5] Quran is the primary source for Islamic law, and is not to be confused with supplemental writings.

[6] Hadith is a collection of sayings of the Prophet Mohammed recorded from oral histories after his death. Mohammed's directive that is most cited as a reason for circumcision is from a question during a speech ... it is not from one of the Prophet's lessons. Those against FGM feel his answer was in essence an attempt to deter the practice.

> "Islam strongly acknowledges women's sexuality and emphasizes her right to sexual satisfaction as long as it is confined to marriage", (p.31).

Therefore a Muslim could view FC as a negative cultural tradition as Mohammed spoke these words to discourage infibulation. The storytellers also felt that if Toubia (1994) was right and her interpretation and authenticity accepted, it could be used as an educational tool. Pointing out that FC is practised in non-Islamic parts of Africa would also help those who thought it was a religious custom to relinquish it.

RECOMMENDATIONS

Based on all the foregoing information I recommend that: (#1-52)

1) Medical professionals and health care workers be educated about FC
PRACTICAL IMPLICATION: This will enable them to be sensitive to the needs of women who have been circumcised. They need to become familiar with pictures and information before they see the first patient. If they can recognize the appearance of a circumcised woman and the potential complications, they will be able to control their reaction.

Since Australia, Canada, Europe and the United States are viewing FC as a public health issue (CBC, February 1993), common strategies could be shared between professionals of these countries. If adopted, health professionals will know the appropriate behaviour to exhibit when faced with women who have been infibulated. *PRACTICAL IMPLICATION: This will aid them to give non-judgemental support to the women and their families.*

2) Patients be shown sensitivity and compassion. This requires that a concerted effort be made to ensure that the health professional learn about cultural mores. Workshops would allow personnel to ask questions that would be inappropriate in a one on one dialogue.

In a one on one setting for example, appropriate phrasing of questions for health care providers can be practised -- 'Are you sexually active?' or, such terms as 'vaginal delivery', make Somali women very uncomfortable. These are not appropriate questions, or terms to use because they are too personal and private to be asked directly. It is more appropriate to ask her: "Have you had a normal delivery?" She would understand immediately that the doctor meant vaginal delivery. *PRACTICAL IMPLICATION: That the patient will feel more comfortable, more trusting of their doctors and the new environment which will ultimately result in her receiving better health care.*

Current stories prove that degrading encounters in health care are still happening even at present, August 1995. They must stop. These incidents cause alienation and embarrassment to K-W Somalis. Health care professionals, because they are not familiar with Somali health issues, may feel uncomfortable when treating them, and this discomfort may be communicated to the Somali client.

3) Hospitals request literature from W.H.O. (World Health Organization). This organization provides linguistically simple, and yet effectively, illustrated educational manuals for use in clinics and hospitals. *PRACTICAL IMPLICATION: The dispersement of knowledge will be culturally sensitive, accurate, holistic, leading to better health care.*

4) **Intrusive personal questions not be asked**. For example, non-medical staff should not ask if orgasms are possible, or request that other personnel be allowed to view the area. These questions are very inappropriate. Auxiliary staff and health workers should not request to see the scars, nor should they be encouraged to question the patient. Questions based on curiosity are not allowed. *PRACTICAL IMPLICATION: The women's cultural values and privacy are respected. She is respected and given the dignity she deserves.*

5) **Canadian providers explain why certain interventions or involvement of certain professionals are necessary.** *PRACTICAL IMPLICATION: This allows Somali patients to make informed decisions that are congruent or compatible with their religious and, or, cultural belief.* Somalis see good health as a gift from God, however they are expected to care for their health. Practices normally prohibited by Islam are permitted if they are to preserve health. For example, the sick do not need to fast during Ramadan; or, women may expose their bodies to male medical practitioners.

A Somali woman must be given a variety of treatment options and she must understand these options. When she does not receive full information about her options and the services available, she feels isolated and powerless. If she has no influence in decision making, with respect to her body, then she is forced to repeat the cycle of not having a choice. At home she had no choice around being circumcised. In her new home she may

encounter forced choice over having a caesarian. Disempowerment through lack of viable choices will not enhance a change in the thinking process for the woman; she will not be encouraged to take charge of her health. The frequent references by Mary to feeling disrespected, embarrassed, stupid and alien, illustrates this point. *PRACTICAL IMPLICATION: She will be encouraged and empowered to make choices based on viable options, which will increase her self esteem and self determination.*

6) **Special care be taken when giving women who have been circumcised an examination**. For example, standard speculum can be painful when a) doing a pap test as the vaginal opening may be too small, and b) during a pelvic examination, as in most cases the pubic skin does not have much elasticity. Health care workers must be cognisant that the opening is usually the size of a corn kernel. *PRACTICAL IMPLICATION: The woman will feel less pain, feel less traumatized by the examination and be more trusting in the doctor's knowledge about FC*

7) **Doctors be made aware that there is an alternative to the caesarian section and use it, whenever possible.** The storytellers indicated that an alternative to the caesarian section is an anterior or medio-lateral episiotomy. Somali mid-wives have used this procedure as they found that a damaged perineum could cause lack of bladder control. *PRACTICAL IMPLICATION: Her recovery will be more rapid and hospital stay will be shorter resulting in less child care expenses for the care of her children. A reduction of*

anxiety will be felt by her not having to have a caesarean delivery because she is accustomed to viewing this kind of delivery from her cultural perspective of it being an emergency procedure; therefore, she thinks something must be dreadfully wrong.

8) Doctors refuse to perform circumcision, and that they do so in a respectful, compassionate and sensitive manner. Medical practitioners are aware of the directive from the College of Physicians and Surgeons of Ontario on FC. The College instructs all physicians to refuse any request to perform circumcision. Doctors must remember that patients who make a request for circumcision are doing what they think is best for their child's welfare. *PRACTICAL IMPLICATION: These women feel respected and most of all their dignity will be left intact, something which can never be over valued. When doctor's have this sensitivity then mother blaming and future re-victimization will not occur.*

9) Health care workers prepare the patient for the feel and new look of their genitalia. The College of Physicians and Surgeons of Ontario directs that women who have delivered their babies vaginally, and had their scar tissue disrupted must not be reconstructed to look circumcised. A woman who has never seen or felt this new genitalia before, may find it ugly. She might perceive that she has been disfigured.

In the case of women whose husbands are in Canada, they should also be educated on the new look of the genitalia so that the wife does not feel unattractive to her husband.

The husband also has to appreciate that a larger orifice does not mean promiscuity. nor does it mean loss of pleasure. *PRACTICAL IMPLICATION: By this new information, the woman and her spouse (where applicable). are being helped to make the cultural transition from the practice of FC to the non-practice, thereby creating a new culturally transformed story which is ultimately more liberating and less painful. and more pleasurable.*

10) The federal government examine the issue of giving new born babies surnames. The government has to dialogue with the community and decide what procedures are appropriate. They then have to communicate to staff a specific directive. Registrars of births can then follow the new directive and allow Somalis to clarify which name is the baby's official surname. At present, the surname is only changed if Somali women pay the cost to have legal name changes done after they leave the hospital.

We have to be aware that when a Somali woman marries she does not claim her husband's surname, but keeps her maiden (family) name. In Somalia, certificates reflect her husband's surname and not her family name. Family names are important in Somali society because they denote lineage. The three important names are; your Christian name, your father's surname and your grandfather's family name.

Immigration Canada should inform new immigrants of our current naming policy. *PRACTICAL IMPLICATION: This will eliminate the surprise women get when they are told*

to give their new born babies their surnames. If a new policy is created making it possible for the father's name to be on the certificate without paying a fee, then money, time and possible struggles are avoided for the woman at this vulnerable time. Also having forms available at the hospital for the women who wish to have this provision there.

Presently, naming is traumatic because the incident occurs at such a vulnerable time in the woman's life, after her baby's birth. When she leaves the hospital, she may have to take the bus to city hall, with her six children including her new born baby. She may be recovering from a caesarean section and so is feeling uncomfortable. The weather, for example winter, would complicate her difficulty. Furthermore, she has to figure out the legal procedure, cost and forms necessary to change the family name to the father's surname. This is compounded also by the fact that she may not be fluent in the language.

11) Hospitals have access to interpreters, and have volunteers who can be reached through an internal foreign language directory. These volunteers can be members of staff. Local hospitals have excellent language diversity among staff and so may be considered a great resource. Interpret who know another language, for example, Italian or Arabic can often communicate with Somali immigrants. *PRACTICAL IMPLICATION: This would enable women to communicate well with staff and medical personnel which would alleviate Mary's concern around breaking her religious diet and her fears about needing a caesarian operation.*

12) **Health care workers carefully establish the boundary that balances a professional relationship with a friendship.** Health care workers would benefit patients and themselves by not taking the role of chief admonisher and by not constantly reprimanding. This attitude, embarrasses the patient, causes cultural cues to be misread, and translates into alarmism for the Somali.

On the other hand, Somali society is less formal than Canada, so when clients become familiar with health care workers, they might expect that their friendship with the provider allows them certain privileges, for example to be seen without an appointment. Health care workers may have to explain that the appointment system is a business arrangement and is separate from friendship priviledges.

Also, their language translation means that they frequently take words literally, for example, their concept of emergency might be that you are seen immediately, you do not have to wait for longer than five minutes. Somalis are not accustomed to many systems. Keeping appointment times, getting referrals by other practitioners instead of self-referrals, and seeking medical attention by regular check-ups all have to be explained carefully.

PRACTICAL IMPLICATION: This would be to avoid embarrassment, feelings of shame in the women and the clients would learn the roles and boundaries of the Canadian medical

profession, hopefully, in an atmosphere that is kind and patient. It is easier and readily adaptable to learn the rules and norms of another culture in an climate of understanding .

13) The College of Physicians and Surgeons of Ontario be made aware that there is the practice of 'less harmful sunna' and make a policy statement on this matter.
I became aware that this practice happens in Chad and Nigeria. 'Less harmful sunna' is pricking the clitoris to release a drop of blood (see example in prologue). This 'operation' is compared to pricking one's finger. The College has to make a policy statement on this issue. Doctors and hospitals need to be made aware of the fact that they might be requested to do this; or they as doctors might consider this practice as a viable alternative for those people who have not yet made the transition to the eradication of the practice. A few African hospitals encourage this as an alternative and call it "less harmful sunna'. People who believe in circumcision believe that to be circumcised "blood must fall from the genitalia" (Graham, 1989).
PRACTICAL IMPLICATION: Doctor's awareness only increases their understanding and effectiveness when helping client who are dealing with these issues. If they consider ' 'less harmful sunna' to be a viable alternative, it could also become a transition stage to the eradication of the practise. Having a policy statement will legally protect doctors, yet respect the woman's cultural values. It may be argued by some that the practice will bridge any dissonance if the woman or her children have to return to Somalia to extended family (This is supported in the prologue, example number three).

14) Health services be made 'Somali-user-friendly'; to the unique requirements of women of this specific target group. The awareness of changed meanings started in Somalia, but it is aggravated or nurtured by Mary's Canadian experiences. The Canadian context, therefore impacts directly on how Somali women and their families feel about FC and it affects their access to Canadian health care. A negative encounter can cost a Somali women her life (for example, if she avoids getting a pap smear this could result in undetected cervical cancer). Fear escalates negative interaction and adjustment difficulties thereby hindering access to service and quality of care. Health care, both preventative and curative, may be unintentionally insensitive to the needs of the Somali woman, but the effect on her is devastating. A negative encounter with the health system becomes a disempowering experience leading to damaged self-esteem and creates more alienation. My research shows a link between negative health care experiences and a fear to discuss female circumcision. The manner Canadian doctors use to deal with, manage or treat Somali women "perpetuates conditions that future deplete and incapacitate her" (p.155), when she is relieved of her "burdens of the good mother guilt" (p.155) her self esteem can be strengthened (Wheeler, 1990).

PRACTICAL IMPLICATION: The awareness of changed meanings about FC can be more progressive if the Canadian experience has a positive impact and influence on women.

15) Issues be dealt with within the context of the events. When a visit with the doctor is made comfortable, it will lead the way for the woman to deal with sensitive issues.

PRACTICAL IMPLICATION: Over time this one to one interaction makes the family doctor an excellent resource for education about FC. The rapport the woman develops with the doctor will ensure that she trusts his/her advice. The doctor as her informal source of education should not be ignored. Using this avenue she can access information in privacy and with dignity. The doctor's ability to facilitate this process is a compliment to the profession and should not be ignored by medical personnel. Caring and sharing information is healthy for both communities.

16) Local media houses educate themselves and publicize facts on the fears and problems of the Somali community. Publicizing information on the problems of settlement and immigration to a new country will enable Canadians to be educated cross-culturally. It will also enable Somalis to feel that all their social issues are understood. The media in Somalia highlights the concept of change and the relationship between the sexes, whereas in Canada we highlight health and the pain of circumcision. *PRACTICAL IMPLICATION: The community has the possibility, at a later date, of using discussion forums, for example the local community television channel to discuss FC in a sensitive context, that respects Somali culture, and at the same time is educating the public.*

17) Education be through a program that partners knowledge with sharing experiences by stories. The consensus was that many women would not seek to infibulate their daughters in Canada; especially if they were made aware of the

consequences. The stigma of being infibulated was also seen as a deterrent to the continued practice in Canada. Some Somalis had also ceased to practice FC in Somalia as they accepted that FC was not sanctioned by religion. The storytellers felt that for the aforementioned reasons, eradicating FC in Canada is very possible from their value base. The issue in my mind is whether Canada should take a reactive, or pro-active stance, to reach this goal. Koso-Thomas (1987), advocates a proactive stance:

> "eradication approach that looks at social, religious and cultural transformation rather than legal decrees, as this approach has proved unsuccessful" (p. 25).

PRACTICAL IMPLICATION: Education and experience will challenge tradition and cause a change in attitude and outlook., and ultimately practice.

18a) Community support groups be used. They can act as a resource for practical and written information for school boards, and other agencies, when required. Somali students should be advised how to answer intrusive questions - for example, 'Are you circumcised?' Somali students must be empowered to have the confidence to state when certain questions are not appropriate, and when they will not be tolerated.

18b) The Somali community learn how to answer and deal with embarrassing questions from strangers. This training can be done through peer counselling, and group discussions. Dialogue must be initiated without attack, threats or blame.

PRACTICAL IMPLICATION: That there will be a stronger voice from the Somali community group which they will be instrumental in portraying. This will lead to more accurate information and less room for misrepresentation through other mediums Furthermore, Somalis will be able to give answers that more effectively deal with intrusive questions as they encounter them in the Canadian context.

19) ESL (English as a Second Language) classes be a forum for women to obtain information. ESL classes can provide simplified books and instructional materials relating to female circumcision and its effects, as library items. *PRACTICAL IMPLICATION: This method will reach many immigrants. The advantage of this is that books may be read in the privacy of the woman's own home.*

20) Education in partnership with religious leaders. I see educating in partnership with religious leaders as a key way to build an awareness, and discuss with Somalis that circumcision is not a requirement of Islam. *PRACTICAL IMPLICATION: The implication is to help free women from the religious obligation to continue the practice.*

21) Somali men support the issue by discussing circumcision with their sons. However, they must be encouraged to start a dialogue with both sexes, although this has not been done traditionally. Contrast needs to be made between the two value systems,

Canadian and Somali, so that *(PRACTICAL IMPLICATION:) children grow up understanding both cultures.*

22) Mothers, Fathers and Spouses be allowed time to talk about, and deal with their fears. *PRACTICAL IMPLICATION: If we give mothers plenty of time to talk about their fears, in a safe environment, they will eventually come to support the eradication point of view.* Fathers need enough time for them to feel they are not being attacked and so justify FC as 'woman's business'. This allows them emotional time to process and will allow them to be involved in the FGM struggle. As Somali spouses must also be encouraged to dialogue around the taboo subject of FC, and from dialogue they too as a couple will come to support the eradication of FGM.

23) Somali women educate not only their daughters but also their sons, and equip them with the tools to survive in both societies. The Somali woman has to find resolution within the following views: - traditional Somali view; versus, the urban Somali view; versus, the current Canadian view; before she can decide what life changes she will make. My research highlighted the fact that many in the community feel that a lot of urban Somalis are not practising FC in Somalia. The CBC report, (February, 1994 and September, 1995) drew the inference that circumcision must be practised on a large scale in Canada because of the prevalence of the custom in Somalia. The storytellers felt that

this was not true. The Association of Physicians and Surgeons of Ontario reported that a few doctors in Toronto had received requests to perform the operation.

It is pertinent that Canadians be made aware that the concept of eradicating FC is not new for Somalis, but what may be new to them is that there are legal consequences associated with the practice of FC in Canada.

PRACTICAL IMPLICATION: Helps her examine the meaning of FC for her Canadian-Somali children.

24) Somali community groups adopt, or adapt, the method now used in Somalia by the Somali Women's Democratic Organization. If these eradication strategies work in Somalia, adapting them to be used by Canadian-Somali women would be a crosscultural bonus. We could treat the Somali-Canadian community as a cultural enclave. The method involves a) day to day verbal action campaign, using dialogue and sharing medical facts. b) asking religious leaders to speak about, and against the practice. c) educating hospitals on what to expect and how to react and treat patients. d) establishing a statistical base and 'library' of facts. e) using community action to disseminate the idea of change being inevitable and the new relationship dynamics between the sexes (McLean & Graham, 1983, p.14). *PRACTICAL IMPLICATION: If the above recommendation is a success, then this model could be used in congruent cultures, for example, Sudan, Eriteria, Ethiopia, and Djibouti.*

25) The process of dialogue starts on all harmful traditional practices a) some of which have been eradicated or, b) are in the process of being eradicated in all cultures. Learning as a community to discuss other harmful traditional practices in all societies is desirable. For example, European chastity belts, putting British unwed mothers in mental hospitals, stoning women for adultery, Asian foot binding, SouthAsian widow burning, lynching of Blacks in North America, and silence around domestic violence and abuse. *PRACTICAL IMPLICATION: This will bring into conscious awareness the fact that not all traditional practices are good.*

> "Women are victims of outdated customs, attitudes and male prejudice. This results in negative attitudes of women about themselves. There are many forms of sexual oppression, but this particular one is based on the manipulation of women's sexuality in order to assure make domination and exploitation. the origins of such practices may be found in the family, society, and religion." (Raqiya Haji Dualeh Abdalla, Somali Women's Democratic Organization, Toubia, 1993, p.42).

26) The objective examination of all current cultural practices. We may not agree with foreign cultural practices but we need to be able to examine all cultural practices objectively, including our own. This entails stepping out of one's own cultural frame of reference. As a community we need to metaphorically get to a place where 'laughter' and 'comfort' can prevail. Only when I had bridged this gap was I able to build trust, understanding and sharing with the storytellers. Bridging gaps is done by two way communication, as it allows feedback. Using avenues that only disseminate information

one way (for example, television) are not the best way to initially communicate with the Somali community. Using two way communication, for example workshops, and personal dialogue will prove to be more effective. *PRACTICAL IMPLICATION: Through the objective examination of all current cultural practices one learns to challenge one's own socialization and discover the cultural similarities of all homo sapiens; that is all cultures have negative and positive influences.*

27) When discussing FC with adults, one uses same sex adult interpreters. *PRACTICAL IMPLICATION: This will aid in achieving 1) the goal of comfort and 2) openness to a discussion and choices.*

28) White persons working with female circumcision try to confront their own socialized racism. If they have never done this, they will be forced to look at their inner self. If feelings of pity, or feeling the 'natives are ignorant' arise, they should be aware that these feelings may often be rooted in racism. They may need to examine their feelings and try to neutralize them. Harriet Lyons (1981) takes an anthropological look at racism (literature review), as it surrounds the issue of circumcision, and would therefore be helpful to White persons.

Whites also have to be prepared that they may be challenged as racist by the persons upholding the practice of FC, as they might view the FGM movement as attacking tradition.

PRACTICAL IMPLICATION: To be effective one has to move beyond both of these and interact at a truly human level.

29) There be a place (physical location or telephone support) where Somali people can seek confidential help regarding FC. *PRACTICAL IMPLICATION: Somalis know where to seek confidential help, regardless of age or gender.* This should be the thrust of most of the current publicity around FC for the community to confidently access resources.

30) Black women take the time, and be encouraged to take care of their reproductive health and encourage others to do the same. FC, viewed from this perspective has much value as an educational tool. The issue of FC must take a holistic approach as it embraces the context and the process of changed meanings. This view was validated by the varied themes of the narrative. Value must be placed on the factors of gender, emotional, social, cultural and economic reality, rather than on the purely physical (anatomy), biological and medical model approach. The medical model is historically from the male perspective. *PRACTICAL IMPLICATION: The aforementioned factors influence meaning and act as positive or negative forces for women to take charge of their health. In this context, health is not just an absence of disease or infirmity; but health enhances life.*

31) Change and acceptance on FC initiatives be spearheaded by those who know the community. Although improving Canadian-Somali women's health requires promotion, education and preventative measures, FC cannot be used as the main tool to introduce health. It is too divisive and opinions are polarised. External self-made experts, who are not empathic and effective are easily recognized by the community. *PRACTICAL IMPLICATION: Programs and initiatives will be matched to the community's need and be therefore be cost effective, efficient. and empowering.*

32) I recommend that we listen, ask, then formulate. We need to listen to all Somali issues and ask pertinent questions when we do not understand, so that together we can formulate an appropriate strategy. Analyzing what is happening in the community is important, to get a sense of key issues of concern. We must remember that, to attack and eradicate the practice of FC is the current Canadian agenda, and is congruent with many other countries. To push our agenda and not acknowledge feelings makes very little sense if the objective is to facilitate conflict resolution within the individual. If we alienate Somalis and then formulate programs, they are doomed to fail. Instead of fools rushing in where wise men fear to tread, we need to listen. This research narrative provides a good beginning. *PRACTICAL IMPLICATION: Listen to individual stories and still keep true to our legal agenda, but doing this we can rewrite and reframe previous stories.*

33) There be validation of the Somali community's ability to know their own need. Canadians must be able to step back and trust the community leaders to know their own needs. To do this sometimes means being willing to play the subordinate role. Like native Canadians, Somalis are suspicious of organizations and systems because they are ... "aware that many mainstream organizations exist and have benefited by grants on this issue, and yet they have not been empowered as a community". They are also aware that ... "a Caesarian section is more financially lucrative for the medical profession than promoting natural child birth." *PRACTICAL IMPLICATION: This has made the Somali community examine overtures for political, financial and hidden agendas. The Canadian, both individually and societally needs to examine power and roles in order to build respectful partnerships that value culture.*

34) Pamphlets, brochures and booklets not only articulate the medical issues around FC but be all inclusive. They should also articulate issues from a gender, personal and familial role and Canadian context perspective, as well as, interpretation of the legal and social issues. These translated materials will become personal resources for Somali women as a) they will be written in a language they understand, and b) they can take the material home and read it privately. Translated material should answer the questions who (is affected), how (can they cope) and why (is this important). These basic questions are asked by all immigrants regardless of the topic as the answer to them provides the basis for understanding and learning the options in a new environment.

PRACTICAL IMPLICATION: Immigrants are capable of functioning within their new context when they know their rights and obligations. In my experience, immigrant women come to Canada with a very defined sense of their role and responsibility. In the process of defining their role as caregiver within this new environment they will examine issues like FC as it relates to shaping their family's future.

35) The term "Female Circumcision" change and become "female genital mutilation" by community consensus. Community ownership is essential as it is allows for collective discussion; from dialogue consensus is reached; from consensus information is disseminated and acted upon.

The difference in perspective between male and female circumcision must therefore be addressed, it cannot be ignored. In our story, Mary wondered at an emotional level, why there was a difference in attitude. She was not convinced that the religious and health explanations on the matter were valid. As a community this needs discussion to help the process of sorting and resolving the matter.

PRACTICAL IMPLICATION: When the act of female circumcision is viewed from the mindset of Female Genital Mutilation, then the individual ceases to advocate for the procedure. The individual's new conviction becomes a part of the community's inaction and so the practice ceases.

36) **The traditional mores that promote dialogue be used in order to ensure that the community listens.** This will facilitate change, for example being critical in direct two-way communication is easier for the community to manage. A favourable frame of mind is needed to enable any message to be received. Currently there is a void in "grass-roots Somali to mainstream Canadian" dialogue on the issue of FC in Kitchener-Waterloo. This has resulted in the community feeling victimized, shamed and disempowered rather than open and willing to share with other Canadians. This was not so in the beginning when Somalis came to Kitchener/ Waterloo, but based on our response, the mood has changed. (see Kitchener-Waterloo Record, Thursday, December 16, 1993, p.B1)

PRACTICAL IMPLICATION: Leaders in trying to eradicate FC cannot hope to achieve success in implementation unless they have broad based support. Refusing to address the core issues -- the mind and spirit of the people -- dooms any effort as non-productive. Instead the initiative will cause conflicts, and high levels of stress. This is illustrated in the current approach to FC in Kitchener-Waterloo, Somalis do not want to be identified with an unpopular community concept, hence the rocky start for my research.

37) **We recognize the differences in gender perspective.** The African mode of thinking is different from the 'North'. Koso-Thomas, (1987) indicated that many African cultures felt that FC kept women monogamous. My research confirmed that many women saw the practice as a protection from being violated (raped) during war. These two views

are congruent, and validate the belief identified by Koso-Thomas (Ibid.) that African societies view gender within their reproductive/procreation role and not in their sexual/sensual role. If FC is seen as a valid protection against rape, then a woman's sensual role is given a subordinate position.

PRACTICAL IMPLICATION: This is the opposite manner from the 'North' where I feel a woman's sensual sexual role is highlighted and her reproductive role is treated as a given, but subordinate.

38) Education by highlighting the procreation role. If the aforementioned is correct, then education regarding the discontinuation of FC could more effectively reach people by highlighting the advantages around the procreation role. Communal roles and responsibilities are important in the African society, thus highlighting of their advantages would be matching information to cultural thinking patterns. Gender roles and responsibilities enhance communal living and bring unity to the extended family. Whereas an emphasis on individual freedoms and rights emphasizes the personal gender role and becomes an expression of individuality. Canada's cultural philosophy is based on the individuality premise, although being Catholic or Protestant influences one's degree of autonomy. Canadian social workers should therefore not be surprised if they find Somali adherence to the communal role more difficult to understand. *PRACTICAL IMPLICATION: For increased understanding, Canadian social workers need to look at these issues from outside their Canadian frame of reference.*

39) Federal agencies concerned with health, citizenship, immigration and settlement tackle FC as a joint top priority. Coordination of these services when tackled as a joint priority will be more comprehensive and cost effective. FC is not just a Somali issue, many of the issues raised in the narrative are relevant to other immigrants. *PRACTICAL IMPLICATION: A comprehensive strategy would be of great benefit to the all Canadians.*

40) Any intervention, program, policy, or plan take into account the cultural value of pride. At present, no initiative does this. However, in the Somali culture, pride is of the utmost importance. *PRACTICAL IMPLICATION: An approach that is respectful of their desire to maintain their self-esteem is a good point for a cross-cultural approach.*

41) There be a comparison of norms so as to aid in problem definition. Comparing norms is a good method to examine and discuss issues, so that all can recognize and define problems. More than half (60%) of the women, in the study, reported having no unusual complications with childbirth, sex and marriage in Somalia. Careful probing revealed, however, that some reproductive and sexual norms were not norms for Canadians. For example; "it often takes six months to consummate a marriage". Many women were not aware that in the Canadian experience this was not the norm. In the group, this was a starting point from which to define what both sides would categorize as 'problems'. After this, problem definition began to include aspects of penetration,

menstruation and child-birth. These had not been viewed as problem areas before. This exercise revealed that FC problems as defined by the 'text' (see literature review), are not internalized by the women as relating to their experiences. *PRACTICAL IMPLICATION: By discussion we came to use a common frame of reference and so spoke the same 'language'. Over time, if we had continued, we would have been able to expand the frame to include a variety of unspoken and unexplained experiences and cues, this would have raised our collective consciousness.*

Discussions to find a common frame of reference lead to our examining the anatomy of sex. This knowledge is valuable for researchers to investigate further; health practitioners to learn; and Canadians to value, as this would also eliminate questions on normality from being asked. We agreed that sexual pleasure was connected to nerve endings and the brain. Using this as a reference, the storytellers were able to explain to me how orgasm could be achieved although the clitoris was infibulated. We discussed the womb's role, which is primarily for reproduction and the clitoris' role which is primarily for pleasure. By discussing the connection between the brain, one's emotions, one's sense of touch, smell and stimulating nerve endings in other areas of the body, we were able to share experiences. By our discussions I concluded that other areas of the body seemed to compensate for the loss of the clitoris by becoming even more responsive to touch. This information was not congruent to the Minority Rights Group (1992) article, but was genuine and truthful to the reality of the storytellers.

42) **Resistance to change as positive.** Nobody likes change except a wet baby, therefore, resistance to change is a natural process and must be expected and so should not cause undue panic or fear. Epps (1994) describes the change process as occurring in four steps, denial, resistance, experimentation and adaptation. They advise that in stage one, denial, the key strategy is to communicate, communicate, communicate. The objective at this stage is to build clarity, familiarity with the new position and provide people with the sense of being involved in the plan. *PRACTICAL IMPLICATION: If this model had been followed, Mary's hospital visit would have been less traumatic, as all her questions would have been answered. She would have been able to feel a level of connectedness. Connectedness helps people through resistance.*

The second stage is resistance and at this point we need to listen carefully to people. The characteristic of being able to listen, listen, listen cannot be overemphasized. At this stage all the complaints, fears, criticisms and challenges appear. People have little capacity to take direction, at this stage, what they want to do is vent. Realizing that this is natural will enable one to keep the feelings of defensiveness in check, it is the situation and not the individual that is under attack. Listening builds empathy and opens the opportunity for examining areas you had not foreseen. It was at this stage in my research that the narrative from my storytellers began to unfold. However, as a community I feel the Somalis have not reached this stage, because there has not been enough dialogue and active listening around the issue of FC. *PRACTICAL IMPLICATION: This is the stage at which*

trust can be built. The narrative was therefore an excellent stage in the therapeutic process.

The third stage was experimentation and it required that one encourages, encourages, encourages. I postulate that the Somali community has not yet reached this stage. Mistakes are common at this stage, therefore, it should not be a problem if some solutions do not work. Its a time for novelty and innovation. At this stage, creating resolutions to cultural differences will be resolved. This is the time when re-formulating or re-writing of personal stories takes place, and persons start to look to the future. When the fourth stage is reached, the focus is on visioning. *PRACTICAL IMPLICATION: Visioning will enable the community to see the possibilities.* Epps (1994) advised that at this stage one must involve as many people as possible in the vision, so that they can 'own' the vision. Through these four stages, resistance to change is not a negative process. Change becomes negative and destructive if it goes unattended.

PRACTICAL IMPLICATION: It is therefore crucial that the Somali community be given the opportunity to work through this process and we become the supporters of their own change.

43) Somali Women use the process of change to benefit themselves. *PRACTICAL IMPLICATION: Somali women must realize that when change occurs it affects relationships and so they must be prepared to deal with this aspect of change within their lives,*

regardless of whether the change is caused by changed meaning and/or changed processes. To help their community deal with FC Somali women have to find out among themselves what they want to develop, the program, the strategies, the tactics. Understanding this will help them decide what type of change they want and the method they need to use to change it. To change the system they need activist type change and they may not be prepared to do this for many years. However they must recognize that this is the type of change the Canadian environment wants hence the current publicity and media drive. Recognizing this will help them depersonalize the hurt. Change in programming requires advocacy, and this type of change may be easier for them to handle over time. This type of change means matching needs to resources. This can be accomplished simultaneously in the areas of education, health and social services through educational partnerships. To achieve change in individual relationships, for example, Canadian to Somali change, or, Somali to Somali gender dynamics change, requires facilitation techniques. These are methods that the community has to learn to use. *PRACTICAL IMPLICATION: Using these methods will aid them to heal some of the emotional pain that confrontational criticism causes as it depersonalizes the attack.*

44) Social workers use narrative therapy. To help the Somali community align with change, social workers should use the principles of narrative therapy to help Somalis re-write any painful personal stories, as it is congruent to the African tradition and conveys the value of respect. Narrative therapy advocates that as social workers we respect our

clients and listen to the connection between cultural, personal and political (personal communication, Just Therapy Workshop, Spring 1994). We must also provide our client with the opportunity to ventilate their feelings and provide a safe place to reconstruct themselves and their cultural values in a new context. Narrative therapy is an appropriate intervention strategy for social workers who deliver service to the Somali community. It advocates valuing oneself, validating feelings and recognition of the truth based on one's reality (personal communication, Just Therapy Workshop, Spring 1994). This approach enables the social worker to use herself as a tool and this skill is very supportive. Cheryl Rampage (1992) believes that as therapists, social workers need to listen carefully to the client's story, seek to understand the client's meaning from the story and discern alternatives with potentially more liberated meanings Sometimes a social worker can create a shift in the client's personal authority, possibly by emphasizing a different aspect or character of her story than the one the client, or society has emphasized. *PRACTICAL IMPLICATION: Narrative therapy can help Somali women become socially imbedded in the Canadian context in a way that is compatible to her own social context. She would amalgamate the Canadian 'truth' with her traditional 'truth', in such a manner that would be comfortable for her and so create her own personal 'truth'. This would help ease the transaction into the Canadian way of life.*

The narrative approach to therapy is also congruent to the African tradition of story telling, and so it can be used as an effective method for counselling Somali clients. Counselling

in an African setting is done by the extended family system or clan. Counselling by a stranger is a new concept, however, the narrative approach will help ease the transition, by linking the cultural storytelling with giving listening and validating feelings.

45) Feminist Therapy be also used. Feminist therapy is another effective counselling style that would be beneficial for the social worker to use when dealing with the Somali client Greenspan (1993) feels that it is vital that women in therapy develop a strong consciousness of female emotional pain, because without this it would be impossible for a female client to obtain an authentic sense of her own power, both individually and along with others. Eradication of FC is an issue that is filled with emotional pain and so the feminist approach would offer the Somali woman an opportunity to come to terms with any forced personal and/or political change, while helping her rethink any conditioned belief about herself. *PRACTICAL IMPLICATION: This would enable the Somali women to work at getting in touch with her own personal strengths and values, and learn to trust herself. She would see herself as the action agent in her life. Through this process the Somali client can learn about her own power and the social worker can help her maintain it. This would reinforce her confidence and self esteem, in a strange and sometimes negative environment. This would be exciting for her as it would help her understand feelings of cultural powerlessness caused by any oppression and activate her personal powerfulness.*

The social worker must know of the psychological, health and social repercussions circumcision has on an individual, family, or group and be able to recognise the signs. If counselling is to be accepted around FC, the feminist philosophy of therapy respects women's stories and truth, and is quite aware that denial can be a method of survival for many women. Feminist therapy is useful as it operates from the "personal is political" (Greenspan, 1993) framework, therefore it is aware of how all socialization, culture, traditions and patriarchal ideology have influenced and victimized us. The feminist therapist does not take the expert role, but together with the client helps her work through issues and problem solve.

46) Somali women actively pursue strategies that will enhance their self esteem.

PRACTICAL IMPLICATION: The Somali woman needs to bolster her self esteem and sense of personal power if she hopes to survive the onslaught of social condemnation she feels she is receiving from her new community. Dorothy Wheeler (1990) encourages social workers to help clients develop this sense of personal power and validation of esteem by increasing their sensitivity to the ways in which patriarchal social structures and ideology oppress many women. This helps social workers to understand the difficulties mothers face when making decisions about choice. Using this empathic understanding, the social worker will be able to connect genuinely with the Somali client so that their interaction becomes a positive experience.

47) **Social workers and agencies use community partnerships, to provide translations services and emotional support for Somali women who are hospitalized.** The narrative story, Episode 3, is an illustration of what happens when this is not done. *PRACTICAL IMPLICATION: Translation enables Somali women to communicate and this decreases dissonance and feelings of isolation.*

49) **Social workers work within the confines of the law.** Although social workers have to work within the confines of the law, it is not intended that they sacrifice cultural perspective taking, empathy and compassion. Social workers must be cognizant of the fact that there are no social workers in Somalia so Somalis will find it difficult to discuss personal problems with us. Somalis would not normally seek out professional counselling, therefore as a profession we might have to reach out to them. We have try to work within their cultural variables in order to make the relationship more comfortable for them. If this is not done the Somali client may become quiet and communication will become difficult. *PRACTICAL IMPLICATION: Without the proper depth of understanding about the Somali culture, well intentioned social workers could quite easily revictimize the clients they seek to serve. This may cause alienation between client and social worker and jeopardize the future health of the client.*

> FORWARD (1989) in the U.K., listed the following emotions as ones they found when dealing with circumcised clients.
> "Lack of trust, fear of strangers, fear of being touched, fear of knives and razors, fear of operations, fear of doctors and mid-wives, fear of getting married and having sex, fear of having children, fear of new situations, separation anxiety from leaving

> friends, older and younger, isolation from other family members including mother and sisters, it's is wrong to cry or shout, to be angry, there is something wrong with being female, being a woman is synonymous with pain." (p.5, Adamson article in FORWARD)

The citation above helps us comprehend the intensity of emotional and physical pain Mary had. It also helps us fathom the intensity of degradation and therefore empathize with Mary when she visited the hospital.

49) A social worker take time to process, before and after counselling sessions feelings about FC. She/he must be aware of the use of self before counselling a patient who has been circumcised, so that she/he can be respectful and yet work from a collaborator role rather than expert perspective. *PRACTICAL IMPLICATION: Being self aware will help her process any prejudicial views or feelings she may have about this topic.*

50) Government funded social agencies have orientation sessions or written translated materials that can be used by Somalis to getting accustomed to Canadian culture. These agencies are among the first to make contact with refugees. *PRACTICAL IMPLICATION: The material and information will provide legalities around FC and explanation of the role of Family and Children Services, which will aid Somalis in their understanding FC in the Canadian context.*

Often newcomers overestimate the power of frontline workers, and think they can change rules and speed up processes. Helpful service providers may be asked to help beyond their areas of jurisdiction, or expertise, and this may annoy or exasperate them. This happens because it is difficult for newcomers to know where to go and how to access information. Written information in the Somali language will solve this problem.

51) Repulse the act and not the person. If family or children service agencies are told that circumcision was performed on a female child, the protocol has already been worked out within the legal framework. However, the worker has to be sensitive to the personal issues the family has to face. *PRACTICAL IMPLICATION: The social workers at Family and Children Services need to be respectful, and supportive of the family, even if they do not support the action and allow for translation services. Even when Canadians, cannot monitor what is translated, it is critical.* The storytellers indicated that this was often not done, because agencies distrusted the Somali client and interpreter relationship as being ultra vires to their own.

52) Training for social workers needs to be crosscultural. Somalis need to learn about programs and services here. Since the community is new and the crosscultural experience is new for social workers and Somalis, problems develop. It is a new experience for Somalis to live in a multicultural society. They may therefore rely heavily on service providers. Recognition of this fact will help providers be more understanding of this

dependency. *PRACTICAL IMPLICATION: Simple problems to Canadians, as they are accustomed to the system and culture can seem like insurmountable problems to immigrants, as they contend with so many new cues. Storytellers illustrated this by recounting individual stories about problems they had getting their children into schools, finding a lawyer for their refugee claims, using the health services and finding living accommodation.*

CONCLUSION

Female circumcision is a subject not openly examined by Somalis as it is considered personal and private. Due to the publicity and stigma attached to the topic it was difficult for me to arrange group sessions. In the beginning my interaction with the storytellers was not as open as I had hoped. Fortunately, because of my research approach, I was able to probe deeper. As the women got to know me better they revealed more of themselves in an open, and honest manner. I was able to reciprocate.

Their openness enhanced my learning as I had to rely on my use of self and my capacity to develop as an agent of change. Over time, we ended up in an therapeutic sharing relationship. This enabled me look at my own issues around female circumcision and caused me to revise my frame of reference from compartmentalizing the issue to expanding my approach to a more holistic and empathic view.

Due to the emotive subject matter, and their culture, the storytellers would not have shared themselves unless our relationship had developed. In the context of trustworthiness and solid connections, qualitative research was a very effective method to conduct this research. If I had used quantitative research, I would never have captured this. I would not have grown to understood that the process of changed meanings is loaded with a sense

of being stigmatized by North Americans. Judy Jordon eloquently expresses my feelings about my social work researcher role:

> "One of the most praiseworthy qualities to bring to a practice (as a social worker) is to help seed and sustain courage through encouragement to another human being. This involves bringing our truths into our relationships in a respectful and empathic manner" (Jordon, p.11, 1990).

I came to realize that to 'Northern' women female circumcision was hard for them to comprehend. They become 'stuck' at the physical mutilation of the genitals. Often women held themselves rigid, crossed their legs and grimaced when female circumcision was mentioned.

In Africa I found a few women who sincerely believed in the practice. They found it shocking that women of the North were not being circumcised. They were as equally disturbed about the women of the North, as the women of the North were about them. This expanded my frame of reference and allowed me to look outside my frame of reference to understand the issue. I came to understand that using pain; physical and emotional, humanity; cruelty versus humane treatment, are often meaningly designations to help dispell the practice as FC is tied to celebrated ideology. This ideology is perfectly defensible for those who believe them.

This topic brings feelings of vulnerability to all. These polarized approaches came to resolution in me when I linked circumcision to my understanding of the force of communal versus individual identity. This resolution is crucial if the Somali-Canadian woman of

Kitchener-Waterloo is to survive within the Canadian environment. The resolution means a chain-like process towards change. It is the process by which the word female circumcision changes from being a celebration of womanhood, accepted, desirable, its scars regarded as wonderful badges of honour; to one that becomes synonymous with destruction, degradation, mutiliation and shame. We must consider that FC is connected not only with oppressing women, sexuality and health but also with the ideologies surrounding adulthood -- (who becomes a man or woman, their responsibilities and the benefits surrounding that categorisation) -- and the power relationships between elders and juniors. Only when we examine all these factors can we appreciate that the change from female circumcision to female genital mutilation, envelopes a kaleidoscope of emotions.

The training gained by this research taught me how to handle these emotions with dignity and yet be respectful and value the stories of my readers. This lesson has future value for me as it will be useful throughout my life.

Narrative research has unfolded for me a new method which I can use to examine life. I intend to use this new skill to explore, and I intend to find other areas in which to practise this skill so as to gain understanding.

Significant to this subject area is the growing number of infibulated women who are having deinfibulation operation procedures done to their genitalia. For those who can afford it,

female genital mutilation can be aesthetically repaired. This often relieves some of the medical problems for example, painful menstruation. It does not resolve the concerns of females who wished their parents had not circumcised them. Reconstructive surgery is not well publicized and further research needs to uncover the facts surrounding it. Nevertheless it brings relief for some women.

APPENDIX A

QUESTIONS FOR FURTHER RESEARCH

How does the following issues impact on FC for Somalis tracked over time; 5, 10, 15, 20 years.

a) Mary's story - tracked through time, to find out her attitudes and the reproductive stories, she and her grown daughter would share? How different would they find these experiences to be? Would they find many commonalities? Will Mary create new traditions? How will they deal with the issue of monogamy, sexuality and virginity?

b) Clan violence has fragmented families so that individual members, live in different localities and countries. What impact does this have on male or female headed household decisions regarding FC? Does it make a difference in the number of male and/or female circumcisions being done?

c) How has the impact of change in so many areas of life impacted on the issue of FC for the rural or more traditional Somali women, has it expanded or narrowed her focus?

d) What is the process of changed meaning for Somali males and how it is tied to gender roles? Does it affect their attitudes a) Somali men married to circumcised women or b) Somali men married to uncircumcised women? Research needs to examine his historical, cultural, religious and role perspective.

e) Is FGM being done in Canada, on how many, by whom, where and when?

f) Is deinfibulation being done in Canada as re-constructive surgery, on how many women, what are the rates of success, who performs it, and where is it done, and of course what are the women's narrative story? Does deinfibulation affect their view of the transition from girl into adulthood -- responsibilities, roles and benefits of adulthood?

g) Why did some of my participants fail to participate? Having read the narrative, would they feel comfortable to participate in another research study on the topic of circumcision?

h) My research did not delve into the minds of children? What is the pain and trauma around the event of circumcision for them? What is psychological effect on behaviour and memories? Can choice be tied to the relationship between elders and juniors, the event and the ideologies surrounding adulthood?

i) What issues would an uninfibulated relative have to deal with on her return to Somalia? (permanent or visit)

APPENDIX B

Letter 1 - INTERPRETER'S AGREEMENT

I agree to participate in the study being conducted by LaFerne Clarke which focuses on Female Circumcision also called Female Genital Mutilation by providing translation services for persons if necessary.

I understand that:

a) any knowledge gained will be confidential and will remain confidential.
b) I also understand that all interview transcripts will be confidential and handled appropriately as such.
c) I will not keep any records of this study, or track any participants in this study.

Furthermore, it is also my understanding that:

e) There are no known risks associated with my participation in this study.
f) There are no direct personal benefits associated with my participation except the positive feelings I have about taking part in a study which promises benefit to my community..

My signature indicates that I have read and understood this letter and I agree to the terms.

Name . . . .
Address . . . .
City . . . .

Signature. . . . .

Date . . . .

APPENDIX C

Letter 2 - INTRODUCTORY LETTER OF INFORMATION

Dear:

I am requesting your participation in a research study on female circumcision. The study is conducted by LaFerne Clarke, Master of Social Work student at Wilfrid Laurier University in Waterloo, Canada, under the supervision of Dr. Kenneth Banks.

The goals of this research project are to:

1. find out if living in Canada changes someone's feelings and action towards female circumcision;

2. to investigate the process of this changed meaning.

3. to gain cultural sensitivity and develop an understanding of the issue by creating a narrative story on the topic.

Your participation is completely voluntary and can be withdrawn at any time. If you agree to participate, please return the signed consent form to me.

The interviews will be group sessions. One group session will last for about two hours and will be audio taped. The only persons who will review the information that you share will be the researcher and the researcher's Thesis Advisor. False names will be assigned to all participants during the group discussions; and numbers substituted for these names when transcribing the data. When the tapes are transcribed no other identifying information will be used. Tapes will be kept in a locked file drawer during the research and will be erased at the end of the study.

We will provide you with a summary of the research report when available, if you sign in the space provided on the consent form

All information you provide will be treated in a confidential manner. I do not believe that there are any risks related to your participation in this study. If you have any questions about the research or group interviews please contact me, LaFerne Clarke at the address below, or Dr. Kenneth Banks (519) 884-1970. Thanks for your consideration.

Yours sincerely

LaFerne Clarke G.I.M.
Student Researcher

APPENDIX D

Letter 3 - LANGUAGE AGREEMENT

I agree to have my group discussion conducted in English.

....

I would also like a copy of the results of the study:

Name & Address:

Telephone #

APPENDIX E

Letter 4 - PARTICIPANT'S CONSENT FORM (Can Be Translated)

I understand that I am being asked to participate in a research study which is being conducted by LaFerne Clarke, Master of Social Work student supervised by Dr. Kenneth Banks at Wilfrid Laurier University.

The purpose of this study is to better understand the process of changed meanings to K-W Somali-Canadians on female circumcision. The data collected in this research will be used to promote this understanding.

The procedure to be used will be focus group discussions which include role play.

I understand that the sessions will be audio-taped and that the proposed length of a group session is approximately three hours.

My participation is completely voluntary and I am free to withdraw my consent at any time. This means that I have the right to refuse to answer some or all questions or to participate in any role plays. I also have the right to stop participating in the group at any point during the research. I understand that no force will be used to coerce me to participate. I have the right, and I will be able to review transcripts. I will also be able to delete some or, comments made by me.

I understand that the research records will be kept confidential. The researcher will use fictitious name tags during the sessions and substitute numbers for the names when transcribing the data. I will not be specifically identified in any publication or discussion. I understand that direct quotations may be used in reporting data, but these will not disclose my identity. I also understand that the researcher will keep all data and transcripts in a locked filing cabinet drawer.

I understand that I can receive feedback on the overall results of this research by means of a report (done in English). This will be made available to me before November 1, 1995. If I have any questions about the research, the procedures employed, my rights or any other research related concerns I may contact the investigator and/or their supervisor at that I can receive feedback on the overall results of this research by means of a (519) 748-2681.

....	....
Investigator & Witness (LaFerne Clarke)	Participant
....	....
Date	Date

My signature indicates that I have read, understood and agree to the letter outlining the purpose and methods of the research. My signature also confirms my verbal agreement.

APPENDIX F

Letter 5 - GROUP DISCUSSION GUIDELINES

1. I gave the letter of information at least one day before the actual group session took place. I did not conduct an session unless I had a signed consent form. I ensured that the sessions took place where we were not interrupted.

2. I read the letter of information with the participants.

3. I briefly summarized my knowledge of female circumcision as stated in the letter.

4. I asked the participants if they have any questions. (Portion # 2 to 4 took 15 - 25 minutes).

a. start and test the tape recorder.
b. Press record and 'test 1-2-3", rewind and play back. Rewind and begin interview.
c. Press record
d. State - date, time, at the title of the session.
e. "You have voluntarily consented to participate in this focus group, and have read and signed the consent form and agree to have the interview taped, is this correct?"
f. Ice-Breaker Introduction:
   - Country of birth
   - Participant's age
   - Past (Somalia) and present (Canada) occupation
   - Number of people in your family
   - Any thing you want to share for the group to get to know you

Guidelines for the narrative agenda

1. Circumcision - an event in one's life. The reaction and feelings about it in Somalia.
2. What coming to Canada unfolded. The events that brought this realization and the feelings and emotions attached.
3. Daughter now needing to be circumcised. The issues and feelings.
4. What decision is made, and by whom.
5. How does she feel about the decision.
6. What support does she need from Canada.

APPENDIX G

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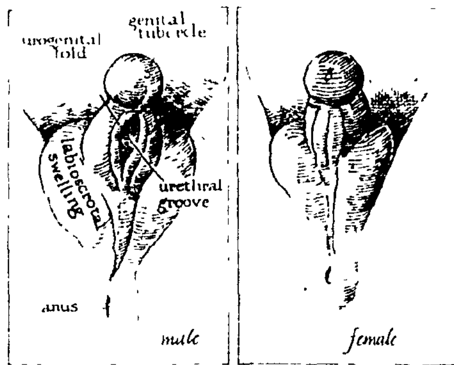
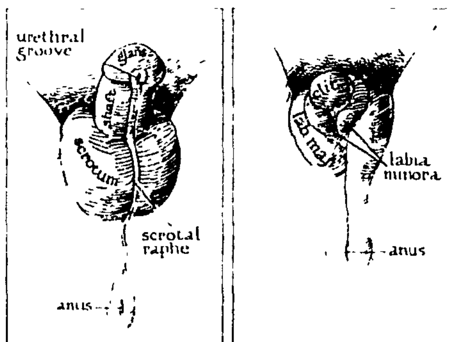
APPENDIX H

FIGURE # 1

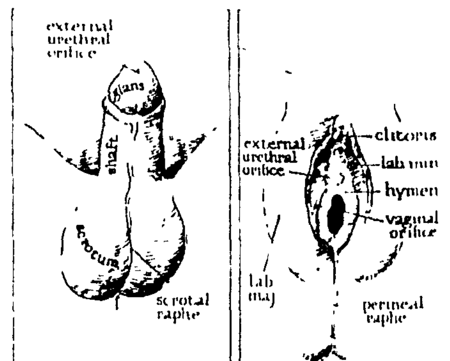
DEVELOPMENT OF GENITALS IN UTREO SHOWING THE CORRESPONDENCE BETWEEN MALE & FEMALE



The external genitalia in the ninth week.



The external genitalia in the tenth week.



The external genitalia at term

Source:
Toubia, Nahid (1993)
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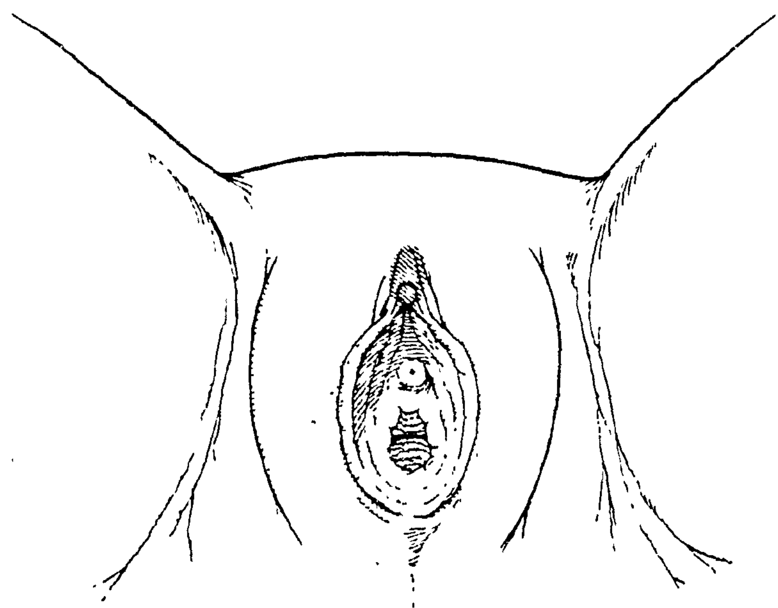
APPENDIX I

FIGURE # 2

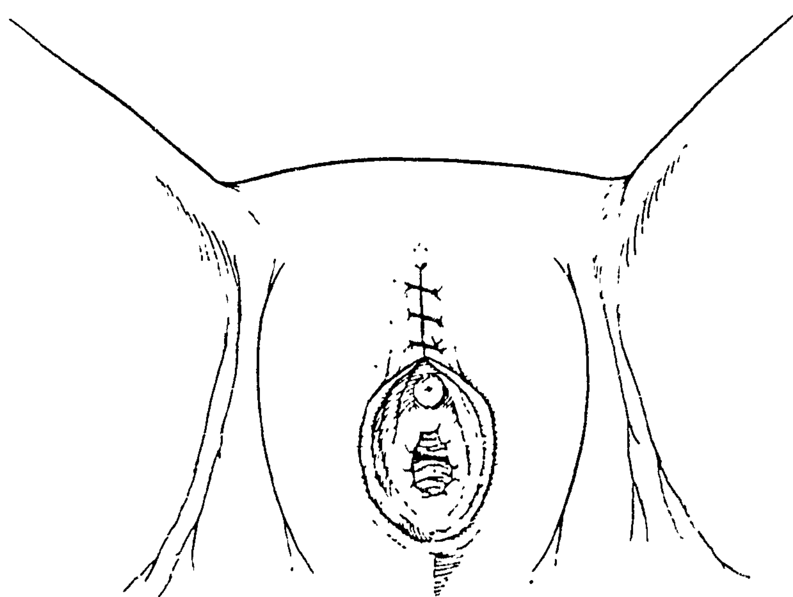


Type I Clitoridectomy.
The hatched area indicates the tissue to be removed.

SOURCE:
Toubia, Nahid (1994)
Female Circumcision As A Public Health Issue
The New England Journal of Medicine,
September 15, 1994, Vol. 331 #11 p.713

APPENDIX J

FIGURE # 3

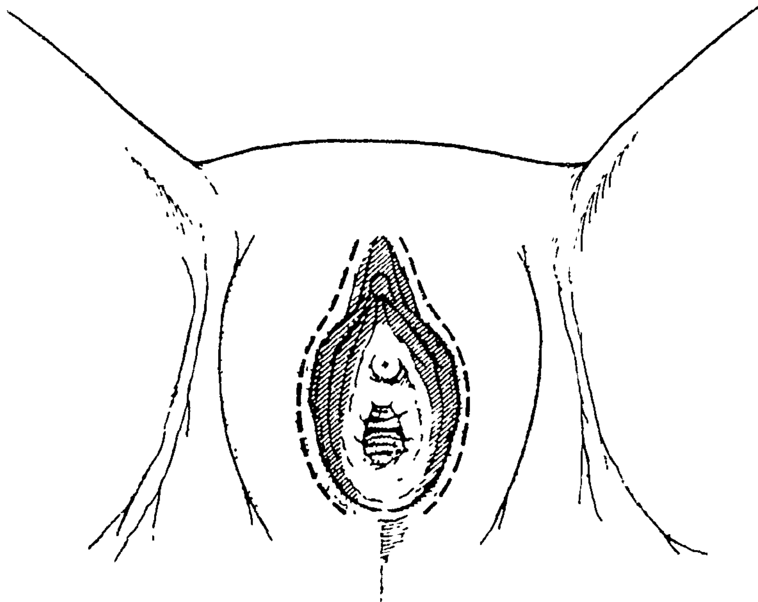


Type II Clitoridectomy (Excision) after Hemostatic Stitching.

Source:
Toubia, Nahid (1994)
Female Circumcision As A Public Health Issue
The New England Journal of Medicine,
September 15, 1994, Vol. 331 #11 p.713

APPENDIX K

FIGURE # 4



Type IV Total Infibulation.
The hatched area indicates the tissue to be removed, and the dotted lines the labial incisions.

Infibulated Vulva

SOURCES:

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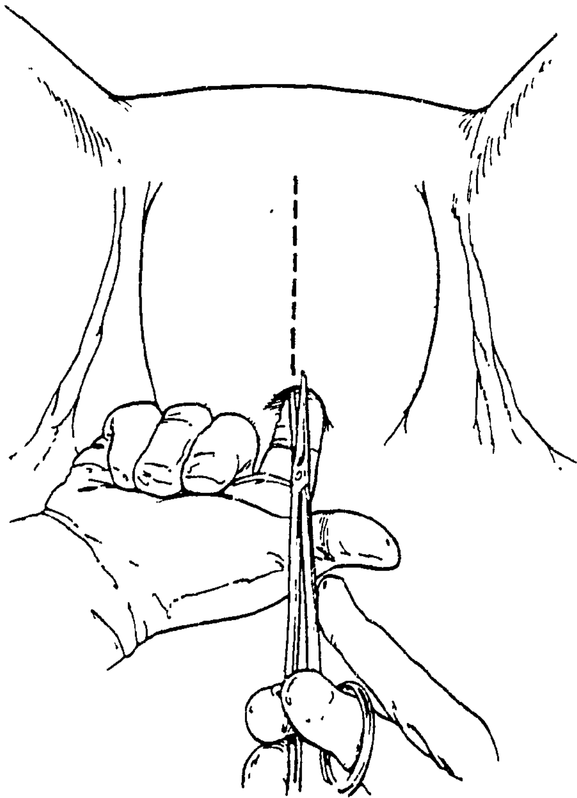
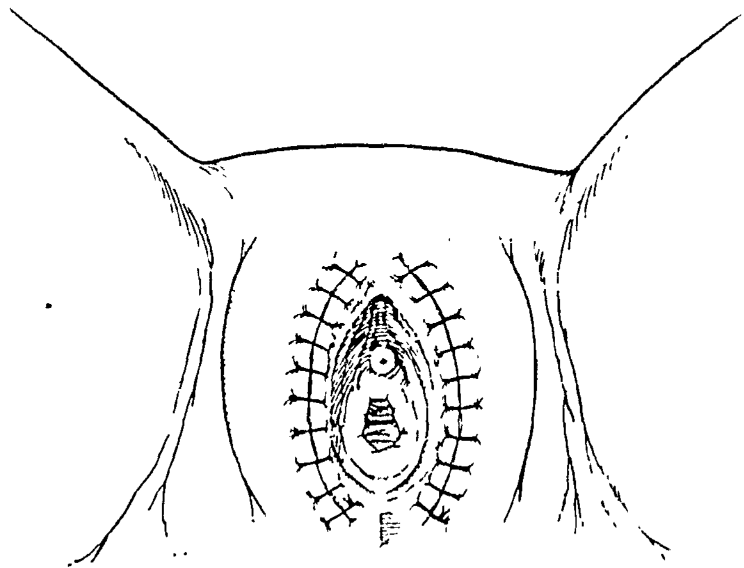
The New England Journal of Medicine,
September 15, 1994, Vol. 331 #11 p.713

APPENDIX L

FIGURE # 5



Deinfibulation Procedure.



Hemostatic Stitches after Deinfibulation.

SOURCE:
Toubia, Nahid (1994)
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