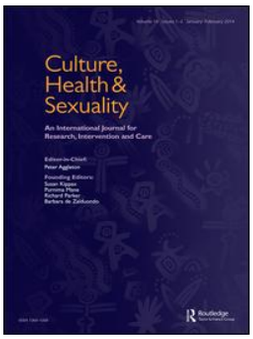

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Undoing female genital cutting: perceptions and experiences of infibulation, defibulation and virginity among Somali and Sudanese migrants in Norway

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ABSTRACT

This paper explores the dynamics of change in meaning-making about female genital cutting among migrants from Somalia and Sudan residing in Norway. In both countries, female genital cutting is almost universal, and most women are subjected to the most extensive form – infibulation – which entails the physical closure of the vulva. This closure must later be re-opened, or defibulated, to enable sexual intercourse and childbirth. Defibulation can also ease other negative health consequences of the practice. In Norway, surgical defibulation is provided on demand by the public health services, also beyond the traditional contexts of marriage and childbirth. This study explores experiences and perceptions of premarital defibulation. It explores whether Somali and Sudanese men and women understand defibulation as a purely medical issue or whether their use of the services is also affected by the cultural meaning of infibulation. This study analyses data from in-depth interviews with 36 women and men of Somali and Sudanese origin as well as participant observation conducted in various settings during 2014–2015. It reports that although all of the informants displayed negative attitudes towards infibulation, cultural meanings associated with virginity and virtue constitute a significant barrier to the uptake of premarital defibulation.

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Introduction

In Somalia and Sudan, the most extensive form of female genital cutting – infibulation – is nearly universal (UNICEF 2013). The practice creates a seal of skin covering the vulva with a small opening left for the passage of urine and menstrual blood (OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, and WHO 2008). This closure must be re-opened, or defibulated, later in life, first to enable sexual intercourse and later for childbirth. In Norway, medicalised defibulation is accessible also beyond these traditional contexts within the public health services. Through an analysis of informants' reflections and experiences of premarital defibulation, this study identifies some of the underlying cultural factors

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that drive or hinder the uptake of these surgeries, factors that may also indicate changes in the perceptions and cultural meaning of infibulation itself.

In most practising communities, female genital cutting is seen as a way of ensuring women's sexual morality (Berg and Denison 2013; Johansen 2007). This is most striking in communities practicing infibulation, where the physical covering of the vulva can be described as a culturally construed virginity (Boddy 1998; Gele, Sagbakken, and Kumar 2015; Johansen 2006b, 2002; Talle 1993), which is associated with virtue, femininity and morality (Abdalla 1982; Boddy 1998; Talle 1993). This understanding is interlinked with a social structure where biological paternity is important to secure patrilineal decent, which in turn is linked to lineage and clan as the guiding principles for overall social organisation (Boddy 1989; Talle 1993). The father's family is responsible for ensuring a girl's virginity and morality by closing her in infibulation at a young age. Later, her husband's family has the right to open the infibulated scar to access her sexual and reproductive resources (Talle 1993).

There is significantly lower support for female genital cutting in countries of diaspora than in countries of origin, particularly against infibulation (Gele, Johansen, and Sundby 2012; Gele, Sagbakken, and Kumar 2015; Johnsdotter 2002; Leye et al. 2014, Jinnah and Lowe 2015). However, little is known about how this relates to meaning-making about the practice (Fangen and Thun 2007). If people no longer support infibulation, how do they experience, reflect on and negotiate the sociocultural values and cultural meaning underlying the practice? Premarital defibulation can be seen as a way of undoing female genital cutting as it removes the physical closure constituting its key meaning: the creation, securing and evidence of virginity. When performed on unmarried girls, defibulation removes the traditional mark of virginity. Hence, high demand for and acceptance of premarital defibulation may suggest a dwindling importance of virginity or detachment from infibulation. Therefore, this study hypothesises that the attitude towards and willingness to undergo premarital defibulation is intimately interrelated with the cultural meaning and importance of infibulation.

Female genital cutting among Somali and Sudanese populations

Population-based prevalence data from 30 countries estimate that approximately 200 million girls and women have been subjected to female genital cutting (UNICEF 2016). The practice is particularly common in Somalia and Sudan, with occurrence rates in the two Somali states of Somaliland and Puntland of 98 and 99%, respectively (UNICEF Somalia and Somaliland Ministry of Planning and National Development 2014; UNICEF Somalia and the Ministry of Planning and International Cooperation 2014), and 87% in Sudan (Central Bureau of Statistics, and UNICEF Sudan 2014). Through migration, the practice is now found worldwide, including approximately 17,300 girls and women in Norway who are estimated to have undergone female genital cutting prior to immigration (Ziyada, Norberg-Schulz, and Johansen 2016). Half of these girls and women are of Somali origin, and approximately 3% are of Sudanese origin. Together, they constitute the major proportion of girls and women who have experienced infibulation in Norway.

Female genital cutting is a general term covering a variety of procedures that are classified into four major types by The World Health Organization (WHO): Type I – removal of part or all of the clitoris; Type II – removal of part or all labia minora, often with the clitoris; and Type III – cutting and apposition of the labia, creating a seal of skin that closes the vulva and most of the vaginal opening (OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF,

UNIFEM, and WHO 2008). Type III, commonly referred to as infibulation, is the focus of this study. Type IV comprises any other procedures that can harm the external genitalia but that do not include tissue removal.

In Somalia and Sudan, the emic classification outlines two major types, *pharaonic* and *sunna*. Pharaonic designates a Type III female genital cutting and highlights the common belief that the practice is of Egyptian origin. Infibulation is the predominant form of female genital cutting in both countries, with occurrence rates of 87% in Somaliland (UNICEF Somalia and Somaliland Ministry of Planning and National Development 2014), 85% in Puntland (UNICEF Somalia and the Ministry of Planning and International Cooperation 2014) and 82% in Sudan (Department of Statistics and Institute for Resource Development/Macro International Inc 1991).

However, the actual prevalence of infibulation is likely to be even higher as there is a general tendency to underreport the extent of female genital cutting (Crawford and Ali 2014; Elmusharaf, Elhadi, and Almroth 2006; Ismail 2010; Lunde and Sagbakken 2014). This is partly due to the lack of a uniform definition regarding what constitutes *sunna*. It is commonly perceived as a minor procedure, often described as 'a prick' or 'removing the tip' of the clitoris or its foreskin without closure (Johnsdotter 2007, Gruenbaum 2006; Johansen 2006a). However, clinical evidence suggests that the procedure is often more extensive and often includes some extent of closure (Crawford and Ali 2014; Government of Puntland Somalia 2012; Gruenbaum 2006; Republic of Somaliland 2014). The use of the term *sunna*, with its Islamic connotation of a 'good deed', is related to the widespread perception that these forms of female genital cutting are accepted or supported by Islam (Fangen and Thun 2007, Johnsdotter 2002; Johansen 2006a).

A statistical estimate found that approximately 9,100 girls and women in Norway may have undergone infibulation prior to immigration (Ziyada, Norberg-Schulz, and Johansen 2016). Based on uncertainty about the type and the tendency to underreport the extent of cutting, the actual number may be higher.

Infibulation constitutes a densely meaningful symbol that is intimately intertwined with the physical extent of the procedure. The opening left in the infibulated scar should be sufficiently small to impede sexual intercourse to fulfil its major role of protecting and proving virginity. Traditionally, only a girl with infibulation would be recognised as a virgin, a virtuous woman and a respectable member of society (Abdalla 1982; Boddy 1998; Gruenbaum 2006; Talle 1993). A woman without infibulation, in contrast, would be seen as lacking limits, self-control or respect. She would be seen as accessible to any man's sexual advances, with a 'large gaping hole'. She would be considered an immoral woman, and the fatherhood of her children could never be trusted. This situation could threaten a major basis of the social structure built on paternal clan affiliation (Helander 1987; Talle 1993). An 'open woman' would also be seen as dirty, ugly and smelly. For these reasons, a woman without infibulation would not be considered marriageable (Abdalla 1982; Johansen 2006a; Talle 1993).

A small orifice is a source of pride, signifying both moral and aesthetic excellence (Boddy 1989, 1998; Johansen 2006a; Johnsdotter 2007; Talle 1993). However, it is this closure that causes many of the health risks associated with infibulation, such as the obstruction of urine and menstrual blood, and birth complications (Almroth et al. 2005; Berg and Underland 2013; Nour, Michels, and Bryant 2006; WHO Study Group on Female Genital Mutilation and Obstetric Outcome 2006). Furthermore, emerging evidence suggests an association between the length of time girls and women remain closed and certain health complications

(Elmusharaf et al. 2014; Ibrahim et al. 2011). Consequently, defibulation can alleviate several health consequences associated with infibulation (Nour, Michels, and Bryant 2006).

Defibulation is also a necessary traditional practice as the virtuous closure of infibulation must be reopened for the woman to fulfil the cultural values of marriage and motherhood. Traditionally, a limited defibulation is first performed to enable sexual intercourse and conception upon marriage. Later, further defibulation is necessary at childbirth. Thus, most infibulated girls and women eventually undergo defibulation.

To accommodate the health needs of women with female genital cutting, Norwegian health authorities have developed medical guidelines (Legeforeningen 2014; Statens-helsetilsyn 2000). The focus was initially on defibulation during childbirth, as although most women had been partially defibulated sufficient for sexual intercourse, further defibulation is often necessary to enable childbirth. Also, some women had become pregnant without penetrative intercourse, and were still fully infibulated until they were to deliver. A study that found higher birth-complications among Somali women in Norway (Vangen et al. 2002) may have contributed to the government's establishment of specialised clinical services across the country.

It has been assessed that 127 women sought help in these clinics in 2013 (Enyam 2014). However, healthcare providers report that many girls and women do not come to appointments, and some decline defibulation. Hence, one can ask whether Somalis and Sudanese understand defibulation as a purely medical issue or whether their use of these services is also affected by the cultural underpinnings of infibulation.

Method and material

A qualitative study encompassing interviews and participant observation in Somali and Sudanese communities was conducted in 2014–2015. Efforts were made to recruit informants with various backgrounds. Geographically, informants were recruited from across the country, with approximately half from the capital of Oslo and the rest in eight other towns and villages.

In-depth and key informant interviews were conducted with 23 women and 13 men of Somali and Sudanese origin. The 28 interviewees referred to as 'settled' were recruited in two ways. Snowball sampling through different starting points was used to recruit 24 informants who had lived more than a year in Norway, and four key informants were recruited through the services in which they worked. The eight newly arrived quota refugees[1] included in the study were recruited through national immigration authorities ('new' in Table 1).

The recruitment strategies selected to include informants with various lengths of stay and migration routes resulted in two groups of informants: long-term residents and newly arrived refugees. The contacts that initially assisted in the recruitment of settled informants had high education and long-term residence in Norway, which probably was the cause of the same bias among these informants. They thus differ from the average among Somali and Sudanese migrants where only 22% of Somali women and 37% of Somali men, and only 21% of Sudanese women and 41% of Sudanese men, were employed in 2014.[2] The newly arrived refugees, in contrast, had no or minimal education and none were employed.

The informants' ages varied from 18 to 65 years, with the majority being in their 30s and 40s. There was no systematic age difference between the various subgroups according to gender, nationality and migration route. Almost all the women had been subjected to female

Table 1. Overview of Somali and Sudanese informants participating in in-depth interviews.

Gender	Total	Somalia	Sudan	Length of stay (*n*)	Marital status (*n*)
Woman	23	14	9	New (6): 3–12 months Settled (17): 3–30 years	Single (2) Married (13) Divorced/widowed (8)
Man	13	8	5	New (2): 3 months Settled (11): 10–34 years	Single (5) Married (6) Divorced/widowed (2)
Total	36	22	14	Average 15 years (Sudanese 6 years, Somali 18 years)	

genital cutting, except one of Somali and one of Sudanese origin. Of those with female genital cutting, all but one was infibulated. Three other women also claimed to have *sunna*, but their subsequent stories included experiences of closure and opening that indicated some extent of infibulation. One of the men said that his wife had had no female genital cutting, whereas the others reported wives and ex-wives with Type III female genital cutting.

Participant observation was conducted in various settings, including several awareness sessions for mixed genders and nationalities run by various providers and organisations. This included an information session for 30 illiterate Somali women attending a literacy course, a discussion group in high school that had invited 12 Somali young men to explore their knowledge needs with regards female genital cutting to inform a pamphlet in the making, and several other similar settings. In these settings, informal conversations were conducted with an additional 30–40 men and women. These are referred to as 'informal informants', and include also the researchers' long-term acquaintances and friends and their networks. Finally, two validation seminars with Somali and Sudanese men and women were conducted in different cities. During these sessions, a draft analysis and a selection of quotes from the interviews were presented for discussion.

Interviews were conducted by the researcher mostly in Norwegian or English and lasted from 20 minutes to 4 hours. In general, the interviews with women lasted longer (an average of two hours), whereas most interviews with men lasted approximately one hour. The newly arrived Somali refugees were interviewed with the assistance of a Somali-speaking co-interviewer, and these interviews lasted the longest. All the Sudanese informants spoke either English or Norwegian. The informants chose the venue for the interview, which included the informant's home, the researcher's or the informant's workplace, the refugee or social office or a public space such as a coffee bar or a park.

The study was described to potential informants as follows: 'Several hospitals in Norway offer help for women who have been circumcised. We will examine what people know about this, what they think and their experiences, why some seek help and others do not, and how communities regard such help. We have contacted you because you have connections to a country where female circumcision is a tradition.'

The interviews were designed as flexible conversations around certain topics, starting with the informant's family background and childhood, education, whether female genital cutting was common where they grew up, and their first awareness of the practice, followed by enquiries about their life in Norway and eventual exposure to the issue of female genital cutting. They were also asked about personal experiences, including exposure to awareness

programmes and health services. Finally, informants were asked about defibulation surgeries and their views and experiences regarding these.

To grasp the emic perceptions, interviews made no concrete reference to potentially relevant factors initially. However, when specific factors, such as virginity, were brought up, they were followed through probing. It is worth noting that questions about their own or their wife's female genital cutting status were never needed, as this information was always volunteered.

Ethical clearance was granted by the Norwegian Social Science Data Services and the Directorate of Integration and Diversity. The study followed approved ethical procedures, including informed consent in relevant languages.

In qualitative research, the researcher is the main methodological tool, and gaining trust is a key task. In interviews with migrants, being an outsider to the community can have both advantages and disadvantages. It can reduce fear of gossip and judgement if the informant reveals experiences and considerations that clash with sociocultural norms within the community (Opaas and Varvin 2015). However, the lack of a shared language and experiences may reduce mutual understanding of subtleties. Furthermore, the researcher's position as a member of the majority population that condemns female genital cutting may reduce trust and willingness to share sensitive information.

In this study, trust may have been facilitated by the informants perceiving the researcher as someone in between an insider and an outsider. Despite being an 'ethnic Norwegian', I have travelled and lived in Africa for many years, including Sudan and Somalia, and studied female genital cutting for almost 20 years. What appeared to be most significant, however, was my former marriage to a Tanzanian, to which many informants exclaimed with apparent relief, 'Oh, so you are my sister.' Furthermore, I have worked with and socialised among African diasporic communities in Norway since the early-1980s, and I have many long-term relations with people from the affected communities.

The interpreter who assisted in interviews with the newly arrived refugees was carefully chosen, and her role was cautiously chosen to facilitate trust and confidence. She was an adult mother and had extensive training and experience in social anthropology and social work. To reduce the risk of distrust due to political conflicts, she was from the same region as the informants. She was probably seen as an insider as she spoke fluent Somali and shared the tradition of female genital cutting. However, her Western clothing, her mastery of Norwegian and her education could mark her as an outsider. To facilitate the flow of communication, she was a co-interviewer rather than an interpreter. Her warmth, sense of humour and relaxed demeanour seemed to put the informants at ease and facilitated trust.

A final measure to reduce discomfort and fear of repercussions was to avoid tape-recording the interviews. Instead, detailed notes were taken during the interviews and were subsequently carefully transcribed. Additionally, the subject of female genital cutting may be less sensitive than often expected by outsiders (Barrett et al. 2011; Johansen 2006a; Johnsdotter 2002), and most informants talked freely and all answered all queries.

Data analysis was conducted consecutively and at the end of the data-collection when recurrent themes and patterns were identified through repeated re-reading and different coding procedures, both manually as well as electronically through the use of HyperRESEARCH (2015). The validation seminars were considered a final sounding board for the data and analysis. Informants are presented with fictive names and approximate ages to provide some context while securing anonymity.

Findings

Overall, the informants had grown up with infibulation as omnipresent and unquestioned; as Ali, a 34-year-old Somali man, formulated it, 'it was in the air we breathed'. Eventually, however, all of the informants had come to see it as a negative practice in need of abandonment. For some, this change occurred prior to migration. For most, however, it occurred much later. Nevertheless, the majority still highly valued the cultural underpinnings of the practice and saw infibulation as closely intertwined with virginity. Most informants were sceptical about premarital defibulation because it was believed to undermine virginity, although there were also people questioning these values.

Negotiating virginity

Most informants identified virginity as a core sociocultural value, both among relatives in their country of origin and in their diaspora communities, as found in other studies (Johnsdotter 2007, Fangen and Thun 2007). This was also the case for those who personally criticised and questioned it. What does virginity mean to Somalis and Sudanese in Norway?

The informants generally talked about virginity as sexual innocence, contrasting virgins with sexually experienced women. This distinction was deeply value laden. Sexually experienced women were commonly described in derogatory terms, such as sexually 'loose', 'used' or 'dirty'. Abdi, a Somali man in his 50s, put it this way: 'If a woman had sex before marriage, that is not good. Then, the girl is a prostitute, and this can transfer to her children.' Zahir, a 44-year-old Somali man, compared marrying a non-virgin to entering a store to buy clothes only to discover that they are second-hand.

However, none of the Somali informants found it problematic to marry a divorcee, and several of the women were married for the second time. This situation is not unusual; divorce has always been both common and socially accepted in Somalia (Helander 1987). Sudanese informants claimed that divorce was less socially accepted in their country, but it was still not infrequent and was acceptable to some extent. However, previous sexual experience from marriage was not seen as problematic. As suggested in Abdi's statement, the question of whether a girl had previous sexual experience was always interpreted as a question of whether the girl had engaged in sexual activity outside the context of marriage.

Thus, it is not virginity in itself that is at stake; rather, virginity was primarily discussed in terms of sexual virtue. That is, a lack of virginity in the first marriage is understood as signifying moral laxity, a weakness of character that can later lead to extramarital affairs, or 'prostitution', in Abdi's terms.

The fear of extramarital affairs is also related to the significance of paternity, as expressed in Abdi's fear that a woman's failure of moral conduct could transfer to her children. In both Somalia and Sudan, children's names, identities and social standing are determined by the father and his lineage, and are thus of utmost importance (Boddy 1989; Talle 1993).

The informants' descriptions of virginity were generally parallel to descriptions of infibulation, suggesting a continuing intertwining of the two concepts. One example is seen in 50-year-old Somali Bilal's answer to my question about how one could identify virginity in a un-infibulated girl, he said: 'When there is blood! When they are stitched, there will be blood. Me and other boys, we wouldn't feel the hymen, but that she is open, because she has been used before.' He thus presented bleeding as evidence of virginity and linked it to

being 'stitched', a common expression for infibulation. Hence, despite being specifically asked about a non-infibulated girl, he explained virginity in terms of infibulation. The answer from Fowsi, a 47-year-old Somali man, about whether a man could accept marriage to a non-virgin was less specific: 'Virginity is up to the girl. It may be that she was engaged before but then it did not result in a marriage. Then, it is up to the boy if he can accept that she is not closed.' Despite referring to virginity as closure, he does not specify whether he refers to infibulation or something else.

Both of the above statements refer to the common idea of virginity as identifiable through the same signs as those of infibulation: 'closed', 'stitched', 'tight' and bleeding, in contrast to the 'openness' of sexually experienced women. This point towards the shared conviction that virginity, and the lack thereof, can be easily proven. Musa, a 45-year-old Sudanese man explained it this way:

> The day of marriage, it would be known if a woman had sex before. It is a difference of size. It is difficult to penetrate. It's not an open hole. You would know, even if you just touch her organ with a finger.

From a medical standpoint, it is not clear how one would identify virginity by touching a woman's genitals unless she was infibulated. Thus, it is not clear from the interview whether this man was referring to infibulation or another form of closure.

Another common perception was that virginity entails a barrier that needs to be broken, which a few, such as a Basra specified as the hymen:

> When a man has sex with a virgin, he will always notice. It is painful, and it sort of 'pops' when the hymen breaks. It did so with me. It could, of course, be due to my circumcision, but I think it was the hymen as well. I have asked my husband, and he says that a man will always notice. With a virgin it is tight, and the man has to force himself in. (Somali woman, 37 years of age)

Although she was unsure whether the 'popping' was due to her hymen or her infibulation, the idea of some sort of membrane that must be broken is typical. The idea of the hymen as an identifiably entity is common in many communities despite challenges by both clinical studies and experience (Hegazy and Al-Rukban 2012; van Moorst et al. 2012). However, the literature does not suggest any traditional concept of the hymen among Somalis (Johnsdotter and Essén 2004), and no informants suggested that the hymen could replace infibulation as evidence of virginity. Rather, virginity without infibulation was discussed in terms of the vagina itself as 'closed' or 'tight'.

Thus, all the informants considered virginity a sociocultural expectation, and most saw virginity as an indication of a woman's moral standard. While it is virtue that is at stake, virtue is believed to be proven through virginity, and ensured through infibulation. Furthermore, almost all of the informants believed that virginity, and the lack thereof, could be proven through physical evidence, in ways that did not distinguish between defibulation and deflowering. What, then, were their perceptions about clinical defibulation?

Virginity and defibulation

As explained earlier, most women undergo some form and extent of defibulation at marriage in order to enable them to commence their sexual and reproductive life. Almost all the informants were aware of existing access to surgical defibulation and talked about it as acceptable. However, while some of the women had undergone surgical defibulation, all but one had done so in the context of marriage or childbirth. In such contexts, the

requirement for premarital virginity and virtue would not be compromised. In contrast, the defibulation of single women was regarded with scepticism. Most informants found it incomprehensible for a woman to remain a virgin after defibulation. On the contrary, premarital defibulation was by the majority of both men and women understood as ruining virginity and thereby undermining women's virtue by enabling, facilitating and even encouraging promiscuity. Thus, the value of virginity and virtue constituted a major obstacle to premarital defibulation.

This resistance to premarital defibulation was expressed both in general views and in concrete accounts. One example can be seen in the account provided by a 38-year-old Sudanese woman we will call Fatima. She came from an educated family, was negative towards infibulation, and said that her mother regretted infibulating Fatima and her sisters. A devoted Muslim, Fatima did not find religious support for the practice. Furthermore, she suffered health complications that caused her daily pain and discomfort and that affected her daily routine. Medical doctors had advised her of the need to defibulate to alleviate her problems. However, this was not perceived as a viable option. As Fatima said, 'I have to cope [with my health problem]. It cannot be treated before I marry. I cannot go for defibulation. I don't want to lose my virginity.'

Several informants provided similar stories of reluctance to undergo defibulation contrary to medical advice. Some stories involved themselves, other friends and relatives. For the men, some of these accounts involved previous girlfriends. Two Somali women, Saynab (51 years of age) and Batuloo (43 years of age), had experienced that many young girls they had encountered during discussions groups had wanted defibulation, but did not dare to go through with it for fear of their parents' disapproval.

Thus, although most informants described premarital defibulation as acceptable in cases of severe health complications, they were resistant in actual cases. As with Fatima, most women explained this reluctance as a fear of losing their virginity and thereby risking social stigma. However, this concern went beyond the fear of failing the virginity test of a future husband. Many also feared that defibulation would lead to rampant sexual engagement and that it would both let loose women's sexual urges and dissolve their self-control. Both defibulated women and women without infibulation were described as constantly 'running after men'. One example was Shukri, an informal Somali informant of 35 years, who laughingly spoke of how she for years had resisted defibulation, fearing the procedure would make her '… crazy about men, wanting sex with anyone I meet'.

False virginity

There was a widespread concern that infibulation could provide a false sense of security because virginity could be faked. One example was Nagi, a 39-year-old Sudanese man, who put it this way: 'People at home don't understand virginity. For them, it's a matter of blood on the blanket. However, a girl might have had sex and then been closed again'. Another example was given by Basra, a Somali woman, 38 years of age:

> Some women misuse the request for virginity. They enjoy themselves [have sex], and then they tighten it back again later. They go to a private clinic. Everybody knows it is done at [name of clinic]. A friend of mine did it, and I have heard about more women who did. This is common knowledge in our community.

In these stories, it was not always clear whether the informants referred to re-infibulation (Gruenbaum 2006), which is illegal in Norway, or hymen repair, which is accessible. It is clear, however, that there was the idea that a physical closure can be recreated to produce a 'false' virginity that 'covers up' illicit sex. However, some informants could not imagine that this was physically possible. One example was Fowsio, a Somali woman of 38 who took part in a group session where the topic was raised, exclaiming with urgency that 'This cannot happen. The man would always know.' She compared reinfibulation to restore an appearance of virginity to repairing a torn cloth. There would be an imperfection in the scar that would give away her cover-up.

While these stories and concerns underpin a link between infibulation, virginity and virtue, there were also diverging views that challenged these connections, which will be explored below.

Seeds of change – disentangling the knot: virginity, infibulation and virtue

Some informants presented views and reflections on virginity and infibulation that indicate seeds of change and wedges that delink virginity, infibulation and morality. The reflections of a 42-year-old Sudanese man called Omar illustrate the ambivalence that was detectible in many men: 'I consider myself an open-minded man. I accept women's right to have sex before marriage.' As an afterthought, he continued, apparently surprised by his own reflections, 'However, personally, if I want to marry a woman and she has had sex before, I will accept it, but I will think twice.' Other men told stories about friends who had married sexually experienced women, which eventually contributed to their divorce, such as Nagi a Sudanese man, 39 years of age:

> In Sudan, if a girl is open, that means she has had illegal sex. That is totally not acceptable in our society. But if you live abroad and marry a girl from home and you find she is open, men don't want to make a scandal, so they stay married even if they are unhappy. I have a friend who this happened to. However, eventually, after three children, they divorced. And this, that she had not been a virgin, was one of the issues that led to their divorce.

Thus, the ideals of virginity that informants often dismissed as 'old-fashioned' and the 'conservative' views of uneducated men from rural areas still had an emotional hold on many.

The strongest critique of virginity was expressed by Ali, a Somali man in his late-30s. He actually considered virginity a drawback in a potential spouse: 'Virginity was not on the list. I wanted an experienced woman who was ready to settle and start a family. If she had been a virgin, she would not have been mature enough.' However, Ali was untypical in his response, but several contacts had suggested that I interview him, describing him as the exception confirming the rule. When quoting his statement at the validation seminars, people expressed disbelief and surprise, and some women laughingly asked for his telephone number.

In spite of the effort to recruit women who had undergone premarital defibulation, only one such woman was identified and was willing to participate in the study. Asha, a 28-year-old Somali woman had been living with a Norwegian family from her early-teenage years due to physical abuse by her biological family. Noticing her health problems, her foster parents had helped her to defibulate at the age of 15. Though she had initially been afraid of the surgery, having it gave her a sense of tremendous freedom. The relief of being able to urinate and menstruate normally was only one aspect. Equally important, she said, was a sense of regaining control over her body. Asha had no concerns about failing her virginity

test as she at the time had no intention of marrying a Somali. She did, however, eventually marry Ali, although he also had been searching beyond his community for a spouse.

Cultural change and defibulation

How can the findings of this study be interpreted in light of the prevailing theories of change with regard to female genital cutting? Most intervention programmes target female genital cutting as a social convention (Mackie 2000; UNICEF 2013) in which initial change is secured through a group that is convinced of the need to abandon the practice due to its associated health risks and human rights violation (OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, and WHO 2008). This is expected to lead to a joint agreement of abandonment. When sufficient numbers of people are negative towards female genital cutting, men will accept marrying uncut women and parents will subsequently be able to abstain from subjecting their daughters to female genital cutting. Broad-scale abandonment is expected to lead to a social 'tipping point', at which time abandonment will continue automatically.

This theory of change stands in an odd relationship to anthropological studies analysing the cultural meanings of the practice (Boddy 1989; Talle 1993). This study finding that all informants were negative towards infibulation may suggest that a tipping point has been reached and that social norms have changed. However, this phenomenon was not found. Rather, the study found that most informants maintained the cultural meanings underlying the practice and the sociocultural norms of virginity and virtue remained high. This finding suggests that the changes in meaning-making and the normative cultural values underlying the practice are too complex to be fully grasped through theories of social convention.

The findings of this study confirm findings in other studies of diasporic communities, such as the fluidity and ambivalence of attitudes towards female genital cutting (Fangen and Thun 2007; Johansen 2006a). However, they do not align with the findings from a study in Sweden where virginity was seen as a matter of trust between the parties rather than something to be proven (Johnsdotter 2007). Although some informants' accounts hinted at this perspective, it was not common. Neither did this study find a systematic correlation between the length of stay in the country and attitudes towards female genital cutting, as was found in a recent quantitative study (Gele, Johansen, and Sundby 2012). This qualitative study included too few informants to draw any generalisations. Still, it is important to emphasise that there were virtually no systematic differences between the various subgroups in terms of age, generation, level of education, country of origin, gender or length of stay. In fact, heterogeneity within these sub-groups was as significant as the heterogeneity between them. The age at and context in which informants had first reflected critically on female genital cutting cut across all categories. For example, almost all the new arrivals had been exposed to anti-female genital cutting messages before leaving the refugee camps, whereas Hani, a 33-year-old Somali woman had first reflected on the topic when she recently became pregnant after 10 years in Norway. Similarly, Bilal, a 49-year-old Somali man who had lived almost 30 years in Norway stated that the interview was the first time he had ever discussed this topic. While several of the Sudanese men had been critical to the practice prior to migration, often as a part of their political engagement, most Somali men had only questioned female genital cutting after migration. There were, however, important differences between

the Somali and the Sudanese informants regarding defibulation at marriage and childbirth, a topic that will be explored in a forthcoming paper.

Concluding remarks

This study found continuity among Somali and Sudanese people with regard to the upholding of the cultural values of virginity and virtue, which hindered the acceptance of premarital defibulation. Surgical defibulation was deemed acceptable but conducted almost exclusively within the traditionally accepted contexts of marriage and childbirth. On these occasions, the role of infibulation to provide evidence of virginity and virtue was not challenged. It did, however, challenge other cultural values related to virility and sexual pleasure that will be explored in a forthcoming paper (Johansen 2016).

Nevertheless, some single women do request defibulation. Though they are few in number and tend to keep it a secret, this can be interpreted as the strongest evidence of abandonment as defibulation not only threatens the woman's social reputation and standing but also renders the suffering caused by the original infibulation useless (Johansen 2002).

One important implication of this study is that sexuality and concern about virginity and virtue must be highlighted in counselling people from female genital cutting practising communities. Focusing only on health risks and human rights is insufficient, as the social values relating to sexuality often carry more weight. Sexual concerns are key to understanding reluctance towards premarital defibulation and the abandonment of infibulation.

The implications and interlinks between female genital cutting and cultural values of paternity, lineage and ethnic and clan identity require further examination. Although these issues were not emphasised by the participants in this study, they may affect changes in practices and attitudes regarding defibulation.

Finally, a deeper analysis within a framework of cross-cultural models of femininity is required. Solheim (1998) suggests that the female body often serves as a core symbol for social borders due to its 'openness', in which the woman's 'inside overflows its shores – as milk, children, blood' (74). She suggests that this 'flooding' is why the woman's body and its borders, particularly its sexual borders, play a core symbolic function in many societies. Thus, to fully understand female genital cutting, it may be necessary to extend our understanding beyond the particularities of each culture. Failure to do so may be one reason why so many projects to end female genital cutting fail. These projects may alter the forms or conditions of the practice, but they do little challenge the root of female genital cutting in the form of concerns about the openness of the female body and, hence, the vulnerability of the social structure and society itself.

Notes

1. Quota refugees refer to refugees who undergo a selection process for resettlement in Norway in a refugee camp. These are initially cleared by UNHCR. Other refugees are asylum seekers who travel to Norway on their own, and apply for refugee status after arrival and their reunited family members.
2. Data were sent by e-mail upon request from Statistics Norway: http://www.ssb.no/en/

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