

Somali Refugee Women and Their U.S. Healthcare Providers: Knowledge, Perceptions
and Experiences of Childbearing

By

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ABSTRACT

As a form of bodily modification, female circumcision has generated unprecedented debates across the medical community, social sciences disciplines, governmental/non-governmental agencies and activists and others. The various terminologies used to refer to it attest to differences in knowledge systems, perceptions, and lived experiences emerging from divergent cultures and ideologies.

In the last two decades, these debates have evolved from a local matter to a global health concern and human rights issue, coinciding with the largest influx of African refugees to Western nations. Various forms of female circumcision are reported in 28 countries in the African Continent; Somalia has one of the highest prevalence of female circumcision and the most severe type.

The practice is antithetical to Western values and poses an ideological challenge to the construction of the normal body, its bodily processes and its existential being-in-the-world. From global health perspectives, female circumcision is deemed to be a health hazard –especially during childbirth– though the scientific evidence is inconclusive from studies conducted post-migration. Yet, Somali refugee women have higher childbearing disparities in host nations, including the U.S. They are also perceived as difficult patients who are resistant to obstetrical interventions. Although their FGC status and “cultural” differences are often cited, there is a lack of adequate explanations as to why and how these factors shape patient-provider interactions and affect outcomes.

The objectives of this dissertation study are to quantitatively and qualitatively explore these questions within and between Somali refugee women and their healthcare providers in Arizona. Two theoretical frameworks and methods –culture consensus and embodiment– are applied to identify variations in childbearing knowledge and to explore how the cultural phenomenon of circumcision is subjectively and

intersubjectively embodied in the context of childbearing. Culture consensus questionnaire (N=174) and ethnographic interviews (N=40) using phenomenology approach were conducted. The analyses suggest cross-cultural disagreements hinged on: faith in science versus God, pregnancy/childbirth interventions, language challenges, and control-resistance issues. Furthermore, intra-cultural disagreement underscores that Somalis are not a culturally homogenous group. Preconceptions of female circumcised body as a cultural phenomenon has different and conflicting meanings that may adversely impact patient-provider interactions and outcomes.

DEDICATION

To Moona and Muna

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CHAPTER 1

INTRODUCTION

In April 2012, a *You-Tube* video showing the Swedish Minister of Culture and guests performing a mock “female genital mutilation (FGM)” on a cake went viral. The cake was a piece of performance art by African-Swedish male artist Makode Aj Linde whose head, as part of this art piece, screamed in agony every time one of guests carved a slice of the cake¹. The “cake” is a blackface² caricature representation of an African woman’s torso (no arm or legs), bare breasted with a long adorned neck, with wide open mouth expressing anguish. The black frosted red velvet “cake” symbolically represented the flesh and skin respectively. Armed with a large knife, the Swedish minister, as the guest of honor for the event³, initiated the “mutilation” by carving out the vagina of the African woman. With each cut, a loud mock anguish cry is let out from the moving head (the artist’s) of the “cake”. These haunting cries were echoed whenever the guests would “mutilate” this African “body” with every slice of the cake. In the video, the juxtaposition of these howling cries from this “mutilation” ritual with the giggling, smiling, photo-snapping guests in the room made the entire video scene surreal and disturbing. In Sweden and around the world, this video evoked a visceral reaction of anger, disgust and horror. Regardless of where they stood on the issue of female genital cutting, critics called it blatant racism which the Minister of Culture appeared to sanction by her attending the event and her participation⁴. She, the artist claims, whispered into his ear

¹ See the video here https://www.youtube.com/watch?v=z8zLM_hIw7Y . The event was honoring the World Art Day, 15 April (2012) in Sweden.

² Reminiscent of 19th century blackface minstrel shows, this cake depicts dark black body with white eyes, disproportionately large open mouth, large white teeth framed by blood red lips.

³ The event was to celebrate the Swedish Art Day: 7th April.

⁴ National Afro-Swedish Association (Afrosvenskarnas riksförbund). A Brussels-based anti-racism group has condemned Swedish culture minister Lena Adelsohn Liljeroth for cutting a

at the head on the cake “Your life will be better after this”⁵. After initially stating his intent was to provoke and highlight the horror of FGM, the artist later clarified that his piece was a social commentary on how FGM is viewed through Western perspectives⁶. This explanation, however, did not satisfy his critics some of whom found him unauthorized to speak for African Women. Ebony Magazine’s News and Lifestyle editor, Jamilah Lemieux, summed up this sentiment:

Far too often, Black men and White women feel emboldened to speak to or on issues regarding Black women from a place of authority that does not actually exist. And while they may have seen their attempts as helpful, the old cliché holds true: the road to hell is paved with good intentions⁷

This video and the subsequent reaction capture the terms, volatile emotions, polarization and globalization of the subject of female genital cutting. This millennia⁸ old cultural practice in diverse countries in Africa and the Middle East has in the past three decades taken global import and the accusations of oppressive patriarchy and of neocolonial racism remain central talking-points in the debate. The term female genital mutilation (FGM) was coined by Western activist, author and feminist Fran Hosken. In *The Hosken Report: Genital and Sexual Mutilation of Females* (1979), Hosken mapped out the practice in Africa for the World Health Organization (WHO). Since then, it has also been reported in parts of Asia and Arabian Peninsula (Shell-Duncan and Hernlund, 2000). Hosken and other feminists argued for eradicating FGM which, they pointed out,

"racist" cake at a Stockholm art museum, demanding the government issue a formal public apology. <http://m.thelocal.se/20120419/40356>.

⁵ See web-based magazine Colorline’s Jorge Rivas piece titled “Swedish Culture Minister Caught in Racist Cake-Cutting Scandal” on April 17, 2012 at http://colorlines.com/archives/2012/04/but_is_it_art_swedish_culture_minister_in_worlds_most_racist_cake-cutting_scandal.html accessed 3/14/2014

⁶ See Ebony magazine’s Jonathan Pitts-Wiley’s “Taking the 'Painful Cake': Reconsidering the Swedish Ministry Art Nightmare” at <http://www.ebony.com/news-views/the-swedish-ministry-art-nightmare#.UyOhZrlOXvi> accessed 3/14/2014

⁷ Jamilah Lemieux. 4/18/2014. “When Art Goes Wrong: Black Women's Pain is Not a Prop” EBONY <http://www.ebony.com/news-views/black-womens-pain-is-not-a-prop#ixzz2w3Jq0TtI> accessed 3/14/2014

was a practice dangerous to girls and women's health and human rights and was product of male-dominated patriarchal societies. Hosken accused those anthropologists who did not share her views of "patriarchal cover-up" and they in turn highlighted the racist colonial agenda of previous attempts to eradicate male and female circumcision (Shell-Duncan and Hernlund 2000, 130-31). African women also were not monolithic in their position vis-à-vis this cultural practice. Some feminists like Egyptian doctor Nawal El Saadawi and Sudanese doctor Asma El Dareer highlighted the associated health risks and described it as merely way to control women's sexuality. Others saw it as yet another example of neocolonial imposition and a distraction from more critical issues affecting women and men alike in Africa (Shell-Duncan and Hernlund 2001). Sierra Leonan-American anthropologist, Fuambia Ahmadu, who challenges eradication views went to Sierra Leon as an adult to undergo the procedure and has argued that "feminist sisters insist on denying us this critical aspect of becoming a woman in accordance with our unique and powerful cultural heritage"⁹. Others from both the East and the West call for more nuanced explorations of the reasons for and risk of female genital cutting.

These positions in the debate on this practice are not about good or bad motives or intentions but a matter of perceptions shaped by one's perspective and the experience of being-in-the-world. Culture indelibly shapes one's beliefs, attitudes, and behavior as well as one's views on the body and bodily processes such as pregnancy, childbirth, and about wellness, illness and disease and health-seeking behavior. One would be justified to say that there are at least, three "cultures" interfacing in any given episode of healthcare provider/recipient encounters: the cultures of the patient, the provider, and biomedical culture of any healthcare institutions. The more different these cultures are,

⁸ Around 3100 B.C.E. (see White 2001).

the more likely that each encounter becomes a landmine for misunderstandings that have potentially serious or even fatal consequences (see Fadiman 1997)—often befalling the seeker of care—but also the providers.

While it is obvious that the U.S. healthcare system is embedded in the American culture, it would not be an exaggeration to say that even average native-born Americans find themselves in foreign territory when they utilize the healthcare system and encounter the culture of biomedicine. Like a foreign country, biomedicine has governing bodies that produce policy and procedures to regulate patients and providers. These border patrol agents regulate entrance into and movement within healthcare and require countless documents (practitioners' licenses, patient's insurance papers, referral orders and identification cards). The natives of biomedicine land have their own language, which they spend years learning¹⁰. They have rigid social hierarchical system where physicians occupy the higher status and even they are ranked by specialty. The natives also have their own values and they, as does each cultural group, see their ways as the best, their technology as supreme and their treatment procedure as unparalleled in efficacy. Its cultural value and system demand compliance with its important values: professionalism, efficiency, competence, rationality, independence, autonomy, privacy, and fitness to name but few. The healthcare system requires its providers to undergo socialization processes embedded in medical education and exams to ensure the practitioners have comprehensive knowledge of its culture, codes and ethics before given licensure to practice and subscribes to a worldview based on scientific evidence. Today's

⁹ John Tierney. "A New Debate on Female Circumcision". New York Times. http://tierneylab.blogs.nytimes.com/2007/11/30/a-new-debate-on-female-circumcision/?_php=true&_type=blogs&_r=0 accessed on 11/30/2007.

¹⁰ Initiates into the medical profession take courses in medical terminologies. But even when the word is not technical or medical jargon, it may have completely different and confusing meaning and common use. For example, in everyday language "positive" is a good thing but in medicine a positive test result is often a sign of a problem and may even be catastrophic news.

medical and allied health schools and institutions have evolved from 1950 era indoctrinations depicted in “*Boys in White*”¹¹ (see Greer et al. 1961). Biomedicine, however, is still very much rooted in the Cartesian ideology (see Scheper-Hughes and Lock 1987). With the dominance of biomedicine culture and system in healthcare, it would not be difficult to think of all the challenges and problems that could be encountered by a patient who is an immigrant or member of minority communities when they enter the healthcare system. This is especially the case for those whose body appears to deviate from the “norm” and given the underrepresentation of minorities in the health professions.

The challenges encountered by patients and healthcare providers due to their respective cultural perspectives are also the central concern of this dissertation. More specifically this project is about how culture is learned and shared as knowledge and practices that are embodied and that provides means to interpret and negotiate our world. Cultural experiences shape how we perceive and engage with the world. That is, what and how one sees and feels is to a great extent shaped by cultures. The concept of culture in anthropology has evolved significantly from how it was conceptualized earlier as knowledge that is shared by and evenly distributed among members of a particular group. Culture then was understood as static system to which members conform and by which they are distinguished from outside groups. Such rigid boundaries have been replaced to include a more global, fluid, ever changing, inter-connected and often contested concept of culture (Merry 2001). Our understanding of culture continues to be under revision as globalization shrinks the world through technology and mass

¹¹ Student culture in Medical School, an ethnographic study conducted in late 1950 to early 1960s. It shows how enrolled young, white men, carried out their activities in medical training by learning what their professors expected from them in tests and exercises, how their “latent culture” (fraternity and non-fraternity men) and peer pressure shaped their medical values and skills in negotiating hospital/clinic in all its complexity; and their perspectives on their futures.

movement of finance, information and most importantly of people that is unparalleled in human history.

Conflicts and economic crises have pushed people from their homelands and scattered the poor and war refugees from the global South around Western Europe and North America. This has led to demographic shifts in Europe and North America fueling identity politics and xenophobia. For example, the 2010 U.S. Census reports that 13%, or 40 million of American residents are foreign-born. This trend is expected to grow, contributing to the revival of nativist anti-immigrant sentiment that has moved from the margin to mainstream public discourse. Many of those who think of America as white and Christian feel threatened by America's new status as the most religiously and ethnically diverse developed nation. Due to geopolitical unrest, the U.S. is now one of the leading resettlement nations for refugees from various regions of the world.

Somalis make up one of the largest African and Muslim refugees to be resettled in America. Their presence, I argue, provides a new dimension to the concept of U.S. multiculturalism. First, they are black Africans in largely white-dominated and color-conscious America. Second, they are Muslims in a still predominantly Christian nation in which Muslims are often perceived as "suspect other," especially post-9/11 America. Third, the protracted civil war which not only destroyed lives but also the basic health and education infrastructure means that they often arrive in America with little to no education lacking English language proficiencies, and some are in poor health. Additionally, female genital cutting (FGC) is a cultural norm among Somalis and they arrive in a country where such practice is stigmatized and regarded as a mark of oppression, backwardness, and, in the context of childbirth, very dangerous. Furthermore, based on the literature reviews, Somali women are labeled as difficult patients to care for when they seek obstetric and gynecologic care. They are noted to be

resistant to standard obstetrical interventions, yet the literature also indicates they are more likely to be subjected to cesarean births (Merry et al. 2013; Råssjö et al. 2013). Also, most clinical studies suggest that Somali refugee women tend to have disproportionately higher burden of adverse birth outcomes post-migration (Jonhson et al. 2005; Small et al. 2008). The question of FGC and adverse birth outcomes is inevitably raised though the evidence to support such plausible claims is not conclusive. This dissertation aims to examine the experiences of Somali women and their obstetric healthcare providers. My overarching goal in this study is to explore how cultures influence reproductive/childbearing health beliefs, behaviors, and practices and shape patient-provider interactions.

Dissertation Questions, Objectives and Structure

Maternal and neonatal mortality remains an important global health concern. It is a well-established fact that reproductive health disparities exist not only between nations but also within each country. In the United States, for example, women of color, especially African-American and Native-Americans, have higher adverse birth outcomes compared to White-Americans (Lu and Halfon 2003; Tomashek et al. 2006). Consistently, race/ethnicity (Center for Disease Control 2010; Dressler et al. at 2005; Smedely et al. 2001; Williams and Collins 2001), residential location (Kreger et al. 2005), and other socioeconomic (Bird et al. 2000; Farmer 2004; Kawachi et al. 1997) variables are suggested to contribute to health disparities including reproductive health outcomes (Anachebe and Sutton 2003; Lu and Halfon 2003). Increasingly, cultural factors are being recognized as equally important variables across all health conditions (Fadiman, 1997; Helman 2007; Kleinman et al. 1978; Thomas 2004). Perhaps this awareness is more poignant in the domain of childbearing (pregnancy, labor and childbirth) because childbearing is beyond human biophysiology since this particular

bodily processes is steeped in cultural meaning and significations (Browner and Sargent 1990; Davis-Floyd 1993; Davis-Floyd and Sargent 1997; Hernandez 2007; Hunt 1999; Jordan 1993; Kirham 2007; Liamputtong 2007; Martin 2001; Squire 2009). Conversely, such awareness has not been appreciated in the biomedical science, as evidenced by the biomedicalization of childbearing (Hahn 1995; Martin 2001). Here the culture of biomedicine including the healthcare system in which it operates as institutions and the culture of healthcare providers encounter that of minority patients seeking care.

In the context of U.S. demographic shifts it is critical to understand not only who is at risk but why some minority women carry a higher burden of childbearing disparities. The study by Johnson and colleagues suggest that Somali refugee women have high rates of adverse birth outcomes compared to native born African-American and White-American women (2005). This control-design study is congruent with several others that have been conducted in Europe on Somali refugee women. Also similar to other studies the cultural practice FGC which is prevalent among this population was eluded as a plausible explanation, but yet none of the studies have substantiated the causal link between FGC and adverse birth outcomes in the host countries (Hernlund and Shell-Duncan 2007). The question is why FGC continues to be postulated as a health risk among Somali refugee women when, in the context of migration, the supportive scientific data is lacking?

FGC is central to this study; my approach, however, goes beyond this bodily status by exploring patterns of intra- and inter-cultural agreement and variation in knowledge in the childbearing domain between Somali resettled refugee women (henceforth SRRW) and healthcare providers (henceforth HCP). Maupin and Ross (2012) argue that understanding patterns of variations and similarities between biomedical providers and patients from different cultural backgrounds is extremely

important. The conceptual differences in the models can have a significant impact on patient-provider interactions and influence treatment-seeking behaviors and adherence to recommended treatment. This is especially important in the wake of demographic shift that is taking place across the U.S. In my review of current literature, I have not found any study that operationalized culture to quantitatively measure patterns of variations/similarity between SRRW and HCP. Hence, the objectives of this study are to investigate what constitutes the ideations of normative beliefs and behaviors in the childbearing domain within and between these groups. More specifically, it examines whether or not variations and/or similarities between the SRRW and HCP childbearing models influence meaning-making that shape patient-provider interactions and outcomes. Additionally, by examining SRRW intra-cultural differences in the context of their historical and ethnic diversity this study adds another dimension to the complexity of Somali refugee women post-migration reproductive health challenges. Furthermore, by juxtaposing SRRW and HCP embodied perceptions of FGC, this study aims to explore and describe a more nuanced perspective that will contribute to a much needed body of knowledge in addressing Somali refugee women's reproductive disparities post resettlement in the USA. The following objectives will guide this research study:

Objective I. To explore patterns of cultural knowledge and variations (cross-cultural agreement and disagreement) between Somali resettled refugee women (SRRW) and healthcare providers (HCP) on childbearing models.

Objective II. To assess patterns of cultural variations within SRRW's knowledge on childbearing model.

Objective III. To explore the perceptual experiences of female genital cutting from the SRRW and HCP's perspectives and describe how they are embodied.

Significance of the study

The cultural practice of FGC among Somali resettled refugee women is central in understanding if, how, and why they are at increased risk for adverse childbearing outcomes. Increasingly, anthropologists and other social scientists have recognized the significance of sociocultural factors and structural barriers as determinants of childbearing outcomes (Davis-Floyd and Sargent 1997; Dundek 2006; Liamputtong 2008; Martin 2001; Squire 2009). The burden of disproportionate childbearing complications among Somali immigrant women in the U.S. needs to be addressed not only in specialized technological obstetric interventions, solely determined from the biomedical gaze of their culturally modified bodies, but also in hearing their unique cultural voices in their quest to negotiate control of their bodies while protecting their childbearing knowledge and rights (Hernandez 2007; Johansen 2006; McMichael 2003). This research will help contribute by providing a more nuanced understanding on Somali refugee childbearing experiences in the context of FGC and migration. I argue that Somali refugee women are a unique immigrant groups in the U.S. Unlike most immigrants, Somalis in the U.S. “do not operate from a collectively shared understanding of everyday realities and cultural and social values” (Kusow 2007, 4). They stand out in terms of their religion, dress code, ‘race’, and FGC - inherently, the potential for cultural conflicts and misconceptions are ever present- on the streets as in the health care system.

As the United States becomes more ‘multicultural’, there is an urgent need to contextualize culture as a shared and learned knowledge (Dressler 2005) that is ever fluid, interconnected, and contested (Lock and Nguyen 2010; Merry 2001) within and between various ethnic groups. Equally important is to understand how culturally shaped world-view or perceptions influence overall health in general and in particular

reproductive health intra and cross-culturally. Despite the global biomedicalization of childbearing, its control has been contested by contrasting knowledge on what are the best practices to ensure successful childbearing outcomes (Davis-Floyd and Sargent 1997; Jordan 1993; Liampittong 2007). This research will also contribute by giving voice to this contested knowledge. Third, this research will advance evidence-base cultural competency literature on Somali immigrant's obstetric needs from cultural consensus modeling. Next, this research will contribute to the embodiment theory by extending culture, social, and political consideration of power (Jenkins 1994; Scheper-Hughes and Lock 1987) by juxtaposing their birthing experiences to those of their healthcare providers. Finally, the study will provide a more nuanced understanding of how FGC is perceived and experienced cross-culturally. Overall, it will contribute to better understand refugee health challenges, especially reproductive health disparities in Somali and other minority refugee communities.

Personal Reflection

There is no easy way to write about female circumcision. The major challenge for me as an African Muslim immigrant woman is how to approach the subject of female circumcision without condoning the practice or condemning its practitioners. In reviewing the copious literature on this topic, it seems that the idea of balanced representation is problematic. The practice is often conflated with Islam and an associated narrative of violence and misogyny. The dominant themes in the female circumcision literature are that the practice amounts to violation of human right and most Western feminists view it as oppressive to women and a violation of their sexual rights. In the global health arena, this cultural practice is perceived as a health risk to women, with short and long-term adverse health consequences, especially during childbirth. The perception among communities who practice female circumcision is one

which considers it to be an intricate part and parcel of their culture. The practice signifies gender and ethnic identity; it is woven into the economic, political and social fibers of the societies. Outside the sociocultural milieus in which female circumcision is practiced, it is stigmatized; this is evident by the dominance of the value laden term “genital mutilation” which tends to evoke repulsion. At the onset of this study, for example, when I was asked the focus of my dissertation, I used to say “I am exploring how cultures influence Somali women with FGC” and before I could finish the sentence I would be interrupted by statements such as: “oh, how awful it is for those poor women”; “such a terrible culture”; “I am so glad that I am not a Muslim”; “I am so glad to be born in this culture [American]” and so forth. I found responding to such views was too time consuming and emotional unsettling. So, finally, my standard response became: “it about culture, the body and health”, or simple “culture and health”.

My positionality

I gravitated to this research topic serendipitously while working as a graduate research assistant with Crista Johnson-Agbakwu, MD (committee member of this study). As a researcher and a physician (obstetrics-gynecologist), Dr. Johnson-Agbakwu’s work focuses on resettled refugee women’s health with particular interest in women with female genital cutting (FGC)¹². While assisting her in organizing and analyzing her data from a study that examined Somali women’s health-seeking behaviors,¹³ pertinent findings from this study suggested that SRRW perceived that they were subjected to

¹² Dr. Johnson-Agbakwu is the co-founder of the Refugee Women’s Clinic within the Maricopa Integrated Healthcare System.

¹³ Dr. Johnson-Agbakwu’s study: “Determinates of Health-Seeking Behavior and Health Care Utilization by Somali Immigrants.” Collected in Columbus, Ohio; aimed to understand Somali women obstetrics and gynecology needs and behavior.

unnecessary biomedical obstetric interventions which they deemed to be harmful to their reproductive health.

Johnson-Agbakwus's study suggested further research needs to be done to: explore and assess cross-cultural knowledge on childbearing meanings and practices; assess intra-cultural variations among SRRW; and contextualize obstetric "risk" and "resistance" within the cultural, social, and political context in order to understand maternal-child disparities among SRRW.

I realized that socioculturally, professionally, and academically, I was well positioned to undertake such a study. As an East African immigrant woman (originating from Zanzibar, Tanzania), and as a Muslim, I share many historical and cultural ties with the Somali community. Many of them speak Kiswahili (my native language) with varying degrees of fluency; we share similar cuisine, celebrate the same religious holidays, have the similar rituals for weddings, births, and funerals. I have close friends and acquaintances within the Somali community. My social tie with the community goes back to the early 1990's when Somali refugees started arriving in Arizona. I actively volunteered in resettlement activities, including cultural and social orientation to American life. I also served as a board member at the Somali-American Association in Arizona. Through these social ties within the community, I became aware of the general issues of day-to-day resettlement challenges such as language barriers, perceptions of discrimination, and access to social and health services that concerned many Somali families. Nevertheless, it was through my association with Dr. Johnson-Agbakwu and her mentorship that I became acutely aware of SRRW childbearing concerns regarding FGC and giving birth in America and decided to undertake this study.

This subject matter involved women’s health and health equity issues that are central to my personal, academic, and professional interests. As a healthcare provider myself, the study topic had a natural appeal and affinity. As a physical therapist, I am part-and-parcel of the U.S. biomedical healthcare system. Having occupied this position for almost three decades, I have developed an extensive network of healthcare providers across various specialties. My familiarity with the system and my networks within it afforded me the needed confidence, particularly in terms of seeking access to physicians and nurses who could participate in this research. My area of professional sub-specialty deals with Women’s health specifically. Hence, a large segment of my work focuses on women’s pelvic floor dysfunctions, such as urinary and fecal incontinence, dyspenuria¹⁴, and other female pelvic floor dysfunctions.¹⁵ This experience grounded within the physical therapy body of knowledge that seeks to alleviate women’s health problems made choosing this doctoral research topic that encompassed culture, gender and health sensible.

Academically, I chose an interdisciplinary track that integrates social, cultural, economic and political aspects of understanding diseases and disabilities in the global context. This afforded me the opportunity to understand qualitative and quantitative methods, essential tools to explore, assess, and analyze how these factors contribute to healthcare distribution. Another advantage is that one of my dissertation committee members is a practicing OB-GYN physician who provided additional insights to the refugee health issues, especially women with female genital cutting.

Given my professional, academic, sociocultural background, as well as encouragement from the Somali community, I was well positioned to pursue this study

¹⁴ Painful coitus during sexual intercourse.

¹⁵ Involving the neuromuscular and muscular skeletal parts of the female pelvic girdle.

but I was naïve about the global controversy surrounding female genital cutting and how my positionality would affect data collection and analysis. I would also like to explicitly state that personally, the cultural practice of FGC is alien to me; therefore, I am in no position to condone or support the practice but I also do not condemn those who do. I do not, however, claim to be a neutral researcher.

Dissertation Organization

After this brief introductory chapter, there are six additional chapters in this dissertation. Chapter 2 presents an overview on female circumcision and the associated globalizing discourse. I begin this chapter by contextualizing female circumcision as one of the various forms of body modifications and highlight how cultural perceptions of the body inform the discourse on female circumcision. I then discuss the terms, types and prevalence of female circumcisions. Tensions over various female body modifications in non-Western and Western societies are presented. I also discuss how migration played an important part on the current global discourse on female circumcision, especially in the global movement for the eradication of the practice by situating it within a historical-sociopolitical context. This chapter also includes the literature review on health consequences of female circumcision in the Africa and more specifically among Somali refugee women post-migration.

Chapter 3 is describes the methodology applied. I begin by comparing and contrasting the different theories and briefly describe how each theory is applied. This is followed by research design and methods. In the last section of this chapter I details how I negotiating the fieldwork. Here, I reflect and discuss the challenges I encountered in conducting this research. The space dedicated for these challenges illustrates their

noteworthiness and the importance of sharing them in details as valuable insights when conducting cross-culture research especially among marginalized communities such as the Somali women participants in this study.

Chapter 4 is an overview of Somalis, tracing their histories and current dispositions which also provide the rationale for considering intra-cultural variations in future studies of Somali diaspora. In this chapter, I also describe the Somalis in America and the multiple challenges they confront as the “other” immigrants/refugees. In the last section I present Somalis in Arizona.

In this dissertation, I draw on two theoretical frameworks which I present in the subsequent two chapters. In chapter 5 I outline the theory of Cultural Consensus Model (CCM) and its application in this dissertation. I then describe the methods by which was able to construct CCM on childbearing and FGC based on participants’ responses. Namely, from the Somali refugee/resettled women in the Phoenix metropolitan area and from the healthcare providers who care for them. I demonstrate the similarities and difference between and within these groups. Here I draw on the data from semi-structured interviews and my field notes to provide more nuances to the data from the CCM.

Chapter 6 focuses on concepts of embodiment, the second theoretical framework guiding this dissertation. More specifically, a phenomenological approach is applied to explore and describe how embodied perceptions of FGC give meanings and shape patient-provider interactions. This chapter puts us in the center of the subjective and intersubjective lived-experiences based on the narratives describing clinical encounter and gives us insight into the cultural gap resulting from the embodied cultural

perspectives which create distress and mistrust between Somali women and their providers.

I conclude with chapter 7 in which I discuss the overall findings of this project and address its limitations. Here I also make recommendations for future studies on Somali refugees as well as other refugees from non-Western countries and provide concluding remarks on the question of FGC, childbearing and cultures.



Figure:1.1 This image of the “Painful Cake” is accessed at <http://www.ebony.com/news-views/the-swedish-ministry-art-nightmare/2#.UyNJ7blOXVg> accessed 3/13/2014



Figure: 1.2 Image of the Swedish Minister of Culture and the “Painful Cake” is found at <http://jezebel.com/5902672/swedish-official-gleefully-cuts-racist-black-lady-cake-crowd-laughs--laughs> accessed 3/13/2014

Chapter 2

Context and Discourse on Female Circumcision

Across the globe, various forms of human body modifications¹ (see Featherstone, 1995) which include *genital circumcision*² have been practiced by different societies throughout history, conducted “in the name of culture, religion, and concepts of beauty, health, or social status” (Hellsten 2004, 249). Of all these forms of human body modification, genital circumcision of both males and females has endured and spanned across time, traversing many cultures, religions, and geographic boundaries (Hellsten 2004; Johnsdotter and Essen 2010; Wilson 2007; White 2001). In the African contexts, the origins of female circumcision can be traced to ancient Egypt (El Dareer 1983), although some suggest the practice was adopted by the Pharaonic Egyptians from older African practices (see White 2001). Regardless of its origin, it predates Judaism, Christianity and Islam (White 2001). Unlike male circumcision, however, the topic of female genital cutting (FGC) has remained contentious. The issue is about perception of the body, gender, race/ethnicity, and cultures. It has become a global health (women’s health) framed in terms of female sexuality and reproduction, human rights, and migration. Consequently, FGC is a political matter. In the last three decades, the topic of FGC has come under intense international scrutiny, coinciding with the largest influx of African refugees and immigrants to the Western nations (Eyega and Conneely 1997). Hence, what was once a local issue, FGC has become a global concern in the context of south-north migration (see Abusharaf 2006; Breitung 1996; Hernlund and Shell-Duncan 2007; Monahan 2007); engaging interests across all social sciences, health sciences, and

medicine (Shell-Duncan and Hernlund 2001). Shell-Duncan and Hernlund contend that the topic of FGC has the ability to arouse visceral responses unmatched by any other in most people, especially for *outsiders* (2001, 1).

Perception

Perception, according to Merleau-Ponty is rooted in the unconscious or pre-reflective state as well as in the consciousness and reflective awareness of being-in-the-world (see Matthews 2006). Csordas elucidates further by stating that it involves “cultural uses and conditioning of the five external senses plus the proprioception (our sense of being in a body and oriented in space), as well as [...] the inner sense of intuition or sensibility” (1994, 4-5). Essentially, what, why and how we come to perceive the body, our own and others, is culturally shaped. Therefore, perception of FGC depends on the perceiver’s cultural conditioning of being-in-the-world.

The general perception among the *outsiders* of the African female body modification known as female circumcision (FC), also known as female genital cutting (FGC), is disconcerting to say the least; Scheper-Hughes and Lock remind us that the body is more than a physical entity, it is also cultural artifact (1987,19). As a cultural practice, albeit with varying cultural nuances FGC is inscribed on the body. In the dominant Western perspective, the body—the African female circumcised body vis-à-vis uncircumcised body— is symbolically perceived to be defective, dangerous to health and unnatural (Hodzic, 2013; Hernlund and Shell-Duncan 2007; Johnsdotter and Essen,

¹ The terminology and range of practices and discourses around the concept of human body modification are addressed by multiple disciplines and space does not allow for exploring them here.

² The practice of FGC varies by types (amount of tissue removed and ways of closing the vagina).

2010; Njambi, 2004; WHO 2008³). The body is also a metaphor for society (Douglas, 1966; Talle 2007). Societies which practice female circumcision are often viewed or described as: barbaric, primitive, cruel and misogynistic (see Ahmadu 2007; Shell-Duncan and Hernlund 2000; Obermeyer 1999; Walker and Parmar 1993). The sentiment reflected in these and similar adjectives is perhaps best captured by the concept of “mutilation” in Female Genital Mutilation (FGM) which is how the practice of African genital modification is referred to in public discourse. Naming involves a conscious act that gives meaning in the process of embodying (Dewey and Bentley, 1949). As such, women who have undergone this practice are perceived to be the embodiment of defective, mutilated, docile bodies, who are victimized by their backward cultures (see Smith 2011; Abusharaf 2006; Njambi 2004). The backwards cultures implicated here are those of Africans and Arabs as well as the religion of Islam (Gosselin 2000; Abusharaf 2001).

Naming and Classifications

The perception within the communities that engage in the practice of FGC is that it is part of their cultural tradition. FGC is considered no more than “the *habitus* of social life—actions inscribed in the body practice and moral forms, which are reproduced without much further reflection” (Bourdieu 1997). “Mutilation” is not how most of them view female circumcision (Shell-Duncan and Herlund 2001). The term *female genital mutilation* (FGM) was coined by Fran Hosken, a radical western feminist (Boyle 2002). It was then adopted by the World Health Organization (WHO) and other multinational

³ Eliminating Female genital mutilation An interagency statement OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO (2008).

organizations and popularized by international and local anti-FGC activists⁴ (World Bank 2004). The term “female genital mutilation” argues Obermeyer “emphasizes the extent of the operation and maximizes dramatic impact, while concomitantly making a value judgment about the intent of those who carry it out” (1999, 84). Ahmadu and other critics argue that this term does little to advance the global anti-FGC agenda, but does more to stigmatize the people who embody this cultural ‘norm’ (Ahmadu, 2007; Allotey, Manderson and Grover 2001; Joseph and Najmabadi 2003; Gruenbaum 2001; Obiora 1996).

Under pressure from African women campaigning for FGM abandonment and from some Western scholars (Shell-Duncan and Hernlund 2001), the WHO and related interagencies agreed to a compromise on naming this cultural practice. In 2006, the WHO finally admitted that terms, such as “mutilation” and “cutting”, used to designate the practice are still the subject of debate. Citing that some sociologists have expressed that involved parents may resent the implication that they are “mutilating” their daughters; “cutting”, they maintain, is less judgmental and corresponds more to the term used in many local languages. Notwithstanding, the UNICEF, WHO, and other international organizations wishing to retain “mutilation” for its presumed dissuasive connotation, have proposed a ‘slash’ compromise: “female genital mutilation/cutting (FGM/C)” (WHO 2006, No. 7:3). However, “FGM” still prevails in public discourse. In this project, I have made a conscious decision to use the terms excision, circumcision and cutting interchangeably except when quoting from anti-FGM sources. As an *insider*, Fuumbai Ahmadu, an American anthropologist eloquently stated that “[y]ou do not need

⁴ All international declarations and consensus documents, human rights conventions, international agencies and the U.N. General Assembly statements and documents use the term FGM. Most of the Laws enacted by 14 African countries and 10 industrialized countries also use the term FGM. The Inter-African Committee on Harmful Traditional Practices (IAC), which has chapters in all countries with FGM prevalence, re-affirmed the use of FGM during their

to use the term FGM, unless you state explicitly that the M refers to Modification and not Mutilation”⁵.

Female genital cutting/circumcision is a catch-all term referring to a constellation of female genital “modification surgeries” practiced by non-Western cultures (Herlund and Shell-Duncan 2007). According to the WHO and various global health multinational organizations⁶, FGM is defined as the following: “Female genital mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons” (WHO 2008).

A major challenge facing these multinational organizations is how to distinguish and classify the variant types of FGC in bioanatomical terms that would capture the heterogeneity of the practice. At present, “[i]nternational consensus about the classification of the different forms of female genital mutilation has, at this writing, not been reached” (WHO 2006, no 7:3). But this has not deterred their efforts in classifying FGC into four broad categories:

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

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

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

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

FGC Prevalence

International Conference on Zero Tolerance for FGM held in Addis Ababa in February 2003 (World Bank 2004,18).

⁵ http://www.thepatrioticvanguard.com/article.php3?id_article=3752

⁶ OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO

The World Bank (2004) reports that that type I and II FGC accounts for 80% of all FGC across Africa, while type III (infibulation/pharaonic) makes up 15 %. The latter type is most prevalent (80-90%) in Somalia and Sudan⁷. While these classifications are based on WHO nomenclature, the circumcision practice (what is actually cut and/or sewn) itself varies significantly and do not fall neatly into the specified descriptive biomedical categories as advanced by the WHO (Abusharaf 2006a; Ahmadu 2007; Gruenbaum 2001; Obermeyer 1999). Gordon and colleagues (2007), for example, report that a majority of the women with the extreme form of FGC (type III/infibulation) undergoing surgical reversal (defibulation) in a London clinic were found to have an intact clitoris. The authors reported being “surprised” by this finding. Hakim (1999) also reported significant inter-subject variations along the WHO FGC classifications. This suggests that the biomedical FGC classifications are overly generalized, failing to capture the heterogeneity of the practice and without consideration to context, meanings and cultural nuances evident in the variation of practice across time, social milieus, and ethnic group or clan affiliation (Leonard 2000; Shell-Duncan and Hernlund 2001). Among those that practice FGC, these classifications do not make sense (Njambi 2011; Nnaemeka 2005).

Within the cultural groups that practice female genital modifications, the procedures are collectively referred to as *female circumcision* (Shell-Duncan and Hernlund 2001). However, this term conceals the extensive cultural nuances reflected in the local lexicons which vary by the types and associated meanings of FGC practices (Njambi 2011) as evident from Rogaia Abusharaf’s non-exhaustive list of local lexicons for what is generally known in English as female circumcision. She includes “Bolokoli, khifad, tahara, tahoor, qodiin, irua, bondo, kuruna, negekorsigin, and kene-kene”

⁷ The current data on Sudan reflect the entire Sudan, which now is divided into two countries: Sudan and Southern Sudan.

(2006,1). These terms are not only linguistically different but also underscore the differences in meanings. For example, *tahara* is an Arabic word for purification (Abudsharaf 2006b), whereas *irua* is a Gikuyu word for initiation that involves circumcision of both female and males (Njambi 2007). In addition to terms such as *phoronic*, *Sudanese circumscicion* (Gruenbaum, 2001), the terms *Sunna*⁸ and *Tahara*⁹ are often used by Somalis and other Muslim communities that practice FGC (Gruenbaum 2001; Boyle 2002). Both *sunna* and *tahara* are purportedly based on a hadith¹⁰ which forms part of Islamic teachings (Abusharaf 2006b; Gruenbaum 2001; Boyle 2002). Most Muslims scholars agree that the hadith on female circumcision is weak and unauthenticated unlike male circumcision which is considered to be an obligatory practice and predates Islam (Hassanin and Shaaban, 2012). Additionally, there is no mention of female circumcision in the Quran (see also El Bashir 2006; Gruenbaum 2001).

It is important to underscore that FGC is not sanctioned in Islam, evident by the fact that the majority of female Muslims do not undergo this procedure and even among communities where FGC has flourished as “*sunna*” this religious permissibility of practice is increasingly being contested and re-evaluated on religious grounds (Talle 2007; Gruenbaum 2001). For the infibulation (type III), which is more prevalent among Somalis, Sudanese, Eritreans and Ethiopians, there is increasing evidence that those in diaspora are shunning this practice on the grounds that it is “considered to be in opposition to Islamic values” (Johnsdotter 2007,110; see also Abusharaf 2006;

⁸ The Arabic word for the tradition of the Prophet Muhammad. These are his actions, statements, or practices he sanctioned or did not oppose.

⁹ Arabic word for purification.

¹⁰ Hadith is the record of the prophet Mohammed sayings: Hadith have 4 categories: 1. Sahih: The genuine Traditions, the authentic ones. 2. Moothaq: Almost like the Sahih but the narration is not as strong as those of the Sahih. 3. Hassan: The fair Traditions although inferior in matter of authenticity. 4. Dha'eef: The weak Traditions which are not so reliable. <http://www.al-islam.org/articles/al-hadith-analysis-and-overview-hashim-md>

Gruenbaum 2001). That FGC is more of a cultural rather than a religious practice limited to Islam is evident by the fact that it is also practiced by Coptic and other Christian sects, Jews in Ethiopia and by followers of traditional African religions (Gruenbaum 2001,33).

The WHO (1996) estimates that globally 100 to 140 million girls and women have undergone some form of FGC and an additional two to three millions are at risk of undergoing a variety of female circumcision annually. Though the practice has recently taken a global dimension, FGC is mostly associated with African women (DHS¹¹ 2004; World Bank 2004) and has increasingly been linked to Arabs and Islam (El Saadawi 2005; Gordan 1991; Gosselin 2000; Shell-Duncan and Hernlund 2001). FGC occurs in 28 nations in the continent of Africa (across most regions with exception of Southern Africa); however, wide variations are reported across nations and within countries (see DHS 2004; UNICEF 2005). For example, the prevalence of FGC in Democratic Republic of Congo is estimated at around 5% while in Somalia the estimates are as high as 98% (see World Bank 2004). Prevalence of FGC also varies within countries along regional and ethnic boundaries; for example, in Nigeria, FGC varies from 0.4 to 57% between different ethnic groups (WHO 2007; UNICEF 2005; see also DHS 2004). Other variables include religion, education, and wealth quintile of the women; the latter two have an inverse relationship to being circumcised (TDHS¹² 2010; UNICEF 2005). Similar trends are reported across countries that practice FGC in the African continent (see DHS 2004; UNICEF 2005). However, a more recent study by Hassanin and Shaaban (2012) reported that this is not the case among upper class and educated Egyptian women. This study found that educated women were as likely to practice “FGM” as uneducated women. The discrepancy between multinational organizations reports on one hand and local researchers on the other hand needs to be assessed. Obermeyer cautioned against

¹¹ Demographic and Health Survey

¹² Tanzania Demographic and Health Survey

linear interpretations and argued for a more critical investigation of “the relevance of models that assume linear positive correlations among variables such as ‘modernization,’ education, and higher ‘women’s status,’ and expect to find invariant negative associations between these variables and the prevalence of ‘harmful practices’” (1999, 89).

Migration and FGC

A once distant cultural practice confined to Africa has now been transformed into an international human rights and global health issue as a result of global migration (Hernlund and Shell-Duncan 2007; McMichael 2003). The internationalization of FGC is directly linked to the largest influx of African refugees, in particular Somalis seeking refuge in the North America, Western Europe and as far as Australia and New Zealand (Hernlund and Shell-Duncan 2007, LaBabera 2011). Every host country has its official figure of how many Somali refugees have been granted asylum and resettled. For example, the U.S. Office of Refugee Resettlement reports granting asylum to 55,036 Somalis during the period 1983–2004¹³. These figures, however, do not reflect the actual numbers of Somalis who joined their families after resettlement or those born in the U.S to refugee parents. Lehman and Eno estimate there are 150,000 Somali-born living in the U.S. (Lehman and Eno 2003). According to 2009 American Community Survey carried out in Minnesota, the estimate is 28,450, the while other sources have placed the number closer to 60,000¹⁴ of people identifying themselves as Somalis.

¹³

<http://www.cdc.gov/tb/publications/guidestoolkits/ethnographicguides/somalia/chapters/chapter1.pdf>

¹⁴ <http://education.mnhs.org/immigration/communities/somali>

Regardless of the figures, the practice of FGC is ubiquitous among Somali women and girls. As FGC has become established as a global health problem that needs to be eradicated as well as a human right issue, the migration of people from societies that practice female circumcision to the West has provided an additional impetus to enforce the eradication of the practice (Essen and Wilken-Jensen 2003; Johnsdotter 2003; Talle 2007). This is evident by various legislations to criminalize all types of FGC¹⁵ implemented by host countries (see Boyle 2002; Essen and Wilken-Jensen 2003; La Barbera 2009; White 2001). La Barbare points out that the “[a]nti-FGM laws accomplish the ideological distinction between ‘Western culture’ and ‘barbaric traditions’” (2009, 486). In some countries, such as the U.S. the anti-FGM law states: “whoever knowingly circumcises, excises, or infibulates the whole or any part of the labia majora or labia minora or clitoris of another person who has not attained the age of 18 years shall be fined under this title or imprisoned not more than 5 years, or both”¹⁶. Other host nations such as Sweden, Denmark, and the UK have more stringent anti-FGM laws. For example, in Sweden anti-FGM law has no age limit or whether consent is given or not (Essen and Wilken-Jensen 2003; Johnsdotter 2003). Furthermore, on the premise that FGC violates international human rights, the anti-FGM law has ushered (most likely unintended) a number of cases of women seeking asylum based on fear of FGM in their countries (Gruenbaum 2001). The case of Fauziya Kassindja in 1996 provides a watershed moment in which “FGM” was advanced as grounds for asylum seeking in the U.S. Kassindja was granted political asylum based on fear that if she returned to her home country Togo, she will have to undergo “FGM” and will be forced into marriage. Aided by the sensational media images of “FGM”, the legal arguments

¹⁵ <http://cyber.law.harvard.edu/population/fgm/fgm.htm>

¹⁶ <http://mgmbill.org/usfgmlaw.htm>

presented by her lawyers were beyond the plaintive case; Piot posited that it “fictionalized and fetishized Africa as the West’s Other” (Piot 2007,157; see also Kratz 2007).

With the increase flow of African immigrants/refugees to the West, the role of popular media as a source of [mis]information on FGC cannot be ignored. Talle reminds us that we are all too familiar “with the ‘Western’ cum global discourse on female circumcision though the tabloid media—in the press, the radio, and television—where the Somalis and others who perform such operations count as less than human” (2007,101). Such portrayals, argues Talle, only incite cultural discord and sharpen the lines between “us” and “them”. El Saadawi, an Egyptian medical doctor who has been campaigning against FGC, also points to how Africans and FGC are represented as “sensational subjects for discussion” in the Western media (2005, 24). On the other hand, negative media attention on African immigrants/refugees “added urgency to the production of knowledge on female circumcision”, particular among anthropologists (with exception of few), who for a long time have overlooked this human experience (Talle 2007).

The Politics of FGC

The political discourse “as currently formulated, overly homogenizes diverse practices, is locked in a colonial discourse that replicates the ‘civilizing’ presumptions of the past, and presents a universalized image of female bodies that relies upon particularized assumptions of what constitutes ‘naturalness’ and ‘normality’” (Njambi 2004, 282). An historical account of FGC eradication provides a preview of political hegemony of the current discourse on FGC. Perhaps the best avenue to understanding the politics of the FGC body is to understand how this cultural body was disembodied

and decontextualized when first “discovered” by the European conquerors in Africa during which the colonial administrators and the early Christian missionaries aimed to conquer, save, and civilize the African *natives* (Abusharaf 2006; Comaroff 1993; Njambi 2004, 2007).

The history of the female circumcision eradication movement can be traced back to the early 1900’s, when most of the African continent was under colonial occupation (Abusharaf 2006; Hunt 1999; Njambi 2007; Prazak and Coffman 2007; Thomas 2001). Citing historical evidence, Abusharaf points out that “angry reactions towards the practice were frequent, especially in the case of European missionaries, who played an integral role in the work of the ‘civilizing’ colonial apparatus” (2001, 114). In the eyes of the colonial enterprise “the savage natives were the embodiment of dirt and disorder” (Comaroff 1993, 306) and needed to be disciplined and tamed (Hunt 1999). From the African “natives” perspectives, “female circumcision was largely seen as a revered rite rather than a senseless act devoid of meaning or significance” (Abusharaf 2001, 114). The current political discourse on FGC has its roots in the eradication efforts that began in the British colonial Sudan (see Abusharaf 2006a, 2001b; Gruenbaum 2001) and Kenya (Njambi 2007; Thomas 2001).

In Sudanese society, historically and now, female circumcision, locally known as *tahara* signifies many things; first and foremost, *tahara* means purification of the body, which implies the body is polluted and performing *tahara* removes bodily impurity (see Douglas 1966). Female circumcision is also deeply embedded in ethnic identity, gender and social roles (see Gruenbaum 2001). In the context of Sudan, for example, some tribes adopted female circumcision as means to ethnically integrate to the larger Sudanese society (Gruenbaum 2001, 106). Abusharaf, a Sudanese born anthropologist

and an activist in ending FGC provides an *insider's* perspective noting that FGC is performed “on the grounds that it creates and reinforces femininity, is aesthetically pleasing, shows respect for tradition, inscribes gender, controls and enhances sexuality, and attests to religiosity”(2006, 215).

When the British colonial¹⁷ administrators first encountered the practice in Northern Sudan, they were horrified; they considered the circumcision of the colonized female bodies “as one of the major social problems” they had to deal with (Abusharaf, 2006, 214). Thinking that the only means to stop this tradition was to criminalize it, they eventually drafted a punitive law banning the practice of infibulation in 1946 (Abusharaf 2006; SDHS 1990) as means to “save” the Sudanese girls and women from their barbaric uncivilized traditions which victimized them (Abusharaf 2006). The ban gained public support in England, especially among the British feminists who believed it was a necessary step towards gender equity (Abusharaf 2006). They perceived female circumcision “as an embodiment of evil, barbarism and unjust treatment of women” (Abusharaf 2006, 223). The British prohibition law was, therefore, meant to liberate and modernize Sudanese women, but as pointed out by Abusharaf, the law in actuality undermined female emancipation and women’s role in ending female circumcision in Northern Sudan:

From the outset, the British attributed the continuation and enforcement of the practice of circumcision to female sadism, which they found extremely alarming. The notion that women rather than men had considerable power in determining whether a girl or woman undergoes circumcision was so threatening to their sense of gender order that the British felt obligated to stamp it out root and branch. In medical reports, meetings and letters exchanged on the subject there was a pronounced consensus that this form of female cruelty should be combated with the help of Imams, Omdas¹⁸ and Nazirs¹⁹—that is, with the collaboration of men who ranked high among colonial subjects (2006, 217-8).

¹⁷ The British begun ruling Sudan in 1898 (see Abusharaf 2006).

¹⁸ Village elders—men.

¹⁹ Public officials.

The deployment of Sudanese elite men to support and enforce the ban on female circumcision meant that Sudanese women were placed under total control of men, or as Abusharaf posited, “decentralized despotism’ in which males, mayors and religious leaders played central roles in surveying a domain that traditionally had been controlled by women. “Female kin, traditional birth attendants, and midwives were criminalized and had to confront men’s systematic scrutiny of their activities at every turn” (2006, 218-9). Despite these heavy-handed restrictions and punitive laws against female circumcision, the British colonial establishment failed to eradicate the practice. Infibulation continued to be performed, albeit with some modification. A less severe version known as *Matwasat*²⁰ that is an intermediate between infibulation and *sunna* circumcision was adopted though the Sunna and infibulation continued to be practiced, though the latter to lesser extent (Abusharaf 2006; El Deera 1982, Islam and Uddin 2001; SDHS 1990).

Abusharaf contends that the British and the Sudanese perceptions of female circumcision become increasingly irreconcilable, culturally speaking (2006). It is one thing to pass a law and another thing to enact the law. It might have aimed to invest power in men but not all men were coopted. This was evident when a university male student organized a protest against a six month jail sentencing of the traditional birth attendant for performing female circumcision (El Bashir 2006). For the ordinary Sudanese subjects, the ban signified another form of imperialist intrusion and oppression, “which emerged as a site of emotionally charged cultural wars that acquired nationalist significance (Abusharaf 2006, 224). The British colonial anti-FGM law in Sudan was intended to eradicate female circumcision, but instead, it led to an intense

²⁰ *Matwasat* varies greatly, but generally entails removal of the clitoris, anterior parts or all of the labia minora, and some or all of the labia majora. The two sides are then stitched together as in

resistance movement to colonial domination (Abusharaf 2006, 224). The movement became known as the “Circumcision Revolution” (El Bashir 2006, 143).

In Kenya, the British colonizers and Christian missionaries were equally mortified by the *natives*’ practice of female circumcision and denounced the practice as “barbaric” (Thomas 2001). Unlike Sudan where the British found Islam was already an established religion, in Kenya most of the people (except the coastal regions) followed traditional religion and customs. The spread of Christianity in Kenya as in most parts of Africa²¹ is traced to European (in case of Kenya, mainly British) colonial era (Comaroff and Comaroff 1986; Robert 2000). The British colonial administrators found female circumcision being practiced by several Kenyan tribes including the Kikuyu, Kisii, and Masai among others. They varied in the types of excisions they practiced and the sociocultural meanings associated with that (KDHS²² 2008-9). Among the Kikuyu of Meru, for example, female circumcision is considered an initiation and a rite of passage by which girls are transformed into women (Njambi 2007). It is a prerequisite for marriage and procreation and it ensures fertility, pleases the ancestral spirits, and changes “mothers of initiates into figures of authority within the community” (Thomas 2001, 131).

In the context of the global discourse on “FGM” in which the heterogeneity of female circumcision is not acknowledged, it is important to note that infibulation²³ was not part of the female circumcision encountered by the British colonial establishment in interior Kenya. The chronological analysis of the female circumcision ban in colonial Kenya by Thomas (2001) provides another important insight into the current political discourse on FGC. The Christian missionaries were precariously positioned between

the pharaonic form, but the opening left may be slightly larger (see Sudan DHS 1990:117). Islam and Uddin described Matwusat as equivalent to WHO’s type II category of FGM.

²¹ Ethiopia and Egypt are an exception.

²² Kenya Demographic and Health Survey

serving the interest of the natives and balancing and advancing the colonization agenda vis-à-vis the church agendas (Hunt 1999; Comaroff 1993). Part of missionary work involved providing biomedical care to the “natives”—particularly attending to childbirth (Hunt 1999; Thomas 2001a). Female reproduction was a central concern to the colonizers in Africa since having free African labor in the fields was essential to advance industries in Europe (Hunt 1999). In this position, the missionaries described female circumcision as “sexual mutilation” that diminished sexual passion and by implication interfered with sexual reproduction. In calling to outlaw it, however, the emphasis was on the medical consequences (Thomas 2001a, 96). Linking female circumcision to female sexuality and reproduction afforded them legitimate and credible concerns as motives in opposing female circumcision. Arguing that female circumcision impedes reproduction and contributes to infant and maternal mortality, the missionaries’ assessment “resonated with colonial officials’ concern with low population growth rates in East Africa” (Thomas 2001a, 96).

As a result, by 1925 to 1927, the health risks of female circumcision provided the motive to convince a selected number of local Kenyan men who were given measured authority under the jurisdiction of the British commissioner to pass a resolution restricting the practice by requiring the girls’ consent, registration of all female circumcisers some of whom were even issued circumcision instruments, and by limiting the extent of genital tissue removed (Thomas 2001, 132). This move by the British colonial administrators was not enough to placate neither the missionaries, nor the British public back home and certainly not the British feminists (Thomas 2001). Disappointed by the lack of stringent colonial law to eradicate female circumcision, the missionaries in Kenya tried to use Christianity as a tool to eradicate the tradition; in

²³ Somali Kenyans are more likely to practice infibulation.

1930 converts were required to sign a statement of loyalty where church membership was contingent upon abandoning female circumcision (Thomas 2001). However, the decree was soon rescinded when the missionaries were confronted with a precipitous drop in the number of converts within a few weeks (Thomas 2001).

As was the case in Sudan, colonial eradication efforts were resisted by the “natives”. Debates and contentious measures were initiated by colonial establishment inside Kenya and in Britain to eradicate female circumcision, but the local Kenyan women were excluded from the debate. Yet, it was a well-established fact that the domain of initiation rite was controlled by authoritative women known as *kiama giano* (council of entering) (Thomas 2001: 136). When the ban was finally passed in 1956, Kenyan young women rebelled by circumcising themselves and each other; this female led rebellion became known as *Ngaitana* (Thomas 2001). Thomas (2001) points out that the *Ngaitana* rebellion cannot be separated from the Mau Mau²⁴ uprising against the British rule. The colonial law banning female circumcision was, therefore, culturally resisted and politically contested (Gosselin 2001; Presley 1992; Wangila 2007). Christoffersen-Deb details how the history of female circumcision in Kenya evolved, “from colonial attempts at purifying the body in the building of an empire; to the appropriation of the practice within the discourse of the independence movement; to its political significance during Kenya’s development as a modern secular state” (2005, 224).

Despite geography, types of female circumcision, and the socio-cultural meanings attached to the practice, the eradication efforts in Sudan and Kenya have much in common in terms of how the practice was viewed and the steps taken against it. In both cases, the *outsiders* (the British colonial establishment and the European feminists)

perceived female circumcision as an embodiment of backwardness or evil and deployed a few local hand-picked men to assist in the eradication agenda while local women were excluded. In the context of British Sudan, Muslim clerics were instrumental in propagating anti-FGM laws (see Abusharaf 2006; Ahmed 2006), in Kenya the church authorities were also actively engaged in eradicating “FGM” (Thomas 2001). In this sense, both religions were used as coercive forces to justify banning female circumcision. Another similarity in both countries is that local resistance to the ban figured prominently in the political struggles against colonial occupation. Abusharaf argues that one important caveat that was overlooked by the British colonial establishment in its eradication process was the significance of the female body in national identity. She notes that:

women’s bodies as signifiers of the nation lies in the province of the emotions. Emotions of honor and shame that society affixes to women are extended not only to recreate women as custodians of morality in the private domain, but also to inscribe notions of morality on them in public. Women become a microcosm of the nation, the quintessential core of moral value the nation strives to safeguard, through the medium of indigenous authenticity deeply etched on their bodies. From a nationalist standpoint, women have to be controlled to make the nation possible—just as, from a colonialist standpoint, women’s power must be circumscribed, their bodies governed, to inscribe colonial rule (Abusharaf 2006, 224).

The irony is that the language and arguments presented by the European colonizer and Western feminists have not changed in the past 100 years; they continue to be applied in the current anti-FGM discourse (Abusharaf 2006). Both Kenya and Sudan governments currently support the eradication of female circumcision, though in the case of Sudan, “FGM” is not criminalized (SDHS 1990). In Kenya, on the other hand, female circumcision is considered “a criminal and prohibitive act” (Christoffersen-Deb 2005, 404). Despite the criminalization of the practice, female circumcision is still

²⁴ The Mau Mau was a militant African nationalist movement active in Kenya during the 1950s whose main aim was to remove British rule and European settlers from the country.

prevalent among Kenyan women, though according to Kenya demographic and health survey (KDHS, 2008-9) the number of women who are circumcised indicates a declining trend. Furthermore, in Kenya medicalized female circumcision is increasingly being practiced. This new trend is happening in many countries (Christoffersen-Deb 2005; Njue and Askew 2004).

The Medicalization of FGC

Studies on the history of medicalization of FGC are scarce (Christoffersen-Deb 2005; Njue and Askew 2004; Shell-Duncan et al 2005), but van de Kwaak (1992), Boddy (1998) Thomas (2001), and Christoffersen-Deb (2005) suggest that some attempts to do so took place in the colonial and post-colonial era in Africa. It is now the preferred method among younger circumcised women and girls compared to older ones (Njue and Askew 2004; Seror 2013) as medically performed FGC is increasingly taking place in many Sub-Saharan African countries as well as in Egypt (DHS 2004). Christoffersen-Deb, a Canadian obstetrics and gynecology physician who worked in Kenya posits that “[t]he introduction of health workers in the performance of the practice has added a new dimension to the debate, as the ‘right to health’ argument forwarded by those that campaign against female circumcision is asserted by those that advocate the performance of the practice by medical personnel” (Christoffersen-Deb 2005, 403).

With the medicalizations of many conditions including pregnancy and childbirth, in due time, it was inevitable that FGC too would be medicalized especially among the more affluent, educated, and urbanites-across all religious (Christians, Muslims, and Traditional) affiliations (Chege et al. 2001; El-Gibaly et al. 2002; El Shawarby and Rymer 2008; Njue and Askew 2004; Manderu 2001; Orubuloye et al.2001).The practice is now carried out by biomedically trained health providers either in medical settings

(public and private clinics or hospitals) or in homes (Njue and Askew 2004).

Medicalization is aimed at lessening the deleterious health effects including infections from unsterile tools and methods that can cause tetanus, septicemia and HIV; shock and severe pain which can result to further complications such as urinary retention; injury to the vagina, the urethral or rectum and sometimes even death (Interaagency 2008²⁵; Reyners 2004; Shawarby and Rymer 2008).

There are divergent opinions as to why FGC medicalization has taken roots in Sub-Sahara Africa. Tobi and Sharief (2003) suggest that the medicalization of FGC may have evolved “as unintended consequences” in response to the anti-FGC campaigns which emphasized health risks and highlighted the extensive list of short term health consequences (as mentioned above). The WHO²⁶ concurs with this assessment, indicating that the dramatic increase in medicalization of FGC can be attributed to the adverse health consequences emphasized in the eradication campaigns. Alternative explanations are that biomedical staff who carry out female circumcision do so for personal monetary gains (Njue and Askew 2004; Sour 2013) and/or from social pressures to serve their communities (Sour 2013; WHO 2008). While these might be factors, the most compelling reason is simply the harm-reduction argument (Christoffersen-Deb 2005; Njue and Askew 2004; Shell-Duncan 2001). The Harm-reduction approach, as explained by Shell-Duncan (2001) has been well-grounded in the field of public health for the last two decades. The aim of this approach is to seek alternative and practical options that can be implemented to mitigate identified public health risk behaviors²⁷. The hallmark of this approach is first and foremost to facilitate

²⁵ Eliminating Female genital mutilation An interagency statement: OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO 2008.

²⁶ http://www.who.int/reproductivehealth/topics/fgm/fgm_trends/en/

²⁷ Harm reduction is an approach rooted in public health and human rights. It aims to improve the lives of people who are affected by drugs or drug policies through evidence-based programming.

safer alternatives to whatever human activities that are deemed to be dangerous to health, but is not limited to total abstinence (Shell-Duncan 2001, 1014). Christoffersen-Deb (2005) posits that though the current harm-reduction strategy may seem like a novel paradigm shift to FGC, it is not new. Medicalization of FGC can be traced far back to the 1920s and 30s, at that time European colonial establishment saw medicalization “as pragmatic responses by health personnel to the practice of female circumcision” (2005, 405).

There are several sources, including media such as YouTube, which provide graphic and viscerally disturbing images of female circumcision “surgeries” depicting young girls being held down, screaming as they lie on dirt grounds in the bushes of Africa, and undergoing genital “mutilation” with crude instruments. Graphic images of female body modification such as breast augmentation, face-lift, and even vaginal rejuvenation surgical procedures are also readily accessible (including on YouTube). But unlike the former, the females undergoing the “surgeries” are subdued, motionless, as they lie on well-lit sterile rooms and attended by medical professionals. Besides the age difference (girls vs. women), the most salient contrast between the images of these body modifications “surgeries” is the two physical environments and methods of practices: dirt floors, unhygienic instruments, no “medical” anesthesia—versus—sterile field with modern instruments and anesthesia.

On the harm-reduction argument, the medicalization of FGC means the likelihood of infections are lessened; risk of hemorrhage is reduced; and pain is controlled (Christoffersen-Deb 2005; Njue and Askew 2004, 3). According to Njue and Askew (2004), healthcare practitioners think medicalization is also changing the practice FGC from a more extensive removal of genital tissue to a more symbolic form of

“psychological circumcision” whereby the clitoris is pricked or nicked and sometimes a small amount of blood is drawn without any cutting (Njue and Askew 2004). In these cases, biomedical health practitioners who perform FGC and the women circumcised under medical supervision report that the amount of tissue removed is less than would have been removed by traditional circumciser. In addition, the study notes that even when FGC is practiced by traditional circumcisers, many health personnel “particularly the female nurses, reported being approached for tetanus toxoid injections to use after the cutting” (Njue and Askew 2004, 3).

Shell-Duncan (2001) passionately argued for medicalization of FGC to reduce the immediate harms associated with the practice and as an intermediary step towards eradicating it. The author cited how strategies in public health have been applied to reduce health risks to individuals and the society at large offering the example of distributing clean needles and providing motel rooms to replace “shooting-alleys” for drug users in order to reduce risk of HIV/AIDS infections. The author also cited public school-based condom distribution and educational programs as means to reduce teenage pregnancies rates and at the same time prevent sexually transmitted disease (STD). These harm-reduction strategies save lives without condoning the behaviors of individual actors; therefore, harm-reduction strategies are rational and ethical responses (see Marllatt 1998; Ruderman 2013). Shell-Duncan hypothesized that medicalization reduces health risks in the women by “ (1) reducing risk of attendant medical complications by improving hygienic conditions, preventive medical measures, and/or skill level of the cutter, and (2) reducing the amount of cutting, and presumably risk of complications” (2001, 1014). Deemed as a global health problem that has proven hard to contain and eradicate, the moral and ethical responsible move is, goes the argument, to

reconsider harm-reduction by the global health players (Ruderman 2013). As Mark Twain said:

Habit is habit and not to be flung / out of the window by any man, but / coaxed downstairs a step at a time

“Zero tolerance” of FGC

Not everyone, however, sees medicalization as a positive step. Anti-FGC advocates see it as a move that will legitimize the practice and will undo achievements they have made through the years. Most importantly, it will undermine the effort towards total eradication of the practice (Shell-Duncan 2011). The global health players such as the WHO made their position clear that it will not tolerate any form of medicalization of the practice (WHO, 1982). This position was echoed by other influential global health agencies and organizations such as the: International Federation of Gynecologists and Obstetricians (FIGO), American College of Obstetricians and Gynecologists (ACOG), the United Nations International Children's Emergency Fund (UNICEF), and the American Medical Association (AMA), United State Agency for International Development (USAID), United Nations Programme on HIV/AIDS (UNAIDS), United Nation Human Rights, United Nation Development Programme (UNDP), United Nations Educational, Scientific and Cultural Organization, The United Nation Refugee Agency (UNHCR), Economic Commission for Africa. Other international and local anti-FGC activist's²⁸ voices cannot be ignored as they are all supporting a “no medicalization” stance; under tremendous pressure African heads of states endorsed the mantra (Shell-Duncan 2001). For example, in 1994 the Egyptian government allowed medicalization of FGC briefly, but due to global pressure it retracted its support to conform to the global health stance on FGC (Seror 2013).

²⁸ There are hundreds of local and international organizations working to eradicate FGC across the globe.

The powerful and influential stakeholders in the anti-FGC movements have invested resources including time and money in the last 30 to 40 years towards eradication of FGC in all forms regardless of the lived-realities of people and meanings attached to the practice. On February 6, 1993, the United Nation (U.N.) designated and sponsored its “Zero Tolerance to FGM” campaign; for the last 10 years this date is commemorated to heighten global awareness of FGC with the explicit goal of total eradication, sealing the impasse on the medicalization of FGC discourse. Despite the failure to eradicate FGC, the eradication stance lobbies remain the only acceptable course of action to this global health problem in the eyes of the most powerful global health players.

Global Campaign to Eradication FGC

“global campaign’: an international movement with the aim of creating and enforcing universal norms defining alterations of the female genitals as fundamentally intolerable” (Shell-Duncan 2008, 225).

The eradication efforts on female circumcision have a long and contentious history spanning at the least over the last 100 years (Shell-Duncan 2008). In the late 1970s through the 1980s, the global campaign to eradicate FGC was framed as intolerable, harmful cultural practice. By the 1990s, it morphed into a global health concern (Christoffersen-Deb 2005; Hernlund and Shell-Duncan 2007). The emphasis on health risk, argued Boyle (2002 cited in Hernlund and Shell-Duncan 2007), was to legitimize the international eradication movement, without seeming to appear as outsiders interfering with national sovereignty. This masquerade was necessary in the historical context of colonialism in Africa (Hernlund and Shell-Duncan 2007, 13). Gradually, however, the health argument fell out of favor. Hernlund and Shell-Duncan pointed out that there were several reasons accumulated to discredit the health risks

stance (2007). For one, the social and cultural significance of FGC took precedence over the risks which they were well aware of. Secondly, the anti-FGM movement over-exaggerated the health risk which undermined their credibility (also see Ahmadu 2000; Boddy 2007; Hastings Center Report no. 6 2012). Thirdly, the FGM eradication campaigns failed to consider the lived-experiences of the people in the context of sociocultural milieu (Hernlund and Shell-Duncan 2007).

In 1995 a joint statement issued by major international organizations including WHO and other UN bodies (UNICEF, UNFPA, and UNDP) on FGM conceded that the health risk argument was a mistake and a misguided counterproductive effort (Boyle, 2002 cited in Hernlund and Shell-Duncan 2007, 14). Consequently, the discourse shifted from one of opposing FGC on health grounds to one framed under the rubric of human rights violation (see Gosselin 2000; Hernlund and Shell-Duncan 2007; Nnaemeka 2005; Shell-Duncan 2008). This paradigm shift, however, does not mean that the health argument was abandoned; in the globalized world, health is increasingly being defined as a “human right” (Lock and Nguyen 2010). The global health discourse continues to play a central role in the overall anti-FGC campaign (Magoha and Magoha 2000; WHO 2008), although the scientific evidence is inconclusive as to who is at risk, why, how, and what constitutes FGC health risk and under what circumstances (DHS 2004 No. 7; Obermeyer 1999, 2005).

Lack of consensus on health risk on FGC has not changed the fundamental ideology from which the discourse on FGC continues to be framed as a health risk; in large part, this is because biomedicine, which is a powerful ideological force, shapes how the body is viewed (Johnsdotter and Essen 2010; Obermeyer 1999). However, this view is not universally shared, and as such, the biomedical healthcare providers’ views on FGC may have nothing to do with health risk per se, but may in reality be based the

ideological values which shape their perceptions of this body as the “other” (Hernlund and Shell-Duncan 2007). Insofar as scientific evidence is lacking on FGC health harm, then what is it about this bodily being-in-the-world that deemed its existence as the “other”? This raises moral and ethical questions that are inherently ideological by nature (see Johnsdotter and Essen 2010).

“The Pot Calling the Kettle Black?”

The term “mutilation” does not escape the legacy of cultural imperialistic colonial gaze which perceived non-Western cultures and traditions as savage, immoral and backwards (Boddy 2007a, in Hernlund and Shell-Duncan 2007; Hunt 1999; Njambi 2004). This ethnocentric view is saliently evident now as more and more affluent Westerner women are participating in various body modification “surgeries” that include—face lifts, breast augmentations, labia, vulva, and clitoris custom surgeries among others (Braun 2005; Goodman 2009) Most all of these plastic surgeries are undertaken on cultural and social grounds which are rarely medically indicated (Allotey et al. 2001; Liao and M Creighton 2007). Gunning, a law professor, has adopted the term “female genital surgeries” to draw attention to the similarities between the two (1991, 25). After all, both of these “surgeries” whether performed in the African bushes or in prestigious Manhattan plastic surgery offices – are based on cultural and social values – rather than medical necessities (Gunning 1991, 25).

However, I concede that there are some differences, such as age which is related to issues of consent which is also a Western concept (Boddy 2007a, 2007b). Yet, when it comes to body modification or cosmetic surgeries in the West, age and individual consent are not considered to be relevant as pointed out by Zuckerman and Abraham (2008). These authors report that in 2005, more than 333,000 cosmetic procedures,

mostly breast augmentations and liposuctions were performed in patients 18 years of age or younger in the United States (Zuckerman and Abraham 2008, 318). Then why is age of consent not applicable to American teenagers but is an issue of contention when it comes to African teenagers undergoing body modification such as FGC? The answer to this rhetorical question perhaps has to do with the debate between universalism and cultural relativism, as “FGC repeatedly emerges as a ‘test case’ for the limits of the latter” (Hernlund and Shell-Duncan 2007, 7).

In the chapter titled *Changing Rights and Changing Cultures*, Merry (2001) describes the difference between universalism vis-à-vis cultural relativism. She described the former concept rooted in European notion of individualism and rights that emerged in the Enlightenment era, which gave rise to the transnational organizations such as the UN, WHO and other organizations. Whereas cultural relativism is based on consideration for cultural differences, central to both concepts is culture. This concept—culture—which once assumed that cultural group members equally shared beliefs and behaviors is no longer valid (Lock and Nguyen 2010). Rather, current anthropological views of culture recognize it “as historically produced, globally inter-connected, internally contested, and marked with ambiguous boundaries of identity and practice” (Merry 2001, 41). Merry attests that in the last fifty years, universalist human rights has evolved to encompass some aspects of cultural rights (Merry, 2001, cited in Hernlund and Shell-Duncan 2007, 8). FGC as a cultural right, however, has not been part of this evolution. As Essen and Wilken-Jensen point out that “the most common reaction to FGC in a Western country is one of disgust and rejection” (2003, 683).

The irony is in the West, the vagina rejuvenations “surgeries” known as “designer laser vaginoplasty” and “laser vaginal rejuvenation” (Conroy 2006) or euphemistically

referred to as “*designer vaginas*” (see Herndlund and Sheel-Dincan 2007, 19) are increasingly gaining popularity among women in the Western societies. Conroy (2006) also point out the difference in the trend of female genital surgeries, while “female genital mutilation” is on a decline among women from the so-called “undeveloped world”, the opposite is true in the “developed” parts of the world. Although “designer vaginas” are not ubiquitously practiced, as of yet, Western societies at large have not expressed the visceral revulsion to these “surgeries” in any sense that is comparable to female circumcision “surgeries” as practiced by non-Western women (Allotel et al. 2001). Sheldon and Wilkenson (1998) argued this can be interpreted as racism; whereas Essen and Johnsdotter (2004) plainly call it a double-standard of Western morality.

Male Circumcision

Arguments of double-stands or cultural relativism are likewise being raised in regards to male circumcision vis-à-vis female circumcision in the West (Hellsten 2004). The premises of these arguments challenge the same prevailing anti-FGM discourse on female circumcision. For one, it violates the notions of consent, since the practice is often carried out on infants or young boys. Second, male circumcision as in female circumcision violates body integrity that results in permanent alteration of the genitals. Third, both are performed on cultural or religious grounds. Fourth, they can cause pain, may harm health and can even in rare occasion cause death (ibid. 2004). Finally, circumcisions of male and or female are not medically warranted but are routinely carried out on infants in hospitals (Alanis and Lucidi 2004).

Proponents of male circumcision have reacted strongly by invoking sentiments on freedom of religion, especially from the Jewish and Muslim faiths. This is evident by the recent German law that called for its abolition after a four year old suffered from

hemorrhage after being circumcised by a German doctor, in Cologne (Paramaguru 2012²⁹). Both the Jews and Muslims in Germany contested this propositional ban (Jordans 2012). The German historical legacy with the Jews played a significant part in the failure to pass this law in the parliament. Speaking to Paramaguru, a reporter from Time News, an American Anti-Defamation League representative commented on the proposed anti-male circumcision stating “that while the ruling did not appear to take an anti-Semitic slant, its effect is to say, ‘Jews are not welcome’” (Paramaguru 2012).

Unlike the female counter part, male circumcision (MC) has historically been accepted without much controversy (Darby and Svodoba 2007), simply known as “male circumcision.” The title on Bell’s article *Genital Cutting and Western Discourses on Sexuality* (2005) draws attention to the fact that *only* female circumcision is singled as harmful practice that violates ethical issues of consent and children and women’s right as chartered by the U.N. (Bell 2005). According to Bell, the reasons used by the international communities and organizations to condemn FGC practices do not appear to be any different than how MC is practiced in Western societies. Yet, “little attempt has been made to explore precisely *why* international opinion remains largely hostile to female genital cutting and indifferent to the male operations” (Bell 2005, 128).

The counter argument that favors MC while condemning FGC is based on balancing health risks and benefits³⁰ (see Alanis et al. 2004; Bailey et al. 2007; Boyle and Bensley 2001; Morris 2007; Short 2004; Tobian et al. 2009; Weiss et al.2000). The global health perspectives on male circumcision are that it is seen as a prophylactic measure. The 2008 WHO interagency report states in unambiguous terms that MC has

²⁹ Paramaguru is a reporter with Time News Outlet article published on June 29, 2012
^{30a)}http://www.hopkinsmedicine.org/news/media/releases/declining_ratesof_us_infant_male_circumcision_could_add_billions_to_health_care_costs_experts_warn b)
http://www.cdc.gov/hiv/pdf/prevention_research_malecircumcision.pdf

been shown to lower risk of HIV infections- especially in Sub-Saharan Africa where the rates of HIV are high (WHO Interagency 2008). A meta-analysis study conducted by Weiss, Quigly, and Hayes (2000) concluded that: “The data from observational studies provide compelling evidence of a substantial protective effect of male circumcision against HIV infection in sub-Saharan Africa, especially in populations at high risk of HIV/STD” (Weiss et al. 2000 2369). Tobian and colleagues study came to similar conclusion; in addition, their study investigated sexually transmitted diseases (STD) primarily focusing on Herpes simplex virus type 2 (HSV-2), human papillomavirus (HPV) and syphilis. They report a significant reduction in the HSV-2 and HPV in circumcised males compared to uncircumcised males but not in syphilis (Tobian et al. 2009). Morris sums the current sanctity of male circumcision, “[c]ircumcision of males represents a surgical ‘vaccine’ against a wide variety of infections, adverse medical conditions and potentially fatal diseases over their lifetime, and also protects their sexual partners. In experienced hands, this common, inexpensive procedure is very safe, can be pain-free and can be performed at any age. The benefits vastly outweigh risks” (Morris 2007, 1147). The notion that male circumcision should be exempted from any scrutiny in terms of its practice being “different” from FGC is questioned by many (see Hutson 2004; Boyle and Bensley 2000; Shell-Duncan 2001; Hammond 1999). None-the-less, unlike FGC, male circumcision is secularized, sanctioned and biomedicalized (Bell 2005; Darby and Svobodo 2007; Hammond1999).

Literature Reviews on Health Consequences of FGC

The health consequences of FGC read like “a laundry list” (Shell-Duncan and Hernlund 2001). Though it is a well-known and established fact that female genital modification “surgeries” are not monolithic in any sense, they are often lumped together

as if they are indistinguishable (Shell-Duncan and Hernlund 2001). Only recently (see WHO 2008,2004; WHO 2006 no.7) have the global multinational organizations attempted to distinguish the health risks according to the severity of “surgeries”. Infibulation is singled out as one of the most severe forms of FGC and accordingly carries the most health risks (WHO 2006). It is important to restate that infibulation or type III accounts for only 15% of all FGC

However, most literature on FGC, especially those generated by anti-FGM researcher and in some epidemiological studies fail to distinguish or tend to conflate the health risk across all forms of FGC. Risks are classified as short-term, long-term and psychological and sexual health risks all the while disregarding the types of the circumcisions or the contexts in which they are carried out (Ahmadu 2004; Shell-Duncan et al. 2004).

As noted earlier, short term health risks include, but are not limited to, pain, hemorrhage, local and systemic infections, shock, urinary retention, and death. These risks are applied across all types of FGC (Shell-Duncan and Hernlund 2001; WHO 2008, 11) though the prevalence, incidence and severity of these health risks remain unknown (Obermeyer 2005) and are highly exaggerated³¹. These potential health risks are more likely to manifest when the circumcisions are carried out in unhygienic circumstances by traditional circumcisers, who have no access to anesthesia and limited knowledge of anatomical and physiological functions of human body (van de Kwaak 1992). It has been documented that circumcisers tend to reuse the same tool to perform circumcision on several girls without even rudimentary sterilization techniques thereby increasing the likelihood for infections (Hakim 2001; Shell-Duncan et al. 2001). This is precisely the reasons used by those who argued for harm-reduction strategy (see

³¹ Hastings Center Report, no. 6 (2012): 19-27.

Rosario et al. 2013; Shell-Duncan et al. 2001, 2000) but whose arguments have been overshadowed by powerful global multinational³² and international organizations whose goal is to eradicate FGC.

The long term health risks include: urinary tract infections, abscesses, genital cysts, neuromas, keloid scarring, chronic pelvic inflammatory disease, dysmenorrhea³³, and hematocolpos³⁴. It is also reported that FGC can cause infertility (Almroth et al. 2005). Obstetric complications may include stillbirth, prolonged or obstructed labor³⁵, excessive bleeding³⁶, perineal tears³⁷, and other neonatal complications (WHO 2006). The third category of health risk includes a cluster of psychological traumas, dyspareunia³⁸ and diminished sexual pleasure. As far as sexual pleasure impairment and FGC, the current studies are inconclusive at best (see Berg and Denison 2012; Catania et al. 2007; Obermeyer 2005; Okonofua et al. 2002; Paterson et al. 2012).

These protracted health risks is what Shell-Duncan and Hernlund referred to as the “laundry list” (2001, 15). The authors posit that these health risks are the cornerstone of global health anti-FGC campaigns which are often repeated; yet, “little attention is devoted to considering the original source of this information” (2001, 15). Most of what is currently considered as health risks are based on the assessments of British colonial physicians 70 or 80 years ago (Shell-Duncan and Hernlund 2001). In 1999, Obermeyer

³² WHO, World Bank, UNDP, UNESCO, UNICEF, UNHCR, to name a few.

³³ Painful menstruation linked to infibulation.

³⁴ Accumulation of menstrual fluid in the vagina—typically associated with women/girls who are infibulated (type III).

³⁵ Prolonged does not necessary mean obstructed labor. The latter is associated with recto-vaginal fistulae in condition that damages the tissue between the vagina and the rectum and or the urethra, resulting in fecal and or urinary incontinence, as well as stillbirth. A devastating maternal morbidity condition with sever social, cultural, and economic consequences for the patient and her family.

³⁶ This is usually associated with defibulation, whereby the infibulated scarring is surgically opened to allow birthing process.

³⁷ Perineal tearing is also associated with infibulation, either due inadequate or lack of defibulation and loss of elasticity due to scarring.

³⁸ This is a condition associated with pain penetrative sexual intercourse- due scar formation or more frequently as from infibulation.

took up the task of sorting out facts from sensational fiction. As an anthropologist-demographer, she conducted a comprehensive literature review of these health risk claims. She concluded that, though there is ample information regarding the harms of FGC, evidence to support these harmful consequences of FGC is scarce. One of the major short-falls of the reviewed studies (a total of 30) pointed out by Obermeyer (1999) was the lack of rigorous scientific design methods in many of these studies. Obermeyer's findings did not prompt a reconsideration of the "laundry list" of health risk; rather, I argue it did influence how subsequent and current study designs and methods are carried out. For the purpose of this study, I conducted pertinent literature reviews of recent studies on FGC and adverse childbirth; the summary of these studies and findings are briefly discussed below and can be found in appendix C.

Hakim's (1999) study was based in Ethiopia, a country with high prevalence of FGC. Here, the majority of the sample observed had type II (86.1%), whereas type I and III accounted for 12.6% and 1.3% respectively. The author reported that perineal tears (without episiotomies³⁹) occurred 13.9% in FGC as compared to 7.8% non-FGC cases. Women with FGC had significant prolonged second stage labor, but no differences were observed in the first and third stage with non-FGC women. Rates and/or differences in cesarean birth were not reported. There was no difference in the perinatal mortality between the two groups. Hakim concluded that FGC has an adverse impact on the soft tissue (perineum) that complicates childbirth but does not seem to affect neonatal outcomes when compared to uncircumcised women. In general, circumcised women were more likely to have complicated deliveries compared to uncircumcised cohorts (5%). The childbirth complications were dependent on the type of circumcision. In women with type I, 18% had childbirth complications compared to 30% and 36% in women with

³⁹ All episiotomies were medio-lateral (sideways).

types II and III respectively. Apart from increased likelihood of perineal injuries associated with severity of FGC types, Hakim's (1999) findings are not supported by the most recent studies (see Kaplan et al. 2013; WHO 2006); granted the methodology including sample size, control groups, and specific focus of this study also differed from recent studies.

Another study by Jones, Diop, Askew, and Kabore (1999) conducted in Burkina Faso and Mali concluded that obstetric complications varied by country. For example, 14 % of women with FGC (any type) in Burkina Faso⁴⁰ experienced at least one obstetric complication compared to 5% in Mali⁴¹. The Malian⁴² women “experienced some complications: 12 percent had episiotomies; 6 percent had perineal tears; 3 percent hemorrhaged, and 3 percent had a cesarean birth” (1999, 225). Whereas in Burkina Faso, “34 percent reported having had an episiotomy; 9 percent, obstructed labor; 5 percent, perineal tears; 1 percent, a cesarean birth; and 2 percent, other difficulties” (1999, 226). The most common obstetric complication observed in Burkina Faso sample was related to perineal tears due to keloid scarring and in Mali hemorrhaging. The Burkina Faso study sample had more type I than the one in Mali and both countries had similar prevalence of type III which has consistently been associated with more severe obstetrics outcomes. Despite mixed results, the authors concluded that FGC women had higher rates of obstetric and gynecological complications compared to non-FGC women, and these complications increase with the higher severity of circumcision. The Morison et al. (2001) study investigated overall long-term consequences among women with FGC compared to non-FGC in Gambia. They found no significance difference in the perineal tears in women with and without FGC. However, they noted that women with FGC had

⁴⁰ Burkina Faso has higher prevalence of type I FGC 56%, type II 39% and type III 5%

⁴¹ Mali has higher prevalence of type II FGC 74%, type III 5% and 21 % type I

⁴² Twenty eight percent of study sample were Malian women.

higher prevalence of HSV2 and sexual transmitted diseases (STI); both conditions are associated with increased risk to HIV infections (see Weiss et al. 2001).

A Nigerian study by Slinger, Snow, and Okonofua (2002) reported no association in perineal tears during childbirth between women with FGC and those without FGC, agreeing with Morrison's (2001) study in Gambia. They also reported that "Genital cutting status, delivery place, educational level, ethnicity, age at first marriage, age at first delivery, and religion had no significant association with cesarean section when controlling for other social variables (2002, 179). In addition, the "results showed that a woman who had undergone circumcision was less likely (only 69% as likely) to report episiotomy at first delivery than was a woman who had not" (2002, 179).

Another study from Nigeria by Larsen and Okonofua (2002) reported that women with FGC had higher rates of a perineal tears during childbirth than the non-FGC group but that was only significant for women with type II. Parity did not afford reduction for these complications. In fact, they reported women with type II FGC were significantly more likely to tear in their second delivery. This finding is in contrast to Morrison and colleagues study (2001) in Gambia. Similar to Hakim's study, Larsen and Okonofua found women with FGC were more likely to have prolonged labor, though the difference was not statistically significant. However, the most surprising findings were that women with FGC (all type I and II) were *least* likely to require episiotomy or cesarean delivery compared to women without FGC. For stillbirth, the result indicated that only when the women with type I and II were merged did the analysis reach a significant difference between women with and without FGC. Larsen and Okonofua theorized that the "mechanism through which type 1 and type 2 circumcision increases the risks of obstetrics complications may be due to the increased scarring of perineal

tissues, which increases the likelihood of tearing and leads to more hemorrhage” (2002, 261-2).

In 2006, the WHO carried out a large (n=28, 393) prospective control study in six African countries: Burkina Faso, Ghana, Kenya, Nigeria, Senegal, and Sudan. The aim of the study was to assess and compare obstetric outcomes in women with type I, II, and III, with non-FGC women. According to the study, all forms of FGC are reported to have higher adverse obstetric outcomes relative to non-FGC women; however, the authors underscored that women with type III FGC had more obstetric complications. The study reported that there were no significant differences between women with type I and II in terms of complications, but compared to non-FGC women, women with FGC II and III were “significantly more likely to be complicated by caesarean section, postpartum haemorrhage, episiotomy, extended maternal hospital stay, resuscitation of the infant, and inpatient perinatal death⁴³” (WHO 2006,1389). The study concluded that the risks of adverse obstetric outcomes are dependent on FGC status, and the risks are proportional to type of FGC type (worse in type III) this “suggests that the relation is causal” (2006, 1840). Upon closer scrutiny of this study, Conroy (2007) noted that the biomedical obstetric risk of FGC and adverse birth outcomes is modest (odd ratio of 1.3 for cesarean birth and 1.6 for stillbirth in women with type III-only). Overall “these findings place female genital mutilation somewhere behind maternal smoking as a risk factor in pregnancy” (Conroy 2007, 106). A study by Kaplan and colleagues conducted in Gambia concurred with WHO 2006 findings; but their sample did not include women with type III FGC (see Kaplan et al.2013). The 2006 WHO study mentioned above has become the gold-standard “evidence” that female circumcision of any type is harmful

⁴³ “It was estimated that, at the study sites, an additional one to two babies per 100 deliveries die as a result of female genital mutilation” (WHO, 2008 interagency:11).

and gives more credence to the global health campaigns to end the practice (WHO 2008).

A more recent study on obstetric outcomes by Kaplan (2013) concurred with 2006 WHO multinational study, though this study was limited to Gambia⁴⁴ and did not include women with type III FGC. A cluster of obstetric complications, according to the authors, “affected 11.7% of the group that had not undergone FGM/C, 39.0% of those with type I and 65.9% of those with type II FGM/C. When the different complications were analyzed, rates of perineal tear need for episiotomy and prolonged labor were significantly increased in women who had undergone type I or II FGM/C. The number of stillbirths followed the same trend. Although the need for cesarean section was low in all groups, it was significantly higher in those with type III FGM/C”⁴⁵ (Kaplan 2013, 326). As for the cesarean births, the authors indicated that “cesarean section was done preventively in women with severe abnormal scarring and/or synechia, which is more frequently observed in women with type II FGM/C” (2013, 329), and that FGC *per se* “does not directly affect the main factors responsible for cesarean section” (2013, 329). Neonatal complications include caput⁴⁶ fetal head; stillbirth was also reported to be significantly higher in women with FGC compared to no-FGC women due to “prolonged second stage of labor, because of obstruction and loss of tissue elasticity” (2013, 328).

In sum, these studies all suggest women with FGC have some obstetrics risks, though they lack consensus on what kind of obstetrics risks are prevalent and the

⁴⁴ Prevalence of FGC (type I and II) in Gambia is 75.6% according to the authors of the study.

⁴⁵ The sample in the study did *not* include women with type III FGC.

⁴⁶ A caput head is more likely to form during a prolonged or difficult delivery. This is especially true after the membranes have ruptured, because the amniotic sac is no longer providing a protective cushion for the baby's head. Vacuum extraction can also increase the chances of a caput succedaneum. A caput succedaneum is sometimes identified by prenatal ultrasound even before labor or delivery begins. It has been found as early as 31 weeks of pregnancy. More often than not, this is associated with either premature rupture of the membranes or too little amniotic fluid

incident rates. Most importantly, none of the studies, including the 2006 multinational study, could identify the mechanism in which FGC poses a risk in childbearing (see WHO 2006:1840). It is well known that the health infrastructure in most Sub-Saharan African countries is far from adequate (Mullan and Frehywot 2007; WHO 2006); where more women die during childbirth there than in any other region in the world. Another reason is the lack of access to adequate care (Grieco and Turner 2005; WHO 2006). Rogo, Oucho, and Mwalali (2006) point out that insecurity from civil wars as one of the major factor contributing to high maternal mortality in Sub-Saharan Africa. The current estimate of maternal mortality in Sub-Saharan Africa is 1:39 compared 1:3800 in the “developed” world (WHO Fact sheet N°348, May 2012). Conversely, according to the WHO (Fact sheet N°348 May 2012) maternal morbidity and mortality in Sub-Saharan Africa has declined from 1990 to 2010 at a rate of 3.1% per year; this rate is well below the targeted rate set by the United Nations Millennium Development Goal⁴⁷ to be achieved by 2015.

In Somalia for example, two plus decades of civil war, in addition to endemic food insecurity, lack of safe water, sanitation and healthcare access have all contributed to this nation having one of the highest maternal mortality rates in the world according to UNICEF⁴⁸. These multiple and difficult conditions makes it hard to isolate how FGC contributes to the high burden of adverse obstetrics outcomes (see van de Kwaak 1999). The UNICEF report indicates that one out of every 12 Somali women die due to

(oligohydramnios). All other things being equal, the longer the membranes are intact, the less likely it is that a caput will form. <http://www.nlm.nih.gov/medlineplus/ency/article/001587.htm>

⁴⁷ http://www.who.int/topics/millennium_development_goals/maternal_health/en/index.html

⁴⁸ <http://www.unicef.org/somalia/health.html>

pregnancy-related causes. The Integrated Regional Information Networks (IRIN)⁴⁹ based in Kenya, suggests that the rate of maternal mortality in Northern Somalia (Somaliland) has declined from 1,600 out of every 100,000 in 1997 to 1,044 per 100,000 in 2006. One can extrapolate that this improvement is mostly due to Somaliland⁵⁰ being more stable compared to the rest of Somalia. This is attested to by the IRIN site, which pointed out that the decrease in maternal mortality maybe attributed mainly to an increase in the access to health facilities, improved living standards and security in the region. The most credible data on Somali obstetrical outcomes have been conducted in the “developed” nations where Somalis have been resettled as refugees (Esse’n et al. 2005; Flynn et al. 2011; Johnson et al. 2005; Råssjö et al. 2013; Small et al. 2008; Vangen et al. 2002).

FGC and Childbirth Among Somali Women Post-Migration/Resettlement

Epidemiological studies of birth outcomes among resettled Somali women suggest varying and conflicting adverse obstetrics outcomes compared to native-born women (Essen et al. 2005; Flynn et al. 2011; Johnson et al. 2005; Råssjö et al. 2013; Small et al. 2008; Vangen et al. 2002). Adverse birth outcomes are not unique to Somali-born women but have also been reported among other foreign-born women living in the West (see Carolan 2008; Essen et al. 2000; Gissler et al. 2009; Gould et l. 2003; Malin and Gissler 2009; Merry et al. 2013; Philibert et al. 2008; Robertson et al. 2005; Saastad et al. 2007; Singh and Siahpush 2002; Vangen et al.2002).

⁴⁹ <http://www.irinnews.org/report/82387/somalia-maternal-mortality-in-somaliland-in-decline-but-still-worrying>

⁵⁰ A semi-autonomous region of Somali that has established its own governing body separate from the rest of Somalia. <http://somalilandgov.com/>

There are various observations and hypotheses advanced to explain the “high-risk” obstetrical outcomes among Somali-born women post-resettlement in the West. The explanations include: limited access and low utilization of healthcare during pregnancy (Råssjö et al. 2013), suboptimal care during antenatal and childbirth (Essen et al. 2002; Malin and Gissler 2009; Merry et al. 2013), lower socioeconomic status (Malin and Gissler 2009; Merry et al. 2013; Vangen et al. 2002), comorbidities (Essen et al. 2000; Råssjö et al. 2013; Vangen et al. 2002), race/ethnicity (Johnson et al. 2005), sociocultural factors (Merry et al. 2013; Vangen et al. 2002), communication and language barriers (Merry et al. 2013; Vangen et al. 2002), and acculturation (Flynn and Brost 2011). Female circumcision and in particular infibulation were also suggested but none of these studies reached a definitive conclusion as to what extent FGC (infibulation) adversely effected birth outcomes.

The first study on Somali immigrants’ birth outcomes was conducted in Norway by Vangen and colleagues (2000). The aim of the study was to examine the risks of birth outcomes among circumcised (infibulated) Somali women in comparison to Norwegian-born women (uncircumcised) using registry-base hospital data. Somali-born women had significantly higher risks for nearly all obstetric complications (except on perineal injuries) compared to Norwegian-born women. They were twice more likely to deliver by emergency cesarean, had significant high fetal distress, as well as fetal intrauterine death, low Apgar scores and perinatal death than Norwegian-born women. Somali-born women were also more likely to require induction of labor, have prolonged second-stage labor, and suffer more post-partum hemorrhage. The authors concluded that infibulation could play a role, but also acknowledged that other factors could not be excluded such as suboptimal perinatal care, low socioeconomic status, and high burden

of diseases including mental stress. They recommended further studies were needed as was a more culturally-sensitive approach in perinatal care for this population.

In 2005, a study by Essen and colleagues concluded that there is “no association between female circumcision and prolonged labour” (2005, 182). This study compared the duration of second stage labor among circumcised Somali and Eritrean-born (both groups have high prevalence of infibulation) with Swedish-born women. The study found that circumcised women “have a shorter labour that was significantly shorter and a lower risk of prolonged labour than the non-circumcised group” (2005, 183-4). Additionally, they were not at increased risk for instrument delivery.

An earlier study by Essen and colleagues published in the Bulletin for World Health Organization (2002a) titled “*Is there an association between female circumcision and perinatal death?*” used registry-base data, similar to their 2005 study discussed above. The authors concluded that there was no association between circumcision and prenatal death. One of the factors usually considered to be associated with prenatal death in circumcised women is the scarring of the perineal tissue from circumcision which may hinder optimal and timely delivery. These authors argued that “the elasticity of the birth canal is no more affected by circumcision scar tissue than by scar tissue induced by episiotomy” (2002a, 630). In the cases in which prenatal death did occur in the circumcised women, the authors reported this was due to preexisting fears (from home countries) of delivery complications and maternal death, which made them either delay or refuse cesarean operations. Miscommunication (language barriers) and suboptimal medical care were also contributing factors (see Essen et al. 2002b). Although circumcised women in this study had higher perinatal death, the authors could not link maternal circumcision status to this outcome. One very important factor that these two

studies have underscored is the need to defibulate women who have undergone infibulation circumcision during or prior to childbirth.

A British study by Yoong, Kolhe, Karoshi, Ullah and Nauta (2005) was conducted comparing Somali-born (50% were circumcised) women with British-born (Caucasians). The authors reported that the former group had more cesarean operative births as well as other instrument-assisted deliveries, low birth weight and preterm birth than the latter group. These findings, however, were not statistically significant. On the other hand, Somali-born women were less likely to use epidurals. In their conclusion, the authors reported their findings may be due to increased awareness by healthcare providers in managing women with female circumcision and that the more recent Somali immigrants are likely originating from more urbanized and “westernized” Somalis.

A study by Johnson, Reed, Hitti and Batra (2005) contradicted the British study discussed above, albeit the study sample, size, design and analysis differed in the two studies. The study by Johnson and colleagues compared 579 Somali-born women with 2,384 US-born black (African American) women, and 2,453 US-born white women (all were singleton births that took place from 1993 to 2001 in Washington State, USA). Fetal distress was higher (5 to 9 times) among Somali-born women than it was in the other two groups, and was the major indication for cesarean operative births. These women were also twice as likely to require operative vaginal births as were U.S.-born-blacks. Risks of perineal lacerations were also higher among Somali-born than in controls groups (5 and 2 times higher in blacks and whites respectively). They had higher gestational diabetes than the control groups but stillbirth outcomes were not statically different across all three groups. Whereas US-born-blacks were at more risk of preterm birth, the opposite was reported among Somali-born women. Somalis were nine times

more likely to deliver at 42 weeks or beyond. Delivering postdates (postdatism) is associated with increased risks for adverse birth outcomes. Data on circumcision type and other variables such as socioeconomic and access to healthcare were provided by the authors. They suggested that perineal lacerations may be attributed to female circumcision status though they did not discuss whether defibulation was carried out prior to or during childbirth in women with infibulation to avert severe lacerations (see Essen et. al. 2005; Ibe and Johnson-Agbakwu 2011). The authors concluded that it is possible that the high cesarean operations among Somali-born women may be due to “obstetric practitioners unfamiliar with the custom are more likely to recommend a cesarean delivery, doubting that a baby might be able to traverse such a small introitus without causing severe lacerations, or at all ” (Essen et al.2005, 482). This observation was also noted by the study by Small and colleagues (2005) discussed below.

A Finnish study by Malin and Gissler (2008) compared the effects of access to and use of maternity services on birth outcomes of foreign-born women from different countries (including Somalia) with Norwegian native-born women. When compared to other immigrants groups and Finns, Somalia-born women were least likely to have instrumental vaginal deliveries; however, they had a significant higher risk for cesarean operative births (28.8%), though not as high as other ethnic African immigrants (40.5%). Somali immigrants were also reported to have a statistically significant increase risk of low birth weight (4.5%) but so did Eastern European (5.9%) and Middle Easterners and North Africans (5.5%) compared to Finns. Epidurals were more frequently used across all immigrants groups than by Finns. African (excluding North Africa) and Somali women had significantly higher risk of prenatal death (six and two folds respectively) and lower Apgar scores compared to other immigrants and Finns. The authors did not find evidence to indicate differences between foreign-born and Finnish women on access

and utilization of maternal health care services. In conclusion, the authors suggested suboptimal factors may have contributed to adverse outcomes in 46% of the cases in the immigrant groups. In addition, they reported that Somali-born women experienced racial stereotyping and were not offered competent medical interpreters when seeking obstetric care.

A meta-analysis study from six host nations (Australia, Belgium, Canada, Finland, Norway and Sweden) was conducted in 2008 by Small, Gagnon, Gissler, Zeitlin, Bennis, Glazier, Haelterman, Martens, McDermott, Urquia, and Vangen. This study compared pregnancy outcomes in Somali-born women with women born in each of host nations. Overall findings noted that though Somali-born women were least likely to be burdened with preterm birth or low weight infants, they had higher burden of childbirth disparities from stillbirths and cesarean operative births compared to women born in all the six host nations. The authors concluded that these “disparities are not readily explained and they raise concerns about the provision of maternity care for Somali women post-migration. Review of maternity care practices followed by implementation and careful evaluation of strategies to improve both care and outcomes for Somali women are needed” (Small et al. 2008, 1630).

A second U.S.-based study by Flynn Foster and Brost (2011) looked at whether acculturation among Somali refugee women has an effect on their preterm birth outcomes. The authors applied age at immigration, duration of residency in the U.S. and use of interpreters during prenatal care as proxy for acculturation. Participants were divided into group one (1993–1999 with longer U.S. residency) and group two (2000–2006 with shorter U.S. residency). Included among the findings was that the incidence of gestational diabetes was significantly higher in group two (15.1%) than in group one

(5.2%). Overall, preterm births among Somali women were reported to be increasing. The study expected group two birth outcomes would be adversely impacted if they did not use interpreters, but this was not the case, suggesting that “factors other than language are stronger predictors of preterm birth, multiple factors reflecting acculturation measured together are necessary to impact birth outcomes, interpreter use is a questionable proxy for language competency, or actual use of interpreters introduced a confounding factor not corrected for in this study” (Flynn Foster and Brost 2011, 229).

The most recent study (see Råssjö et al. 2013) on Somali birth outcomes living in Sweden found they have increased risks for fetal death and low birth weight compared to Swedish-born women. When compared to Swedish-born women, Somalia-born women tend to delay seeking prenatal care as well as have less frequent visits; this, noted the authors, may contribute to adverse birth outcomes. Emergency cesarean operation associated with fetal distress was more common among Somali-born women than their Swedish cohorts.

Another meta-analysis study by Merry, Small, Blondel and Gagnon (2013) reported immigrant women with origins from Sub-Saharan countries, including Somalis as well as southeast Asians have consistently higher rates of cesarean operative childbirths than other immigrant groups (notably Vietnamese and Eastern Europeans). Overall, African women had the highest burden of emergency cesarean operations compared with women born in the host nations in the West. In their discussion, the authors pointed out that the “most frequently postulated risk factors for caesarean risk in migrant populations include: language/communication barriers, low SES, poor maternal health, gestational diabetes/high BMI, feto-pelvic disproportion, and lack of prenatal care” (2013, 23).

In the last decade, several qualitative studies have emerged examining Somali childbirth experiences in the context of FGC and migration. These studies can be grouped into four categories: 1) Studies that examined only Somali women's perspective (Ameresekere et al. 2011; Berggren et al. 2006; Bulman and McCourt 2002; Chalmers and Hashi 2000; Essen et al. 2000; Herrel et al. 2004; Hill, Hunt, and Hyrkäs 2012); 2) Studies that investigated healthcare professional's perspectives (Hess et al. 2010; Johansen, 2006; Relph et al. 2013; Straus et al. 2007; Tamaddon et al. 2006; Widmark, Tishelman, and Ahlberg 2002); 3) One study that examined Somali men's perspective (see Johnson-Agbakwu et al. 2013 perineal; and 4) Studies that juxtaposed Somali women's and healthcare profession's perspectives (Essen et al. 2011; Thierfelder et al. 2005; Vangena et al. 2004).

Though the methods of the studies varied, the general findings can be summarized as: 1) Somali women do not associate FGC with adverse childbirth (Chalmers and Hashi 2000); 2) Healthcare providers lack technical know-how to manage FGC (Chalmers and Hashi 2000; Thierfelder et al. 2005); 3) Somali hold a strong faith in God in a pragmatic way in which they understand birth events and outcomes (Essen et al. 2000; Hill, Hunt, and Hyrkäs 2012); Somali women believe Cesarean delivery (henceforth C-section) may result in death (Ameresekere et al. 2011; Brown et al. 2010; Essen et al. 2011), contrary to healthcare providers (Essen et al. 2011); and 4) Due to their FGC status, Somali women are confronted with issues of shame (Berggren, Bergstrom, and Edberg 2006) and stigmatization (Chalmers and Hashi 2000; Johansen 2006). Most of these studies suggest that cultural differences and language barriers are the major contributors to adverse childbirth experiences and outcomes for the Somali refugee women (see appendix C).

I have not, however, found any studies that have measured the cultural variation patterns between Somali refugee women and their healthcare providers. Additionally, given the general repulsion and rejection of FGC in America, the question of how this perception is embodied and shapes human interaction deserves further exploration, especially from the perspectives of the SRRW and their HCP. My aim in this study is to measure and identify patterns of variations of these frequently referred “cultural differences” in the domain of childbearing within and between Somali resettled refugee women (SRRW) and their healthcare providers (HCP) in the contexts of Maricopa County, Arizona, a growing resettlement location for Somali refugees. Additionally, I aim to explore and describe how the perception of FGC is embodied by juxtaposing SRRW vis-à-vis HCP perspectives and experiences.

Conclusion

The discourse on FGC is emotional and culturally and politically controversial. The historical origins and the heterogeneity, culturally and corporally, of these practices make this already complex topic even more challenging in the context of migration to the West of circumcised women. This is especially the case when seeking obstetrical and gynecological healthcare (Essen and Wilken-Jensen 2003). For one, the Western antipathy to FGC is rooted in the biomedical concept of the body in which this body does not fit its ideological construct of biology, gender, and sexuality (Johnsdotter and Essen, 2010). Second, the history of eradicating FGC is part and parcel of African colonialization in which African bodies, reproduction, and cultures were perceived to be the embodiment of dirt and disorder in need of civilization, liberation, and biomedicalization (Abusharaf 2006; Comarof 1993; Hunt 1999; Thomas 2001).

In the late 1970's FGC once again emerged as a concern, albeit just an intolerable cultural practice; a decade or so later, it became a global health hazard which gradually changed to a human rights issue in the 1990s (Boddy 2002). In part, this paradigm shift was due to anti-FGM organizations not being attentive to contexts, underestimating the local people's knowledge about their lived experiences (Hernlund and Shell-Duncan 2007); but also as a result of globalization as the world has become more interconnected not only economically but also in terms of migration patterns (Hernlund and Shell-Duncan 2007; Shell-Duncan and Hernlund 2001). Most scholars, regardless of whether they are hostile to or hold a more nuanced perspectives regarding FGC, agree that the major impetus that highlighted the global "problem" of FGC came about in the 1990s which ushered in the largest influx of African refugees/immigrants along with their problem cultural bodies that imported the medical hazard and other culture challenges into the West (Elgaali et al. 2005; Johnsdotter 2007; Kratz 2007; Monahan 2007; Talle 2007).

In terms of female reproductive health risk, the clinical evidence is inconclusive, though current literature conducted in six African countries support that the practices adversely affect women's health, especially during childbirth (see WHO 2006). It is well known that Sub-Saharan Africa has one of the worst maternal and neonatal outcomes in the world. On the other hand, though overall maternal and child under five mortality in Sub-Saharan Africa is reported to have improved, the rates are still significantly higher than those of most regions of the developing world (Wang et al. 2011). The high rate of adverse reproductive health is not limited to countries in which FGC is prevalent. For example, FGC is rarely practiced in Malawi while in Tanzania the prevalence is approximated to be at 20% (Yoder, Abderrahim and Zhuzhuni 2004). Yet, Malawi has a

higher maternal and neonatal mortality⁵¹ compared to Tanzania (Malawi DHS 2011, Tanzania DHS 2010). Hence, the argument that “FGM” is a causal factor for adverse reproductive health is problematic, even in the in developing nations, let alone in resource-rich nations where circumcised women now call “home”.

⁵¹ Tanzania: infant mortality rate is 51 per 1,000 live births, and 454 maternal deaths per 100,000 live births. Malawi: infant mortality 66 deaths per 1,000 live births, and 675 maternal deaths per 100,000 live births.

CHAPTER 3

Theories of Culture Consensus and Embodiment

In this study, I draw on two theoretical perspectives namely, culture consensus (Romney, Weller and Batchelder 1986) and embodiment (Csordas 1999, 1994, 1990; Merleau-Ponty 1989). The culture consensus model (CCM) was applied to explore shared cultural knowledge and beliefs on childbearing models within and between Somali resettled refugee women (SRRW) with female genital cutting (FGC) and healthcare providers (HCP). In addition, a phenomenological approach was used to probe subjective and intersubjective perceptions of FGC embodiment and to better understand the role of perceptions in shaping patient-provider interactions. The rationale of multiple theories and methods is because the subject matter: FGC, especially in the context of childbearing and migration is complicated and emotive. It goes beyond just individual perceptual experiences but also shared beliefs and disagreements. By incorporating these two theories, each with their own methodologies will help shed more light on the topic—which it warrants—instead of just having one perspective.

At first glance, the two theories appear to be diametrically opposite but they are in fact complimentary, as each provides a different perspective to fully explore the complexity of this dissertation topic. In the first theory, the locus of culture is in the mind; members of cultural groups learn and share cultural knowledge (Romney, Weller and Batchelder, 1986). Hence, cultural knowledge is what members of a cultural group broadly agree on and share through social interactions. The culture consensus model is a method that aims to quantitatively describe cultural agreement patterns. The central premise of the culture consensus method is to measure the degree of shared ideation about beliefs and behavioral in any given domain of knowledge (cultural models) among

members of a cultural group (Weller 2007). A cultural domain consists of a set of coherent or related items that makes sense, linguistically speaking (Weller and Romney 1988). For example, flowers or names of different types of flowers belong to a different domain of knowledge from fruits. The domain of knowledge examined in this study is childbearing which includes: pregnancy and prenatal care, and labor and childbirth as its subdomains. Because a majority of the Somali women including the SRRW have experienced FGC in early childhood (WHO 2008), FGC figures prominently in childbearing issues and knowledge (Johnson-Agbakwu et al. 2013; Ibe and Johnson-Agbakwu 2011; Johnson, Ali, and Shipp 2009) and thus, in this study, is considered as a third subdomain in the overall childbearing domain of knowledge.

Culture can be considered as a vast collection of models (Shore 1996). For example funeral, wedding, birth, and menstruation, are prime examples of cultural models. Cultural models define beliefs and behavioral norms among its members and can be observed by non-members (Shore 1996). For example, every cultural group has its own cultural belief about what constitutes childbirth norms. This normative knowledge about childbirth –childbirth cultural models – provides meaningful mental guidelines informing members about what is expected. They also shape and, when necessary, adapt behaviors in particular situations.

Cultural models are therefore imbued with cultural meanings that shape and are shaped by beliefs and behaviors. What is cultural about a belief or behavior is learned (mind) and the ideation is shared as a cultural belief. Culture consensus is, therefore, a normative domain of knowledge that exists among members of a cultural landscape; however, cultural knowledge is not evenly distributed across group members. For example, in traditional societies women tend to know more about childbirth than their

male counterparts that is evident in that most traditional birth attendants are women (Jordan 1993).

In contrast, the “body being-in-the-world” is the locus of the embodiment theory (Csordas, 1999, 1994, 1990; Merleau-Ponty 2002¹); it is the lived bodily experiences that perceive, receive, and give the body its meanings of existence in the world. The body is an inseparable unit of sensory perceptions; since the world exists prior to the body; the body learns about and, at same time, shapes the world through lived bodily perceptual experiences. This being-in-the-world is a bodily temporal-spatial-social experience (Csordas 1990; Merleau-Ponty 2002). In other words, our bodily experiences of being-in-the-world is how knowledge (awareness) about self and world including other people is constructed as meaningful insofar as perception is embodied and contextually grounded (Csordas 1990, 1994, 1990). By context Merleau-Ponty (2002) meant all perceptual bodily experiences in its entirety, including social, cultural and historical to which the body in-the-world has been exposed. Because the world existed before the body came into existence, what and how things appear (phenomena) and their meanings are pre-objective. That is, what and how the body perceives (a phenomenon) are determined by prior experiences in the context of culture. Accordingly, all bodies are culturally experienced and cultures are expressed by bodies (Csordas 1999, 1994, 1990).

In this sense then, the embodiment theory is parallel to the culture consensus model in which knowledge is learned and shared among individuals; for individuals to learn something, it requires intimate social interactions that would expose them to ideas that exist in the knowledge domain before it can be learned and shared. In essence, both theories are concerned with culture and how culture gives meaning to our world and, perhaps more importantly, shapes human perceptions and interactions.

However, where the former puts emphasis on the mind, the latter binds the mind to body and the body to mind. As such, culture consensus and embodiment suggests that individuals give and receive their meanings of their world by social interactions and lived experiences. Hence normative cultural beliefs and/or mode of perceptual awareness of individuals in a cultural group shape and are shaped by interactions with other beings in the context of cultural environments and histories. Meanings of what and how things appear, especially the human body, are imbued with culture (Csordas 1990). Meanings of the “mundane” and the “strange” world are culturally shaped through shared knowledge (cultural knowledge) and lived-experiences of being-in-the-world (embodiment).

The purpose and design of this study is to operationalize these two theoretical approaches to explore normative intra and cross cultural childbearing models and how the embodied culture in the context of female circumcision and migration shapes patient-provider interactions. It is not only important to identify patterns of variations in the conceptual childbearing models within and between Somali refugee women and their healthcare providers in the U.S., but equally critical, to understand why and how these differences emerged and are sustained. In the following section, I will briefly discuss these theoretical terms and concepts to show their utility in this study and then outline the research design and methods, followed by negotiating fieldwork in which I describe my person experiences in conducting this research.

Theory of Culture as Consensus

Conceptualizing culture as a shared ideation about a particular worldview is grounded in what is called cognitive anthropology (see D’Andrade 1995, 2001). The general concept was that a group of people in a particular place and time tend to agree

¹ Translated from French by Colin Smith (2002) version.

more with each other or share ideas about their world that are different from non-members of the group. Because culture is in large part learned (in the mind) and shared through social interactions, culture consensus is concerned with cultural meanings about beliefs and behaviors that are shared (consensus) among individuals in a cultural group (Romney, Weller, and Batchelder 1986). As such, normative beliefs and behaviors of cultural groups are not arbitrary but are organized and functional, in that they provide meaningful knowledge in negotiating and making sense of the human experiences; therefore, they are imbued with cultural meanings that are specific to a domain of knowledge among group members in that place and time (Shore 1996; Weller 2007). Bradd Shore used the term *conventional mental models* to illustrate that they are more than idiosyncratic mental models; their existence is contingent and they are negotiated through a dynamic social interaction and are a necessary resource for meaning making in a given situation (Shore 1996, 45-47). Another way to understand cultural models is to think of them as “a cognitive schema that [are] intersubjectively shared by a cultural group” (D’Andrade 1990, 809). Cultural groups organize their shared beliefs and behaviors in accordance with cultural models that emerge in the course of social interactions that are meaningful in a given domain of knowledge.

Cultural Consensus Model (CCM)

The concept of culture consensus model (based on culture consensus theory) was introduced by Kimball Romney, Susan Weller and William Batchelder in 1986. Their aim was to “make objective the criteria by which we might measure our confidence in inferring correct answers to cultural questions, i.e., to help answer the epistemological question of ‘How do we know what we know?’” (1986, 313). The operational premise of CCM is that shared cultural knowledge and variations can be measured by presenting a

sample of individuals a series of questions or statements pertaining to a specific domain of interest. The patterns of agreement between individuals in the sample correspond to shared (cultural consensus) knowledge (Weller 2007). Formal CCM analysis is applied to test whether or not there is consensus which depends on meeting three criteria. First, the eigenvalue ratio between first² and second factor to be high, generally 3:1 or higher; second, individual factor loading should all be positive; and third, the extent of variance is explained by the first factor (Ross 2004:147). If these criteria are met, then a shared model can be inferred (Romney et al. 1986). The analysis also measures the level to which each individual (competence score³) agrees with the group; that is their cultural competence. Weller (2007) explained that there are three conditions that have to be met when applying this method:

- 1) Responses to individual questions have to be original and independent. That is, each individual must respond to questions without consultation with other members in their group. In other words, CCM cannot be administered in a focus group format. Although it can be conducted in a group setting, provided participants adhere to responding independently.
- 2) All questions should relate to the single domain of knowledge.
- 3) Answer choices to the questions must be single set to each question (yes/no, agree/disagree, true/false).

Because the model does not create consensus, it requires a level of congruency among participants' responses to the individual questions to indicate whether or not there is a consensus (Weller 2007). Hence, this can raise potential problems with CCM regarding

² The first factor loading or culture competence reflects the knowledge about the domain (see Barnard and Ryan, 2010:183).

³ Competence score of at least 0.05 is suggested depending on the number of participants and the items in the CCM questionnaires.

reliability and validity. Reliability by definition requires a certain amount of agreement or consistency across a number of people (sample). Weller argued, however, that in CCM, reliability is concerned with the agreement patterns (aggregated) rather than on the questionnaire items. Validity on the hand is a measure of accuracy of a claim or a true representation of a claim (Burns and Grove 2005). Weller (2007) suggests that in anthropology, issues of reliability can be extrapolated when there is high agreement between participants across same items in questionnaire and validity apply when same responses are provided by multiple participants. Hence, high reliability (aggregated responses) aid in validating the claim. CCM's validity depends on the aggregated responses (eigenvalue ratios) across the individual participants, their individual competence scores (which suggest the participant knows the answer to the question) and the average competence scores (the proportion of questions on which a group agree) in the conceptual model. As the numbers of participants and question items in the CCM questionnaire increase so is the reliability and validity of responses. This also means the sample size can be small, so long as there is high aggregated agreement among participants across the questions items in domain of knowledge under investigation (Weller 2007).

However, a contentious issue within CCM is how to account for individual responses that do not align with the rest of the participants' answers (Hruschka and Maupin 2013) or when the group responses are split in the middle (Weller 2007) and or when there is more than one answer key (Hruschka et al. 2008). Ross (2004) used the term imperfect agreement to highlight these issues which he said have traditionally challenged anthropological inquires and analyses about what is cultural about a specific (cultural model) claim. Ross argued that if within group variation is left unattended during the research process (from data collection, to analysis and interpretation), the

conclusion, he warned will more likely “produce authoritative and essentializing description of culture and cultural patterns” (Ross 2004, 6). This led him to articulate CCM methods and analytical approaches necessary to justify whether or not aggregating patterns of agreement fit into a single cultural model which is critical in data interpretation (see Ross 2004). Hruschka and Maupin (2013) also provide recommendations on when and how CCM data set warrants further analyses.

Culture or what is considered cultural, however, is not a straight forward concept. Delimiting to just the Western civilization, hundreds of definitions of cultures have been offered by different disciplines foremost among which is anthropology (Lock and Nguyen, 2010). Clifford Geertz, one of the founding fathers of American anthropology, defined culture as “public” knowledge among members of cultural group about what things means (1973). This broad definition is currently considered to be outdated and has increasingly been contested in the wake of globalization and escalating displacement of people whether forced or voluntary migrating across nations and continents (Lock and Nguyen 2010). Merry (2001) posited in this globalized world, culture is unbounded, even fluid and changing, it is ambiguous in terms of identity and practice, contested, and inter-connected (2001, 41). Regardless of its historic and current challenges, culture and cultural analysis remain a viable conceptual means by which human values and behaviors can be explored and understood (Lock and Nguyen 2010).

The culture consensus model (CCM) has been applied in several studies to measure the level of shared knowledge in various domains of cultural knowledge. Some of the more recent and pertinent applications of CMM in cross and intra cultural comparative studies included: global concepts of body norms and fat stigma (Brewis et al. 2011); folk medical models among Mexican migrants in Nashville (Ross, Maupin and Timura 2011); comparison of medical staff and Mexican migrants on models of illness

(Maupin and Ross 2012); resilience of folk medicine (Ross, Timura and Maupin 2012); exploring concepts of illness knowledge from gendered experiences of migration (Maupin, Ross and Timura 2011); cultural theories on postpartum hemorrhage in Bangladesh (Hruschka et al. 2008); health beliefs on diabetes in Thailand (Ratanasuwan et al. 2005); value differences between patient, residents and staff physicians in a clinical setting (Smith et al. 2004); Latino beliefs about diabetes (Weller et al. 1999), and structure and meaning of breast and cervical cancer risk among Latinas, Anglo women and physicians in the U.S. (Chavez et al. 1995). This list is by far non-exhaustive.

One of the strong features of the CCM is it allow participants to respond in independently and in anonymity. This makes this method most reliable in measuring individual and group variations in a given domain of knowledge (Hruschka et al. 2008). Additionally, it is also suitable for studies that investigate sensitive topics. Hence, the operational application of CCM fits well for the purposes of this study, particularly considering the polarizing nature of the subject matter under investigation.

Embodiment

Conceptually, embodiment is the bodily perceptual essence of being in-the-world; the body is both the subject and, at the same time, the object upon which culture, social institutions, economy and politics are lived and experienced (Kreiger 2005; Csordas 1999, 1994, 1990; Merleau-Ponty 2002). The embodiment idea is largely credited to Maurice Merleau-Ponty, a French phenomenological philosopher, whose philosophical orientations were influenced by other existential philosophers, most notably Martin Heidegger and Edmund Husserl (Langer 1989; Matthews 2006). As did his predecessors, Merleau-Ponty centered the body-self as the existential unit of perception and making meaning of being-in-the-world; however, he disagreed with Husserl's notion

of researchers transcending or bracketing biases⁴. In contrast, Merleau-Ponty suggested that the “very experience of transcendent things is possible only provided that their project is borne, and discovered, within myself” (Merleau-Ponty 1989, 369).

The centrality of the body as an inseparable unit of perception collides with Cartesian notion of dualism (mind-body separation) and the empirical logic upon which Western ontology and epistemological traditions operates (Merleau-Ponty 2002; Scheper-Hughes and Lock 1987). The empirical logic tradition is credited to René Descartes’ (1596-1650) philosophical argument and is summarized in a three word dictum: *Cogito, ergo sum* (I think, therefore, I am). From this statement, Western philosophical tradition has long grappled with how to transcend the *Cogito* concept in which the mind (self) is presented as detached (disembodied) “consciousness” severed from flesh, history, society and culture.

Merleau-Ponty (2002) argued that the notion of *Cogito* depreciates the inseparable unity of perception (the mind-body connection or embodiment) of self and of others and is prejudicial by reducing human existence to awareness or consciousness. He disagreed that having mere thoughts (in a disembodied mind) is self-evidence of human existence; instead he suggested that “all cognitions are sustained by a ‘ground’ of postulates and finally by our communication with the world as primary embodiment of rationality” (Merleau-Ponty 2002, 25). He went on to say that rationality is a blending of perspectives in which perceptions confirm an emerging meaning and is proportioned to the lived experiences of being-in-the-world (2002, xxii). As such, Merleau-Ponty points out that what we call rationality is based on subjective perceptions, and perceptions are

⁴ Also known as ego transcendence, phenomenological *epoche*, where one distances or puts aside (researcher) their own biases or preobjective ideas of the subject in question.

embodied and meanings of the lived world derived from the bodily perceptual experiences that are contextualized within our sociohistorical and cultural context.

In contrast, the body, from a Cartesian perspective, exists as a mere material entity (mechanistic biological object) in the world or reduced to lower its “animal nature” of self (Weiss and Haber 1999). The physical body occupies the lesser rung of existence, whereas the intangible mind is a distinct and separate entity, capable of comprehending the objective world and God (Weiss and Haber 1999). This simplistic separation or Cartesian dualism, as argued by Schepers-Hughes and Lock, has successfully persevered the physical human body to the domain of science as a biological organism (object), especially in the biomedical science, and ceded the mind (or the soul, as Descartes intended) to the realm of reasoning and theology (1987, 9).

Merleau-Ponty was not convinced that the empirical explanation of the world was either sound or unbiased. He rejected the scientific explanation of perceptual awareness as mere consciousness of sensation (awareness of stimulus). Such objectivist description disregards human experiences and meanings by treating the body as a causal mechanistic object that can be empirically explained. Such reductionist perspective is based on “[O]bjectification”, that is, “the product of reflective, ideological knowledge” which is biased to history, time and place (see Csordas 1994, 7). The empirical view, hence, fails to distinguish between what is preobjective and what is the objective intentionality of the human existential experience (Csordas 1994, 7; Matthews 2006; Merleau-Ponty 2002). As such, the scientific endeavor that aims to explain the world is inherently flawed in thinking it is capable of absolute and unbiased knowledge (Matthews 2006; Verheijde 1999).

Csordas (1990) elucidates the term preobjective (as used by Merleau-Ponty) to mean the bodily existence of being immersed in a cultural world in which the body experiences the being-in-the-world. Preobjectivity, then, is essentially our cultural lenses with which we see and experience the world. The perceptual body operates in a social and cultural world that existed prior to the body and the body is inseparable from the world in which it resides; or as Merleau-Ponty stated: “[m]y personal existence must be the resumption of a personal tradition. There is, therefore, another subject beneath me, for whom a world exists before I am here, and who marks out my place in it. This captive or natural spirit is my body” (1962, 254). In other words, how things appear (phenomena of perception) is always preobjective, embodied and contextually grounded in culture. Merleau-Ponty goes on to say (or rather warn) that objectification often results from failure to see the social and cultural forces (intentional and pre-objective) of the bodily experiences in the world. Hence, what is a preobjective (embodied cultural phenomenon) in one cultural context can be mistakenly objectified in another culture (Strathern 1997, 179). For example, the cultural perception of female circumcision is embodied as a natural-cultural bodily existence among some cultural groups, while in other cultures the same body can be perceived as an object of defective bodily existence. Csordas underscored Merleau-Ponty’s idea of preobjective perhaps to emphasize that the process of cultural perception can end in objectification of the ‘other’ body (Csordas 1994, 7).

The term intentional as used by Husserl was also clarified by Merleau-Ponty. Husserl used the term intentionality of consciousness to expound that the conscious is always an intentional consciousness, directed towards or in reference to some object outside the self (end product). Intentionality for Merleau-Ponty, “is not a thought” that springs up to consciousness from nowhere “but [one that] takes for granted all the latent

knowledge of itself that my body possesses” (Merleau-Ponty 1962, 233-270).

Intentionality according to Merleau-Ponty, therefore, is how our senses are culturally conditioned to perceive (have meaning) the being-in-the-world. To illustrate this concept, he used an example of encountering a bolder; unless the bolder needs to be surmounted, it may not be perceived as an obstacle object (see Csordas 1990, 10). How the encountered (preexisting) bolder is perceived (as a cultural object) and negotiated (climbed or detour around it) depends on what meaning is given to the perceived object, or intentionality (Csordas 1990, 10). Hence, how we perceive ourselves, the bodies of others or any phenomenon in the world depends on intentionality (meaning based on preobjective perceptions). These perceptions are meaningful within the context of our bodily lived experiences in their entirety: history, social, cultural.

Perception is how we see and make meaning of the world and intentionality is the meaning we give to what we perceive. As such, the perceived “object is the end product of perception, and perception is always embodied” (Strathern 1997, 178). The circularity between subject and object makes perception indeterminate. Because perception is a subjective and active process, its engagement with the world is based on the intersubjectivity experiences that give and receive meanings in day-to-day human interactions with the world (Strathern 1997, 178; Langer 1989). In other words, the perpetual body is never a passive receptor to stimuli, but an engaged, intentional receptor of the stimuli (Thomas 2005).

Perception and intentionality are culturally determined, i.e., preobjective. One can argue that perception is a subjective experience of being-in-the-world. On the other hand, phenomenologists have argued that even our most basic experiences of physical objects are based on intersubjective experiences rather than subjectivity alone (Desjarlais and Throop 2011). Insofar as we inhabit the world along with others, we are

influenced by and learn (e.g. culture) from other people as Merleau-Ponty argued (1989); therefore, intersubjectivity is the bedrock of the very possibility of lived experiences of the being-in-the-world (Desjarlais and Throop 2011, 91). It is precisely the subjective and the intersubjective perceptual experience of female circumcision that I explored in this study, because bodily perceptual experiences are about intersubjectivity experiences that are embodied in engagement with the world or relationship between people.

Embodiment: cultural phenomenology

Embodiment as stipulated by Merleau-Ponty (1989) can only be understood from bodily perceptual experience of being in the cultural world from which the perceived phenomena (how things appears) gets their meanings (cultural). Phenomena simply imply “that which appears” and phenomenology is a methodological approach that describes that which appears or is perceived (Groenewald 2004). As a descriptive science, phenomenology is concerned with perceptual meaning which begins by taking account from first person experience without idiosyncratic presumptions or metaphysical explanation of what it means to experience the body in the world (Csordas 1990). Perception is embodied and indeterminate (Csordas 1999, 1994; Merleau-Ponty 2002, 1989); that is, the bodily experiences of being-in-the-world is as dynamic as is the culture it embodies which in turn influences how the body perceives and is perceived in various facets of live—including health and illness existential experiences.

Phenomenology is the science of approaching human existence as an embodied being; it is not concerned with giving causal explanation; rather, it aims to provide a direct descriptive account of the lived experience (Desjarlais and Throop 2011). As suggested by Merleau-Ponty in his seminal work titled *The Phenomenology of Perception* (1989), the purpose was to nudge us to “examine the immediacy of

experience before it is objectified by science” (Thomas 2005, 65). This, he argued, is the essence of phenomenology of perception and went on to say “phenomenology is also a philosophy which puts essences back into existence, and does not expect to arrive at an understanding of man and the world from any starting point other than that of their ‘facticity’” (Merleau-Ponty 2002, xxiii). The first person experience of being in the cultural world was what Merleau-Ponty emphasized. Phenomenology is an approach that guides or provides access to the concept of embodiment. That is, what do perceptual bodies perceive, how are perceptions embodied, and how does the notion of embodiment shape human interactions and behaviors?

Female genital circumcision is central to my study. As such, female circumcision is about the body and culture; a body that is culturally grounded in one context but not in the other (due to bodily displacement by forced migration: refugee). In the context of displacement, the perception of the cultural female circumcised body as being in the new cultural world may have different subjective (cultural) meanings, especially when encountered during childbearing events. It is precisely what and how these intersubjective perceptions shape interactions (patient-provider) and how they influence behaviors (of Somali resettled refugee women and their health providers) that this study is attempting to explore. Application of Merleau-Ponty phenomenological approach to embodiment provides a platform to capture the subjective and intersubjective perceptions of the female circumcised body as it is immersed in multiple cultures (Csordas 1999, 1994, 1990), including the cultures of childbirth (Jordan 1993), which is also a cultural even of the bodily being-in-the-world .

This dissertation goes beyond identifying the cultural gap by quantitatively measuring the cultural differences within and between SRRW and the HCP on

childbearing model in the context of migration and FGC. Additionally, it explores FGC embodiment by juxtaposing the SRRW and the HCP subjective and intersubjective perceptual experiences of being-in-the-world. To do so, this research was designed to include a variety of approaches, including culture consensus questionnaires, semi-structured interviews, and observation participatory methods which are discussed in details, including the study objectives in the following section.

Research Design

The study was designed to include quantitative and ethnographic methodologies, namely the cultural consensus model (Romney, Weller, and Batchelder 1986) and phenomenology approaches (Csordas 1990; Merleau-Ponty 1989). The cultural consensus questionnaires were applied to identify and measure agreement and disagreement patterns in childbearing models within and between SRRW and HCP. A phenomenological approach was used to explore and describe perceptions of female circumcision embodiment.

My objectives in this research are threefold:

Objective I. To identify and measure patterns of cultural knowledge and variations (cross-cultural agreement and disagreement) between Somali resettled refugee women (SRRW) and healthcare providers (HCP) on childbearing models.

Objective II. To investigate and measure intra-cultural variations in the domain of childbearing knowledge among Somali resettled refugee women.

Objective III. To explore the subjective and intersubjective perceptions of female circumcision.

The first and second objectives aim to identify and measure normative cultural knowledge, beliefs on childbearing models within and between SRRW and HCP in the context of female genital cutting and migration; the third objective aims to explore and describe FGC embodiment by juxtaposing the SRRW and HCP's subjective and intersubjective perceptual experiences. The methods include culture consensus questionnaires, semi-structured interviews and participatory observations. Data collection was conducted in two phases; 1) the focus was on collecting culture consensus questionnaires; 2) ethnographic data collection, which was also a large part of the fieldwork. Participatory observation was carried out throughout the data collection phases. Next, I will discuss the culture consensus questionnaire instrument development, and detailed sampling strategies employed in study.

Methods

Participants.

I.CCM: Purposive sample and snowballing technique (Bernard and Ryan 2010) were utilized to recruit two groups of participants (n=147): SRRW (n=73) and HCP (n=74). To address the second objective⁵ of this study, SRRW participants were drawn regionally rather than by "ethnic/clan" identity. Though most Somalis identify themselves along clan/tribes genealogy lines rather than by "ethnicity," the task of identifying participants based on clan or tribe membership can be arduous. Regional affiliation based on the geography of Somalia, however, better indexes the ethnic/clan affiliations (Gendel 2009; Eno et al. 2008; Lewis 1962). SRRW participants in this study are drawn to correspond with major regions: the Northern (n=19) and the Southern Somalis (n=32) and the Bantus (n=22) who are small minority Somali group in southern Somalia. All SRRW participants were asked and self-identify themselves into one of these three groups.

Selection criteria were: minimum 18 years of age (range 18-70 years) with dual⁶ and or single⁷ country obstetric experiences. The second group of HCP (n=74) included labor and delivery nurses (n=42), midwives (n= 5), physicians (n=24), and nurse practitioners (n=3). All HCP participants had various levels of provider-patient interactions with SRRW.

II. Semi-structure Interviews: Of the 147 participants, 40 participants were selected for further interviews using the phenomenology methodology: Ten HCP and thirty SRRW (n=10 from each group: Bantus, Southerners and Northerners). Data from these interviews were used to describe perceptions of female genital cutting (FGC) embodiment and to augment the quantitative data. Socio-demographic profiles and pertinent information of the participants are presented in tables 3:1-4.

Table 3:1: Somali demographic profile.

Variable	Somali Bantu (n=22)	Northern Somalis (n=19)	Southern Somalis (n=32)
Median age, years	34	30	35
Marital status			
Married	91% (n=20)	84% (n=16)	91% (n=29)
Divorced	-	15.7% (n=3)	6% (n=2)
Widow	9% (n=2)	-	3% (n=1)
Education			
No formal	41% (n=9)	5% (n=1)	37% (n=12)
Primary	22.7% (n=5)	26% (n=5)	25% (n=8)
High school	22.7% (n=5)	15.7% (n=3)	9% (n=3)
College	14% (n=3)	53% (n=10)	28% (n=9)
Employment			
None	86% (n=19)	42% (n=8)	66% (n=21)
Part time	9% (n=2)	21% (n=4)	9% (n=3)
Full time	4.5% (n=1)	21% (n=4)	18.7% (n=6)
Self employed	-	15.7% (n=3)	3% (n=1)

⁵ whether ethnically/clan diverse SRRW share a childbearing model

⁶ Somali women who have given birth pre and post migration/resettlement.

⁷ Somali women who have given birth either pre migration or after resettlement in the U.S.

Table 3:2: Duration of residence in the U.S., language and literacy levels among SRRW.

Variable	Somali Bantu (n=22)	Northern Somalis (n=19)	Southern Somalis (n=32)
Average years of U.S. residency	7	12	9
Speaks no/some English (interpreter needed)	86% (n=19)	47% (n=9)	69% (n=22)
Speaks English (no interpreter needed)	14% (n=3)	53% (n=10)	31% (n=10)
Reads and writes English	16% (n=3)	53% (n=10)	28% (n=9)

Table 3:3: FGC status and obstetrics history.

Variable	Somali Bantu (n=22)	Northern Somalis (n=19)	Southern Somalis (n=32)
Average age at first pregnancy, years	17	20	19.5
No. of births			
In U.S. only	36% (n=8)	68% (n=13)	40.5% (n=13)
In Africa only	14% (n=3)	11% (n=2)	19% (n=6)
Dual obstetrical experiences (U.S. & Africa)	50% (n=11)	21% (n=4)	40.5% (n=13)
Average number of children	6	3.5	4.5
SRRW Cesarean births			
In U.S.	41% (n=9)	42% (n=8)	28% (n=9)
In Africa	-	-	3% (n=1)
Dual (U.S. & Africa)	-	-	3% (n=1)
FGC status			
Yes	95% (n=21)	84% (n=16)	94% (n=30)
No	-	10.5% (n=2)	6% (n=2)
Not disclosed	4.5% (n=1)	5% (n=1)	-
Do not know	-	-	-
Type I-II (Sunna)	50% (n=11)	37% (n=7)	19% (n=6)
Type III	45% (n=10)	47% (n=9)	75% (n=23)
Reason for FGC			
None	-	-	3% (n=1)
Culture or tradition	82% (n=18)	74% (n=14)	84% (n=27)
Religion	14% (n=3)	21% (n=4)	6% (n=2)
Do not know	-	5% (n=1)	3% (n=1)
Cleanliness	4% (n=1)	-	3% (n=1)

Table 3:4: U.S. HCP Profiles.

Variable	MD	NP	MW	RN
No. (%)	24 (32)	3 (4)	5 (7)	42 (57)
Average age, years	37	47	48	42
Gender				
Female	18 (75)	3	5	42
Male	6 (25)	0	0	0
Ethnicity (%)				
African-American	3 (4)	0	0	1 (1.3)
Asian-American	2 (2.5)	0	0	2 (2.7)
Caucasian	14 (19)	3 (4)	5 (7)	36 (49)
Hispanic	5 (6.5)	0	0	3 (4)
Years in practice				
0-5	12	1	2	11
6-9	7	-	1	7
10-19	2	1	1	11
≥20	2	1	1	12
Provided Ob-Gyn Care to patients with FGC				
Yes	23* (31)	3 (4)	5(7)	41*(55)
No	-	-	-	-

*Missing data: one MD and one RN.

Materials

The culture consensus questionnaire (CCM) was developed from pertinent literature reviews (Bernard 2002; Weller 2007) and from secondary data originally collected in Ohio by Crista Johnson-Agbakwu, MD. The questionnaire with dichotomous responses (true/false) as initially constructed contained 150 propositional statements which were carefully balance between positive and negative items as suggested by Weller (2007). The questionnaire was pretested (Bernard 2002) on 8 healthcare providers and 12 Somali women (English version, see below) and was accordingly modified to incorporate the feedback received. The final culture consensus questionnaire contained 87 true/false (coded 1=true and 0=false) propositional statements, divided into three relevant subdomains. The first subdomain contained 22 questions on pregnancy and

prenatal care, the second had 41 questions concerning labor and childbirth, and the third domain contained 23 questions on FGC and childbirth. The cultural consensus questionnaire was then translated and back translated (see Chen and Boore 2009) in Somali and Kiswahili (Swahili) languages.

Procedure: The CCM questionnaires were administered on-line, one to one (face-to-face) and in small groups, but responses were independently completed (see below). The rationale for this multi-methods approach was time consideration and low literacy. Cave and colleagues, among others, have reported time constraints as one of the major barriers in hindering healthcare providers from participating in research (Asch et al. 2000; Cave et al. 2009; Levinson et al. 1998). To overcome these constraining factors, I posted the survey on-line (surveymonkey.com).

I found the on-line approach to be the most effective means to collect data among healthcare providers. For example, I was able to collect 87.5% (n=84) of my CCM responses from HCPs via the on-line method, compared to 12.5% (n=12) using the traditional face-to-face hard-copies that I personally administered. The advantage of the online instrument is that participants have total control in terms of their decision to participate, and their level of participation (e.g. the option of skipping questions). They can start and pause and return to the survey later, giving them control of time. The survey took 20-30 minutes to complete. The disadvantage, on the other hand, is that participants may either get distracted or even bored, ending up with incomplete surveys. For example, though I had collected 84 CCM responses, in reality I ended up with only 74 fully completed surveys. The other ten CCMs had to be discarded due to missing data, making the CCM questionnaires invalid for analysis (Weller 2007).

The option of utilizing the on-line data collection was not appropriate for SRRW participants. In part because most of the participants in this group are illiterate and/or do not have access to or familiarity with computer use. For the participants who spoke English or Kiswahili, I personally administered the questionnaires. For Somali and May speakers, ethnically matched (or neutral, i.e. Kenya Somali) interpreters conducted the surveys; however, I was present during all data collection activities. As for the participants with low literacy, the interpreters would read the questions and write down their responses (true/false) accordingly.

The majority of the survey responses (63.5%) were collected in the privacy of individual women's homes; one was at a mosque, another at a café. Face-to-face method provided the opportunity to interact with the participants, affording ample time for participant observation. In some instances, this venue provided ample of time to engage with the participants and observe their day to day activities; additionally, it provided an opportunity to recruit participants for semi-structured interviews. On the other hand, this method also proved to be very time consuming.

To expedite CCM data collection, four different group settings (4-7 participants) methodology was also applied to expedite data collection (Weller 2007). The group size varied from four to seven conducted at four locations: an indoor room in a public park, at the Mosque, and two were held at different Somali Associations office facilities. To enable me to conduct this group interview method, I was assisted by two Somali interpreters⁸; one monitored the participants to ensure they did not consult with one another; the second assisted the participants by reading out loud the CCM questionnaire. For the women who did not read or write, the interpreter read each question and instructed the participants to place an "x" in the appropriate box. I also personally

monitored the process. The participants were instructed that there are no “correct” or “incorrect” answers; the aim was to assess whether they agree or disagree with the items on the questionnaire. Participants were also informed that if they were not sure of their choice of responses, they may respond according to what they feel or guess (see Weller 2007). These methods and instructions were given in all the settings.

To minimize interruptions during the group settings, participants were told they can hold discussions after the completion of the “test.” They were also invited to participate in individual semi-structured interviews if they so wished. Refreshments were provided at the conclusion of group setting sessions. I found that this method was more efficient compared to private home structured interviews (CCM) with a single participant at a time. It also served to recruit participants for in-depth semi-structured interviews. At the same time, these “gatherings” provided the women and opportunity to socialize. This approach yielded 27 (36.5%) CCM survey responses all of which were independently completed. In hindsight, I would recommend the group setting method when using questionnaires for gathering data in the Somali communities. A total of 73 CCM responses were collected from SRRW.

As described below in this chapter (negotiating fieldwork) five interpreters were involved during CCM data collection in semi-structured interviews with SRRW participants for two main reasons. One was my inability to speak Somali (and other dialects such as May May spoken by Bantu Somalis) and another was due to the complexities of inter-clan/tribal differences among Somali resettled refugee communities. Essentially, I had to ethnically match interpreters with the participants. The advantage of having multiple assistants/interpreters enabled me to reach all ethnic

⁸ The assisting interpreters were clan-ethnically matched with the participants.

groups and thereby increasing heterogeneity by recruiting additional participants through their respective social networks.

My primary research assistant/interpreter, *Asmahan*⁹ is a Kenyan-Somali (ethnic Somali). She and I have had social ties long before the onset of the fieldwork. We both speak Kiswahili as our native language, in addition to English. She also speaks Somali along with several other dialects. Furthermore, she is a graduate student and worked with refugees in Kenya prior to coming to the U.S. (although not a resettled refugee herself); she continues to work with resettled refugees while pursuing her degree in Social Work and Health Administration. As a Kenyan-Somali, she was not associated with any particular Somali clans; therefore, her association within the community was more fluid or “neutral” and she could easily transcend clan and ethnic divisions.

The semi-structured interview in the second phase of the study applied phenomenology methodology to address the third objective. A phenomenological approach (Groenewald 2004) was applied to explore how perceptions of female circumcision are embodied. This approach entailed asking participants (SRRW=30 and HCP n=10) to describe their perceptual experiences with female circumcision as a phenomena in the context of childbearing events so as to discover the common and variations of this phenomenon as experienced firsthand by both groups (Baker et al. 1992). All HCP interviewed were specifically asked whether they provided gynecological and/or obstetric care to SRRW in during the semi-structured interviews but not for the CCM survey. Only those with such experiences were purposively selected to participate in the semi-structured interviews. Because FGC is most prevalent among SRRW, these groups of participants (n=10 from each of group: Northerners, Southerners and the Somali Bantu) were not asked whether or not they were circumcised prior to selection.

Unlike most interviews methods where a set of predetermined questions are strictly followed as guides, the phenomenological approach requires more flexibility to allow reflection, request for clarifications, examples and description of lived experiences of participants that are relevant to the research objective (Schmidt 2005; Wimpenny 2000). The guides to these interviews are in Appendix A. As mentioned above it is critical to have a good general understanding and appreciation of the diversity in the Somali refugee community. In the final section of this chapter I share my experiences in hope that it will assist future independent investigators who are contemplating conducting studies involving this community.

Negotiating Fieldwork

The conventional wisdom on conducting research among vulnerable communities in the global context abounds with cautionary tales (see Bloch 2007, 2004; Ellis et al. 2007; Johnson, Ali, and Shipp 2009; Sultana 2007). First, there are the challenges of implementing the strict institutional ethics (see Bhattacharya 2007) such as obtaining informed consent and complying with confidentiality and anonymity issues amongst participants who are not well acquainted with research protocols (Bloch 2007, 2004; Leaning 2001). Then there are methodology issues such as access and trust (Johnson, Ali and Shipp 2009), language barriers, and the role of interpreters (Temple 2008; Wallin and Ahlström 2006). There are also moral and ethical responsibilities of disclosure and representation of the research by the researcher (see Sultana 2007; Weems 2006). The focus of this section is to share my fieldwork experience and how I navigated and negotiated these challenges.

⁹ Pseudonym.

Vulnerable population

The term *vulnerable population* has a wide range of meaning in social science research. The term is applied to all persons deemed to be incapable of decision making and/or whose status is one being dependent on others (Levine et al. 2004). These persons include prisoners, the mentally disabled, pregnant women, children, and refugees among others. Stringent ethical codes have been put in place¹⁰ to protect their vulnerable disposition. The term may also be applicable to individuals who may not be in a position to voluntarily make a choice to participate in a research project due to poverty, illiteracy, fear and marginalization either due to political or other circumstances, such as immigration status (Bloch 2004, 2007; Levine et al. 2004).

The mere fact of being forcibly displaced from one's country of origin, uprooted from one's culture, and often separated from family members, greatly increases a sense of vulnerability (Ellis et al. 2007). Nine of the participants were single parents separated from their husbands because of the procedural quagmire in the refugee resettlement process. One of the participants has been separated from her husband for over five years, pending resettlement clearance. This is how she expressed her plight:

They brought me here without my husband, four months pregnant and with six kids. My husband was told he had to wait in the refugee camp in Kenya. Now it is 5 years, I am here alone with the kids. I cannot go to work; I have not gone to school. I am a single mother with seven small kids in America. It is a big problem for me and the kids. The kids need their father to teach them what is good and what is bad in American culture. I have no relatives here to help me, just friends. I worry about the kids. I pray to God to protect them (the kids); only God knows my anguish.

¹⁰ Belmont Report (U.S. National Commission 1979). The U.S. Congress created the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (the National Commission) in response to Nazi (World War II) abuse of captive prisoners and to domestic abuse e.g. Tuskegee (see Levine et al. 2004).

Though these participants are resettled refugees and safe from the war, many suffer the distress of separation from their larger families, the challenges of language barriers, cultural shock and the disadvantages of illiteracy. This can make them reluctant or fearful to participate in research (Atkinson and Flint 2001; Bloch 2007; Robinson 2002). Though they may feel disempowered by these circumstances, refugees do still have the power to make decisions on who to talk to, what to say and what to withhold so long as researchers do not use coercion (Lammers 2005b). This power was exercised by many who were very assertive participants in this project as will become clear later. One young Somali-Bantu resettled refugee woman even outright refused to participate in this study despite the fact that she and the interpreter was from the same tribal group. As such, not all refugees are incapable of making voluntary decisions on whether or not to participate in studies (Ellis et al. 2007). In fact, such generalization risks trivializing the notion of vulnerability, or worse yet presenting obstacles to doing the badly needed research of refugee groups (Ellis et al. 2007). Nevertheless, one should proceed with prudence; throughout this fieldwork I remained mindful of power differentials between me and the participants (see Fonow and Cook 1991) and tried, during the entire data collection process, to be sensitive to participants when they seemed hesitant to participate. In all, I encountered only one case of refusal among SRRW which I describe below.

Informed Consent

Obtaining informed consent can be particularly challenging in Somali communities due to variety of factors, including language barriers and social norms (see Leaning, 2001). In this study, for example, getting written consent was almost impossible in part due to the high illiteracy rate among participants and also because the Somalis are traditionally, an oral society (Abdi 2007; Kusow 1994). The concept of

obtaining signed agreements/consents is often viewed with suspicion (see Johnson, Ali, and Shipp 2009) in a society where one's word is binding. I disclosed this predicament in my application to the IRB at Arizona State University and was allowed to bypass written consent in lieu of obtaining a verbal consent record (audio taping). Accordingly, all consent was obtained verbally and audio taped. This method was not without flaw, as evident from my field notes and observations.

While Asia¹¹ and I were conducting a semi-structured interview with Fatma¹² this morning, her two neighbors (Khadija and Mariam) knocked on the door and came in (unannounced visits within Somalis is a norm). After five minutes of greetings (in Somalia,) they settled down on the sofa next to me. Fatma was in the kitchen making more tea for the guests. Asia introduced me to the two ladies. Khadija was wearing bright orange and green deirah¹³ with a matching scarf on her head. She looked younger than Mariam; I guessed they are both in their thirties. Mariam was wearing a blue cotton deirah and a black scarf over her shoulders, head not covered. I gathered Asia must have told them that I was conducting a research, because Khadija turned to me and said, "We too have our story to tell you." Mariam nodded, in agreement, "I have too much problems in the hospital". By this time, Fatma was pouring tea to the new visitors. She explained that they were her neighbors. I told the two ladies that I was delighted and thanked them for wanting to share their stories with me. I turned to Asia and asked her if she can read them the consent letter in Somalia before we proceed. Asia started reading the consent letter, when Khadija, said: "Is it not enough that we want to talk to you? Do you have to make Asia read this special (consent) letter to us? We are all one people- if Fatma (the lady being interviewed) agreed to talk with you, we agree too. We not asking you to sign or read a letter before you can talk to us (laughter)". I had to laugh with them because they were right in a sense. Asia came to my rescue, explaining first in English and then in Somalia: "This is a research requirement not her rule". Mariam waved her hand in the air dismissively and said: "In America everything is paper, this special paper, that special paper; even going to the bathroom requires special paper (laughter)". Finally, we all settled down with more tea and they both gave their verbal consent (taped recorded) and proceeded with the interviews.

This was not an isolated incidence where getting consent was a challenge. On another occasion, I was interviewing Taiba, an elder Bantu SRRW in her seventies, through Aysha, a May May interpreter. Taiba was a traditional birth attendant back in Somalia. During the interview, her neighbor Habiba "dropped-in". A slightly younger

¹¹ One of interpreters pseudonym (Southern Somalia)

¹² All names are pseudonyms.

Somali Bantu, Habiba was also a well-known a traditional birth attendant in Somalia and currently practices spiritual healing and traditional medicine. After exchanging greetings, Habiba joined in the interview in process. Aysha informed me that the Habiba wanted to talk to me about her daughter-in-law's birth experience in America and would like to "help you understand the problem with American doctors." Aysha told her that she has to read the 'letter of consent' to her and obtain her verbal consent before proceeding with the audio recorded interview. Habiba she looked at me with kind eyes, but with a very stern voice of admonition said:

Why? Are you not one of us; we are all *jama'a*¹⁴. Don't forsake your cultural upbringing! Everything here is sign paper, sign paper; sign here, sign this. There is no trust in God here. You see, I have delivered more than a hundred babies back home (pause), nobody signed any papers and none of the babies died, or their mothers. I want to talk to you; if I did not want to talk to you, I would just leave or shut my big mouth. You came to us and we received you well, right? This is not a marriage, where I have to give consent, even so, in marriage we need just to say 'yes' or 'no' and have three witnesses.

Again, after a lengthy explanation about institutional (IRB) requirements and the assurance that she did not need to "sign" any papers (consent forms), Habiba agreed to give her verbal consent (audio recorded) and participate in the interviews. Obviously, these incidents illustrate the different cultural understandings of giving "formal consent." To these participants, my insisting on formal consent was absurd, to say the least. It is important to understand that in some minority communities such as the SRRW, the notion of putting emphasis on signed consent can be considered not only culturally insensitive but may even dissuade some individuals from participating in studies (Barata et al. 2006).

¹³ A long, loose gown.

Insider-Outsider and In-between: Negotiating Access and Trust

From the onset of this research, I relied on my social ties and my cultural affinity with the Somali community to gain the access and trust that were essential to my ability to collect credible data material (see Kusow 2003). Merton (1972) defined an investigator with a cultural affinity with research participants as an insider researcher (see also Merriam et al. 2001); an insider is one that possess a priori intimate knowledge of the study group. In contrast, lacking cultural intimacy would define a researcher as an outsider (Merton 1972, 14). As I have found out during this fieldwork, such distinctions are more complex and fluid (see Merriam et al. 2001). My positionality and possessing a priori intimate knowledge of the Somali community afforded me some advantages in accessing the community. On the other hand, I had good reasons to be ambivalent to this privy positionality. For one, I had no personal experience of FGC, a subject central to this research. Even though I share many cultural elements with the community, FGC was one exception. FGC has never been practiced in any form in the Zanzibar archipelago (my province of origin) where 95% of the population is Muslims. Second, there was a language barrier that hindered direct communication with some of the participants who spoke neither English nor Kiswahili. Though I had the privilege of having interpreters, nonetheless, I was aware that sometimes meanings were lost in the translation.

The other reason for my ambivalent positionality as an insider was the power differential (see Sultana 2007; Merriam et al. 2001) between SRRW participants and myself. Throughout my fieldwork, I was acutely aware of my privileged position in terms of education and socioeconomic status compared to most of the SRRW participants. On several occasions for example, I was asked how long I had lived in the U.S., the neighborhood I live in, type of work I do and where I worked (aside from being a

¹⁴ *Jama'a* is an Arabic term that means a community of believers and also kinship.

graduate student). I was truthful in responding to their queries; admittedly though, it made me uncomfortable because it underscored my socioeconomic advantage vis-à-vis theirs. Not because I was unaware of this socioeconomic gap beforehand but, naively, I was not prepared to be asked leading questions that would accentuate the power differential between us. Reflexively, I confronted the differential power positionality and discarded the idealism of equality between the SRRW participants and myself (see Lammers 2005b; Merriam et al. 2001; Sultana 2007).

Consequently, my ambivalence of being neither an insider nor an outsider made me wary of being perceived suspiciously as the “other” (see Kusow 2003; Sultana 2007). I tried to be prepared by asking as many questions as possible about the potential participants from the interpreters and some of my Somali friends before we went to their homes. In contrast, such wariness was negligible during my interactions with the HCP, this is because as a physiotherapist I was among my own peers professionally and did not hesitate to enter a healthcare setting or approach a HCP in my quest to recruit this group of participants. With the SRRW on the other hand, despite the shared cultural ties, there were differences and tensions that I had to carefully negotiate and re-negotiate throughout my fieldwork. The following experience elucidates my ambivalence positionality and how I negotiated some of these tensions.

In the first week of my fieldwork, I visited a predominantly Somali refugee neighborhood. I was accompanied by Titi, one of my Kiswahili speaking friends who helped me gain access and who served as an interpreter. We were there to conduct a structured interview for the CCM. Upon completion, Titi suggested that we walk to another nearby building, where she knew another lady who might want to participate. While walking towards our destination, she gave me some background information on the lady we were about to visit. She told me that she had just been divorced and had had

two children in the refugee camp in Kenya and two here in the U.S. As we approached the house, the lady was sitting on the door threshold. We exchanged the customary greetings then Titi explained to her the reason of our visit and asked if she would be interested in participating in the study. This conversation was conducted in May. While Titi was addressing her, the lady's gaze was on me. While still looking at me, she asked Titi, "Who sent her here?" Titi translated and continued conversing with the lady. I sensed the tone of the conversation was getting tense between them. I gently pulled Titi aside and told her that we should thank that lady and leave immediately. I reiterated the relevant research ethics to Titi; that once a person shows any hesitation after we explain the purpose of our visit, it is best to leave graciously. We bid the woman a good day and as we were heading back to Titi's house, I asked why the conversation between them had become tense. Titi said:

She kept asking who sent you, but she would not hear me out. I was not upset that she was reluctant to participate, but I got upset when she said you were a spy from the American government sent to collect information on Somalis. She even said you are not a Muslim. That really upset me. She does not know you, but I know you; your mother and your brother and his family were here. How can she say you are not a Muslim? It is a sin to call a Muslim a non-Muslim. That is what I was telling her. She also said that the bag you are carrying is a 'spy' camera and the pen in your hand was recording the conversation. I even tried to tell her that you are a *jama'a* (kin) from Tanzania. She was disputing that too, just because of your light skin and soft hair; she assumed you are a '*mzungu*' (white person). On top of that, she has no shame. As we were leaving, she said she will agree to participate if you paid her \$30.00. She has no shame. She said that is the going rate of "selling" her information to the government you work for.

It was fortunate that this encounter took place in the first week of my fieldwork. It underscored the importance of being reflexive and prepared to negotiate "multiple axes of differences" (Sultana 2007, 374), both real and imagined. This incident showed me the deep distrust within the community towards "officials", including researchers, asking questions, (see Johnson et al. 2009). It also underscored the ambivalence of "insider-outsider" meanings and disposition (Kusow 2003) and helped me realize that

navigating fieldwork is an on-going process involving sensitive negotiations with the interpreters as well as participants. To begin the negotiating process, I took to heart Bernard's discussion of the importance in complying with a dress code while conducting fieldwork (Bernard 2002). Usually, I do not wear *hijab* (Islamic head covering for women), whereas, almost all Somali women cover their hair for cultural and religious reasons. So, while doing fieldwork I donned my *hijab* and also stopped wearing trousers, since all of the Somali women I was working with during this study do not wear trousers in public and instead mostly wear long dresses or skirts. These changes, while seemingly insignificant, afforded me the needed authenticity by asserting my Muslim-ness and my Swahili heritage.

Early on, I realized that I could not take for granted my social connections to gain access within the Somali community; that the issues of trust and access are complex and hard won. For example, contrary to Johnson's study (2009), I found that it was more challenging to gain access to those who arrived within the previous five years. Though I have well established social ties in the Somali community, I have not been as active in the past few years as I once had been. With this realization, I decided to meet up with the key stakeholders to let myself be known to newer members, to explain my research topic and to seek their cooperation in letting the community know about my research project (Bloch 2004, 2007; Johnson, Ali, and Shipp 2009).

Despite having multiple channels to gain access to the SRRW, recruitment of ethnically diverse Somali women was not as easy as I had anticipated. In part, as noted earlier, is that Somalis have strong community identities that are clan or ethnic oriented and are often suspicious of outsiders (Johnson, Ali, and Shipp 2009) and of other ethnic groups (Ellis et al. 2007). Navigating among Somalis, therefore, required a good understanding of Somali history, politics, awareness of inter-clan/ethnic relationships

and cultural sensitivity. Historical distrust among different Somalis groups was exacerbated by the atrocities of the civil war (Lewis 2002; Kusow 1994; Kusow and Bjork 2007) in which Somali minorities, such as Bantus and Braves (aka Barawa), were specifically targeted and consequently suffered the most during the war. Those who fled and found refuge in the West have not forgotten the atrocities they endured or witnessed. For example, one Bantu participant whom I have known for five years made it very clear to me that she does not trust non-Bantu Somalis and warned me “these Somalis with soft hair are not to be trusted.”

Being aware of the distrust and resentments among the different SRRW, I sought advice from some of my Somali friends on how to best navigate the inter-clan dynamics and overcome access barriers. They suggested recruiting research assistants/interpreters who were ethnically/clan “acceptable” within their respective groups; that is, ethnically match the research assistant/interpreter with the participants (Johnson, Ali, and Shipp). They emphasized that I needed to approach and explain my research aims and method to gatekeepers (Bloch 2007) such as mosque *imams* (religious leaders) and Somali organizations leaders and to identify key community women leaders/elders. Taking to heart these suggestions, I was able to gain wider access to diverse SRRW. I found that collaboration with the gatekeepers was an essential prerequisite to facilitating trust and gaining access to the diverse SRRW who participated in this study.

I also made myself more visible by attending several Somali social functions such as Friday prayers,¹⁵ weddings, picnics, and other women’s gatherings throughout the city. During these social gatherings, I felt more at liberty to approach the Somali women either directly if they spoke Kiswahili or English, or through my Somali social

¹⁵ I mostly attended the Somali mosque in Phoenix, where Friday sermons are held in the Somali language with occasional English translations for non-Somali speakers.

connections (interpreters) to introduce myself, and tell them about my research and ask if they would like to participate by providing their telephone contacts. The objective was not just to get participants, but to, most importantly, gain legitimacy through my connection to the community. Collectively, these approaches proved to be essential in establishing rapport in navigating this fieldwork and in being able to reach diverse segments of the SRRW.

Navigating Language Barriers

There are two options in conducting cross-culture research among non-English speakers. One is to exclude participants who do not speak English and the other is to recruit interpreters to assist in the research process; each of these approaches has its own advantages and disadvantages (see Wallin and Ahlstrom 2006). Studies that exclude non-English speakers may avoid time and financial burdens but may run the risk of over generalization or even misrepresentation of the group under study (Wallin and Ahlstrom 2006). On the other hand, recruiting study samples with limited and or without English proficiency requires collaboration with interpreters which can be time intensive and costly. Additionally, interpreters introduce another challenge as they become part of the knowledge production (see Temple 2002). Weighing these two options, I felt that being inclusive trumped the alternative. First, it reduced sample bias by increasing internal validity making it more representative of the study population. Second, it enabled me to gain a better understanding of social and cultural differences among the SRRW. Having said this, I also admit navigating language barriers within the context of clan /ethnic division among the SRRW proved to be a sensitive cultural negotiation.

To match interpreters with participants, I was able to get five ethnically/clan diverse¹⁶ Somali female interpreters¹⁷. Three of the five interpreters had prior experience in assisting research among their own communities. For the experienced interpreters, I spent an average of six hours in one-on-one training sessions on how to conduct the survey¹⁸ and semi-structured interviews. As for the inexperienced interpreters, I repeated the same process with additional training in which I personally conducted the survey on the two interpreters to model how to ask and record the responses. I emphasized issues of confidentiality among all the interpreters.

The advantage of working with multiple interpreters who were well respected and known within their respective groups, facilitated trust and access across diverse SRRW participants (see Baker 1981; Hennings et al. 1996; Wallin and Ahlström 2006). Their collaborated assistance was indispensable to the successful completion of this study. The challenge was to accommodate their availability to accompany me as we traversed into various Somali enclaves across the city, as well as talking to different gatekeepers in their respective communities. This required patience and flexibility while at the same trying to meet the planned timeframe in collecting data for this study.

It is well understood in cross-culture research that concepts and contexts are difficult to translate linguistically and culturally (Larkin, Dierckx de Casterlé, and Schotsmans 2007; Temple et al. 2006;). As such, I was well aware that my research collaborators (interpreters) interjected their own social realities in the context of the data production (Larkin, Dierckx de Casterlé, and Schotsmans 2007; Temple et al. 2006). This was more challenging during semi-structured interviews than when conducting the

¹⁶ Two of the interpreters were Southerners (one Kenyan-Somali), two were Bantu Somalis, and one Northerner.

¹⁷ I credit this achievement to my established social ties within the community and to Dr. Johnson-Agbakwu refugee clinic associates.

CCM questionnaire which only involved reading a translated text and recording either agreement or disagreement to the statement.

In this study, I use Baker's (1981) approach to distinguishing between translator and interpreter. Translators work with written material, translating texts from one language to another; while the interpreter's role is to interpret spoken language (conversations) back and forth between individuals (Baker 1981). Though this is a useful distinction, many researchers do not make such a distinction (see Temple 2002). I used translators to translate the CCM instrument, recruitment letter, consent form from English to Somali and to Kiswahili. All the documents and instruments were translated verbatim as much as possible, while maintaining appropriate cultural meaning through back-translations to verify the content (Patto 2002) of the CCM questionnaire. Below are the profiles of the CCM translators (see table 2).

Table 3:5. Profiles of translators

Bilingual Translators	Language	Profession
A.H.* (male)	English-Somali	Business Owner
E.Y.^ (male)	Somali-English	PhD (Education)
L.F.* (female)	English-Kiswahili	PhD candidate
A.Z.^ (female)	Kiswahili-English	Language Professor (retired)

*Translation; ^Back translation.

In contrast, interpreting is a social process of engaging in a dialogue with (not through) one or more people (Temple, 2002; Larkin et al., 2007). Interpreters in this study had two roles: first, to read to participants who were not literate a translated consent form and the CCM questionnaire and to write down participant responses, a binary choice true/false. Their second role was interpreting the dialogues between me and the participants during the semi-structured interviews.

¹⁸ I explicitly emphasized the three conditions required to conduct CCM (see Weller 2007).

Unlike the structured interviews (the CCM questionnaires), semi-structured interviews involves “at the very least the translator mak[ing] assumptions about meaning equivalence that make her an analyst and cultural broker as much as a translator. The translator always makes her mark on the research” (Temple and Young 2004, 171). Consequently, I acknowledge the role of my interpreters in this knowledge production (Temple and Young2004).

In most cases interpreters are paid to assist researchers (Temple, 2002); this was not the case in this study. Only two of the translators¹⁹ were paid for translating/back translating the IRB documents and the CCM questionnaires. In contrast, none of the interpreters who assisted me in this research received financial payment. At the onset of the study, I disclosed to all the interpreters that I did not receive funding that would have enabled me to compensate them. Aware of my position, all five agreed to assist me without any formal financial gains.²⁰ I attribute this privilege to the social ties I have nurtured with various members of the Somali community and perhaps the merits of this study to their community.

Table 3:6. Profile of Somali interpreters

Interpreter	Ethnicity	Language Proficiencies	Profession
Asmahan ^	Kenya-Somali	Somali/English/Kiswahili	Graduate student
Asia ^	Southern- Somali	Somali/English	Unemployed
Marwa ^	Northern- Somali	Somali/English/Kiswahili	Nursing student
Aysha	Somali-Bantu	Somali/May May/English	Healthcare

¹⁹ English-Somali and Somali-English written translators were pain from the available funding received earlier in the project. I translated from English to Kiswahili and Kiswahili to English was translated by a retired language professor friend of mine.

²⁰ By formal gains I mean a fixed monetary rate for their service. However, I took all possible chances to reciprocate their generousities by other means such as paying for lunch, dinner, and other tangible and non-material contributions.

Titi	Somali-Bantu	Somali/Kiswahili/Kizigua; May May	Unemployed
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^formal training/experienced research assistants

During the entire fieldwork process, I was very aware of the need to balance the pressing issues of time management in data collection against patience, reflexivity, and cultural sensitivities as well as time consideration and availability of the interpreters. For example, a majority of the data was collected in the privacy of participating women’s homes thus requiring prior arrangement. Though arriving at pre-determined times, sometimes participants were not able to participate due to various reasons such as having unexpected guests for mid-morning tea, having a sick child, having to assist a neighbor/friend, etc. and we would have to wait for several hours to begin the interview process. I usually depended on the accompanied interpreter’s cue as whether to wait or move on to the next participants. On several occasions, rather than wait, we took the liberty to ‘drop-in’ to the next apartment²¹ which is a culturally acceptable practice.

In keeping with the Somali etiquette, upon arrival in the participant’s homes, we exchange greetings and I was introduced as “sister”²² or “mama”²³ depending on which interpreter I was accompanied by, and/or the age of the participant. Culturally, these kinship terms established a level of respect and trust. The purpose of my visit as a researcher would be introduced after we settled down between making small talks about life in general, while sipping sweet spiced tea, a customary hospitality in Somali homes. Keeping with the Somali cultural etiquette, I conducted myself as a guest first and a researcher second. As a guest, I asked about the family welfare while sipping tea, and

²¹ Often, there are several families in the same low income apartment complex.

²² In Islamic culture, the term “sister” indicates community kinship, “*Umma*,” based on shared faith and respect.

contributing to discussion of raising Muslim children in “American culture”, a conversation that would almost always emerge among SRRW with small children. I ate meals and joined in prayers when it was time²⁴ with my hosts. Some days, this is all that we would be accomplished; in that case, we would request another visit to actually conduct the interviews. Nevertheless, these interactions afforded me time to gather ample field notes and learn more about the Somali social interactions within the enclaves’ dynamics. I also got to know their friends and relatives, as well as their trials and triumphs as Somali immigrants, and in turn they got to know me, too.

On several occasions during the data collection process, I was asked medical questions or for advice on what to do with a medical problem. During these interactions, I examined and treated them by prescribing physical therapy exercises for back, neck, leg, and shoulder pain. I educated some regarding exercises for weight loss and posture. I also accompanied a couple of women to their medical appointments. I was also asked to fill in ‘official’ forms (for example, passport applications, employment applications, etc.) either by some of the participants or their friends and neighbors who popped-in during data collection sessions. A couple of times, I was asked to contact real estate agents to help search for affordable homes for a couple of the women looking to purchase homes. All these extra activities would prolong the interview process. Sometimes it took 5-8 hours to complete a single CCM survey due to the unplanned circumstances that would arise; hence, was the reason to conduct some of these CCM questionnaires in a group format (see methods section above).

²³ Within the East African culture, “mama” signifies respect in accordance to age differences within a community.

²⁴ Muslims perform five daily prayers that are set to times of the day: at dawn, at noon, at midafternoon, at sunset and at night.

Summary: The subject matter and the issues of this study are complex, emotive, and diverse; therefore, require multiple theories and methods to be able to address them more adequately and to provide a more comprehensive perspective. The CCM provides means to measure and identify cross and intra-cultural variations in the childbearing domain of knowledge. This method will help discern whether or not SRRW and HCP share a conceptual model, as well as determine if the SRRW, as a group, agree or share on a single conceptual model. It also provides information on their discrepancies, that is, on which questions across the three subdomains in the CCM questionnaires the groups differ the most. Identifying variations patterns is an important step needed to begin addressing and improving birth experiences and outcomes in the SRRW communities.

To understand how embodiment of FGC emerges in the context of childbearing and migration, it requires a phenomenological approach to contextualizing the subjective and the intersubjective perceptual experience of female circumcision body. How this body and its bodily processes is perceived in engagement with the world? The subjective and intersubjective narratives of such encounters are necessary to describes how these experiences shape interactions between SRRW and HCP. This framework allows us to go deeper beyond shared knowledge into how and why differences emerge, embodied and are sustained. If embodiment is about cultural phenomenon as Csordas claims (1999), then it is critical to juxtapose SRRW and HCP perceptual experiences of FGC and childbearing to begin to understand how it may influence patient-provider interactions.

In the research design section, objectives of the study are given and methods applied are discussed in details; also the participants and their profiles are presented. The materials sources, development and the procedure in data gathering are also discussed in details. Inevitably, every research project has its unique challenges. There are elements of unpredictability that are inherent in all research designs and perhaps

more so in ethnographic studies (Huisman 2008). Conducting research among resettled refugee communities is fraught with methodological and ethical challenges that requires careful ethical, cultural and methodological considerations (Ellis et al. 2007; Goodkind and Decon 2004; Jacobsen and Landau 2003; Mackenzie et al. 2007). Familiarity with the researched population is not only desirable but imperative (Bloch 2007; Johnson et al. 2009).

This study, for example, illustrates the importance of having a good understanding of the diversity in the Somali community, their cultural nuances, from the historical perspectives to the post-migration context and establishing legitimacy with the gatekeepers as well as social relationships with the participants and the interpreters and or cultural guides. All these were imperative in gaining access and trust. I have also presented how disclosure, positionality, and personal contacts with the SRRW have their own advantages and predicaments. For example, while they may have facilitated access and trust, they also presented ethical challenges such as obtaining formal consent. Navigating language barriers and using interpreters presents additional challenge (for example, see Temple 2008) in this fieldwork. It required careful and detailed considerations and understanding of the Somali history, cultures, and social fissures. Most important lessons learned: Somali refugee communities are diverse; contextual understanding is indispensable in conducting research. Trust is not given, but earned through negotiations, cultural sensitivity, and reflexivity. Above all Somali resettled refugee women are most generous in all respects, as individuals and as cultural group irrespective of their intra-cultural differences.

CHAPTER 4

LOCATING SOMALIS

This chapter is divided into pertinent sections that are relevant to this study. The first section, Locating Somalis, provides a brief history of the Somali people, their sociocultural and economic systems including differences that distinguish the Somalis from non-Somalis or the Somali Bantus will be presented. Next I touch on the civil war of Somalia and the refugee crisis which has that resulted in the global Somali diaspora. The following section describes the Somalis in America and the multiple challenges they confront. Finally, Somalis in Arizona, where this research was conducted are presented.

Somalia as Homeland.

The Somali peninsula occupies the northern corner of the Horn of Africa, bordered by Ethiopia to the northwest, Kenya to the southwest, the Indian Ocean to the east, and the Gulf of Aden to the northeast. Currently, Somalia is geographically and politically divided into three uneven autonomous regions: south central Somalia, Somaliland (in the northwest) and Puntland (in the northeast). The largest of the three is south central Somalia where 70% of the population lives; 20% of the population lives in Somaliland and Puntland has 10% of the total population and is the smallest of the three regions²⁵ (WHO 2011). Unless specified otherwise, the media reports on “Somalia” as a country refers to the south central part of Somalia ²⁶; excluding Somaliland which has seceded and declared autonomous from the rest of Somalia. This part of the country is located at the far northwest part of Somalia: borders with Djibouti to the west, the Gulf of Aden to the north, Puntland to the east, and Ethiopia to the south). Puntland is also semi-autonomous region of Somalia, it forms the “horn” of Africa, located to the east

²⁵ WHO 2011; <http://www.state.gov/r/pa/ei/bgn/2863.htm>

of Somaliland, also borders the Gulf of Aden to the north and the Indian Ocean to the east, its southern border adjoins with the Somalia. (see map 1²⁷).

Figure: 4.1 Map 1 Of Somalia



The People and Cultures of Somalia: Samaals and non-Samaals

Evidence from archeological records suggests that the people of Somalia have an ancient history dating back to 100 A.D. and possibly even earlier (Fitzgerald2002; Kusow1994; Lewis 2002, 2008). According to historical, anthropological, and linguistic studies, the Somalis—also known as *Samaals*—belong ethnically to the Cushitic-speaking family²⁸ located within the Eastern Cushitic group of people whose language, Somali, is classified as Afro-Asiatic (Fitzgerald 2002:31;Lewis 2008). Though nearly all Somalis speak the Somali language, there are several dialects that vary considerably across clans and regions (Kusow 1994).

²⁶ This is the region that the international community recognizes as Somalia – albeit often referred to as a “failed state.” (ref. <http://www.emro.who.int/somalia/>).

²⁷ Map source: <http://www.lonelyplanet.com/maps/africa/somalia/>

²⁸ The Cushitic languages are spoken by large numbers of people in various eastern and northern regions of Africa: the Oromo (northern Kenya), Afar (Ethiopia; also in Eritrea and Djibouti). Cushitic peoples are also known as ‘Hamitic’.

Samantar (1992: 628) contends that genealogy constitutes the heart of the Somali social system. The people of Samaal, or the Somalis, share a common ancestry that is traceable through the paternal lineage and divided into six major clan-families, which are further divided into hundreds of sub-clans occupying different geographic terrains (Lewis, 2002). The six major clans are: the Dir and the Ishaaq clans occupy the northwest and north central Somalia respectively; the Hawiye occupy the coastal central Somalia; the Daarood who constitute the largest and politically dominant clan and occupy the northeast and southern territory of Somalia (Kusow 1994; Lewis 2002). Traditionally, these clans are predominantly nomadic and make up the majority (85%) of Somalis (Lewis 2008). The other two major clans are Digil and Rahanweyn, known collectively as Digil Mirifle or Sab; being significantly smaller (15%) mostly farmer clans, and occupying the fertile regions between the Shebelle and Juba rivers in the southern central region of the country (Lewis 2008). Being pastoral nomads or settled farmers is the primary dividing line among clans in Somalia (see Lewis 2008) but Kusow (1994) adds that these six major clans of Somalia represent two linguistically and culturally distinct groups. See map 2²⁹ for clans/ethnic divisions across Somalia

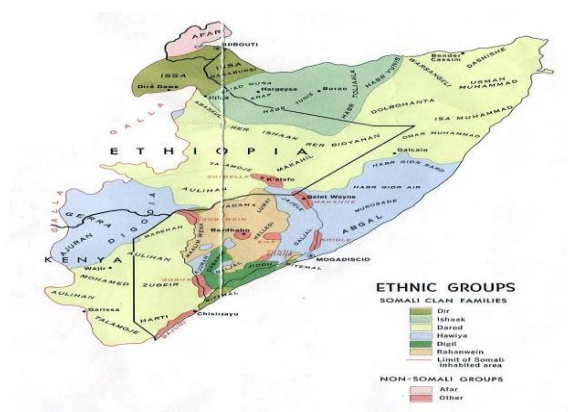


Figure: 4.2 Map 2 Somalia Clans/Ethnic Divisions

²⁹ <http://www.worldofmaps.net/en/africa/map-somalia/map-ethnic-groups-somalia.htm>

Somali Minorities

Beside these six clans major there are several smaller ethnic groups³⁰ who are not part of these clans, such as Somali Bantus who are culturally and linguistically distinct. These groups are mostly farmers (Eno and Eno 2007; Lewis 2008; Stephen 2002). The Sab (or non-Samaals), according to Lewis,³¹ are actually an amalgamation of Digil and Rahanweyn (Digil Mirifle) and Bantus, Oromos, Barawa, Bajuni, Hamar, Indians, and Arabs (Lewis 2008). Though most literature tends to represent Somalis as a homogenous group (Kusow 1994), this is far from factual; even the Somali-Bantus are not a homogenous group (Lewis 2008; Stephen 2002) and are made up of at least six tribes including Zigua, Zaramo, Magindo, Yao, Makua and Manyasa.

The Zigua and the Zaramo Bantu Somali tribes have their origin in Zanzibar and Tanganyika (Tanzania), whereas the Manyasa trace their historical roots in Malawi, and the Magindo, Makua and Yao were originally from Mozambique (Stephen 2002). Lehman and Eno (2003), however, argue that some of the Somali-Bantus are indigenous to Somali³² while some tribes among the Bantus were originally brought to Somalia as slaves from Zanzibar and the other countries (Tanganyika, Malwai and Mozambique) to work in the agriculture sector about 200 year years ago (Eno and Eno 2007; Lehman and Eno, 2003; Lewis 2008; Stephen 2002). The Somali-Bantus, therefore, have different physical features that distinguish them from the Cushitic Somalis (*Samaals*). For example, the former are shorter in stature and have harder hair texture while the latter are taller, leaner with relatively softer hair textures (Lewis 2008; Stephen 2002).

³⁰ Oromos, Barawa, Bajuni, Hamar, Indians, and Arabs are also members of ethnic minority groups in Somalia (see Lewis 2002, 2008).

³¹ I.M. Lewis is Emeritus Professor of Social Anthropology at the London School of Economics and Political Science. He is a well respected scholar of Somalia.

Lehman³³ and Eno (2003),³⁴ purport that because of their slavery ancestry, Somali-Bantus were among the most marginalized ethnic minority in Somalia. The Somali-Bantu along with other minority groups such as Barawa, and Bajuni have retained their own tribal languages, folklore, music and other cultural nuances (Eno and Eno 2007; Lewis 2008; Stephen 2002). For example, the Barawas speak Barawa, a dialect of Kiswahili, while some of the Somali-Bantu speak May May or Kizigua (Kiswahili dialect).

The Somali-Bantu, and in particular the Mushungulis (i.e. Wazigua) tribe, have never integrated with other Somalis or with the larger Somali-Bantu (Stephen 2002). The Mushunguli Somali-Bantus succeeded³⁵ in establishing their own “independent state within Somalia” in the forest region of southern Somalia, a place known as *Gosha* (Eno and Eno 2007). Some other Bantu-Somali tribes moved to Gosha-land founded by the Ziguas (Lehman and Eno 2003). Their isolation from the rest of Somalis meant that the Zigua tribe “were not entirely ‘Somalized’” (Eno and Eno 2007:19). They retained their Kizigua dialect of the Kiswahili language, and also held on to their southeastern African identity, ancestral cultures and other customs which are distinct from the rest of Somalis (Lehman and Eno 2003). In Gosha-land,³⁶ Kiswahili and May May remained the dominant languages, though most Somali-Bantus also speak the Somali language (Eno and Eno 2007; Lehman and Eno 2003).

³² The Bantu tribes of Somalia who are original to the country were not identified by authors.

³³ Dan Van Lehman is a scholar and advocate for Somali-Bantus and has worked with the United Nations High Commissioner for Refugees (UNHCR) field officer in the Dagahaley Refugee Camp from 1992 to 1994.

³⁴ Omar A. Eno is the first Bantu to advocate in an international forum for civil and human rights on behalf of the Bantu people in Somalia. See <http://www.youtube.com/watch?v=WAU9BQjobec>.

³⁵ After a successful uprisings to free themselves from slavery. The uprising was led by a Zigua woman by the name of *Wana-Kucha* (see Eno and Eno 2007).

³⁶ Goshaland inhabitants are called Wagosha which translates to “people of the forest.” See Lehman and Eno 2003.

Hence, there has been little interaction among majority and minority clans and in particular between northerners and Somali-Bantus. This was evident during my fieldwork when I learned from one of my northern Somali participants:

I was shocked to learn that there are people in Somalia who are Bantus, and also Somalis. You see, I grew up in the Hergesa (Somaliland capital city); we never travelled to Mogadishu (the capital city in the South). Whenever we traveled, it was within the northern territory or we went to Aden (South Yemen). When the war broke out in the 80's, we had been in Aden and never returned to Somalia. We moved to Dubai, where I met my husband (African-American), and after we were married, we came to the U.S. I had all my three kids here. Only then did I learn about Somali refugees here (in the U.S.) called "Somali-Bantu". I was curious to see them. I always thought that all Somalis were the same, just different clans. I never thought that some Somalis are different [in physical features]. They look different, they speak a different language – not just a different regional dialect! I learned all this here in America. I am ashamed actually, that I did not know much about my own country and people until now.

From historical, geopolitical and ecologically perspectives, one can therefore extrapolate that generally, Somalia and Somalis are more fragmented than they are an integral whole as a nation, people or culture. The major clans and the minority groups not only occupy different territories, but they have also had different social, cultural and political experiences (Kusow 1994; Lewis 2008; Samantar 1992). For example, the northeast of Somalia (currently Somaliland) was colonized by the British while the Italians occupied the central and southern parts of the country. Each of these colonial administrators had their own system of ruling and consequences for the ruled. The British for example, had an indirect rule; refraining from interfering with the Somali culture (Kusow 1994). Other than the official governing authorities, they did not establish British settlements. As such, with the exception of a few Somali elite families with whom the British had direct contact, the northerners were able to preserve their traditions and cultures without much Western (British) influence. In contrast, Italian rule encouraged settlers to emigrate from Italy in large numbers and spread across large territory in southern Somalia (Lewis 2008). Consequently, some of the Italian settlers

acquired the most productive land for agriculture, resulting in the encroachment on the Somali-Bantu's only means of economic freedom (Lehman and Eno 2003).

Another Somali cultural distinction is evident in the education systems which colonizers of both nations established. Education and Christian missionary work to gain converts went hand-in-hand in all of colonized Africa (Asafo 1997; Fabian 1983). Lewis (2008) gives the account that in Somaliland, the British observed sensitivity to the local Muslims' resistance against missionary work; hence the first Government [i.e., non-missionary] school to offer Western education in the North was established in 1893. This school educated males only, and it was not until the 1950s that another school for girls was established (Lewis 2008). In contrast, Italian Somalia had "a wider level of education with a varied curriculum, though with lower standards, [which] was instituted by the Italians, and mission activities were not totally excluded" (Lewis 2008: 31). The presence of missionary activities in central-south Somalia accounts for why Somali Christians (less than 1%) come mainly from central-south Somalia (Lewis 2008).

Though Somalis are not culturally, linguistically or "ethnically" homogenous people, they do share a salient cultural trait: Islamic faith as 99.5% are Muslims (Kusow 1994; Lewis 2007; U.S.D.S 2009³⁷). FGC is another culturally shared practice that transcends geographic, socio-cultural and clan/ethnic divisions. Hence, the universal prevalence of FGC among Somali women and girls is often associated with Islam though the practice pre-dates Islam (Asmani and Abdi 2008; White 2001).

In summary, though Somalis (*Samaal and non-Samaals*) share many cultural features such as religion and female circumcision, they are not culturally homogenous people, evident by their genealogy, geography, political background and economic

³⁷ U.S. Department of State.

engagements. Their diversity has often been unappreciated or even ignored until very recently, with the advent of the civil war and its' aftermath of atrocities and displacement. To avoid the complex Somali clan system but yet to capture the cultural diversity that is representative of Somalis, Somali resettled refugee women (SRRW) participants in this study were recruited along the cultural-regional distinctions: Northern Somalis, Southern Somalis, and the Somali-Bantus³⁸(as a minority group).

The impact of Somali conflict and Somali Refugees

The Somali civil war began in the 1980s but 1991 marked the final fall of Sa'id Barrer's regime (Kusow and Bjork 2007; Lehman and Eno 2003). Like most civil wars, issues of territorial control, ethnicity, and foreign interventions all played a major role in igniting and fueling the war in Somalia (see Kusow 1994; Lewis 2002; Marangio 2012). Kusow (1994), a sociology professor and Somali native, argues that genesis of the civil war can be traced to clan disputes. Before her independence in 1960, Somali was divided into more or less clan territories. Kusow attests that, even prior to the colonial period in Somalia, the six major clans were restricted to their own geographic territories, with distinct cultures and economic activities.

When the former Somali president Sa'id Barrer took power in 1969, he unified the fragmented country into a nation state of Somali by introducing written Somali language and by banning tribalism (Kusow 1994). Yet, ironically, Kusow posits that Barrer's regime started to collapse as early as the late 1970 due to clan disputes between the president's clans (from the south) and the other clans, particular in the north. Clan divisions, argued Kusow have presented a challenge to "the last venue of Somali unity, namely Islam" (Kusow 1994, 42). Consequently, the current civil war in Somalia "is a

³⁸ Non-Samaals.

direct result of both the long suppressed historical, cultural, and ecological differences among Somali clans families and how they have used history” (Kusow 1994, 42).

Somalia has been at war for almost three decades; countless people have been killed, many others displaced, and the social fibers dismantled and economic development arrested (UNDP 2001³⁹). The Somali-Bantu, along with other minority groups, such as the Barava, Bajuni and the Hamar, were disproportionately victimized during the war; this was because they neither belong to, nor are allied with, the politically powerful clans for protection (Eno and Eno 2007; Lehman and Eno 2003; Lewis 2008; Stephen 2002). Additionally, the ravages of war and insecurity, drought and famine have compounded the human suffering. Needless to say, the current Somali health infrastructure is totally devastated, as the WHO (2012) current country health profile indicates (see table 4:1).

The WHO (2012) report⁴⁰ estimates the population of Somalia to be at 9.3 million, with 33% of them living in the urban areas. Life expectancy is 51 years for both males and females. The mortality rate for children under five years of age is 180 per 1,000 live births (18%); maternal mortality is four-fold the regional (Sub-Saharan Africa) average at 1,000 per 10,000 live births (10%). Somali maternal mortality figures are higher than those for Afghanistan, a country which has also experience prolong war (WHO 2012). The probability of dying between the ages of 15-60 years is 366/1,000 (36.6%), compared to regional /global averages of 188 (18.8%) and 76 (7.6%), respectively. Less than 30% of the population has access to clean water and sanitation. Communicable diseases, such as TB and HIV, are equally alarming when compared to regional and global prevalence. Literacy rates among those 15 years and older is only

³⁹ United Nation Development Programme

⁴⁰ <http://www.who.int/gho/countries/som.pdf>

25%⁴¹. The 30 years plus of war has made Somalia one of the most unstable and poorest nations in the world, with 43% of its population living in extreme poverty, surviving on less than one U.S. dollar per day (UNDP 2004).

Table 4:1.Somalia Health Profile

	Somalia	Regional (Sub- Sahara) avg.	Global avg.
Population	9 331		
Life expectancy (male/female)	51/51	64/67	66/71
Under five mortality (per 1,000 live births)	180	68	57
Adult mortality (probability of dying between 15-60 yrs. Per 1,000 population)	366	188	76
Maternal mortality (per 100,000 live births)	1000	250	210
Population with access to improved water and sanitation	<30%	-	-
TB (per 100,000 population)	513	173	178
HIV(per 1,000 population)	7	2	8

The Somali health profile, in summary, reflects the current state of the nation; it is bleak and the prospects of improvements in the near future, seem guarded at best. Until the humanitarian crises are resolved, this situation will likely continue to forcefully displace Somalis internally and internationally, adding to the already overwhelming refugee crisis locally and globally.

The Somali Refugee Crisis: Global Somali Diaspora

In addition to the atrocities of war and disintegration of civic society, another tragic toll of Somalia's civil war is the massive displacement of its population, both internally and internationally (Kusow and Bjork 2007). The Somali diaspora is estimated to be around two million worldwide (Lewis2008; UNCHR⁴² 2012). The most current

⁴¹ <http://www.emro.who.int/somalia/> Country profile WHO

⁴² United Nation High Commissioner for Refugees (UNHCR)

figures by the UNHCR (2012) indicated that one million Somali refugees are currently registered in various refugee camps in Kenya, Ethiopia, Djibouti, Tanzania, Egypt, and Yemen, and the flow of Somali refugees arriving at these UNHCR camp sites continues to grow. However, not all fleeing Somalis end up in refugee camps; some are able to join their families resettled in other countries through “family reunification” immigration programs or as asylum seekers (Barnett 2003), thus bypassing the official UNHCR figures of registered Somali refugees in the camps awaiting resettlement. These groups, though by all practical standards are refugees, are not counted as refugees upon entering the U.S. (or other host nations) and thus may skew the official numbers of Somali “refugees” in the host countries including the U.S.⁴³. Currently, there are 26 nation states that participate in refugee resettlement, and the U.S. ranks first among the nations that participate in this humanitarian program (UNHCR 2012). Somali resettled refugee communities are scattered everywhere; the Somali diaspora is global (Kusow and Bjork 2007)⁴⁴.

⁴³ See Proposed Refugee Admissions For Fiscal Year 2012
<http://www.state.gov/documents/organization/181378.pdf>

⁴⁴ The official estimate of Somalis in the UK is 350,000, though the UK Council of Somali Organizations places the figure at 1 million (Muir, 2012). The Netherlands (Wolf, 2011), Italy, and Finland, as well as all three Scandinavian countries (Denmark, Sweden, and Norway) have granted resettlement to a sizeable number of Somali refugees and their dependents (WB). Somali refugees have also been resettled in Canada and the USA; Somali refugee communities are to be found in Australia and New Zealand (Allotey, 2003). A large number of Somalis diaspora communities are established in several African nations (outside of Somali) including South Africa, Kenya, Tanzania, Ethiopia, Uganda, and Djibouti (UNHCR, 2014). The Arabian Peninsula—United Arab Emirates and Saudi Arabia—has its share of Somali diaspora communities, and of course Yemen’s geographic proximity to Somalia has attracted a large Somali refugee population (UNHCR 2012; Lewis 2008).

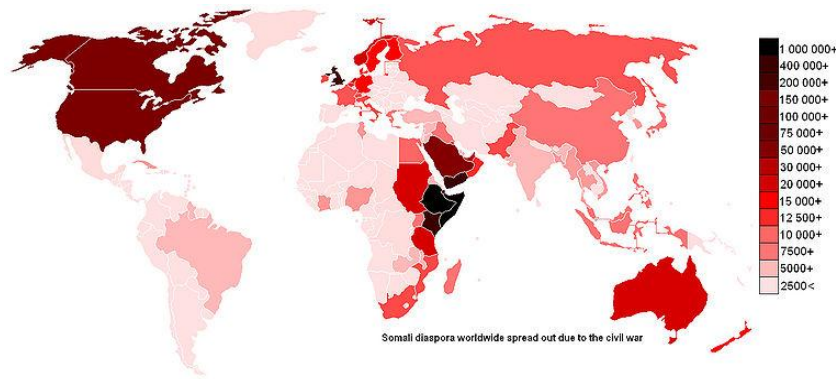


Figure: 4.3 Map3 Somali Global Diaspora 45

Most Somali refugees have an extended social support system through their clans' members who had resettled earlier and who assist in their resettlement process (Kusow and Bjork 2007). Through the clan networks, newly arriving Somali refugees are assisted in getting jobs and other social services; this, however, is not the case for the majority of Somali-Bantus (Stephen 2011). The Somali-Bantu resettlement to the U.S. started in 2003 (Barnett 2003), much later than the non-Bantu Somalis, who started coming in the late 1980s and peaking in 1995-2005 (ibid. 2003). Unlike many other refugees from Somalia, the majority of Bantu Somalis do not come from urban centers so they have had limited exposure to modern life, such as flush toilets and other technological appliances, thus accentuating their "cultural shock" of resettlement (Lehman and Eno 2003). Furthermore, Somali refugees overall have a low literacy rate (Kusow and Bjork 2007) and the Bantu have the lowest rates in literacy (Stephen 2011).

The most striking feature among Somali diaspora communities is the tendency to relocate again and settle within their own clan groups (Kusow and Bjork 2007; Lewis 2008; Stephen 2003) and this was evident during my fieldwork. The Somali diaspora resettlement patterns reflect the pre-migration patterns of clan-tribal (ethnic)

associations and allegiances, as well as pre-migration animosities and distrusts (Lewis 2008). Hence, conducting research among Somalis requires not only a good understanding of their current dispositions but also an appreciation of their historical background and a cultural sensitivity in navigating fieldwork.

Somali Resettled Refugees in America

Somalis make up the largest segment of the African born population in the U.S. (Abdi 2011; Goza 2007). The largest influx of Somali refugees in the U.S. took place from the mid-1990s to 2005 (U.S. Census 2009), though a small number of Somali refugees started arriving as early as the mid 1980's⁴⁶ (Metz 1992). Though there are no reliable statistics regarding Somali-born and U.S.-born populations, figures from the U.S. Census Bureau (2010) report that 19,478 Somali refugees were admitted to the U.S. in a five year period from 2005 to 2010. Earlier estimates by the U.S. Census (2000) estimated 35,760 Somali-born people to be living in the U.S, but this figure is well below the 150,000 that was suggested by Lehman and Eno (2003). Regardless of the accuracy of current figures of Somalis in America, the number is projected to be increasing due to the following reasons: First, Somalia's political and economic crises remain unresolved, forcing more people to flee the country (UNHCR 2012); second, the process of refugee resettlement often results in the separation of families, and U.S. reunification immigration law allows resettled refugees and immigrants in the U.S. to sponsor their relatives to join them⁴⁷; third, Somalis have high birth rates, with the average family having seven to nine children (Hernandez 2007). Additionally, although the numbers of Somali refugees

⁴⁵ SomaliNet Forums is one of the largest on-line sites frequented by the Somali diaspora. <http://www.somalinet.com/forums/viewtopic.php?f=250&t=178567>

⁴⁶ Northern Somalis were the first African refugees to be resettled in the UK (as subjects of its former colony), in some other European countries, and also in the U.S. Some of the early refugees were students in these countries when the civil war broke out and subsequently sought asylum there.

entering the U.S. has declined by half from 10,405 in 2005 to just 4,884 in 2010 (U.S. Census 2010), the flow of refugee resettlement has not stopped.

There has been a concerted effort to expedite the resettlement program, especially of Somali-Bantu refugees (Barnett 2003; Lehman and Eno 2003). As a group, they have been identified as “priority” Somali refugees for resettlement because of the historical discrimination and intensified persecution from the ongoing civil war (Barnett, 2003; Lehman and Eno 2003). As a minority group, the Bantu lack clan protection which increases their vulnerability in the clan-based social system in which ethnicity is one of the several factors that continues to challenge peace in Somalia (see Lewis 2002; Marangio 2012). As the war continues to ravage Somalia, inevitably the number of refugees will continue to rise and seeking refuge in the other countries, including the U.S. This means the number of Somali-born and U.S. born Somalis will certainly contribute to the racial and ethnic demographic shift that is taking place in the U.S. (Fix and Passel 2003; Kusow 2006).

Being the Different “other” Immigrant in America

As a group, Somalis in the U.S. encounter unique challenges in comparison to other recent refugees or immigrant groups (Shandy and Fennelly, 2006). First and foremost, Somalis are Black and Muslims (Kusow 2006:543-544). These salient racial and religious identities in a color conscious Christian majority nation make Somali immigrants stand out as different “others” in America (Shandy and Fennelly 2006; Snyder 2008). For example, the Islamic and culturally patterned attire that most Somali women wear makes them conspicuous in public spaces (Kwan 2008). Shandy and Fennelly (2006) point out that religion plays a significant role in the assimilation and

⁴⁷ http://www.ecslongisland.org/ecs/immigration/Family_Reunification.pdf

integration process of immigrants in the host country. In their study, they compared the integration of Somalis who are Muslims and southern Sudanese refugees⁴⁸ who are mostly Christians (Lutherans) in a U.S. Midwestern town. The southern Sudanese had an easier integration process into U.S. society through their churches. These researchers have posited that being a member of a dominant religious organization affords the Sudanese refugees more access to jobs and upward social mobility into society, compared to their Somali counterparts. In this case, with all other factors being equal, such as “race”, language barriers and immigration status (resettled refugees), it is religion that differentiates the two group’s integration. The former group Islamic faith “was not an integrative force, but a barrier to acceptance by their Christian-European origin neighbors” (Shandy and Fennelly 2006, 23).

Overt resentment to Somalis, unlike the south Sudanese, immigrants was captured by a 2003 report from the Center for Immigration Studies (Barnett 2003). The author reported that Senator Sam Brownback of Kansas vehemently opposed resettlement of Somali-Bantu refugees in his state. When the senator was asked why he previously supported resettlement of the southern Sudanese but now opposes this refugee group, he responded, “They [the south Sudanese] know English. They’re very pro-American” (Barnett 2003, 9). Though the senator did not directly mention religion, his remarks nonetheless imply such—since the underlying difference between the southern Sudanese and all the Somali Bantus is just that, religion since neither arrived in America already fluent in English.

Decades of often polemic and politicized U.S. media coverage about the conflict in the Middle East, the Iranian revolution and hostage crisis, the events of September 11,

⁴⁸ Commonly known as the Lost Boys.

U.S. military invasion and occupation of Iraq and Afghanistan, and the Somali piracy operations, among other negative news, has stirred negative public sentiment against Muslims in general (Bail 2012; Liard et al. 2007). The failed military mission in Somalia and images of U.S. military personnel being dragged through the streets of Mogadishu heightened U.S. public suspicion⁴⁹ and at times hostility toward Somalis in particular and Muslim communities in general (Kwan 2008). Hollywood's production of the film "Black Hawk Down" is based actual events (as told from the U.S. side) in Somalia which depicts the "barbaric" nature of Somalis. After the shooting down of an American helicopter, three U.S. soldiers were captured, killed and their bodies were publically desecrated in September, 1993⁵⁰; this film further escalated the suspicion, hatred, and discrimination of resettled Somali refugees (Schaid and Grossman 2007).

Recent polls in America indicate that the majority of Americans have negative opinions of American Muslims (Marrapodi 2011). For example, a radio host Jerry Klein⁵¹ exposed the depth of anti-Muslim bigotry in the American public when he suggested that Muslims in America should be tattooed with a crescent over their foreheads and other identifying markers (Debusmann 2007). Several listeners called into the radio station in support; some went even further to suggest that the Muslims should be rounded up into encampments similar to what happened to the Japanese Americans during World War II. Other callers wanted Muslims to be "shipped out of the country." Such remarks from

⁴⁹ NPR news 2009: The Somali community in the U.S. is one of the communities that intelligence officials really worry about, 'cause they tend to be less integrated than other immigrant communities; they tend to be poorer as a group; they keep tabs on the political process in Somalia really closely and really don't get involved with the political process here.' (NPR "Homegrown Terrorists Pose Biggest Threat" by Dina Temple-Raston report of Somali-Americans recruited to fight in Somalia. Sept. 10, 2010).

⁵⁰ See The United States Arm in Somalia: 1992-1994.
<http://www.history.army.mil/brochures/Somalia/Somalia.htm>

⁵¹ According to Mr. Klein this particular radio broadcast was meant to be a spoof. Bernard Debusmann, "In the U.S., fear and distrust of Muslims runs deep." (Feb 25, 2007

the general public are disturbing, to say the least. Many Muslim women and in particular a majority of Somali women wear *hijab* (head covering) or *abaya* (loose outer garment), and this inevitably makes them conspicuous in American public spaces and potential victims of various harassments and other hate crimes⁵² (FBI 2011; Kwan 2008; Piggott 2012).

More disturbing is that the negative sentiments and a stigmatization of Muslims in America is ubiquitous in the media (see Aleaziz 2012; Bail 2012), and that it is supported by some U.S. legislative members in various States,⁵³ including on Capitol Hill⁵⁴ (see Saylor 2012). Hence, it is not surprising that ordinary people among the public can and do express these negative sentiments toward Muslims with impunity. For example, recently a friend⁵⁵ of mine who wears a *hijab* was treating a patient in a healthcare setting. While administering treatment she was paged, and as she glanced at her pager, the patient said to her, “Are you about to blow yourself up?” Bail (2001 2008) posits that religion remains an extremely salient symbolic boundary in assimilation and integration; in other instances, it is “race, language, or culture” that determines how new immigrants are allowed to cross these assimilation and integration boundaries. In post 9/11 America,⁵⁶ religion appears to trump race, language and culture. For example, Schaid and Grossman (2003) compared Latino with Somali immigrants’ challenges of

<http://www.reuters.com/article/2007/02/25/us-usa-muslims-sidebar-idUSARM55127020070225>

⁵² Jeff Spross with ThinkProgressive.Org. reported: Hate crimes against perceived Muslims, jumped to 50% in 2010, largely as a result of anti-Muslim propagandizing, and has remained relatively unchanged last year, according to 2011 FBI hate crime statistics.

⁵³ The major of Lewiston, Maine, Robert Macdonald, told a growing Somali immigrant community in his town to “accept our culture, and leave your culture at the door.” He later told a reporter that immigrants shouldn’t “insert your culture—which obviously isn’t working—into ours, which does” (Associate Press Oct. 14, 2012).

⁵⁴ Rep. Peter King, June 2012, Congressional hearings on “radicalization” of American Muslims.

⁵⁵ My friend is a U.S citizen of Somali origin, educated and having lived in Arizona, U.S. for almost three decades.

⁵⁶ The FBI reported a 1,700 percent increase of hate crimes against Muslim Americans in 2000-2001(post 9/11).

assimilation and integration in a small-town America. Their findings indicated that though both immigrant groups faced similar challenges, such as a language barrier and differences of culture and race, the Latinos, however, assimilated more easily vis-à-vis Somalis. They concluded that, “The Somalis were not only foreign immigrants, but were racially, religiously and culturally more distinct than previous immigrants” (Schaid and Grossman 2003:19). Kusow⁵⁷ narrows it down to cultural and religious identities which make them the “other”, more than the color of their skin (Kusow 2006: 544). The author delimited the “race” factor based on interactions between Somali immigrants and African-Americans, finding that skin-color similarity has failed to be a unifying identity force.⁵⁸Essentially, the Somali resettled refugee communities have multiple “axes” of being the “other”.

⁵⁷ Kusow: “You can look just alike and appear to be on the same team, but we’re as different as night and day [...] Just because we are all black or originate from Africa doesn’t mean anything.” He went on to say: “We have a separate language, culture, and religion. It is a big thing. This is not an issue of colour” (Kusow 2006, 544).

⁵⁸ See Peter Brosius’ Children’s Theater Co. “Snapshot Silhouette” production. In this play, Brosius as the artistic director portrays the tension and conflict between Somali immigrants and African Americans. Through the eyes of two 12 year old girls, the play examines this cultural clash.

Summary: The first section of this chapter provided the context of the Somalis as a diverse people with distinct histories, cultures and social systems. Clanship rather than nation is central to Somali identity. Similarly, the Somali minority communities such as the Somali Bantu are equally diverse, and divided along tribal lines. Therefore, it is important to have a good general understanding and appreciation of their diversity. As Kusow (1994) pointed out, the concept of Somalis as a homogeneous people is a myth. In America, the Somali refugee communities continue to be divided across clan and ethnic lines. They present a unique group of “new immigrants” in terms of integration and acceptance in their host nation; faced with discrimination which is compounded by low levels of literacy, poverty, and language barriers. Also, because of the prevalence of FGC among Somali women, their bodily modification status is antithesis to the general American public opinion which adds another dimension of their resettlement challenge, in particular when seeking obstetrics and gynecological healthcare in the U.S.

Somalis in Arizona

This southwestern state has been a resettlement destination for Somalis refugees since 1992 (Singer and Wilson 2007). One of the Somali Associations in Phoenix⁵⁹ estimates that 70% of the 12,000⁶⁰ Somalis in Arizona live in the city; this figure is much higher than the 5,173 reported by the Arizona Department of Health services (1980-2013). The discrepancy might be because the department of health is only reporting on those directly settled in Arizona (as first entry point) which does not account for the Somalis who moved from other states (inter-state migration). As Huisman (2011:57) has pointed out, Somalis rarely remain where they are resettled.

El-Nasser (2001) has suggested that large discrepancies between “official” figures and actual residents among minority populations are not uncommon and that often minorities are undercounted in the Census. Similar discrepancies at state level have been reported by Schuchman and McDonald (2004) on Somalis in Minnesota whom the official records estimate to be less than 20,000 when in actuality there are between 50,000 and 75,000. Hence, the actual number of Somalis in any given state remains an estimated figure since there is no specific agency or institution that has kept track or collected data on the whereabouts of resettled refugees by ethnicity or nationality (Schuchman and McDonald 2004). The lack of accurate population data may partially explain why little is known about the Somali refugees’ overall health and in particular their childbearing beliefs, practices and outcomes in the U.S. generally

⁵⁹ Somali American United Council of Arizona
<http://www.somaliunitedcouncil.org/upload/Somali%20Refugee%20Women%20St.%20Luke.pdf>. Note there are several Somali Associations in Arizona, including the Somali Bantu United Association of Greater Phoenix and Tucson.

(Carroll et al. 2007; Johnson-Agbakwu et al. 2013; Johnson, Ali, and Shipp 2009; Nilsson et al. 2008), and in Arizona in particular.

For some Somalis, Arizona has been their first port of entry in their resettlement program as refugees. In this study for example, 59% (n=43) of the SRRW identified Arizona as their first entry point in the U.S. Increasingly though, the Arizona is attracting Somalis from other states with higher density of resettled Somali refugees. There are several reasons for this—other than the weather—for one, the move provides an opportunity to start their lives afresh but more importantly, to protect their youth from the grip of the gangs⁶¹, and to lessen the chances of being recruited to fight in Somalia⁶². Some are simply moving to Arizona for its weather. As an elderly Somali refugee from a Midwestern State, said, “Here in Arizona the sun is always there. Arizona is sunny and warm just like Somalia or Kenya”.

To my knowledge there are no credible socioeconomic data on Somalis in Arizona. Some information could be extrapolated from the data from Minnesota (Bernauer et al., 2011) and from the 2010 U.S. Census Bureau to shed some light on the socioeconomic profile of Somalis in Arizona. In Minnesota over 61% of Somali households have an income of around \$14,900; hence, a majority of Somalis rely on Minnesota social services for health coverage and many are on food stamps and require housing assistance. Figures from the 2010 U.S. Census Bureau indicate that 51% of Somalis live in poverty; they have the lowest median incomes of all foreign born U.S.

⁶⁰ Estimated by Dr. Crista Jonson-Agbakwu (see Roberts and Smith, 2014 <http://www.nbcnews.com/news/world/horrific-taboo-female-circumcision-rise-u-s-n66226>)

⁶¹ Laura Yuen with Minnesota Public Radio (MPR news, 29 May, 2009) reported that nine Somali men all under the age of 30 have been killed in gang violence within a period of less than two years. The report further states that the Somali gangs are divided along the same clan lines that mirror the ethnic divisions that destroyed Somalia in the first place. Similar gang activities are reported by the FBI (see FBI 2011, National Gang Threat Assessment).

residents. Stephen (2002) posits that Somali-Bantus have even higher poverty rates among the resettled Somali refugees in the U.S.

Findings from this study indicate that a large number of SRRW participants were recipients of government assistance in housing, food and health coverage. For example, 60% of SRRW participants in this study live in low-income government assistance housing, and 80% of them have government health insurance (Mercy Care). The majority (66%) of the participants were unemployed. High unemployment may be explained partly by low literacy and language barriers. Of SRRWs in this study, 44% had not received any formal education and 25% had a primary level of education only. This is consistent with other studies reporting high illiteracy rates among Somali refugees (Johnson et al. 2009; Kusow and Bjork 2007; Olden 1999; Pavlish et al. 2010).

Yet, despite of lack of credible data on Somali in Arizona, I found this community to be resilient and resourceful. For example, 30% of my research study participants are enrolled or have completed college education, post-resettlement in America. Four of the SRRW are self-employed, these women are running their own businesses and employing other Somali men and women. Besides these formalized business establishments (mostly groceries, restaurants, and clothing markets serving the Somali community), Somali women are also engaged in informal entrepreneurship—selling scarfs, phone cards (international calling cards), traditional perfumes, jewelry—and even homemade sweets (see Fong et al. 2007). Employed Somali men and women mostly work in low skilled service jobs such as the airport, car-rental businesses (mostly at the airport) and laundry mates. Some of the husbands of the Somali women participants in this study work in the transportation sector as taxi drivers and or as inter-state truckers. Another

⁶² See/Listen to: “Minnesota Case Re-Opens Wounds Among Somalis” Oct. 19 2012 by Dina Temple-Raston <http://www.npr.org/2012/10/19/163258560/minnesota-case-re-opens-wounds->

example of their resiliency and growth is evident by their effort to organize themselves. For example, the communities have established their own Somali Associations to address the needs of their members. There are at least two such organizations in Maricopa County serving the different Somali clans/ethnic groups.

One of the hallmarks of the strong and growing Somali presence in Arizona can be measured by an informal banking system known as “*hawala*”⁶³; the “*hawala*” system is a quintessentially Somalian enterprise that embodies their free spirited nature (Ali, 2011). *Hawala* is an informal banking system established by the Somali diaspora to meet the needs of remittances to their relatives and friends after the fall of a formal banking system in Somalia (Ali 2011; Powell et al. 2008; Pieke et al. 2007; Schaeffer 2008). Another sign of social and cultural resiliency of Somalis in Arizona is that they have established their own mosque, where Friday sermons are conducted in the Somali and English languages and where children are taught the Quran. Other East African communities (non-Somalis) also attend this mosque and send their children to attend the ‘*madrassa*’ (a Quran school). There is a Somali strip-mall and other business establishments such as driving school and interpreting/translating services to name a few.

Besides the multiple challenges confronting the Somalis refugee communities, perhaps one of most pressing issue for the Somali refugee women in Arizona (and elsewhere) is the high prevalence of FGC (WHO 2008). For example, 92% of SRRW

among-somalis

⁶³ <http://www.thefreedictionary.com/hawala>: A system for remitting money, primarily in Islamic societies, in which a financial obligation between two parties is settled by transferring it to a third party, as when money owed by a debtor to a creditor is paid by a third party??? person who owes the debtor money. *Hawala* transactions are usually based on trust and leave no written record. The dictionary is correct except that since events of 9/11 detailed records of senders and recipients are kept and regularly subject to FBI inspections. For detail see: http://www.au.af.mil/au/awc/awcgate/fbi/dealing_with_hawala.pdf

participants in this study self-identified as being circumcised. This figure is slightly lower than 98% prevalence rate among Somali refugee women who seek obstetrics and gynecological healthcare at the Refugee Women’s Health Clinic, in Phoenix, Arizona⁶⁴, which Dr. Crista Johnson-Agbakwu is the founder (Roberts and Smith 2014). Somali refugee women with FGC may have different needs that are not “standard” medical procedures which makes getting adequate care a challenge (Ibe and Johnson-Agbakwu et al. 2011; Johansen 2006). Additionally, stigma associated with FGC, makes Somali refugee women highly anxious and fearful when seeking healthcare (Johnson-Agbakwu et al. 2013). Language barriers in this community have been identified as a major obstacle resulting in suboptimal care leading to distrust, miscommunication and even refusal of care to common obstetric interventions (ibid. 2013, 2). Furthermore, they are often described by healthcare providers as difficult patients –ethically and emotionally – to care for (Johansen 2006).

Summary: This chapter provided the context of the Somalis as a diverse people with distinct histories, cultures and social systems. Clanship rather than nation is central to Somali identity. Similarly, the Somali minority communities such as the Somali Bantu are equally diverse, and divided along tribal lines. Therefore, it is important to have a good general understanding and appreciation of their diversity. As Kusow (1994) pointed out, the concept of Somalis as a homogeneous people is a myth. In America, including Arizona, the Somali refugee communities continue to be divided across clan and ethnic lines, evident by different Somali Associations. None-the-less, they are resilient and resourceful people despite of their multiple challenges. Somalis in America and Arizona present as a unique group of “new immigrants” in terms of integration and acceptance in

⁶⁴ Refugee Women’s Health Clinic in Phoenix, Arizona is one of the two medical centers in the U.S. that provides specialized care to women with FGC.
<http://www.nbcnews.com/news/world/horrific-taboo-female-circumcision-rise-u-s-n66226>

their host nation; faced with discrimination which is compounded by low levels of literacy, poverty, and language barriers. Also, because of the prevalence of FGC among Somali women, their bodily modification status is antithesis to the general American public opinion which adds another dimension of their resettlement challenge, in particular when seeking obstetrics and gynecological healthcare in the U.S.

CHAPTER 5

CROSS CULTURAL CONSENSUS

From antiquity—broadly speaking—the biological process of childbearing has been appreciated as a culturally specific life event, shaped by social, political and economic circumstances (Browner and Sargent 1990; Cheung 2002; Davis-Floyd and Sargent 1997; Davis-Floyd 1994; Green 2002; Jordan 1993). Members of a cultural group share a certain degree of cultural knowledge consisting of beliefs, norms, and behaviors pertaining to childbearing that are particular to their sociocultural milieu (Callister 1995; Floyd-Davis and Sargent 1997; Morling et al. 2003; Steinberg 1996). Cultural background, ethnicity, as well as religious beliefs, for example, play a crucial role in how childbearing is viewed and the way meanings are conferred on the entire process—from conception to after birth (Binder et al. 2012; Callister et al. 1999; McLachlan and Ulla Waldenström 2005). Childbearing cultural beliefs and behaviors are accordingly observed, sanctioned, and shared among members to ensure the wellbeing of the women during pregnancy and to orchestrate safe childbirth (Callister et al. 2003; Davis-Floyd and Sargent 1997; Khalaf and Callister 1997; Liamputtong et al. 2005). These shared cultural beliefs and behavioral norms form the basis of childbearing cultural models; every social group has cultural norms that provide meaningful guidance throughout pregnancy and childbirth. However, insofar as culture is fluid, ever changing and inter-connected (Merry 2001); similarly, cultural models of childbearing are dynamical evolving and contested (Jordan 1997).

Of all childbearing cultural models, the biomedical childbearing model has gained an unparalleled global authority over all ethno-obstetrics⁶⁵ (Barker 1998; Browner and Press 1999; Johanson, Newburn and Macfarlane 2002; Jordan 1997). The term biomedicine implies the formal medical system of the West, by which the practice is rooted in the Cartesian ideological understanding of the human body or biological medicine (Gaines and Davis-Floyd 2004). In the biomedical model, pregnancy and childbirth are considered pathological female conditions from onset to end (Hahn 1995; Jordan 1997; Lorentzen 2008; Trevathan 1997). Pregnancy has acquired International Classification of Disease (ICD)⁶⁶ code, similar to any other disease, such as malaria or cancer⁶⁷. As such, pregnancy is considered a condition that requires medical management; it is medicalized from the onset to birthing (biomedicalized childbearing). Across cultures, it is recognized that there are known and unknown risks in pregnancy requiring prenatal care and anticipated and unanticipated childbirth complications that must be dealt with accordingly (see Green 2002; Hunt 1999). Therefore, though the biomedicalization of childbirth is recent (Jordan, 1993), the concept of prenatal care and assisted childbirth is not a novel Western (biomedical) invention (Green 2002; Jordan 1997, 1993). The globalization of biomedical education and practice has marginalized indigenous (ethno-obstetrical) knowledge and given rise to a biomedical model of childbearing that Jordan (1993) referred to as *cosmopolitan obstetrics*. This medical system has become hegemonic, Jordan notes, because

⁶⁵ Ethno-obstetrics is a sociocultural system of childbirth grounded in commonly shared knowledge among indigenous members about pregnancy and childbirth management (Jordan 1993).

⁶⁶ According to the WHO the “International Disease Classification (ICD) is the standard diagnostic tool for epidemiology, health management and clinical purposes. This includes the analysis of the general health situation of population groups. It is used to monitor the incidence and prevalence of diseases and other health problems.”

<http://www.who.int/classifications/icd/en/>

⁶⁷ WHO <http://www.who.int/classifications/icd/en/>

Biomedicine's symbolic value, independent of its value, encapsulates modernization and progress., while traditional ways comes to epitomize the "ignorant" and backwardness that the developing programs are trying to eradicate, and are thus dismissed out-of-hand, regardless of any efficacy they might have. [1993:201].

The quest behind biomedicalization was to minimize maternal mortality and morbidity; accordingly, it ushered in the concept of biomedicalized prenatal care (Alexander and Kotelchuck 2001; Johanson, Newburn and Macfarlane 2002). Prenatal care requires pregnant women to be under medical surveillance until they deliver (see Donnay 2000). The concept of biomedical prenatal care originated in Europe⁶⁸ in the late 1890s and was adopted in the United States in the early 1900s (Alexandra and Kotelchuck 2001). By 1987, this concept was adopted globally through the Safe Motherhood Initiatives⁶⁹ (AbouZahr 2003), a period that coincided with the peak of HIV⁷⁰ epidemics in Africa⁷¹ (Cartoux1998; Zaba et al. 2013). A 2003 UNAID study points out that the prevalence of HIV among pregnant women is a good indicator of general adult population infection rate, and a study by Gray and colleagues (2005) suggested the risk of contracting HIV doubles during pregnancy. Global health initiatives to combat HIV transmission, in part, gave impetus in making biomedical prenatal care more accessible to African mothers (UNAID 2003). Hence, biomedical prenatal care⁷² as a monitoring program for all pregnant women has become a global concept and practice, even in remote and destitute places, such as refugee camps; although the access and quality of care are often very basic if not outright meager (UNFPA 2011; UNAID 2003).

⁶⁸ Prenatal care was established by Dr. Ballantyne, a Scottish physician in 1894.

⁶⁹ In February 1987, WHO, UNFPA and the World Bank jointly sponsored the first international Safe Motherhood Conference in Nairobi to address the high burden of maternal and infant mortality and morbidity in the developing nations.

⁷⁰ Human immunodeficiency virus (HIV).

⁷¹ Screening for HIV-AIDS and other communicable diseases (sexually transmitted) aimed to reduce maternal-infant transmission of HIV. Safe Motherhood initiative provided means to increase transmission surveillance of HVI/AIDS through prenatal care services (see Zaba et al., 2013).

⁷² Including diagnostic ultrasound imaging.

While the quality, access, and the practice of prenatal care also vary widely within and among nations (Barber, Bertozzi and Gertler 2007; Say and Raine 2007; Williams 2002), biomedical prenatal care is now universally sanctioned (AbouZahr 2003). This does not, however, mean that the traditional models have been fully replaced by the biomedical model, nor are traditional and cultural beliefs and practices relinquished in favor of biomedical culture (Ross, Timura, and Maupin 2012; Say and Raine 2007). In most developing countries, the two models often co-exist and there is some space for negotiation (Obermeyer 2000). That space for cultural negotiation between traditional and biomedical models, however, shrinks drastically for immigrant and refugee communities living in the West. This is particularly so in the United States where the biomedical model prevails and medical care is privatized (Barker 1998; Alexander and Kotelchuck 2001). Immigrants and refugees may feel compelled to comply with the biomedical model without understanding the rationale of such model. In such cases, resisting the model may put them at unnecessarily high risk for birth complications and/or cause them to be labeled as in-compliant and/or difficult patients.

The role of culture in childbearing beliefs and behaviors advanced by anthropological inquiry has inspired many and provides the epistemological foundation that is indispensable to the field (Jordan 1993). Brigitte Jordan credits Margaret Mead for being one of the earliest anthropologists who set the vision for a cross-cultural approach to understanding the role of cultural beliefs, behaviors, and their meanings in childbirth (Jordan 1993: xi). In the globalized world where cultures are in constant flux and contestation and people, ideas, goods and capital move at a dizzying speed, the approach these anthropologists pioneered is more pertinent than ever before. For example, female genital cutting (FGC) – also known as female circumcision among Somali women – is embedded in their cultural identity, traditions, and beliefs. This

cultural practice takes on new cultural nuances in the context of childbirth post migration (Essén et al. 2011; Shell-Duncan and Hernlund 2001; Hill, Hunt, and Hyrkäs 2012; Johansen 2006; Wiklund et al. 2000).

Somali refugees have been resettling in several Western nations since the early 1990s when their country embarked on a protracted civil war. However, only in the last decade have we seen studies that focused on Somali women's reproductive health concerns and outcomes. Retrospective studies based on clinical records have reported that Somali refugee women have a higher burden of childbearing disparities compared to native born women in the host countries (Essén et al. 2002b, 2002a ; Johnson et al. 2005; Malin and Gissler 2008; Merry et al. 2013; Råssjö et al. 2013; Vangen et al. 2000; Vangen et al. 2002). These studies report Somali immigrant/refugee women are in the "high risk" category (Vangen et al. 2000); they are more likely to have perinatal complications including perinatal death (Essén et al. 2002b; Malin and Gissler 2008; Vangen et al. 2002), prolonged labor (Vangen et al. 2002), more likely to deliver postdate (Johnson et al., 2005), and to suffer other childbirth complications, including perineal tears (Johnson et al. 2005). They also tend to have more cesarean births, even though they have a strong aversion to obstetric interventions (Johnson et al. 2005; Råssjö et al. 2013; Small et al. 2008).

Qualitative studies have shown that post-migration childbirths in Somali women are complicated for several reasons. There is a pervasive fear of cesarean operative birth (Ameresekere et al. 2011; Brown et al. 2010), healthcare providers often lack cultural sensitivity (Berggren, Bergstrom, and Edberg 2006; Chalmers and Hashi 2002, 2000; Essén et al. 2002b), or lack cultural knowledge about the management of women with FGC during birth (Bulman and McCourt 2002; Johansen 2006; Thierfelder, Tanner and Bodiang, 2005; Vangen et al. 2004), these women tend to receive suboptimal care (Essén

et al., 2002). There are also different cultural understanding between patients and providers regarding health beliefs (Abdullahi et al. 2009; Pavlish et al. 2010) and childbearing practices (Essén et al. 2011; Essén et al., 2000; Hill, Hunt, and Hyrkäs 2012; Wiklund et al. 2000). Furthermore, issues related to discrimination/ stereotyping (Bulman and McCourt 2002; Chalmers and Hashi 2002; Herrel et al. 2004), language and other cultural barriers and structural factors (Bulman and McCourt 2002; Carroll et al., 2007; Davies and Bath 200; Johnson, Ali, and Shipp 2009) all complicate the patient-provider encounter and have determining effects on the experience and outcome.

The theme in these studies alludes to cultural discordance (variations) between the Western healthcare providers (HCPs) and Somali immigrant women in the childbearing domain. In addition, most studies on Somali refugee women often represent them as a culturally homogenous group, ignoring the historical and cultural nuances which differentiate their lived experiences. Ross (2004:21) argues that in comparative culture studies, it is not enough to highlight the cultural differences without distinguishing what is culturally shared by individuals in a group and then, accounting for shared and unshared cultural ideas that reflect the distribution of patterns of differences in agreement in individual beliefs and behaviors. Failure to do so may result in “[e]xotic description and the production of the otherness” (Ross 2004:21).

To explore the issues encountered and the experiences of Somali women in labor and delivery, this study draws on Ross’s insights and takes a different approach from previous studies of Somali women. It does so by applying the cultural consensus model (Romney, Weller, Batchelder 1986; Weller 2007) to measure and describe cross-cultural variation between Somali resettled refugee women (SRRW) and healthcare providers and (HCP) and intra-culturally (within SRRW) in the childbearing domain. The Cultural Consensus Model (CCM) is based on the theory developed by Romney, Weller, and

Batchelder in 1986. The theory is credited for clearing the hurdle in anthropological inquiries on how to describe patterns of beliefs and behaviors that are shared (cultural knowledge) by individuals in a given society and at the same time account for variations in these patterns among individual members (Hruschka and Maupin 2012). The CCM is a statistical method that measures patterns of agreement to see if there is an underlying consensus within and between cultural group's responses to questions in a specific domain of knowledge (Batchelder and Romney 1988; Romney, Weller, and Batchelder 1986; Weller 2007).

The praxis of CCM is to measure the patterns of correct answers in a given cultural domain of knowledge from which it could be objectively inferred whether or not it constitutes shared cultural knowledge (culture consensus) among individuals in a group (Romney, Weller, Batchelder 1986). As such, it helps to “answer the epistemological question of “How do we know”” (1986, 313).

Research Questions and Objectives: This is precisely what this study intends to investigate and the focus of this chapter: How do we know that SRRW and HCP have different childbearing models? More specifically, where and on what issues (subdomains) do they vary? Additionally, how do we know whether SRRW agree/disagree on a single childbearing model? Hence, the operational application of CCM fits well for the purposes of this study, particularly considering the sensitive nature of the topic. In addition, qualitative data is used to augment the CCM data analysis to contextualize meanings of the emergent patterns of beliefs and behaviors cross-culturally and intra-culturally. In this chapter, I have two objectives to address these research questions:

- To explore patterns of cultural knowledge and variations (cross-cultural agreement and disagreement) between Somali resettled refugee women (SRRW) with female circumcision and healthcare providers (HCP) on childbearing models.
- Assess whether or not Somali resettled refugee women with female circumcision share a single childbearing model (intra-cultural consensus).

METHOD

Participants: Non-probability sampling strategies (snowball and convenient) were used to recruit all participants (n=174). Sample size for the Cultural Consensus Model was determined by the level of cultural competence of the participants and the number of questions. The overall sample sizes of the groups meets the suggested criteria (see Romney et al., 1986). Somali resettled refugee women (SRRW) participants (n=73) were drawn from three ethnic/clan/regions of Somalia: Bantu (n=22), Northern (n=19), and Southern (n=32). All SRRW identified themselves as Muslims, over the age of 18 years, with at least one childbirth experience (either in the U.S. or pre- migration or both). Status of female circumcision was self-disclosed⁷³.

The HCP (n=74) participants included physicians (n=24), nurse practitioners (n=3), midwives (n=5), and labor and delivery nurses (n=42), with different levels of experience in providing obstetric and gynecological healthcare to SRRW. Most HCPs were female (91.8%) and Caucasian (78%). Socio-demographic profiles and pertinent information of the participants are presented in tables 1-4 in chapter 3.

⁷³ Self-reporting on type of FGC is not considered a reliable method, see Snow et al. 2002.

Materials: Detailed construction of the culture consensus (CCM) questionnaires is discussed in chapter 2. The aim of this questionnaire was to measure and identify variations in childbearing domain within and between SRRW and HCP. The CCM instrument contained 87 true/false (coded 1=true and 0=false) propositional statements, divided into three subdomains (see Appendix B). The first subdomain contained 22 questions on pregnancy and prenatal care, there are 41 questions concerned labor and childbirth in the second subdomain, and the third subdomain contained 24 questions on FGC and childbirth.

Procedure: The culture consensus questionnaire was conducted in three languages: English, Swahili, and Somali. A majority of HCP (87.5% [n=84]) accessed and responded to the questionnaire online (SurveyMonkey.com). The rest (n=12) used hard-copies that I administered one-on-one in clinical settings with the exception of two which were conducted in the participants' private homes. All SRRW participants (n=73) were interviewed or completed the questionnaires using hard-copies. Forty six (63%) of the participants were then individually interviewed in their homes; the rest (n=27) of the interviews were conducted in public venues as a class-room test taking (Weller 2007): in a mosque (n=9), in a public park (n=10), and at two different Somali Association offices (n=8). Participants responded independently without sharing their answers. For the Somali participants who spoke English and/or Kiswahili, I personally administered the questionnaires. For the Somali and May May speakers who were unable to read or write in their language, ethnically matched (or neutral, i.e. Kenya Somali) interpreters assisted the participant by reading the questionnaire and allowing them to place an 'x' on the answer box. I was present during all data collection activities.

Analysis

Formal cultural consensus analysis was used to investigate whether participants of each group agree more with each other than with other groups (Weller 2007). The CCM analysis measures the participants' level of agreement by averaging the number of matching responses between respondents, adjusted for guessing, it also estimates the competence scores between respondents, generating a respondent-to-respondent agreement matrix across all statements in the culture consensus questionnaire. It also calculates the respondent-to-respondent variability (Romney, Weller and Batchelder 1986; Maupin, Ross, Timura 2011). These analyses were performed using UCINET 6.365 (Borgatti et al., 2002).

The analyses of the groups were as follow: 1. All participants (n=147); 2. each group individually (total 5 groups); 3. paired SRRW groups (total 3 paired groups). This analytical process yielded nine culture consensus models and results (see Table 5:1). The eigenvalue ratios of the first to the second factor were of 3:1 or greater, and there were no negative competence scores for all nine models. These criteria are conventionally used to indicate consensus or within group agreement of a conceptual model (Weller 2007). Competence scores are the proportion of answers each participant knows without guessing which emerge as factor loading on the first factor (ibid. 2007). The average competences scores are conventionally used to indicate the agreement between participants, higher scores suggest higher inter-participants agreement or competence in the conceptual model (Brewis et al. 2011; Hruschka and Maupin 2012; Weller 2007). The averages competence scores ranged from 0.4 to 0.5 (rounded) for all nine models, the

HCP scored highest (0.5) and the Northerner-SRRW the lowest (0.36) on their respective models.

To account for within and between group member variability (whether or not the paired groups agree/disagree more within member group than with non-members) residual agreement analysis was applied to the paired⁷⁴ CCM which met the threshold of eigenvalue ratio greater than 3:1 (Maupin and Ross 2012; Ross 2004; Weller 2007). The residual analysis process entailed subtracting the predicted agreement (the product of two participants' first factor loadings) from the observed agreement (Maupin and Ross 2011,2004). The rationale for applying residual analysis on these models is to identify subtle differences between paired groups⁷⁵ and to measure the respondents' agreement that goes beyond consensus (Ross 2004). The results from residual agreement matrixes was further analyzed using one-way analysis of variance (ANOVA) to determine the level of variations within and between groups that would suggest the presence or lack of independent i.e. subgroups (Maupin and Ross 2012; Maupin et al. 2011; Weller 2007).

Using the answer key from CCM, all 87 questions with differences were identified and then tested using Fischer's chi square test to compare raw responses to see if participants' answers were significantly different (across the three subdomains described below). This helps discern whether or not respondents have strong cultural preferences (Weller 2007: 341-2).

RESULTS

To delve deeper into patterns of agreements and divergence emerging from this analysis, I first explore the agreement patterns among Somalis women and their healthcare

⁷⁴ See results section. The aggregated (non-paired) CCM analyses on SRRW, HCP, Bantu and Southern SRRW met the eigenvalue ratio criteria suggesting separately that each group is culturally cohesive (has consensus).

providers in section one. Next, in section two, I examine intra-cultural agreements or variations among Somali women from their different subgroups (Bantu, Northerners, and Southerners). In both sections, I bring in the voices of project participants to elaborate the meanings of the quantitative findings.

Section One: Cross-cultural Agreement Patterns

The cross-cultural results from the aggregated CCM (n=147) analysis indicate that respondents do not agree on the overall questionnaire, with a low eigenvalue ratio of 2.338 (largest eigenvalue 32.891 second largest 14.068). The group average competence score 0.455 (with 0.142 and 0.694 lowest and highest competence scores respectively) and standard deviation of (+/-) 0.129. The result suggests that the SRRW and the HCP lack cultural consensus on the overall childbearing model. On the other hand, both groups hold consensus on their own. The eigenvalue ratio was 6.220 (largest eigenvalue 20.592, second largest 3.320) and 7.294 (largest eigenvalue 23.933, second largest 3.281) amongst the SRRW and HCP respectively, with no negative competency scores in either model. The CCM explorative findings indicate that: (a) the SRRW and the HCP are two distinct cultural groups, and (b) each group has their own childbearing cultural model that is different from the other⁷⁶.

⁷⁵ Because the CCM model between the SRRW and HCP and within the Northern SRRW did not meet the consensus criteria, they were excluded for further analysis.

Table 5:1. CCCM: Competency Scores and Eigenvalues

SAMPLE	AVERAGE	Standard deviation	Eigenvalue Ratio
HCP (n =74)	0.493703	0.120509	7.294
SRRW(n=73)	0.415904	0.12731	6.202
SS (n =32)	0.446844	0.08747	7.938
SB (n =22)	0.419227	0.14944	8.426
NS (n =19)	0.359947	0.143457	2.537
HD vs. SRRW (n = 147)	0.455068	0.129528	2.335
SS vs SB (n=54)	0.435593	0.116239	6.186
SS vs NS (n =51)	0.414471	0.118122	6.426
SB vs NS (n=41)	0.391756	0.147923	4.259

Answer Key Analysis

To investigate the aggregated individual group responses, content analysis compares how each group varied in responding to the CCM questionnaire items, where one group says yes and the says no. A binomial test was conducted by aggregating individual responses on all 87 culture consensus statements in the three subdomains. Fischer’s chi square to measure whether the raw response variations are statistically significant (alpha level set at .05). The results indicated that the SRRW and the HCP differ on 34 culture consensus statements across all three subdomains of which 32 (39% of all questions) were statistically significant ($P < .05$). The proportion of modal response differences was not uniformly distributed across all three subdomains.

The results suggest that the subdomain of pregnancy and prenatal care had the least proportion of differences (27.2%), followed by FGC and childbirth (39.1%) and the greatest proportion of variation was in the Labor and Childbirth subdomain (45.2%). These findings indicate that the extent of cultural differences between the SRRW and the HCP is subdomain specific (Maupin and Ross, 2011). Table 6 shows modal responses

⁷⁶ Residual analysis was not required because there was no overall agreement between SRRW and HCP

with significant differences between the SRRW and the HCP across the three subdomains.

Table 5:2: Significant Modal Responses Differences by Subdomains

Subdomain I: Pregnancy and Prenatal care	6 (27.2%)
Subdomain II: Labor and childbirth	19 (45.2%)
Subdomain III: FGC and childbirth	9 (39.1%)
Total	34 (39%)

Subdomain I. Cross-culture Modal Response Differences on Pregnancy and Prenatal care

The low modal response variations (27%) suggest more cross-cultural agreement pattern (73%) than disagreement. Both groups agree that pregnancy increases vulnerability to other illness and the need to participate in prenatal care. They disagreed on whether all pregnancies require medical management and the necessity of obstetric diagnostic ultrasound, to which the SRRW responded “true” and the HCP “false” in both statements. Similarly, the majority of SRRW (75%) agreed that first trimester is the most dangerous period for the mothers, whereas the HCP (82%) disagreed. Other opposing modal responses were whether pelvic exams during prenatal care caused pain. Here a majority (73%) of SRRW agreed that pelvic exams during prenatal care are painful, whereas over half (57%) of the HCP disagreed. The modal response variations were also noted on statements exploring whether patient-provider race/ethnicity match was an important consideration in seeking healthcare and on perceived discrimination, which the SRRW and the HCP responded “true” and “false” respectively.

Table 5:3: Questions of pregnancy and prenatal care (subdomain I) with significant differences (n=147).

Statements	Answered True, %		Answer Key		Exact Significance (1-sided)
	SRRW	HCP	SRRW	HCP	
Q2. All pregnancy requires medical management by a doctor	82	31	True	False	.000*
Q4. The first three months of pregnancy is the most dangerous period for the mother	72	17.5	True	False	.000*
Q12. 7. Prenatal care involves painful pelvic exams	74	35	True	False	.000*
Q15. 1. It is necessary to have an ultrasound during pregnancy	78	43	True	False	.000*
Q78.1. The race/ethnicity of patient/provider is not an important consideration in providing OB/GYN healthcare to Somali/African immigrant women	67	32	True	False	.000*
Q84. 7. Women dressed in <i>abaya</i> (Islamic dresses) are not treated any differently by healthcare providers compared to women dressed in Western style	59	39	True	False	.019*

*Significant at the $p < .05$ level.

Subdomain II: Cross-cultural Modal Response Differences on Labor and Childbirth

Of the three, this subdomain had the most modal response variances (45.2%) compared to the other two subdomains. Out of 42 CCM statements there were 19 modal response differences between the SRRW and the HCP and 18 were statistically significant ($P < .05$). The HCP, on the other hand, responded in the opposite direction from the SRRW responses. The salient disagreement between the SRRW and the HCP in this subdomain hinged on belief in God vis-à-vis the science of biomedicine in childbirth respectively.

Table 5:4: Questions of labor and childbirth (subdomain II) with significant differences (n=147).

Statements	Answered True, %		Answer Key		Exact Significance (1-sided)
	SRRW	HCP	SRRW	HCP	
Q29. 7. Childbirth outcomes are in God's hands	96	47	True	False	.000*
Q23. 1. Childbirth is extremely dangerous for all women	64	89	True	False	.000*
Q19. 2. Only God knows the due date	88	43	True	False	.000*
Q20. 3. Going past due dates increases adverse risk for childbirth complications	27	72	False	True	.000*
Q21.4. It is normal for women to deliver 15 days or more beyond their due dates	96	19	True	False	.000*
Q25. 3. Only female relatives/friends should be in the delivery room	66	8	True	False	.000*
Q36. 2. Presenting to the hospital before imminent birth increases the risk of having a cesarean birth	86	28	True	False	.000*
Q38. 4. Delaying going to the hospital increases a woman's chance for having a vaginal delivery	79	39	True	False	.000*
Q46. 1. Induced labor (e.g. with pitocin) invalidates nature's way of childbirth	85	3	True	False	.000*
Q47.2. Women should be allowed to use their own cultural methods (e.g. herbs, manual massage, etc.) to induce labor	49	78	False	True	.000*
Q53. 2. Epidurals are dangerous for the mother	90.4	15	True	False	.000*
Q54. 3. Enduring labor pain brings God's blessings to the mother during childbirth	93	24	True	False	.000*

Q55. 4. In my opinion, African immigrant women have higher tolerance to childbirth pain than U.S. born women	89	45	True	False	.000*
Q56. 5. Epidurals prolong the delivery process	82	34	True	False	.000*
Q57. 6. Epidurals interfere with a mother's control of her birthing process	89	44.5	True	False	.000*
Q65. 6. Cesarean operations are avoidable with prayers and patience during delivery	79	23	True	False	.000*
Q66. 7. Cesarean operations should only be done to save the mother's life	75	7	True	False	.000*
Q73. 4. In my opinion, the longer a Somali/African immigrant woman lives in the U.S., the more likely that she will have less childbirth	79.4	42	True	False	.000*

* Significant at the $p < .05$ level

Nearly all (96%) of the SRRW agree that *childbirth outcomes are in the hands of God*, in contrast only 47% of the HCP agreed. The prevailing sentiment among SRRW was that pregnancy is a not a medical condition— but rather a *baraka* (blessing) —and any difficulties are a test of *iman* (faith) from *Allah* (God). Therefore, pregnancy and its outcomes are not within their or anybody else's control except for *Allah* (God). This difference in beliefs is critical and comes into play in the patient-provider encounter as will be seen later.

Other statements with opposing modal responses were on predetermined due date. The majority of the SRRW (with the exception of one) believe *Only God knows the due date*, whereas 57% of the HCP disagreed. This statement underscores the cultural disagreement between the groups. For example, the following quote from Casandra a

nurse practitioner (NP) working in outpatient clinic serving a large Somali community: “We tell them their expected due-dates like we do for all other women who come here for their prenatal care, but they don’t seem to take us seriously on that.” Similar sentiments were echoed by most HCP. In contrast, Batuli a 48 year old woman of Southern-SRRW says, “It is *only* God who knows when a woman conceives, what she is carrying in her womb, when and how her delivery will unfold. How can humans claim to know with certainty that which God has created inside a woman’s womb? Are they partners with God? *Asta-aghfiru-Allah*⁷⁷ (seeking forgiveness from God).”

An overwhelming majority (96%) of the SRRW believes that it is normal for women to deliver 15 days or more past their due dates. Over 73% of the SRRW responded “false” and 72% of HCP “true” (72%) to the statement regarding that there is increased risk in birth complications due to postdatism⁷⁸. In other words, SRRW do not believe going past the due date increases childbirth complications. The two groups also disagree on whether childbirth is perilous for all women. Sixty-four of the SRRW hold this belief, whereas the majority of the HCP (89%) disagree. Similarly, they disagree on the meaning of childbirth pain. Ninety-five percent of the SRRW believe that enduring labor pain brings God’s blessings to the mother during childbirth, while 76% of the HCP disagree.

Modal response variations were also noted between SRRW and HCP on applications and meanings of biotechnology obstetrics interventions such as epidurals, induced labor and cesarean birth. On epidurals, 90% of SRRW believe these procedures

⁷⁷ From the Islamic perspective, God is ONE without partners or associates. Therefore to associate God with partners is considered sinful, requiring repentance.

⁷⁸ Post-term pregnancy, pregnancy that has advanced beyond 39-42 weeks of gestation <http://medical-dictionary.thefreedictionary.com/postdatism>

are dangerous whereas 85% of the HCP disagree. A Bantu-SRRW narrated her experience with epidural as:

They would say “push, push”, but I don’t feel anything to push. I did not feel my body or the babies inside of me. After I agreed to their injection [epidural] they said I was too weak to push; now they want to cut my stomach [cesarean operation] to deliver my babies. I regret it until today, my back and my whole body has never been the same since that injection and operation. Back home, I had twins without the injection or the operation. Those injections are dangerous, so I tell other women to avoid them.

On whether *epidurals prolong the labor process*, the majority of the SRRW (82%) agreed with the statement while 66% of the HCP disagreed. Likewise, 89% of the SRRW believe *epidurals interfere with their sense of control during childbirth*, a belief not shared by 54% of the HCP. On induced labor, SRRW (85%) believe that *induced labor⁷⁹ invalidates nature’s way of childbirth*, whereas 69% of the HCP hold a contrary belief. Seventy-nine percent of the SRRW agreed that cesarean operations are avoidable with prayers and patience, while 77% of the HCP disagreed; and when cesarean is indicated, the SRRW (75%) believe that the operation should be carried out *only* to save the mother’s live while 93% of the HCP disagreed. The rationale in prioritizing saving the mother’s lives rather than that of the fetus is elaborated by a SRRW participant:

“What good is it to save the unborn child if the mother dies? They [the HCP] should focus on saving the mother’s life first; if the baby dies she will have another chance, *InshaaAllah* (by God’s will), to a successful pregnancy and to be a mother. But if they [the HCP] focus only on the child, the child will be born an orphan....what a terrible burden to be a motherless child in this world”.

The modal responses on childbirth pain tolerance also suggested a significant disagreement pattern. The majority of SRRW (65%) responded it is “true” that they have a higher pain tolerance compared to American born women, while HCP (38%)

⁷⁹ In induced labor Oxytocin/Pitocin are delivered intravenously to start, facilitate, or hasten uterine contraction. <http://effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productid=353>

responded “false”. The two groups’ modal responses also varied significantly on when a pregnant woman should present to the hospital once labor begins. Seventy-nine percent of the SRRW share a belief that *delaying going to the hospital increases the women’s chance of vaginal delivery* and 61% of the HCP disagreed. Most of the SRRW (86%) believe that presenting to the hospital before birth is imminent increases the risk of cesarean delivery, while 72% of the HCP disagreed. A young SRRW mother of three explained:

For my last childbirth, I waited in labor [at home] for a day and half before deciding to go to the hospital, because I know that if I go there before I am ready to deliver the child, they [the HCP] will tie me down and before I knew it, they shoved papers in my face telling me, “Sign here”. When they do that, you know they [the HCP] are going to cut you up. I learned my lesson from the first child I delivered in America. They cut me up for no reason.

Another Bantu-SRRW young lady who had her first baby less than six months before this study said:

I did not know anything about childbirth, but I was told by all my relatives not to go to the hospital until labor pain are constant and I can feel the baby is ready to come out. So, when I felt that, my husband and my neighbor rushed me to the hospital. I delivered in less than an hour. I labored at home with my relatives attending to me. I thank God. We have learned just to stay home and wait until the baby is ready, so we can have normal deliveries with the help of Allah (God).

On the issue of gender preference, SRRW and HCP had opposing responses on who should be allowed to be in the delivery room. The majority of SRRW (67%) responded “true” that *only female relatives/friends should be in the delivery room*, and HCP (91%) responded “false”. An overwhelming majority (79%) of the SRRW believed that the duration of their residency in the U.S. has an inverse relationship to their childbirth outcomes; that is the longer the residency, the less likely the complications. By this is because they think many of the challenges they encounter are because of miscommunication resulting from language barriers. As they gain linguistic competency

with time, they told me, they and their providers will have less problems understanding each other and their childbirth experiences will be less complicated. Less than half (42%) of the HCP, however, agreed with that assessment. In the words of the HCP: “It does not matter how long they are here. Some of the Somali patients who come here speak good enough English, but they just plainly refuse to take our medical advice seriously. It is their culture, not just language. I believe it is their culture that is a major problem for them.”

It is interesting to note that it was mostly the HCP (80%) participants who thought that *women should be allowed to use their own cultural/traditional means (herbs, manual massage) to induce labor*. However, a closer examination suggests that the SRRW lacked definitive consensus in their response pattern; barely half of the SRRW (51%) disagree while the other half (49%) agree.

Subdomain III: Cross-cultural Modal Response Differences on FGC and Childbirth

The twenty-three culture consensus statements in this subdomain aim to understand how FGC in the context of childbirth is perceived and managed cross-culturally. The analysis indicated nine modal response differences, of which eight were statistically significant ($P < .05$).

Table 5:5: Questions of labor and childbirth (subdomain II) with significant differences (n=147).

Statements	% Answered True		Answer Key		Exact Significance (1-sided)
	SRRW	HCP	SRRW	HCP	
Subdomain III					
Q11. 6. In your opinion, FGC makes it uncomfortable for women to seek prenatal care	41	71.6	False	True	.000*
Q31. 2. In my opinion, FGC does not increase the risk of adverse childbirth outcomes	70	29	True	False	.000*

Q34. 5. In my opinion, women with FGC should have a midwife rather than a doctor to deliver their babies	64.3	11	True	False	.000*
Q40. 2. Once a woman is married, defibulation is not necessary for safe childbirth	56	19	True	False	.000*
Q50. 2. Episiotomies are necessary to avoid major tearing during childbirth for women with FGC	78	27	True	False	.000*
Q51. 3. In my opinion, women with FGC have more problems after midline or mediolateral episiotomies than other women without FGC	63	44.5	True	False	.019*
Q85. 8. Women with FGC present a moral and ethical challenge to U.S. healthcare providers	45	81	False	True	.000*
Q87. 10. Women with FGC are victims of oppressive cultures	42.4	67.5	False	True	.002*

*Significant at the $p < .05$ level.

The analysis indicates that the SRRW and the HCP had several opposing modal responses in this subdomain. The first disagreement was on whether or not FGC status *makes women uncomfortable in seeking prenatal care*. More than half (59%) of the SRRW participants disagreed that FGC status makes a woman uncomfortable in seeking prenatal care, whereas the majority (72%) of the HCP held a contrary belief. Second, the HCP and the SRRW disagreed on the link between FGC and adverse childbirth outcomes. Here 70% the HCP believe that FGC increases the risk of adverse childbirth outcomes, while equal numbers of the SRRW (70%) disagreed. Third, HCP disagreed with SRRW on the question of preference of providers to assist with delivery; over 60% of the SRRW agree that women with FGC should be attended by a midwife rather than a physician. In contrast, the majority of the HCP (89%) disagreed.

Similar modal response variations were observed in exploring agreement patterns on FGC management during childbirth. On the one hand, over half (56%) of the SRRW agreed that defibulation⁸⁰ is not necessary for safe childbirth in married women but the majority (81%) of the HCP disagreed. The majority of the SRRW (78%), however, think episiotomy procedures are necessary to avoid major tearing during childbirth for women with FGC while 73% of the HCP disagreed. They also disagreed on how episiotomies should be performed. Sixty-three percent of the SRRW modal responses agreed that women with FGC have more problems following mediolateral (middle-side) incisions and or midline episiotomies, while over half (55%) of the HCP disagreed. Similar disagreements on perceptions of FGC status were found between SRRW and HCP. The majority (55%) of the SRRW disagreed that *women with FGC present a moral and ethical challenge to the U.S. HCP*, while an overwhelming majority (81%) of the HCP agreed. On whether or not women with FGC are victims of oppressive cultures, again the SRRW (58%) responded “false” to this culture consensus statement, whereas most (86%) of the HCP agreed.

Discussion

The cross-culture CCM analysis (n=174) suggested the SRRW and the HCP lack consensus on a childbearing model. Content analysis results indicated Pregnancy and Prenatal Care subdomain I had the least proportion of differences (27.2%), followed by FGC and Childbirth (39.1%) subdomain II, and the greatest proportion of variation was in the Labor and Childbirth subdomain III (45.2%).

Subdomain 1: Pregnancy and Prenatal Care

⁸⁰ Defibulation is a surgical procedure to open infibulation (type III FGC).

It was not surprising that the SRRW and HCP agreed more than disagreed here, given that the biomedical childbearing model (prenatal care) is sanctioned by most all countries globally. What was surprising though was that, for most part, the SRRW seem to endorse the biomedical model more ardently than even the HCP. For example, they believed that all pregnancies need medical supervision, a belief that was not supported by the HCP. As noted earlier, in part this may be explained by their familiarity with biomedical concept of prenatal care from the global health efforts undertaken during the heightened HIV epidemic in Africa to screen⁸¹ pregnant women (Zaba, et al., 2013; Cartoux, 1998). Hence, most all of the SRRW participants were aware and have experienced some form of biomedical prenatal care even prior to resettling in America.

The WIC⁸² program is another plausible explanation, since majority of the SRRW are economically struggling to feed themselves and their children. All SRRW participants informed me that one of the stipulations (besides financial hardship) to obtain this assistance is that they have to attend prenatal care during their pregnancies. Other plausible interpretations of the pro-medicalization stance among the SRRW may **not** necessarily reflect their **actually** held beliefs and practices (i.e. anti-traditional), but rather what they may understand to be the most appropriate *required* (seemingly modern minded) response –on the official CCM questionnaire (see Jordan, 1993: 183). That is, there is an incongruity between the response given during the formal CCM survey and semi-structured interviews and day- to-day interaction. Ethnographic data appear to support this alternative interpretation. For example, the belief among SRRW

⁸¹ Screening for HIV-AIDS and other communicable diseases (sexually transmitted) aimed to reduce maternal-infant transmission of HIV.

⁸² WIC (Women, Infant and Children) provides supplemental foods, healthcare referrals, nutrition education, and breastfeeding promotion and support to low-income pregnant, breastfeeding, and postpartum women, and to infants and children up to age five who are found to be at nutritional risk. <http://www.fns.usda.gov/wic/women-infants-and-children-wic>

was that ultrasound during pregnancy was necessary, contrary to what HCP believed.

When asked why, one of the SRRW participants said,

Actually it is rule⁸³ [in] America. Yes, its rule. They [HCP] have to see baby inside in tummy. Right now if you feel pregnant, you go to doctor they have to know if you're pregnant, they take you ultrasound after four months usually. If I go and say I think I have pregnant he tell me do the ultrasound. I already know I am pregnant, but I do it, because it is rule here.

Another 40 year old mother of ten with dual obstetric experiences confirms the impression among Somali women this and other prenatal measures are required by law of the host country. She explains that “we have no choice. If we do not go [to prenatal care], we will not be able go to the hospital to give birth. That will mean our child will not get the papers [birth certificate] to be a U.S. citizen.” They do it because they think it is mandated by them and see the value of some procedure and reluctantly submit to others as noted by this participant:

they take blood [blood test] and pressure [blood pressure], so it's good. They give me vitamins and give help like WIC [program] – you know that is good for me and other Somali ladies. I don't like the down exams [pelvic exams], I don't like the ultrasound, but it's OK for one time. I don't want any troubles in this country.

It was remarkable that most of the SRRW understood prenatal care as a “law of the land” with which they had to comply, even if some of the procedures such as pelvic exams were experienced as painful. It was also interesting that they really did not see the efficacy of ultrasounds and some were suspicious of it. A young mother of three children, all born in the U.S., has this to say regarding ultrasound efficacy as utilized in prenatal care:

They look at their machines [ultrasound] and then tell you your baby is this and that, but in reality only God knows. In my first pregnancy, they say the baby is wrong, is sick. I worry a lot, but Alhamdulillah (gratitude to God), the baby girl is three [years] now and is good – she talks, walks, laughs—everything; she is not sick. The machines [ultrasound] lie.

⁸³ By rule, the participant means that it is a law.

A 34 year old mother of five, four of whom U.S.-born, shared that many Somali women do not do get the ultrasound done as early as the doctor orders. This is because it only adds to their stress. If something worrisome is revealed by the exam there is nothing that could be done anyway because only God truly knows. They also worry that the ultrasound might in fact be harmful and in any case it is “fifty-fifty” because “sometimes, the doctor says, right now you baby is healthy; but when you born [give birth] your baby is sick, some time they say your baby is sick after he born—he is fine”

Meanings of pregnancy risk

The SRRW believe that the first trimester is the most dangerous period for pregnant women; their beliefs are grounded in their lived experiences. For example, 28% of the SRRW in this study reported at least one miscarriage, all of which occurred during the first trimester. Their lived experiences with miscarriages seem to have scientific merits considering that 20-25% of all spontaneous abortion⁸⁴ tend to occur in the first trimester, which corresponds to the first 13 weeks of gestational development⁸⁵ (see Maconochie, Doyle, Prior, and Simmons 2006). Surprisingly the HCP disagreed with the SRRW experiences which are in fact supported by scientific studies. The differences may reflect the divergent cultural/religious meanings of pregnancy, of the fetus, and of how risk is assessed, and who is considered to be incurring the greatest risk and why.

From the SRRW perspectives, it is the pregnant women who are carrying the risk by being pregnant. The unborn fetus is considered part of the woman’s body and not a separate entity until pregnancy ends. In accordance with Islamic teachings, the fetus

⁸⁴ Miscarriage is also known as spontaneous abortion.

⁸⁵ Miscarriage is the most common type of pregnancy loss, according to the American College of Obstetricians and Gynecologists (ACOG). Studies reveal that anywhere from 10-25% of all clinically recognized pregnancies will end in miscarriage.

<http://americanpregnancy.org/pregnancycomplications/miscarriage.html>

begins as a lump of flesh⁸⁶ that goes through stages of development and ensoulment occurs several weeks after conception⁸⁷; thereafter, the angel delivers the soul as per God's command (Deuraseh and Yaakub 2010). Conversely, the American public sentiment poll as reported by Rowland⁸⁸ (2013), on when life begins⁸⁹ for the fetus remains divided and changing. According to this poll, more Americans (50%) believe that life begins at conception (see Gallagher 1987; Krauss, 1991; Roth 2000). As such, it may reflect the HCP perspectives, whereas from the SRRW it is the opposite.

For the SRRW the spontaneous abortion risk (irrespective of the gestational age) is a risk to their bodies as a potential mother. The SRRW lived experiences have made them cognizant of a higher risk of spontaneous pregnancy termination during their first three months of pregnancy and consider this to be directly related to their own personal health and wellbeing—emotionally, spiritually and physically. As one of the Southern SRRW in her early 60's narrates:

You see, pregnancy is like normal life. Whenever there is life there are also trials in one's life; during pregnancy those trials are doubled for the pregnant woman. It is her body. The baby inside is also part of her body. If the fetus is lost, it is only the pregnant woman's body and soul that bears the pain and sorrow. Whatever happens though, it is by decree of Allah (God). It is Allah who knows best.

⁸⁶ [We] then formed the drop into a clot and formed the clot into a lump and formed the lump into bones and clothed the bones in flesh; and then brought him into being as another creature. Blessed be Allah, the Best of Creators! (Qur'an, 23:14)

⁸⁷ There are at least four schools of Islamic thoughts – each has their own interpretation as to when the soul is delivered to the fetus (range from 40 to 120 days post-conception); hence abortion after that is not permissible unless on medical grounds.
<http://www.islamawareness.net/FamilyPlanning/Abortion/abortion3.html>

⁸⁸ While the issue remains highly divisive, there's been a 32-point turnaround in those labeling themselves "pro-life" vs. "pro-choice" in the national Gallup Poll since the mid-1990s. In 1995, those accepting the "pro-choice" designation held a 23-point margin, 56 percent to 33 percent. By 2012, however, the "pro-life" label was preferred by 9 points, 50 percent to 41 percent – a record low for the "pro-choice" group (Rowland 2013). By Darrel Rowland. In The Columbus Dispatch. Sunday, January 20, 2013 <http://www.dispatch.com/content/stories/local/2013/01/20/pro-life-position-gaining-support.html>

⁸⁹ Relating to abortion rights, those opposing abortion ("pro-life") believe that life begins at conception; "pro-choice" proponents on the other hand argue that a woman has a right to terminate her pregnancy by her choice, if she deems that it endangers her life or for any other reason of her choice.

Seeking healthcare providers is one of the major concerns for SRRW during pregnancy and childbirth (see chapter embodiment). Overall, they prefer female providers; although race/ethnicity of the provider is not a concern to them, contrary to HCP beliefs. On the other hand, the results suggest that less than half of the SRRW participants are concerned about perceived discrimination based on their outward appearance, namely their Islamic attire, but the ethnographic data suggests otherwise. What was surprising however, was that the majority of the HCP concurred that women in Islamic attire are treated differently, suggesting presence of, or recognition of potential, discrimination.

Subdomain II: Labor and Childbirth Knowledge, Meanings and Beliefs.

This sub-domain underscores cross-cultural tensions between the SRRW and the HCP (biomedical) childbearing models, evidenced by having the most modal response variations.

Faith in God vs. Faith in Biomedicine

The most salient cultural tension noted on parturition⁹⁰ models between the SRRW and the HCP is the supremacy of the belief in God vis-à-vis in biomedicine. At one end of the spectrum is the biomedical power to control *risk*; a power vested by the biomedical authoritative knowledge. On the opposite end is the metaphysical power of faith; a total trust in God. This point of contention was pithily expressed by one of the HCPs: “I admire these women’s strong faith. We all have faith, but they absolutely put their God first, and what we tell them is secondary, even if we have scientific evidence to

⁹⁰ The process of childbirth, i.e. labor and birth.

back what we do and say. No. They [SRRW] absolutely, believe in God’s will. It is impossible to try to reason with them [SRRW].”

The position held by most HCP is that childbirth is always a risk, “something can always go wrong, so why take a risk”. The notion of risk aversion during childbirth can be understood in the context of the larger social norms as explained by one of the HCP: “Because it is such a litigious society, you just can’t take those risks. We cannot take any chance that open the way to lawsuits and goes against the scientific knowledge we have. That is kind of the mindset we operate on”. Such mindset, however, is alien to most SRRW; it is in accordance with God’s will that a woman gives birth and determines when and how childbirth will unfold.

The SRRW strongly believe that only God knows when the fetus will be born and what happens to mother and child; therefore, the notion of due-dates is meaningless to them. It is why they strongly reject the idea of induced labor to hasten childbirth. Likewise, the idea of postdatism as a risk factor for complicated childbirth is irrelevant to the SRRW. Many SRRW participants conveyed that conception and delivery dates are set by God since he is the only one with certain knowledge. Humans are just guessing the dates. Their “adamant refus[al]” of induction especially if “*their blood pressure is too high and have gone two weeks beyond their given due-dates,*” is beyond the comprehension of HCP who consider SRRW’s actions and beliefs to be “*fatalistic*”.

Fatalism

Acevedo explains the notion of a fatalistic collective mindset as “one that is adverse to the ideals of self-empowerment and individualism that characterize many democratic, Christian nations. Instead, it places the burden of life’s outcomes at the hands of omnipotent, metaphysical forces” (2008, 1712). Since a primary dimension of

Islam is the submission to the will of God, the adherents of this faith, in contradistinction to a purported individualistic Christianity, are often characterized by critics as fatalistic. Yet, accepting the will of God does not engender fatalism as commonly defined⁹¹.

American scholar of Islam, Vincent J. Cornell, explains the difference:

Islam is the conscious and rational submission of the contingent and limited human will to the absolute and omnipotent will of God. Islam's advocacy of self-surrender should not be thought of as irrational, however, or dismissed as the product of a passive or fatalistic mentality. On the contrary, the type of surrender Islam requires is a deliberate, conscious, and rational act [1999, 67].

Submission to God, however, does not mean passivity nor does it negate seeking means to manage adversity or to exert oneself. In fact, an oft repeated statement of Prophet Muhammad is “trust in God and tie your camel” makes clear that having faith does not mean inaction and fatalism. Submission to God's will is, therefore, a rational disposition; “that prepares Muslims to face hardship and fosters perseverance during temporary trials” (Hodge 2005:166). A nurse practitioner made this observation about the SRRW patients in her care:

They [SRRW] are very strong-willed people with strong faith. Their [Islam] faith seems to help them deal with the childbearing misfortunes. I see very little depression after a miscarriage or stillbirth in this community. When I see them after a miscarriage or stillbirth, I would say how sorry I am for their loss, but they just say, “It was God's will, and we accept it.” They don't seem to get depressed and sad like women from other ethnic groups. So, I guess their faith serves them well.

As Hamdy (2009) argues, that reliance on and submission to God's will and supremacy does not negate human agency; rather it requires a persistent engagement with self, where the self is central, informed by the lived experiences and by cost-benefit considerations which may be expressed in religious terms. For example, a young Bantu SRRW said, “I was in labor for two days, but the baby could not come down; my mother

⁹¹ An attitude of resignation in the face of some future event or events which are thought to be inevitable, philosophers usually use the word to refer to the view that we are powerless to do anything other than what we actually do. <http://plato.stanford.edu/entries/fatalism/>

and relatives agreed that I had to get the operation [cesarean] or I would die and the baby would die too. There was nothing I could do but accept my fate as God's will. ” Among the SRRW, childbirth as with other human conditions, such as illnesses regardless of outcomes are believed to unfold in accordance with God's will (Callister 1995). Furthermore, science and technology themselves are not rejected on principle because, Muslims believe, all knowledge ultimately has divine source as they are reminded in the first verses revealed from Quran (96, 1-5) which also reminds humans of their humble beginning created as they are from a “clinging substance”.

Interventions: Meanings and Negotiations

Jordan (1993) points out that in the U.S. how biomedical obstetric interventions such as inductions, episiotomies, lithotomy position during delivery, cesarean surgeries and uses of various medications to alleviate pain are the norm rather than exceptions. SRRW find these norms problematic and refuse to accept these obstetrical interventions *carte blanche*. The two groups have very different beliefs systems on when, how, and why such interventions should be implemented. The SRRW associate induction with drugs⁹² delivered intravenously (IV) and other mechanistic technological procedures such as fetal monitors to be unnecessary, counterintuitive to childbirth and an erosion of their active participation in the “natural childbirth”. For example, most SRRW participants view electronic fetal monitors as being “*tied down*” with tubes (IV) and wires (electronic monitors), thereby limiting their mobility and active participation in the childbirth process. This is because these to Somali's, as articulated by Anisa, a mother of 4 children (Southern-SRRW), “women in labor have to walk, walk, walk, until

⁹² Pitocin is the most commonly used drug to induce labor.
<http://www.mayoclinic.com/health/inducing-labor/pro0117/nsectiongroup=2>

they cannot walk anymore. She cannot be tied down in bed like they do it here. It is wrong.”

Oddly but not surprising, it was only a U.S.-born midwife that concurred with the SSRW. She believed that the idea of strapping laboring women down with IV's and various other high technological machineries delays the “natural” childbirth process. Rather than using electronic fetal monitors, she advocated use of *Pinard*⁹³ arguing that even the American College of OB/GYN has concluded that intermittent auscultation provides information as reliable as the continuous electronic fetal monitors. She is quite sure that “the electronic fetal monitors are the biggest, unnecessary interventions thrown on women the moment they hit the hospital door. They are tied to the bed and that’s awful.” This assertion was countered by a labor and delivery nurse; from her perspective, women in labor, except for the “*simply difficult*” Somali woman, have no issues with standard obstetrics procedure such as electronic fetal monitors, IV etc.

On the other hand, the HCP support the idea that the SRRW should be allowed to use their own cultural methods (herbs, massage, etc.) to induce labor. While it seems surprising that over half of the SRRW disagreed, it is most likely their response was because they understood this to be about whether or not they are “allowed” to use such methods within the American healthcare system. My conclusion here is supported by discussions with the SRRW who shared that they indeed use “traditional methods” to facilitate labor while at home. This, in fact, is one of the reasons that many SRRW believe medical induced labor invalidates natural childbirth and that is why they delay going to the hospital and instead “*wait at home*”. It is evident then that though the HCP do not disagree on the use of these traditional methods, the SRRW do not realize they are “allowed” to do so; this is an example of the misunderstandings between the two groups.

There is, however, some agreement between the two when it comes to induction. Some HCPs agree with the SRRW that the women who present to a hospital before birth is imminent are more likely to be induced. This suggests that though induced labor is a serious decision that needs to be based on medical necessity (Westfalla and Benoit 2004), this might not always be the case in practice. Fifa, a labor and deliver nurse explains that physicians follow what is known as the labor curve⁹⁴ to evaluate the progression of labor through three stages indexed by the degree of cervical dilation. Physicians become alarmed if stage two is slower than indicated by the curve and are most likely to resort to chemically accelerate the process through induction drugs. This process, notes this nurse, does not makes sense as it expects all “to fit neatly along the plotted lines of this curve.”⁹⁵ This nurse also echoes the SRRW impression that these interventions are sometimes done for the provider’s convenience rather than medical necessity. Sometimes, she wishes she could “advocate for the women...especially, the poor women who cannot speak English” who are pressured to have these interventions.

As previous studies have suggested, Somali refugee women have strong aversions to obstetric interventions, including epidurals and especially C-section. Findings from this study provide a more nuanced understanding of these aversions. Notwithstanding the known risks associated with the procedure, (see Klein 2006; Osterman and Martin 2011), the aversion to epidural has another dimension associated with the spiritual

⁹³ A hand held fetal stethoscope to monitor the fetus heart beats.

⁹⁴ Also known as the Friedman curve, developed in the 1950s. Friedman’s curve is based on the relationship between the duration of labor and cervical dilation as a sigmoid curve, which consists of latent and active phases, followed by the second stage of labor. In 2002, Zhang, Troendle, and Yancey conducted a study to re-examine the pattern of labor progression among nulliparous women in contemporary obstetrics practice. The study findings support that childbirth labor appears to progress more slowly than the Friedman curve indicated. They concluded that Friedman’s curve as a diagnostic criteria for protraction and arrest disorders of labor may be too stringent in nulliparous women (see Zhang, Troendle, and Yancey 2002).

⁹⁵ A study on the labor curve by Gurewitsch et al. 2002 compared grand-multiparous women (women with 4 or greater childbirth) with nulliparous women(first childbirth). Their findings

aspect of pain. Labor pain has a cultural and spiritual significance among the SRRW which they do not want to easily relinquish. In part, this may explain why the SRRW believe they have a higher labor pain tolerance compared to American born women. SRRW believe labor pain is part of the “natural” childbirth process and a spiritual trial in which to persevere. As such, to bear labor pain is to show piety which is rewarded with blessings; this gives meaning to labor pain in the childbirth process. However, this does not mean seeking pain relief is a sign of impiety. Fadumo, a young Southern-SRRW mother of two US-born children, explains how one decides:

One should try to give birth as naturally as possible, for God said in the Quran: “He makes ease that which is difficult when you call onto HIM”; but if the pain is so much that it interferes with your ability to push, of course you should take medicine that can ease the pain, because God does not want you to suffer. It is *haram* (forbidden) to hurt oneself when there is medicine to help you ease your suffering.

Her assessment may explain why at least 26% of SRRW participants have had (at least one) epidural for pain control during childbirth. Though, this number is relatively low compared to the national trend of 60% of all women (Klein 2006; Osterman and Martin 2011), it has to be contextualized not only with cultural meanings of labor pain but also pre-migration conditions, where access to pain modulating modalities of any sort are scarce or non-existent (Johansen, 2006) There is also a common belief among SRRW that epidurals in fact delay the birthing process because the woman cannot feel the force of pushing.

Parallel to epidural use, cesarean operation births has been on the rise in the U.S. exceeding the 10-15% recommended by the WHO (WHO 2010)⁹⁶. The estimate of

suggested that in women in the former group tend to have slower dilation during their second phase of labor and therefore should not be considered as an “abnormal” progression of labor.
⁹⁶ WHO background paper No. 29 Determinants of caesarean section rates in developed Countries.

current⁹⁷ cesarean births in the U.S. is at 32% (Hamilton and Martin 2006; MacDorman, Menacker, and Declercq 2008; Martin et al. 2005; Menacker and Hamilton 2010⁹⁸). The prevalence of cesarean operative births varies by state and racial categories (Menacker and Hamilton 2010). In this project, both providers and patient agree that cesarean operation births are pervasive in the U.S. and 35.6% of the SRRW participants reported undergoing at one such operation. This is higher than the national rate (32%) and the state-wide rate for Arizona (26.2%) (see Menacker and Hamilton 2010). Unaware of these statistics, the SRRW unanimously believe they have higher incidents of cesarean operations that are performed in haste and unnecessarily since “back home” the birthing process may take as many as four days. Evidently, these beliefs are framed from their collective childbirth experiences and knowledge at pre-migration juxtaposed with post-migration childbirth culture and their social conditions (Essen et al. 2011). SRRW beliefs are embedded in an unwavering faith in God; it is in this context, the SRRW believe cesarean operative births are avoidable with patience and prayers. However, if and when indicated, the main reason for cesarean operations should be to save the mother’s life, first and foremost. This is not because the SRRW do not want to save their unborn child or would reject medical advice at all costs but because the mother is necessary for welfare and future childbirth.

Language and Cultural Barriers

Language barriers have been reported to contribute to health disparities across the U.S. (Carter-Pokras et al. 2004; DuBard and Gizlice 2008). In response, most all hospitals/clinics serving SRRW patients have interpreters to assist with language barriers. From the HCP participants’ perspectives language barriers are a source of

⁹⁷ 2006 estimates.

⁹⁸ Also see NCHS Data Brief No. 35 March 2010

frustration and a major obstacle in patient-provider relationships. Studies from the U.K., Canada, and Sweden concur that language barriers have the most negative impact on Somali immigrant childbirth outcomes (Bulman and McCourt 2002; Carroll et al. 2007; Essen et al. 2002; Merry et al. 2013). In this study, nearly all of the SRRW participants believe a language barrier is one major cause that complicates their childbirth events in U.S. hospitals and that overtime, as they become competent, the process will be easier. This perception is not shared by the HCP participants who contrast the SRRW patients with other non-English speaking Latina patients and conclude that the difficulties they encounter dealing with SRRW is not due to “the language, but their culture.”

Subdomain III: Female Genital Cutting (FGC)

Regarding childbearing knowledge, beliefs and practices post-migration, HCPs and the SRRW have divergent beliefs about the meanings and management of FGC in the context of childbirth. The general consensus among HCP in this study is that women with FGC have an increased risk of adverse childbirth outcomes, a position that is vehemently rejected by majority of the SRRW. If FGC necessitated C-section, argued an elderly SRRW participant, they would all be “walking around with big scars across [their] bellies”, and none of them would know what vaginal birth was. For SRRW, female circumcision is normal neither being an obstacle to vaginal deliveries nor hindering prenatal care. These assertive declarations, however, conceal the fact that SRRW do indeed feel uncomfortable during prenatal care and labor and delivery because of their FGC status for reasons I will discuss in the subsequent chapter.

Infibulated women (type III FGC) may require defibulation⁹⁹, an additional obstetric procedure during childbirth to avert complications such as perineal tears and cesarean operations (see Ibe and Johnson-Agbakwu 2011; Thierfelder et al. 2005). It is at this juncture that cultural tensions may manifest as fears, anxieties, and frustrations (see Johansen 2006). The lack of cultural awareness and technical skills in managing women with FGC during childbirth was expressed by both groups in this study. According to SRRW participants, there is no particular “cultural” pattern on when defibulation is carried out; it varies within one clan/ethnic group, rural versus urban, and the social milieu. It was explained that defibulation can occur just before marriage to allow sexual penetration or may gradually occur with the force of sexual penetration. If not already done for intercourse, defibulation is often necessary procedure that takes place during the first child delivery and is performed the traditional ways by the circumciser or midwife or in medical settings. The decision has to be made by birth attendants who have clinical experience and cultural competence in assisting women with FGC during childbirth (Ibe and Johnson-Agbakwu 2011). There are few medical experts (see Johnson 2009; Johnson and Nour 2007; Zaidi et al. 2007) in the U.S.A. who perform these procedures surgically and with cultural sensitivity; Crista Johnson-Agbakwu, MD is one of the Arizona physicians with such competence. The SRRW perspective, however, is that once a woman is married, defibulation is not indicated during childbirth, though they believe (contrary to HCP) episiotomies are indicated to avoid or control perineal tears.

Another area of disagreement is on the incision angle of episiotomies. Episiotomies in Somalia are performed mediolaterally verses in America where midline incisions have been the standard (Herrel et al. 2004). The angle of episiotomies is a

⁹⁹ Surgical opening of the infibulated type III FGC, see Johnson, Ali, and Shipp 2009 and

major concern for the SRRW. Due to scarring from the FGC, the midline incision from the episiotomies can be detrimental to infibulated women (Ibe and Johnson-Agbakwu 2011). Yet, the HCP do not consider this to be a problem. This suggests that the HCP are unaware or inexperienced in managing infibulated women during the childbirth process and this becomes yet another source of trepidation for SRRW that they endure during childbirth. One of the Northern Somali participants narrated her birthing experience that illustrates this tension and her anxiety,

I keep telling them that they need to open up the scar (infibulation) by cutting upwards first to allow the baby to come out. But they did not listen to me, they cut down. My mother was with me, she too was yelling to the doctor not to cut down. I had several stitches after that because they did not listen to us. I still have much pain down there because the doctors don't know what they are doing.

Cultural knowledge and lived experiences lead most SRRW, particularly those who have given birth prior to migration, to prefer midwives to physicians. Having experienced home-births with traditional birth attendants or trained midwives in their communities, they do not see the necessity of having a physician. For the few who had hospital deliveries pre-migration, less than a handful reported being attended by a physician. Post-migration, the SRRW preference of midwives to physicians is framed with different meanings. For example, during interviews, SRRW reported that the hospital births are rushed and physicians keep their eyes on the clock and not on their needs. Some of the SRRW also report that doctors make more money performing surgeries; therefore, it is an additional incentive to rush them. The rationale for midwives¹⁰⁰ preference is that “they are patient” and have no incentives to force or rush them to “be cut” (i.e. cesarean operative birth). Meanings of FGC, in particular during childbirth, varied between the two groups. The majority of the HCP believe that SRRW

Johnson and Nour, 2007.

¹⁰⁰ Majority of the SRRW are on Government health plans, such plans do not cover midwife services outside the hospital settings.

with FGC are victims of an oppressive and backward culture who present moral, ethical, and medical challenges. While many SRRW empathize with the HCP and understand how “shocking [it could be] for them to see a circumcised woman”, they, nevertheless think, the HCP’s views representation of them are unwarranted.

Section Two: Cross-cultural Agreement Patterns

Intra-cultural CCM Analysis and Results

The second objective of this study is to explore whether the SWRR from diverse clans and ethnic groups share a single childbearing model. In other words, whether or not results from the cultural consensus analysis from individuals and groups would justify aggregation of a single cultural model: a Somali childbearing model.

CCM Analysis: The UCINET data analysis (n=73) shown in Table 5 indicated that the SRRW as a group share a conceptual cultural model¹⁰¹. When the three SRRW groups were analyzed separately, the results suggest that only the Bantu¹⁰² and the Southern SRRW¹⁰³ eigenvalue ratio met the threshold of each being a cohesive cultural group but not the Northerners¹⁰⁴.

Next, the UCINET analysis was conducted by pairing the SRRW: Bantu-Southern. The eigenvalue ratio results for this (see Table 5:1) suggest that all paired groups met the criteria of a cohesive cultural group; yet separately, the Northern group

¹⁰¹ SRRW (n=73): Eigenvalue of 6.202 with no negative competency scores (average competence score of 0.415 and standard deviation 0.127).

¹⁰² The Bantu (n=22) was: 8.462 (the largest eigenvalue ratio among them being 8.839, and the second largest eigenvalue ratio 1.045) with no negative competencies. Average competence score 0.419 (lowest score 0.217, highest score 0.634) with standard deviation of 0.149.

¹⁰³ The Southern (n=32) was 7.938 (the largest eigenvalue ratio being 11.620 the second largest eigenvalue ratio 1.464) with no negative competencies. Average competence score of 0.446 (lowest score 0.213 and highest score 0.595) with standard deviation of 0.087.

was not cohesive, indicating a lack of within group agreement. In other words, the Northern had more disagreement among themselves as a group than between them and the other two groups when paired. The CCM results can be extrapolated to suggest that the Northern group share some aspects of cultural knowledge in the childbearing model with the Bantu and the Southern SRRW cohorts, but separately they hold divergent ideas as a group, unlike the other two groups.

Intra-cultural Residual Agreement Analysis

The residual analysis was applied to the paired Bantu and Southern SRRW. It excluded the Northern group because of the lack of within group consensus. Results of the residual agreement analysis (Bantu-Southern SRRW) suggest that each group agrees on a subset of questions not shared by the other group. One-way-analysis of variance (ANOVA) results indicated each group was statistically different ($p < 0.000$) from the other. The CCM and residual agreement analyses suggested that the Bantu and the Southern SRRW have cultural differences that warranted further exploration to understand intra-cultural variation.

Modal response difference between Bantu and Southern SRRW

To assess intra-cultural variation, content analysis followed by Fischer's chi square was conducted pairing the Bantu with the Southern SRRW as described earlier in section one. The results indicate that there are twenty one (24%) overall modal response differences between Bantu and Southern SRRW; however, only 11 statements (19%) of these were statistically significant ($p < 0.05$). Below is the proportion of modal response variation across the three subdomains. The most modal responses differences were

¹⁰⁴ The Northern (=19) was 2.537 (the largest eigenvalue ratio 3.973 the second largest eigenvalue ratio 1.566) with no negative competencies. Average competence score of 0.359 (lowest score

related to pregnancy and prenatal care (41%). This is an interesting finding, particular when compared with cross-cultural analysis, which had the least amount (27.2%) of variability in this subdomain. The second subdomain, labor and childbirth, had the least modal response variability (12%), which is also very different when compared to cross-culture analysis in which the groups had the most (45.2%) differences. The last subdomain, FGC and childbirth, modal responses suggest intra-cultural variability (29%) was ten percentage points lower than it was in cross-culture analysis. This means that despite having different responses on the subset of questions, the Bantu and Southern SRRW agreed more with each other than with HCP because of the overall within group consensus and lack of between (SRRW-HCP) group agreements.

Table 5:6 Intra-cultural modal variations with significant differences

Subdomain	Variable	No. (%)
I	Pregnancy and Prenatal care	9 (41)
II	Labor and childbirth	5 (12)
III	FGC and childbirth	7 (29)

Subdomain I: Intra-culture Variation on Pregnancy and Prenatal Care.

The results indicated that the Bantu and the Southern SRRW had nine different modal response variations (41%) out of twenty-two cultural consensus statements; of that, five were statistically significant ($P < .05$).

0.164 and highest score 0.563) with standard deviation of 0.143.

Table 5:7: Questions of pregnancy and prenatal care (subdomain I) with significant differences (n=54).

Statements	Answered True, %		Answer Key		Exact Significance (1-sided)
	Bantu	Southern	Bantu	Southern	
The first 3 months of pregnancy is the most dangerous period for the mother	50	87.5	Split	False	.003*
Pregnant women are most susceptible to the evil eye	77.2	28	True	False	.000*
Pregnant women should not see a medical provider before three months into pregnancy	54.5	28	True	False	.047*
An ultrasound have to be done six months into pregnancy	59	31	True	False	.040*
Pregnant women need to eat a special diet	41	87.5	False	True	.000*

*Significant at the $p < .05$ level.

The Bantu-SRRW responses were split (50/50) on that statement that the *first trimester was the most dangerous for women*, though a majority of Southern-SRRW responded “true”. The two subgroups had opposing modal response on belief of evil eye and pregnancy; unlike the Southern SRRW, the Bantus-SRRW decisively agreed. Similarly, the two groups disagreed on when to initiate prenatal care and on the timing of diagnostic ultrasound. The Bantus and Southern SRRW had opposing modal responses on whether pregnant women need to eat a special diet during pregnancy.

Subdomain II: Intra-culture variation on Labor and Childbirth

Table 5:8: Questions of labor and childbirth (subdomain II) with significant differences (n=54).

Statements	Answered True, %		Answer Key		Exact Significance (1-sided)
	Bantu	Southern	Bantu	Southern	
Childbirth is extremely dangerous for all women	95.4	46.8	True	False	.000*
In my opinion, childbirth in the U.S. is more difficult for Somali/African immigrant women compared to U.S. born women	50	78	Split	True	.032*

*Significant at the $p < .05$ level.

The Bantu and the Southern-SRRW had five out of forty one (12%) modal response differences in this subdomain only two of which are statistically significant ($p < 0.05$), indicating a large amount of intra-cultural agreement in concepts of labor and childbirth. The analysis indicates that all Bantu-SRRW (with the exception of one) believe that *childbirth is extremely dangerous for all women* compared to only forty-seven percent of Southern-SRRW who share the same view. On the other hand, Bantu-SRRW lack a definitive direction on whether *childbirth in America was more difficult for Somali/African immigrant women compared to American born women*, whereas Southern SRRW (78%) agree with this statement.

Subdomain III: Intra-culture variation Female genital cutting and Childbirth

The results in this subdomain suggest only four out of the seven modal response variations are statistically significant ($p < 0.05$). The Bantu-SRRW have a different and opposite understanding from the Southern-SRRW on whether or not *it is necessary to*

perform defibulation before every childbirth on women with type III FGC and on how episiotomy incisions should be performed. Intra-cultural differences were also evident (P .000) in their modal responses on whether or not *women with FGC have different OB/GYN needs from other women without FGC*. Here, the Bantu-SRRW (82%) agreed, while the Southern-SRRW disagreed (75%). Finally, 73% of the Bantu-SRRW agreed that *women with FGC present a moral and ethical challenge to U.S. healthcare providers*, whereas 72% of Southern-SRRW disagreed.

Table 5:9: Questions of FGC and childbirth (subdomain III) with significant differences (n=54).

Statements	Answered True, %		Answer Key		Exact Significance (1-sided)
	Bantu	Southern	Bantu	Southern	
It is necessary to perform defibulation before every childbirth on women with type III FGC	77	28	True	False	.000*
In my opinion, women with FGC have more problems after midline or mediolateral episiotomies than other women without FGC	40.9	72	True	False	.023*
In my opinion, women with FGC have different OB/GYN needs from other women	81.8	25	True	False	.000*
Women with FGC present a moral and ethical challenge to U.S. healthcare providers	72.7	28	True	False	.001*

*Significant at the $p < .05$ level.

Discussion

The culture consensus analysis indicates that the SRRW as a group are culturally cohesive; that is, they share a conceptual childbearing model. Separately, however, the finding suggests they have significant intra-cultural variations. First, the paired residual

agreement analysis suggested that the Bantu-SRRW and the Southern-SRRW are unique subgroups when compared against each other. Out of eighty-seven CCM statements, the Bantu and the Southern SRRW subgroups have 21 (24%) modal response variations, though only eleven (12.6%) were statistically significant. Intra-cultural variations were most pronounced in the pregnancy and prenatal care followed by female circumcision and childbirth and the least variation on the labor and delivery subdomain. This suggests that though these two subgroups may share cultural practices and beliefs, they differ on specific subsets of questions.

Secondly, the Northern-SRRW displayed a considerable within group variations to the extent that they do not meet the culture consensus criteria of a cohesive cultural group. Hence, the Northern-SRRW either lacks a cohesive childbearing model within themselves as a group, or they may have multiple cultural beliefs (Weller, 2007:341). Thirdly, neither the Bantu, the Southern, nor the Northern SRRW agreed more with the HCP¹⁰⁵ than with each other. These findings have shed a new light on understanding the SRRW. The question remains as to why the Northern-SRRW (unlike the Bantu and Southern SRRW) lack intra-group cultural consensus and yet do not agree with HCP?

The Northern-SRRW Conundrum

The acculturation process is one plausible hypothesis that may explain the Northern- SRRW as a group within the larger Somali community participants in this study. Compared to their cohorts, Northern-SRRW on average have longer residency in the U.S. (3-5 year) compared to the Bantu and the Southern SRRW. Flynn posits that the first five years of post-migration affords sufficient time to observe social, cultural and health changes among immigrants/refugees (2008). Second, compared to their cohorts

¹⁰⁵ To compare groups F-test and ANOVA was applied; the results were not significant.

they are also younger group (on average by 4.5 years); this means that they were much younger when they first resettled in the U.S. Age at migration has been reported to have a direct relationship to acculturation (see Kimbro 2009). The resettlement process places them in close proximity with other Somali groups from whom they are likely to learn some of the general Somali cultural beliefs. That is, the younger the age at migration, the higher the level of acculturation; this suggests early exposure to various cultural and social values which are different from their own may differentiate the Northern from their cohorts.

Higher acculturation levels are evident among Northern-SRRW participants in their linguistic competence. Forty-two percent of them are fluent in the English language, compared to 14% and 37% of the Bantu and the Southern SRRW, respectively. Finally, unlike their cohorts, most of the Northern-SRRW chose the English version of the culture consensus questionnaire rather than the Somali or Kiswahili version. Duration of stay in the host country (Flynn 2008), age at migration (see Kimbro 2009), and language proficiency (see Lee, Nguyen and Tsui 2011) have been used as proxy measurement for acculturation (see Carter-Polkras et al. 2009). Another plausible explanation could be that the sample size may be too low to detect agreement. However, this by itself does not adequately explain why the Northern as a group disagree amongst themselves. On the other hand, though they lack a cohesive cultural model, they nonetheless did not agree with the HCP childbearing model.

Bantu-Southern SRRW Intra-cultural Variations

Out of 87% CCM statements, the Bantu and the Southern SRRW subgroups have 21 (24%) modal response variations, though only eleven (12.6%) were statistically significant. Intra-cultural variations were most pronounced in the pregnancy and

prenatal care followed by female circumcision and childbirth and least variation on labor and delivery sub-domains. This suggests that though these two subgroups may share cultural practices and beliefs; yet, differ on specific subsets of questions.

Subdomain I: Pregnancy and Prenatal care model Between Traditions and Law.

Compared to the Southerners, Bantu appear to be more traditional in their beliefs and behaviors regarding how they view pregnancy and prenatal care. For example, the concept of “evil eye” is part of the day-to-day lexicon among Muslims¹⁰⁶; the Bantus believe pregnant women are more prone to an evil eye. According to Islamic traditions, the evil eye is associated with envy that can cause misfortunes including illnesses.

Anthropologist Aref Abu Rabia explains that envy

is said to be conveyed by a strange gaze, or by admiration without a blessing¹⁰⁷. The evil eye is said to cause impairment of sexual activity, impotence, sterility, disorders in menstruation, problems in pregnancy and childbirth, deficient breast milk, mastitis, a baby's refusal to suckle, and so on (2005, 241).

As discussed in chapter 4, as non-Samaals, the Bantus were socially and culturally isolated in Somalia (Lewis 2002), which may have enabled them to retain most of their African traditional beliefs. In traditional African beliefs, the evil eye and witchcraft are ever present to explain various misfortunes, particularly in reproductive outcomes, such as death of an infant, miscarriage, infertility (Caldwell and Caldwell 1987). The amalgamation between African traditional beliefs and Islam may reinforce the Bantu-SRRW belief in the evil eye. Consequently, this subgroup believes that pregnancy must be kept a secret until the end of the first trimester; therefore, the

¹⁰⁶ When praising and or admiring someone, it is customary to precede with MaashaAllah, an Arabic phrase adopted by Muslims worldwide to expresses sincerity of good intention and to remember that all goodness is by the will of God (Allah). Hence, by saying this phrase the one who expresses admiration—verbally or non-verbally—proclaims sincere intention and goodwill free of envy and jealousy.

¹⁰⁷ For example, one would praise a baby: “You are cute, MaashaAllah”.

expecting-mother should not seek prenatal care before that time to avoid pregnancy envy. This is further supported by Bantu-SRRW beliefs that a pregnancy diagnostic ultrasound needs to be delayed until after the first trimester (i.e. until after six months). Although only 50% of the Bantu-SRRW disagreed (whereas majority of Southern-SRRW agrees) that the first trimester is the most dangerous period of pregnancy, this split response does not negate the deeply-rooted beliefs on envy (evil eye) exacerbated by pregnancy status. For example, a middle aged Bantu participant underscores this belief in her narration:

You see, a Bantu woman would not announce their pregnancy. Never! We even deny it, when asked. One never knows the intention of others around you—some may be envious and cast an evil eye—suddenly the pregnancy is spoiled¹⁰⁸. It is much easier for a woman to spoil [miscarriage] the pregnancy in the early months when it is *mimba change* [unripe pregnancy]¹⁰⁹. We keep pregnancy a secret as long as possible...but then the big stomach gives you away—eventually--hahahaha. I have personally experienced the effects of evil eye during my pregnancies. I spoiled three pregnancies from an evil eye of other women. After the first loss, my family took me to see *mganga* [traditional healer] who prescribed *hirizi* [amulets] for protection. In our village, there were many problems caused by evil eye and witchcraft. When I conceived again, the same thing happened; after that I had to leave the village and go to my mother's village. Some people in my village were determined that I remain barren; a barren woman is a curse that comes from envy. So, the evil eye is real. Even the Quran¹¹⁰ has mentioned it, so how can we deny something that is real.

In comparison, a Southern-SRRW in her 30's admitted that evil exists, but said, "Of course the evil eye is everywhere, but I trust and seek protection from God. If one has faith and prays for protection, that is enough. I don't worry so much about envy. Sometimes bad things happen, but it is the will of God, a test of faith".

¹⁰⁸ The Swahili term for miscarriage is *kuharibu mimba*, that translates as 'spoiling the pregnancy.'

¹⁰⁹ The Swahili term for first trimester is *mimba changa* which literally translates 'unripen pregnancy.'

¹¹⁰ *Al-Falaq* (The rising dawn) is one of the suras (chapters) in the Quran that address fear of evil by seeking God's protection (Mohammad Asad 1980).

The Southern-SRRW had a more nuanced explanation as to why the first trimester is more dangerous period for the mother. The danger associated in this phase of pregnancy is miscarriages, when the fetus is not well “anchored” in the womb, as explained by Surayah a 38 years old Southern SRRW mother of three:

The lump of flesh that begins to form in the womb needs to establish roots to attach itself to the mother. That is why the mother gets sick and vomits in the first three month. If there is too much shaking and stress the baby fails to attach and miscarriage happens. But after the three months the lump of flesh is formed into a baby, now it is strong and well attached to the mother it becomes a baby and the soul is delivered and if God wills, will be carried to term.

On issues of food during pregnancy, a Southern participant explained that a pregnant woman should avoid eating too much food. When asked why, she said so as to avoid having a big baby that will make delivery more difficult. A Bantu participant further explained that is not what should eat but what to avoid eating that matters. For example, eating lamb meat may result in miscarriage.

Overall, the two subgroups have divergent beliefs and practices when it comes to pregnancy meanings and management, including seeking prenatal care in the healthcare system. The Southern-SRRW seemed to hold a relatively less traditional pregnancy model compared to the Bantu-SRRW. The implication for this is that the Bantu-SRRW as a subgroup may more likely delay in seeking prenatal care.

Subdomain II: Labor and Childbirth, a Shared faith and Vulnerability

There was more intra-cultural agreement and less modal response variations in this subdomain than of all the three subdomains¹¹¹. This is not surprising considering that both subgroups share several social, cultural, and spiritual beliefs. For example, pregnancy and childbirth are considered to be natural-God event (Hill, Hunt, and

¹¹¹ It is important to recall that this particular subdomain had the most modal variations cross-culturally (see section I)

Hyrkäs 2012); on the other hand, they acknowledge that there is risk associated with pregnancies and parturitions (Essen et al. 2011). The most notable intra-cultural difference is to what degree childbirth is perceived to be risky. Among the Bantu-SRRW (95%), childbirth is very dangerous; this belief is explained by a lively Bantu participant in her 30s.

It takes courage to give birth, courage to endure pain and to see your very own soul is hanging in the balance, as thin as a thread- between life and death. Childbirth is like embarking on a journey without knowing the destination. Some women die in childbirth. That is why when a woman dies during childbirth her soul goes straight to paradise, because she has already suffered enough by going through the childbirth process. God is most merciful during childbirth.

Although Southern SRRW responses were less robust (47%), this does not negate their shared sense of vulnerability and anxiety during childbirth. A young Southern-SRRW mother with one child born in the U.S. shared that one of her sisters had died in Somalia during childbirth so she knows from experience the risk to herself and her baby. Since it is ultimately all in God's hand, she finds comfort in reading the Quran during labor and delivery.

Having left behind family and friends, their social support system and the familiar birthing ritual and customs are often lacking as they encounter traditions that may be contrary to their own (Hill et al., 2012). For example, most of SRRW participants indicate they miss their extended family and friend's support that they had back home during and after childbirth. Back home, they would be exempt from any exertion and carefully attended to for forty days during which their only "work" would be breastfeeding their infant. Family members would take care of all other needs of the baby and of the mothers. Here, they are alone and only "have God to help". It was not surprising then that the majority of the Southern-SRRW indicated birthing in the U.S. was more difficult for them.

While the cultural consensus shows a split among the Bantu-SRRW, the ethnographic data suggests that they were not in total disagreement. Those who disagreed had a more nuanced understanding of the question. Their take on the question was more about the access and quality of care in the U.S. vis-à-vis pre-migration, rather than just comparing the actual birth events with U.S. born women. For example, when I asked one of the Bantu participants to explain why, she listed the difficulties of being alone with no help while “still raw from birth”. Instead of a 40-day rest, she is in the hospital two or three and must go home to children and chores. She shared that she cries every time she realized she is pregnant but finds some solace in “good hospitals” and “sometimes a kind heart nurse.” She is cleared eyed about the harsh realities she left behind about life in the refugee camp and a substandard hospital care in Somalia. Another Bantu-SRRW with dual obstetrics experience compared delivery positions in the two countries and how she delivered three children in Somalia in squatted position and did not need “a single stitch”. In contrast, in spite of fighting it she had to deliver lying on her back in U.S. hospitals and as a result “tore badly” and “had to be stitched all the way down” then had to go home to children and a household with no help.

Subdomain III: FGC and Childbirth

Considering that the majority of the Southern-SRRW and only half of all Bantu-SRRW self-reported having type III FGC or infibulation (see table 3:3 in chapter 3), it was not surprising that most Bantu-SRRW believe *defibulation should be performed before every childbirth on women with type III FGC*, whereas, the Southern-SRRW strongly disagree. Whether or not defibulation is indicated, the size of the incision, as well as skills to carry out the procedure, are all critical decisions that need to be considered so as to minimize perineal tears and other childbirth complications (see

Johnson-Agbakwu 2013; Vangena et al. 2004). Lack of knowledge or skills to perform defibulation remains a challenge among HCP and has been cited as one of the major reasons for higher cesarean births in Somali immigrants/refugees (Small et al., 2006; Vangena et al. 2004). Intra-cultural disagreement on this specialized care for women with FGC underscores the need to consider FGC variations during childbirth as well as within group differences (see Abdulcadir et al. 2011; Vangena et al. 2004). On the question of *how* to perform episiotomies (i.e. the incision angle) on women with FGC, only 41% percent of Bantu-SRRW agreed that women with FGC have more problems after midline or mediolateral episiotomy incisions, compared with 72% among the Southern-SRRW. Variability of FGC types and prevalence of a particular circumcision among the subgroups may explain their differences.

Finally, the other two statements with significant differences between the Bantu and the Southern SRRW is on how each considers the status of FGC in the context of obstetrics needs and migration. Unlike the Southern-SRRW and similar to the HCP, the Bantu-SRRW strongly believe that women with FGC not only have different Ob-Gyn needs but they also present ethical and moral dilemmas to the HCP. The Bantu-SRRW affinity to side with the HCP in these CCM statements is incongruent with their overall beliefs in this study. One plausible explanation is that the Bantu-SRRW relative to the Southern-SRRW are more recently resettled refugees. All refugees are required to participate in cultural orientation while undergoing immigration processing in the refugee camps as well as upon arrival in the host country. FGC is prominently featured and discussed in these orientations as “not a good thing.”¹¹² It is more likely, therefore, that the Bantu-SRRW recent recollections of these cultural orientations have influenced their understanding of FGC as counter to the American culture. A Bantu mother of five

¹¹² <http://www.slideshare.net/rccook/cultural-orientation-1240320>

said “We were told that circumcision is not a good culture. It is not normal for women have circumcision. It makes it difficult to get pregnant and the baby can get stuck”.

Berg and Denison (2013) argue that the Western countries’ rejections of FGC along with the anti-FGM laws are important macro-level factors that influence the changing attitude of FGC among Somalis immigrants/refugees. Hence, this may in part explain Bantu subgroup views. That is, it is possible that the Bantu-SRRW are reexamining FGC practices and meanings in the context of childbirth from the biomedical cultural model. It is also plausible that the Bantu-SRRW are closer in negotiating and accommodating themselves to these changes. In other words, the Bantu-SRRW are straddling between traditional and biomedical models of FGC in the context of childbirth—a subgroup in a cultural transition—relative to the Southern SRRW. This can be supported by day-to-day observations and interactions during fieldwork. For example, most of the Bantu participants have no desire to return to Somalia even if conflict resolves. One went as far as saying that she distrusts non-Bantu Somalis so much that she would “rather die in America than to return to Somalia”. This sentiment was shared by most the Bantu. In contrast, most of the Southern-SRRW subgroup share a dream of returning to Somalia someday. In fact, one of friend from Southern Somalia who assisted me in this study left with her young sons to Somalia just after completion of data collection.

Summary: Giving birth in a foreign country often entails having less social support and even lesser access to the familiar birthing rituals and customs and may be even enduring practices contrary to one’s culture and traditions. In this study, the culture consensus analysis was an ideal method to explore and assess cultural beliefs and behaviors between immigrant patients and their providers. It provided an innovative approach to explore cross-cultural variations in the childbearing model between the

SRRW and the HCP. To my knowledge, this is the first time that CCM has been utilized to explore and assess a cross-cultural childbearing model between the SRRW and the HCP. The findings from this CCM explorative analysis support the argument that the SRRW and the HCP are two distinct cultural subgroups. In addition, each group has a different cultural orientation across all three subdomains (Pregnancy and Prenatal care, Labor and Childbirth Knowledge, Meanings and Beliefs, and FGC) in their respective childbearing models. The findings emphasize the need to identify and specify the depth and the breadth of the cultural-discrepancies so as to determine where concerted efforts need to be focused in addressing cultural differences between the SRRW and their HCP in childbearing models. This will be a critical step to effectively address SRRW reproductive healthcare disparities and decrease the stress and frustration for both patients and providers.

The intra-cultural cultural consensus analyses and narratives suggest that, while sharing overall agreement in response to the questions, the Bantu and the Southern SRRW also constitute unique subgroups when compared against each, suggesting that the two groups negotiate their beliefs and practices differently when it comes to pregnancy management and seeking prenatal care. Compared to their Bantus counterparts, Southern SRRW appears to be less traditional in their beliefs and practices. The implication for this is that the Bantu SRRW subgroup may be more likely to delay seeking prenatal care. In addition, this finding suggests that further studies are warranted to better understand effects of acculturation on health in Somali communities' at large, but more important the studies need to consider ethnic-clan variations on health beliefs and behaviors.

Although ethnically and culturally different, these Somalis nonetheless share many cultural ideations on meanings of childbearing, particular in childbirth. The

practice of female circumcision is central to their traditional beliefs and practices, albeit with considerable variations on meanings and management at childbirth. Despite many shared beliefs, it can be extrapolated that they are distinct subgroups within the larger SRRW group. In Arizona, the Northern-SRRW, on the other hand, did not seem to be a culturally cohesive group unlike their cohorts. Each of the other two groups had more within group agreement than between group agreement. As to the question of whether there is a single Somali childbearing model, the tentative answer is guarded yes. This means in healthcare settings, the notion of culture competence needs to be interpreted with caution rather than being accepted as an objective “truth” of any given cultural group.

CHAPTER 6

Perception and Embodiment of Female Circumcision

Culture and the human body are ubiquitous, but neither is universal in their mode of existential presence and experiences of being-in-the-world; this is evident in how the “other” emerges either as cultural groups or individuals (Lock and Nguyen 2010). Case in point is the culture of female circumcision and the engendering of a unique cultural body. Female circumcision is a bodily representation of a particular culture, history and sociopolitical milieu. In the context of migration and childbirth experiences, these particular cultural bodies embody the “other”. Perceptually, such bodily presence appears as objects of culture based solely on its status of circumcised female body (Johansen 2006). On the other hand, from the existential experience of circumcised women, female circumcision is perceived as the cultural bodily norm of being-in-the-world (Ahmadu 2007; Gruenbaum 2001; Johnson, Ali, and Shipp 2009; Smith 2011). As such, when the host culture encounters the “other” culture represented by the female circumcised body during childbirth in biomedical settings, the questions of culture versus nature and other dichotomies inherent in dominant Western ideological meanings of the body and cultural perceptions of bodily experiences inevitable rise to surface. This is what Merleau-Ponty’s philosophical orientation on embodiment and perception aimed to address (Merleau-Ponty 1989).

Merleau-Ponty rejected the scientific view of body objectification and its seemingly superficial separation of body-mind, object-subject, culture-nature, to name a few other dualistic concepts. Embodiment as presented by Merleau-Ponty was, therefore, essentially anti-Cartesian and anti-reductionist. Convincingly, he argued that it is the body that perceives, and that perception is embodied and gives and receives cultural meaning of being-in-the-world (Merleau-Ponty 1989). Insofar as this body perceives and

is always immersed in culture, time, and place in its engagement with the world, it is culturally mindful (Csordas, 1999, 1994; Scheper-Hughes and Lock 1987; Van Wolputte 2004). Building on Merleau-Ponty's concept of embodiment, Csordas advanced embodiment as the study of embodied cultural phenomenon of being-in-the-world rather than the body *per se* (Csordas 1994, 1999, 1990). In this context, perception of the circumcised female body is, therefore, about culture more than about corporality. Because this body is culturally defined and (inter)subjectively experienced in its existential engagement in the world, it is at once a cultural object and a subject of culture (Csordas 1999, 1994, 1990).

The displacement of the African female circumcised body to the West has generated a plethora of literature that has focused mainly on the intentionality or meanings this body conveys when it is encountered in the biomedical settings during childbirth. Such bodies have been described as a "cultural" rather than a "natural" body that require additional, adaptive, and uniquely specialized obstetrics skills during childbirth (Johansen 2006). Biomedically, these bodies represent dangerous childbirth in women who are seen as resistant to medical interventions and thus as high obstetric risk.

The term intentionality as used by Merleau-Ponty and elucidated by Csordas (1994:147) captures the meaning we attach to the object we perceive when we encounter it. Here, it is perception that gives meaning to the objects and perception is not precultural but is imbued with culture, history and place. In other words, it is not what the object appears to be that matters, but what the object actually means from the perceivers' cultural point of view or preobjectively. Intentionality, therefore, conveys "a sense of existential meaning beyond representational meaning" (Csordas 1999: 147). In the case of female circumcision, for example, it is not how the genitals appear visually (that is, the type of circumcision) to the Western healthcare provider, but what cultural meaning

(preobjective) the female circumcised body (as a cultural object) conveys to them when encountered. Perception, however, is neither unidirectional nor merely a static sensory unit because the body is the object of someone else's perception and at the same time an actively engaged perceiving subject. Consequently, the bodies of the Somali resettled refugee women and their health care providers are engaged in an active and unfolding process of a dialogical perception.

The cultural bodies of Somali resettled refugee women (SRRW) in the West are largely perceived by healthcare providers (HCP) as an impediment to “normal childbirth delivery” (Essen, Binder and Johnsdotter 2011; Johansen 2006). This is culturally alien and worrisome to them. To the Somali women, successful childbirth and motherhood is intricately tied to their cultural, social, and gender identity and has economic and political ramifications (Al-Sharmani 2006; Kusow and Bjork 2007; Kapteijns 1995). Having as many healthy children as possible is part and parcel of being a Somali woman (Hernandez, 2007). Childbirth to them is a natural bodily process and not a “medical condition” to be managed (Allotey et al. 2004). In healthcare settings, the idea that their childbirth experiences will inevitably be labeled as “complicated” is distressing to them as it is to their healthcare providers (HCP). For one, most HCP lack the specialized knowledge of SRRW ethno-anatomical configuration required in facilitating safe and “natural” childbirth (Johnson-Agbakwu et al. 2013; Johansen 2006; Small et al. 2008). Second, this particular anomaly of the cultural body when encountered in a biomedical setting is more likely to be perceived preobjectively as the body of the “other”, an embodiment of risk, fatalism, lack of agency, and so forth. Additionally, their country of origin (Somalia), immigration status (refugee), skin color (Black), religion (Islam) and language barriers (limited English) often converge with the objectification of the body and the culture it represents. Complicating the matter, the SRRW's fear and anxiety is

perceived as irrational resistance to the powerful knowledge of science as embodied by the HCP.

From global health perspectives, female circumcision embodies one of the most pressing women's health issues: reproductive health and childbirth (WHO 2006, 2008). This is evident in the global campaigns to eradicate a cultural practice perceived as oppressive, barbaric, primitive, and misogynic (Njambi 2004). At an individual level, this body is perceived to lack autonomy and agency (Leval et al. 2004). Socially, such a body represents the "otherness" of societal backwardness of being-in-the-world (Wade 2009). Politically, female circumcision is the object of culture and the objective of global eradication movement, surveillance and control at national and international level (UNICEF 1990; WHO 1997, 1998). Such a body is antitheist to Western sensibilities and body ideals, and the Cartesian dualism upon which the Western [bio]medical knowledge stands on (Scheper-Hughes and Lock 1987).

As a unique cultural knowledge system, biomedicine has contributed immensely in addressing human health issues, including reproductive health (Lock and Nguyen 2010). The notion of a universal body that is the object of the science of medicine emerged as a unique Western cultural by-product of dualism (ibid. 2010). As such, the female circumcised body does not "fit" into the constructed constitutionality of the universal body, especially in the context of [bio]medicalized model of childbirth (Johansen 2006) as practiced in the host nations where the displaced circumcised female bodies now resides and give birth. Insofar as perceptions are grounded in a particular cultural and historical context that gives and receives meanings in orchestrating the bodily process and practice (Csordas 1990, 1994), childbirth is quintessentially a cultural phenomenon (Hahn 1995; Jordan 1993). In the context of migration, cultural phenomena convey a multiplicity of meanings. The preobjective cultural meanings of this particular cultural

body when encountered during childbirth have been problematic for both the circumcised women and their healthcare providers (Berggren, Bergstrom, and Edberg 2006; Essen, Binder, and Johnsdotter 2011; Johnson-Agbakwu et al. 2013). This is evident by plethora of studies focusing on Somali resettle refugees in the West.

If embodiment is about making sense of lived experiences –albeit from one’s cultural point of view (preobjective perception) as Csordas posited (1990) – then the perception of female circumcision is a question of understanding cultural differences. This question has not been adequately explored. The host culture’s perception of the body and of childbearing may differ greatly from the SRRW’s perception of their bodies and from their beliefs and practices of what constitutes normal childbearing. How the two cultural groups perceive female circumcision and the meanings conveyed when interacting is precisely what I explore in this study. Perhaps equally important is reexamining the concept of cultural competency in the cultural world of biomedicine where Somali women and other minorities seek healthcare. The aim of this project is not to challenge the scientific evidence regarding female circumcision or the science of childbirth. Rather, my purpose in this chapter is to apply a phenomenological approach to explore and describe how perceptions of female circumcision are subjectively and intersubjectively embodied during childbirth encounters. Shedding light on these lived experiences will contribute to a better understanding of the reproductive health disparities among Somali refugee women and other minorities.

Phenomenology

Phenomenology according to Merleau-Ponty (1962) begins from an embodied state in its spatial, temporal and cultural bodily sense of being-in-the-world and engaging with the world (also see Csordas 1990; 1994a, 1994b). Its philosophical underpinning is concerned with meaning-making in the context of perceptual lived experiences of being-in-the-world as perceived from first person perspectives. It is to ask “what is the experience like” (Lavery 2003:4), while attempting to grasp the meaning of the lived experience. Merleau-Ponty argued that it is only from this philosophical approach (phenomenology) that we can begin to understand the “facticity” of individuals in the world (Transl. Smith Colin 2002).

It emphasizes the body as the source of perception and meaning-making and embodiment as the existential condition being-in-the-world (Csordas 1994). Building on Merleau-Ponty, Csordas argued that the body is more than a biological entity (an object); rather, it is a subject of culture of being-in-the-world (1990). Phenomenology, therefore, is concerned with synthesizing the immediacy of embodied perceptual experiences with multiplicity of meanings in which the body is always immersed (ibid. 1994:143). It offers an alternative to empirical claims originated from the Cartesian dualism which has shaped the Western ideology (Husserl, cited in Lavery 2003; Schepers-Hughes and Lock 1997). It is therefore, a best suited methodology to explore FGC bodily phenomenon.

Phenomenology as a Methodology

Phenomenological studies have been applied in several ways and in different social science disciplines. The approach and application of this methodology depends on

the nature of the research questions and other methodological concerns such as selection of study population, the researcher position, and environments (Cooney 2011; Lavery 2003). Because it is concerned with human experience and meanings, the researcher is required to use “good judgment and responsible guiding principle rather than rules to guide research process” (Lavery 2003:26).

There are generally two methodological or philosophical considerations in conducting phenomenological studies: phenomenology¹¹³ (also referred to as existential phenomenology or phenomenology proper, see Csordas 1994; Giorgi 1985) and hermeneutic phenomenology¹¹⁴. This study follows the former approach. While the two methodological approaches share many similarities (see Lavery, 2003) they differ in “the position of the researcher” particularly during “the process of data analysis” (ibid. 2003:28); thereby, the end product can be strikingly different depending on the methodology. Phenomenology proper is descriptive in nature and the focus is on the structure of experience and its meaning; it seeks to “make the invisible visible” (Lavery 2003:27). The main difference between the hermeneutic phenomenology and phenomenology proper is that the latter follows the “naïve description” given by the participants rather than giving the interpretation from the researcher’s theoretical point of view (De Castro, 2003). Also of importance is that it underscores intentionality and reduction or bracketing (discussed below). Intentionality¹¹⁵ is that which gives the meaning of the lived experience; it focuses on what does the phenomenon conveys (Csordas 1990).

Susann Lavery (2003) suggested some guidelines for conducting phenomenological studies which this study has adopted. First, the nature of the

¹¹³ Originated by Edmund Husserl (1859-1938) and later adapted and credited to Maurice Merleau-Ponty (1908-1961).

¹¹⁴ Credited to Martin Heidegger (1889-1976),

¹¹⁵ Both methodologies focus on intentionality.

questions asked has to be very open, with follow-up discussion being led not by the researcher as much as by the participants themselves. This is to encourage participants to stay as close to the lived experiences as possible. Second, what is not said is as important as what is said because it is in the “silence of the unspeakable and the silence of being or life itself” that “one may find the taken for granted or the self-evident” (ibid. 2003:29).

Regardless of which of two types is selected, the most important feature of phenomenological methodology is reflectivity or critical self-awareness.¹¹⁶ The process of awareness or reflectiveness is also known as “bracketing” or “reduction” or “transcending”, and these terms are used interchangeably (Desjarlais and Throop 2011). Giorgi (2008) states that this involves the researcher doing two things: paying attention to only what is being revealed to consciousness and avoiding presumptions or past knowledge of what is investigated. Secondly, avoiding making absolute claims of reality of the experiences other than what is presented.

Phenomenologists have different views on how “bracketing” should be applied. Merleau-Ponty disagreed with Husserl on the notion of transcending. He argued that who we are is borne from our perceptual lived experience of being-in-the-world which is grounded in history, time and place. It is within this context of our preobjective¹¹⁷ subjective and inter-subjectivity engagement with the world that Merleau-Ponty advocated as the existential condition of embodiment (Csordas 1990; Matthews 2006). As such, interpretative phenomenology is most relevant to this study as it affords a greater attention to the nature of the subjective (including “I”) positionality of being-in-the-world.

¹¹⁶ Keeping a journal and writing my thoughts was one way of being aware of my biases.

¹¹⁷ A given positionality or situated cultural knowledge, because “the world exists before the body”(see Matthews, 2006).

Csordas posited the goal of phenomenology “is to capture that moment of transcendence in which perception begins, and, in the midst of arbitrariness and indeterminacy, constitutes and is constituted by culture” (1990:9). The indeterminacy means unpredictability of human encounter prior to the encounter and beyond. Therefore, it is not possible and even unproductive to “transcend”; rather, it is necessary to be aware or reflective of one’s cultural biases, particularly during data analysis (Translation, Smith Colin 2002: xiii). For it is here that issues of representation and rigor of the study are confronted. How and what we write is a major criticism of phenomenology and other qualitative studies (Csordas 1990; 1994; Desjarlais and Throop 2011). Issues of representation align with concerns of contextualizing time and place as well as the relationship between the researcher and the researched which are intertwined with politics, socio-economics, race/ethnicity, and gender to name a few (Sultana2007). These are all major concerns and sources of criticism of all qualitative studies including those that apply phenomenological approach to embodiment.

While Csordas acknowledged these concerns, he argued that in the phenomenological tradition there is a clear distinction between representation and being-in-the-world. The former is nominal and does not constitute experience of being-in-the-world and the latter is conditional; the being-in-the-world underscores the relation between mode of “existence” and the “lived experiences” (1994a:10; 1999). As such, conditionality (phenomenological speaking) captures the essence of the lived moment as experienced by being-in-the-world, “as a temporally/historically informed sensory presence and engagement; and not unmediated in the sense of a precultural universalism” (ibid: 1994:10). This distinction, however, is much harder as pointed out by Csordas (1990); something I also found out during fieldwork and especially in writing the analysis of this study.

Csordas (1999) posited that textual interpretations remain a central concern to all these issues of representation. Language (as text), he argued, can be understood in terms of representational or alternatively as being-in-the-world; the latter should supersede the text, insofar as the language (text) does not only represent but rather “discloses” the experience of being-in-the-world (Csordas 1994a: 11). In an attempt to address the representational concerns from phenomenological perspective, Csordas suggested adding reflexivity as a move forward from “representational trap for cultural theory” of embodiment (1994, 12). Csordas also proposed adopting a dialogical partnership between the researcher and the research participants in which “the author figures into the text in a self-conscious way and in a sense the text includes a dialogue with the voice of the indigene” (1999, 150). As such, the reflexive attitude of the researcher “constitutes a restructuring of representation rather than offering an alternative to the primacy of representation” (1999, 150). Recognizing the necessity of the dialogical partnership in this project, I identify my partners by pseudonyms to respect their privacy and use “me” when I embedded my own excerpt from the interview exchange (see Holthuysen 2011).

Methods

My objective in this study was to explore and juxtapose SRRW vis-à-vis HCP perceptions on female circumcision. My intent is to further understand how perceptual embodied experiences influence patient-provider interactions and ultimately shape outcomes. Rather than structured list of questions, the two groups were asked open ended questions to describe their lived experiences with follow-up questions based on participants’ responses (Schmidt 2005). This is because phenomenology is attentive to what individuals’ experiences mean to them and how they make sense of a lived experience. This method allows the interviews to evolve and reflect what is relevant to participants (ibid: 123). I personally conducted all the interviews with SRRW who speak

English or Kiswahili (n=9) and enlisted an ethnically matched interpreter with those who did not.

Participants: group of ethnically and clan diverse Somali resettled refugee women (SRRW, n=30) and a group of Healthcare Providers (HCP, n=10) were purposively selected for the in-depth semi-structured interviews.

Socio-demographic profiles of participants

I. Somali Resettled Refugee Women (SRRW)

Table 1 illustrates the socio-demographic profile of SRRW participants and duration of U.S. residency. All of the Bantu-SRRW were married at the time of this study, except for one who is a widowed¹¹⁸. Nine of the ten participants are unemployed; the one works part-time in a medical facility. Five of the Bantu participants had no formal education, two had some primary education, one completed primary education, one is attending college and one had completed community college. As for Southern-SRRW, eight are married, one is widowed, and one is divorced. Employment status is also low among Southern-SRRW; only two are fully employed, one is part time employed, and seven are unemployed. Four of the ten Southern-SRRW participants had no formal education, one had some primary education, the other five are either attending¹¹⁹ or have completed college. On average Northern-SRRW are slightly younger and all, except for two divorcees, are married. Three of Northern-SRRW are self-employed business owners, two have part-time employment, and five are unemployed. Unlike the other two SRRW groups, all Northerners had some education; four with some primary education and six with college level education.

All SRRW participants self-identified as resettled-refuge immigrants with varying duration of resettlement. For example, the Bantu-SRRW average time in U.S. is 6.4

¹¹⁸ Her husband was killed while crossing a road in Phoenix.

(median 6) years; whereas the average was 7.3 (median 5.5) and 11.5 (median 11) years among the Southern and Northern respectively. Eight of Bantu-SRRW reported they needed an interpreter when seeking medical care, whereas only four of Southern and Northern-SRRW reported needing interpreter's assistance.

Obstetrics-gynecology Histories

FGC status was self-reported by type and all have had it, except for a Bantu woman who did not want to disclose if she had the procedure and a Southerner who did not know which type. The majority of participants (4 Bantu, 9 Northerners, 6 Southerners) had type III (infibulation/pharaonic) and the rest (5 Bantu, 1 Northerners, 3 Southerners) reported type I-II (Sunna).

Bantu-SRRW had the highest number of children (average 6.3; median 7) and Northern had the lowest (average 3.7; median 4.5) and Southern in the middle (average 5.9; median 5). Forty percent (4 Bantu, 3 Northerners, 5 Southerners) of all SRRW had dual childbirth¹²⁰ experiences. Twenty six percent had only American childbirth experience (post-migration), of that Northern-SRRW had the highest (n=5), followed by Bantu and Southern-SRRW (n=3 and 1 respectively). While thirty percent lacked American childbirth experienced, meaning their childbirth experiences were all pre-migration¹²¹.

Interview languages

Interviews among SRRW were conducted in multiple languages: Kiswahili (n=6), May-May (n=2), English only (n=15), Somali with some English (n=7). The English interviews was transcribed in English, the Kiswahili interviews were first transcribed in Kiswahili, translated into English and then back translated (see Sibley et al., 2007). The

¹¹⁹ Three attending college and two have completed college education.

¹²⁰ Dual childbirth experience refers to SRRW who have given birth pre and post resettlement migration.

¹²¹ African childbirth experiences while in Somalia, Kenya, Ethiopia, or Egypt.

May-May interviews (n=2) were transcribed directly into English¹²². Interviews from HCP were all conducted in English, and accordingly transcribed.

Table 6:1: Somali Resettled Refugee Women Profiles

Variables (n)	Somali Bantu (n=10)	Northern Somalis (n=10)	Southern Somalis (n=10)
Median age, years	34	34.5	30
Average age, years	37.5	34.7	34.5
Marital status			
Married	9	8	8
Divorced	-	2	1
Widow	1	-	1
Education			
No formal	5	-	4
Primary	3	4	1
High school	-	-	-
College	2	6	5
Employment			
None	9	5	7
Part time	2	2	1
Full time	1	-	2
Self employed	-	3	-
FGC Status			
Type I (sunna)	5	1	3
Type III	4	9	6
Don't know	-	-	1
Not disclose	1	-	-
Parity (no. of children)			
Median	4.5	1	5
Average	3.7	9	5.9
Birth Experience			
Dual	4	3	5
America only	3	5	1
Africa only	3	2	4
Interview language			

¹²² This is because I could not find a May-May interpreters/translators who could write in May-May and English.

English	3	8	4
Kiswahili	4	-	2
May-May	2	-	-
English-Somali	1	2	4

Concerning external validity, I sought representation across SRRW with respect to age, obstetric experiences (parity, dual¹²³ and non-dual¹²⁴), and socioeconomic profile including acculturation (measured in terms of English proficiency and duration of stay in USA). The majority of the SRRW participants live in neighborhood clusters of government-assisted, low-income housing scattered across the metropolitan Phoenix area. Accordingly, participants were recruited from several different neighborhood clusters for heterogeneity. Except for one that was conducted in a café, the semi-structured interviews took place in participants' homes.

II. Health Care Providers (HCPs)

All participants are female and the average age of HCP is 52.4 years and median age 57.5. Except for one African American and two Latinas, participants self-identified as White. Two of HCP are medical doctors (MD); one a midwife (MW), two nurse practitioners (NP), and five are labor and delivery (L&D) nurses. All HCPs reported to have provided obstetrics-gynecology care to SRRW with FGC; with average professional experience of 17.3 years (see Table 3). None of them had received didactic training on caring for women with FGC and all indicated they support such training.

All HCP participants' selection criteria included an experience in providing Ob-Gyn healthcare to the SRRW in Arizona. This sampling selection method, also known as

¹²³ SRRW with both pre-migration and post-migration childbirth experiences.

¹²⁴ SRRW with either pre or post-migration childbirth experiences.

“judgment sampling” (Bernard, 2002) was most appropriate for this study because there are very few Ob-Gyn HCP who serve SRRW. External validity among HCP was addressed by deliberately selecting participants from different types of facilities (out-patient, in-patient, non-profit and for-profit hospitals) and professions (physicians, nurses, midwives, and medical assistants) to maximize heterogeneity. Six of the interviews were conducted in the clinical settings, two in a café, and two in private homes.

Table 6:2 Healthcare Providers Profiles

Facility	Age	Profession	Yrs. in Practice	Race/Ethnicity	Pseudonym
Teaching hospital	30	L&D nurse	8	Biracial	Daisy
Outpatient clinic	62	MW	30+	White	Lucy
Teaching hospital	50	L&D nurse	20+	White	Fifa
Outpatient clinic	55	NP	15+	Hispanic	Mindy
Teaching hospital	60	L&D nurse	20+	Hispanic	Mary
Teaching hospital	63	L&D nurse	20+	White	Wendy
Teaching hospital	61	L&D nurse	20+	White	Tammy
Outpatient clinic	45	MD	10	White	Sandy
Teaching hospital	38	MD	10	White	Jane
Outpatient clinic	60	NP	20+	Hispanic	Casandra

Phenomenology Analysis

Data from open-ended semi-structured interviews were analyzed to identify perceptions of female circumcision in the context of the meanings of childbearing within and between SRRW and HCP. These personal narratives of perceptions of these cultural

phenomena describe the lived-experiences of project participants and they are not claims about the “absolute reality” (empirically) of phenomenon of perception. After several readings of the narratives, text data was coded in two stages. I first identified and sorted quotes that are similar and different (Bernard and Ryan 2010). This was followed by inductive explorative approach to identify salient themes emerging from the data (Bernard and Ryan 2010). I manually coded the data five times after several readings with at least a month between the readings so as to have a fresh approach in managing the data.

Narratives from participants were marked for:

- Repetitions of words and phrases where redundancy indicated how significant experiences were perceived by participants (Bernar and Ryan 2010; Giorgi 2006).
- Transition, including silence, avoidance and other utterances or gestures (Bernard and Ryan 2010).
- Participant’s responses were kept verbatim and written as a third person to avoid projecting their descriptions of their experiences (Giorgi 2006).
- Observation including gesture, vocal intonation and body language recorded during field notes were referenced in the analysis (Crist and Turner 2003).

The analytical process (including my observations and reflection during field work) identified the following six paired themes and related subthemes: Culture-Nature; Normal-Abnormal and God-Science. These themes were not distinct but overlapped significantly and would make sense to be deconstructed into the three thematic bodies and embodiment themes: the individual body, the social body and body politic. In their seminal piece *The Mindful Body: A Prolegomenon to Future Work in Medical*

Anthropology, Scheper-Hughes and Lock (1987) introduced these three perspectives on the body to deconstruct old binaries of body/mind, nature/culture and so forth that have shaped the medical field. As an alternative, they propose the body is all the elements at once and is “securely anchored in a particular historical moment” (1987:7). The *individual body* refers to the lived-experiences of the self-body, in the phenomenological sense of being-in-the-world. It constitutes both the physical (material, biological) and the mind (psychic, soul) in its engagement with the self-body, as well as in relating to other bodies. In this sense, the individual body is experienced as an embodied-self and at the same time perceived by others as an embodiment of the other. The individual body is presented as the most self-evident of the three bodies, because most of us have a sense of self-awareness as being or existing separately from other individuals around us (ibid. 1987). The *social* and *body politic*, on the other hand, need further elaboration which I will do in related sections.

FINDINGS

The Individual Body

In talking with SRRW participants, I found there was a wide range of perceptions on how they described their experience of being-in-the-world as circumcised women in the context of seeking gynecological and obstetric healthcare post-migration. However, despite the subjective perceptual variations of being-in-the-world, the existential circumcised body was always described as a culturally normal way of being-in-the-world. In contrast, most HCP perceived the circumcised body as cultural body; unnatural, an anomaly, and one that is upsetting and difficult to deal with. The encountered body evoked various emotional sentiments and wonder that was repeatedly expressed in terms of being-in-the world with a different-body.

Me: What is your perception about female circumcision?

Tammy: I guess Oprah Winfrey had a show years ago that talked about how horrible this butchering is and so I guess in my mind I think oh, these poor women. I feel sorry for the poor women.

Me: Why do you feel sorry for them?

Tammy: It is something done to them not their choice (long pause). It is their culture, but the fact it is women that will do it often times to these young girls. I feel sorry for them, but do I judge them or do I think that they are (long pause) – no. I feel bad for them because I can see the physical *anomaly* that it is and I know that it causes infections and everything else. It is just horrible, *horrible thing* done to them.

Tammy is in her early sixties, white and very a dedicated professional charge nurses in birth and delivery department in one of the teaching hospitals. She was the first labor and delivery nurse I interviewed. I was introduced to Tammy through a friend of a friend. I have found that having a mutual friend somewhere in the link before interviews made access easier and the interview process more open and candid. When I first met Tammy and told her about my research, she was very excited and said: “It’s time that we get a study that looks into these problems and to understand these poor women while they are here”. While describing her perception, Tammy was emotional and emphatic about her “facts”. In this excerpt, Tammy used the term *anomaly* suggesting the female circumcised body is deviant from normal body and embodies health risks ranging from “infections” to “everything else”. As a follow-up question, I asked Tammy whether infections were commonly seen in SRRW presenting to her hospital for childbirth. She paused, then said “actually, I am surprised that I really have not seen that, they must have an amazing hygiene habits”. Paradoxically, good hygiene was one of the reasons given by SRRW who support female circumcision. Hagol, a middle aged Somali Bantu said: “Circumcision is healthy; we don’t get diseases like other women with open vaginas. Because it is closed, it stays clean, beautiful, and smells like a flower (laughs)”. This perception was shared by a few, mostly older (45 years and up), Bantu and Southern SRRW. In fact, Hagol and some other women in her age group revealed that their perception of uncircumcised female bodies as unhygienic and slightly unpleasant.

For these participants, the circumcised female body was described in terms of positive adjectives such as beautiful, clean, honorable, and so forth. Yet, most participants were very critical of female circumcision, in particular the pharaonic (type III) with over seventy percent of them describing the pharaonic (type III) as un-Islamic. The lesser cut was acceptable to some, “just Sunna is OK,” while some perceived it as a religious obligation. Among the latter group, perhaps it was their bodily existential experience post-circumcision and/or perhaps the experience of childbearing and migration to a country where their bodily existence takes a different meaning of being-in-the-world.

The Silent Gaze

Me: Can you share with me your experience as a circumcised woman?

Farida: I personally didn't have a good experience from being circumcised. Nor have I heard many of my friends say, “oh, it was a wonderful experience” (laughter). It's just very uncomfortable. Every time I went to a new gynecologist, I was uncomfortable. That first look from them was the most uncomfortable thing for me because I just sense this sense of shock when they examine me. I know they make it in their face, but I always can sense it in my entire body. I think to myself, they are just going to be thinking like, “oh my God! What is this? I have never seen anything like this!” I always hope I am not the first woman who is circumcised that they have seen. I never want to be the first one they look at. If I live outside the Somali community area, especially in Arizona, I am probably it—most places I go, I am the first one.

Me: Do you feel that you have to explain your body to somebody else?

Farida: Yeah! You have to always be like...(pause), when you hear the silence from them. I am like, yes, I am forced to say I was circumcised. Then I hear them say, “I see.”

Me: How does that make you feel you different?

Farida: We should not feel like that—(pause), but it does. Do other women feel the same way, mostly yes. I guess it's not just one thing, its multiple different things that make us different from other women. Maybe I am more sensitive to the look; that first look followed by silence.

The physicians and the nurse practitioners among the HCP confirmed that they do not ask the SRRW about their circumcision status before performing pelvic exams: “You just see it and that is it”, or “I look and do what I need to do” said June and Mindy,

a gynecologist and a nurse practitioner respectively. When I asked if they were familiar with the different types of circumcision and/or what type their patients commonly present with, they gave me a blank stare first, followed by a usual response: “I am not sure of the types” or “we see variation, but I cannot tell you by type”. Sandy, a gynecologist and one of the two physician participants, described a patient who was “totally closed, there was just a small pin size opening.” This made her wonder how the woman got pregnant. When I inquired if she had asked the patient about having any pain during sexual intercourse, Sandy replied: “No. She was there for prenatal care. She did not seem to be bothered by it.” She did not know what type of procedure the patient had, but it was different from what she had seen in her practice and it made Sandy feel “sad for her, though it seems not to bother her [the patient] at the least”. As a follow up question, I asked Sandy if she expected that the woman would tell her that she was bothered by how she looked. To that Sandy replied:

um, well, (pause). I really did not know what to expect. But one would feel that it is such a horrible experience that they would be psychologically damaged or bothered and stuff like that. Or even feel ashamed to be so different...(pause). I don't know. It is a weird cultural thing for us...(pause) but I felt for her it was like a normal thing...(pause); just weird how different they are from us...(pauses)...stuff like that.

Like most HCP, Sandy's source of information about female circumcision was from the media¹²⁵ before she actually encountered her first patient. She appears perplexed about her patient's lack of awareness of being a “different” body; her preconceived idea (likely shaped by media) of a damaged body and mind did not match her experience when she actually encountered such a body. The incongruent perception (pre- and post-encounter) was simply resolved by differentiating the weird cultural “other” vis-à-vis the normal cultural “us”.

¹²⁵ See below for more detailed role of media as source of “FGM” information among HCP.

In the context of these dialogues, the HCPs seem oblivious to the discomforts and anxieties of their patients' bodily consciousness under their salient gaze. Evident by the narratives from Farida, the awareness of the silent gaze was disconcerting. Farida described her intersubjective engagement with HCPs in much more details compared to most of the SRRW participants, who mostly described their experience as "they did not ask me anything about circumcision". The dialogue gravitated to whether and how their circumcision status was discussed. Though several of them said their status was not discussed or mentioned by their HCP, nonetheless, some described feeling stigmatized, disrespected and/or treated as disembodied "freaks", unaware of their bodily presence. Excerpts from the interview with Baado's further illustrate the bodily awareness of the silent gaze. Baado, a Southern young mother of three children all born in the U.S., shared her first encounter with HCPs which occurred in an Emergency Room (ER). She was in her first trimester and was bleeding.

Me: Tell me your experience when you went to the ER.

Baado: Really my sister, I can never forget that day. You see, it was my first year in America. I came to be with my husband, he was in the university at that time. I was young and my sister came with me [from Kenya] to America when I was a new bride. I knew I was pregnant but did not see a doctor, a gynecologist. Maybe 9 to 11 week [pregnant]. I woke up bleeding; my husband, he had to go university so he dropped me and my sister at the hospital, in the ER. I told him no need to stay, so he left. But at that time, my English was not good, but OK. My sister, she don't speak English. I stay in the room and the doctor, a man come and ask me questions, and he want to look. OK, he look, and he stand up very quickly and left the room. I say to my sister maybe he forget something. After few minutes, he come again and a nurse lady. They look down there again...and again they leave. No nothing. My sister and I start to get worry. Then other doctors, and another I don't know how many, maybe 5 or 7 doctors and nurses they come look and leave. Another doctor look and ask me if I get into accident. I said no. I just woke up and bleeding. I am pregnant. He left; more doctors come me, now I was very worried. My sister ask me to ask what is going on. I said it's OK. But really I was thinking very bad things, maybe they see the baby is dead? After that a nurse lady comes in with a big mirror, she gives me. I said to her what is this? She said it's a mirror. I know it is a mirror, I said to her, why you give me a mirror? She said to me, "I want you to look down there to see yourself. You don't know your body. Your body is not right." I look at her and then I understand what she say...."aaahhh, I said, I know my body. My body is normal, I have circumcision. You don't know about circumcision? This is our tradition. It is

normal for women from my culture. I am here because of bleeding and pregnant, that is why I am here.” After that she left and the first doctor came, and said sorry, he heard about it but he never saw it before. I tell him, “you can ask me if you don’t know, but this way is not good. You stress me too much.”

Me: I am so sorry you have to go through that. Did that experience change the way you interact with your doctor? A new doctor?

Baado: I feel like I was a dead body and doctors just come to see my body like a show in TV when they come to see a dead body. I was worried that maybe I have very bad disease! (laughter). It is funny now, but *Wallahi* (I swear by God) I was very worried...(pause) and later I was very angry. But it’s OK. Now, when I see a new doctor, I tell them first, I am circumcised, first before they do examination. I don’t want that looking again!

Baado’s experience, as described, negates the fundamental idea that *everybody is conscious of their body*. Given a mirror to view her own body is tantamount to her bodily experiences of being-in-the-world as disembodiment self, an object rather than a subject engaged in an intersubjective encounter. Baado told me that she did not take the mirror from the nurse, “because I know my body, my body is normal in our culture”. Mariam, a stay home Southern Somali mother of three and a history of two miscarriages, had a similar experience when she presented to the ER with a miscarriage in her first pregnancy. She described the doctor who first examined her as “freaked out” by Mariam’s bodily presence. The doctor “looked and left”, just to come back with an entourage of other healthcare providers to “take a look” at this cultural object.

Me: What do you mean by “freaked out”?

Mariam: It was a female doctor. She freaked when she see it, she jump. She said I don’t know this, she left the room. I hear when she was talking to the other doctors. She said I don’t know. Something happened to this lady. Is she get suture or is she get born like this? So the other doctors come in and looked. Then they asking me “when you was young did something happen to you? Are you get burn?” No, I say no, no. I understand because I was in Minnesota, I was hearing a lot of Somali women talking about that. I made them explaining, so they understand. They said, oh, OK. I ask them do you ever treat some people come from Somalia? They say not that much. That is why I like to see only doctors who treat other Somali ladies.

Me: Why?

Mariam: Because it's too much stress for me. It is better when they know before. Like that day, so many doctors just come and look, I feel...(pause). I cannot explain in English.

Me: Try, I know it's hard for you.

Mariam: Yes. Like...a thief coming to your house (sigh).

Most SSRW participants, with exception of Farida, said they were not asked for their consent to be gazed at by multiple providers and multiple times. As for Farida, she was just twelve or thirteen years of age when she had to undergo a surgical procedure to remove a cyst that had been a source of severe pelvic pain since her circumcision back in Somali at a tender age of nine. She said, "I felt I did not have a choice, so when the doctor asked me if it's OK for other doctors to come and look, I said OK. If it was now I would say, certainly NO! This is not a freak show". When I asked her if she thought circumcised body is freaky, she said "Yes! It may be normal in our culture, but to them they think it's a weird cultural thing."

What I found to be surprising at first was that just a handful of SRRW participants described their first gynecological encounters as uncomfortable and or distressing experiences. As evident above, they describe their experiences in detail. In probing this further, however, I learned that just about every woman had some anxiety when seeking healthcare because most of the participants were aware that female circumcision was considered a negative cultural practice in the U.S. prior to migration. In fact, they told me it was one of the topics that were discussed with them by resettlement official agencies in preparation to migrate to America. The participants explained that "we already knew they don't like this culture" but, "this is the natural body we have"; therefore, "we have to be brave".

Me: What do you mean by you have to be brave?

Sauda: To be brave when we go to doctor, because we are different. You just pray for *subra*¹²⁶(patience) to be very strong, because we already know what they are thinking, they don't talk but we know what they are thinking.

Me: Like what are they thinking?

Sauda: Like this is bad culture. A big problem for them, they don't know anything about us, but they thinking...(long pause).

Me: You pray that they don't ask you about the circumcision?

Sauda: Yes... we pray...we pray for *subra* (patience). If they ask is better, but they don't like to ask, they just look and think. No problem to ask. Big problem for us when they don't ask anything. We can talk, is normal not problem.

The sense of awareness amongst SRRW that their circumcised bodies were different from other female bodies was acutely heightened through the silent gaze during gynecological and obstetric healthcare encounters and interactions with their providers. Similarly, such awareness was perceptually experienced by HCP, who repeatedly described how SRRW have different bodies, unnatural or cultural “butchered” bodies. Yet, most all of the providers disclosed that they do not address the status of their patient's bodily presence in time and place.

From these dialogues, I was left with the sense that there was level of cultural ineptitude that deterred the HCP from directly addressing the proverbial elephant in the room, so to speak. Talking to some of the HCPs, it seemed that the circumcised female body was not only perceived as different, but that it was as uncomfortable to gaze at (object) as the SRRW were being gazed as bodies (subjects). Could it be gender empathy? Since, all of the HCPs interviewed were female, which perhaps made them more sensitive to this different cultural body presence? “No, it's not just that”, rather, “it is about being from a different culture” said Fifa, a labor and delivery nurse who migrated to America from northern Europe.

¹²⁶ *Subra* is derived from an Arabic word used by Muslims to ask for patience and solace when confronting a hardship.

Me: Can you share your experience of female circumcision and elaborate what you mean by “different culture”?

Fifa: I have visited and worked in many developing countries, so I am familiar with female circumcision. I have seen circumcised women before coming to America...for me it is just one other variety of cultural norm and I respect that (pause). But again I am a foreigner here, so my views will be different from the other nurses and doctors here. For them, it is a horrible thing. That is how they see it and talk about it. They make it like it's a big deal. You know (short pause) how it is here; *it's my way or no way*. That is the American mentality on just about everything outside the main stream culture.

As Fifa described it, female circumcision is cultural normal body, albeit a variant one. She points out that her foreignness and multi-cultural experience sets her apart from her American colleagues. It differentiates her perceptions of being-in-the-world and what meanings circumcised bodies convey. Her perception is also shaped by the fact that her experience with female circumcision actually took place while engaging (face-to-face) with circumcised women in labor in other cultural environments, rather than the one dimensional sensationalized U.S. media version being the first source of exposure to female circumcision. These experiences gave her more nuanced perspective vis-à-vis her colleagues. Fifa's perceptual experience with female circumcision was indeed an outlier, closely followed by that of Lucy.

Lucy¹²⁷ was a gentle, soft spoken midwife in her early sixties, whom I met through a mutual friend a few months before this interview took place. She worked in a very busy outpatient women's clinic in a less affluent section of town which is affiliated with another hospital where most of the SRRW go to give birth. She described her working environment as “the United Nations, with women adorned in their colorful garbs. We have patients; most of them come to this country as refugee from Sudan, Somali, Burundi, and Congo. We also have some Iraqi women, Myanmar and Nepal. They all

¹²⁷ Lucy died suddenly just 9 months after this interview. My relationship with Lucy was beyond researcher-participants, we were friends. Though we did not know each other for a very long time (just 2 years), we spent quality social time together and planned to go to Tanzania the following year.

come dressed up with their children.” She said “I love it”. Lucy explained all of her colleagues are female, and that is the main reason, “the women come to us. They know that they will be attended by females only”. In addition to providing prenatal care, the HCPs in this setting (including Lucy) also assist the women during childbirth at the hospital. Lucy was a middle aged, very kind and matter-of-fact woman. She was well travelled, had spent time volunteering in Uganda as a midwife, and wanted to do more of that after her retirement. In our dialogue regarding perception on female circumcision, Lucy said:

I read it somewhere in my early midwifery years. I think the way it is presented here is very sensational and that goes along with our culture. It’s really unfortunate that healthcare providers are so influenced by what goes on TV shows that they don’t take time to understand the other perspectives or other people who are different from them. It’s plain ignorance and arrogance, sadly (sigh). As for the Somalis, it’s part of their culture and there are some women who have had it done to them who see no problem in it. I mean that’s their culture. That’s what was supposed to be done. They know nothing else. And there’s other women who are like, oh no, I don’t want that done to my daughter. So you see, in the community, there is a wide spectrum of opinion about it. To me, the difference is the same when I see a circumcised penis versus uncircumcised. It’s a different sort of thing to accommodate during childbirth, but again it depends on the severity of the cut....sometime or I’d say most of the time it is a non-issue. And as how it makes me feel personally? (pause) I am not sure how to answer that (pause) other than to say it is part of their cultural practices, and some among them want to continue and other wants to stop it. I don’t think we have any role to play (pause). We, here in America, have our own cultural challenges poverty, racism and a list of things we need to address.

Lucy described her perception in a more “global” perspective, or perhaps she had a culturally relativist perspective on female circumcision. Her positionality, I sensed may be influenced by her travels and work with women from different cultural backgrounds. Her description underscored the importance of preobjectivity of perception in meanings-making. For Lucy, female circumcision is a contested cultural practice amongst the women whose culture requires them to participate; thus she feels it is best to leave it up to them to address it. Drawing from her years of experience, she believed that, for most part, the female circumcised body *per se* did not cause additional risk during childbirth.

Perceptually, the circumcised female body was generally experienced as both natural and cultural body among SRRW; albeit the degree of this monistic embodiment of this individual body is culturally contested, particular in the context of childbirth experiences post-migration. In contrast, the salient theme of the circumcised female body from the HCP perceptual experience is that it is a cultural and not a natural body. This cultural body symbolically embodies a culture of ignorance and submissiveness; when encountered in the healthcare settings, the circumcised individual body is perceived as a representational object of that culture.

The Social Body

The *social body*, writes Scheper-Hughes and Lock, is simultaneously a physical, natural and a cultural artifact, a symbolic representational of culture, nature and the social milieu (1987:19). It is the story-teller of embodied realities of that space and time (see Kreiger 2005). Mary Douglas postulated that “everything symbolizes the body and the body symbolizes everything” (Douglas 1966:122). It is this through this body that we can begin to understand social orders and tensions in a given culture (Lock 1993); this social body provides context to understanding female circumcised body.

In exploring the general perception of female circumcision, I learned that most of the HCP initial experiences with these “cultural bodies” were formed through the public media, particularly the Oprah Winfrey Show. This shaped their views before any face-to-face interaction in a medical setting or otherwise. When encountered during childbirth events, the bodily presence of SRRW affirmed their socially and culturally different bodies and evoked repeated sentiments of sympathy, “those poor women” victims of “butchering culture.”

Daisy, a young and vibrant Latina labor and delivery nurse, and millions of Americans watched a 1995 episode of the Oprah Winfrey show where two “FGM

survivors”, a Somali and an Ethiopian American, detailed their experiences of this “barbaric practice”. In voice-over grainy black and white pictures of her childhood, Soraya Mire, the then 34 year old Somali American woman, says:

My name is Soraya. I knew what he was doing to me. I will always remember the sound of the scissors cutting into the flesh between my legs. The pain was horrendous. I struggle to get away but I was held down by three women, including my mother. I know I’m a woman but I think there is something wrong with me. I want you to help me. I want you to lessen my pain¹²⁸.

As the camera pans out to the mostly female audience, almost everyone is in tears. The show included images of a crying girl undergoing the procedure. These are the sights and sounds that have shaped the perspectives of Daisy and many others who heard Soraya’s call for help. The episode “changed everything” for Daisy; she changed her career choice from a doctor to a nurse midwife whose goal was to work in Africa and to assist and remain with women after childbirth to “make sure they would never do that to their daughters”. She describes her reaction as she watched the Oprah episode:

Daisy: Oprah [some years ago] had a show that talked about female mutilation and showed how it is done. Oh, the shock I felt from that (pause), Ough ... (sigh), it just hit me hard (pause). The top of a girls face, oh, (long pause) I’ll never forget it. The little girl was held down and she was eight years old and just screamed over and over “No, no, no, no.” And that image forever was burned into my mind and there was no depiction of closure or reason behind it...(pause) it was just brutality and forever changing a young girl’s life.

Me: what do you mean by forever changing the girls’ life?

Daisy: I mean like, um, she will be different from other women (pause) and treated differently in this country. Like when she comes to the hospital during childbirth (pause). I am saying this from my experience and how nurses and doctors feel and talk about these poor women when they come [for childbirth].

Me: Can you give me some examples of how your colleagues talk and feel about these women?

Daisy: I would really cringe to say it, but (pause), I want to say that the view is like...(pause) like an animal in a way.

¹²⁸ On her website, Mire describes herself as a “Human Rights Worker, author, speaker, filmmaker” who “speak[s] for the voiceless”. She has testified against FGM before the UN and WHO among others. The Oprah Winfrey show video clip is found on her website at <http://www.sorayamire.org/> accessed 2/11/2014

Me: OK..(pause). But why? Is it just the changed anatomy from female circumcision that they see these women as animals?

Daisy: I think that at times, but I want to say it's mostly with nurses who feel sorry for them. Because of their experiences with FGC¹²⁹, I also think it reaffirms in the nurses' minds the primitive nature of their culture to engage in such an act as FGC and if the culture would engage in this act, then it also reaffirms the fact that they don't value babies lives, and don't value their lives as much. So when it comes time for an emergency C-Section – they won't even do that. What a primitive culture, (pause), is what they are basically thinking! And if they don't even care enough about their lives, then why should I treat them like somebody else...(pause) or I don't care as much about them. And that may translate into actions, in not giving them...(pause) not offering a blanket when it's cold. Not ...(pause) you would go in their room and the patient had only one pillow when most patients have four. It's not...(pause) it's not over the (pause)... doing things that are...(pause) illegal or harmful but it's not as caring as you would be to somebody else. And I think it originates from the culture of women with FGC. It's snowballed from there.

Me: So in your view, the Somali women are treated differently by the nurses and doctors because of their culture; that is the culture of female circumcision?

Daisy: Yes. So ...(pause) if they refuse to do what they are told, such as when they refuse to get epidural or C-section, or even to stay in certain position during birth, it is interpreted as its part of their backward culture. They basically have no right to refuse us (pause)... the authority of us nurses and doctors; because they do not know any better coming from such primitive cultural background.

It is interesting to note Daisy's point that the show did not contextualize the practice by discussing "the reason behind it". Instead, it showed that "it was just [a] brutality" that "forever chang[ed] a young girl's life". To Daisy, this dramatic "change" in the girl's life was not so much the immediate or long term risk of infections and other physical risks but the fact that "she will be different from other women". This "difference" from the American norm will cause her to be "treated differently in this country". The labor and delivery care this woman will receive will be within the letter of the law, but she may not receive equal care, comfort, or respect. Furthermore, she seems to be subjected to a punitive treatment that repudiates her rights to refuse or even question the authoritative powers of the HCPs. If this "mutilated" woman does not even have the awareness of her "damaged" and different body – the thinking goes – she must

lack agency and intellect to evaluate and refuse medical interventions. Thus, she cannot be trusted to make such a decision. The primitive culture that enables its members to commit such “barbaric” rituals on young girls must lack moral and ethical values about the sanctity of life. A woman from such culture, therefore, is assumed to be incapable of making ethically sound rational decisions about obstetric interventions regarding the fetus, the integrity of her bodily existence and bodily processes during childbirth. One could argue that what happens in such encounters is more about culture than it is about how to properly care for differently appearing anatomy. Here, the body is merely a symbol of culture.

“Docile Bodies”, Strong Minds

The most recurrent theme among HCP participants was that the culture of female circumcision was symbolically represented by docile bodies. Yet, this preconceived image of docile cultural bodies of these “poor [agentless] women” becomes incongruent with face-to-face encounter with strong women questioning recommended biomedical interventions. Though challenged by language and cultural barriers and these bodily differences, women with “FGM” did not fit the docility of the bodies let alone lack of rational minds or will power [re]presented on the TV screens. In her interview, Daisy told me how she marveled at the courage and determination of her Somali patients. She gave the example of a Somali pregnant patient who walked in the scorching Arizona summer midday and came alone to the labor and delivery room. Daisy exclaimed: “Can you imagine that?! (Pause)... None of the American women can or will do that, but she did not have a ride and did not know to call for an ambulance because she could hardly speak the language”. By the time she arrived, Daisy said, “she was ready to deliver,

¹²⁹ Daisy used “FGC” after I shared with her that “FGM” is contested and seen as offensive. She said “oh, I didn’t know”. Though FGC is the preferred term, FGM is prevalent in the literature.

naturally that is vaginally, without any epidural or any other routine obstetric interventions”.

Tammy, who earlier vividly described her emotional experience with female circumcision on the Oprah Show, later shared how she was puzzled when the image of a culture of “submissive behavior” painted by the show clashed with incidents that were uncharacteristic of submissive women. Speaking on her impression of her Somali patients, Tammy said “One thing that stands out the most for me is that they are strong women and strong willed! My God!”. When I asked her why she seemed surprised she explained: “as I have said, I think the whole thing to me, the butchering, is a submissive behavior. It must be their culture that teaches them to accept things done to their bodies without questioning or fighting. But at the same time, they are tough patients to deal with.”

To clarify what she means, Tammy contrasted her Latina and Somali patients. Latina women, she said, would go along “a 100% with anything we tell them, they trust us 100%. The Somali ladies, on the other hand, are challenging. I think it is their culture or religion. They simply will not go along with medical suggestions, even if their lives and the babies’ lives are at risk”. To illustrate her point, she describes her experience with a Somali patient who arrived with very high blood pressure and who “needed to get induced or C-section, anyhow, the baby needed to come out soon. But she plainly refused. The thing is they come here for help and we want to help them but they are just no, no.” Tammy conceded that language barriers might be a primary reason but also wonders “if there is a religious belief or a cultural belief” dictating that “that we shouldn’t intervene with certain things”. These patients, she points out, “come to us for help yet they don’t necessarily want to have our help if it goes against what their beliefs; even if

that means allowing the mom and the baby to die.” Tammy expresses the exasperation and dilemma she and her colleagues confront with this patient. She says:

We just cannot stand by and watch these things happen. It is very difficult. We tried to get her to stay, she wouldn't. I cannot remember the details but I know she delivered a dead baby at another hospital because we told her she had high blood pressure she needed to be delivered. She just walked out on us. Just like that (pause). It is amazing. I never have seen that behavior in my entire professional life. It is this is it. They do as they please. Like, (pause) done; deal with it.

Cassandra, a nurse practitioner in an outpatient clinic with a large number of SSRW patients, concurs that SRRW's religious beliefs are the reasons for refusing interventions. She says that “[i]f they go overdue or it is breech and they require a cesarean section, they would prefer no intervention. They believe (pause) they have a strong belief in God and God's will, and they are willing to accept whatever God's will is.” Cassandra says these beliefs are “fine with” her so all she can do is “explain to them the medical perspective and the potential risks of following through with inductions or cesarean sections”. She tells them that she “respect[s] their wishes” and since as providers “there is nothing” they can do since they “cannot force them,” these patients become “pretty much hands-off”. She reaffirms they are “very strong willed.”

Such sentiments were shared by most, but not all, HCPs. For example, Fifa, the labor and delivery nurse of northern European background quoted earlier, has a different take on the reasons for this sentiment. Having been exposed to other cultures through her travel and work in East African and the Middle East, Fifa finds it “less stressful” to assist ethnic minority female patients. Prefacing that her assessment is perhaps based on her “foreign opinion”, Fifa theorizes that the reasons some American providers have “a hard time caring for any minority women” may have to do:

with cultural perspective or understandings that you can appreciate a different culture from your own. For most, they take it as a challenge or already a stigma, that OK, because we have different culture or experience this is going to be a challenge. It is up to

the provider to build up trust with the patient regardless where they from...(pause). The approach may be different from patient to patient or culture to culture, but the bottom line is still the same, you need your patient to trust you. It is the responsibility of the nurses and doctors to reassure the patients, to get their trust.

Though the culture of both patient and provider play a role in the interaction, Fifa also identifies the variation among providers and how that influences outcome. Problems arise, she notes, if patients “get uncomfortable and distressed about the delivery process or if the doctor is not reassuring or what not or as soon as they are not staying on the labor curve like any other patient here.” She explains that doctors are “very keen on sectioning patients” who diverge from the labor curve. She identifies this as the critical moment “when distress hits and when things get harder” and, “to be on the safe side,” physicians “simply resort to C-section.” This is the usual procedure with all patients not just Somalis. Fifa is very matter-of-fact about the critical role of individual providers on outcome. She explains how as nurses pick their assigned patients and doctors’ list, they not only “look at the patient’s story but [also] look at the doctor who has them and that tends to influence the outcomes of delivery and the kind of day you are going to have.”

Clashes of Perspectives

The HCPs’ gaze of these bodies “mutilated” by a primitive culture and their belief that medical procedures such as C-section are necessary interventions to save distressed mother or fetus at once confront and confirm SRRW’s fears and distrust. One of the salient themes among SRRW was that the biomedical authority represents a coercive power. They described their experiences during childbirth as being punitive and targeting them for unwarranted obstetric interventions, in particular C-sections, to limit their reproductive capacities. This commonly held belief among participants was best captured by this exchange with Anisa and Saadiya during an interview:

Me: Why do think Somali ladies are targeted for C-section?

Anisa: Some people, the people here, mostly they don't getting too much kids. That is usually what I feel, and the Somali ladies, they wanna get whatever Allah give them, no matter who much. The doctors get surprise these women are getting too much kids. They feel we are dumb people because of how much kids we have. But we are not dumb. We not! That is normal. That is nature. That is natural. That what we have before. The kids cannot make you anything but happy. So the kids is gift from Allah. Just is a gift from God. A lot of people here in America don't believe that. Some doctors here think these ladies are dumb when getting more than four, five kids. That want to stop the kids, they try how to stop to getting the babies. That is what I feel.

Me: So you say C-section is to stop Somali ladies from getting many kids?

Anisa: A hundred percent that what I feel.

Saadiya: You know, it is very incredible, mother she get five, six kids, and the seventh one, she getting a C-section! They say you cannot getting the baby natural. The doctor not supposed to say that. They have to give her time to get the baby. If they cannot see the baby is serious, they cannot say it is serious. They don't give her chance to get the baby deliver for the natural way. I know so many ladies getting rush, rushed, not given time. One day one of my friends, she have a pregnancy. Her doctor, she wanna go to the vacation. Her OB/GYN doctor wanna go vacation before the baby is born. She said to my friend, 100% I am sure you cannot get this baby. You have to get C-section. Your first baby you have high blood pressure and your sugar is too high, so I wanna do C-section before that happens again. My friend she say I cannot have that risk, no C-section because I have no other problem to getting C-section. Her doctor she get mad, mad, mad. She say the only choice you have is C-section because I don't have time to wait. My friend say, what you talking about? The doctor say, I wanna take vacation. I am not staying to give you time. You have to get a C-section before that time you get high blood pressure. She say, no, I am not getting C-section. I have to try to get the natural delivery. When the time comes, my friend get the contraction, she go to hospital she get natural delivery. No C-section. She get no problem, baby get no problem. The doctor only want to get the money to go to vacation. She want to waste this baby and the mother health for nothing. Only for money, and for stopping more kids to my friend. That is what I feel. The doctors many time they make mistakes, sometime yes, the mother need C-section, but a lot of time the doctor rush the Somali ladies. That is what we feel.

Rather than necessary lifesaving procedures, Anisa and Saadiya like many others, think C-sections are performed on them to generate revenue, for physician's convenience, or as punishment and a birth control tool to limit their family size. This last reason is an affront to the central Somali cultural belief that children are a gift from God and one should have many. Furthermore, to these women, childbirth is a natural bodily process that does not adhere to a clock but which unfolds gradually. The participants frequently complained they were "not give[n] time" and a natural process was "rushed".

Another prevailing perception narrated by SRRW was that their bodies were used by doctors for financial gains and by medical student “to learn to do the operation”. As such, when a SRRW is told that she needs a C-section but refuses and later delivers naturally, these perceptions and fears are confirmed and another story is added to the narrative of being punitively targeted for C-sections.

Wendy, a nurse whom I met at an in-service about FGC and childbirth given by Dr. Crista Johnson-Agbakwu, in one of the teaching hospitals, told me afterward how useful the lecture was. She has been working in labor and delivery for over 20 years and it still upsets her and she finds it very difficult to work with “these poor women”, but she wanted to understand so she can give them better care. I asked her what is hard about working with these women and if the anatomical modification resulting from circumcision was the problem. She said she was not sure how much of an issue that was but there seems to be a “cultural clash” because these women’s “culture makes it hard for them to accept our culture.” Wendy also offers C-section refusal as an example of the difficulty and a sign of this cultural clash. The women’s refusal of the procedure might be because “they are just ignorant and don’t understand what we know as risk factors. They don’t know; we know because we are trained, they have no training in childbirth (pause). I mean they know something but obviously not enough due to lack of knowledge and their background.” While she recognizes language barriers might pose an obstacle to how providers convey the risk for mother and child, Wendy asserts that more than language, “it is their culture and everything that goes with it” that is the problem.

During my interview with Wendy, she revealed a keen awareness of a sense of fear among her SRRW patients. She gave an example of how a Somali women patient actually jumped out of a moving gurney that was taking her to an operating room for C-section delivery. The woman “land[ed] on the bare floor”. Refusing assistance to get up,

she just “picked herself up and walked back to the room”. The doctor was very angry with the patient but Wendy said she only felt sorry for her and “could see the fright in her eyes”. The husband and other members present were not fluent in English and the doctor was yelling at them. In this “utter chaos”, family members were shouting “wait, wait, give her [the patient] time”.

Part of the challenge is also the difference in understandings regarding decision making processes. The SRRW I spoke with said that decisions are always collectively made because “that is how Somali culture works”; there is always consultation that goes on among family members and close friends. Healthcare decisions are no exception and C-section is considered a more serious operation because it influences the future reproductive health of the women. Consequently, the husband (father of the child) has a critical role in decision making. When I asked Mariam why so, she laughed and said, “How can a woman make such a decision alone? The husband has to agree, because it is his child too in the stomach of his wife. The baby can die, the wife can die, he has the right to say OK or to wait”. If he is not available for consultation, then the mother or the mother-in-law and the woman lead the deliberation process with everyone else weighing in before the decision is reached.

From the HCP perspectives, the idea that the final decision of whether or not to have C-section operation is not solely an individual decision of the patient but a collective one involving the husband was perceived as lack of agency and autonomy, symbolizing the submissive culture of circumcised women vis-à-vis men. Tammy recounted her experience in one such situation though she prefaces it by saying this was merely her interpretation “100%”:

I felt that because she had had a Cesarean section before, what she thought was against her will, but her baby was in trouble and they were trying to save their lives. I almost felt

that either she had suffered some sort of persecution from the men. I think she was willing to go along with it before the men were. I think that was my interpretation. So it was finally when the men agreed in her community whoever they all were, I don't know if they were family or friends. I know there were some brother-in-laws there because of previous family I recognized they were related. I believe that she was afraid to say for whatever reason whether pride or whether she had suffered repercussions because she was unsuccessful the first time and this is going to be her second C-section delivery.

Tammy starts by saying that she thinks the woman might have been initially hesitant to have this second C-section because of what might have happened the first time. Though she has no way of knowing what led to, transpired during, or followed that first surgery, Tammy theorizes that the woman might have suffered repercussion from her men folk. The woman's hesitation notwithstanding, Tammy thinks the woman was willing to have it before the men "whoever they were" agreed, but it was only after they agreed that the decision was made. Tammy thinks the woman was afraid to decide on her own because of pride or fear of repercussion. However, since the deliberation was in a different language, Tammy had really no way of knowing what transpired, the power dynamics, and the role of the various actors in this process. Perhaps the woman's initial hesitation was due to repercussions from the family or merely due to her own fear of being cut open again. Perhaps the family was convincing her or maybe she was convincing them; it is all conjectures. But the context of Tammy's interpretation is not only her preconceptions of Somali women and their culture but also a particular understanding of autonomy that prevails in medical practice.

In medical practice, autonomy is often understood as individual based decision-making. Beauchamp and Childress, who formulated the now globalized Principlism theory of bioethics, defined autonomy as "at a minimum, self-rule that is free from both controlling interference by others and from limitations, such as inadequate understanding, that prevent meaningful choice" (2001:58). Principlism, its definitions of its concepts, and universal applicability are subject of great debates in bioethics and

are contested even within the West by Feminist (Mackenzie and Stoljar, 2000), religious (Engelhardt, 2009), and African American (Garcia, 2007) bioethicists. These critics argue that Principlism's purported universality erases specificities shaped by their particular history and group (gender, religious, race, sexuality) based concerns. Nevertheless, essential to the principle of autonomy is liberty and agency, both of which do not exclude consultation and both of which could be limited and infringed upon by providers and family alike.

In addition to these differences about the timeframe of labor, there are differences about the best position for the woman to be in during delivery. Lying down during delivery— the standard position in hospitals— does not make much sense to many SRRW. Farida, an interpreter for Somali refugee women, has witnessed incidents where women, especially Somali Bantu, argue for sitting up during delivery and the providers are “shocked” and refuse to accommodate these requests. She relates on such incident:

I went with one of the Bantu to the delivery room; she said to me I don't know how I can deliver laying down. They said that goes against gravity. So, that too was most shocking for them. The lady said to tell the doctor the baby is not gonna come out with me lying down. But the doctor does want to believe them. The doctors wanna keep them chained on the bed with heart monitor, for nothing but purely for insurance purposes. They won't let them off the bed for five minutes. They want them on their backs, flat! So, this lady refused to lay down. She asked why won't they let me squat or sit up? I would think that is a reasonable thing for the hospitals to accommodate. So, I asked the nurses to help me sit her up. They said no! She is gonna have to give birth lying down. She was one of the brave ones, though she did not speak English, she just sat up, and said they are either going to catch it [the baby] or I am going to do it myself (laughter). They eventually caught the baby with her sitting up.

These differences in perspectives do not always have to be a source of conflict. Mutual respects, effective communication, and attempts at accommodations are pathways to resolutions.

“Words Don’t Come Out Right”

When speaking with SRRW it was clear that their lack of language proficiency and thus their inability to express themselves adequately complicated their childbirth experience. It is interesting to note that most of the SRRW said they empathized with the HCPs who were likewise frustrated with the inability to communicate adequately with them. Nasifa, a mother of four, captures this sentiment and communication dilemma:

a big problem for us and the doctors and nurses. They don’t understand what we say, and we don’t understand what they say. Even when we have interpreters, the words don’t come out right, but mostly they are not sensitive to our needs. They just want us to do what they want, like we are ignorant because we don’t speak English, but in that case they too are ignorant because they only speak English and don’t speak Somali (laughter).

Farida, a Northern SRRW, mother of four vaginally-delivered children, is young and very active member of the community. She came to the U.S. at age ten so she spoke fluent English. Because of her bilingual proficiency and long residency, she accompanied and interpreted for several SRRW during childbirths. She described her experience in the community as more of an advocate than just an interpreter during these events. I asked Farida if she recalled a particularly memorable incident while interpreting for Somali women. She said there many noteworthy incidents but one stood out because it:

was so dramatic. The gynecologist was just blown away when this lady refused to have C-section. She and her husband both refused to C-section. The husband and the mom both said they want to wait and take their chances. The doctor insisted that the baby’s heart rate was going down or dropping or something like that. The husband and wife, did not really believe him, they wanted to wait longer. The doctor was so furious with both of them, but more at the husband. They threaten to go to get a court order to force them into C-section, on the lady, so that they can save the baby. When they hear about the court and police they got scared and gave in. The doctor was yelling and threatening him. Finally, they broke him [the husband]. He finally agreed at the end, just before they got the court order in process. It’s not so much what happened. It is the way the gynecologist was yelling at them, especially to the husband.

After she narrated this story, I asked her about her own birthing experiences. She said her experiences are generally very different because she speaks the language and the providers “would not get away” with treating her as they do women for whom she

interprets. With her last delivery, however, her doctor was away and another female doctor substituted. Because the circumcision scar is an “automatic red flag”, the nurses had told her she would need episiotomy to “give [her] more room”. Yet the new doctor did not perform the episiotomy and Farida “tore badly” during delivery. Farida has her theories about why the doctor did not perform episiotomy: “she must not have read my notes or was just plain insensitive and maybe felt too dumb to ask me questions. Thinking she knew it all because she was a doctor.” The doctor, however, told her she simply thought she had enough room for the baby, but that was not sufficient reason for Farida who “wr[ote] her up [and] did not let her get away with that.” She also tries to stand up for the refugee women she accompanies and tells the providers to stop yelling at them and to stop “make[ing] the choices for them” and to give them options.

From Farida’s narrative, we see that her linguistic competence notwithstanding, healthcare encounters are greatly shaped by power and social position differential between patient and provider. The power biomedicine bestows on providers challenges and intimidates all patients no matter their background which is why safeguards such as Informed Consents and Patients’ Bill of Right¹³⁰ have been put in place. The challenge is greater for those who are further disempowered by the intersection of race, culture, religion, and class. The resultant charged patient-provider encounter contributes and confirms mutual negative perceptions and instills fear and mistrust among patients. Tammy confirms Wendy’s earlier conclusion that the difficulties providers have with SRRW is, as Tammy put it, “more than just a language barrier, it is their culture”.

These dialogues reflect that female circumcised body *per se* (the anatomical modification) was not perceived as the “problem”. Rather, it is the intentionality of what

¹³⁰ See American Hospital Association website for details <http://www.aha.org/advocacy-issues/communicatingpts/pt-care-partnership.shtml>

the body represented when encountered and the meanings it conveys to the HCPs. Interactions with the symbolic body are culturally and socially challenging and are at times incongruent with their perceptions. SRRW cultural differences and language barriers are conflated as representational embodiment of difficult social body that female circumcised bodies symbolize. On the other hand, my dialogues with SRRW participants described their experience with HCPs as equally or perhaps more challenging due to culture and language barriers. Perceptually, they were acutely sensitive to how their bodies were culturally and socially viewed as different bodily presence in medical settings; this shaped their views of obstetric interventions, particular C-sections, as a punitively motivated rather than a normative necessary medical procedure.

The body politic

Body politic is the third dimension of Scheper-Hughes and Lock Mindful Body. This body refers to the interplay of power and control. Power (political and legal) depends on regulating and controlling the first and second bodies —discipline the individual body and controlling the social body—from deviate behaviors or politically incorrect bodily existence. The politically correct body in the U.S. is androgynous, youthful, strong, and healthy looking, though the meaning given to facial features, body parts, and value placed on fertility and longevity may differ depending on political and social context (1987,25). Threats to social order will intensify self and social control which manifest in anxieties over “penetration and violation of bodily exists, entrances, and boundaries extended to material symbols of the body—the home, [...] around which many protective ritual, prayers, and social customs served to create social distance and

sense of personal control and security” (1987,24-25). In other words, societal concerns with threat will galvanize to resist the perceived threat.

It was not my aim to explore why SRRW are resistant to and fearful of obstetric interventions, or the legitimacy of such interventions, particularly C-sections, from HCP perspectives. However, the topic of C-section was repeatedly raised and emerged as a central point of perceptual contention from both groups of participants. The frequent recurrence of this topic was narrated with intense level of emotionality, perhaps more so among the SRRW. At the same time, it was clear from both groups that the perception of the female circumcised body *per se* (the anatomical modification) was not the “problem” or causal factor for such interventions. In recounting the experiences of participants, we can get a more nuanced embodied perspectives as experienced by SRRW vis-à-vis HCP during childbirth encounters.

Contending Powers: Control and Resistance

In speaking with HCPs, I was able to gain insights to how their sense of authoritative knowledge¹³¹ is challenged by SRRW. The challenges from SRRW were incongruent with the embodiment of submissiveness culture that is symbolic of their cultural bodies. In addition, as members of the biomedical community, the HCPs participants embody power of science rather than faith in God in controlling childbirth outcomes. As for the SRRW, I was able to see that their understandings of childbirth differ greatly from that of the HCPs in several ways. Firstly, the SRRW define a successful childbirth is one that has minimal if any biotechnology interventions. Secondly, in determining birth outcomes, ultimately God’s will supersedes and prevails over human efforts, scientific knowledge and power. Thirdly, obstetric interventions, in

particular C-section are perceived not only as “unnatural” birth modes, but also as a threat to their health in general and, most alarmingly, as a coercive and powerful biomedical tool applied to control their reproductive potentials which are central to Somali culture. Consequently, in the context of these meanings, C-section is feared, contested and resisted. Ironically, though their bodies are often described as “mutilated”, they described C-section as, “mutilation of our bodies”.

Although the HCPs embody power in medical settings, it was evident that the power is relative and hierarchical, with doctors occupying the top rungs of the power ladder and the patient at the other end. One of the issues repeatedly raised by the SRRW was trust; they do not trust the HCPs. When I asked about the reasons, I was told different stories depending on the participants’ experiences. For example, Marwa told me her doctor allowed her to tear badly during childbirth because he did not know how to manage her circumcision status. She tried to guide him by telling him to “cut sideways not down. But he did not listen. He thinks I am stupid”. Several shared her assessment that the doctor would often “cut wrong way” which later caused them to have problems. Others related how they would “fight” not to have C-section and would only submit to it when they were too tired and too stressed to fight.

This conflict between patient and physician about the C-section is not necessarily always one about medical knowledge conflicting with patient’s lack of it. Some of the HCP participants acknowledged that some doctors who are unfamiliar with FGC resort to C-section because, as Fifa described “they do not know what to do when they encounter circumcised patients” and feel “forced into performing C-section just because of that. I have seen that many times but here, as a nurse you cannot tell the doctor what do.” This assessment confirms the SRRW general impression. This lack of knowledge in

¹³¹ The term authoritative knowledge as used by Brigitte Jordan implies that a particular cultural authority’s view of reality and judgment count as rational and valid above all other

managing circumcised women during childbirth is a major source of the struggle for control and resistance between HCP and their Somali refugee patients during childbirth. To the HCPs, patient must follow orders and do as they are told without resistance; after all “the nurse knows best, knows better than the patient.” Daisy says that while other patients follow orders, those from “the Somali culture, the African culture, they take their time. If they don’t want to get in bed they don’t get in bed.” This is perceived by the provider as the patient being defiant and resisting orders and the provider experiences “a sense of potential for complete loss of control.” Daisy argues that “there is a huge control element in healthcare that is necessary to maintain order and safety and maintain their process.” There is also the ever present fear of sanctions for not following institutional policy and procedures and of being sued by patients. Whether it is for safety or fear, the ability of providers to maintain order and control, Daily points out, depends on “decreasing variables” as much as possible, even if that is “uncomfortable for the patient.”

The patient-provider interactions are complicated by cultural differences in time orientation, in the birthing process, in understanding the subtle linguistic differences between a command and a request, along with a patient’s need to maintain some sense of control in situations where they have little of it. Additionally, though Somali women have earned a reputation for resisting C-sections, many women in general who believe in vaginal birth see having the surgery as sign of their failure. This is the assessment of Tammy who through the years has seen women who “wanted to deliver vaginally and they couldn’t do it they see it as I failed. My body didn’t do it; whether they are Somali or Caucasian or Hispanic or whatever it is, nobody wants [...] ‘okay, Uncle, I give up’.” She likens this sense of failure to how women feel when they want to but cannot breastfeed.

views/knowledge (see Jordan 1997).

When I asked SRRW whether they feel they have power to control their birthing events, they overwhelmingly responded with a resounding “*no, not without a fight.*” There is a commonly held belief within the Arizona and American Somali community that they are targeted for C-section. When I asked why they feel targeted, Sahra said that is because “doctors don’t know about us and our culture. They don’t respect us. That is why I always warn other ladies of doctors”. These warnings quickly spread in the community through word of mouth and greatly influence women’s decisions and actions. She says:

we always talking about. If we go early, we get in surgery because the doctors, they counting time. Most doctors, they saying you are 12 hours, you are 24 hours. The baby cannot be there longer. It is not breathing, no water. The heart beating too much or the heart is going down. No. My country, some ladies they getting the contraction like three, four, five days and the baby get health. It comes out healthy. Mommy get the health, so why we did not get the chance to get the delivery natural for the bay? That [is] what I question all the time. But if they counting only time and they saying to mommy, she getting contractions like 24 hours, we cannot wait longer than that. That is not good. I am not accepting for counting time, I am not accepting.

Sahra’s account was very typical of how most SRRW described how they try to have a sense of control in a medical setting during childbirth. I was assured that every Somali woman, whether they are long term residents in the country or just arrived, seeks advice from other SRRW, SRRW who have been here long change doctors when they are dissatisfied with their current one or when they hear so-and-so doctor is a “good doctor”. The mark of a “good doctor” is one who “will allow” them natural delivery and only resort to C-section when it is absolutely necessary. But even with such “good doctors,” the women tend to wait at home until birth is imminent. Their reason for this is that if they arrive and their doctor is not available, the one who takes over their care would not know them or “cares to ask anything [and] will just rush to C-section”. Most of the SRRW participants voiced these concerns expressing them in terms of “worrying” but it can best be understood as fear and it is, as Madiha puts it, a “real fear.” Madiha is fluent

in English and other Somali dialects, owns her own business and also work as an interpreter for the Somali community. She is well known in the Somali community and often accompanies SRRW seeking gynecological and obstetric in healthcare. When I asked her where the fear comes from, Madiha said that this is constantly a topic of conversation in the community. If a woman is induced then ends up having a C-section, that spreads in the community and women lose faith in induction and the doctor. They warn each other to resist induction because, as they see it, it is nothing but a prelude to C-section.

Madiha relates how when she was interpreting for a recently resettled woman about to have her first child in the USA, the woman asked her to tell the doctor that her children are born after ten, not nine, months. Madiha was puzzled and asked the woman why; the woman informed her that is because “they mutilate our bodies” adding that she heard throughout the community that “American doctors will do C-section to all Somali women”. Madiha told the doctor that the woman says she delivers at ten months and he documented that “just to please her.” Madiha posits that language barriers and the illiteracy of many women contribute to the doctors doing what they are “supposed to do” and not “want[ing] to communicate and waste time.” Since she interprets for women, I asked her if interpreters intervene as cultural brokers and facilitate communication. She said “they [the providers] don’t talk to the interpreters; they order us to tell the patient this is what they are going to do, because the baby heart’s is going down. There is no choice. They say it is danger; they have to do C-section right away.”

Telling the doctor that she delivered at ten months rather than nine months was not something this woman invented. Titi told me she and others have done that or have deliberately given the wrong date of their last menstrual cycle to throw off the calculated due date so they are not put “on the clock” and rushed to deliver. SRRW described

several reasons they fear presenting to the hospital for childbirth delivery and not speaking the language is one, even though hospitals provide interpreters. In the cultural consensus analysis chapter, I discussed the SRRW belief that early presentation to the hospitals, that is before birth is imminent, will often result in unnecessary obstetric interventions such as induction and C-section and the latter in particular is intended to limit their procreative capacities. Therefore, to avert these interventions, most SRRW use these delay tactics as means of asserting some control or resisting the embodied power of HCPs.

Faith in God vs. Faith in Science

In talking to SRRW and HCP participants, I found they did not have different perceptions regarding the sanctity of life; however, they differ on the meaning and source of power that gives and sustains life, especially during childbirth events. In general, the latter group placed their faith in science. Although they admired the SRRW “strong faith”, providers think that “science trumps their faith when they come to America,” as Daisy pointed out. In contrast, the SRRWs’ faith in God superseded faith in the science that is embodied by the HCP. Deeqa, Asila, Titi and a majority of the SRRW stressed that “first of all, we believe in Allah [God]” and only God truly knows when a child is conceived, it’s sex, the day it will be born. Thus the circumstance of birth will unfold in accordance with God’s Will and God’s Will alone. Hafsa, a young mother of four, said “in our country we don’t have doctors; we get babies without any doctor help, only God help us. God make us survive, the mother survive, the baby survive. It is natural”. I asked Hafsa if is it not true that though God helps, sometimes the mother or child die because a doctor is not there to help. She responded by saying that yes, that may be the case; but “here too mother dies and baby die sometimes. Doctor cannot stop

death. Only God can do that.” In response to my explaining how the doctors’ medical science knowledge prepares them to better help the mother and child, Hafsa responded saying

Childbirth is natural, not science. It is natural from God. God gives everything to us. Science too is from God. God give us knowledge to learn and to know everything, but life and death is God’s secret alone. Doctors say maybe this disease or this problem...not sure. He can say you gonna die, but he is not knowing when the soul is going back to God. He guessing only. *Allahu ya allam* (only God knows best).

Some do acknowledge that few cases of pregnancies require obstetric interventions and are willing to accept that, provided the doctors have given the woman ample time for natural delivery and doctors are “not imagin[ing]” but are absolutely sure that “the problem is serious.”

I brought up the SRRW concerns with HCP during the interviews and they found them baseless. Tammy summed up their position by reiterating that all childbirth events are risky “so why take a risk when we have scientific evidence that is proven to save the mother and her child?” To illustrate how the Somali women’s delay tactics cause serious problems that providers must then manage, she gave the example of young Somali woman who came in with “baby’s feet hanging down, she was breached” because she was “so resistant to C-section” The providers then had to “scramble to deliver this baby in breached position who nearly died. I must say her prayers must have been answered by her God; it was a close call”.

Concluding Discussions

This chapter discussed how female circumcision is perceived bodily and how culture gives meanings to perceptions. It also shows how embodiment is about making sense of the lived experiences of being-in-the-world. In the context of migration and childbirth, female circumcision embodies a multiplicity of meanings depending on the

perceptual experiences of the perceived and the perceiver. In other words, the cultural background of the individuals influences what they see and how they see each other. By juxtaposing SRRW and the HCP individual perceptions of female circumcision, we begin to understand how complex and emotionally charged this cultural body is experienced as lived subjectively and intersubjectively.

These findings suggest that the two groups have opposing perceptual experiences with female circumcision as a bodily existence and culture as well as in the context of childbearing meanings. The HCPs perceived the circumcised female body as culturally “different” from the norm, the natural body; the existential presence of the body symbolically represents a primitive culture, one that is fatalistic and resistant to authority and science. These perceptions allude to the dualistic understanding of the body that separates the body entity from the mind, culture from nature, subjective from objective and so forth. Such dualistic concepts are pervasive in biomedicine and among HCP and serve to sustain the perception of the “other” body and culture; consequently it justifies distrust and fear among SRRW.

In contrast, the SRRW narratives provided opposing perspectives, one that is more monistic than dualistic. They do not make sharp distinctions between culture and nature; female circumcision is embodied simply as being-in-the-world. They concede that female circumcision maybe different but, for them, it is “culturally normal” in every sense of being-in-the-world. Additionally, their sense of the body is that it is endowed with the will to preserve its bodily integrity and safeguard procreation potentials. Furthermore, the body is perceived to be sacred, unified in spirit and flesh and God’s Will is supreme. Based from their individual and collective experiences, they perceive HCPs as representatives of powerful biomedical institutions who want to control their cultural bodies and natural childbirth bodily processes. At the same time, they are

empathetic with HCP frustrations as they perceive language barriers in addition to cultural differences further disadvantage their sense of being-in-the-world, albeit in the new world; a world that gives their existence and experiences a different meaning of being as women and mothers.

Chapter 7

Discussions and Conclusions

Human body modifications are as old as human civilization recorded history and genital circumcision of both males and females has existed across epochs, cultures, religions, and geographical boundaries. While the debates on male circumcision periodically grab headlines, the discourse on FGC is more prevalent and more pugnacious. It is an academic and a public discourse that is always contentious and never apolitical; a discourse pertaining to the body, gender, race/ethnicity, cultures and one that cannot be disentangled from recent and remote history or the politics of migration. In the last three decades, FGC has become a critical global health issue regarding female sexuality and reproduction and a human rights matter. What was for centuries a local practice challenged or championed from within has become an emotionally charged issue playing out on the global stage involving diverse actors of activists, academics, healthcare practitioners, and scientists. Even what to call the practice – whether it is genital circumcision, cutting, mutilation, or surgery – is contested and indexes the ideological position of the actors. Whichever term is used, it does not capture the variation within this practice and the discourse often reduces it the most severe and least prevalent (infibulation) homogenizing the diverse religious, cultural and national groups who practice this type of bodily modification. Within the African continent, female genital cutting or female circumcision is prevalent in Somalia and several other countries. As a cultural practice, it varies significantly in how it is carried out and its cultural significance and meanings within and between countries.

The internationalization of FGC is closely linked to the large influx of conflict displaced African, and particularly Somalis, seeking refuge in the North America, Western Europe and as far as Australia and New Zealand (Hernlund and Shell-Duncan

2007; LaBabera 2011; Rogers 2007). Encountering bodies marked by this cultural practice in their midst has provided impetus to Western actors to highlight FGC as global health problem that needs to be eradicated and as human right issue that needs to be addressed through international agencies. The WHO (2006) has accepted that from global health perspectives, the body—the female circumcised body vis-à-vis uncircumcised body – is one that puts women’s reproductive and sexual health at greater risk. The practice has been criminalized in several Western countries establishing in the process what La Barbare called “the ideological distinction between ‘Western culture’ and ‘barbaric traditions’” (2009, 486). This criminalization is to a great extent based on assertions of FGC posing significant dangers to women’s reproductive and sexual health. Evidence for this is cited from the plethora of literature about reproductive health disparities between Somali women vis-à-vis native born women in the host nations, especially childbirth. Yet medical and social science literature do not definitively identify FGC as a casual factor in the adverse birth outcomes observed among Somalis with FGC post-migration (Essen et al. 2005; Essen et al. 2002a, 2002b; Johnson et al. 2009)

The dominant Western view, including that of some feminist groups (see Petchesky 2003) is one that sees the body of a woman with FGC as unnatural, defective, and lacking agency; a body that symbolically represents a misogynistic primitive culture (Njambi 2004). There are certainly more nuanced perspectives about this circumcised body, though such voices are relatively muted in comparison (see Hastings Center Report, no. 6, 2012). Those subscribing to this more nuanced view challenge the “laundry list” of health risks associated with FGC, especially regarding childbirth in the context of migration to resource rich countries. They highlight the heterogeneity of cultural meanings and signification of bodily modification practices. After all, what is considered a “natural” or “normal” body and bodily processes such as childbirth are not

acultural. At the same time Western actors view their model of the body as normal, while people who practice FGC also see it as the natural-cultural existential way of being-in-the-world. This makes the topic of FGC controversial and highly emotional (Shell-Duncan and Hernlund, 2001). FGC, therefore, is not merely about the body and bodily processes; it is also about cultures including that of biomedicine.

Childbearing – pregnancy and childbirth – is a universal bodily process, yet it is highly cultural and shaped by local and global social, political and economic circumstances (Callister et al. 2003; Floyd-Davis and Sargent, 1997; Jordan,1993; Khalaf and Callister,1997; Liamputtong and Naksook2003). Thus childbearing is as much about culture, place, and time as it is about biology and or the body as a material entity. If culture is learned and shared knowledge as it is defined by social scientists, then cultural beliefs and behavioral norms form the basis of childbearing cultural models; every culture, including biomedicine, has its own indigenous childbearing model that provides meaningful guidance throughout pregnancy and childbirth (Hahn 1995; Jordan 1993; McClain, 1975). In places where FGC is prevalent, indigenous shared cultural knowledge in the domain childbearing or ethno-obstetrics is indispensable to the health of the expecting mothers and the process of childbirth.

Much has been written about the relationship between the individual and the society and what is clear is that individuals are neither wholly inventive in their actions and attitudes nor are they social dummies that internalize all that a society presents. Individuals do draw on cognitive models shaped by their societies to evaluate and understand others. Broadly defined, social cognition is the “general abstract mental representations which govern shared mental representations (knowledge and attitudes) of a social group” (Van Dijk 2000:95). These cognitive frames or schemas are created and expressed in social practices through everyday discourse and linguistic symbols.

While blatant racism in the public sphere has given way to political correctness, the dominant discourse about minority groups is nevertheless infused with what Van Dijk (1993:21) calls “elite racism.” This discourse is marked by biased presentations of situations where the complexities of issues are reduced either by what is said or what is left unsaid thereby counting on the audience to fill in the missing information by using the group’s cognitive models (Van Dijk 1993). The media plays a well-documented and an undeniably powerful role in shaping public opinions. Unfortunately, (mis)representing Africans regardless of national origin is not a new phenomenon (Hawk 1992; Ibelema and Onwudiwe 1994; Scott 2009; Sreberny-Mohammadi et al. 1985). Irrespective of the subject matter being covered, dominant media sources have yet to emerge from the euphemism of “the dark continent”¹ representation of African cultures and people. Portrayed as exotic and shrouded in mystery, Africa is endemically portrayed in the American media as a “problem” continent (Hawk 1992). The impression most Americans have of Africa and its people can be summed as:

a National Geographic image [...]. The mention of Africa typically conjures up stereotypical images of lush jungles and wild animals, poverty and famine, corruption and "tribal" warfare, and deadly diseases, such as the Ebola and AIDS viruses. These stereotypical images are further reinforced by the nature of media reporting, which, when it does focus on Africa, usually concentrates on the sensationalist and often negative aspects of the continent (Schraeder and Endless 1998:29).

It is not that the images are not grounded in some reality; it is that they are decontextualized and thus draw on prior cognitive schema shaped by colonial and

¹ February 27, 2008 NPR newscaster Jean Cochran reported that President Bush was heading to Africa to visit the "dark continent."

postcolonial imaginaries. The chaos and crisis resulting from the civil war in Somalia, famine in the region, the headlines about warlords, pirates and *Al-Shabab* (the youth) terrorists all shape the images of the Somali people. The headlines about outlaw Somali groups' encounters with Americans are brought alive through cinematic dramatization of Somali villains and American heroes in highly acclaimed films like *Black Hawk Down* (2001) and the recent *Captain Philips* (2013) reaffirming the lines of "us" and "them". But this Somali "other" is now on American soil and arriving in growing numbers since the geopolitics situation in Somali is far from being stable; consequently, the flow of Somali refugees into the U.S. will continue and inevitably contribute to the demographic shift in the U.S. population.

Somali resettled refugees like most refugees confront numerous social, cultural, and economic integrations challenges which often greatly impacts their health and wellbeing (Bollini et al. 2009). However, the intersection of their history, ethnicity/race, religion and refugee status have made integration challenges in the U.S. more burdensome for Somalis in general (Kusow 2006; Waweru 2008). Their image as backward Africans and bellicose Somali warlords or pirates has converged with images and portrayals by post-911 discourse on Islam and Muslims as violent and misogynist. In post-911 America, public opinion of Muslims has been problematic to say the least; evident by violations of rights, negative sentiments, and stigmatization of Muslims in America that are fueled by the acts of violent Muslim extremists and by the media (see Aleaziz 2012; Bail 2012; Kwan 2008; Navarro 2010; Saylor 2012)². That fact that some misguided Somali American youth have, unbeknownst to their parents or community, returned to Somalia to fight with Al-Shabab terrorist group has also raised fears and suspicions about and within Somali communities in American. Additionally, Somalis are

generally represented as homogeneous people, sharing one culture that is undifferentiated by history, geography, or political experiences (Kusow 1994, 31). This myth of cultural homogeneity persists post-resettlement. In part, this is because little is known about Somali refugees/immigrants beyond what is shaped by negative media attention (Schraeder and Endless 1998). The challenges are compounded for the Somali women who also have to deal with the issue of the FGC which is often attributed to their Islamic faith. FGC in the minds of the public is a barbaric cultural practice that, purportedly, only illustrates male dominance and the devaluation of women. As such being Black, Muslim, and Somalian disadvantages the Somali resettled refugee communities, in particular the Somali women with multiple axes of the “otherness” that hinder their integrations (Högberg 2004; Kusow 2006)

Healthcare providers, as members of a larger U.S. society, are equal recipients of these reports and images, and, therefore, are not immune to media influences about Somali people and their culture symbolized by the problems of FGC and their religious faith. In fact, the reader may recall the vivid description of the visceral reaction a nurse had to the Oprah episode featuring FGC in the 1990s. This nurse was not alone; several of the HCP participants identified the media as their primary source for what they know about the “horrors of FGM”. Having these preobjective perceptions shaped by the media, it was not surprising that the majority of the HCP in this study describe SRRW with FGC bodies as butchered and unnatural; an embodiment of primitiveness of the individual bodies and collective culture. This was emotionally upsetting to them.

When the preobjective or cultural perceptions of bodies marked by FGC come face-to-face during the clinical encounter with the bodies of Somali women who have

² For analysis about the resurgence of Islamophobia rhetoric in the media post-911 see Zemni, 2011; Navarro, 2010; and Nur 2010.

undergone FGC, both the patient and the practitioner must grapple with a multiplicity of meanings of being-in-the-world. Drawing on the three bodies framework proposed by Shaphred-Hughes and Lock (1987), these meanings emerge as intentionality (what the body conveys) on the individual body, collective social body, and body politic dimensions. To the HCP, at the level of individual body being treating, this body conveys something about itself (the intentionality of the body). It conveys the body as an object of something that is abnormal; that it is an embodied anomaly that can potentially pose a challenge to the providers' understanding, skills and knowledge. This body also conveys a message about the society/culture to which it belongs; it symbolizes a barbaric culture and lack of agency of its women. To the Somali woman, on the other hand, her body is merely circumcised and a normal bodily way of being-in-the-world, of being a Somali female who has been initiated into womanhood. At the same time, she is acutely aware of negative way her body is perceived by her providers. The result is anxiety and stress of both the provider and the patient and that affect them physically (becomes embodied) and manifests in thought and behavior.

These embodied tensions between these two bodies (the individual and the social as seen by the patient and the provider) give rise to the third body dimension, the body politic. Here power and control through surveillance and regulation encounter resistance and subsequent counter-resistance measures in a process that often results in marginalization and disparity. The provider embodies the institutional power of biomedicine and the social power of the dominant society and enacts that power upon this anomalous body through a disapproving gaze, or coercing it into unwanted procedures, or by not attending to it as best as possible. The power to name and to define is evident in the evaluative and emotive term "mutilation" used to describe this "primitive" deviant behavior (FGC) of that "barbaric" "other" society.

We see this process play out in how most of the HCP in this study perceived SRRW as challenging, difficult, and emotionally upsetting patients to care for, far beyond language barriers. These patients do not do as they are told, they second guess interventions providers deem necessary, and they even tell providers to slow down and wait for labor to progress unaided and instruct doctors how to cut during episiotomy. For many providers, the cultural mark of FGC symbolically represents the “other’s” existential cultural body, rather than a “natural” body; it is a defective unhealthy body distinct from the wholesome healthy body they know. When this defective body dares to resist the authoritative power in charge during labor and delivery, it only confirms the HCPs’ preobjective notion of its embodied primitiveness. In this sense the circumcised body is objectified; it is perceived as an object of culture rather than an active and perceiving subject in these intersubjective encounters.

On the other side of this intersubjective encounter are the SRRW who do not perceive their bodies as objects and artifacts of culture but who experience their circumcised bodies as a natural and normal way of being-in-the-world as a Somali woman. In the context of their migration experience and minority status in the U.S., they realize that they are different. But difference does not mean defect in body or deficiency in intellect or culture. In fact, the older SRRW participants described their bodies as an embodiment of honor, beauty and femininity. The existential awareness of their being-in-the-world is grounded in the sacred unification of their corporality and their spirit as governed by the supremacy of God’s will. As such, they have a sense of willful submission and responsibility to God in preserving their body-spirit integrality including safeguarding their God-given potential to procreate. Consequently, when they think they are being coerced into accepting interventions, they perceive the powerful biomedical establishment represented by the HCP as a threat aimed to restrain their will and ability

to control their bodies and what they consider as a natural bodily process in childbirth. These attempts are antithetical to their beliefs about the unity of body-spirit and the omnipotence of God; so they resist. They mislead providers about due dates, they delay arrival at the hospital until birth is imminent, they refuse what they think are unnecessary procedures, and they implore the providers to wait and “give [them] a chance” to deliver without induction or operation. If the provider is not familiar with how to manage FGC bodies during delivery all they need, the Somali women say, is to ask.

It seems, however, that their intersubjective experiences – at individual and collective levels –with the HCP have sensitized SRRW to be acutely conscious of being objectified and disempowered. Insofar as the “normal” childbirth in the U.S. is about engaging with the body in the biomedical setting (Cosans 2001), then how the HCP perceive FGC body will determine the scope of these clinical experiences for themselves and for the SRRW seeking care. A key finding from the CCM analysis indicates that the two groups hold different normative beliefs and practices on childbearing. The most salient theme of these variations in the childbearing domain further underscores the cultural differences on what constitutes normal or natural childbirth. Here, the overwhelming majority of SRRW considered childbirth a natural process rather than a medical condition; furthermore, all of them believe that childbearing outcomes –from pregnancy to birth – are ultimately determined by God and neither the science of medicine nor anything else could change that which God decreed. The supremacy of God’s will was unequivocally clear in the CCM results as it was in the ethnographic analysis. As noted above, however, this reliance on God’s Will should not be interpreted as fatalistic passivism.

In spite of an overall intra-cultural agreement on childbearing model across all three subdomains, there were noticeable variations between the Southern and the Bantu SRRW and within the Northern-SRRW. The pattern variations between the Southern and the Bantu-SRRW were not surprising, given that the Bantu were socially and culturally isolated from the broader Somali society pre-migration. This enabled them to retain their ancestral traditional African views to explain misfortunes and to amalgamate these views with similar views regarding the evil eye from the Islamic perspectives. Based on this belief, they are guarded regarding early disclosure of pregnancy status either verbally or in seeking prenatal care such as diagnostic ultrasound. The Northern-SRRW, on the other hand, did not meet the criteria of cohesive cultural group. As postulated earlier, this may be the effects of acculturation and other socioeconomic variables within the group. Another reason might be their smaller sample size in Arizona relative to the other groups. Despite these intra-cultural variations, the CCM analysis overall supports that there is a Somali childbearing model that is distinctly different from the HCP model. The cross-cultural variations pattern in all three subdomains underscores the childbearing model differences. Also, how these differences are often (mis)handled resulted in a general consensus among SRRW that childbirth experience in America was more stressful due to cultural and language barriers.

Although the HCP childbearing model differed significantly from the SRRW model, the HCP were not a monolithic group. Some of the views in fact were closely aligned with the SRRW beliefs. For example, 39% of the HCP believed that delaying presenting to the hospital does in fact increase the chance of vaginal delivery. Similarly, about a third of the HCP disagreed with their cohort but agreed with the SRRW on the question of whether or not epidural impedes the mother's control in birthing process and also on the assessment that SRRW have higher pain tolerance during childbirth. Also, a

high number (47%) of the HCP believes that childbirth outcomes are ultimately in the hands of God, though there was no such close alignment on the effectiveness of prayers in order to avoid C-section. This divergence on some questions notwithstanding, the general consensus among HCP in this study was that women with FGC status have an increased risk of adverse childbirth outcomes and that such women present ethical and moral dilemma. Yet, the literature on the risk of FGC and childbirth is not so conclusive.

Studies have postulated several factors which contribute to adverse childbirth outcomes among Somali refugee/immigrant women. For example, healthcare providers' lack of cultural knowledge of FGC may exaggerate obstetric health risks (Essen et al. 2000) that have been claimed by the global health and anti-FGM activist organizations. Lack of cultural knowledge among healthcare providers has been suggested to contribute to unnecessary cesarean deliveries among Somali refugee women (Small et al 2008; Thierfelder et al. 2005). Other factors include: language barriers (Brown et al. 2010; Bulman and McCourt 2002; Carroll et al. 2007; Chalmers & Hashi 2000 Morris et al. 2009); negative perceptions of FGC (Bulman and McCourt 2002); discrimination (Essen, Binder and Johnsdotter, 2011; Herrel et al. 2004); cultural differences between Somali women and healthcare providers on what constitutes normal pregnancy and childbirth (Essen et al. 2002, 2011), and cultural differences on the meaning of motherhood and fertility (Hernandez 2007; Salem et al. 2012). Collectively or individually, these factors may contribute to suboptimal care in terms of access and quality as well as the care-seeking behavior of SRRW. This directly or indirectly adversely affects childbirth outcomes and widens the reproductive disparities between Somali and native born women in the host nations (Eseen et al. 2002).

While FGC presents a unique complication, suboptimal healthcare including prenatal care and childbirth and the consequent adverse outcomes, however, are not

limited to Somali refugees/immigrants. It has been reported to contribute to the overall reproductive health disparities in other minority population in the developed nations (Alderliesten et al. 2008; Bollini et al. 2009; Ekeus et al. 2011). Race/ethnicity and discrimination are the underlying causes of these disparities (Krieger 1999). In the U.S., racial health disparities are well documented and described. In fact, the concept of cultural competence has emerged as one strategy to redress this disparity and has become more pertinent in the light of changing U.S. demographics (Betancourt et al. 2003).

Summary

As presented in my positionality section, I came to this topic of dissertation while working with Crista Johnson-Agbakwu as one of her research assistants. It was the data she had collected on Somali refugee women in Ohio that motivated me to explore this topic further. Based on her preliminary data analysis, the Somali refugee women did not associate FGC with adverse childbirth outcomes as some of studies had suggested. The health consequences of FGC reported by some of her project participants were ones related to pain with sexual intercourse, menstrual difficulties, and urinary tract infections. These women expressed experiencing anxiety when seeking care because of what they perceived as providers' lack of the necessary cultural knowledge to care for women with FGC. Furthermore, there was a significant fear of the medicalized childbirth. These anxieties and fear led to reluctance towards and even resistance to routine obstetric care.

These preliminary findings were consistent with emerging studies on Somali refugee/immigrant women living in the West which allude to cultural discordance

between Somalis refugees/immigrants and their healthcare providers. My approach in undertaking this study was to quantitatively and qualitatively explore and identify these patterns of cultural variations in the domain of childbearing within and between SRRW and HCP in Arizona. I also aimed to explore and describe how cultural perceptions of FGC are embodied and how that affects the clinical encounter during obstetric care. I set out to examine the complexities of SRRW's childbearing experiences in the context of migration and female circumcision and provide more a nuanced perspective on how culture shapes knowledge and how subjective and intersubjective perceptions are embodied and gives meaning to experiences.

To achieve these aims, it was first necessary to probe normative childbearing beliefs and practices by quantitatively analyzing the patterns of variations between SRRW and HCP in this domain of knowledge. In the context of the growing Somali refugee population in Arizona, it is important to understand exactly on what the two groups agree upon and where they disagree so as to address the cultural gap and improve birthing experiences and reduce reported reproductive disparity burden among SRRW. This will also reduce frustration and stress among HCP. Findings in this study support the fact that that SRRW and HCP do indeed have significant cultural differences about what constitutes normative childbearing beliefs and practices. That, however, does not mean the absence of areas of agreement between the two groups, as discussed earlier. Secondly, literature on Somali refugees/immigrant often ignores the cultural diversity within the Somalis, which motivated me to explore intra-cultural variations on childbearing model. Therefore, I sought to examine if there is a single Somali childbearing model and as the previous chapters demonstrated there are intra-Somali regional differences. Despite this variation, however, the CCM analyses demonstrate that, overall, the SRRW are a culturally cohesive group who agree more with each other

than with the HCP. The SRRW participants in this study have their own childbearing cultural model which is sufficiently different from the model held by the HCP participants.

Medical anthropologists and other scholars have problematized the Cartesian duality which separates the nature/body from culture/mind that is the normative *modus operandi* in biomedical establishments. Instead, alternative concepts like the *Mindful Body* and *embodiment* have been proposed to better capture the intimate interplay of biology, history, and sociocultural elements that literally *constitute* the human body. While all humans have bodies, their bodies are in actuality context dependent at the cellular and gene level where deprivation, distress, marginalization, and environmental toxins leave an indelible mark embodied for generations. How does the embodiment of FGC play out in the clinical encounter? That is the final objective which I aimed to explore using a phenomenology methodology. The rationale of this objective was to describe subjective and intersubjective embodiment of the circumcised SRRW body and to shed light on how and why perceptual experiences convey meanings and shape patient-provider interactions. The Phenomenological analysis in this project suggests that the preobjective perceptions shape their normative beliefs on what the individual and the collective circumcised bodies represent. To the HCP, this body is defective and raises a red flag of danger and risk that requires the benevolent power of biomedicine authority and technology to intervene. Also, the mere FGC status symbolizes to them that this body is victimized by an oppressive primitive and as such must lack agency. The resistance of SRRW to bio-obstetric interventions both confronts and confirms HCP's preobjective perception to whom such resistance seems irrational and based on a fatalistic religious faith. FGC status distinguished the SRRW as the "other" and signified

everything about the Somali society and culture. The resultant tension between SRRW and the HCP is one about power, control, and resistance which are also embodied.

My approach in this study adds another dimension to the body of literature on FGC and on minority health disparity by exploring the complexities of SRRW's childbearing experiences in the context of migration and female circumcision. By juxtaposing the SRRW and HCP cultural beliefs and the embodied subjective and intersubjective perceptual experiences of being-in-the-world, I have attempted to provide a more nuanced perspective on culture and to underscore its influences in shaping normative beliefs in childbearing practices and the multiplicity of existential meanings the FGC body conveys when encountered. Key findings from the quantitative and qualitative analyses support the centrality of culture in the study of the normative childbearing beliefs and practices; equally, embodiment of FGC is about cultural perception of being-in-the-world. What we know, believe and practice in our day-to-day life is learned based on meaningful engagement with other members from our cultures. Also, the meanings we attribute to a cultural phenomenon such as childbirth or of FGC are shaped by our cultural environments and experiences. Another important finding of this project challenges what other studies have postulated to be the reason for Somali women's resistance to interventions such as C-section. These studies have attributed the resistance to fears of death and of other serious complications that SRRW might have experienced or heard about before immigration (Brown et al. 2010; Essen et al. 2011). The participants in this project, however, explain that they do not fear their or their child's death because that is after all in God's hand but they resist C-section because it will "mutilate" their bodies. It is ironic that bodies which biomedicine and its providers consider "mutilated" by FGC fear being "mutilation" by biomedicine and its practitioners.

The voices of the SRRW participants in this study seek to be heard and insist they not be seen as defective bodies or oppressed victims of a barbaric culture, but as women endowed with will and rational minds with the capacity to grapple with complicated issues and to decide what is best of them and their families. They are very aware of being perceived as “other” in multiple ways, as being Refugees, Black, Somalis and Muslim and all the negative attributes and images these labels conjure. In post-migration context, they are also aware of the intense negative perception of their bodies modified by female circumcision, euphemistically referred to as “female genital mutilation” in the global discourse and in most biomedical settings. Time and again during this project, participants asked that I represent them accurately and convey their side of the story and their concerns to HCPs. They want their providers to understand that they resist being coerced or rushed to comply with unnecessary obstetric interventions for the convenience and/or financial gains of the HCP at the expense of violating their bodily integrity, their faith and their embodied sense of being-in-the-world – the existential body.

Global health discourse increasingly framed as a universal human rights matter abstracts the body from its socio-cultural-historical context. Add to that preexisting colonial construction of the “other”, the biomedicalization of childbirth, the ever increasing South-North migration, and negative and sensationalized portrayal of Somalis and Muslims that are not balanced by positive humanizing images. All these elements inform the different subjective and intersubjective perceptual experiences of being-in-the-world of SRRW and HCPs. It is at this juncture of intersubjective engagement between cultural bodies that FGC embodiment of the “other” body emerges. By juxtaposing SRRW and the HCP individual perceptions of female circumcision and

childbearing, we begin to understand how complex and emotionally charged this cultural body is experienced and lived subjectively and intersubjectively.

Implications of Research Findings

1. There is a need for didactic training of Ob/Gyn healthcare providers to be competent in managing women with FGC. Somali refugee women place high value to competent and empathetic healthcare providers rather gender and or race/ethnicity of providers.
2. FGC bodily status alone should not justify biomedical intervention in the childbirth process.
3. It is not enough to have female trained interpreters but also culture brokers involved in healthcare institutions catering to Somali refugee women.
4. Religious and community leaders have to be part of the outreach efforts in educating the community of the U.S. childbearing standard procedures and rational for emergency interventions.
5. Cultural competence training in the medical education need to emphasis self-awareness and reflexivity rather than the mechanistic do's and do not that have potentials to perpetuate stereotypes by narrowly define and confine cultures and objectify individuals.
6. Need for evidence-base studies that document purportedly high risk and dangers of FGC & childbearing and to differentiate between how much of these risk/danger are "direct" consequences physical/anatomical changes and how much of them are "indirect" and resulting from delay/avoidance tactics of SWRR or lack of training of their providers or both.

Challenges, Limitations, and Future Research

The challenges of conducting cross culture research are well documented. I have addressed some of these challenges and how I negotiated them in the methodology section of this dissertation. These challenges included having access to SRRW and the HCP, language barriers with SRRW who did not speak English or Kiswahili, and constructing the CCM questionnaire that is culturally relevant to all groups of participants. The focus of this study, the limited sample, and time constraints dictated that I prioritize having survey questions that make sense culturally to the SRRW rather than balancing the questionnaire to capture the both group's cultural perspectives. This is one of the limitations of this study. Not analyzing how educational attainment, duration of resettlement, age at migration and type of FGC may affect responses across all 87 questions was another limitation. Exploring these issues are potential areas for future research.

The topic of FGC is controversial to say the least, asking HCP about their perceptions of FGC and their experiences in dealing with Somali women in childbearing entails reflecting on their own their beliefs, practices, and understanding about race/ethnicity, gender, religion, the body, and cultures. Such critical self-reflection is difficult enough for anybody without having the added burden of sharing that information with another person. It is even more difficult in a society where political correctness and tolerance of cultural diversity are considered the mark of civility. In these circumstances, expecting the HCP's disclosure of their perceptions may be inherently problematic and this could also be a limitation of this project. In fact, I sensed such reluctances during semi-structured interviews in a couple of the HCP.

For future research, this methodology could be applied in the study of other marginalized minorities, especially newly arrive refugees from non-Western nations to examine their childbirth experiences in America. Additional important research area could compare the perspectives of Somali women in the diaspora. Such studies may examine these women's childbearing experiences between Europe and North America, for example, or between Western and non-Western countries or compare first generation Somali immigrants and their Western born offspring who have reached reproductive age.

Conclusion

The biomedicalization of childbearing was conceived as means to safeguard women and their families from the perils associated with this natural bodily process, but in the process it has decontextualized the body from its cultural milieu. The biomedical model defines the body and bodily existential experiences of being-in-the-world in a narrow and a specific ways, with little room to accommodate alternative perspectives let alone allow the negotiation or contestation of its interventions. This is in large part due to the body-mind and objective-subjective dualism where the former is considered to be the domain of science and the latter relegated to metaphysics. If these attitudinal stances are normative among HCP and are left unexamined from within the biomedical culture, they will only serve to sustain the construction of the "other" and reinforce anxiety, fear and distrust among SRRW and other minority communities seeking care. Consequently, we will miss the very ethical and moral attempts to readdress the disproportional higher burden of reproductive disparities that currently exists in the Somali refugee women and other minority population in Arizona, in the wake of demographic shift in the U.S.

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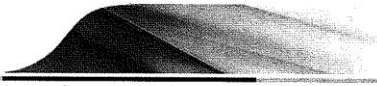
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APPENDIX A


INSTITUTIONAL REVIEW BOARD HUMAN SUBJECTS EXEMPTION


PHASE I & II IRB APPROVAL



Office of Research Integrity and Assurance

To: Alexandra Brewis
ANTH

From:  Mark Roosa, Chair
Soc Beh IRB

Date:  04/09/2010

Committee Action: Exemption Granted

IRB Action Date: 04/09/2010

IRB Protocol #: 1003005011

Study Title: Somali Women and US Clinicians: Understanding Childbearing Practices

The above-referenced protocol is considered exempt after review by the Institutional Review Board pursuant to Federal regulations, 45 CFR Part 46.101(b)(2).

This part of the federal regulations requires that the information be recorded by investigators in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects. It is necessary that the information obtained not be such that if disclosed outside the research, it could reasonably place the subjects at risk of criminal or civil liability, or be damaging to the subjects' financial standing, employability, or reputation.

You should retain a copy of this letter for your records.



Office of Research Integrity and Assurance

To: Jonathan Maupin

for From: Mark Roosa, Chair *SM*
Soc Beh IRB

Date: 01/18/2011

Committee Action: **Exemption Granted**

IRB Action Date: 01/18/2011

IRB Protocol #: 1101005880

Study Title: Somali Women and U.S. Clinicians: Understanding Childbearing

The above-referenced protocol is considered exempt after review by the Institutional Review Board pursuant to Federal regulations, 45 CFR Part 46.101(b)(2).

This part of the federal regulations requires that the information be recorded by investigators in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects. It is necessary that the information obtained not be such that if disclosed outside the research, it could reasonably place the subjects at risk of criminal or civil liability, or be damaging to the subjects' financial standing, employability, or reputation.

You should retain a copy of this letter for your records.

INTERVIEW INFORMATION LETTER

SWAHILI INTERVIEW RECRUITMENT SCRIPT *Barua ya Kiswahili ya ushirikiano ya utafiti*

Wanawake wa Kisomali na Wanazahanati za Marekani: Kufahamu Mazoezi ya Uzazi.

Tarehe: 20 Oktoba 2010.

Salamu kwa anayehusika na kujadiliana na utafiti huu,

Mimi ni mwanachuo ambaye ninamaliza masomo chini ya uongozi wa Profesa Jonathan Maupin, kwenye Idara ya Anthropologia, Shule ya Mageuko ya Binadamu na Mabadaliko ya Kijamii, Chuo cha Sanaa za Kilebrali cha Chuo Kikuu cha Arizona State University (ASU).

Ninafanya utafiti wa kufahamu vizuri zaidi kuhusu maana, na matokeo ya uzazi katika jamii ya wanawake wa asili ya Kisomali hapa Marekani. Ninaomba ushirikiano kwenye mazungumzo haya ambayo yatachukua muda wa saa mmoja takriban. Nitakualiza masuala juu ya uzazi wako, vile ilivyokua na matokeo yake hadi kuzaa. Upo huru kukataa kujibu au kughairi kujibu saa yoyote bila ya lawama.

Ingawa hutopata faida ya binafsi (kama kulipwa) kutokana na ushirikiano huu, majibu yako yataweza kutumika kwenye uchapishaji au kwenye mambo mengine ya kitaalamu. Kushiriki kwako hakuna uhatarishaji au mambo ya kuleta shida ya baadaye.

Majibu wako watakua ya siri. Sitatumia jina lako au kitambulisho chochote chako ambacho itawezeka kukutambulisha. Nitatumia nambari ya siri badala ya jina lako. Kwahizyo kila utachosema tikahifadhiwa ili usitambuliwe, jina lako halitokumiwa kwenye utapishi wowote. Kitabu cha kodi ya siri kitaandikwa jina lako na hio nambari ya siri. Iwapo nitatumie maneno wako, hio nambari ya siri ndio itawotumiwa. Kibatu hicho kifungiwa kabatini ilowepo chumba 155 ndani ya offisi ya SHESC.

Nikakuomba ruhusa kuchuku sauti wako kweje tepu rikoda. Tafadhali niambie kama hutaki nikurikodi. Pia unaweza kubadili kauli yako saa yoyote, hata baada ya kwanza mazungumzo haya. Tepu ya sauti itahifadhwa katika kabati (chumba 155 offisi ya SHESC) na baada ya kumaliza kazi ya kusikiliza na kuandikwa mameno hayo, tepu itafutwa baina ya miezi 12.

Umefahamu barua hii? Unamasuali yoyote? Umekubali kushirikiana nami?

Ukiwa na masuala yoyote kuhusu utafiti, tafadhali wasiliana na kikundi cha utafiti:

Lubayna Fawcett
School of Human Evolution and Social Change (SHESC)
Arizona State University, Tempe, AZ 85287
Ph: (480) 451-7775; email: lubayna.fawcett@asu.edu
Au

Dr. Jonathan Maupin
School of Human Evolution and Social Change (SHESC)
Arizona State University, Tempe, AZ 85287
Ph: (480) 727-9879; email: jmaupin@asu.edu

Ukiwa na masuala yoyote kuhusu haki zako kama ni mmoja/mshiriki katika utafiti huu, au ukihisi umewekwa kwenye kuhatarisha, unaweza kuwasiliana na Chair of Human Subjects Institutional Board, kwa kupitia ASU Office of Research Integrity and Assurance, at (480) 965-6788.

Wako mkweli,
Lubayna Fawcett

English Recruitment Script for INTERVIEWS

Somali Women and U.S. Clinicians: Understanding Childbearing Practices

Date 20 December 2010

Dear Participant:

I am a doctoral candidate under the direction of Professor Jonathan Maupin in the Department Anthropology, School of Human Evolution and Social Change, College of Liberal Arts at Arizona State University.

I am conducting a research study that aims to explore perception, knowledge, and understanding of Somali-born women's beliefs and practices regarding childbearing. I am inviting your participation in an in-depth interview involves answering questions for about 30-60 minutes. You have the right not to answer any question, and to stop the interview at any time.

Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, there will be no penalty.

Although you will receive no personal benefit from answering questions (such as pay), your ideas may be used in publication or for other academic purposes.

Should your words be repeated, your name and identifying information will not be used. To maintain your confidentiality, the researcher will associate your name with an identification number. All notes containing your words will use only that number. A separate codebook will connect your name and identification number. That book will be kept in a separate location from the notes and will be protected by secret password (in case of electronic file) or locked cabinet (in case of paper copy) in room 155 in SHESC.

I would like to audiotape this interview. The interview will not be recorded without your permission. Please let me know if you do not want the interview to be taped; you also can change your mind after the interview starts, just let me know. The tapes will be kept in locked cabinet (in room 155 in SHESC) and will be destroyed (shredded) after transcription is completed within 12 months.

Do you understand what I have read? Do you have any questions? Do you agree to participate?

If you have any further questions concerning the research study, please contact the research team:

Lubayna Fawcett

School of Human Evolution and Social Change

Arizona State University, Tempe, AZ 85287

Ph: (480) 451-7775; email: lubayna.fawcett@asu.edu

OR

Dr. Jonathan Maupin
School of Human Evolution and Social Change
Arizona State University, Tempe, AZ 85287
Ph: (480) 727-9879; email: jmaupin@asu.edu

If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Institutional Review Board, through the ASU Office of Research Integrity and Assurance, at (480) 965-6788. Please let me know if you wish to be part of the study.

Somali Women and U.S. Clinicians: Understanding Childbearing Practices.
Cover Letter

Date 20 December 2010

Dear Participant:

I am a doctoral candidate under the direction of Professor Jonathan Maupin in the Department Anthropology, School of Human Evolution and Social Change, College of Liberal Arts at Arizona State University.

I am conducting a research study that aims to explore perception, knowledge, and understanding of Somali-born women's beliefs and practices regarding childbearing. I am inviting your participation in filling out a cultural consensus survey, a simple yes/no questionnaire consisting of 87 items, in addition to questions on socio-demographics, obstetrics-gynecology history, and acculturation. This survey will take approximately 30-40 minutes of your time.

Your participation in this study is voluntary. You can skip questions if you wish. If you choose not to participate or to withdraw from the study at any time, there will be no penalty.

Although you will receive no personal benefit from answering questions (such as pay), your ideas may be used in publication or for other academic purposes.

To maintain your confidentiality, the survey will not have your name. The researcher will associate your survey response with an identification number. All notes containing your words will use only that number. A separate codebook will connect your name and identification number. That book will be kept in a separate location from the notes and will be protected by secret password (in case of electronic file) or locked cabinet (in case of paper copy) in room 155 in SHESC. The results of this study may be used in reports, presentations, or publications but your name will not be known.

Do you understand what I have read? Do you have any questions? Do you agree to participate?

If you have any further questions concerning the research study, please contact the research team:

Lubayna Fawcett
School of Human Evolution and Social Change
Arizona State University, Tempe, AZ 85287
Ph: (480) 451-7775; email: lubayna.fawcett@asu.edu
OR

Dr. Jonathan Maupin
School of Human Evolution and Social Change
Arizona State University, Tempe, AZ 85287
Ph: (480) 727-9879; email: jmaupin@asu.edu

If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Institutional Review Board, through the ASU Office of Research Integrity and Assurance, at (480) 965-6788.

Please let me know if you wish to be part of the study.

Somali Cover Letter

(CCM Survey)

Somali Women and the U.S. Clinicians: Understand Childbearing Practices.

Cover letter to the Cultural Consensus, Sociodemographics, Obstetrics/Gynecology history, and Acculturation Survey

Date: 20 Disemba 2010

Haweenka Soomaliyeedh iyo takhaatiirta Mareykanka: Aqoon baaris ujeedaduna tahaay isfahamkoodha. Sida taranta bulshada, isfahamka kusaabsan liqabsiga daqanka, iyo takhaatiirta cuduraha haweenka.

Taariqda:

Marwooyin Soomaliyeedh,

Waxaan ahaay ardeyad jaamici (graduate) lishaqeeyo Professor Janathan Maupin, kashaqeeyo isguulka kusabab barashada daqanadha, sido kale isguulka isbedelka umadeed iyo bulsho, Jaamacadha Gobolka Arizona.

Waxaan baaraya aqondarisnujeedadiisu tahay faham balaaran oo udhaxeeya taqaatiirta kutaqaasustee cuduradha haweenka dareen kooda, iyo fahaamka uleeyihiin dumarka Soomaaliyeed oo qahootiga iyagoo kadigtoonaya daqanada iyo aamisnaanta aay kaqabaan dhalmada. Waxaan idhinkucazuumaya kaqeebqaadashada buuhinta fomka cilmi barista islifahanka daqan. Fomka waxaa u kakoobanyahay 87 soaalo oo ubadan haa iyo maya oo kuguqaadankarta 30-40 daqiiqo oo waqti gaaga.

Kaqeebqaadashada cilmi baaristani waa akhtiyaar. Hadhii aad rabto waadkaboodhi kartaa soasha aadhan rabin innaadkajawaabto. Cilmi baaristan, markaad donto baad katagikarta iyadho wax diba kaasoogaarin.

Waxaa suragala in loo isticmaalo jawaabtadha aqoon kororsi daabacaad gasha. Majirto Qatar iyo fadeexad kaagaimaankarto cilmi baaristaan.

Cilmi barista waxaa lagu qabanaya “Survey Monkey.com” iyo waraaqaha lagudiro boostada. Sida daraaded jawaabtaadu waa sir. Waxii kazoo behe cilmi baaristaan, waa suargala in loo isticmaalo warbixin iyaddoo marna aay kujirin magacaa.

Fadlan maiitujumi karta? Mafahantey waxii aankuuakhriyey?

Waxii suaala? Maogoshahay in aadh kaqeebqaadato?

Hadii aad sual kaqabto cilmi baaristaan, fadlan laxariir Koxda climi barista:

Lubayna Fawcett

School of Human Evolution and Social Change

Arizona State University, Tempe, AZ 85287

Ph: (480) 451-7775; email: lubayna.fawcett@asu.edu

Ama

Dr. Jonathan Maupin

School of Human Evolution and Social Change

Arizona State University, Tempe, AZ 85287

Ph: (480) 727-9879; email: jmaupin@asu.edu

Hadii aad waxsualo kaqabto xuquqahaga kaqebgalka cilmi baaristaan amaa aad umaleynayso inaad wax qatara aad kujirto, waxaad lixirrikarta Maamulka Cilmi Baaristaa ASU, Ph: (480) 965-6788.

Swahili Cover Letter for Somali Women

Wanawake wa jinsia ya Kisomali na Watibabu wa Kimerikani: Ufahamisho wa tabia za kizazi Somali Women and U.S. Clinicians: Understanding Childbearing Practices. Cultural Consensus Survey Cover Letter
Arizona State University.

Ninafanya utafiti wa kufahamu bora sehemu ya uzazi kati na baina ya jamii ya wanawake wa jinsia ya Kisomali na watibu wa aafya wa wanawake na kizazi hapa Merekani. Hasa, tunataka kufafanua na kufahamu vipi wanatafuatiana kwenye mawazo, fahamu, na ujuzi wa kuzaa. Nakukaribisha ujibu maswali mafupi idadi yake ni 87, ambayo yakachukua karibu ya muda wa dakika 15-20. Pamoja na kujibu maswali hukusu demografia, historia kuhusu uzazi wako baina ya kabla ya uhamiaji na baada ya uhamiaji, pamoja na kuelewa daraja ya mawoea ya tabia za kigeni.

Majadiliano wako ni ya hiari. Unaweza kujibu unavyokata hata bali kughairi kujibu wakati wowote.

Kwa majadiliano wako ya hiari, na muda wako wa majidiliano, utatunza na \$10.00 (gift certificate). Majibu yako yatatumiwa kwa maandhishi ya kisomo rasmi. Hatutotumia jina lako wala kitambulisho chochote ambacho kitaweza kukufananua wewe binafsi. Majadaliyano wako kwenye utafiti huu hautarajiwi kuwa na dhara yoyote kwako.

Utafiti huu utafanyika uso kwa suo, lakini tunashititiza kuwa majibu wako yatahifadhiwa bila ya utambuzi wowote ambao utahusiana nao au kukutambua wewe binafsi.

Iwapo una maswali juu utafiti huu, tafadhili jadiliana na temu ya utafiti huu hapo:

Lubayna Fawcett
School of Human Evolution and Social Change
Arizona State University, Tempe, AZ 85287
Ph: (480) 451-7775; email: lubayna.fawcett@asu.edu

OR

Dr. Alexandra Brewis Slade
School of Human Evolution and Social Change
Arizona State University, Tempe, AZ 85287
Ph: (480) 727-9879; email: alex.brewis@asu.edu

If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Institutional Review Board, through the ASU Office of Research Integrity and Assurance, at (480) 965-6788.

Lazima utamke ua uweke saine wako kuwa umekubali kwa hiari kujadiliana kabla ya kuanza majibu.

Kwa heshima,

Lubayna Fawcett

In-Depth Interview Recruitment Letter

I am a graduate student under the direction of Professor Alexandra Brewis-Slade in the Scholl of Human Evolution and Social Change, College of Liberal Arts at Arizona State University. I am conducting a research study to better understand structural and cultural barriers that may explain poor childbearing outcomes among Somali women from obstetric and gynecology providers' perspectives.

I am recruiting health care providers with and or without experiences in providing obstetric and gynecology care to Somali immigrant women to participate in one-to-one in-depth semi structured interview lasting approximately 60 minutes.

Your name will not be used and or any other identifier will be protected. The interviews will be audio recorded and the tapes will be stored in locked cabinet in Dr. Brewis-Slade's ASU office when not being transcribed. The audio tapes will be erased and transcribed texts will be destroyed after twelve months of data collection.

Your participation in this study is voluntary. If you have any questions concerning the research study, please call me at (480) 451-7775, or Dr. Brewis-Slade at (480)-727-9879.

**Obstetric & Gynecology Care Providers
Questionnaire: Socio-demographic and Experience**

Age 21-29 30-39 40-49 50-59 60-69 70-over

Ethnicity African-America White Hispanic Asian-American Other
Born in the U.S.? Yes No

Sex Female Male

Profession	Years in Practice (since completed training)				
	0-5	6-9	10-15	16-20	20 & over
M.D.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Midwife	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N.P.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RN/LPN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fellow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Experience

In the past have you provided OB-GYN care to patients with female genital cutting?
Yes No

If yes, how many?

Less than 5 Less than 20 More than 20 More than 50

Do you currently provide OB-GYN care to women with female genital cutting?

Yes No

If yes, mostly with:

Type I Type II Type III Other

Does your current patient population include Somali refugee/immigrant women?

Yes No

If yes, how many?

Less than 5 Less than 20 More than 20 More than 50

Please rank most common to least common type of FGC you have encountered:

Type I Type II Type III Other

Did you receive special (didactic) training in caring for women with female genital cutting as part of your training? Yes No

Would you recommend special (didactic) training to OB-GYN providers who care for women with female genital cutting? Yes No

APPENDIX B
SURVEY FORMS

Section I. (A-D) Pregnancy and Prenatal Care: Practice and Beliefs:

I. A.	Prenatal Care		
1.	Pregnancy makes a woman more vulnerable to other illness	T	F
2.	All pregnancy requires a medical management by a doctor:	T	F
3.	Pregnancy must be kept a secret until after 3 months or longer:	T	F
4.	The first 3 months of pregnancy are the most dangerous period for the mother	T	F
5.	Pregnant women are most susceptible to evil eye	T	F
I. B.	Prenatal Care		
1.	Doctors should be consulted only when there is a problem with pregnancy	T	F
2.	Pregnant women should not see a medical provider before three months into pregnancy:	T	F
3.	Pregnant women need to eat a special diet:	T	F
4.	The more successful pregnancies one has had, the less need there is to seek prenatal care before six months:	T	F
5.	Women are more likely to attend prenatal care when provided are female.	T	F
6.	In your opinion, female genital cutting (FGC) makes it uncomfortable for women to seek prenatal care:	T	F
7.	Prenatal care involves painful pelvic exams:	T	F
8.	It is important to attend all prenatal care appointments for the health of the baby and mother:	T	F
9.	Internal pelvic examination are not good for the pregnant mother:	T	F
	Ultrasound		
1.	It is necessary to have an ultrasound during pregnancy	T	F
2.	Ultrasound have to be done before six months into pregnancy	T	F
3.	Ultrasound information is only useful to the doctors	T	F
I. D.	Due-date		
1.	Most women deliver on due-date :	T	F
2.	Only God knows the due-date:	T	F
3.	Women who do not deliver on due-dates have higher risks for complications during childbirth:	T	F
4.	It is normal for women to deliver 15 days or more beyond their due-dates:	T	F
5.	Going past due-date increases the risk of C-section delivery.	T	F
6.	Going past due-date increases adverse risk of childbirth complications.	T	F

Section II. (A-J) Childbirth Practice, Technology, and Beliefs:

II. A	Childbirth		
1. Childbirth is extremely dangerous for all women		T	F
2. Women should only give birth in a hospital		T	F
3. Only female relatives/friends should be in the delivery room		T	F
4. Pregnant women should not be walking around during labor		T	F
5. Squatting is the best position for the mother during childbirth/delivery		T	F
6. In my opinion, childbirth in the U.S. is more difficult for Somali/African immigrant women compared to U.S .born women		T	F
7. Childbirth outcomes are in God's hands.		T	F

II. B.	Female Genital Cutting (FGC) and Childbirth		
1. In your opinion, only type of FGC is associated with increased risk of adverse childbirth.		T	F
3. In my opinion, FGC does not increase the risk of adverse childbirth outcomes:		T	F
3. In my opinion, women with FGC in Africa have greater risks of childbirth complications than women with FGC giving birth in the U.S.:		T	F
		T	F
5. In my opinion, women with FGC should have a midwife rather than a doctor to deliver babies		T	F
II. C.	Presenting for childbirth:		
1. Pregnant women should present to the hospital at the first sign of labor		T	F
2. Presenting to the hospital before imminent birth increases the risk of having cesarean birth:		T	F
3. Risk of induced labor increases when one present to the hospital before birth is imminent:		T	F
		T	F
4. Delaying going to the hospital increases women's chances for vaginal delivery:		T	F
		T	F
II. D.	Defibulation (surgical opening of the sutured/infibulation of the labia majora, i.e. type 3 FGC)		
1. It is necessary to perform defibulation before every childbirth on women with type III FGC:		T	F

2. Once a woman is married, defibulation is not necessary for safe childbirth:	T	F
II. E. Re-infibulation: (suturing/restoring type 3 FGC/infibulation)		
1. All women with FGC should be re-infibulated (sutured back to restore type 3 FGC) after vaginal childbirth:	T	F
2. To avoid re-infibulation, women with FGC should be have cesarean operation birth:	T	F
4. Re-infibulation is illegal in the U.S.:	T	F
II. F. Fetal Monitors		
1. In my opinion, compared to U.S. born women, Somali/African immigrant women do not like to be attached to machines (fetal monitors, IV, etc.) during labor and delivery:	T	F
2. In my opinion, most Somali/African immigrant women get anxious when attached to machines (Fetal monitors, IV, etc.) during labor and delivery:	T	F
II. G. Induced Labor		
1. Induced labor (e.g. with <i>Pitocin</i>) invalidates nature's way of childbirth:	T	F
2. Women should be allowed to use their own cultural methods (e.g. herbs, manual massage, etc.) to induce labor:	T	F
3. In my opinion, women with FGC require induction (e.g. with <i>Pitocin</i>) to facilitate childbirth:	T	F
II. H. Episiotomies		
1. It is better to have a cesarean than to have episiotomy for women with type 3 FGC:	T	F
2. Episiotomies are necessary to avoid major tearing during childbirth for women with FGC:	T	F
3. In my opinion, women with FGC have more problems after mediolateral episiotomies than other women without FGC:	T	F
II. I. Epidural and Childbirth Pain		
1. Labor pain is part and parcel of "natural" (vaginal) childbirth:	T	F
2. Epidurals are dangerous for the mother	T	F
3. Enduring labor pain brings God's blessings to the mother during childbirth:	T	F
4. In my opinion, African immigrant women have higher tolerance to childbirth pain than U.S. born women:	T	F
5. Epidurals prolong delivery:	T	F
6. Epidurals interfere with mother's control of her birthing process:	T	F
7. Most American doctors believe childbirth should be pain-free:	T	F
8. A loud expression of pain during childbirth is normal:	T	F

	T	F
II. J. Cesarean		
1. Too many women in the U.S. have unnecessary cesarean operation deliveries:	T	F
2. In my opinion, Somali/African immigrant women are least likely to have cesarean delivery than other women in the U.S.	T	F
3. Do you think that women in the U.S. with type III FGC are most likely to deliver by cesarean section?	T	F
4. Cesarean operations are not always necessary even if the baby is breech:	T	F
5. Cesarean operations are necessary when women are 15 days or over past their due date:	T	F
6. Cesarean operations are avoidable with prayers and patience during delivery:	T	F
7. Cesarean operations should only be done to save the mother's life:	T	F
	T	F
8. Once a woman has had on cesarean birth, subsequent births will most likely be by cesarean:	T	F
9. Doctors make more money performing C-sections than vaginal deliveries:	T	F
10. Male health care providers are less likely to offer cesarean operation than female healthcare providers:	T	F

III. Communication/Acculturation:

Communication/Acculturation		
1. In your opinion, speaking good English in the U.S. improves birth outcomes for Somali/African immigrant mothers:	F	T
2. Not speaking English in the U.S. increases anxiety for women in labor and delivery:	F	T
3. Women with FGC want to discuss and/or be asked about their beliefs, knowledge, and issues regarding FGC with medical staff:	F	T
4. In my opinion, the longer a Somali/African immigrant woman lives in the U.S., the more likely that she will have <i>less</i> childbirth complications:	F	T
5. It is critical to have an interpreter in the labor room for women who do not speak English:	F	T
6. In my opinion, Somali/African immigrant women have a different understanding of childbirth than those of U.S. born women:	F	T
7. In my opinion, Somali/African immigrant women cultural beliefs regarding pregnancy and childbirth runs counter to the U.S. obstetric and gynecological knowledge and practice	F	T
8. In my opinion, Somali/African immigrant women's childbirth events are more complicated compared to U.S. born women	F	T

VI. Healthcare system and culture

Healthcare system and culture		
1. The race/ethnicity of patient-provider is not an important consideration in providing Ob/Gyn healthcare	T	F
2. The gender of the Ob/Gyn provider is an important factor to Somali/African women seeking healthcare	T	F
3. In my opinion, most U.S. Ob/Gyn healthcare providers do not know how to care for women with FGC	T	F
4. In my opinion, women with FGC have different Ob/Gyn needs from other women.	T	F
5. In my opinion, women with FGC are not afforded the same respect as other women without FGC by healthcare providers.	T	F
6. Nurse midwives are more likely to give women more time to deliver vaginally than would doctors	T	F
7. Women dressed in <i>abaya</i> (Islamic dresses) are not treated any differently compared to women dressed in Western style by healthcare providers	T	F
8. Women with FGC presents moral and ethical challenge to U.S. healthcare providers:	T	F
9. U.S. Healthcare providers should take the opportunity to educate women against FGC practices when they counsel their patients.	T	F
10. Women with FGC are victims of oppressive cultures:	T	F

APPENDIX C
LITERATURE REVIEW TABLES

LITERATURE REVIEW TABLES

Authors and Year	Study site and Sample size and Selection	Aim	Methodology / Design	Results/Conclusions
Råssjö , Byrskog, Samir, and Klingberg-Allvin (2013)	Sweden. 262 Somali women and 523 Swedish-born women (through manual search of the labour ward logbooks for the years 2001 to 2009).	To analyze health problems and the outcome of pregnancies.	Retrospective, registry study Registry-base, case-control study.	Compared to Swedish born women, Somali women booked later and made less visits for antenatal care. They were more likely to have chronic infections and anemia. More likely to have emergency cesarean birth, dystocia and increased risk for intrauterine fetal death, intrauterine fetal growth restriction, and low birth weight.
Merry, Small, Blondel and Gagnon (2013)	Meta-analysis from seventy-six Western studies.	To compare caesarean rates between international migrants and non-migrants living in industrialized countries.	Meta-analysis. Seventy-six studies met inclusion.	Consistently higher caesarean rates for Sub-Saharan African, Somali and South Asian women. Emergency caesarean rates was higher for North African, West Asian and Latin American women, but lower for Eastern European and Vietnamese women. Certain groups of international migrants consistently have different caesarean rates than receiving country-born women. There is insufficient evidence to explain the observed differences.
Flynn, Foster and Brost. (2011)	U.S. Minnesota State, 584 charts reviewed, non-random sampling.	To explore effect of acculturation and preterm birth outcome	Secondary data analysis	Effects of acculturation are increasing among Somali women but did not account for increased preterm birth.

		s among Somali immigrants.		
Small et al. (2008)	Meta-analysis from six host countries: Australia, Belgium, Canada, Finland, Norway and Sweden. A total of 10431 Somali-born women and 168891 receiving country-born women.	To investigate pregnancy outcomes in Somali-born women compared with those born in each of the six receiving countries: Australia, Belgium, Canada, Finland, Norway and Sweden.	Meta-analyses to compare outcomes for Somali-born and receiving country-born women across the six host countries.	Compared with receiving country-born women, Somaliborn women were less likely to give birth preterm or to have infants of low birthweight, but there was an excess of caesarean sections, particularly in first births and an excess of stillbirths. The disparities are not readily explained and they raise concerns about the provision of maternity care for Somali women postmigration.
Maili Malin and Mika Gissler (2008)	Finland. 6,532 women of foreign origin (Somalis n= 14 [12.5%]) compared to 158,469 Finnish born women.	To compare the access to and use of maternity services, and their outcomes among ethnic minority women	Registry-base, case-control study	Women of African and Somali origin had most health problems resulted in the highest perinatal mortality rates. Women from East Europe, the Middle East, North Africa and Somalia had a significant risk of low birth weight and small for gestational age newborns. Most premature newborns were found among women from the Middle East, North Africa and South Asia.

		having a singleton birth.		Primiparous women from Africa, Somalia and Latin America and Caribbean had most caesarean sections while newborns of Latin American origin had more interventions after birth.
Yoong, Kolhe, Karoshi, Ullah and Nauta (2005)	UK 69 Somali refugees 69 British-born Caucasian women	To evaluate the obstetric performance and fetal outcomes of Somalia women; (50% had undergone circumcision).	Case control Descriptive	Somali women use less Epidural but otherwise there were no significant differences between the two groups with regard to maternal age, rates of induction of labor, cesarean sections, duration of labor, premature deliveries, instrumental deliveries, and birth weights. The demographic characteristics of the Somalian female population appear to exert minimal effect on obstetric and fetal outcomes.
Johnson, Reed, Hitti and Batra. (2005)	U.S. Washington State. 579 Somalis, 2384 Black and 2345 White women.	To compare maternal and neonatal morbidity among Somali immigrants, US-born blacks and whites in Washington state.	Retrospective, cross-sectional population-based registry study (using birth certificate data and hospital discharge records between 1993 and 2001)	Somali immigrants are a high-risk subpopulation. Cesarean deliveries in this group are associated with fetal distress and failed induction of labor. They were more likely than both control groups to deliver after 42 weeks gestation, have gestational diabetes, significant perineal lacerations. Newborns of Somali women were at increased risk for prolonged hospitalization, lower 5-minute Apgar scores, and assisted ventilation. Pregnancy outcomes should be evaluated within ethnically and culturally unique groups.

Esse'n et al. (2005)	Sweden. 68 circumcised nulliparous women from the Horn of Africa were compared to cohort of 2486 uncircumcised who gave birth at a university hospital setting in Sweden, 1990–1996.	To compare the duration of the second stage of labour between circumcised and non-circumcised women.	Retrospective, cross-sectional population-based registry study.	Circumcised women were found to have shorter (35/53 min, respectively, p 0.001) second stage labour, than the non-circumcised group. Prolonged labour does not seem to be associated to female genital circumcision in affluent societies with high standards of obstetric care.
Vangen, Stoltenber, Johansen, Sunby, and Pedersen. (2002)	Norway. Somalia (n=1733) and Norway (n=702192) birth records from 1986 to 1998.	To examine the risk of perinatal complications among ethnic Somalis and to discuss its relation to circumcision.	Retrospective, cross-sectional population-based registry study.	Somali women had more perinatal complications compared to origin than ethnic Norwegians. These included induction of labor, fetal distress, secondary arrest, prolonged second stage of labor, operative delivery and perinatal death. The results are not informative on whether the adverse birth outcomes are caused by infibulation as such or in combination with suboptimal perinatal care, intercurrent diseases and sociocultural factors. Somali women represent a high-risk group in obstetrics, calling for special attention and care.
Essen, Bodker, Sjoberg, Landhoff-Roos, Greisen, Gudmundsson, and Ostergren. (2002b)	Sweden. 63 Somali, Eritrean and Ethiopian refugee women	To test hypothesis whether suboptimal perinatal care services	Retrospective, registry-base audit of perinatal deaths between 1990-96	African refugee women had more perinatal deaths than Swedish women. The higher prevalence of suboptimal factors in the perinatal care received by children born in Sweden to mothers from the Horn of Africa was likely to result

		resulted in more perinatal deaths among East African women than Swedish women.		in a higher incidence of potentially avoidable perinatal death than their counterparts born to native Swedish mothers. Differences are attributed to different sociocultural pregnancy strategies, but also suboptimal performance of the Swedish perinatal care system.
Essen, Boöcker, Sjöberg, Gudmundsson, Östergren, and Langhoff-Roos (2002a)	(n = 32 for Ethiopia/Eritrea; n = 31 for Somalia). 63 perinatal deaths of infants born in Sweden over the period 1990–1996 to circumcised women.	to test the hypothesis that genital circumcision is a contributing factor to the increased rate of perinatal death among infants of immigrant women who gave birth in a community with a high standard of obstetric care.	Retrospective. Registry-base study.	Findings We found no evidence that female circumcision was related to perinatal death. Obstructed or prolonged labour, caused by scar tissue from circumcision, was not found to have any impact on the number of perinatal deaths. Conclusion The results do not support previous conclusions that genital circumcision is related to perinatal death, regardless of other circumstances, and suggest that other, suboptimal factors contribute to perinatal death among circumcised migrant women.

Somali refugee women with FGC: **Qualitative studies**

Authors and Year	Study site and Sample size and Selection	Aim	Methodology / Design	Results/Conclusions
Johnson-Agbakwu, Helm, Killawi and Padela. 2013. <i>Perceptions of obstetrical interventions and female genital cutting: insights of men in a Somali refugee community</i>	Purposive sampling; sample size 8 Somali men in individual interviews; 32 men participated in focus groups	To explore Somali men perspectives toward FGC and women's childbirth experiences in one refugee community in the USA.	Community-based participatory research. Individual and focus group interviews.	Somali men: (1) did not support FGC; (2) were aware and concerned about FGC-related morbidity; (3) perceived that there is an alarming increase in cesarean deliveries among their wives upon resettlement to the USA; and (4) felt excluded from the intrapartum decision-making process.
Isman , Ekéus , and Berggren (2013, Sweden) , <i>Perceptions and experiences of female genital mutilation after immigration to Sweden: An explorative study</i>	8 women from Djibouti, Eritrea, Ethiopia and Somalia. Snowball sampling.	To explore how immigrant women from countries were female genital mutilation (FGM) is normative perceive and experience FGM after immigrating to Sweden.	Semi structured and open-ended questions.	The women felt ambivalent about the practice of FGM. On one hand they recognized the negative health effects of FGM, but on the other hand, they still acknowledged the positive cultural values of the tradition. All the women said that the tradition of FGM is strongly linked to culture, identity and a sense of belonging. All the respondents stated that they

				opposed FGM, regardless of whether they had undergone FGM themselves and each expressed a desire to support change in the tradition. The study indicates that young girls still might be at risk for FGM even after immigration to Sweden.
Essen, Binder and Johnsdotter, (2011, UK) <i>An anthropological analysis of the perspectives of Somali women in the West and their obstetric care providers on caesarean birth</i>	39 Somali women and 62 obstetric care providers . snowball sampling technique	To address the relationship between Somali women and their Western obstetric care providers. And to identify potential factors which might lead to adverse obstetric outcome.		The Somali women in our study believed that C-Section delivery might likely result in maternal death, while the providers identified C-Section as preventive care that is intended for saving t to culture, he life of mother and infant. .
Ameresekere , Borg , Frederick , Vragovic , Saia , Raj (2011, USA), <i>Somali immigrant women's perceptions of cesarean delivery and patient–provider communication surrounding female circumcision and childbirth in the USA</i>	23 Somali women. Snowball sampling	To explore perceptions of cesarean delivery and patient–provider communication surrounding FGC and childbirth.	Interviews focus on birth experiences pre/ post migration, norms and attitudes on childbirth practices.	Fear: Cesarean births are associated with death or disability. Poor patient-provider communication. FGC rarely discussed by healthcare with their patients. Cultural beliefs can affect how Somali immigrant women understand labor and delivery

				practices in the USA and can explain why some women are wary of cesarean delivery.
Hill, Hunt and Hyrkäs (2012, USA), <i>Somali Immigrant Women's Health Care Experiences and Beliefs Regarding Pregnancy and Birth in the United States.</i>	18 Somali immigrant women. Convenience sampling.	To describe Somali immigrant women's health care experiences and beliefs regarding pregnancy and birth.	Focus group interviews.	American health care system is complex, difficult to navigate, and language barriers and perceptions of disrespect were deemed to be obstacles to care. Findings also indicate lack of cultural acceptability affected quality of care. Somali women had more faith in God than in medical science.
Safari (2011, UK), <i>A qualitative Study Of women's lived experience after deinfibulation in the UK</i>	9 women (Somalin =8 and Eritrean n=1) previously and underwent deinfibulation between Jan. 2008 and Sept. 2009. Purposeful sample.	To explore women's experience of deinfibulation and its aftermath.	Semi-structured interviews.	Three key themes emerged from the analysis that are particularly relevant to the work of health-care practitioners: cultural meaning and social acceptability of deinfibulation; the consequences of deinfibulation within marital relationships; and feelings about the appearance of genitalia post deinfibulation and thoughts on reinfibulation. Data suggests that deinfibulated women maybe disconcerted by

				and dislike the new appearance of their genitalia.
Brown, Carroll, Fogarty and Holt, 2010. <i>"They Get a C-Section . . . They Gonna Die": Somali Women's Fears of Obstetrical Interventions in the United States.</i>	44 Somali and Bantu Somali women.	Exploratory study to investigate prior experiences in Africa to determine if previous dissatisfaction could affect current opinions. And whether resistance to C-section and other obstetric interventions might vary according to specific practices or by Somali group.	grounded theory,	Key findings: most participants (both Bantu Somali and non-Bantu Somali women) women refused cesarean sections because of a fear of death. Somali women believe that they are often rushed labor and delivery. They felt that U.S. clinicians were more likely to introduce medical interventions to hasten delivery, to ignore natural processes, and disregard the woman's faith in God's will regarding the time of delivery.
Pavlish, Noor, and Brandt (2010, USA), <i>Somali immigrant women and the American healthcare system: Discordant beliefs, divergent expectations, and silent worries</i>	57 Somali refugee women. Purposeful sampling.	Investigate health concerns and experiences among Somali immigrant and how they manage their health.	Individual interviews and focus groups interviews. Community-based Action-research study.	There is a discordant health beliefs between Somali culture and the biomedical cultural system. Cultural misunderstandings and divergent expectations can result in unsatisfactory and unproductive relationships which could fuel disparities for some immigrant groups.

<p>Upvall , Mohammed, and Dodge (2009, USA), <i>Perspectives of Somali Bantu refugee women living with circumcision in the United States: A focus group approach.</i></p>	<p>23 resettled Somali Bantu women. Purposive sample. And one female physician caring for the Somali women during their recent pregnancies.</p>	<p>To explore healthcare perspectives of Somali Bantu refugees in relation to their status as women who have been circumcised and recently resettled in the United States.</p>	<p>Focus groups interviews. Language: Af-Maay.</p>	<p>Among the Somali-Bantu, FC is a normality rather than an aberration. Communication is underscored as a major challenge to receiving care. Marginalization continued once they arrived in the U.S. Use the traditional healing practices persist post migration.</p>
<p>Johnson, Ali, and Shipp, (2009, USA), <i>Building Community-Based Participatory Research Partnerships with a Somali Refugee Community</i></p>	<p>500 women through purposive and snowball sampling techniques. And 14 providers serving Somali women.</p>	<p>To build trust and empowerment among Somali refugees. To explore barriers and health seeking behavior among Somali refugee women.</p>	<p>Mixed-method community-based participatory research. Using Surveys (69 questions) , semi-structured focus groups, and individual interviews.</p>	<p>Community-based participatory research using mixed-methods is critical to facilitating trust building and engaging community members as active participants in every phase of the research process, enabling the rigorous and ethical conduct of research with refugee communities. This method is based on shared goals of voicing unique healthcare concerns of the community to inform the development of interventional programs to improve culturally-competent care.</p>

DeStephano , Flynn, and Brost (2009, MN USA), <i>Somali prenatal education video use in a United States obstetric clinic: A formative evaluation of acceptability.</i>	28 Somali refugee women and 25 healthcare providers. Convenience sample.	To explore acceptability of health education videos by Somali refugee women in a clinical setting.	Post-test questionnaire for clients and a self-administered questionnaire for health providers.	A video format for prenatal education is acceptable to Somali clients and recommended by providers.
Abdullahi, Copping, Kessel , Luck, and Bonell (2009, UK), <i>Cervical screening: Perceptions and barriers to uptake among Somali women in Camden</i>	Fifty Somali-born women. Snowballing sample.	To explore barriers to, and ways to improve, uptake of cervical screening among Somali women in Camden, London.	Focus group interview. Language: Somali	Majority of participants believed that a woman only got cervical cancer by the will of God; however, many recognized that additional risk factors were involved and need for screening. Concept of preventative health is unfamiliar to many Somalis, especially to new refugees. language difficulties were a barrier to attending screening, and many also expressed dissatisfaction with the quality of interpreters provided.
Ness (2009, USA), <i>Pain Expression in the Perioperative Period: Insights from a Focus Group of Somali Women</i>	4 Somali women. Sampling snowball.	To explored how pain is communicated and expressed by Somali women post general surgery.	Focus group interview	All surgeries are associated with serious illness that leads to death. Pain is freely expressed- including verbal and non-verbal means. Strong

				belief and reliance on God (Allah) to forebear and alleviate pain.
Carroll, Epstein, Fiscella, Gipson, Volpe, Jean-Pierre (2007, USA), <i>Caring for Somali women: Implications for clinician–patient communication</i>	44 Somali resettled refugee women (including Somali-Bantu). Community-based sample.	To explore and identify characteristics associated with favorable treatment in receipt of preventive healthcare services among Somali women.	In-depth interviews.	Qualities that favored receptivity to preventive healthcare services includes: respectful communication, access to healthcare services with female interpreters and clinicians, and community programs to promote health literacy. Patient-provider gender concordance is important to many Somali women, especially for gynecological concerns.
Johansen, E. 2006. <i>Care for Infiltrated Women Giving Birth in Norway: An Anthropological Analysis of Health Workers' Management of a Medically and Culturally Unfamiliar Issue</i>	Norwegian healthcare workers (n=40): 25 midwives, 12 medical doctors (nine gynecologists and three general practitioners), and three nurses. Focus on health workers' perceptions and experiences of	To examine Norwegian health workers' perceptions and experiences of Somali circumcised women in antenatal care and delivery.	In-depth interviews, participatory observations and case reviews immediately following deliveries.	Health workers in Norway experience when encounters with infiltrated women is challenging at many levels. 1. Technical challenges related to how to cut; 2. Interpretative challenges related to how to understand the pain behavior of Somali women, and 3. Emotional challenges related to caring for women who had

	circumcised women in antenatal care and delivery. Also participatory			undergone what health workers saw as the ultimate expression of male oppression and occasions of retraumatization. 4. Stigmatization and negative emotions related to FGC may also have created an emotional detachment. Key finding: health workers' efforts to provide culture-sensitive care at times led to an overinterpretation of culture. This affected care in the sense that health workers sometimes provided care procedures that were detrimental to birth care and contrary to medical guidelines and which differed from Somali personal and cultural needs.
Lundberg and Gereziher (2006, Sweden), <i>Experiences from pregnancy and childbirth related to female genital mutilation among Eritrean</i>	15 Eritrean immigrant women. Purposive sampling & snowball technique.	To explore <u>Eritrean</u> immigrant women's experiences of female genital mutilation (FGM) during pregnancy, childbirth and	Semi-structured interview and open-ended questions.	Fear of cesarean birth, and anxiety due to lack of FGC/M and childbirth knowledge. Pelvic pain- with initiation of intercourse and pelvic

<i>immigrant women in Sweden</i>		the postpartum period.		examinations. They thought that the preparation for care of circumcised women was good in Sweden (overall birth experience good -relative to home experiences). They were happy to comply with Swedish law, which prohibits re-infibulation after deinfibulation at birth. Indicated no desire to circumcise their daughters.
Berggren, Bergström and Edberg (2006, Sweden), <i>Being Different and Vulnerable: Experiences of Immigrant African Women Who Have Been Circumcised and Sought Maternity Care in Sweden</i>	21 women originally from Somalia, Sudan, and Eritrea living in Sweden. Snowball/network Sampling.	To explore the Somalia, Eritrea, and Sudan with FGC encounters with the Swedish health care system.	Explorative interviews.	The women expressed a double shame at being different. Not having FGC was perceived as shameful in the countries of origin, but to have submitted to FGC was shameful in the encounter with Swedish maternity care. Lack of individualized, culturally adjusted care, support. A need for systematic education about FGC for Swedish health care workers.
Thierfelder, Tanner, Bodiang (2005, Switzerland),	29 women from Somalia and Eritrea; 37	To gain perspectives how women with FGM	Qualitative: including focus groups among	Inadequate Ob-Gyn care for women with FGC. Most Swiss health

<i>Female genital mutilation in the context of migration: experience of African women with the Swiss health care system</i>	healthcare providers (MDs and midwives). Purposeful sampling.	experience Ob-Gyn care in the Swiss health care system, and to investigate if physicians and midwives treat and counsel FGM related complications adequately.	Somali/Eritreans women. Telephone interviews with healthcare providers.	professionals lack experience and guidance on how to care for such women. Clinical decisions are often based on assumptions rather than on evidence or on established guidelines.
Herrel, Olevitch, DuBois, Terry, , Thorp, Kind, and Said (2004, USA), Somali Refugee Women Speak Out About Their Needs for Care During Pregnancy and Delivery	14 Somali refugee women. Snowball sample.	To understand how Somali women have experienced pregnancy and childbirth in Minnesota, determine the specific childbirth education needs of Somali women, determine the most effective ways to increase attendance at prenatal visits, and determine the most appropriate approach to childbirth education for Somali couples.	Focus groups interviews (in Somali language).	Somali women expressed: Concern on availability and quality of interpreters. Cultural difference on pain management, consent issues, and fear of cesarean births. Also a need for more culturally appropriate health education materials on labor and delivery for the Somali refugee community.
Vangena, Johansen, Sundby, Traen, Stray-Pedersen (2004, Norway), Qualitative study of perinatal care experiences among Somali women and local health care professionals	23 Somali immigrants and 36 Norwegian health care professionals. Snowball sampling.	To explore how perinatal care practice may influence labor outcomes among circumcised women.	In-depth Interviews.	Circumcision was not recognized as an important delivery issue among Norwegian health care professionals. Somalis expressed a strong fear of cesarean birth, lack of experience of healthcare providers, and

<i>in Norway.</i>				suboptimal treatment at delivery. FGC was not addressed antenatally.
Bulman & McCourt (2002, UK), <i>Somali refugee women's experiences of maternity care in west London: a case study.</i>	12 Somali refugee women. Sampling method unreported.	To explore the experiences of Somali refugee women using maternity service.	Case study. Semi structured interviews using a narrative approach.	Somali women lack of familiarity with UK culture and health services reinforced the sense of fear and isolation. Women with FGM expressed care providers 'lack of knowledge on FGC, cultural insensitivity and discrimination. Communication barriers underscore negative maternity experience.
Essen, Johnsdotter, Hovellius, Gudmundsson, Sjoberg, Friendman and Ostergren (2000, Sweden), <i>Qualitative study of pregnancy and childbirth experiences in Somalian women resident in Sweden.</i>	15 Somali women. Convenient sampling.	To explore attitudes, strategies and habits of Somali immigrant women related to pregnancy and childbirth, to gain understanding as to how cultural factors affect perinatal outcome.	Interviews.	Reduce food intake in order to have smaller fetus, an easier delivery and avoid cesarean birth and mortality. Somali women do not associate FGC as an adverse risk in childbirth. Wide range fear of being delivered through cesarean section. All women placed strong faith in God in a pragmatic way.

				Overall, Somali women have different practices, strategies and attitudes regarding pregnancy and childbirth, which should be viewed in the light of their previous life experiences prior to migration. Safe delivery means vaginal delivery.
Chalmers and Hashi (2000, Canada), 432 <i>Somali women's birth experiences in Canada after earlier female genital mutilation.</i>	432 Somali immigrant women. Snowball sampling.	To explore perceptions of perinatal care and their earlier female genital mutilation	Closed – ended (122 questions) individual interviews.	On FGM: most all women were proud for undergoing the tradition. Women reported short term complications included needing to repeat the process, pain, bleeding, urinary retention, and infections. Long-term complications: related to sexual initiation experience. On birth experience: Most were fearful of seeking prenatal care, majority delayed (20 week of gestation) prenatal care. women wanted to be re-sutured after birth. Most all women did not associated FGM with birth complications/obs

				truction, had little say on birth process and pain management.
<p>Wiklund, Aden, Håberg, Wikman and Dahlgren (1999, Sweden), <i>Somalis giving birth in Sweden: a challenge to culture and gender specific values and behaviors.</i></p>	<p>16 Somali immigrants(9 women and 7 men).</p>	<p>To study the childbirth experiences of Somali women and men in Sweden.</p>	<p>Semi-structured interviews.</p>	<p>Giving birth in a foreign country implies little or no access to your own traditions and social support. One striking finding was the Somali man's dramatic entrance into childbirth, which seemed to have a strong impact on the Somali woman's well-being during delivery. The study showed difficulties in getting used to the Swedish model of parenthood and in finding new role divisions in the couple relationship. The meeting between Somalis and Swedish antenatal and delivery care can be summarized as a challenge, both for the Somali couple and the Swedish health-care system. Somalis' experiences of childbirth in</p>

				Sweden can be understood by using the theoretical concept of gender, rather than culture.
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Authors (Yr. and Place) & Title	Study Sample & Selection	Aims	Methodology & Design	Results/Conclusions
Widmark, Tishelman and Ahlberg (2002, Sweden), <i>A study of Swedish midwives' encounters with infibulated African women in Sweden.</i>	26 midwives Convenient and Purposeful sampling.	To obstetric care of circumcised women in Sweden from health care providers' (midwives) and women's (Somali immigrants) perspectives .	Focus group and individual interviews.	(a) emotions and communication challenges involved in caring for infibulated women, (b) knowledge and skills needed for care provision and (c) the midwives' reliance on the Swedish law when dealing with the dilemmas they face in their interactions with the women and their families. An overall impression is that despite midwives' ambitions to provide equal

				care for all, our data indicate that both obstetric and psychosocial care of circumcised women may not be optimal.
Relph, Inamdar, Singh, and Yoong (2013, UK), <i>Female genital mutilation/cutting: knowledge, attitude and training of health professionals in inner city London</i>	79 health care professionals (out of n=85 distributed questionnaire).	To assess the knowledge, attitude and training on female genital mutilation/cutting (FGM/C) amongst medical and midwifery professionals working in an area of high prevalence of the condition.	Prospective study, using 19-point paper questionnaire.	Majority of healthcare respondents (especially those from African countries) were aware of FGM/C. Ability to identify the associated morbidity remain suboptimal; only 31.6% knew the optimal timing for defibulation (for safe childbirth). More training is recommended. And 10% support the idea of medicalising and therefore making FGM/C legal and safer.
Straus, McEwen, and Hussein (2007, UK), <i>Somali women's experience of</i>	8 Somali women working in the UK healthcare system	To study perceptions of childbirth from Somali health	In depth narrative interviews (ethnographic approach).	Mismanagement of care for women who have been circumcised,

<p><i>childbirth in the UK: Perspectives from Somali health workers.</i></p>	<p>(general and Ob-Gyn nurses). Snowballing sampling.</p>	<p>workers in the UK.</p>		<p>aspects of communication, continuity of care and attitudes of health professionals. Reluctance of health professional staff to accept the knowledge of Somali women in birthing process.</p>
<p>Hess, Weinland, and Saalinger (2010,US), <i>Knowledge of Female Genital Cutting and Experience With Women Who Are Circumcised: A Survey of Nurse-Midwives in the United States</i></p>	<p>600 certified nurse-midwives (CNM, random sample from list of registered CNM names) 243 CNMs responded to survey.</p>	<p>To assess certified nurse-midwives' (CNMs') knowledge of FGC and to explore their experiences in caring for African immigrant women with a history of genital cutting.</p>	<p>Descriptive Survey.</p>	<p>Through inductive analysis three themes emerged from those descriptions: reinfibulation after childbirth, complications of FGC, and clients' preference for female providers The respondents exhibited more correct medical knowledge about FGC than knowledge of cultural and legal issues. Discussions between CNMs and clients who were circumcised regarding FGC-related concerns and</p>

				<p>complications were minimal. Women with a history of FGC want female providers. Reinfibulation poses an ethical dilemma for some CNMs.</p> <p>.</p>
<p>Tamaddon, Johnsdotter, Liljestrand, and Essen (2006, Sweden), <i>Swedish Health Care Providers' Experience and Knowledge of Female Genital Cutting</i>.</p>	<p>2,707 mailed to healthcare providers. 769 out of 2,707 questionnaires were returned, (response rate of 28%). Purposeful sampling.</p>	<p>To evaluate the experiences and knowledge of health care providers in Sweden concerning FGC as a health issue.</p>	<p>Quantitative and structured inquiries (questionnaires)</p>	<p>The majority of Swedish health care providers working in areas where immigrants from Africa's Horn live have seen patients presenting with FGC. Only 7 out of 769 respondents (pediatricians) claim to have suspected a patient with FGC performed recently. In contrast to the publicly announced risk assessments that allege 5,000 African girls risk undergoing FGC, our findings indicate that pediatricians do not encounter young African girls with FGC,</p>

				which we think would be the case if the practice were to occur in Sweden to the same extent as in their country of origin.
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