THE SOUNDS OF SILENCE:

A hermeneutic interpretation of the childbirth experiences of women who have been excised

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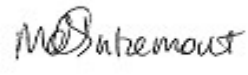
Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signature  Date October 31, 2011

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Abstract

This study explores the childbirth experiences for women who have been excised. Drawing on the hermeneutic philosophy of Gadamer, it uncovers the hidden meanings of excision and childbirth and reveals how they are translated into the experience of giving birth.

Participants for this study were women who are currently involved in the call to abandon excision. By conducting semi-structured interviews with these women, observing and listening to their stories, hidden and subjective meanings of excision and childbirth emerged and became explicit for both the participants and the researcher. This involved moving beyond narrative accounts to focus on the social construction and interpretation of meaning and how it is translated into their experiences of childbirth in terms of care, attitude, language, assumptions, social expectations and power relations.

It appears that for the women who participated in this study, the meanings of childbirth and excision have been largely constructed through silence. The notion of 'silence' is identified as the main theme of this research and has been broken down into three sub-themes: (1) the silence that surrounds (2) the silence that keeps and (3) the silence that is broken. These sub-themes correspond to different stages in the lives of the participants. Initially, silence was seen as a presence that surrounded them, a veiled form of communication that effectively defined their ways of being in the world by establishing the parameters of acceptable behaviours and the consequences of divergence. Once these women were excised, the silence no longer remained a presence only; it became assimilated into identity

and selfhood, a permanent part of being. The act of excision forever changed these women's lives and the ways in which they experienced life. With the act of excision, both silence and excision became inherent parts of their being.

The triumphs of these women are seen in their acts of breaking silence. These are acts of victory and defiance, self-agency and freedom. They are also acts which carry risk and the possibilities of rejection and isolation. Understanding the meanings of breaking silence, its risks, its rewards and its difficulties is important to understanding these women's experiences of childbirth.

In weaving through the silences which have filled these women's lives, new understandings and meanings of childbirth have emerged. It is hoped that these enlarged horizons have revealed new possibilities of being, not only for those girls and women who have been excised but additionally, for midwives and other health professionals with whom lies the responsibility for the provision of safe midwifery and obstetric care.

Abbreviations

AUT Auckland University of Technology

AUTEC Auckland University of Technology Ethics Committee

CEDAW Convention on the Elimination of All Forms of Discrimination against Women

CRC Convention on the Rights of the Child

FC Female circumcision

FGC Female genital cutting

FGM Female genital mutilation

FGM/C Female genital cutting/mutilation

FIGO International Federation of Gynecology and Obstetrics

GAMS Groupe pour l'abolition des mutilations sexuelles & des mariages forcés

GTZ Deutsche Gesellschaft für Technische Zusammenarbeit

IAC Inter-African Committee on Traditional Practices Affecting the Health of Women and Children

ICN International Council of Nurses

INED Institut National Etudes Démographiques

NICE National Institute for Health and Clinical Excellence

OMS Organisation Mondial de la Santé

UN United Nations

UNDP United Nations Development Programme

UNICEF United Nations Children's Fund

UNFPA United Nations Population Fund

WHO World Health Organization

WMA World Medical Association

Chapter One

Orientation to the Study

Introduction

Excision is a worldwide practice that is estimated to have affected 100-140 million girls and women alive today, with approximately three million more undergoing this practice each year (The World Health Organization [WHO], 2006b). In addition to being recognised as a violation of human rights, excision is a serious health issue associated with increased rates of morbidity and mortality in girls and women.

While much research is dedicated to the harmful, physical outcomes of excision and the implementation of various strategies aimed at its eradication, there is relatively little research focussing on the childbearing experiences of women who have undergone this practice. In asking the question: "What are the experiences of childbirth for women who have been excised?", this study will contribute to this body of research.

Focus and aims of the research

This hermeneutic study explores the experiences of giving birth for women who have been excised. In analysing the narratives of four women, the multiple meanings and understandings of excision and childbirth are explored with the intention of offering perspectives and interpretations of the childbirth experience. For women who have been excised, it is hoped that these interpretations offer an opportunity to view their experiences with an enlarged horizon of understanding. For midwives and other birth attendants, these

interpretations may introduce a pathway of understanding that encourages the provision – and reception - of safe, appropriate and respectful care.

Definition of excision

> The term "female genital mutilation" (also called "female genital cutting" and "female genital mutilation/cutting") refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. (WHO, 2008, p. 1)

According to WHO (2008), these procedures can be classified into four types:

> Type 1: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
>
> Type 11: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
>
> Type 111: Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
>
> Type 1V: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization. (p.4)

Terminology

Over the years, the term for these procedures has undergone various changes. Originally referred to as "female circumcision" (FC), the expression "female genital mutilation" (FGM) gained support from the late 1970s as it establishes a "clear linguistic distinction from male circumcision, and emphasizes the gravity and harm of the act" (WHO, 2008, p. 22). It is the term that is currently employed by the WHO and the United Nations (UN). However, there is evidence that this choice of language has negative connotations which may estrange practising communities and possibly hinder the process of social change for the elimination of the practice. Consequently, the last two decades have seen the terms

"female genital cutting" (FGC) and "female genital mutilation/cutting" (FGM/C) increasingly employed by some agencies and in research. The term "female genital mutilation/cutting" is now used by the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) as it captures the significance of the term "mutilation" at the policy level while employing non-judgemental terminology for practising communities (UNICEF, 2005a; WHO, 2008). However, in France where this research was conducted, "excision" is the term commonly used to refer to all types of FGM/C (C. Traore, personal communication, May, 2010; WHO, 2008) and in consideration of this, I have chosen to employ this term throughout the study. One participant however, referred to the practice as "circumcision" and I have respected her choice of language in the presentation of the data.

The context of this study

Excision is practiced worldwide. Although it is difficult to obtain accurate reports identifying the rate and prevalence of this act (Denholm, 2004; Matthews, 2011), at least twenty eight African countries are officially recognised as practicing some form of excision; eighteen of these twenty eight are estimated as having prevalence rates of at least 50 per cent (Rahman & Toubia as cited in Wurtzburg, 2002). Studies in India, Indonesia, Iraq, Israel, Malaysia and the United Arab Emirates have also documented these practices while anecdotal reports on excision have emerged from other countries including Colombia, the Democratic Republic of Congo, Oman, Peru and Sri Lanka (WHO, 2008).

Political and economic factors such as civil unrest and natural disasters are attributed as

causes for the increased migration and displacement of practicing communities to other parts of the world including Europe, Australasia and North America where traditionally, excision has not been practiced. Both New Zealand (Denholm & Powell, 2008) and Australia (Matthews, 2011) have witnessed an increase in the number of women arriving from practicing communities and in Canada, most of the 40,000 women who arrived from eastern and northern Africa between 1986 and 1991 had undergone some form of excision (Lalonde, 1995). In the European Union, findings from the Institut National Etudes Démographiques (INED) estimate that 220,000 girls and women have experienced excision or are at risk of being excised (Andro, Lesclingand, & Pourette, 2009) and the "Existing evidence suggests FGM will increasingly become an issue of EU-wide rather than localised concern" (Powell, Leye, Jayakody, Mwangi-Powell, & Morison, 2004, p. 159). In the United Kingdom, the substantial number of women identified as being affected by excision prompted the introduction of African Well Woman Clinics as a response to the particular needs and concerns of this population. Alongside the provision of specific training for health care professionals, these clinics offer affected women and their families support, information, advice, counselling, medical and psychological care and if appropriate, deinfibulation services. Other countries including Denmark, Belgium, the Netherlands and Sweden have also recognised the specific, obstetric needs of this population and have responded by introducing national, clinical guidelines for the management of pregnancy and childbirth (Leye, Powell, Nienhuis, Claeys, & Temmerman, 2006). There are approximitely 21,000 women affected by excision living in Germany (Utz as cited in Powell et al., 2004) and in France, estimates taken in 2004 indicated that 53,000 adult women living in the country were excised (Andro & Lescingand, 2007). France is identified as being the European country posing the greatest risk of excision, followed by

Italy, Germany and the United Kingdom (Gynécologie Sans Frontières, 2010).

Of the twenty two regions in metropolitan France, ten are identified as having populations for whom the risk of excision is heightened. The Rhône-Alpes, where I currently live, is recognised as being one of these regions (Gynécologie Sans Frontières, 2010).

The impetus for this study

This study has come about as a response to the needs of both the women who have been excised and the midwives who care for them. Firstly, women who are excised and who seek midwifery care need to feel assured that the care they receive is both appropriate and safe. They need to know that they can articulate their fears and their needs without the risk of reprisal or rejection, that even if the practice of excision is condemned, they themselves are not. They need to be treated with the respect and dignity deserving of all human beings.

This study, in showing the hidden or ignored meanings of excision and childbirth, will reveal to these women new and different perspectives from which to expand their understandings of these experiences. From such understandings may come the recognition that there exist many other possible, alternative ways of being and of living with excision.

Secondly, this study addresses the needs of midwives who must be able to respond to the challenges associated with excision in a manner that is safe, ethical and professional. Reliance on professional codes of practice to guide and ensure the provision of such care is insufficient. While safe care admittedly requires the good will of both parties,

responsibility lies with midwives for providing women with access to this care by opening channels of communication and understanding. By exploring the multiple meanings and experiences of childbirth and excision, midwives may be better equipped to understand the implications and realities of providing such care.

Understanding the childbirth experiences for women who have been excised is therefore an area of study that has significance for both women and midwives. Despite this, there is relatively little research on the topic. In specifically addressing this issue, this study will contribute to this body of knowledge.

Why hermeneutic phenomenology?

Hermeneutic phenomenology is an appropriate methodology for conducting this research because its approach is grounded in both experience (phenomenology) and interpretation (hermeneutics) with a focus on text. Phenomenology is the study of lived experience; it is an approach that lets phenomena show themselves as they are, allows them to unfold and reveal their true being. It is "a deep questioning of something... [and] aims at establishing a renewed contact with original experience" (van Manen, 1990, p. 31). Phenomenology provides the "point of departure in the *situation*" (van Manen, 1990, p. 18), offering meanings which then allow the possibility of analysis, description, and interpretation. Hermeneutics, on the other hand, is "the theory and practice of interpretation" (van Manen, 1990, p. 179), a search for understanding "that is deeper or goes further than the author's own understanding" (Crotty, 1998, p. 91). When these two philosophies, phenomenology and hermeneutics, are joined together, the resulting methodology is referred to as

hermeneutic phenomenology which has a two-fold approach to inquiry: (1) to reveal the essence of lived experience and (2) to interpret this experience in order to uncover new meanings and understandings.

In this study, the textual focus of hermeneutic phenomenology requires that women share their stories. Providing women with the time and and space to freely tell their stories is a seemingly simple act that enables them to have voice and to validate their experiences. This alone can be empowering and as this research will show, it contributes to breaking the silence which has surrounded and partly defined these women. The "articulation of experience is part of our experience [and]...is among the hallmarks of a self-determining individual or community" (Lugones & Spelman, 1983, p. 574). The subsequent interpretation of the stories is equally important as it is this process which allows new meanings to emerge, thereby enlarging the horizons of understanding and the possibilities of being and becoming. "It is only by looking at the human past, and rethinking it, that we can fully appreciate the potentiality for human becoming, rather than merely human being" (Booth, 1999, p. 60).

In keeping with my chosen methodology, this research is guided by Han-Georg Gadamer (1900-2002) and his work, *Truth and Method* (1975) and is supported by *Being and Time* (1962), by Martin Heidegger (1889-1976).

The presuppositions of this study

I come to this research believing that: (1) the meanings and values given to excision and

childbirth are fluid and socially constructed and (2) excision influences and shapes the experience of giving birth. Both the practice of excision and the process of giving birth are largely defined by society's traditions, expectations, language, culture and politics (Moffitt, 2004; UNICEF, 2005a; Wagner, Epoo, Nastapoka, & Harney, 2007; Walley, 1997). It is this social construction of meaning with its attached expectations and values that lies at the heart of understanding these events. To grasp more fully the relationship between excision and childbirth it is therefore necessary to understand and interpret the underpinning social constructions of excision and childbirth and how they are translated into the giving and receiving of midwifery care. This seeking is especially suitable to Gadamer's (1975) philosophical approach to inquiry which explores the nature of our social, historical understandings "with a spirit of self-criticism" (Gadamer, 1975, p. 253).

Why I came to this study

I was first exposed to the concept of excision many years ago when I read Alice Walker's novel, *Possessing the Secret of Joy*. I found it shocking, troubling and revelational. When I finished the book, I went to the library and looked up all the references, wanting to learn more about excision. It was a foreign concept to me and although I disagreed with it, I recognised its complexities. Surely, the fact that it continued to be widely practiced irrespective of its dangers meant that there was more to it than what could be 'seen through the eye'. I wanted to learn about excision and understand it and so I read enough to satisfy my curiousity. However, with the passing of time, I slowly forgot about the importance of excision. I had no contact with women who were excised, I was not aware of massive media reporting on the subject and excision was not currently fashionable as a topic of

conversation among friends. Perhaps I lost myself in a sea of doubt, questioning my worth and role in the fight against such a complicated practice or perhaps my interest had been mere curiousity, easily satisfied by superficial understandings.

But then came the day when, as a student midwife and under the guidance of my mentor, I found myself caring for a woman who intrigued me. I did not know her; I had come to work my hospital shift and suddenly found myself caring for a woman who was in advanced labour. This is never the ideal situation as it leaves little room and time for developing relationships and asking questions. I remember coming out of the birthing room confused, thinking to myself that something was different, something was wrong. I told myself that I had to go back to my anatomy books and study more carefully the diagrams of normal genitalia because I obviously missed something. It never occurred to me that this woman was excised. The labour progressed and the woman gave birth spontaneously. It was after the birth of the baby that my mentor told me that the woman had been excised. I later wrote this about the birth: *"The woman never said a word, hardly moaned...Was it the shock of the birth that made her look so despondent? And what about the tears?! This woman had been circumcised - no clitoris, no inner labia. And how she cried when once examined! I felt so much for her. She was alone and could I even begin to understand…?"*

Throughout my career as a midwife, I have rarely encountered women who have been excised. However, this story from my days as a student was a reminder that we, as midwives, are responsible for providing women with the best possible care, a never-ending endeavour that demands that we keep ourselves informed not only of the pertinent issues in

midwifery but also of any recent developments and research findings. This means categorically refusing to attend births as passive participants, concerned with the act of birth rather than the process. It means looking for the answers to the questions which we ask ourselves, seeking ways to understand, in order that the experiences we share with these women may enrich the lives of everyone involved.

I believe that my interest in birth and excision has always been present. In becoming a midwife, I have focussed most of my energy and time on birth and have left my interest in excision largely unexplored. Despite this, both of these subjects have special significance for me and form a part of who I am. Having the opportunity to bring them together in this research therefore seems like a natural and wonderful thing to do.

Structure of the thesis

In order to facilitate the reading and understanding of this thesis, the structure of the research is outlined below:

Chapter One: Orientation to the Study

The introductory chapter frames the thesis. The aims of the study are identified and the terminology is defined and clarified. Background information exposes my personal relationship with the research and explains why I believe this study to be significant. Situating the area of study within a global context provides support for the undertaking of the study.

Chapter Two: Literature Review

This chapter explores the meanings of excision within a global context. Linking this information to the context of the study allows a deeper insight and richer understanding of the aims and findings of the research.

Chapter Three: Methodology and Method

This chapter explains the philosophical underpinnings of the study and places the research in the context of this methodology. The reasons for choosing this methodology are revealed and its appropriateness to the research topic is discussed. The method of the study is also explained to show how the actual research was undertaken. Issues of trustworthiness are addressed.

Chapter Four: Findings of the Research

In this chapter, the data is shown as verbatim excerpts taken from the narratives of the participants. This data is thematically analysed and put into the context of Gadamerian hermeneutics. My interpretation of the data is shown and everyday, hidden meanings and understandings are revealed and explored.

Chapter Five: Discussion and analysis

This chapter examines the findings and highlights the implications for further research, education and practice. It suggests ways forward in the fight against excision and discusses both the limitations and the strengths of the study.

Summary

This introductory chapter provides an overview of the thesis. It informs you, the reader, of what to expect in the coming pages. In this chapter, I have readily exposed the understandings that I have brought with me to this study and the reasons why I feel that this area of research is significant and worthy of attention. In providing this information it is hoped that you will be able to put this research in its current context and so appreciate the meanings and understandings which have been uncovered during this process of inquiry.

Chapter Two

Literature review

Introduction

Childbirth and excision are complex, social conventions whose "meanings represent a fluid variety of possibilities" (Gadamer, 1975, p. 238). In order to arrive at a hermeneutic understanding of the childbirth experiences for women who have been excised, it is necessary to explore some of these meanings in relation to present theories and practices. In listening to the "variety of voices in which the echo of the past is heard" (p. 252), an understanding arises based on "an expectation of meaning that follows from the context of what has gone before" (p. 259). Weaving through the voices and echos of the past are a multitude of thoughts, attitudes and understandings which in Gadamerian terms are referred to as "traditionary texts" (as cited by Dickinson, 2004, p. 36), those "historical ontological understandings that have been handed down to us in language and text and to which we have a connection" (Dickinson, 2004, p. 36). Their significance lies in the fact that they are part of our consciousness and are taken with us into the research process thereby contributing to the historical horizon of the study and allowing it to be placed within an historical context. True to the notion of the hermeneutic circle, fusing the meanings of the historical and present horizons allows for new interpretations to arise (Gadamer, 1975). In the context of this study, these interpretations are key elements in the process of change for the elimination of excision and the care of girls and women already excised. Girls and women assimilate these meanings into their daily lives, they carry these meanings and messages with them. So too, strategies and policies aiming for the abandonment of this

practice are founded upon these interpretations; an understanding of the inside meanings of traditionary texts is therefore essential to the development and implementation of effective care and policy.

This chapter will explore some of these traditionary texts to uncover their meanings and impacts on women who have been excised. These meanings are relative to time and place and may appear contradictory. For example, excision in Guinea may mean possibility and pride whereas in France it may mean violence and pain; in Mali, childbirth may be seen as obligation and in New Zealand, it may be viewed as choice. In hermeneutic inquiry, these very different interpretations are equally valid; together, they provide a depth of understanding that allows new perspectives to be revealed.

To date, there is little available research exploring the experiences of childbirth or excision from a hermeneutical perspective. Studies tend to focus on anthropological perspectives (Abusharaf, 2001; Boddy, 1982; Diallo, 2004; Gordon, 1991; Gosselin, 2000) and the implications of excision for health and well being (Behrendt & Moritz, 2005; Calder, Brown, & Rae, 1993; McCaffrey, Jankowska, & Gordon, 2005; Obermeyer, 2005; Vangen, Johansen, Sundby, Træen, & Stray-Pedersen, 2004; WHO, 2006a; WHO, 2006b). Comparatively little research is available concerning women who live in adopted countries and the studies that were found tend to focus on the specific issues associated with infibulation (Chalmers & Hashi, 2000; Denholm & Powell, 2008; Johansen, 2006; Thierfelder, Tanner, & Bodiang, 2005) although Christiansen (1995) does explore these experiences from a hermeneutical perspective. Citing research from Anderson (1991), she emphasises that the problems generally associated with displacement i.e. marginality, social

isolation, alienation and language, compromise "the ability of immigrant women to successfully manage complex health-related issues" (p. 10). These obstacles possibly result in a new definition of self which "leads to a feeling of being devalued" (Anderson, 1991, p. 713). Problems with articulation in a second language and its impact on the safeness of care are also highlighted in other studies (Andro et al., 2009; Bulman & McCourt; 2002; Denholm & Powell; 2008;).

The relative lack of hermeneutical research may be better understood by exploring texts outlining the evolved interest and discourse of the international community and its subsequent influence on the areas and types of research. However, the aim of this chapter is not to unravel the evolution of the research but rather, to provide insight into how the women of this study have come to understand themselves and their experiences. This chapter will therefore explore the ways in which traditionary texts influence women's perceptions of themselves and of excision. The views women have of themselves are a reflection of how they are seen by others and it is worth exploring how women internalise and translate these meanings. "Until we can understand the assumptions in which we are drenched, we cannot know ourselves" (Rich, 1990, p. 414). For those women who are displaced from their country of origin, recognising and living with extreme notions of excision may result in confusion and anxiety. Understanding these tensions will therefore offer new insights into the often ignored, underlying stresses of living with excision and cultivate a deeper appreciation of the experiences revealed in this study.

Why excision is practiced

Various reasons have been offered for the continued practice of excision. These reasons are linked to specific political, cultural and historical contexts and in order to fully appreciate their meanings, they must be examined individually (Gosselin, 2000). Such an exploration is beyond the scope of this study but globally, these reasons can be summarised to include certain beliefs: (1) *Female excision is necessary to achieve femininity*. In Mali, Kenya, Sudan and Nigeria, it is commonly believed that the clitoris is the male organ of the female and only by removing it can gender be clearly demarcated. Left unexcised, the clitoris will enlarge to resemble the male penis and may eventually pose a threat to the safe passage of the baby during childbirth (Abusharaf, 2001; Dorkenoo & Elworthy, 1992). Removing the 'masculine element' from a girl thus enhances her beauty and attractiveness and makes her more eligible for marriage (Boddy, 1982; Dorkenoo, 1994; WHO, 2008). (2) *Excision protects girls and women*. In societies that practice excision, female purity and chastity are held in high regard and it is only by attenuating female desire that these qualities can be assured and protected. The clitoris, recognised as the focus of this desire, must therefore be excised in order to remove women from temptation, immorality and disgrace (Abusharaf, 2001; Dorkenoo & Elworthy, 1992; MacCormack, 1979; WHO, 2008). Furthermore, the dampening of sexual desire through excision empowers women and allows them to become masters of their selves and of their sexuality (Diallo, 2004). (3) *Excision is a religious requirement* (Diallo, 2004). Reports from Mali have associated excision with "ablution or ceremonial washing" (UNICEF, 2005a, p. 12) but more commonly, this practice is linked to Islam. Mention of "sunna" excision in the Koran has been cited as the religious justification for the practice despite no Koranic text requiring the cutting of female

genitalia.

These reasons suggest that behind the practice of excision lie good intentions. The perceived "benefits for girls and women" (Abusharaf, 2001, p. 136) are extended to the community; these meanings and messages are assimilated to form part of a communal belief system.

Involvement of the international community

As early as the 1950s and 1960s, attempts were made by the UN to recognise the practice of excision as a violation of human rights. These efforts were unsuccessful as the international community refused to address what it considered to be domestic matters, fearing that "Addressing the issue without explicit invitation by the concerned government would impinge on the sovereignty of the nation" (Lee, 2008, p. 13). Requests to the WHO by the UN to study the "ritual practices to which girls are exposed in some parts of the world" (UN, 1959, p. 205) were also refused on the premise that "the practices concerned were of a social and cultural rather than a medical nature" (UN, 1959, p. 205). Large scale international involvement in excision was not acknowledged until 1979 when the WHO held an international conference on female excision in Khartoum, Sudan. The significance of this conference lies firstly with its recognition of excision as an issue of concern within the international health and development community and secondly, with the recommendation by the WHO for the total eradication of the practice (Lee, 2008; Toubia & Sharief, 2003). The WHO conference therefore marked a distinct departure from previously adopted stances and set the stage for excision to be framed within a medical or

scientific discourse recognizant of the adverse physical complications of the practice.

Compromising the right-to-health

Multiple research studies have consistently shown that excision compromises the rights to life, physical integrity and health (UNICEF, 2005a). Reports indicate that while the intense pain of the procedure may lead to shock, there is also an immediate and elevated risk of septicemia, gangrene, haemorrhage and death. In the long term, those who have been excised may suffer with chronic pain, neuromas, anaemia, difficulty with evacuation of menstrual fluids and the passing of urine and faeces, increased risks of pelvic, urinary, vaginal and sexually transmitted infections, the formation of fistulae, epidermal cysts and keloid scar tissue and painful and/or difficult sexual relations (Almroth et al., 2005; El-Defrawi, Lotfy, Dandash, Refaat, & Eyada, 2001; Epstein, Graham, & Rimsza, 2001; UNICEF 2005a; WHO, 2008). Additional research by the WHO (2006b) has also found that women who have undergone excision are more likely than those who have not to have adverse obstetric and perinatal outcomes which include increased risks of caesarean section, post partum haemorrhage and extended hospital stays. Furthermore, babies born to affected women are at increased risk of stillbirth, neonatal death, resuscitation at birth and low birthweight. The WHO study (2006b) concluded that these risks increase with the more extensive forms of excision. Psychologically and psychosomatically, females who are excised are likely to suffer memory loss, mood changes, impaired cognition, disordered eating and sleeping habits, anxiety, depression, concentration difficulties, post traumatic stress disorder, poor academic performance and panic attacks (Behrendt & Moritz, 2005; Deutsche Gesellschaft für Technische Zusammenarbeit [GTZ], July, 2007; UNICEF,

2005a ; WHO, 2008).

Adoption of right-to-health approach

Although the impingement upon these rights may be included under the wider umbrella of human rights, in the decade that followed the 1979 WHO conference, the intervention strategies and messages adopted by the international community to eradicate excision focussed on these risks from a health rather than human rights perspective. It was believed that the provision of factual, non-judgmental information to practicing communities would suffice as the impetus for behavioural change (Lee, 2008; Toubia & Sharief, 2003).

Medicalisation as a possible solution?

Early advocacy efforts aimed at eradicating excision centered their arguments solely on the health implications of the practice. A consequence of this approach was and continues to be the significant increase in the medicalisation of excision. Parents, in heeding the health warnings, are increasingly choosing to have their daughters excised by health professionals who have access to hygienic conditions and anaesthetics (Shell-Duncan, 2001). Advocated as part of a harm reduction strategy that "shares the goal of eventually eliminating female genital cutting, but is willing to promote intermediate steps that offer safer solutions in the process of change" (Shell-Duncan, 2001, p. 1021), this approach can be considered a coherent response from communities who wish to address the health concerns of excision by decreasing its risks (Shweder, 2000).

Egyptian data from 2000 shows that 61% of daughters who were excised had the procedure

performed by medical personnel, a 44% increase from 1995 (Yoder, Abderrahim, & Zhuzhuni, 2004). Although relatively high rates of medicalisation have also been reported in Kenya (34%) and Sudan (36%), the most substantial increases have occurred in Egypt, Guinea and Mali (Gosselin, 2000; Yoder et al., 2004). In Guinea, communities working in partnership with GTZ to eliminate excision proposed "a transition period" (Lee, 2008, p. 101) during which minimally invasive operations could be performed. This was rejected by GTZ as being incompatible with the aims of abandonment. In Europe, where "the issue of medicalisation is repeatedly emerging" (Leye et al., 2006, p. 367), proposals to adopt a harm reduction approach were submitted in the Netherlands, Germany and Italy. Although rejected, these proposals argued that allowance to perform minor incisions would reduce the risk of the more extensive forms of the practice (Leye et al., 2006).

The international response to medicalisation

The argument for medicalised excision as an acceptable part of a harm reduction strategy is repudiated by both international agencies and professional organisations including GTZ, UNICEF, FIGO (International Federation of Gynaecology and Obstetrics), WHO, WMA (World Medical Association) and the ICN (International Council of Nurses). They cite it as a violation of professional health ethics and medical deontology (Leye et al., 2006; Shell-Duncan, 2001; UNICEF, 2005b; WHO, 2010) and fear that its admittance will lead to a false understanding of its acceptability and legitimacy (UNICEF, 2005a). In turn, this may encourage some health care providers to develop "a professional and financial interest in upholding the practice" (WHO, 2010, p. 9). Indeed, without any evidence to prove the efficacy of medicalisation as a first step towards full abandonment of the practice, its

acceptance may actually prove counter-productive to elimination efforts (WHO, 2010). It must also be emphasised that any act performed as part of a harm reduction strategy falls under the WHO (2008) definition as being a type 1V excision and is classified as a violation of the human right to health and bodily integrity. Finally, the medicalisation of excision ignores the dynamics of culture and dismisses the possibility of change in human behaviour (Boddy, 1991; Leye et al., 2006; Shell-Duncan, 2001).

The risks of refusing medicalisation

The refusal by the international community to accept medicalised excision as part of a harm reduction approach is not however, without risk. Firstly, rejecting the internal attempts by practicing communities to find culturally acceptable alternatives carries the risk of inciting anger and confusion. Ultimately, this may prove counter-productive to elimination efforts by polarising attitudes, thus entrenching the practice even deeper into cultural norms.

Secondly, such responses evoke the dilemma of whether it is best "to protect women's health at the expense of legitimating a destructive practice...Or to hasten the elimination of a dangerous practice while allowing women to die from preventable conditions?" (Shell-Duncan, 2001, p. 1013). In refusing to accept the medicalisation of excision, the international community has adopted a paradoxical stance that on one hand, has identified health risks as its primary concern and on the other hand, refuses to accept alternatives that may reduce these risks. In addition, practicing communities may recognise "the hypocrisy of a medical establishment that condemns even the mildest forms of FGC while condoning male circumcision and non-medically necessary cosmetic surgery" (Shell-Duncan, 2001, p.

1019). In comparing excision with breast augmentation, Wilson (2002) says that "Women's bodies, in both cases, are altered in the interests of male sensual pleasure" (p. 516). What then, is the distinguishing factor that constitutes acceptance of one and not the other if in both cases, the procedures are performed on consenting adults?

Finally, warnings have been issued to treat the findings of health related research with caution. Difficulties with design, data collection and analysis have been identified and may result in an investigative process that is compromised (Obermeyer, 2005). According to Obermeyer (2005) "The available evidence indicates that female circumcision is associated with some health conditions but that for many of those that are investigated, no statistically significant associations are documented" (p. 259). Thus stated, the "right-to-health argument" (Shell-Duncan, 2001, p. 1013) which has formed the basis of the anti-excision movement needs more careful investigation. At the same time, efforts to distinguish between the real and perceived risks of excision may be seen as a minimisation of these concerns and a condonation of the practice.

From right-to-health to human rights

During the 1960s and 1970s, efforts by women's organisations to raise awareness of the harmful effects of excision on the lives of girls and women coincided with an increased international awareness of women's rights. The adoption of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 1979, the establishment of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) in 1984 and the Convention on the Rights of the Child

(CRC) in 1989 were significant in promoting awareness of gender equality and the rights of girls and women (UNICEF 2005a). The 1993 UN Conference on Human Rights was another powerful voice in the promotion of excision as a violation of human rights. However, despite the attention garnered by this movement, the international community continued to address the practice of excision from a health, rather than human rights perspective. It was not until 1995 that the international focus on excision shifted, following a joint statement issued by the WHO, UNICEF, UNFPA and UNDP (United Nations Development Programme), admitting the medical discourse to be a "mistake" (Boyle, as cited in Lee, 2008, p.15). This statement was a public acknowledgment that health-based interventions, though successful "in breaking the culture of silence surrounding the practice of FGC...have not resulted in large-scale behavior change" (Hernlund & Shell-Duncan, 2007, p. 49). Subsequent to this, there has been a real and recognised need to better understand the "sociocultural underpinnings" (WHO, 2006b, p. 8) of excision, accompanied by its multiple meanings and perspectives. Currently, the WHO (2010) identifies excision as "a self-enforcing social convention or social norm...a socially upheld behavioural rule" (p. 2) and recognises that in those areas where large scale abandonment of the practice has been achieved, "it has been the result of an approach that reinforces the human rights values and social support that are shared by communities" (p. 2).

How are human rights defined?

Despite the relative success associated with the human rights argument, its application to excision has been challenged. The international community argues from a platform that recognises human rights as being universal, individual and non-discriminatory. Ibhawoh

(as cited in Lee, 2008) contests this view and contends that human rights "are not static or universal and that they need to be recognized as distinct cultural constructs" (p. 47). This is supported by Abusharaf (2001) who says that multiple notions of human rights can exist; indigenous concepts do not necessarily maintain rights as being individual and inherent to being, but may be social acquisitions, intimately linked to communal responsibility and solidarity. In practicing communities, those who undergo excision are allowed access to certain rights and benefits such as marriage and its subsequent higher social status with greater communal resources (Dorkenoo, 1994). In this sense, excision is seen as providing rights rather than violating them, an argument that is often cited by mothers as justification for the continued excision of their daughters (Diallo, 2004; Dorkenoo, 1994; Gosselin, 2000; UNICEF 2005a; WHO, 2010). The notion of rights is therefore closely linked to the social structure of the community and in any "highly stratified society" (Diallo, 2004, p. 186) appeals for equality may be seen as "an overt attack to its foundation" (p. 186) which sees stratification as a means of preserving power rather than equalising it (Bledsoe, 1980). The international community must therefore take care that its attempts to eliminate excision through increased social parity and participation are not perceived as having overtones of colonial imperialism (Fahs, 2003; Gosselin, 2000). Protecting individual rights on one hand while undermining society's cultural values on the other is not a valid option and efforts must be made to ensure that the cultural, historical and political diversities of individual practicing communities are acknowledged and respected.

Summary

By exploring some of the traditionary texts on excision, this chapter has highlighted some

of the arguments framing international discourses. In revealing the multiple, subjective and sometimes conflictual meanings and perceptions surrounding the practice, it has attempted to provide insight into the complexities of excision. Exploring these underpinnings is key to understanding the everyday tensions associated with excision and provides a deeper appreciation of the aims and the findings of this study. The question must now be asked as to how women live with these often conflicting messages. How do these messages translate into the attitudes and the lives of women? How are they transported and translated into other cultures when these women migrate outside of their communities of origin? Does a Malian or Guinean woman coming to France suddenly see herself as being incomplete, a victim of violent mutilation and abuse, a victim of sexism? Where does this shame originate? Is it contained within the messages aimed at abandonment? Or does this woman find continued and strengthened pride in her educational upbringing and the ways of her elders? Is she angered by what she considers to be 'outside' influence in domestic matters? Does she consider French society to be immoral and hypocritical by encouraging women to reclaim their sexuality and their right to choice? How do women and their families live with these extreme notions of excision?

Indeed, if the international community wants to claim authenticity in its call for “full abandonment of the practice” (WHO, 2010, p. 8), it must demonstrate a strong sense of coherence and justice. There must be a recognised need and willingness to question and examine our own practices, ever conscious of “the ongoing importance attached to 'authentic voices' and the presumed ability of such voices to speak for others” (Walley, 1997, p. 428). Failure to do so is both hypocritical and incoherent and risks being counter-productive to elimination efforts. The question must also be raised whether there is a need

for compromise, with absolutes giving way to more flexible approaches.

Those who are working to eradicate the practice of excision must not forget the importance of accompanying those girls and women already affected, in order that they may see themselves as fully contributing members of society, whose worth is not measured by their bodies but by their persons. While the act of excision merits condemnation, the categorical repudiation of its underlying intentions and meanings do not; care must therefore be taken to ensure that the rejection of the practice is not displaced to the person. At the same time, we of the 'west' owe it to these women to seek true understanding and common meaning, a fusion of horizons (Gadamer, 1975). "Understanding a practice is not the same as condoning it" (Boddy, 1991, p. 16) but it does allow the possibilities of communication, negotiation and change. By revealing some of these many meanings, it is hoped that this chapter has contributed to the understanding of excision and how it may influence and affect women's experiences of giving birth.

Chapter Three

Methodology and Method

Introduction

This study is guided by a methodology of hermeneutic phenomenology based on the interpretive philosophy of Hans-Georg Gadamer.

In this chapter I will briefly discuss Heideggerian hermeneutic phenomenology as a pre-cursor to the philosophical underpinnings of Gadamerian hermeneutics. I will discuss how the philosophy of Gadamer has guided my study and is congruent with my research question. The method of the study will be addressed in relation to methodological fit, the recruitment of participants, interviewing, data analysis, ethical considerations and rigour.

Philosophical underpinnings of the methodology

Hermeneutic phenomenology

The term "hermeneutics" derives from the "Greek verb hermēneuein, generally translated "to interpret," and the noun hermēneia, meaning "interpretation" (Palmer, 1969, p. 12). It is an ancient discipline most often associated with the critical interpretations of biblical texts (exegesis) which sought to uncover the hidden meanings of scripture (Palmer, 1969). However, the earliest example is Talmudical hermeneutics, dating back to to the Second Temple era and which was based on the oral tradition of Jewish scholarship ("Hermeneutics", n.d., 2.2.1). Over time, the realm of hermeneutics evolved to comprise

six different domains that include: (a) the theory of biblical exegesis (b) a general philosophical methodology (c) the science of linguistic understanding (d) a methodological foundation for human sciences (e) phenomenologies of existence and existential understanding and (f) systems of interpretation (Palmer, 1969). According to Allen and Jensen (1990), it is the latter two applications which constitute the domain of modern hermeneutics with the writings of Martin Heidegger and his student, Hans-Georg Gadamer, acting as references for hermeneutic phenomenology.

Phenomenology is "the study of the lifeworld - the world as we immediately experience it pre-reflectively...without taxonomizing, classifying, or abstracting it" (Van Manen, 1990, p. 9). Its purpose is to understand basic, everyday, human experiences in a deeper, ontological way (Van Manen, 1990), to remove the implications and associations of being in order to arrive at its essence. Hermeneutics, on the other hand, applies a "critical theory of interpretation" (Rundell, as cited in Crotty, 1998, p. 91) to these phenomenological understandings in order to "understand in a different way" (Gadamer, 1975, p. 264). In this sense, understanding is an "epistemological and ontological phenomenon...encompassing modes of understanding that have to do with our very being-in-the-world...it is an historical encounter which calls for the personal experience of being here in the world" (Palmer, 1969, p. 10). It requires historical situation. From these understandings, interpretation arises; interpretation is how we make meaning from understanding. This ability to engage with the world, to shift "from one interpretation to another at the appropriate moment is a sign that we do understand the world...[it] shows that we can cope with the various demands the world places on us (Hoy, 1993, p. 173).

Although this study is guided by the philosophical approach of Gadamer, it must be acknowledged that his work is significantly influenced by his predecessors, Schleiermacher (1768-1834), Dilthey (1833-1911) and Heidegger (Geanellos, 1998). Schleiermacher is credited with changing the focus of hermeneutic inquiry from theological and legal interpretations of text to an examination of understanding itself. Following from this, Dilthey emphasised the historical and ontological dimensions of hermeneutic philosophy, recognising that understanding is "contextual, existential and situated within time and place" (Geanellos, 1998, p. 159) i.e. historically situated. The importance of textual interpretation and historical consciousness reappear as major themes in Gadamer's philosophy and will be examined more closely in relation to this work. As "Hermeneutics is a method that assumes the philosophical tenets of Heideggerian phenomenology" (Leonard, 1989, p. 55) some familiarity with Heidegger is also required.

Heideggerian hermeneutic phenomenology

Much of Heidegger's philosophical inquiry focuses on the study of ontology or the nature of being which he calls 'Dasein' (Heidegger, 1962). Dasein reflects the "kind of beings we are prior to the reflective, conscious ego of the Cartesian tradition" (Leonard, 1989, p. 42).

> Everything we talk about, everything we have in view, everything towards which we comport ourselves in any way, is being; what we are is being, and so is how we are. Being lies in the fact that something is, and in its Being as it is. (Heidegger, 1962, p. 26)

Questioning the meaning of Dasein is the focal point of Heidegger's philosophical inquiry. He proceeds from an interpretive phenomenology that recognises the immediate awareness of existence; "ontologically, all occurrences and activities of existence [are] meaningful,

and hermeneutic inquiry [reveals] the implicit meaning of existential facts" (Christiansen, 1995, p. 49).

For Heidegger (1962), interpretation through understanding is only achieved when fore-structures (fore-having, fore-sight and fore-conception) are identified and assimilated into the process of inquiry. Fore-structures situate our understanding and in order to "make the scientific theme secure" (p. 236) they must be identified and worked out "in terms of the things themselves" (p. 236). He says that "Meaning is the "upon-which" of a projection in terms of which something becomes intelligible as something; it gets its structure from a fore-having, a fore-sight, and a fore-conception" (p. 193). In this regard, understanding and interpretation are "permanently determined by the anticipatory movement of fore-understanding" (Gadamer, 1975, p. 261). These projections are not rigid and need to be constantly revised (Gadamer, 1975). "An initial understanding becomes refined and corrected by the work of interpretation; fresh questions are raised that can be answered only by returning to the events studied and revising the interpretation" (Packer, 1985, p. 1091). This fluidity of movement between understanding and interpretation leads Heidegger to the notion of the hermeneutic circle which will be discussed in relation to Gadamer and his hermeneutic philosophy.

Gadamerian hermeneutic phenomenology

The notion of prejudice

According to Gadamer (1975), 'historically effected' consciousness is a key dimension in hermeneutic inquiry. Gadamer carries Heidegger's notion of fore-structures with him in his hermeneutic inquiry, citing them as prejudices, or judgments that are "given before all the

elements that determine a situation have been finally examined" (p. 240). They include "the shared understandings that reside in and through language, history and culture" (Spence, 2001, p. 626). They are part of who we are, they form part of our tradition and therefore cannot be isolated from our being; "we stand always within tradition" (Gadamer, 1975, p. 250). As such, we take them with us, either consciously or unconsciously, into the research process and it is only by consciously assimilating them that we can avoid "the tyranny of hidden prejudices that make us deaf to the language that speaks to us in tradition" (Gadamer, 1975, p. 239). By this, Gadamer is referring to the truth and hermeneutical understanding that he believes, lies in tradition. In the words of Geanellos (1998):

> Truth does not reside within individuals but in and through tradition. Tradition is handed down, thus it comes from the past; it is what we live in, thus it forms the present; and it is handed on, thus it shapes the future...As a result, understanding comes into being through history, it is *effected* by history and simultaneously influenced by history, it is *affected* by history. (p. 160)

In this respect, the recognition of our historical consciousness is not a limitation or "an obstacle to inquiry but a condition of its possibility" (Piercey, 2004, p. 261).

The prejudices I bring with me

In conducting this study I have had to question the prejudices and assumptions that I take with me into this research process. To begin with, I am an educated, Eurasian woman, fluent in both English and French, who has lived my life in the "western world". I have travelled and explored many of life's possibilities. As someone who has not been denied options and choice, I question my deep held beliefs and understandings concerning female excision. Coming from a culture where most of the exposure concerning excision has been

negative and based on curiousity and horror, such perceptions have undoubtedly influenced my opinion of excision, leading me to disagree with the practice. The question is why?

Firstly, as a midwife, I understand and acknowledge the negative effects that this practice can have on the health and well being of women and their families. Secondly, as a believer in universal human rights, I recognise the right to a life of physical and emotional integrity and I question what 'real choices' are available to women in communities that practice excision. The rights of the individual are not always congruent with the responsibility to the community and before I can fully abandon myself to accepting the self proclaimed right and desire of the individual to undergo excision, I believe that the multiple layers of meaning surrounding the politics of gender and identity need to be uncovered. At the same time, there are inconsistencies in my discourse insofar as my culture has many accepted examples of body-altering practices including breast augmentation, hymen repair and waist reduction. Though I do not endorse these practices, I have not actively fought them and this personal inaction suggests a passive acceptance and an underlying double standard which assumes the politics of gender, choice and identity in 'developed' countries to be fundamentally superior to that of other countries. Such an attitude begs the question: who and what define acceptable behaviour?

These assumptions and questions have been an on-going part of my research process, influencing my approach to the study. My search for the participants was through an association entitled GAMS Rhône-Alpes (Groupe pour l'abolition des mutilations sexuelles & des mariages forcés) which comprises of women who are fighting for the abolition of excision. In deliberately choosing these women as participants, I believe that the

possibilities for open dialogue and shared understandings were facilitated. In recognising my personal biases as well as those brought by the women as activists against excision, it is hoped that the "text may present itself in all its newness and thus be able to assert its own truth against [my/our] fore-meanings" (Gadamer, 1975, p. 238). At the same time, I must also acknowledge that such a deliberate approach colours this study.

The fusion of horizons

Similar to the notion of prejudice is Gadamer's (1975) concept of "horizon" which he defines as "the range of vision that includes everything that can be seen from a particular vantage point" (p. 269). It is the fusing together of the horizons of the present and the past that enables a situation to be historically situated and hermeneutical understanding to occur. The prejudices that we bring with us to hermeneutics constitute the horizon of the present but since these prejudices are ever-changing, this horizon is being continually formed and re-evaluated (Gadamer, 1975). The horizon of the past refers to the historical horizon, the ability to "understand the meaning of what has been handed down, without necessarily agreeing with it, or seeing [oneself] in it" (p. 270). The bringing together of these two horizons results in a shared, common understanding that is "not to be thought of so much as an action of one's subjectivity, but as the placing of oneself within a process of tradition in which past and present are constantly fused" (Gadamer, 1975, p. 258). Gadamer refers to this place of meaning, this place of hermeneutical understanding and interpretation, as the "fusion of horizons".

The fusion of horizons of this study

Achieving a fusion of horizons in this study necessitated an exploration of the historical

horizon of the participants i.e. the multiple social and cultural meanings of childbirth and excision that these women carry with them. I have fused this historical horizon with that of the present. The present horizon looks at the meanings of excision from a contemporary, 'western' perspective. This is carried out in the literature review. At the same time, I have opened myself to finding the goodness of intention behind the act of excision, hoping that in doing so, I could understand these women more fully and facilitate the finding of a shared meaning of their childbirth experiences, one that incorporates the historical situation with that of the present.

The hermeneutic circle

According to Heidegger (1962), "The 'circle' in understanding belongs to the structure of meaning, and...in the understanding which interprets" (p. 195). This movement between understanding and interpretation is also described by Gadamer (1975) as a circular relationship and is a central tenet of his philosophy. Referred to as the "hermeneutic circle", it takes into account the fluidity of the relationship between the part and the whole. The processes of understanding and interpretation are without beginning and without end; they rely and expand on each other. Both are required – as a unity that has melded together and as separate entities that form part of the whole. Gadamer (1975) says:

> The anticipation of meaning in which the whole is envisaged becomes explicit understanding in that the parts, that are determined by the whole, themselves also determine this whole...Thus the movement of understanding is constantly from the whole to the part and back to the whole. Our task is to extend in concentric circles the unity of the understood meaning. (p. 259)

My entry into the hermeneutic circle

By applying the concept of the hermeneutical circle to my study, I realise that many different understandings and interpretations are possible. The meanings that I share with the women in this study are a few of many, each of equal value and each bringing different insights. These can now form the basis of future interpretations.

I also had to take the understandings that arose from each interview, with me, into the next interview. The conversations that were shared with me by each woman guided the next interview, which guided the next, showing me which questions to ask.

The importance of language and text

Gadamer's understanding of the hermeneutic circle extends from that of Heidegger. Heidegger's perspective is ontological, with the circle providing a pathway to the understanding and the "grasping of Being itself" (Crotty, 1998, p. 98). Gadamer, on the other hand, emphasises the importance of language and text (Kinsella, 2006; Koch, 1996; Laverty, 2003). Texts result from the fusion of past and present horizons, they therefore "always express a whole" (Gadamer, 1975, p. 352). Written texts "present the real hermeneutical task" (p. 352) insofar as they rely on language to impart meaning that is understood and shared, creating "the possibility for particular ways of feeling and of relating that make sense within a culture" (Leonard, 1989, p. 43).

The language I chose

The hermeneutical emphasis on textual interpretation speaks of the importance of language. Finding the words to convey the meanings and understandings of these women's

experiences was important; the women needed to know that we were talking about their stories and their experiences. Giving back to the women their own, written stories allowed them the possibility to understand these experiences from a different perspective, from an enlarged horizon.

Words are imbued with meanings and choosing appropriate terminology is important. I opted to use the term "excision" in this study. Believing it to be a sign of respect for the women with whom I was working, I also believed that it would facilitate understanding and help create dialogue whereas the term "genital female mutilation" would possibly create tension and estrangement. Throughout the study, I have also referred to "women who have been excised" rather than "excised women". This choice of language emphasises my belief that women are not and should not be defined by their bodies but should be recognised as persons who have undergone this practice.

The interpretive philosophy underpinning Gadamer's hermeneutic inquiry has guided me throughout this study. It has influenced the manner in which I approached this research and as the next section will show, it has also impacted on the chosen method.

Method of the research

The research question

This research asks the question: What are the experiences of childbirth for women who have been excised?

Ethical approval

The Auckland University of Technology Ethics Committee (AUTEC) granted approval to this research in January, 2010 (Appendix A). Support and approval for this study was also granted from GAMS in October, 2009. Copies of this approval letter are provided in Appendices B1 and B2. Please note that this study was conducted in France; all supporting documents and letters are therefore provided in both English and French.

Throughout this study I have respected my obligation to protect the participants. I have taken measures to ensure that the women conducted these interviews at a place and time of their convenience. Given the sensitive nature of the topic, the possibility of counselling services was made available. This need however, did not arise during the study.

Recruiting the participants

The women who participated in this study were recruited via the GAMS association in Lyon, France. Prior to commencing the research process, I met with the regional GAMS co-ordinator, Madame Traore, to discuss the possibility and benefits of this project and to learn more about the work of this association.

Originally, I believed that local, excised women attended GAMS meetings in order to discuss in a group, their situation and its impact on their lives. I learned that this is not how it happens. In reality, the GAMS association is open to everyone who would like to become involved financially and/or logistically. GAMS meetings are generally focused on local and national incentives to increase awareness about the issue, with regular meetings

between different government agencies and departments. At the same time, GAMS is involved in organising reconstructive surgeries for excised women at one of the local hospitals. On a more intimate level, GAMS provides support to women through one-to-one meetings with Madame Traore, who assures a regular presence at two different locales. It is therefore through her efforts that I was able to contact women about participating in this study. In her meetings with various women, Madame Traore asked their permission for me to contact them and present myself and this project. Sampling methods for this study are therefore purposive. This is coherent with my chosen methodology as deliberate selection of participants facilitates in-depth knowledge and understanding about the phenomena under study (Jones, 2002). Although it may be argued that I have relied on 'convenience sampling', the intention behind the deliberate use of GAMS to recruit women is discussed in further detail under the section entitled 'Trustworthiness'.

Initially, I contacted the women by phone. I presented the details of the study and asked if they would be interested in participating. If they consented, I then mailed out written information detailing the study (Appendices C1 and C2) along with exemplars of questions (Appendices D1 and D2) that might possibly be asked during the interview. This was to ensure that women were fully aware of what participation meant. If the women still agreed to participate, interviews were arranged at a time and place convenient to the woman. It was at this meeting that the consent forms were signed (Appendices E1 and E2).

Inclusion criteria for the study included speaking French or English, having undergone excision and having given birth vaginally post excision (either pre and post excision or post excision only). The women also needed to understand the nature and purpose of the

research and provide informed consent. A total of five women were invited to participate in the study, with four accepting. It was originally anticipated that between five and eight women would be interviewed, however, given the wealth of data emanating from the interviews and the amount of work required in translations, my supervisors and I decided that four women would be sufficient. Phenomenological research is designed to explore and describe the essence of a phenomenon; its aim is not to produce information that can be generalised to a larger population (Kleiman, 2004; van Manen, 1990). Basing the sample size of this research on the amount, quality and depth of the data is therefore methodologically appropriate (Jones, 2002; Sandelowski, 1986; Smythe & Giddings, 2007). It is also important to note that this research is conducted in two languages: English and French. This thesis is to be presented to the Auckland University of Technology (AUT) in English. However, the research is conducted in France with French speaking participants. Logistically, this means that while the interviews and initial transcriptions were in French, the stories that were crafted from the transcriptions were written in both languages. In addition, it is anticipated that GAMS and the participants will receive summarised reports of the thesis, written in French. This ongoing process of translation from French to English and English to French involves a substantial amount of work and time and was a considered factor regarding appropriate sample size.

The participants

Three of the four women are from Mali and the fourth is from Guinea. All women spoke French and all had given birth vaginally post excision. In accordance with their expressed preferences, two have chosen to use pseudonyms for this study and two have kept their own names. To place their data in context, brief descriptions of the women are listed below.

However, to safeguard their confidentiality, this biographical information is not linked with either their names or pseudonyms.

- A married woman who had a vaginal birth with her first child in Mali in 1969. Her subsequent three children were all born in France by elective caesarean sections.

- A single mother who has given birth to one child in France.

- A married woman who has four children, all born in France.

- A married woman with five children, the first of whom was born in Mali. At the time of this birthing, she was unmarried. Her subsequent children were born in France.

Participant protection

While anonymity of the women was not sought during this research, confidentiality of information and identity is preserved. Firstly, all women were offered the possibility of using pseudonyms. Secondly, by choosing the interview venue according to the women's stated preferences, respect, privacy and confidentiality were ensured. Thirdly, respectable and appropriate terminology was used when addressing the practice of excision. In France, "excision" is the commonly used term for all types of female genital mutilation/cutting and in adhering to its usage, I reduced the risk of offending or estranging the participants. Finally, given the sensitive nature of the subject, risk to the emotional and psychological well-being of the participants was identified. To mimimise this risk, I ensured that the

women were adequately prepared for the nature and aims of the research. Women were informed that they could refuse to answer any question with which they did not feel comfortable and were free to withdraw from the study at any time, without being disadvantaged. Madame Traore agreed to be available for any woman experiencing distress and counselling services were also offered.

None of the women appeared to suffer emotional harm during the interviews and all agreed that talking about their experiences was positive and beneficial.

All of the participants lived a fair distance away (45 kms-170 kms). In order to protect their privacy, minimise their travel and respect their time, all four women were interviewed at a time and a place of their convenience. The women exercised freedom in choosing where and when the interviews would happen. This meant that I was conducting interviews in unfamiliar territory and to ensure my safety, my support person was notified of the location and time of each interview and re-contacted once the interview was completed. The meetings with these women were filled with warmth and trust and I feel honoured to have had the privilege of meeting them and sharing their stories.

Interview structure

Before beginning the interviews, I explained to the women once again the focus of the research study and asked them to sign the consent forms. In keeping with the research question and my chosen hermeneutical methodology, the interviews were informal and ranged from semi-structured to open structured (Britten, 1995; Kleiman, 2004; van Manen, 1990) lasting between one and two hours. The interviews were audiotaped and generally

began with a question about the meaning and importance of childbirth. I believe that focusing the earlier part of the interview on their experiences and understandings of childbirth gave these women the time and the space to feel comfortable with me before talking about their experiences of excision. While some women required very little prompting, others needed more direction. At the same time, I was mindful of letting these women tell their stories as they saw fit. One of the aims of this study is to give voice to these women. I also recognise that valuable information can often be discovered in unlikely places, hidden among the words.

Three of the women were interviewed once. The fourth woman requested a second interview after receiving a copy of the written transcript, feeling that it did not do justice to our encounter.

All interviews were conducted in French, this being the second language of all four participants and myself. None of the interviews were conducted in a first language of any participant. The issues involved with multiple languages and translation are discussed in the following section.

Transcribing the interviews and crafting the narratives

To avoid transcription errors and inconsistencies (Maclean, Meyer & Estable, 2004), I undertook the task of transcribing the interviews. Once a written, verbatim transcript of the interview was produced in French, I read and re-read the transcripts and deleted irrelevant information. Listening to a story is "an active search for the teller's meaning via one's own" (Rosen, 1986, p. 231), an active process of shared seeking and communicating. It was

therefore important to let the voices of the women speak and using their words, to try "to bring about the self-showing of what is said" (Gadamer, 2006, p. 21). Gadamer (2006) reminds us that language has both a revealing and self-concealing nature. What then, were the meanings behind the words? Why were these words chosen by the women? Asking these questions was especially important given that French is the second language of both the women and myself; it was therefore important to acknowledge that meanings emerge not only through the spoken word but also through the non-spoken, that which is deliberately chosen to not be said. Meaning is also communicated through the silences and the gestures, perhaps even more so when communicating in a second language since finding the apt and true word can be elusive. It was important to listen for the silences, searching for their meaning. Silence may reflect "the stillness of an agreement in understanding" (Gadamer, 2006, p. 17) and I therefore incorporated these silences and the intonations of the voices into the written words, understanding that these were an important part of language (Caelli, 2001, van Manen, 1990). The stories of the women began to emerge. Using the transcripts and their words, I crafted their narratives, the logical reconstructions of their stories. These narratives were returned to the women for validation and all agreed that this was their story. Once this understanding was reached, I translated these narratives into English.

Translations

Larkin, Dierckx de Casterlé and Schotsmans (2007) argue that in order to maintain trustworthiness, both the process and the influence of translation need to be acknowledged. In this research, threats to trustworthiness were minimised by the fact that I conducted the interviews and also did the translations. Any doubts about meaning were therefore directly

addressed during the interviews, avoiding the possibility of confusion during translation.

Careful translation acknowledges “the capacity of each language to create its own meaning” (Larkin et al., 2007, p. 469). The words that are chosen in translation therefore need to reflect “a certain life relationship...its unity of meaning from a certain life context” (Gadamer, 2006, p. 21). This means “letting the other speak to us” (Gadamer, as cited in Lampert, 1997) without superimposing our own interests, our own meanings. “The ability to let the other culture's texts speak is necessary for understanding not only that culture's thought but our own as well...each text or culture comes into relief only at its points of contact with others” (Lampert, 1997, p. 358). Translation, therefore, needs to remain true to its context while revealing a common meaning, a further reference to Gadamer's fusion of horizons.

This research requires translations from French to English and English to French. The aim of the translations is to communicate meaning that is particular to the context by finding words that are true and just. Doing so necessitated firstly finding the essence of the women's stories in French (which is our common language) and then finding the words and the language to translate these narratives and their meanings into English. This was a lengthy process requiring a great deal of reflection, attention and time. Despite the careful consideration given to the choosing of the words and the construction of the phrases and sentences, initial efforts were often discarded and the process of reflection, research and choosing began again. Once the narratives were translated into English, the emerging theme was explored and analysed. This process is discussed further under analysis of data. A summarised, a French report of the completed thesis is also expected in order to provide

the participants and GAMS with copies.

Participant involvement

The crafted narratives were returned to the women who had the option of modifying or deleting any of the information. One woman made three changes to the narrative; the others left their stories unchanged. The first woman who was interviewed was also given a verbatim copy of the transcript but was worried about how the information was presented; she subsequently requested a second interview. I reassured her that the transcript was a work in progress and not a finished piece of work. However, due to the confusion, I decided not to return any further transcripts to the women, only the written narratives in which grammar and sentence structure had been tidied. Each woman was also offered a written report of the completed thesis, all of whom accepted. During the writing of this thesis, I also contacted all four women and informed them of my progress and the expected timeframe for them to receive their copy of the report.

Analysis of data

Hermeneutic phenomenology looks for new ways in which to understand phenomena. In order to arrive at these new understandings, data is analysed to reveal interpretations that are different or deeper than previously thought. In this study the written transcripts and narratives that arose from the interviews constitute the data and are referred to as text.

Analysing this data involved different processes, fusing together. Firstly, analysis meant a constant, circular process of reflecting, reading, writing and re-writing. It meant being open to new ideas and notions, of recognising the importance of language and translation, of

questioning the superficial meanings and assumptions and reading between the lines. It was "trying to discover the sense of the words, hesitations, or incoherencies in the data and seeking to clarify the sense made of particular passages with the participant" (Caelli, 2001, p. 274). Giving meaning to the silences, the hesitations and the voice tones is a form of active interpretation and is essential to the process of analysis.

Secondly, data analysis meant finding the historical horizon of the participant as well as my own, present horizon. To discover the historical horizon, I had to understand the multiple meanings of childbirth and excision - both within and outside the context of these women's cultures. This was carried out in the literature review. To understand the prejudices that I brought with me into the research and which form part of my horizon, I had to go back to my earlier scribblings and journal entries and reflect on my principles and beliefs. Only after I had identified these two horizons as part of the research process could I say that the study was historically situated. The next step was trying to fuse these horizons together, in order to arrive at a shared meaning called interpretation.

Deliberately choosing the participating women for this study facilitated the fusion of horizons. The pre-understandings that I assumed arose from their involvement with GAMS meant that there already existed between us a shared understanding and meaning. In addition, the fact that these women were willing to partake in the research showed that they themselves were willing to move and/or expand their own personal horizons. My interest in giving these women a voice with which to tell their stories also meant that my horizon was flexible.

Fusion of our horizons happened when the texts were analysed. Each narrative was studied for themes, flows and patterns (Caelli, 2001). Once themes were uncovered in individual texts, they were analysed in relation to the rest of the data. While understanding the individual themes placed them in the context of the whole, understanding the whole required each of the individual themes. The thematic, textual interpretations that emerged constituted the essence of childbirth for women who have been excised. Arriving at this place of understanding and interpretation is the process of data analysis and is congruent with Gadamerian hermeneutics.

Trustworthiness

The aim of establishing trustworthiness in research is to provide a coherent and congruent decision trail for the reader (Koch, 1994). The terms 'credibility', 'dependability' and 'transferability', initially coined by Lincoln and Guba, are specific to the aims of qualitative research and are appropriate for describing this process (as cited in Hamberg, Johansson, Lindgren, & Westman, 1994).

Credibility

Credibility needs to be demonstrated in both data collection and analysis (Hamberg et al., 1994). I established credibility in data collection in two ways: (1) I used purposive sampling methods which commonly, are used to ensure diversity in findings (Barbour, 2001; Mays & Pope, 1995). Although recruiting women through GAMS may not have yielded a very wide spread of data, it facilitated hermeneutic understanding and interpretation by ensuring that I had access to rich data that could be studied in depth (2) I

made my prejudices and tradition transparent. Putting all of the data 'out there' allows the reader to better understand the context of the research situation as well as the relationships formed between the women and me; the reader can therefore identify more easily with its interpretations (Grbich 1999; Guba & Lincoln, as cited in Koch, 1994; Jacobson, Lin-Lin Chu, Pascucci, & Gaskins, 2005; Koch, 1994; Sandelowski, 1986).

To establish credibility in the analytical phase a solid relationship between the research question and the methodology needs to be transparent to the readers. This was discussed in the methodology section. In addition, care must be taken with analysis of data to ensure that it is honest. Referring to Meleis' criteria for culturally competent scholarship, Jacobson et al. (2005) call for a shared ownership of data, evidenced in this study by the return of the narratives to the women, in order that the story they give is indeed the story that they want to give. During the research, I also gave copies of the narratives to Madame Traore and I regularly sent copies of my writings to my AUT supervisors. Regularly referring to my journal of scribblings that chronicles the insights, fears and understandings that I have experienced throughout this journey has also been valuable in revealing how my interpretations have been constructed (Hamberg et al.,1994; Koch, 1994; Sandelowski, 1986). These processes of sharing ideas and understandings emphasised the notion that meanings, despite being individual, are equally credible and worthy of contribution to the hermeneutic circle of understanding and interpretation.

Credibility therefore, refers to the questions and self-critique that have surrounded me as I proceeded through the research. It is the wondering whether I have said enough or said too much and if I have said it well. This remains an ongoing part of the study as I look to you,

the reader, the participating women, Madame Traore, my AUT supervisors as well as the literature, for feedback and recognition of my journey. Living and conducting this research in France, it has not been possible for me to attend the New Zealand seminars and presentations available for AUT post-graduate students. Nor is midwifery research a common occurrence in France. I have therefore relied heavily on the persons directly connected with this study in the hope that their reflections would guide me. I have not been disappointed.

Dependability

Dependability refers to the congruence and coherence of data. Sandelowski (1986) claims that dependability provides an audit trail for its readers, allowing them to understand the research process in order that "another researcher could arrive at the same or comparable but not contradictory conclusions given the researcher's data, perspective, and situation" (p. 33). For Koch (1994) this means addressing "the theoretical, methodological and analytic choices throughout the study" (p. 978) including evidence of legal, professional and ethical acceptability.

This chapter highlights the emphasis placed on the historical consciousness of this study, thereby allowing the thread of dependability to be woven throughout the research. Language and terminology are carefully chosen with regard to clarity and precision (Sandelowski, 2007) and the presentation of the study is thought to be easily understood. I believe that congruence between methodology and method, as defined in this chapter, has been demonstrated throughout this study.

Transferability

Transferability refers to the ability of the audience to view the research findings "as meaningful and applicable in terms of their own experience" (Sandelowski, 1986, p. 32). Providing demographic information of the researched populations i.e. socioeconomic, ethnic and familial status, is thought to help the audience understand the context of the study, thereby allowing them to determine whether or not the findings are relevant in other situations (Hamberg et al., 1994). However, Walley (1997) warns us that over-generalising "obscures the diverse geographic locations, meanings, and politics...and rhetorically constitutes a generic "they"...and a generic "we"" (p. 429). Warning heeded, I nevertheless included in this study some detail concerning the demographics of the participants i.e. marital status, country of origin, etc. The aim of providing this information is to further explicate the cultural meanings of excision and childbirth which in turn helps to reveal the historical horizons of the women.

As a concept, trustworthiness is difficult to define and compartmentalise. Smythe and Giddings (2007) sum it up well by saying that research deemed to be trustworthy "adds colour, vibrancy and meaning to 'information'...It speaks to the soul and brings 'knowing'" (p. 57). Research that is trustworthy evokes notions of truth, wisdom and trust. It means that the research findings resonate with the experiences of others, they can recognise their voices and stories in the work that is before them.

Summary

Throughout this chapter I have tried to guide you, the reader, as easily as possible through

the many twists and turns of this journey. In describing the relation between philosophy and logic, between methodology and method, I have strived to be coherent and remain true to the seeking. In showing you my path to understanding and interpretation, it is hoped that you too, will be able to walk with me on my journey and share in its learning and its wonders. The following chapter will begin this journey with the presentation of the data. Verbatim excerpts from the women's narratives are included followed by my interpretations of the stories.

Chapter Four

Findings of the Study

Introduction

Childbirth and excision are significant life events that profoundly impact on the lives of girls, women and their families. They are social constructions whose meanings are fluid, dependent upon the cultural, societal, familial and political values attributed to them by community and culture. Despite coming from different communities, the four women who participated in this study commonly describe matters of childbirth and excision as being governed by a culture of silence, a way of being in which a condition or situation is recognised "but by tacit communal unspoken consensus is not talked about or acknowledged ("Conspiracy of silence [expression], " n.d.; para. 1). In other words, a culture of silence is a socially constructed and unwritten set of laws that determines the parameters of socially acceptable behaviour or ways of being. Acceptable behaviours include passivity, acceptance and silence and exclude open discussion and questioning.

According to Mohanty (1984), analyses and understandings are limited in both their significance and their application when "socio-historical and cultural specificities" (p. 341) are ignored. In order to critically understand the experiences of childbirth for women who have been excised, it is necessary to recognise that both excision and childbirth have multiple meanings that are particular both to the individual history of the woman as well as the historical and socio-cultural influences of the community.

The four women who participated in this study have been excised and although these experiences have directly and profoundly impacted on their lives, the focus of this study is to seek understanding of childbirth. To do so, it is necessary to understand the cultures of silence in which these women were born and grew up.

The notion of silence is uncovered as the essential theme in this research. It is a veil through with these girls and women experience life and form relationships – with the world, with others and with themselves. How girls and women move through their worlds of silence is expressed as three distinct stages or subthemes. These are: (1) the silence that surrounds (2) the silence that keeps and (3) the silence that is broken. In this thesis, I will explore women's experiences of childbirth and excision as seen through this veil.

The data is broken down into timeframes which correlate to the periods before excision, excision, pregnancy, childbirth and the present day. Chronologically situating these experiences not only facilitates understanding but also emphasises the impact of one experience on another. These experiences are analysed thematically through the meanings of silence and its three identified subthemes. Consequently, this chapter moves in parallel with the women as they experience life. The silence that surrounds the participants corresponds to the earlier part of their lives before they were excised while the act of excision shows itself to be the pivotal moment in their lives when they enter the phase of keeping silence. By virtue of the fact that they have participated in this research, all of the women demonstrate that they have at some point, broken silence and continue to do so.

I will begin this chapter by showing how the taboos and social expectations placed on

young girls and women are, without question, silently accepted. It is the silence that surrounds. Next I will show how it becomes internalised to form an integral part of their self identity, an essential part of their being and their experiences of excision and childbirth. Now the silence not only surrounds them but also becomes them and keeps them. Finally, I will show how these women experience the breaking of silence. Breaking silence is an act of defiance, a rejection of the social laws and values with which one has lived, a disregard that risks reprisal. However for these women, breaking silence is also an act of self-determination and valorisation that both heals and empowers.

Silence is part of who these women are and how they live. This is reflected in the stories they tell. Understanding the culture of silence that has surrounded them will allow us to see how silence has kept them throughout their experiences of excision and childbirth and enable us to realise the enormous steps they have taken to break the silence and create change.

The weave of silence

In this research, silence is an essential theme as well as being a part of these women's traditions and historical horizons. It is an unseen force or presence that has shaped their understandings of the world and their ways-of-being; its importance in this research cannot be ignored. This research, guided by the methodology of Gadamerian hermeneutical phenomenology, requires that we acknowledge and integrate these influences and meanings into the research in order to historically situate the study. I will therefore begin by looking at how cultural expectations are surrounded by silence.

Silence is everywhere. It speaks. It speaks through the taboos and the unspoken understandings that girls and women navigate as they pass through childhood and adolescence into adulthood. It is "woven into the texture of society" (Gordon, 1991, p. 9).

> *You can't ask too many questions, it's forbidden. Everything is taboo, even the most simple things; with all of the superstitions there are questions you can't even ask! Ah, don't touch it, don't ask a question, it's not done! Regarding sexuality there are a lot of unsaid things. The least little things! A mother doesn't explain to her daughter that at some point she is going to have hormones, grow up and have periods. No one is going to explain it to her, one day it's going to happen to her, that's all. It's horrible, really! There are so many things to do on this level.*

> *I never talked about the births with my mother. No, no, it's really impolite, even between daughter and mother. You can't, everything that has to do with sexuality is taboo. We are in the 21st century, it's still taboo.*

> *If I had stayed in my village, maybe I would have reproduced the same thing as my mother. My mother reproduced what her mother did with her, nothing was explained to her, she discovered everything. She was married at the age of 14, what did she know of life? At 15 and a half, she had her first baby.* (Aicha)

To advocate respectful behaviour and emphasise the focus of sexuality as being "a commitment to family roles and obligations" (Diallo, 2004, p. 185), the community voluntarily withholds information on sexuality while encouraging young girls to learn gender roles and responsibilities (Abdi, 2003; Diallo, 2004; Gynécologie Sans Frontières, 2010). Such "proceedings are often performative rather than discursive" (Arnfred, 2004, p. 74). In this way silence maintains and perpetuates the taboos surrounding female fertility and sexuality. These taboos become so embedded in community practice and custom that the silences that accompany them are unquestioningly accepted and respected even in the intimate relationships between mothers and daughters. Mothers do not prepare their daughters for the changes of adolescence and adulthood nor for the sexual responsibility

that accompanies them. This information is kept in silence, a silence which allows life to be thrust upon young girls and women who may not understand these changes and responsibilities and who have few possibilities of choosing differently. "Sexuality is crafted around specific notions of social identity" (Diallo, 2004, p.174) and young girls and women, despite their lack of information and preparation, are nevertheless expected to fulfill their socially assigned roles: to be excised, marry and have children (Abusharaf, 2001; Andro et al., 2009; Dorkenoo & Elworthy, 1992).

> *It's like that. To be married, a girl must know how to cook and be circumcised.* (Christiane)

Excision is a familiar fact of life, as common as the simple act of cooking a meal. Requiring both excision and the ability to cook as prerequisites for marriage normalises the act of excision, banalises it. Excision is the first milestone in a girl's life as it is considered to be preparation for marriage. The pressure to be excised and marry, to conform to society's demands is overwhelming. Despite the ever-expanding horizons offered by technological innovation: the freedom to travel, to defy barriers, to dream and discover, the future of these young girls is limited to the hope of marriage and childbirth (Dorkenoo & Elworthy, 1992). In an age in which posters of Michael Jackson adorn even the poorest huts in many African villages, in which Kenyan villagers celebrate the election of Obama as president of the United States, the horizons for these girls and women are nevertheless defined by the unwavering social expectations of marriage and motherhood:

> *For married women, it's important to have a child. To keep their family home, to stay with their husband, they must have children. But in our culture it's not done getting pregnant out of wedlock.* (Mariama)

The social expectations placed on women are coupled with the threat of rejection and isolation should they fail to comply. Communally, women's worth is viewed in terms of their ability to produce legitimate children and it appears that girls who marry at the age of fourteen and who have children at fifteen are more socially secure than those who are childless or who have children out of wedlock. Having children outside of marriage destroys the social fabric of the community and is therefore unacceptable. Marriage is the prerequisite to having children; excision is the prerequisite for marriage. These three events: excision, marriage and childbirth appear to be the ultimate goals of women's existence as determined for them by society. To effectively ensure that girls and women accept these assigned roles and behaviours, society construes cultures of silence that remain closed to the possibility of change. Consequently, females are more easily channelled into the roles and behaviours which society deems as acceptable - beginning with excision and continuing into marriage and childbirth.

The silence that surrounds excision

Chalmers and Hashi (2000) support the belief that in order to better understand the childbirth experiences of women who have been excised, it is necessary to firstly examine their experiences surrounding excision. Accordingly, this section will explore these experiences and their meanings.

Hides truth

> *I was nine years old. It was at the hospital in the city. I was on holiday at my maternal grandmother's in Conakry, the capital. And she talked about that with my mother on the phone. Afterwards, she called my aunt, my mother's little sister. One day, she bought me a pretty dress with shoes. I put it on. She told me that we were*

> *going to see a friend who had given birth. We left. There was my aunt and my grandmother; my mother wasn't there. It was like that! I didn't know that I was going to be excised. I was all alone, there weren't any other girls. I didn't stay at the hospital, I left right away…it was painful to be excised without anesthetic and to walk all the way home....I asked my mother if she knew that my grandmother did that to me. She told me "Yes, yes, it happens like that". They had a celebration. Me, I wasn't at all happy, no, no.* (Mariama)

Mariama's story describes a conspiracy of silence in which adults deliberately hide the truth of excision from young girls. Truth is hidden behind the spoken words that lie and transform excision into something it is not: a friendly visit at the hospital, a cause for celebration and new clothes. Mariama's experience does not equate with happiness and celebration; for her, excision is defined by pain and deception. Perhaps the truth of excision is multifaceted but if one aspect of being is hidden, the truth cannot be fully shown. These contradictions and confusion are also seen in Habi's story:

> *I knew what excision was and I was scared but when my aunt decided, without my mother's consent – I liked the idea. I accepted it in order to not hear all of my friends repeating in my ear that I was a boy. It was very, very, very important in order to be accepted. But at the time, I didn't know that they hadn't done my mother. And I don't know why my mother never explained to me that she wasn't excised. Me, I thought all girls were like that. I didn't know that it was serious.* (Habi)

Habi agrees to be excised, not fully understanding what this means. Her mother, though non-consensual, remains silent in the face of Habi's excision, a silence that leads Habi to false beliefs and allows her to mistakenly believe that 'all girls were like that'. She does not realise that not being excised is a possible 'way-of-being'. She is denied this possibility, denied the understanding of the "potentiality-for-Being" (Heidegger, 1962, p. 184) that would allow her to see "the possibilities and potentialities of life" (Koch, 1999, p. 30).

Christiane, too, does not understand the consequences of excision. Nothing is explained to her:

> *After the excision, I told myself now I am a girl. I am not a boy, I am a girl. But I still found it strange because I was really, really open and suddenly, they did that… well, I told myself: "that's what excision is."* (Christiane)

The lack of information concerning excision hides the truth of the practice from young girls and women and in doing so, removes from them any possibility of choice. Christiane understands excision to be a simple vaginal closure but in reality, it is much more than that. It is an act of which the serious, short and long term consequences on health and well being need to be fully acknowledged and understood (Almoth et al., 2005; Behrendt & Moritz, 2005; UNICEF, 2005a; WHO, 2006a; WHO, 2008).

Creates fear

Although young girls may not know what excision involves, they know that it is dangerous and its unspoken dangers make it even more frightening (Abdi, 2003). There is fear of the unknown and always, there is fear of death. Even those who do not live in the community are vulnerable. Mariama says:

> *I had seen a little girl who came from France, her parents took her to Guinea to excise her. She was in my neighbourhood. They excised her and she died. In my mind, that was going to happen like that for me. That was going to be exactly the same.* (Mariama)

There are no reassurances or words of comfort after the excision. There is no acknowledgement of the act, no attempt to stay the fear. Perhaps those who practice excision are themselves, eluded by its meanings, its justifications and its possible

consequences. It is almost as if the practice itself has a veil of invisibility; even the deaths that result from excision are silenced and unacknowledged by the community.

Equality Now, an international organisation working to end gender based discriminatory practices, recently wrote an update on Fanta, a young Malian girl who was excluded from her community due to urinary incontinence resulting from excision. It says that "The same community that required her, in accordance with tradition, to undergo the process of genital mutilation, shunned her as a result of the harm it caused her" (Equality Now, 2008).

How then do communities that practice excision take responsibility for this practice and how are the associated risks of excision justified? More importantly, how are the lives of these people acknowledged? What does it mean to be fully accepted into a community? What are the rights and the responsibilities of such status?

Excludes and denies choice

The cultures of silence that surround the practice of excision excludes young girls and renders them invisible and voiceless. In Malian culture, "collectivism and interdependency are strongly favoured" (Diallo, 2004, p. 185) while attention to personal interests and emphasis on individuality are socially undesirable attributes to be rejected and scorned (Diallo, 2004). Conditioning young girls to believe that excision is a social necessity, that it cannot be avoided "strengthens social identity and cohesion" (Diallo, 2004, p. 185) and is seen as beneficial to the community. Abusharaf's (2001) research in Sudan supports this claim, stating that "the relational rather than the individual context is the most significant aspect of circumcision rituals" (p. 133). Christiane says:

> *It wasn't that I was happy...but knowing that everyone must go through it....it's nobody's fault. My grandmother, my mother, my aunt all went through it. It's like that. I wasn't happy but I knew that they would no longer treat me as 'bilakoro', like those who weren't done. When you are circumcised, you enter into another world, a world that they created themselves, belonging to those who "have nothing that sticks out." There is an Arabic term that means 'initiated'. They say that.* (Christiane)

However, the social pressure to conform creates enormous stress on not only on girls but also on their mothers (Gosselin, 2000; WHO, 2008). Habi, in recounting how her mother lied in order to protect her younger sister from excision, reveals some of her mother's earlier pain and regret:

> *And my mother, when they asked her, she said "Yes, yes, I had it done over there. I already did it." She didn't lie, my mother! Because she saw how we had suffered. There is nothing worse than that. Nothing worse than that…seeing your child suffer like that!* (Habi)

But as Diallo (2004) states "the price of refusing or confronting the will of the elderly is often perceived as more destructive than putting one's children through female genital mutilation" (p. 176). This is emphasised by Habi who tells of a conversation with her girlfriends:

> *They said: "You know, it's the family, we can't do anything, we're forced to let our girls be done." They replied like that. In the family, a woman is thought of poorly if she doesn't let her children be excised.* (Habi)

What then are the real choices available to women? More importantly, what are the consequences of these choices? Gadamer (1975) says that "to have a horizon means not to be limited to what is nearest, but to be able to see beyond it" (p. 269). Should alternative pathways be created with the intention of providing the same rights and status inferred by

acts of excision? Or should other, expanded horizons be shown, horizons extending beyond marriage and childbirth? If so, with whom lies the responsibility of revealing these horizons? Arguments that authentic voices exist only within the critiqued culture are refuted by Walley (1997) who claims this to be a reductionist view and Fisher (2004) who fears that such arguments focus more on "*who* is discussing it [rather than]...*which* situation is under discussion" (p. 117). But if it is agreed that authenticity can exist outside of culture, then surely this comes laden with ethical responsibilities toward the other. While Caelli (2001) argues that adult decisions arising from new knowledge are made freely, I believe that the act of stepping over the threshold into other, foreign cultures requires a deliberate examination of our impact on the social fabric of the community. In doing so, we show concern in our thoughts and actions and in terms of others' "ownmost potentiality-for-Being-their-Selves" (Heidegger, 1962, p. 344).

Allows possibility

At the same time, there continues to be widespread belief in practicing communities that excision enhances social status and safeguards women's power in society (Diallo, 2004; Shweder, 2000). A study involving Somali women states that most of its participants "reported being very excited in anticipation of their circumcision, and many were pleased about it being planned or were envious of others who had already been circumcised" (Chalmers & Hashi, 2000, p. 230). This is reinforced by Aicha who says:

> *And really, the women were persuaded that excising the children was something good, they really thought that for a long time. It wasn't to harm them because they adore their children. (*Aicha)

Interpretations of rightness and goodness are complex, numerous and seemingly contradictory. Hermeneutic research recognises the existence and worth of these multiple ways of being and interpreting. As Gadamer (1975) reminds us, all interpretation is valid and reaching to the historical horizons of others requires understanding but not necessarily agreement. Although I argue that the silence surrounding excision denies young girls and women the possibility of empowerment and self agency, it is also true that many communities practicing excision believe it to be the only possible means through which females can achieve their destiny as wives and mothers and be fully accepted as members of society (Dorkenoo & Elworthy, 1992). The notion of cultural authenticity is therefore relative and as Booth (1999) points out, it is also "profoundly political...for what is defined as authentic in a culture is more an expression of the prevailing balance of forces rather than the discovery of an Archimedean point" (p. 38). Perhaps the priority is to therefore address the economic, social and political disparities that exist as chasms between countries in order that the horizons of possibility may be expanded. Acknowledging excision as being "both an obvious effect of poverty (because of weak physical and political ability to resist or retaliate) and a contributing sense of poverty (with its destruction of self-confidence and severe impact on health and basic capabilities)" (McFerson, 2010, p. 56) is essential to understanding and confronting this practice.

The silence that keeps excision

The change from being surrounded by silence to keeping silence is crucial to being. In this research, excision is seen as the pivotal moment when life and living are irrevocably changed, when silence becomes internalised to henceforth affect everyday ways of being in

the world. The following section reveals what it means for these women to keep silence in their daily lives.

Threatens to exclude

> *I had skipped a grade and I found myself with older kids. All of the class was circumcised: "Hey, you, go away!" In their conversations, they probably said things that I wasn't supposed to hear. If I had joined in the conversations with the older kids, ooh, la la, I would have run away! I always heard it said: "If you're not circumcised, you don't come with us." You're excluded. I played with girls my own age. We were circumcised the same year. We chatted among ourselves. We said: "Look here, if we had known, we would have hidden!" Yes, because they tell you that you will have presents, you will have this, you will have that but no one.....And afterwards, I also played with non-cicumcised girls but I held my tongue, I didn't say anything. It was like that.* (Christiane)

The silence, the words and the exclusion all speak to Christiane and forewarn her of the consequences of not being excised. But the words do not show truth in its entirety nor do the threats and the exclusion come with discussion or understanding. Christiane still does not have any real understanding of excision, does not fully realise the significance of this act and does not understand what it will mean for her. The truth is kept from her and it is only after she has been excised that she recognises the threat, the danger and the truth which were hidden in the silence and in the words.

The omnipresence of silence removes choice from girls and women. Perhaps Christiane's idea of running away to avoid excision is improbable (Dixon, 2004) but in having silence kept around her, she is denied the truth and consequently, any chance of self determination. At the same time, once excised, Christiane also chooses to keep silence with the non-circumcised girls. Is this due to society's pressure to conform or a sense of helplessness and impotence? Or is it possible that the silence and taboos of exision create an aura of mystery

and fear which young girls like Christiane are unable to penetrate, understand and communicate and so are trapped and disabled in their not knowing? Christiane, in continuing her story, shows that despite a strong desire to break silence, the pressure to keep silence is also strong:

> *I was 8 years old and I always cried for those who came afterwards. So, I can't say that I was happy. There was a cousin who told me: "Ah, la la, they are going to circumcise me!" I didn't want to tell her but I thought of her all the time, I felt so bad for her because you know what you have gone through. You feel the same pain again. I wanted to tell her, I felt bad for her but I couldn't tell her. You can talk with the older kids but not with those who aren't, in order not to frighten them. Me, I understood it like that. And also, the older kids told us: "If you talk, we'll cut off your tongue! You can't say anything to her." Already, you're threatened! Otherwise, it's too easy to say to the little ones: "Watch out!!!"* (Christiane)

As a young child Christiane already recognises the danger of silence and the power of words. Once excised, Christiane is expected to keep silence; automatically, her status changes from being surrounded by silence to keeping it, to having it become an integral part of her way of being with others. Aware of the danger of keeping silence, Christiane struggles with her decision to conform. What are the lasting effects of such behaviours on young children? How do children cope with the belief that despite their impotence they are in part, responsible for the pain and the hurt experienced by others?

Asks 'who have I become?'

Excision changes a person – physically, emotionally and psychologically. Sometimes these changes to identity are not recognised or understood but nonetheless, they are present. For girls and women who have been excised, excision is part of who they are, who they will become, how they will relate to others and how they will experience life. Often, living with excision means living with its questions, fears and trauma in silence.

> *And the worst is for peeing! You hold back, you hop up and down, you do it little by little. Sometimes even now, when I go to pee, I happen to think about it...* (Christiane)

Mariama says:

> *I have had vaginal discharges for the last ten years and I'm prone to infections. Regarding sexuality, it hurts me when I make love.* (Mariama)

Habi continues:

> *In truth, I was in pain during intercourse, I was in pain. And that, I never told anyone, not even my husband. I thought that's the way it was.* (Habi)

Evidence shows that excision incurs an increased risk of vaginal and urinary infections along with painful sexual intercourse (Almroth et al., 2005; UNICEF 2005a; WHO, 2008). This impacts on the daily lives of girls and women who suffer these effects in silence, accepting these consequences as being a normal part of life. However, it is important to recognise the psychological impacts as being equally important (Behrendt & Moritz, 2005).

Mariama says:

> *Before the excision I had lots of projects in my head. I said "I'm going to do this, I will go to school"...well, after the excision, I renounced my projects a little. I was traumatised in fact. I was obliged to go to school but I didn't want to anymore, I wasn't concentrating.*
>
> *I have always dreamed of working in the hospital environment, to become a nurse, but until I was thirteen, the walls of a hospital reminded me of when I was nine. I work now but it's not in this area, it's nothing like it: I clean people's houses. It's hard. I want to train to become a care assistant...perhaps later, nursing auxiliary.* (Mariama)

Mariama recognises the trauma of excision and how it has affected her life, her way of

being. It is akin to having her dreams stolen. The child who existed before the excision no longer existed afterwards. Excision altered her in unwelcome ways and became an integral and permanent part of her being. This is reiterated by Christiane who says:

> *You cannot forget. Never. Never. It's a traumatism that has stayed in my brain and isn't erased. That's it! Everything that touches this part...I'm afraid now, I'm not reassured. I was scared for my first cervical smear. Even now, when I go to the gynaecologist, I take medication. It's crazy, but this part of me, I'm scared...* (Christiane)

The violence and trauma of excision cannot be erased from memory or from being. If Christiane experiences fear each time she sees a gynecologist, how does she experience childbirth? For many non-excised women, the prospect of giving birth is already daunting and frightening; how then does this experience translate for excised women who carry the trauma and the fear of excision in their very being? Gadamer (1975) says that memory is an essential part of a person's historicity and cannot be denied. The notion of the experience of excision going before itself to form part of the experience of childbirth is referred to by Heidegger (1962) as being “anticipatory” or “ahead-of-itself” and will be discussed more fully under the subtheme 'the silence that keeps' (birth as excision).

Earlier, Christiane described excision as being the porthole to another world. It is a closed world but notwithstanding, it is the only one in which girls and women can talk freely with one another about excision. For Christiane, this world and its silences has become such an intrinsic part of her being that even as an independent adult living in France, she cannot easily forget or defy its rules.

> That which has been sanctioned by tradition and custom has an authority that is nameless, and our finite historical being is marked by the fact that always the authority of what has been transmitted – and not only what is clearly grounded – has power over our attitudes and behaviour. (Gadamer, 1975, p. 249)

The voice of authority and tradition are too strong for Chistiane to break away easily. She continues to keep silence:

> *We talk amongst those who are done; it's true that we don't talk about it with the younger ones. My three youngest sisters weren't circumcised and the youngest didn't even know that I had been circumcised.* (Christiane)

What do these silences hide? What do they show? Does the silence hide the shame of being excised, of being different? How deep is this shame? How do excised women feel and react when they learn that not all females are excised? Is this a new sort of shame that they have to contend with? Habi says:

> *People don't understand, they don't think that things can go that far. And that embarrasses me. When there are people around, I can't talk about it. Discuss it with French women…I don't know what they think of me. It bothers me. I always ask myself: What do you think of us, that we aren't women or that we are women… I don't know…so I don't like to show that I was excised. When people are talking, I say that it's a bad thing, it's a bad thing - but I don't say that I was stuck together. It's stupid. But in my head, the others don't think that I am a woman like them.* (Habi)

Excision affects the identity of self. In the communities that practice excision, this act is seen as a means of gaining acceptance into society, of having the possibility to continue along society's determined path; it is considered status quo. However, in non-practicing communities, those who are excised are confronted with the reality that excision is not the norm and that most females are in fact, not excised. For these women and girls, their

image of self undergoes a sharp and dramatic shift as they question their womanhood, their culture and the belief system with which they grew up. (Abdi, 2003; Andro et al., 2009; Dorkenoo & Elworthy, 1992). This may be an extremely difficult process that leads to grief, anger, shame, emotional scarring and pyschological trauma. The curiousity and horror with which the non-excised community approach excision (Abdi, 2003; Fahs, 2003) contribute to the difficulties these women face in trying to accept their differences. As Habi shows, this realisation causes tremendous doubt and anxiety and contributes even further to a sense of shame and a life of silence.

While communities practicing excision shroud the practice in a culture of silence, both local and international communities have focussed on the subject since the mid 1970s (Dorkenoo & Elworthy, 1992). Many governments worldwide have criminalised the act (Denholm, 2004; Gynécologie Sans Frontières, 2010; Matthews, 2011; UNICEF, 2005a) and alongside non-governmental organisations, have implemented information about excision in their educational and health care programs (Denholm & Powell, 2008; GTZ, July, 2007; Gynécologie Sans Frontières, 2010; Lee, 2008; Sissoho, 2008). Despite this, there is reluctance and/or ignorance on the part of health care professionals to recognise excision and deal with it appropriately. Habi shares her experience with French health professionals:

> *When I started having visits at the hospital for the pregnancy – well, at this time there weren't a lot of excised women – the doctor and the students came, they did a vaginal examination on me. There were some who thought that I didn't understand French or I don't know what! There was one who said: "Where is her thing?" It was a boy. "Where is her thing?!" I looked at him like that...his colleague told him: "It's like that with Africans, they take it out." Then there was someone, a female student who said: "We don't believe you" but he said "Okay, I'll explain it to you." I didn't like that. Afterwards, I told myself it was normal, they're not*

> *used to seeing that. But afterwards, each time, each morning there were rounds and students came, I was really embarrassed. So embarrassed that sometimes I didn't want them to touch me.* (Habi)

In France, Habi is made to feel different. In Mali, 92% of females aged 15-49 have been excised (GTZ, November, 2007) and it is therefore likely that most of Habi's female, Malian aquaintances are excised. Habi is now confronted with being in a minority, of being in a situation in which excision is abnormal, strange and curious (Thierfelder et al., 2005). The health professionals, shocked by the excision, do not address Habi directly. She is presumed ignorant because she is excised; she is treated as an object, invisible and without any worthy input. She is talked about. Habi resents this treatement and is shamed by it. The shame that has always surrounded excision finds new roots in France. The shame is different, it comes from being treated as a monstrous object of curiousity, of being objectified, but it is there nevertheless. Unable to overcome the embarrassment and the shame of her excision, Habi remains voiceless and invisible while seeking to excuse the attitudes and ignorance of the health professionals. In doing so, she continues to live in a culture of silence.

Fahs (2003) refers to this "horrified gaze" as a Western construction of non-Western women and their "strange, inferior, and often outrageous" (p. 48) body practices. Mohanty (1984) takes the claim of colonial imperialism further by stating this attitude as being the typical, racially stereotyped image of the "average third world woman", constrained both by gender and by being "third world" i.e. "ignorant, poor, uneducated, tradition-bound, domestic, family-oriented, victimized, etc" (p. 337).

Understanding is a reciprocal process, one that involves communication and respect. If any understanding is to be sought concerning the experiences of childbirth for excised women, there needs to be a move away from such derogatory attitudes and beliefs toward a real and honest effort to understand. Though hermeneutical inquiry emphasises the importance of history and tradition, this in itself does not define the present. Defining a woman by her history ignores her personhood and her voice and contributes to the keeping of silence.

The practice of excision and silence are parts of a circle whereby each depends on and perpetuates the other. The experiences of these women show that the practice of excision is often silenced. Apart from the gifts and the celebrations, there is no real understanding of the practice. Often, those about to be excised are not foretold, reassured or given explanations. This results in feelings of confusion, fear, anger, impotence, shame and deception. The silence that surrounds excision hides its truth and causes young girls and women to believe that it is necessary, something that all females, without exception, must endure. The silence keeps this lie and consequently, the practice continues. After excision, feelings of shame, helplessness and vulnerability may be experienced. Personally admitting to these emotions and accepting them may be a long and difficult process; discussing them with others even more so if discussion carries with it the risk of mockery or rejection. In an effort to protect themselves, girls and women may prefer to hide the situation and keep the silence. As a result, the culture of silence is maintained.

The impact of excision and its silence on the integrity of girls and women is profound and permanent. Those who are excised are forever altered, forever changed; this experience affects how these individuals live their lives and interact with themselves, with others and

with the world. For these four women, the experiences of pregnancy are marked by excision. The next section will explore this more fully.

The silence that keeps pregnancy

How women give birth is deeply influenced by their experiences of pregnancy (Crowe & von Baeyer, 1989). The physical, emotional, psychological and spiritual journeys travelled by pregnant women provide the foundation for childbirth, helping to shape and define this experience. Exploring these women's experiences of pregnancy through the veil of silence will help to understand their experiences of giving birth.

Asks what is safe

The silence that surrounds excision extends to pregnancy. As Christiane shows us, the silence suppresses knowledge and knowing and in doing so, creates unsafeness.

> *It's true that I was quite worried. I didn't know how one comes into this world and my aunt told me that it comes out from the place where you pee. I said: "But it's not possible, you see the shape of your stomach, it's big, it's fat"...she said: "Yes, yes, yes, you'll see, nature knows what it is doing. You only have to look at the little lambs, look at the mother, well, it's the same thing, it's nature. The body always adapts." She also told me that sometimes, it doesn't happen like that. But she told me not to worry.*

> *In Mali, women died but people said that it hadn't gone well, that there had been a haemorrhage. I thought of all these women who were dead. For me, it was because of haemorrhages. I told myself: I don't know how it's going to be for me: good or bad?* (Christiane)

The culture of silence surrounding matters of sexuality and excision serves to perpetuate dependence and passivity. Though pregnant, Christiane "doesn't know how one comes

into this world" and her questions are met with vague answers advising her to trust in nature. With this limited access to knowledge, how can Christiane assume control of her body and of her decisions? How can she ensure her safety and that of her child during labour? Both Christiane and her aunt recognise that childbirth sometimes goes badly, that it incurs the risk of death, yet nothing is done to alleviate these risks. They are neither discussed nor fully understood yet they are readily accepted as part of life. Habi continues:

> *I had just gotten married – a religious marriage – and I got pregnant. I was very happy to be pregnant and the pregnancy went well. I went for my visits at the dispensary next to my home.*
>
> *At one point, near the end of my pregnancy, in the eighth month, I went to visit my mother. My mother says to me: "I don't know, you must walk, walk, walk, I don't know what will happen, I can't help you, my daughter, you are excised, I am not, I don't know. I hear women say that excised women suffer more than the others to have babies, more than the women who are not excised. Around here, nobody says anything, people are ashamed, they are ashamed to talk about it, and me, I don't know how to help you." Poor thing, she cried. "I can't do anything, I gave birth to you and it's like that. I don't understand, I can't help you." I kept that in mind and I was scared. It scared me.* (Habi)

The taboos and silences surrounding excision are so deeply engrained in the community that despite having regular, antenatal care, Habi goes through most of her pregnancy unaware of the risks associating excision and childbirth. Seemingly, this has not been discussed with the midwives. Do midwives intentionally minimise or ignore the health risks of excision or is this practice so common and familiar that the dangers are no longer seen? Smythe (1998) says that "The being of safe/unsafe is abundant with possibilites that go before the situation" (p. 133) and she questions where safeness lies. Is it in prevention, anticipation, control or recognition? It would appear that for both Habi and Christiane, whose care lacked in all of these elements, unsafeness is already present. There is also the

possibility that those health professionals entrusted with providing care to pregnant and labouring women are in fact, the very practioners of excision (Abusharaf, 2001; Equality Now, 2008; Gosselin, 2000; Obermeyer, 2005; WHO, 2008). If this is the case, what are women's expectations of midwives? How are relationships formed and are they based on trust?

Habi's mother says that those who practice excision consider it shameful and it is this shame that leads to silence. It would seem paradoxical that the very community which encourages and continues the practice of excision would consider it shameful and need to cover its shame with silence. The community which has sanctioned Habi's excision does not support her or provide her with information and consequently, Habi is scared and helpless. Mariama shares a similar story:

> *Regarding the excision, I was scared because when I was in Guinea, I saw lots of women who died. Either it was the child who dies and she lives or she dies and the child lives. I was scared because of that. But I asked for information when I was in Guinea: they had a campaign on excision and I asked questions about the women who gave birth and the children who died and they told me that it was due to a certain lack of medical attention.* (Mariama)

Once again, the communities which practice excision appear to lack readiness in sharing their common knowledge of excision and childbirth and Mariama, prompted by fear of death, has to actively search outside of her community for information concerning the risks and dangers. The practice of excision is shown to be envelopped in silence and from this silence, fear is born.

Mariama's early antenatal care in France also highlights issues of safety:

> *The first five months I had my check-ups at the clinic and the last four months, at a public hospital by a gynecologist. She remarked that I was excised. I asked a question regarding that. I worried a bit, she told me to stop, that in Africa, it wasn't the same methods and that it was going to be okay for me. And that reassured me a lot.* (Mariama)

Despite having regular and early antenatal care in France, Mariama's excision is not discussed until she sees a gynecologist later in pregnancy. Like Habi, Mariama's story raises questions of how familiar and comfortable health professionals are with recognising excision and addressing its impact on the provision of health care. Johansen's (2006) research of infibulated women in Norway revealed that "Health workers rarely discussed FGC with their patients...as their expression of respect for what they perceived to be a taboo subject in practicing cultures" (p. 523). This raises questions of how health care is received by these women: Do they recognise the intended respect or are they made to feel invisible? Do they feel comfortable enough to ask questions?

In many countries there is an increasing trend to encourage women to accept responsibility for their care and to share in the process of decision making (Davis, 2005; Health and Disability Commissioner, 2008; Légaré, Ratté, Gravel, & Graham, 2008; National Institute for Health and Clinical Excellence (NICE), 2007; New Zealand College of Midwives, 2000). If this is so, who is responsible for addressing the issue of excision and its impact on care? Does responsibility for health and well-being lie with the health care provider or the health care recipient? Despite the growing emphasis on informed consent, the increased demands of this model of care on both consumer and provider (e.g. time constraints, consensus of what constitutes appropriate amounts of information, political agendas, clear demarcation of realms of responsibility and personal biases) may cause difficulties for this

concept to be upheld in practice (Jomeen, 2007; Légaré et al., 2008) .

These problems are highlighted by Aicha who, during pregnancy, believed that consensus of labour care and procedures had been reached with her obstetrician.

> *My antenatal care was through private consultation with the obstetrician so I hadn't seen any midwives. I gave birth at the hospital where my doctor practiced in order to facilitate things. He had told me that if I gave birth there, there wouldn't be any worries: he would leave orders for me to have an epidural because I was very, very afraid and for him to be notified so that he could come see how things were going. He reassured me. He always told me that a woman is made for having children, that for ages, women have had children without being medically assisted. Everytime I asked him questions, he told me that things would be fine. He explained that until the ninth month, the body prepares little by little for the birth, so don't worry, everything will be okay, I'll be there.* (Aicha)

Aicha emphasises the shared understanding that supposedly exists between herself and her doctor. Although this perception is later shown to be non-reciprocal, during her pregnancy Aicha is reassured by the care she receives; she trusts in her doctor and in the health care system. The doctor, like Christiane's aunt, believes in the forces of nature during childbirth; unlike Christiane's aunt, he expresses no fear or doubt about its outcome. Childbirth is not associated with danger or death and excision does not appear to be a health issue. It appears that the risks associating childbirth and excision do not exist in France or are silenced. Does the standard of health care negate these risks or are they simply ignored and unacknowledged? How do health care professionals treat the issue of excision with women? What are the ethical and legal responsibilities binding them to a code of conduct that is consistent with the aim of preventing future excisions of young girls and babies?

The silence that keeps birth

Giving birth is a singular experience that is shaped by a multitude of factors. Insofar as no two situations are identical, no two births are alike. While the uniqueness of each birth is recognised and appreciated, this following section seeks to explore the meanings of childbirth for women who have been excised, to understand the common essence of these experiences.

Shows unsafeness

During her pregnancy Habi is vaguely warned by her mother of the hidden dangers of excision. However, it is during childbirth, as the danger makes itself known, that she fully and finally realises what the silence has hidden from her. Smythe (1998) talks about situations in which unsafeness, though unseen, is already present; it appears that for Habi this unsafeness, though hidden from her by the community and the health professionals, has been ever-present by virtue of her excision. She simply did not realise it. She says:

> *I can't say that the birth went well. The contractions began in the morning, they hurt and I went to the hospital with an aunt. On foot. It was the midwife who took care of me all along. They managed to do a vaginal examination but I was a bit stuck together. From the excision. It seems that blood had clotted there, had coagulated and closed me a bit. I didn't know that some part was stuck together. The midwife saw it when I was about to give birth. She explained to my aunt that it was from the excision. She said that I couldn't give birth without being cut...otherwise the baby won't come without a caesarean section or I can lose the baby. My aunt knew right away what needed to be done. Nobody asked me what I thought. I was there in pain...withough pain relief, nothing...it hurt a lot.* (Habi)

Apart from the issue of physical safety, this story raises the issue of invisibility and the assumption of authority and power. During labour, Habi seems almost non-existent insofar

as she has no voice and no responsibility. Faced with the possibility of danger, the midwife addresses her concerns to Habi's aunt; nobody asks Habi for her opinion, nobody concerns themselves with her state of being - her emotions, her pain and her fears. Though her role as a labouring woman should make her a determining and central figure in the process of labour, she is considered ignorant of the situation and her role is to passively submit to the decisions made by her aunt and her midwife.

Health care workers are increasingly expected to provide safe, appropriate care based on partnership (Davis, 2005; Health and Disability Commissioner, 2008; Légaré et al., 2008; New Zealand College of Midwives, 2000). While the concept of partnership may not be a priority in countries such as Mali and Guinea where access to basic health care and education are severely compromised (Banque Mondiale, 2010; Organisation Mondiale de la Santé (OMS), 2009a & 2009b), striving for such a model of care is an important step in advocating both safeness and self agency. Individual assumption of responsibility and self-determination require access to information that is easily understood and non-judgemental, that allows individuals to partake in choosing appropriate options of care. The absence of such information and choice facilitates dependence and unsafeness by creating relationships based on power and inegality in which the desires and needs of one party are either ignored or made invisible. Aicha says:

> *When she examined me she said « Ah, here's one ! » That means « here's someone who is excised ». I don't know if she was surprised to see that I was an excised woman, maybe she supposed that I was an illiterate woman, that I didn't understand.*
>
> *She got me settled and she left. I suppose that she went to speak with her*

colleagues because afterwards, there was a little parade. A second one passed, then two more. Me, I was installed with my legs spread apart…they came to see. I really sensed the curiosity. As a result, I didn't know who was the midwife, who was the nursing auxiliary, who were the care staff and I didn't see any reason why they came to see me except for the fact that I was excised. All those people who came, who entered into my intimacy without my authorisation, who didn't ask me if it bothered me…I felt that it was an agression. Maybe they are used to seeing women but the look was different. They came and then afterwards, they whispered. I took it badly.

When it was painful, I made the midwife come. She examined me and said that I wasn't open enough, that I had to wait more. Of course I asked for the epidural and I didn't have it. The midwife said that it was too late, she judged that I didn't need it. It's she who judged. And yet, I think that when a young woman comes to give birth to her first child, it's the minimum! Because giving birth is a horrible suffering. Me, I suffered like a martyr. You imagine it but you don't know what it is. That shocked me, this pain, this violence. Is it because of the excision? I can't say, I don't know.

Finally, I gave birth...there wasn't just one person, there were at least three people in the room. But not my husband, unfortunately. He didn't come, I gave birth all alone. The midwife told me several times that she would call him. Each time that I asked: « Did you reach my husband? », she replied: « No, we are going to wait a bit ». I don't think that she took me seriously and then, she couldn't have cared less. Maybe if my husband had been there, it would have been different. They wouldn't have come to look at me as a group, to navigate, to tell the others to come see. There were two people at the birth who had no reason to be there. Maybe they were there to help, I don't know, but I would have preferred that my husband be there and not strangers who were there by curiousity more than anything else. (Aicha)

Like Habi's story, Aicha's description raises the question of relationships, power and safeness. Aicha is alone during her labour. She repeatedly asks for her husband but the midwife refuses to call him, saying it is too early. Yet when the pain becomes intense and Aicha asks for an epidural, the midwife refuses, saying that it is too late. Aware of her domination but unable to articulate her needs, Aicha remains helpless and voiceless while the midwife maintains a strict position of authority and control. What are the factors disabling Aicha, keeping her from breaking silence and asserting her rights and her person?

Does her perceived impotence stem from the midwife or from her experience of having lived in a culture of silence in which passive acceptance is the expected norm? Hollins Martin (2007) cites research conducted by Milgram in 1974 which shows "that under situational pressures and within hierarchical relationships, people have a propensity towards submission to authority" (p. 480). This statement implies that the acts of ceding authority and control are passive acts; authority and control are submitted or surrendered. However, according to Gadamer (1975), "authority cannot actually be bestowed, but is acquired and must be acquired if someone is to lay claim to it...authority has nothing to do with obedience, but rather with knowledge" (p. 248). This implies that even if the acts of assuming and ceding authority are not consciously decided, they nevertheless require a specific action from both parties; authority is not passively given, but is actively taken. Perhaps Aicha's responses are due to a combination of these factors which, when taken together, would severely impede her ability to speak out and assert her needs and her rights.

Aicha, who had no concerns about her excision during pregnancy, now finds herself defined by and objectified because of it. Her rights and her dignity are ignored and discounted. Similar to Habi's antenatal experience in France, Aicha is automatically classified as an "average third world woman" (Mohanty, 1984, p. 337), because she is excised. She becomes meaningless and invisible to the midwife.

Female excision is not the cultural norm in countries such as France and New Zealand (Denholm, 2004; Ministère des solidarités et de la cohésion sociale, 2007). For excised women coming to these countries, what are the expectations and the realities? Are these women automatically labelled and classified based on personal assumptions and beliefs or

is there an honest and determined effort to understand these women and their experiences? How much do health professionals (and midwives in particular) invest in the care they provide to women? Are real attempts made by midwives to break the silence and the taboos associated with excision? A report by Thierfelder et al. (2005) states "FGM and related complications are not commonly talked about in the private life of these women. Many of them had never spoken with their husbands about the subject and even among women themselves FGM was said to be a taboo topic" (p. 88). Given that such discussions do not occur easily in the more intimate settings with family and friends, it is not surprising to discover that barriers in communication exist in the relatively more formal relationships formed between women and their health care providers (Chalmers & Hashi, 2000; Denholm & Powell, 2008; Johansen, 2006; Thierfelder et al., 2005). The question is whether or not we address these issues in a respectful, appropriate and safe manner.

Both the 1993 Report of the Expert Maternity Group and NICE (2007) cite the emotional and physical well-being of the woman as the foundation for safe maternity care that identifies and respects individual needs. If midwives, in their silence, fail to recognise women as individuals having particular stories and backgrounds that may influence care and its outcomes, then such care may be considered substandard and unsafe. "The quality of relationships is inevitably linked to the quality of communication, and effective communication is essential for safe practice" (Hunter, Berg, Lundgren, Olafsdottir, & Kirkham, 2008, p. 133). Mariama says:

> *I had a midwife for the birth. She said nothing about the excision. I didn't ask anything but I was worried because the baby wasn't coming. I found that it was a bit long…with the pain despite the epidural. I was all alone, the father of my child*

> *wasn't there. The family came later but in the birthing room, I was all alone.* (Mariama)

Mariama, too, is alone during childbirth and is unable to voice her fears or to ask questions. She has already associated childbirth with the risk of death and despite her gynaecologist's reassurances, she is worried. The midwife acknowledges neither her excision nor her fears and concerns; like Mariama, the midwife keeps the silence. This lack of effective communication between them results in compromised safety (Hunter et al., 2008), leaving invisibility to reign.

> *I was left on my own. In any case, that's the impression I had. I didn't have the fortune to be accompanied or to have my husband at my side. I couldn't ask questions even when I tried. I was in pain, I screamed, that's it. For me, it's a very bad memory.* (Aicha)

There exist different cultural views regarding childbirth. Johansen's (2006) research reveals that for Somali women living in Norway, their perception of birth differs from that of the midwives. Whereas the Somali women believe birth to encompass the entire period of labour, from onset to birth of the baby, midwives consider birth to be the expulsion period only. Left unaddressed, these differing expectations and perceptions of birth may result in women feeling abandoned during labour.

The role of the midwife is to accompany women during childbirth, to help them overcome their pain, to enable them to feel safe and less alone on their journey to motherhood. Derived from old English, the word 'midwife' means 'with woman', thus highlighting one of the principal roles of the midwife, to 'be with woman'. However, studies have shown a growing trend to replace the focus of midwifery care from 'being with women' to 'doing to

women' (Bennett, 1997; Faby, 1998; Hunter, 2002). This trend reduces midwifery to a series of tasks and acts, replacing the physical and emotional accompaniment once offered by midwives with machines that monitor vital signs and supervise progression (Hodnett, Gates, Hofmeyr, Sakala, & Weston, 2011; Johansen, 2006). Physical safety assumed, the midwife can thus attend to other tasks and other women and need only be in the birthing room to 'catch the baby'. There is little or no emotional accompaniment as women are expected to assure their emotional well-being either personally or through their chosen support person. For those women who have lived and remained voiceless in a culture of silence, 'doing midwifery' encourages women to re-adopt attitudes of submission and passive acquiescence. For these women it is more important than ever that this trend be reversed, that the common 'diagnostic touch' be replaced by a more 'supportive touch' (Kitzinger, as cited in Johansen, 2006) and that midwives return to providing safe, appropriate, respectful care that encourages these women to have a voice and to participate in their labour.

Defines birth as excision

Being excised is a profound, life changing experience that cannot be separated from being. According to Heidegger (1962), such an event becomes part of one's identity and memory. It therefore contains the possibility of impacting on all future childbirth experiences by going “ahead-of-itself” to define them. For women who have been excised, the essences of the being of excision i.e. pain and fear, are projected into the future to become part of the process of giving birth. In other words, women experience birthing through their past experiences of excision, interpreting childbirth as something which “'historizes' out of its future on each occasion” (Heidegger, 1962, p. 41). “These aspects - the pain, the memory

of the pain, the fear of repeated pain, and flashbacks from the circumcision – all [seem] deeply entwined" (Johansen, 2006, p, 533).

> *I never had an episiotomy. But I had stitches this time. Frankly, I was scared because an episiotomy, for me, it's frightening....it's with scissors and you revisit the same nightmare that you were subjected to when you were 8 years old. All this violence, you're scared, it stays with you...the fear can only come from that.* (Christiane)

Excision creates a permanent fear that goes ahead-of-itself to become part of future childbirth experiences. Given that decisions to perform episiotomies are generally made when the second stage of labour is well advanced, it is possible that women who have been excised experience most of the duration of their labours in a constant state of fear, apprehension and dread. "By the very nature of expecting, the possible is drawn into the actual, arising out of the actual and returning to it" (Heidegger, 1962, p. 306). Regardless of whether or not an episiotomy is performed, the dread and the fear that it provokes are therefore a real and actual part of childbirth. Do midwives recognise and acknowledge this as being an unsafe situation for the woman? How are these issues addressed in order to ensure safeness?

Once again, effective communication that allows information to be shared and acknowledged is identified as being vital to the provision of safe, appropriate care (Hunter et al., 2008; NICE, 2007; Report of the Expert Maternity Group, 1993; Smythe, 1998). Safeness may also be facilitated by concepts that incorporate both continuity of care and caregiver (Hatem, Sandall, Devane, Soltani & Gates, 2009; Saultz & Lochner, 2005). However, in a country such as France where midwifery care is often shared between the obstetrician, general practitioner and the maternity unit staff (Blondel, Pusch, & Schmidt,

1985), the concept of continuity may be difficult to achieve and the question remains as to how these issues can be properly addressed. How can a woman and a midwife, meeting for the first time halfway through the woman's labour, come to have a trusting relationship in the course of a few hours? Even if both parties have good intentions, the situation is far from ideal.

> *When I think about my delivery there is pain, fear. I thought about the women that I had known...But it's when they cut me. That reminded me of the excision. I told myself that I had been excised twice in fact...I said that to myself. That if it wasn't for the wellbeing of the child, in order that the baby is born, they wouldn't have cut me like that! The fact also that they sewed me...I didn't ask not to be cut.* (Mariama)

Despite her worries and her pain, Mariama says nothing to the midwife; the silence that is part of her being disables her from asking not to be cut. She likens her episiotomy to being excised a second time. Having identified her (primary) excision as a traumatic event that has negatively impacted on her life, how does the experience of giving birth, recalled now as a second excision, impact on Mariama and her child? Does it affect their relationship or Mariama's parenting abilities? What, if any, are the emotional and psychological implications and will this affect future experiences of giving birth?

Habi too, defines the episiotomy as second excision:

> *I stayed like that and then they told me that the baby is coming. It was late evening. This had dragged on all night and day and I was afraid that the baby wouldn't come, that he wouldn't be alive. The midwife helped me, she told me to push. The head started to come out, then went back in and came back out again. There, I told myself: "but why won't she come out? I'm pushing hard, I'm pushing hard, I push as I am told, why doesn't she come out?" "But that comes from the excision, you were stuck together, but it will come, it will come". I'm pushing, I'm pushing, my*

> *aunt helped me too, she told me to push, push, push. It took a long time, a long time. She didn't come right away, it was really hard, really hard. I suffered, suffered a lot. I had already suffered during the labour and then…it's when they cut me. They used alcohol and it stung. I said right away, I even said to my aunt who was next to me - I said: "I see that I have been excised even more today. A woman suffers. Me, I suffered, it's the second time I suffer." The baby arrived, the cut widened. The pain, I can't forget it. I can't. After the baby was born, she didn't cry right away…all of that scared me. I am happy to have my daughter but still, with lots of suffering.* (Habi)

Habi's labour is long and worrisome. The midwife explains that this, along with the need for an episiotomy, is a direct result of the excision. Excision therefore has a primary and definite impact on the birth experience, shaping and in part, defining it. Like Mariama, Habi considers her episiotomy to be a second excision, a second suffering. Although the events of excision and birth are separated temporally, they are fused together at this moment of childbirth to become part of the other. While this once again refers to the Heidegger's (1962) anticipatory notion of excision going ahead-of-itself to define future experience, it also relates to the concept of the hermeneutic circle (Gadamer, 1975) insofar as the understandings of excision form the interpretations of childbirth which in turn, create new meanings of excision.

Asks 'how do I cope with pain?'

In many cultures, pain is accepted as part of a woman's life and to stoically endure is considered a sign of strength.

> *In these days, they didn't give you painkillers. Everyone, all women suffer like that, we must endure it, cope with it every day, every single morning, it's like that, it's life. Your mum suffered to have you, you too, you will suffer. Having children, it's like that, every woman goes through it. That was engraved in my head, in my heart, you must endure, you must endure.* (Habi)

Pain is a criteria that often defines birth. In many cultures, this pain and suffering is considered as an obligatory part of a woman's life, something to be accepted and endured (Clark Callister, Khalaf, Semenic, Kartchner, & Vehvilainen-Julkunen, 2003). In French culture however, many women readily accept epidural anesthesia in labour, rejecting the pain as unnecessary and unwanted (Ministère des solidarités, de la santé et de la famille, 2005). How do women balance these opposing views when traversing different cultures and countries? Mariama says:

> *The birth didn't go that well in fact, because I had a lot of pain. I hurt too much, too much. I had an epidural. It worked but it was still painful. The pains were like period pains but it was more than that, in fact. At times I had an atrocious pain, insupportable. I told myself that the pain, it's like that, it's natural, even women who aren't excised have pains, it wasn't only me…one must accept it.* (Mariama)

For expatriate and immigrant women, adopting different expectations about labour and birth may not be easy. Like Habi, Mariama has been conditioned to accept the pain of labour as being a natural part of its process. However, Mariama is alone and unsupported during her labour. She discovers that she cannot cope with the pain and consequently, opts for an epidural. How does this affect Mariama's identity of self? Does she now see herself as being a failure, unable to live up to her expectations? A study of the birth experiences of Somali women in Canada (Chalmers & Hashi, 2000) revealed that of those women wanting a vaginal birth without pharmacologic analgesia, 35 per cent of them ended up having pain relief with most reporting "little say in, or discussion about, procedures associated with birth and pain management" (p. 232). Once again, questions about the provision and reception of care need to be asked: does the gap between expectation and reality reflect inattentiveness to the needs and desires of these women? Are midwives listening to women or are women being ignored and treated as though invisible?

Can be positive

During the labour of her second child, Aicha discovers that the silences can also be positive.

> *I saw that she saw that I had been excised. She didn't talk about it and that didn't shock me. I didn't feel bad about it because I didn't hear the whisperings, there wasn't this movement of people passing by to look. She did her job, period. Maybe she noted her medical findings in the file. But she didn't talk about it, she behaved as if everything was normal, well, so to speak.* (Aicha)

Silence does not always hide, exclude, disempower or create fear. It can be filled with understandings and respect and provide the space that people need in order to feel safe. In Aicha's story the midwife's silence does not hide or ignore but communicates to Aicha the acknowledgement of the excision along with the understanding that it will not affect her or her labour. Words are not needed as the silence between Aicha and her midwife contains an unspoken understanding, a cushion of safeness.

The silence that is broken

Breaking the silence of excision is part of a healing process that enables women to accept who they are - both in body and in mind. In breaking silence, women come to the realisation that they are not 'excised women' but rather 'women who have been excised'. They are individuals who are the sum of their personhood, not to be defined simply by their bodies, their histories or their culture. Alongside these realisations, breaking silence is also a difficult and painful process that requires the courage and the willingness to accept its risks. To understand how the breaking of silence translates into the childbirth experiences of these women, I will firstly discuss how this changed way of being impacts on their daily lives.

Carries risk

> *There was a cousin who came to see me, to say hello. She came with her daughter. The baby had peed and she was cleaning her. I saw the mercurochrome and I said to her: "But what have you done?"*
> *She says: "Yeah, I did that. She's excised."*
> *"But you are crazy!"*
> *"You, since you went to France, you have changed, you have completely changed!"*
> *She got mad, she took her child and she left.* (Habi)

Habi is accused of of having changed. In the eyes of the community, she has adopted foreign ways, rejected her culture and excluded herself from the community. It would seem however, that it is the community that has ostracised Habi insofar as it rejects all possibility of discussion or deviation and is hostile toward the suggestion of change. Living in a culture of silence, the community remains closed, accepting only those who abide by its rules. How does this emotional trauma of exclusion translate into the daily lives of these women? How do women cope with rejection by one community alongside the difficulties of integration into another? How does it affect their ways of being - with themselves and with others? Does the fear of further exclusion result in a future defined by passivity and submission?

Mariama also faces the rejection of her community:

> *I received a phone call from the father of my daughter – he lives in Guinea – saying that it was time to excise her. She was what? She was one year old. I said "There's no question of it!" Afterwards, it was his sister who phoned me all the time to take her to a clinic. I said "There's no question of it, I had it happen to me, I know what it is, what the pain is, I don't want my daughter to be submitted to that". People tell me that I'm too integrated now that I live in France. I tell them "But no, it's not that. One must see things as they are, face the reality". And imagine that I go with her to Africa and I leave her at my parents!. My parents, I know that they won't do it, they won't do it anymore. But if her father's family come and say "I'm taking her", they will let her go. In Guinea, women have no rights over their children, it's the father. I know that they will do her. Over there, there is no law that bans it. Not exactly…they made a law but nobody repects it, nobody. And what is done is done!*

Afterwards, I will come back here, I will go directly to jail! (Mariama)

Living in France, Mariama is balancing two different cultures. If she goes back to Guinea with her daughter, her daughter will be excised against Mariama's will. In view of the fact that French law states excision to be a criminal offence (Code Pénal de la République Française, articles 222-7, 222-8, 222-9, 222-10, 222-12), punishable not only for those acts that occur within the country but also for any act inflicted upon French residents overseas (Code Pénal de la République Française, article 222-16-2), Mariama risks legal repercussions on her return to France. What is encouraged in one culture is defined as criminal in another. Her decision not to excise her daughter causes her to be isolated and excluded from her community of origin; at the same time, she may not feel completely integrated into the French culture. She may question where she belongs.

It takes a great deal of courage for women to accept their excision and its consequences on their lives. Doing so within a community that considers it as a monstrosity (Fahs, 2003) and automatically judges women by their history and their culture rather than by their personhood (Johansen, 2006; Mohanty, 1984) is even more difficult. Cultures that practice excision are often shrouded in silence, secrecy and shame (Fahs, 2003; Thierfelder et al., 2005) which discourage women from talking easily. Over the years, the increased media focus on the subject of excision (Dorkenoo & Elworthy, 1992) may encourage these women to renounce silence but nevertheless, excision remains a sensitive topic. Even without the fear of reprisal and rejection, talking about excision in non-practicing communities is still difficult. Gadamer (1975) recognises such hardship when he says that "...this movement into maturity in his own life does not mean that a person becomes his own master in the

sense that he becomes free of all tradition" (p. 249). This is emphasised by Christiane who, despite having trusting and intimate relationships with her children, does not readily talk with them about her excision:

> *I've done everything to talk with my children. And if I can't do it with certain things, I send them to the doctor. Otherwise, periods, body hair, transformations, I explained it to them. But I haven't talked about my circumcision. We talk about excision, that it's not good but they didn't know about me. In fact, the question has never come up and I never had the idea to tell them.* (Christiane)

Heals and helps

Despite the difficulties, talking about excision is recognised as being beneficial both to the larger community and to the women themselves. The women in this study express the hope that by breaking the taboos and talking, communities can share ideas and knowledge and become open to the possibilites of change. On a more personal level, breaking the silence of excision is healing.

> *Sometimes, it's difficult to speak about it. The last time that I talked with my girlfriends, it was in school, when I did a presentation on excision. They didn't know what it was. They asked me questions, if I was excised. I said yes, most of the young African girls are excised. Now they are beginning to talk about it here. I participate in interviews. It's to inform people who don't know or people who have suffered the same thing as me. To help.* (Mariama)

Christiane says:

> *It does me good to talk about it. Even when I talk about it with my cousin, it does me good. We know what we suffered and so much the better for us if we've managed to come through it alright. Even if there has been progress, it has to stop. It's very important because children suffer, it hurts. And afterwards, it stays with us. And lots of women don't dare talk about it.* (Christiane)

Habi continues:

> *It helps me that you ask questions. It helps me, it helps me. Like that, I talk about what's in my heart, what I suffered. I can explain. Maybe that can help me, maybe that can help to save other people.* (Habi)

Although the breaking of silence is marked by pain and risk in the daily lives of these women, its benefits are also recognised. However, in order to understand these women's experiences of giving birth, we must consider the breaking of silence in the context of pregnancy and childbirth.

In the context of pregnancy and childbirth

While some women may welcome the transitions of pregnancy and childbirth, others may find them destabilising and confusing. The physical changes that accompany pregnancy i.e. changes to body shape, increased fatigue, inability to continue with established routines, etc., may result in an altered sense of identity that for some women, is difficult to accept (Upton & Han, 2003). The emotional upset associated with hormonal changes may also be difficult to manage and equilibrate (Smith et al., 1990). During labour, some women may find themselves in a situation which contradicts their perceived self image. They may feel uncomfortable with the physical process of labour or ashamed of its messiness. The intensity of labour may be frightening and overwhelming, causing some women to feel out of control or embarrassed by their reactions and coping strategies (DiMatteo, Kahn, & Berry, 1993). So too, the upcoming challenges and responsibilities of parenthood – both in creating and expanding a family – can seem daunting and cause women to question and doubt their ability to succeed as good parents (Bergum, 1991; Pascali-Bonaro & Kroeger, 2004).

Irrespective of how women respond to these stresses, they are nevertheless present. However, for women who have been excised, these stresses are compounded. Not only do they have the worry and fear stemming from the possible physical complications of excision (WHO, 2006a) but additionally, if living in a community where excision is not customarily practiced, these women have the added onus of talking with the health professionals about their excision.

> *I was always well cared for by the midwives and especially, the gynaecologist. She's really great. Since I come from Mali, she guessed right away that I was circumcised. She's used to it, she must have seen other women.* (Christiane)

Christiane does not need to initiate the conversation about excision. Her gynaecologist, sensitive to the concerns of Malian women, immediately acknowledges the probability of her being excised, providing the foundation for a trusting and honest relationship. There is no need to hide, no stress of trying to remain hidden. Christiane continues:

> *The midwives can talk about it during the pregnancy. You can easily see it when you examine. You need to talk to the woman, ask her her opinion, explain the bad parts to her so that she won't do it to her daughter.*

> *During the labour, they spoke to me about my circumcision and I was happy. I was more comfortable. We have a tendancy to hide the situation. But if you talk about it, you need to be gentle: "Madam, I see something isn't normal, have you been circumcised?" There. And then, you touch on the subject. You can talk about it. Say that if it goes badly, maybe we will do a caesarean section but there's no need to be scared, we also perform caesarean sections on women who aren't circumcised. It's not because a woman is circumcised that we are going to do a caesarean. And also, the episiotomy...*(Christiane)

For women who have been excised, talking about these experiences is difficult at the best of times; expecting these women to initiate such conversations during the trying times of

pregnancy and childbirth is therefore inappropriate and unrealistic. It is the midwives and other health professionals who, as providers of safe maternity care, need to assume the responsibility for introducing this topic in a manner that is both respectful and professional. Christiane's remarks concerning women's fears of an eventual caeasarean section are supported by the research (Chalmers & Hashi, 2000; Denholm & Powell, 2008; Johansen, 2006; Thierfelder et al., 2005). To avoid a situation similar to the ever-present fear of an episiotomy, the fear of caeasarean section therefore needs to be directly addressed so that 'the waiting for a caeasaren section' doesn't becoming a defining aspect of pregnancy. For these women then, acknowledgement of the excision is reassuring both physically and psychologically.

> *I think that we must talk more because there is a sort of taboo, even in hospital. One sees but pretends not to have seen. Or they whisper amongst themselves but they dare not come to see you...I think that there is a taboo and there mustn't be any.* (Aicha)

If a culture of silence maintains taboos, then open discussions will break them and in doing so, create communities where knowledge and information are shared and where differences are recognised. Indeed, if midwives are reluctant to talk about excision because they are uncomfortable with it or do not understand it, vital information cannot be shared and care is unsafe. This silence deprives women of information concerning care options and accentuates their uncertainty and fear regarding "inadequate care procedures" (Johansen, 2006, p. 524) during labour and birth. The result is increased anxiety and discomfort for both the woman and the midwife. To avoid this, midwives must understand the risks of excision for women and babies and convey this information to women in a non-judgemental way so that women feel safe in articulating their needs and their concerns.

> *There is education and then there is the savoir vivre, the know how. One can be a midwife, a doctor and have absolutely no savoir faire. The reaction to a patient, whether she is excised or not, should be the same. I want to say that someone who comes to the hospital or clinic and who needs care, first of all, you accompany her, you listen to her and you don't hesitate to ask her questions.* (Aicha)

The silence surrounding excision needs to be broken. Given the sensitive and intimate nature of the topic, the shame and embarassment that these women suffer in being 'different', the disrespect and lack of understanding that non-practicing communities show and the difficulties that these women experience in overcoming the cultures of silence in which they grew up, the onus for breaking silence during pregnancy and labour rests with midwives and other health professionals (Denholm & Powell, 2008). However, the 'how' of the approach is important. Shabatay reminds us that "in the cross-cultural context, the patient from another culture, by being present, asks not only for care, but also that his or her heritage and condition be respected" (as cited in Spence, 2001, p. 626). This requires an appproach that incorporates professionalism with humanity, respect with right conduct and ethics with safeness. Only in this way can both women and their carers be safe.

Summary

The data presented in this section has followed these women through their veils of silence as they move from childhood to adulthood, their passages in life marked by excision and childbirth. Their stories reveal the meanings of silence in their lives, how it has impacted on their understandings and shaped their ways of being in the world. Silence is shown as a presence that begins as an envelopment and becomes a way of being; the women in these stories move from being surrounded by silence to keeping silence and from there, to the breaking of its bonds. Although we cannot change our tradition, who we are and what we

become are acts of determination. The four women who participated in this study have broken and continue to break silence in their everyday lives; in doing so, they continually shape their present and their future ways of being. "Tradition is not simply a precondition into which we come, but we produce it ourselves, inasmuch as we understand, participate in the evolution of tradition and hence further determine it ourselves" (Gadamer, 1975, p. 261).

Breaking silence is the multitude of individual acts that these women carry out everyday. It is the telephone conversation to the cousin living in Mali who recently had a baby, reminding her that excision is both dangerous and illegal. It is the having the courage to dream about a different future, in which the halls of a hospital no longer hold fear. It is the partaking in this study, of being able to look me in the eye and ask "what do you think of me?" It is telling our children the stories of their births, in celebration of nature and the human body. It is the determination that our children will not suffer as we have. Women who break silence exhibit courage and vision, the ability to see beyond the risks to oneself toward the possibility of a new and different future - not only for themselves but also for those who follow them. Breaking silence is a gift to all of the girls and women who are today, unexcised, that they may have the chance to remain that way; for those who have been excised, breaking silence provides others with the opportunity to share and to heal and to know that they are not alone.

In keeping with Gadamer's (1975) philosophy of hermeneutic inquiry, this chapter has set out to "clarify the conditions in which understanding takes place" (p. 263). The multiple meanings of silence were determined as constituting the tradition and the historical horizons

of the women and their experiences of excision and childbirth were discussed within the context of these meanings. New insights and meanings developed and these, too, were added to the circle to allow for further understanding and interpretation. The circle does not end and the meanings that have been uncovered in this chapter are not finite; they are simply part of the continuing process of the search for understanding. It is hoped that by participating in this study, the women too, have walked away with questions and insights that will enable a deeper understanding of their experiences to emerge. In presenting this data, I have taken to heart Gadamer's (1975) belief that "understanding itself has a fundamental connection with language" (p. 357) and have therefore made every effort to choose language that does justice to these women and their stories and that facitilates the pathway to understanding.

Chapter Five

Discussion and Conclusion

Introduction

The previous four chapters have introduced, explained and presented the research and its findings. They reveal excision to be an issue of global concern that affects women and their families as well as the communities in which affected women are living.

The justification for this hermeneutic phenomenological study is two-fold. Firstly, it lies with the continuing prevalence of the practice despite the multiple and sustained efforts aimed at its abandonment. Current research findings and recommendations emphasise the need for qualitative studies that focus on the social meanings of excision in the hope that a better understanding will result in more efficient methods and greater success with elimination. Secondly, justification lies with those girls and women who are already excised and whom must not be forgotten. Midwives and other health professionals must acknowledge those who are affected by ensuring that when these girls and women seek access to maternity services, the provision and reception of such care is respectful, appropriate and safe.

This chapter will summarise the aims and findings of the research. It will further highlight the appropriateness of the chosen methodology and will also suggest possible ways forward.

Aims of the research

By inviting women to share their stories and experiences of childbirth, they have had the opportunity to make their voices heard. In offering these women different perspectives of these experiences, it is hoped that their horizons of possibility and ways of being will be enlarged. For midwives and other birth attendants, it is anticipated that this research will reveal pathways of understanding that encourage the provision of safe, appropriate midwifery and obstetric care for affected women and their families.

Methodological fit

Hermeneutic phenomenology combines the philosophies of both hermeneutics and phenomenology and as such, it is a suitable methodology for this research. The stories of these four women who were excised were told using their voices and their words. As participants of this research, they broke the silence encircling excision.

In keeping with the hermeneutical aspect of the methodology, these findings are interpreted with the aim to discover deeper insights around an issue often avoided or ignored. Extrapolating from Mohanty (1993) who says that "All experience...is socially constructed" (p. 50), it can be assumed that the socially attributed meanings of experience are fluid and relative to society and culture. In this study, the values associated with childbirth and excision are changeable and are spread across a wide range of possible meanings. Hermeneutics explores and examines the various angles of these meanings to discover different and/or deeper perspectives that materialise in and through text as a continual process of interpretation referred to as the hermeneutic circle. The hermeneutic circle is the

fusing together of the old with the new, the melding of previous interpretations and newly forged meanings, the coming together of the historical context with that of the present. Each interpretation is acknowledged as being valid, arising from an individual, historical context that points the way toward infinite ways of understanding and being. In this sense, the hermeneutic circle gives rise to the concept of the fusion of horizons, an understanding "within a process of tradition, in which past and present are constantly fused" (Gadamer, 1975, p. 258).

This study has revealed some of these meanings and interpretations. These insights may not be novel, falling instead "within the horizon of average everydayness" (Heidegger, 1962, p. 94). Nevertheless, it is hoped that this study has shown the possibility of looking at these understandings differently to arrive at a deeper interpretation of what childbirth can possibly mean for these women and for the midwives who care for them.

Furthermore, the emphasis of this methodology on textual interpretation underlines its appropriateness for this study. Although it was not anticipated as being a finding of the research, silence has been shown as a major theme weaving throughout the lives of these women. Hermeneutic phenomenology, with its emphasis on text and language, is therefore particularly fitting as it encourages these women to find a language that corresponds to their experiences and which now applies to their altered consciousness. Whether communicating these experiences to others or silently repeating them to themselves, this articulation is part of a validation process, an act of self-agency for which words and language are needed. Rich (1990) puts it succinctly when she says that "We need to know the writing of the past, and know it differently than we have ever known it; not to pass on a tradition but to break

its hold over us" (p. 414). Hermeneutic phenomenology brings this task to hand by acknowledging the profound importance of women's voices, both past and present. It is therefore an apt and significant choice of methodology.

Discussion of the findings

Silence is identified as a major theme of this study. It is described by Johansen (2006) as being a "deafening silence" (p. 523), weighted down with innuendoes, hidden meanings, expectations and taboos. In this research silence appears as a constant weave throughout the lives of girls and women to become an integral part of their being, a veil through which they see the world and live their lives. Matters of sexuality including excision and childbirth are taboo and cannot be openly discussed. Despite this, from an early age, girls are aware of the social costs and stigmas associated with being unexcised, unmarried or childless. Silence is shown to be an extremely effective means of communicating not only the acceptable codes of behaviour but also the assumed risks of divergence. Practices such as excision become so natural and normal that they are rarely accompanied by the need for justification (Andro el al., 2009). This "form of conversational silence" (Bonomi, Allen, & Holt, 2006, p. 2260-2261) robs girls and women of freedom and potential by denying them a language and the possibility of choice and self-determination. Such denial indicates society's refusal to recognise the potential and existing capacity of girls and women as fully participating members of society and amounts to a form of exclusion (Fraser, 2000). Bonomi et al. (2006) argue without the language and the vocabulary necessary to describe and validate experience, girls and women may not know how to address these issues and talk about them. This limits the possibility of shared understandings which in turn,

perpetuates the silence. “Silence eclipses possibilities” (Christiansen, 1995, p. 91).

Like silence, excision has become part of these women's identities with meanings relative to community and culture. Despite the fact that the women who participated in this study have broken and continue to break silence in their daily lives, excision and silence remain inherent aspects of their being. These experiences have in part, defined who they are and who they will become. Silence and excision cannot be separated from them and any attempt to understand these women must acknowledge this. In Heideggerian terms this may be referred to as “Being-a-whole” (Heidegger, 1962, p. 279) whereby individual elements are necessary in order to constitute the whole and the whole, in turn, requires the sum of the individual parts. In his words: “The togetherness...is characterized as a “*sum”*, and so is that lack-of-togetherness which is founded upon it” (Heidegger, 1962, p. 287).

For a Guinean or Malian woman living in her country of origin, excision may be viewed as a means of achieving elevated social status and privilege. It may be a source of pride and opportunity. In coming to France, these meanings may change and these women may now see their bodies as incomplete or mutilated, their bodies a source of shame and embarrassment. Such perceptions are conflicting and unsafe and midwives need to recognise the potential dilemmas that may accompany these attitudes.

Understanding these meanings and their attached silences is key to understanding the birth experiences of these women. This study has attempted to explore the meanings of excision which women have brought with them to France, to understand how these meanings are transferred and translated into their experiences of childbirth. For midwives who are

unaccustomed to the practice of excision, this understanding is especially important if the care provided to these women is to be both safe and appropriate. While it has been shown that midwives do not always feel comfortable addressing the issue of excision, the onus of doing so falls within their realms of professional and ethical responsibilities. Assuming and attaching meanings of convenience to these silences i.e. ignorance or agreement, denies these women the possibility of addressing their concerns and disregards their right to participate in their care. The findings of this study reveal that the voicelessness of women is not due to ignorance or their lack of concern but rather due to a deeply ingrained belief that matters concerning sexuality and excision are taboo and should not be discussed. Acknowledging excision and silence to be a part of a woman's personhood recognises and adresses this dilemma and is the first step in providing safe care.

The way forward

Globally, the aim to eliminate excision is coupled with the need to provide appropriate care for those girls and women already excised. This study joins in the call for an integrated and coherent approach to excision that on one hand, addresses the need for effective strategies aimed at abandonment and on the other hand, provides affected families with access to appropriate services. There is evidence that African communities living in Europe continue to practice excision by either sending their girls to Africa, inviting excisors to come to Europe or requesting health professionals in Europe to perform the procedure (Andro et al., 2009; Leye et al., 2006). There is therefore an identified need for a coordinated approach both on national and international levels to ensure the cooperation and consistency between various agencies including those providing educational, social, legal and medical services

(Powell et al., 2004). "One of the major problems is the degree of operational coherence between health and social care services and other agencies (e.g. police, immigration officials, lawyers)" (p. 155). In order to make appropriate choices for themselves and their daughters, women need to know the associated health risks of excision, the laws guiding the practice, the legal repercussions of non-compliance as well as the social and medical services available. Having access to this information in a culturally sensitive manner will enable families living in Europe and elsewhere to better resist the pressures to excise their children.

Implications for practice

In paraphrasing Heidegger, van Manen (1990) says that "the more important question is not: Can we do something with phenomenology? Rather, we should wonder: Can phenomenology, if we concern ourselves deeply with it, do something with us? (p. 45). With this is mind we must ask ourselves how our practice is coloured by the findings of this study? What is the way forward for midwives and other birth attendants caring for women who have been excised?

Firstly, there is a need for communication and understanding. The women in this study have emphasised the need for midwives to communicate with them, to break the taboo of silence, to talk about excision in an open, respectful manner. Women have identified the need for this part of their being to be acknowledged; failure to do so leaves women with lingering fears, concerns and questions and compromises the safeness of their care. Together, midwives and women should construct clear and concise care plans as a means of addressing these concerns. Women need to know that they are in safe hands, that they and

their babies will be safe. At the same time, constant repetition of their situation to various midwives is likely to cause discomfort; the provision of one-to-one midwifery care may therefore be of particular benefit to this population.

Secondly, given the cultures of silence in which many of these women were raised and the subsequent difficulties they may have in initiating conversations about excision, the onus for beginning such conversations lies with midwives and other health professionals. Health care professionals are ethically and professionally bound to provide safe care that does not endanger health or well-being. This necessitates open dialogue in which information is shared and may require the use of interpreting services. Without appropriate language support, women may be unable to describe their experiences, their fears or their needs, thus compromising the safeness of care. For those women having access to this vocabulary in their mother tongue, it is important to acknowledge that problems and frustrations may arise when they attempt to articulate their experiences in a second, foreign language (Bulman & McCourt, 2002).

Finally, midwives and other labour attendants need to be mindful that the woman in front of them is a 'woman who has been excised' rather than an 'excised woman'. She should not be defined by her excision and is deserving of the same respect as other, non-affected women. The care given to these women should reflect this respect.

Implications for education and research

According to Dorkenoo and Elworthy (1992), “the first step towards eradication is to expose the custom by speaking about it widely, trying to understand the reasons for its

perpetuation, and undertaking epidemiological, psychological and sociological research" (p. 26).

Talking about excision destroys taboos, supplies factual, objective information and provides the language with which to address the subject. In this regard, media is a particularly useful tool as it allows information to be widely and easily disseminated through various outlets including television, internet, posters, magazines and radio. For those girls and women who lack vocabulary specific to excision, seeing words in print or hearing them on radio may help to identify their situation and validate their experience. Internet venues, apart from providing information, encourage and facilitate communication through discussion forums which allow experiences to be shared in a manner that limits personal risk.

Introducing this topic in schools as part of compulsory sexual health and education programs is another important step in breaking barriers and facilitating communication. It is also possible that young girls may identify friends who are at risk of being excised. The subject of excision should also be included in all educational programs designed for health care professionals. Not only must health professionals be aware of the 'at risk' signs, they must also be capable of addressing the topic of excision in a competent manner, fully informed of the current legal, social and medical positions. This necessitates attendance at workshops and study days in order to keep up to date with research findings and recommendations.

Continuing research is therefore needed to provide the theory for practice. Given the current emphasis of excision as a social phenomenon and the relative success of elimination

efforts originating from this stance, it can be argued that further studies need to be directed at "messages and other inputs beyond the health concerns" (Toubia & Sharief, 2003, p.260). This highlights the need for research that focuses on understanding the multiple meanings of excision in order to develop and employ more appropriate measures aimed at its abandonment and the care of those already affected. Qualitative studies that explore such meanings are therefore significant, including those with phenomenological or hermeneutic underpinnings. This study then, in exploring the childbirth experiences for women who have been excised, contributes to this demand for research.

Weaknesses and strengths of the research

Although attempts have been made to limit the weaknesses of the research and ensure its trustworthiness, certain factors have nevertheless impacted on this study. Firstly, as discussed in the methodology section, there are issues of language and translation. This research has been conducted in the second language of all participants, including myself and despite the fact that everyone was comfortable conversing in their second language, it is possible that translations and interpretations have been given a fair amount of latitude.

Secondly, this research is conducted in France, where scant English resources are available. This meant that I did not have access to library resources and had to rely on internet for all supporting documents. France is also a country without a culture of midwifery research and although I found local support amongst the GAMS network, family, friends and colleagues, it was sometimes difficult to convey the understandings and meanings of this study. Meeting with likeminded phenomenological researchers to discuss this project has

not been possible; the 'phenomenological nod' has therefore come from a distance.

The number of women participating in this study is limited. Other hermeneutic studies have cited optimal numbers of participants to be in the range of five to eight. This research has deliberately chosen to include four participants only. This is due firstly, to the wealth of data obtained and secondly, to the amount of work involved in language translations. In this sense, the number of participants can be seen as both a weakness and a strength since it is in part dictated by the richness of the findings.

Added to the strength of this research are the strong, complementary relationships between the aims, methods, findings and methodology of the study with their emphases on text, narrative, voice and silence. Such complementarity weaves together all aspects of the research and may therefore be considered an added strength.

Closing remarks

This study has explored the experiences of childbirth for women who have been excised. It has interpreted the narratives of four women using a phenomenological hermeneutic methodology underpinned by Gadamerian philosophy. These interpretations have revealed how the meanings of childbirth and excision, taken with women into the processes of labour and birth, impact on their experiences. This study shows the meanings of childbirth and excision to be socially constructed through silence; over the last few decades these meanings have also been influenced by the anti-excision messages coming from the international community. For midwives and other labour attendants, understanding how

these meanings affect women and their experiences is necessary for the provision of safe, appropriate care. In adopting a hermeneutic approach that focuses on textual interpretation of meaning, this research process has provided the participating women with the opportunity to develop insights and understandings that may not have been previously considered. In turn, this enlarged horizon has created the potential for change or difference, by offering a glimpse of the infinite possibilites of being.

As researcher, I came to this study with fears. Fear that my convictions were not strong enough and that in trying to understand, I would be swayed into accepting the practice of excision. I feared that by asking questions, I would acknowledge personal doubt and weakness and the unacceptable possibility of change. During the process of research, I have confronted these fears, expanding my horizons, hesitantly at first, to allow other possible ways of being and seeing. In doing so, I have learned that understanding is not the same as accepting; understanding is not a weakness, but a strength. Understanding is not to be feared.

This study then, is a pathway of hope. Hope that the practice of excision will be abandoned. Hope that those girls and women already excised will discover new ways of living with excision, in harmony with their bodies and their minds. Hope that a bridge of understanding will enable affected girls and women to receive care in a manner that is respectful, safe and appropriate. And for you, the reader, hope that this journey through the research has left you with rich understandings that will lead to a stronger, more coherent stance against excision, understandings that may further contribute to the hermeneutic circle of interpretation. Gadamer (1975) says that "It is enough to say that we understand

in a different way, if we understand at all" (p. 264). I take this further with the hope that the journey through this research has left you with a sense that we have travelled together through the sometimes winding and crooked path to arrive at a place of common understanding and shared meaning. I leave you, the reader, to decide.

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Appendix A

MEMORANDUM

Auckland University of Technology Ethics Committee (AUTEC)

To: Liz Smythe
From: **Madeline Banda** Executive Secretary, AUTEC
Date: 29 January 2010
Subject: Ethics Application Number 09/304 **The experiences of childbirth for genitally mutilated women: a critical hermeneutic study.**

Dear Liz

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC) at their meeting on 14 December 2009 and that I have approved your ethics application. This delegated approval is made in accordance with section 5.3.2.3 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTEC's meeting on 8 February 2010.

Your ethics application is approved for a period of three years until 29 January 2013.

I advise that as part of the ethics approval process, you are required to submit the following to AUTEC:

2 A brief annual progress report using form EA2, which is available online through *http://www.aut.ac.nz/research/research-ethics*. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 29 January 2013;

3 A brief report on the status of the project using form EA3, which is available online through *http://www.aut.ac.nz/research/research-ethics*. This report is to be submitted either when the approval expires on 29 January 2013 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this. Also, if your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply within that jurisdiction.

When communicating with us about this application, we ask that you use the application number and study title to enable us to provide you with prompt service. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 8860.

On behalf of the AUTEC and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Madeline Banda
Executive Secretary
Auckland University of Technology Ethics Committee

Appendix B1

Approval Letter

GAMS
Groupe pour l'Abolition des Mutilations Sexuelles et autres pratiques traditionnelles néfastes à la santé des femmes et des enfants
Section Française du Comité Inter-Africain

Madame Michele d'ENTREMONT
Rue St Exupéry
69590 SAINT SYMPHORIEN /COISE

LYON, October 17, 2009

Michele,

This letter is in response to our meeting on September 21st during which you presented the subject of your proposed research concerning excised women.

We are convinced of the value of this study. It gives voice to these women, allowing them to express how they were affected by their childbirth experiences. We assure you of our full support and we will put at your disposition any means we can provide.

For ethical supervision, you can rely on the mediation of the coordinator of GAMS RHONE-ALPES, Mme Catherine TRAORE. We hope that this covers your requests.

Yours sincerely,

The coordinator
C. TRAORE

The President GAMS RHONE-ALPES
J. DAHANNE

GAMS
Siège Social : 67 rue des Maraîchers, 75020 PARIS
Tel 01.43.48.10.87./06.74.16.77.38. Fax 01.43.48.00.73. Courriel : association.gams@wanadoo.fr
Haute-Normandie (Le Havre) 06.30.36.42.42. - (Rouen) 06.78.04.40.29. Ile-de-France (Yvelines) 06.70.83.31.73.
Champagne-Ardenne 06.32.22.79.99. PACA 06.73.43.96.33. Rhône-Alpes 06.07.89.48.62.
Site http://perso.orange.fr/..associationgams/

Appendix B2

Lettre d'approbation

GAMS
Groupe pour l'Abolition des Mutilations Sexuelles et autres pratiques traditionnelles néfastes à la santé des femmes et des enfants
Section Française du Comité Inter-Africain

Madame Michele d'ENTREMONT
Rue St Exupéry
69590 SAINT SYMPHORIEN / COISE

LYON, le 17 octobre 2009

Madame,

Nous faisons suite à notre rencontre du 21 septembre dernier au cours de laquelle vous nous avez exposé le sujet de l'enquête que vous souhaitez entreprendre auprès des femmes excisées .

Etant convaincues de l'intérêt de ce travail qui vise à donner la parole aux femmes afin qu'elles puissent s'exprimer sur la manière dont elles ont vécu leur accouchement, nous vous assurons de notre soutien et mettrons à votre disposition les moyens dont nous disposons.

Vous pourrez compter sur la médiation de la directrice du GAMS RHONE-ALPES, Mme Catherine TRAORE pour faciliter les relations avec les femmes.

Espérant avoir répondu à votre attente,

Nous vous prions d'agréer, Madame, nos salutations distinguées.

La Directrice
C. TRAORE

La Présidente GAMS RHONE-ALPES
J. DAHANNE

Siège Social : 67 rue des Maraîchers, 75020 PARIS
Tel 01.43.48.10.87./06.74.16.77.38. Fax 01.43.48.00.73. Courriel : association.gams@wanadoo.fr
Haute-Normandie (Le Havre) 06.30.36.42.42. - (Rouen) 06.78.04.40.29. Ile-de-France (Yvelines) 06.70.83.31.73. Champagne-Ardenne 06.32.22.79.99. PACA 06.73.43.96.33. Rhône-Alpes 06.07.89.48.62.
Site http://perso.orange.fr/..associationgams/

Appendix C1

Participant Information Sheet

Date Information Sheet Produced:

November 27, 2009

Project Title

The experiences of childbirth for genitally mutilated women: a critical hermeneutic perspective.

An Invitation

I am a mother, midwife and student. I am the mother of two young boys, a practicing midwife at Montbrison Hospital and a student enrolled in a masters program (in midwifery) with Auckland University of Technology (AUT) in New Zealand. As part of my studies, I am required to complete a research project. I have chosen to study and learn more about women's childbirth experiences post excision and I have approached GAMS asking for their support. They have invited me to come here and present myself. I am inviting you to participate in this study, to meet with me for interviews and tell me your childbirthing stories. I realise that this may not be an easy topic for some of you to talk about and I respect this. Your participation is voluntary.

What is the purpose of this research?

In part, the purpose of this research is to allow me to obtain a masters degree in midwifery. As such, there will be a written thesis written lodged with AUT. It is also expected that papers will be submitted for publication to appropriate journals as well as a translated copy of the research presented to GAMS. It is hoped that the findings of this study will contribute to better understanding how excision affects the experiences of childbirth and be a useful tool in providing better care for labouring women.

How was I chosen for this invitation?

You are invited to participate in this study because of your involvement with GAMS. I believe that you are aware of the negative consequences of excision and may be willing to participate in research that might help to provide better care for those affected by this practice. In order to be included in this study you must 1) speak either English or French 2) have undergone excision and 3) have given birth post excision. Again, please note that your participation in this research is voluntary. Exclusion criteria for this study are that you do not want to partake, you

do not speak either English or French, have not experienced excision, are childless or have had a planned caesarean section for birth.

What will happen in this research?

Firstly and with your consent, I would like to attend the GAMS meetings, as a way of learning more about the organisation and about excision. It will also provide us with the opportunity to get to know each other before any formal interviewing occurs and indeed, for you to decide whether or not you would like to participate in the study which will take the form of individual, recorded interviews at a time and a place of your choice. Once the interviews have been transcribed (written out), they will be returned to you for your consent and approval; if, at this stage you would like to change or delete any data, this will be respected. Any audiotapes or recordings of interviews will be destroyed once the research is completed.

What are the discomforts and risks?

It is possible that reliving your childbirthing experiences will be emotionally and/or mentally difficult. Athough talking about these events may in fact, have long term benefits for you as part of a healing process, I will in no way force you to continue with a conversation that you would like to end. For those of you who have had positive birthing experiences, sharing these stories is often joyful. However, I am also aware that partaking in these interviews may not always be acceptable to your families, friends and community. For this reason, if you decide to participate, I will make every effort to guarantee your safety and wellbeing by ensuring that these interviews are confidential and occur at the places and times of your choice.

Please note: If, during the interviews, information is shared concerning girls who are at risk of being excised or who have recently been excised, I have a legal and moral obligation to inform GAMs and either the Attorney General of France or the social/medico-social sevices in order that any instances of genital excision are prevented or alternately, to allow those who have undergone the procedure access to proper medical care and to ensure that those who have participated in such acts are held legally responsible.

How will these discomforts and risks be alleviated?

If at any time:

1. you would like your stories or comments to remain unrecorded and/or
2. you find the interviews emotionally or mentally difficult and/or
3. you wish to withdraw from the study,

these choices will be respected without any adverse consequences to you. In addition, counselling services may be offered and provided. These services will remain confidential. If you would like to have a support person with you during the interview(s), this is fine and does not pose any problem.

What are the benefits?

There are various benefits of this research:

1. It is possible that for those of you who have had difficult labour and birthing experiences, the telling of your stories may be a valuable part of the healing process. In my experience as a midwife, women who have had negative experiences in the past often appreciate this opportunity. They no longer silently carry the trauma of the past and are able to take a healing step forward. Please note, however, that this is a possible outcome and benefit and cannot be assured.

2. The information from this study may highlight more appropriate childbirth care and conduct for midwives and other labour attendants and thus improve future maternity services.

3. This research will enable me to complete my masters degree

   There is relatively little research on women's childbirth experiences post excision. The insights and understandings that emerge from this study will contribute to a body of knowledge that can be incorporated into practice in order to provide appropriate support and care for excised women in labour.

How will my privacy be protected?

Care will be taken to protect your identity and no real names will be used. All information provided will be confidential and used solely for the purpose of the intended research. Any written information related to this research will be kept safe and secure and destroyed six years after the completion of the study.

What are the costs of participating in this research?

This research will take the form of interviews lasting approximately one hour. It is possible that I will ask you to be interviewed more than once if issues or comments need to be clarified. You are free to choose the time and place for the interviews and any financial costs incurred in association with these interviews will be reimbursed.

What opportunity do I have to consider this invitation?

It would be appreciated if you could respond to this invitation within a four week period. If any further information/clairification is required during this time in order to make your decision, please do not hesitate to contact me at my workplace (details below) or through GAMS. After this four week period, those of you who wish to participate will be contacted in order to arrange further meetings. Once again, please note that your participation in this research is strictly voluntary. Those of you who prefer not to partake or those of you who withdraw from the study will not be disadvantaged in any way.

How do I agree to participate in this research?

Those of you who wish to participate are asked to please complete and sign the consent and confidentiality forms.

Will I receive feedback on the results of this research?

Once the study is complete, a translated copy of the research report will be made

available to GAMS. If you would like to receive a personal copy, simply note this on the consent form. In addition, once the research in finished, I will contact GAMS and arrange for a presentation of my findings.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, ***Madame Catherine Traore, GAMS, Lyon, tel: 06.07.89.48.62***

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Madeline Banda, *madeline.banda@aut.ac.nz* , 921 9999 ext 8044.

Whom do I contact for further information about this research?

Researcher Contact Details:

Michele d'Entremont
Maternity Ward, Montbrison Hospital, Montbrison
Telephone : 04.77.96.74.16

Project Supervisor Contact Details:

Primary supervisor: Dr. Liz Smythe
School of Health Care Practice (Midwifery)
Associate Professor, AUT
Telephone: ext. 7196
Email: liz.smythe@aut.ac.nz

Secondary supervisor: Dr. Judith McAra-Couper
School of Health Care Practice (Midwifery)
Senior Lecturer, AUT
Telephone: ext. 7193
Email: JMARACO@aut.ac.nz

Appendix C2

Informations relatives à l'enquête

Date de rédaction:

27 novembre 2009

Le thème

L'accouchement et les femmes excisées

L'invitation

Je suis maman, sage-femme et étudiante. Mère de deux jeunes garçons, j'exerce le métier de sage-femme à l'hôpital de Montbrison (42) et je prépare un master en obstétrique dans une université d'Auckland, Nouvelle-Zélande (Auckland University of Technology, 'AUT'). Avant de finaliser ce master, je dois proposer et réaliser une enquête. J'ai choisi d'étudier le cas de femmes ayant accouché après avoir été excisées et j'ai demandé au GAMS de m'aider. J'ai été invitée à venir me présenter et vous rencontrer. Je suis donc là pour vous demander de participer à mon enquête, de me laisser vous interviewer afin que vous puissiez me raconter vos accouchements. Je respecte les appréhensions qu'éprouvent sans doute certaines d'entre vous à aborder ce sujet. Votre collaboration ne se fera que sur la base du volontariat.

Le but?

En premier lieu, cette enquête doit me permettre d'obtenir mon master. Il me faudra pour cela présenter à l'université d'Auckland un rapport écrit de mes rencontres avec vous. Le GAMS en aura une copie en français et il est possible que cette thèse soit publiée dans des revues accréditées. En second lieu, j'espère sincèrement que cette enquête permettra de mieux comprendre combien l'excision peut affecter l'accouchement et qu'elle contribuera à améliorer la qualité des soins proposés aux femmes en labeur.

Pourquoi moi?

Vous êtes invitée à participer à cette enquête en raison de vos liens avec GAMS. Je pense que vous êtes consciente des conséquences néfastes de l'excision et que l'idée de pouvoir aider celles qui sont victimes de cette coutume ne vous laisse pas indifférente. Pour être sélectionnée, vous devez 1) parler anglais ou français, 2) avoir été excisée, 3) avoir accouché après l'excision. Votre participation ne peut-être que volontaire. Il ne vous sera pas possible de participer à cette étude si 1) vous ne parlez ni anglais ni français, 2) vous n'êtes pas excisée, 3) vous n'avez pas d'enfant post-excision, 4) vous avez accouché post-excision par césarienne planifiée.

Que va-t-il se passer?

Tout d'abord et avec votre accord, j'aimerais assister aux rencontres du GAMS afin de mieux connaître votre organisation et en apprendre plus sur l'excision. Cela nous permettra aussi de nous découvrir mutuellement avant de commencer les interviews et vous aurez ainsi toute latitude pour vous porter volontaire à ces interviews enregistrées en tête à tête aux lieux et dates de votre choix. Une fois ces interviews imprimées, elles seront soumises à votre approbation afin que vous puissiez y apporter toutes les modifications que vous jugerez nécessaires. Tous les enregistrements seront détruits après la rédaction définitive des interviews.

Quels sont les problèmes et les risques?

Il est possible que vous éprouviez des difficultés mentales ou émotionnelles à revivre un accouchement. Parler peut-être libérateur mais je ne vous imposerai en aucun cas de poursuivre une conversation que vous souhaiteriez abandonner. Pour celles d'entre vous qui ont eu des expériences heureuses, les raconter c'est partager un moment de bonheur. Je suis aussi tout à fait consciente que votre entourage peut ne pas voir ces interviews d'un bon œil. C'est pourquoi elles resteront confidentielles et se dérouleront selon vos propres termes, en l'heure et lieu de votre choix .

IL EST IMPORTANT que vous sachiez que si, au cours d'une interview, vous faites référence à une jeune fille ou une femme courant le risque d'une excision ou ayant été récemment excisée, je suis légalement et moralement responsable d'en informer les autorités concernées (soit le Procureur de la Republique ou les services sociaux et médico-sociaux ainsi que le GAMS) afin qu'elles puissent intervenir pour prévenir l'excision ou poursuivre ceux et celles qui ont participé à une pratique condamnée par la loi française.

Comment éviter risques et problèmes?

Si à tout moment:

1. vous trouvez les interviews émotionnellement trop difficiles à supporter,

2. vous souhaitez que votre récit et vos commentaires ne soient pas enregistrés,

3. vous souhaitez ne plus participer à cette enquête

ces choix seront respectés, sans aucune conséquence pour vous. Un soutien psychologique vous sera offert. Ce service restera confidentiel. D'autre part, il vous sera toujours possible de vous faire assister lors des interviews..

Et quel intérêt pour moi?

1. Pour celles d'entre vous qui ont eu une grossesse ou un accouchement difficile, le simple fait de raconter cette expérience peut aider à cicatriser la douleur morale. Sage-femme, j'ai rencontré des femmes soulagées de pouvoir partager leurs peines et leurs douleurs. Elles ne sont plus seules à porter le traumatisme et cela les aide parfois à surmonter le passé.

2. Il y a eu très peu de recherches sur l'accouchement de femmes excisées. Les informations recueillies dans cette étude peuvent aider à la mise en pratique d'une approche et de soins plus appropriés et ouvrir ainsi la voie à un meilleur accueil dans les maternités.

Mon anonymat sera-t-il protégé?

Votre identité ne sera jamais révélée et toutes les informations resteront confidentielles et ne seront utilisées que dans le cadre de cette recherche.

Yaura-t-il des frais?

Les interviews dureront environ une heure. Sans doute devrez-vous participer à plusieurs interviews afin d'apporter précisions et commentaires. Tous les frais induits vous seront remboursés.

Quand et comment participer?

Je vous serais reconnaissante de donner votre réponse à cette invitation dans un délai de quatre semaines. Il vous suffira de remplir la fiche de renseignements, de signer la clause de confidentialité et de me les remettre. N'hésitez pas à me contacter, soit au GAMS soit à mon travail (voir ci-dessous) si vous avez besoin de plus d'informations. Ensuite, nous mettrons ensemble en place les interviews. Je tiens à vous rappeler qu'aucune pression ne sera exercée sur vous, que vous soyez volontaire ou non.

Que faire si j'ai des problèmes avec l'enquête

Toute interrogation sur la nature de l'enquête doit être discutée avec le superviseur du projet: *Madame Catherine Traore, GAMS, Lyon, tél: 06.07.89.48.62.*

En cas de doute sur la conduite de cette enquête, prière d'en référer à la secrétaire de direction d'AUTEC, Madeline Banda, *madeline.banda@aut.ac.nz* , 921 9999 ext 8044.

Pour plus d'informations:

Pour me contacter:

Michele d'Entremont
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Appendix D1

Examples of questions

Please read the following questions before signing the consent form. These questions do not require an answer. They are listed here as possible examples of the types of questions you may be asked during the interview(s):

Were you aware that you had been excised before giving birth?

How does your culture treat childbirth?

What are the expectations/responsibilities associated with childbirth?

Were you happy to be pregnant?

Did you feel prepared for labour and birth?

Who was with you during the labour and birth?

Did you feel supported in labour by your friend/family?

Did the hospital have protocols for women who have been excised?

Were the protocols appropriate?

Did you feel that you had a choice as to how things happened?

Did you understand what was happening?

What was the reaction of the midwife/labour attendant when she saw that you had been excised?

Was the midwife/labour attendant reassuring/knowledgeable?

Appendix D2

Exemples de question

Veuillez lire attentivement les questions avant de signer le formulaire d'acceptation. Ces questions ne nécessitent aucune réponse immédiate, elles ne sont que des exemples de questions qui pourront vous être posées durant les interviews :

Aviez-vous conscience d'avoir été excisée avant d'accoucher?

Comment l'accouchement est-il considéré dans votre culture?

Quelles sont, dans votre culture, les attentes et les responsabilités associées à l'accouchement?

Etiez-vous heureuse d'être enceinte?

Vous sentiez-vous préparée à l'accouchement?

Qui étaient avec vous pendant l'accouchement?

Aviez-vous le support d'amis ou de votre famille durant l'accouchement?

L'hôpital avait-il mis en place un protocole particulier pour les femmes excisées?

Ce protocole était-il approprié?

Aviez-vous le sentiment d'exercer un certain contrôle sur le déroulement de l'accouchement?

Est-ce que vous réalisiez ce qui se passait?

Quelle a été la réaction de la sage femme ou de son assistante lorsqu'elles ont vu que vous aviez été excisée?

Avez-vous appécié le savoir-faire et le réconfort de la sage-femme ou de son assistante?

Appendix E1

Consent Form

Project title: ***The experience of childbirth for genitally mutilated women: a critical hermeneutic perspective***

Project Supervisor: ***xxx***

Researcher: ***Michele d'Entremont***

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 27 November 2009
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ○ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ○ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- ○ I agree to take part in this research.
- ○ I wish to receive a copy of the report from the research (please tick one): Yes○No○

Participant's signature:.....
.....
Participant's name:.....
.....
Participant's Contact Details (if appropriate):
.....
.....
.....
.....

Date:

Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted AUTEC Reference number type the AUTEC reference number Note: The Participant should retain a copy of this form.

Appendix E2

Formulaire d'acceptation

Titre du projet: ***L'expérience de l'accouchement de femmes excisées: analyse herméneutique et critique***

Superviseurs: ***Liz Smythe, Judith McAra-Couper & Catherine Traore***

Chercheur: ***Michele d'Entremont***

- ○ J'ai lu et compris les informations du 27 novembre 2009 relatives à ce projet de recherche
- ○ Je confirme que je parle anglais ou français.
- ○ Je confirme que je suis excisée et que j'ai accouché après avoir être excisée.
- ○ J'ai eu toute latitude pour poser des questions et prendre connaissance des réponses.I
- ○ Je comprends que les interviews seront enregistrées et transcrites.
- ○ Je comprends que je peux à tout moment arrêter de participer à cette enquête sans que cela me soit en aucune façon préjudiciable
- ○ Si j'arrête de participer, je comprends que je peux demander la destruction de toutes les notes enregistrées et transcrites relatives à ma participation à cette enquête.
- ○ J'accepte de prendre part à cette enquête.
- ○ Je souhaite recevoir une copie de la publication de cette enquête (cocher la case):Oui○ Non○

Signature de la participante: .....
.....
Nom de la participante: .....
.....
Coordonnées de la participante (si possible)
.....
.....
.....
.....

Date

Approuvé par Auckland University of Technology Ethics Committee le 14 décembre 2009
AUTEC numéro de réference 09/304
Note: Le participant doit garder une copie de ce formulaire