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Editorial

ABOUT AJRH

African Journal of Reproductive Health (AJRH) is published by the Women's Health and Action Research Centre (WHARC). It is a multidisciplinary and international journal that publishes original research, comprehensive review articles, short reports and commentaries on reproductive health in Africa. The journal strives to provide a forum for African authors, as well as others working in Africa, to share findings on all aspects of reproductive health, and to disseminate innovative, relevant and useful information on reproductive health throughout the continent.

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The Women's Health and Action Research Centre (WHARC) is a registered non-profit organization, committed to the promotion of women's reproductive health in sub-Saharan Africa. Founded in 1995, the centre's primary mission is to conduct multidisciplinary and collaborative research, advocacy and training on issues relating to the reproductive health of women. The centre pursues its work principally through multidisciplinary groups of national and international medical and social science researchers and advocates in reproductive health.

WHARC receives core funding and support from the Ford Foundation and technical cooperation and mentorship from International Perspectives on Sexual and Reproductive Health and Studies in Family Planning. Principal funding for the journal comes from the Consortium on Unsafe Abortion in Africa. The goal of the centre is to improve the knowledge of women's reproductive health in Nigeria and other parts of Africa through collaborative research, advocacy, workshops and seminars and through its series of publications – the *African journal of Reproductive Health, the Women's Health Forum* and occasional working papers.

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Revue Africaine de Santé de la Reproduction

Editor: Friday Okonofua

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Editoriaux

APROPOS AJRH

La Revue Africaine de santé de la Reproduction (RASR) est publiée par le Women's Health and Action Research Centre (WHARC). C'est une revue à la fois pluridisciplinaire et internationale qui publie des articles de recherche originaux, des articles de revue détaillés, de brefs rapports et des commentaires sur la santé de la reproduction en Afrique. La Revue s'efforce de fournir un forum aussi bien à des auteurs africains qu'a des professionels qui travaillent en Afrique, afin qu'ils puissent partager leurs découvertes dans tous les aspects de la santé de reproduction et diffuser à travers le continent, des informations innovatrices, pertinentes et utiles dans ce domaine de santé de la reproduction.

La R*ASR* est indexée et figure sur I'Index Medicus/MEDLINE. Les résumés et les tables des matières sont publiés en ligne par INASP sur le site web *http:*//www.ajol.info/*ajol* tandis que le texte est publié à http://www.ajrh.info par Bioline International sur le site web *http://www.bioline.org.br/.* Il est également résumé dans *Ulrich Periodical, feminist Periodical et African Books Publishing Records*

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Le WHARC est une organization non gouvernementale à but non-lucratif s'engageé dans la promotion de santé de la reproduction chez la femme en Afrique sub-saharéenne. Fondé en 1995, le Centre a pour objectif principal de mener des recherches pluridisciplinaires et en collaboration, de promouvoir et de former des cadres en matières relatives à la santé de la reproduction chez la femme. Le Centre travaille surtout à travers des groupes mutidisciplinaires de chercheurs aussi bien nationaux qu'internationaux en sciences médicales et en sciences économiques dans le domaine de santé de la reproduction.

Le WHARC recoit une aide financière pricinpale de la Fondation Ford et bénéficie de la coopération technique de l'*International Perspectives on Sexual and Reproductive Health* et de *Studies in Family Planning*. Le financencement principale pour la revue vient de la part du Consortium on Unsafe Abortion in Africa. L'objectif du Centre est d'ameliorer la connaissance en matière de santé de la reproduction chez la femme au Nigeria et dans d'autres régions d'Afrique à travers la recherche en collaboration, le paidoyer, des ateliers et des séminaires à travers des séries de publication - *La Revue africaine de santé de la reproduction, Le Women's Health Forum* et des rapports des recherches de circonstance.

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EDITORIAL

Revamping the Reproductive Health Agenda in Africa After 2014

Friday Okonofua

Editor, African Journal of Reproductive Health

The International Conference on Population and Development (ICPD) which took place in Cairo in 1994[1] was particularly significant for sub-Saharan Africa as compared to the rest of the world. Before then, previous population conferences had focused principally on the singular objective of reducing population growth through family planning as the solution to global development. Consequently, development assistance to Africa at the time largely targeted family planning, with less attention paid to other components of development. It took the findings of research in the mid-1980s[2] that documented the impact of social, economic and cultural factors on the high rate of mortality in the continent to convince the rest of the world that development goes far beyond numbers. Specifically, after years of intense debate, the world identified widespread poverty and the social exclusion and under-development of women as the root causes of the high fertility and high rates of mortality that characterize most parts of the developing world. Women advocates argued that unless these are addressed, there will be little hope to reverse the parlous indicators of health (especially maternal health) that most countries face. Although ICPD was a global initiative, Africa's situation presented a natural laboratory for global experimentation to test the hypothesis that focusing on women's empowerment and improving economic fortunes will result in substantial decline in fertility and improve the social well-being of populations.

September 5, 2014 will mark the 20th year that the ICPD began in Cairo. During the conference, member countries adopted a 20 year Plan of Action (POA) to deliver a more equal and sustainable global development. The ICPD POA highlighted the relationship between gender inequality, poverty, poor health, poor educational attainment and sustainable economic growth. Since the original POA was made, governments of member states have re-affirmed their commitments every five years. The key thematic areas addressed in the POA include: poverty and inequality, women and girls, young people, reproductive health and rights, environmental sustainability, ageing, and urbanization and migration.

The past months have witnessed intense activities relating to ICPD+20 reviews aimed at identifying what has worked and not worked in various parts of the world, with the aim to generate a new sets of ideas for propelling global development in years to come. It is within this context that the *African Journal of Reproductive Health*[3,4] a journal that was established in 1997 to document the processes, achievements and challenges in ICPD implementation in sub-Saharan Africa is issuing this comment. No doubt, considerable progress has been made in the 7-thematic areas of the ICPD in Africa over these 20 years. In particular, Africa has witnessed considerable economic growth, with evidence indicating that many countries in the continent have achieved some of the most rapid GDP growth in recent years. Yet, World Bank data[5] also show that despite this increasing prosperity, the region still has the highest proportion of persons living in abject poverty. It indicates that Africa is still faced with mounting inequality and marginalization, a key indicator for measuring the success of the ICPD.

Sexual and reproductive health and rights (SRHR) being the cornerstone of the ICPD, the results of various programming efforts have been difficult to predict for much of Africa. Although some indicators of SRHR have improved in most parts of the continent, Africa still remains the region with the worst indicators of sexuality and reproductive health in the world. Rates of maternal and child mortality, unsafe abortion, female genital cutting and HIV/AIDS are still disturbingly high in the continent, with little systemic pattern

seen to indicate that further progress will be made in reducing the burden of disease anytime soon. This is in large part, due to the fact that much of the principles and ideas on which the success of ICPD was premised have not materialized in the continent. High and rising rates of poverty, the continuing marginalization of women, denial of reproductive rights and cultural and religious hindrances still stand in the way of realization of the ICPD POA in Africa. Additionally, there has been lack of political will and determinism by many African governments to implement the POA, with some of the affected countries not domesticating the most basic of the agreed principles. By contrast, most ICPD-related SRHR programming in Africa have been donor-driven, with limited country-ownership and supervision. It is increasingly evident that such programs will be unable to attain substantial scale and impact unless efforts are concentrated at prioritizing the programs as major agenda items owed and driven by the countries themselves.

Thus, the experiences of ICPD programming in Africa since 1994 can best be described or summarized as "work in progress". Although 20 years have gone, Africa is still at the threshold of transformation and social change in the field of sexual and reproductive health. In our view, three critical interventions are now needed to accelerate the pace of development of the sexual and reproductive health and rights agenda in Africa, going forward.

The first is to ensure that countries not only sign the documents and affirm the decisions reached at ICPD+20, but that they actually take steps to domesticate the processes and to implement policies and actions that would ensure social cohesion and fast-track development in their countries. Specific areas where government actions are needed are: addressing norms and harmful cultural/religious practices (e.g. forced early/child marriage) that prevent the full expression of sexual and reproductive health and rights by citizens, the integration of sexual and reproductive health into development frameworks through actual budgeting and disbursement of funds, and the promotion of economic justice through the elimination of poverty and social inequality for all citizens. Indeed, we posit that country ownership should be the buzz word in any program that aims to sustain global development post-2014, rather than one that continues to promote dependency mentality for affected African countries.

The second intervention needed in Africa after ICPD+20 is to include the development and implementation of a purposeful and multi-pronged agenda for the development and social integration of young people. Available data indicate that youth less than 30 years old constitute more than 60% of Africa's population. Thus, youth development is not just a demographic necessity, but surely one of the priority interventions that can propel overall national development and eliminate social inequity in the continent. Africa's growing population can only become a demographic dividend rather than a liability, if African governments make the right kinds of investment through high quality education and health care for its young people which will result in immeasurable benefits in years to come. Although the ICPD POA made provisions for youth in its initial documents, it focused more on its immediate outcomes rather than its determinants. More and more the intermediary and distal outcomes of youth development are becoming nightmares in Africa's efforts to promote SRHR, and unless these are addressed, very little will progress will be made in the years that lie ahead.

The third intervention needed for Africa's SRHR development is genuine efforts made to empower women, to eliminate gender inequality and to mainstream women into developmental agenda of most affected countries. ICPD POA made strong provisions for the empowerment of women and emphasized it as a key cornerstone for achieving informed decision-making and improved sexual and reproductive health outcomes. Unfortunately, over the past 20 years although some gains have been made in the empowerment of women, this has not attained a scale that would see attendant improvement in SRHR indicators. By contrast, the continent continues to witness increased marginalization of women in social, economic and political spheres, with trends showing that the continent still lags behind the rest of the world in various gender parity indicators. Going forward, we recommend

that indicators of gender development be included in countries reporting frameworks, and that specific measures to hold governments accountable for performance in these indicators be clearly delineated.

In conclusion, the ICPD POA provided great hopes that Africa would fast-track its human development through the implementation of a composite sets of policies based on human rights and the promotion of sexual rights and reproductive justice, the elimination of social and economic inequality, and the abandonment of harmful cultural norms and practices. Our review indicates that progress has been slow, largely due to the poor integration of the values and principles of SRHR into development agenda in the continent. Going forward, the prioritization of country ownership, especially those that foster the development of youth and the empowerment of women stands a greater chance of success.

Conflict of Interest

None

References

1. ICPD. Program of Action, Cairo, Egypt. September 2014.
2. Harrison K. 1985. Childbearing, health and social priorities: a survey of 22,774 consecutive hospital births in Zaria, northern Nigeria. BJOG 1985; 92 Supplement 5, 1-119.
3. Okonofua FE. Economic Development and Reproductive Health in Africa. Afr J Reprod Health 1997, 1:2,6 – 7.
4. Rachel Snow and Okonofua FE. Launching the African Journal of Reproductive Health. Afr J of Reprod Health 1:1; 3 – 4, 1997.
5. World Bank. The state of the poor: where are the poor and where are they poorest? Poverty reduction & Equity. Accessed at: http://www.worldbank.org/content/dam/worldbank.

EDITORIAUX

La Refonte du Programme de santé de la reproduction en Afrique après 2014

Friday Okonofua

Rédacteur, *Revue africaine de santé de la reproduction*

La Conférence internationale sur la population et le développement (CIPD) qui s'est tenue au Caire en 1994[1] a été particulièrement importante pour l'Afrique subsaharienne par rapport au reste du monde. Avant cette date, les conférences précédentes sur la population ont porté principalement sur l'objectif singulier de réduire la croissance de la population grâce à la planification familiale comme la solution au probleme du développement mondial. Par conséquent, l'aide destiné au développement en Afrique à l'époque visait largement la planification familiale, en consacrant moins d'attention à d'autres composantes du développement. Il a fallu les résultats de la recherche au milieu des années 1980[2] qui a documenté l'impact des facteurs sociaux, économiques et culturels sur le taux élevé de mortalité sur le continent pour convaincre le reste du monde que le développement va bien au-delà des chiffres. Plus précisément, après des années de débat intense, le monde a identifié la pauvreté généralisée et l'exclusion sociale et le sous-développement des femmes comme les causes profondes de la forte fécondité et des taux élevés de mortalité qui caractérisent la plupart des régions du monde en développement. Les avocates ont avancé l'argument que sauf si ces problèmes sont abordées, il y aura peu d'espoir d'inverser les indicateurs déplorables de la santé (la santé maternelle en particulier) auxquels font face la plupart des pays. Bien que la CIPD soit une initiative mondiale, la situation de l'Afrique a présenté un laboratoire naturel pour l'expérimentation mondiale de tester l'hypothèse que la concentration sur l'autonomisation des femmes et l'amélioration de fortunes économiques entraînera une baisse importante de la fécondité et améliorer le bien- être social des populations.

Le 5 septembre 2014 marquera la 20e année que la CIPD a commencé au Caire. Lors de la conférence, les pays membres ont adopté un plan de 20 ans d'action (PA) pour assurer un développement mondial plus équitable et durable. Le PA de la CIPD a souligné le lien entre l'inégalité des sexes, la pauvreté, la mauvaise santé, le faible niveau d'instruction et une croissance économique durable. Depuis le PA original a été élaboré, les gouvernements des Etats membres ont réaffirmé leurs engagements tous les cinq ans. Les principaux domaines thématiques abordés dans le PA comprennent : la pauvreté et les inégalités, les femmes et les filles, les jeunes, la santé et les droits de la reproduction, la durabilité environnementale, le vieillissement et l'urbanisation et de la migration.

Les derniers mois ont vu les activités intenses liées aux revues de la CIPD +20 ayant comme objectif d'identifier ce qui a fonctionné et ce qui n'a pas marché dans diverses régions du monde, afin de générer un nouvel ensemble d'idées pour propulser le développement mondial dans les années à venir. C'est dans ce contexte que la Revue africaine de santé de la reproduction[3,4], une revue qui a été créé en 1997 pour documenter les processus, les réalisations et les défis de mise en œuvre de la CIPD en Afrique sub-saharienne publie ce commentaire. Sans doute, de progrès considérables ont été accomplis dans les 7 domaines thématiques de la CIPD en Afrique au cours de ces 20 ans. En particulier, l'Afrique a connu une croissance économique considérable, avec des preuves indiquant que de nombreux pays du continent ont atteint certains de la croissance du PIB plus rapide au cours de ces dernières années. Pourtant, les données de la Banque mondiale[5] montrent également que malgré cette prospérité croissante, la région a encore la plus forte proportion de personnes vivant dans une pauvreté extrême. Il indique que l'Afrique est toujours confrontée de plus en plus à des inégalités et de la

marginalisation, un indice clé pour mesurer le succès de la CIPD.

La santé et les droits de la reproduction (SDR) étant la pierre angulaire de la CIPD, il a été difficile de prévoir les résultats de diverses initiatives de programmation dans plusieurs régions d'Afrique. Bien que certains indices de la SDR soient améliorés dans la plupart des régions du continent, l'Afrique reste la région avec les pires indices de la sexualité et la santé de la reproduction dans le monde. Les taux de mortalité maternelle et infantile, l'avortement à risque, l'excision et le VIH/sida sont encore anormalement élevés dans le continent, avec peu de modèle systémique en vu pour indiquer que de nouveaux progrès seront réalisés très bientôt en ce qui concerne la réduction du fardeau de la maladie. C'est en grande partie dû au fait que beaucoup de principes et d'idées sur lesquelles le succès de la CIPD reposait n'ont pas matérialisés sur le continent. Les taux élevés et la hausse de la pauvreté, la marginalisation continue des femmes, le déni des droits de la reproduction et les obstacles culturels et religieux se dressent encore sur le chemin de la réalisation du Programme d'Action de la CIPD en Afrique. En outre, il y a un manque de volonté politique et de déterminisme chez de nombreux gouvernements africains pour mettre en œuvre le Programme d'Action étant donné que certains pays touchés n'ont pas domestiqué les principes convenus les plus fondamentaux. En revanche, la plupart des programmes SDR liés à la CIPD en Afrique ont été soutenus par les donateurs, n'ayant qu'une appropriation nationale et une supervision limitées. Il est de plus en plus évident que tels programmes seront incapables d'atteindre l'échelle et l'impact considérable sauf si les efforts sont concentrés à donner la priorité aux programmes comme les principaux points de l'ordre appartenant aux pays et actionnés par les pays eux-mêmes.

Ainsi, l'expérience de la programmation de la CIPD en Afrique depuis 1994, peut être décrite ou résumée comme un «travail en cours». Bien que 20 ans se soient passés, l'Afrique est encore au seuil de transformation et de changement social dans le domaine de santé sexuelle et de la reproduction. À notre avis, trois interventions critiques sont maintenant nécessaires pour accélérer le rythme du développement de l'ordre du jour de la santé et des droits sexuels et de la reproduction en Afrique, en avançant.

La première est de veiller à ce que les pays signent non seulement les documents et affirment les décisions prises lors de la CIPD+20, mais qu'ils prennent effectivement des mesures pour domestiquer les processus et de mettre en œuvre des politiques et des actions qui garantissent la cohésion sociale et le développement accéléré dans leur pays. Des domaines spécifiques où les actions du gouvernement sont nécessaires sont: les normes d'adressage et les pratiques culturelles/religieuses nuisibles (par exemple le mariage précoce forcé/des enfants) qui empêchent la pleine expression de la santé et des droits sexuels et de la reproduction par les citoyens, l' intégration de la santé sexuelle et de la reproduction dans les cadres de développement grâce à une budgétisation effective et le décaissement des fonds et la promotion de la justice économique grâce à l'élimination de la pauvreté et de l'inégalité sociale pour tous les citoyens . En effet, nous postulons que l'appropriation nationale doit être le mot à la mode dans tout programme qui vise à soutenir le développement global post- 2014, plutôt que celui qui continue à promouvoir la mentalité de la dépendance pour les pays africains touchés.

La deuxième intervention nécessaire en Afrique après la CIPD +20 est d'inclure le développement et la mise en œuvre d'un programme volontariste et multiaxes pour le développement et l'intégration sociale des jeunes. Les données disponibles indiquent que les jeunes gens âgés de moins de 30 ans représentent plus de 60 % de la population de l'Afrique. Ainsi, le développement de la jeunesse n'est pas seulement une nécessité démographique, mais sûrement l'une des interventions prioritaires qui peuvent propulser le développement national et éliminer les inégalités sociales dans le continent. La croissance démographique de l'Afrique peut seulement devenir un dividende démographique plutôt qu'un passif, si les gouvernements africains font de bons types d'investissement à travers l'éducation de haute qualité et des soins de santé pour ses jeunes qui se traduira par des avantages incommensurables dans les années à venir. Bien que le PA de la CIPD ait pris des dispositions pour les jeunes dans ses documents initiaux, il s'est

concentré davantage sur ses résultats immédiats plutôt que de ses déterminants. L'intermédiaire et les résultats distaux du développement des jeunes deviennent de plus en plus des cauchemars dans les efforts de l'Afrique pour promouvoir la SDR et à moins que ceux-ci soient abordés, très peu de progrès seront réalisés dans les années à venir.

La troisième intervention nécessaire pour le développement de la SDR de l'Afrique est de véritables efforts déployés pour l'autonomisation des femmes, pour éliminer les inégalités entre les sexes et pour intégrer les femmes dans l'ordre du jour de développement des pays les plus touchés. La PA-CIPD a pris des dispositions fortes pour l'autonomisation des femmes et l'a souligné comme une pierre angulaire pour la réalisation de la prise de décisions éclairées et l'amélioration des résultats de santé sexuelle et de la reproduction. Malheureusement, au cours des 20 dernières années, bien que certains progrès ait été réalisés dans l'autonomisation des femmes, ce qui n'a pas atteint une échelle qui montrerait ainsi l'amélioration des indices de SDR. En revanche, le continent continue d'assister à une marginalisation accrue des femmes dans les sphères sociales, économiques et politiques, les tendances montrent que le continent reste à la traîne du reste du monde dans divers indicateurs de parité entre les sexes. Pour l'avenir, nous recommandons que les indices de développement du genre soient inclus dans les cadres des pays déclarants et qu'il faut clairement limiter des mesures spécifiques pour tenir les gouvernements responsables de la performance de ces indices.

En conclusion, le PA de la CIPD a fourni de grands espoirs que l'Afrique accélérerait son développement humain à travers la mise en œuvre d'un ensemble composite de politiques fondées sur les droits humains et la promotion des droits sexuels et de la justice en matière de la reproduction, l'élimination de l'inégalité sociale et économique et l'abandon des normes et des pratiques culturelles néfastes. Notre examen indique que des progrès ont été lents, en grande partie en raison de la mauvaise intégration des valeurs et des principes de la SDR dans le programme de développement dans le continent. À l'avenir, la priorité de l'adhésion des pays, en particulier ceux qui favorisent le développement de la jeunesse et de l'autonomisation des femmes se trouvent une plus grande chance de succès.

Conflit d'intérêts

Aucun

Références

1. La CIPD. Programme d'action du Caire, en Egypte. septembre 2014.
2. Harrison K. 1985. Procréation, la santé et les priorités sociales : une enquête auprès des 22 774 naissances consécutives à l'hôpital à Zaria, dans le nord du Nigeria. *BJOG* 1985; 92 Supplément 5, 1-119.
3. Okonofua FE. Développement économique et la santé de la reproduction en Afrique. Afr J Reprod Health 1997, 1 :2 ,6 - 7.
4. Rachel Snow et Okonofua FE. Lancement de la *Revue africaine de santé de la reproduction. Afr J Reprod Health* de 1:1; 3 - 4, 1997.
5. Banque mondiale. La Situation des pauvres : où sont les pauvres et où sont-ils les plus pauvres ? Réduction de la pauvreté et d'équité.
6. Consulté à : http://www.worldbank.org/content/dam/worldbank.

ORIGINAL RESEARCH ARTICLE

Family Planning Needs of Women Experiencing Severe Maternal Morbidity in Accra, Ghana: Another Missed Opportunity?

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Abstract

Women with severe maternal morbidity represent an important group to target for increasing contraceptive uptake. Our objective was to explore the future fertility intentions, use of family planning including methods and reasons for not wanting to use contraception among a group of women who had traumatic delivery experience at a tertiary teaching hospital in Accra, Ghana. Our results show that despite higher educational attainment, longer hospital stays and intention to limit or stop childbearing among women, there is a missed opportunity for family planning among women with severe maternal morbidity in this urban African hospital setting. Integrating postpartum family planning consultations by linking available services such as reproductive health clinics at the facilities rather than including additional tasks for the midwives and the doctors in the wards could be a sustainable solution in such urban, high-volume settings. *(Afr J Reprod Health 2014; 18[2]: 15-21).*

Keywords: near miss, maternal morbidity, family planning, postpartum contraception, Africa, integration, facility delivery

Résumé

Les femmes qui souffrent de la morbidité maternelle sévère représentent un groupe important à cibler pour faire avancer l'utilisation de la contraception. Notre objectif était d'étudier les futures intentions de fécondité, l'utilisation de la planification familiale, y compris les méthodes et les raisons de ne pas vouloir utiliser la contraception chez un groupe de femmes qui ont vécu l'expérience traumatique d'accouchement dans un Centre Hospitalier Universitaire à Accra, au Ghana. Nos résultats montrent que, malgré le niveau de scolarité plus élevé, de plus longs séjours à l'hôpital et l'intention de limiter ou d'arrêter de procréer chez les femmes, il y a une occasion manquée pour la planification familiale chez les femmes qui ont vécu la morbidité maternelle sévère dans ce milieu urbain de l'hôpital africain. L'intégration des consultations de planification familiale post-partum en reliant les services disponibles tels que les cliniques de santé de la reproduction dans les installations plutôt que d'inclure des tâches supplémentaires pour les sages-femmes et les médecins dans les salles, pourrait être une solution durable, dans de tels milieux urbains et à volume élevé. *(Afr J Reprod Health 2014; 18[2]: 15-21).*

Motsclés: presque manqué, morbidité maternelle, planification familiale, contraception post-partum, Afrique, intégration, accouchement dans un établissement de santé

Introduction

Maternal morbidity is often an overlooked but important cause of disease burden, especially in low and middle-income countries[1]. For every woman that dies, there are at least 20 more women who suffer from injuries, infection and disabilities relating to pregnancy and birth[2]. Severe maternal morbidity, maternal near miss, is defined as "a woman who nearly died but survived a complication that occurred during pregnancy, childbirth or within 42 days of termination of pregnancy"[3] and these women represent an important group to target for increasing contraceptive uptake[4]. Recent research in Ghana underlines that morbidity is a continuum and indicates that if the underlying causes of poor maternal health outcomes are addressed, it is likely that changes will improve health outcomes across the continuum of morbidity[5]. Many women who have experienced a severe morbidity are considered as high-risk obstetric patients in

subsequent pregnancies. This is especially the case when the interval between the pregnancies is shorter than what is recommended. The World Health Organization (WHO) asserts that birth-to-pregnancy intervals of around 18 months or shorter are associated with increased risk of maternal, neonatal and perinatal mortality[6].

Even though the use of family planning is pivotal in achieving the Millennium Development Goal 5 (MDG-5) on reducing maternal mortality and universal access to reproductive health, contraceptive use is low in many West African countries, including Ghana[7]. In Ghana, the maternal mortality ratio is 350 maternal deaths per 100,000 live births and the modern contraceptive prevalence rate is 17%[8,9]. According to the Demographic Health Survey, the total fertility rate is 4 and about 35% of women have unmet need for family planning[9]. Furthermore, family planning needs among women with severe maternal morbidity have been under-studied in developing countries, including Ghana.

Pregnancy and immediately postpartum period are important opportunities for counseling women on the use and adoption of family planning[10]. In this study, our objective was to explore the future fertility intentions, use of family planning including methods and reasons for not wanting to use contraception among a group of postpartum women who had traumatic delivery experience ranging from complications to near miss identified by the new WHO criteria[11] at a tertiary teaching hospital in Accra, Ghana.

Methods

Semi-structured interviews with 36 women who experienced severe maternal morbidity were conducted between October 2010 and March 2011 as part of a larger prospective study using mixed methodology and focusing on severe maternal morbidity and quality of care[12,13]. This study took place in Korle-Bu Teaching Hospital in urban Accra, which is one of the main teaching facilities in the country. Our qualitative methodology is described elsewhere in detail[13]. Briefly, as part of the quantitative component of the parent study, women with severe maternal morbidity were identified based on the occurrence of the following maternal health outcomes, using patient records: 1) potentially life-threatening conditions were identified based on severe complications and/or critical interventions; and 2) near-miss cases were identified based on organ system dysfunction based on clinical criteria, laboratory markers and management-based proxies[13,14]. The specific criteria can be found in the supplemental document 1. The inclusion criteria were not restricted to gestational age at which the complications happened and women with abortion or ectopic pregnancy related morbidities were included. Women who developed such complications outside pregnancy or after 42 days termination of pregnancy were excluded.

In order to elicit honest responses without the fear of retribution from the staff, women were invited to participate in the study just prior to or immediately after their discharge from the hospital. All women who agreed to participate in the study gave a written informed consent. The IRBs at the Johns Hopkins Bloomberg School of Public Health and University of Ghana Medical School approved the study. The interviews were conducted in English or Twi. Those conducted in Twi were translated and transcribed in English, and a second researcher reviewed all translations and transcriptions before data analysis.

The interview guide included topics on initial expectations related to the pregnancy, perception of complications, the processes of transfer and care women received at the facility. As part of these interviews, the women were also asked about future fertility and family planning.

Thirty-four women had completed medical data extraction forms and 36 women had completed the semi-structured interviews. We performed basic tabulations on morbidity level, socio-demographic, reproductive and maternal health variables extracted from the medical records. The interviews were analyzed for thematic content based on the interview guide.

Results

Among the thirty-six women interviewed, almost all of them were married, Christians and working women with at least junior high school training (Table 1). Overall, 17 women (47%) were

identified as a near miss based on WHO criteria and 15 women (42%) had potentially life-threatening complications. The average age was 31.4 and the average gestational age was 36 weeks. On average, the hospital stay was 13.4 days. It should be noted that none of the women approached for the interview declined.

Table 1: Characteristics of the women (N=36)*

	Number (%)
Near Miss Status	
Near Miss	17 (47)
Potentially life-threatening conditions	15 (42)
Other complications	4 (11)
Mean age	31.4 (Range: 20-42)
Marital Status	
Married	32 (94)
Single	2 (6)
Religion	
Christian	32 (94)
Muslim	2 (6)
Education	
None	1 (3)
Junior High Secondary	12 (35)
Senior High Secondary	14 (41)
Tertiary	3 (9)
Missing	4 (12)
Occupation	
Trader	19 (56)
Hairdresser/Seamstress	6 (18)
Other (Secretary etc)	9 (26)
Mean Hospital Stay (days)	13.4 (5-31)
Reproductive Health Indicators	
Mean parity	1.67 (Range: 0-6)
Mean Gestational age	35.9 (Range: 24-43)
Ever had a miscarriage	22 (63)
Ever had an abortion	19 (53)
Ever had a stillbirth	24 (67)

*Only thirty-four women had completed medical data extraction forms.

Two sets of questions were asked related to family planning. The first asked about fertility intentions in the future. Of the 36 women interviewed, nineteen women (54%) reported wanting more children and 14 (40%) women reported that they would like to limit childbearing. Of the 19 women who wanted more children, more than half of them wanted to space births. The reasons for spacing varied among the women ranging from financial concerns to trying to avoid complications experienced in the previous delivery, underlining the extra burden these women and their families face due to severe morbidity.

"My delivery has been costly, both of my two deliveries [explaining why she does not want to get pregnant again]" (31 years old, near miss, 21 days hospital stay, two kids)

"If I had the chance I will not deliver again but I can't decide… because he is the man who is married to me, so what he says is what will happen. But left to me alone, I would not deliver again. … Because the ways I always suffer in labor, I have lost interest in giving birth again." (25 years old, potentially life-threatening condition, 8 days hospital stay, two kids)

The second set of questions was about future use of contraception and reasons for intended non-use. A majority of the women interviewed (60%) wanted to use contraception, whereas 20% of the women were unsure and the rest (20%) did not want to use. Reasons for not wanting to use contraception included never having used contraception, personal experience of side effects, hearing about the possible side effects of the methods or simply "*not liking it*".

"I'm not using family planning and I don't like it. I have not done some [family planning] before but if I get tablet that I can take that won't worry me, I will." (34 years old, potentially life-threatening condition, 7 days hospital stay, two children)

"I haven't used any [family planning] but they say if you use it for some time and you stop… it becomes difficult to have children after using it for some time. That is why I said I am not going to use any family planning." (41 years old, potentially life-threatening condition, 12 days hospital stay, two children)

Some women cited the importance of joint decision-making with the husband before choosing a method, emphasizing the important role of male partners in the uptake of family planning in Ghanaian context.

"I have to see the advice from the doctors which one would be best for me. But first of all, I have to decide with my husband."(33 years old, near miss, 8 days hospital stay, two children)

"If I use family planning and I did not inform my husband and he finds out, it might lead to

divorce." (25 years old, potentially life-threatening condition, 8 days hospital stay, two children)

Overall, majority of the women who wanted to use family planning for spacing or limiting did not receive any counseling and left the hospital without any methods.

"I don't know any [family planning] so I will come to the hospital for them to educate me on which one will be suitable for me." (37 years old, near miss, 15 days hospital stay, two children)

"For me, I haven't used it before, so until we come back to the hospital, I don't know [which method to choose]" (33 year old, near miss, 7 days hospital stay, one child).

FOR WEB ONLY – if possible

SUPPLEMENTAL DOCUMENT 1: WHO criteria for identification of maternal near miss*[11]

	Clinical	Laboratory	Management
Cardiovascular dysfunction	o Shock o Cardiac arrest	o pH <7.1 o Lactate >5	o Use of continuous vasoactive drugs o Cardio-pulmonary resuscitation (CPR)
Respiratory dysfunction	o Acute cyanosis o Respiratory rate >40 or <6/min	o PaO2/FiO2 <200 mmHg o Oxygen saturation <90% for ≥60 minutes	o Gasping o Intubation and ventilation not related to anesthesia
Renal dysfunction	o Oliguria non responsive to fluids or diuretics	o Creatinine ≥300 mmol/l or ≥3,5 mg/dl	o Dialysis for acute renal failure
Coagulation/ Hematological dysfunction	o Clotting failure	o Acute thrombocytopenia (<50 000 platelets)	o Transfusion of ≥5 units of blood/red cells
Hepatic dysfunction	o Jaundice in the presence of pre-eclampsia	o Bilirubin>100 mmol/l or > 6,0 mg/dl	
Neurological dysfunction	o Coma/ loss of consciousness lasting 12 hours or more o Metabolic coma (loss of consciousness AND the presence of glucose and ketoacids in urine) o Stroke o Status epilepticus/ Uncontrollable fits/total paralysis		
Other severity proxy			o Hysterectomy due to infection or hemorrhage

*A women presenting with **any** of the conditions listed in this box and surviving the complication is considered a maternal near miss case.

Discussion

There is a missed opportunity for family planning among women with severe maternal morbidity in this urban African hospital setting. Despite the higher levels of education in our study population, we found insufficient knowledge, lack of prior use and lingering fears about side effects such as post-

contraceptive infertility among the interviewed women, supported by a recent study in urban Accra[15]. A cross-sectional study from urban Senegal showed that less than 3% of the women received a family planning method during postpartum period (delivery, postnatal care, immunization for children), whereas a majority of the women who did not receive the services indicated an interest[16]. The high reported desire to learn about and use family planning among women in our study, yet not receiving any family planning consultation or provision during the postpartum period underlines the importance of and the need for postpartum counseling among women with severe maternal morbidity. Moreover, due to their medical conditions, these women stay longer at the hospital allowing time for family planning counseling and provision.

Obstetric complications and severe morbidity may significantly influence women's sexual health, wellbeing and fertility, and differences in health systems and cultural contexts in low-resource settings might accentuate these effects. WHO recommends a pregnancy interval of at least 24 months before attempting the next pregnancy in order to minimize the risk of adverse maternal, perinatal and infant outcomes[6]. Research shows that adequate family planning coverage is essential for those who survive a severe complication because of the potential adverse health and socio-economic impact among those women bearing new pregnancies[4,17].

Current recommendations for improving contraceptive uptake generally include adequate counseling and provision of modern contraceptive methods to recently delivered mothers wanting these services before they are discharged from the hospital[17]. However, as highlighted in a recent multi-country analysis the postpartum contraceptive uptake is generally low in many low- and middle-income countries[18]. The common barriers in these settings include difficult geographical access, limited method choice, financial costs, the status of women, medical and legal restrictions, provider bias, fear of side effects and misinformation, some of which were also highlighted in our findings[19].

Different approaches have been tested such as group counseling and inclusion of males in contraceptive decision-making and should be applied based on specific context of the country[20,21]. Given the misperceptions around contraceptive use and the highlighted role of men in our study, comprehensive counseling and inclusion of partners in this process should be considered for future programs. It should also be noted that we conducted our study in an urban setting and the role of the partners can be even a greater factor in rural areas. A survey examining the factors influencing the intentions of women to adopt postpartum family planning in rural Ghana found that most women (90.5%) who wanted to adopt a method reported that they would need the approval of their partners[10]. Furthermore, attention should be paid to counseling women with a poor perinatal outcome or early pregnancy loss as they may be more likely to desire to become pregnant again as early as possible compared to the women with live births[17].

Recent estimates indicate that Ghana is making progress with respect to achieving the MDG-5 with maternal mortality ratio of 350 per 100,000 live births[8]. However, this figure is still unacceptably high. Every pregnancy is an exposure to the risk of life-threatening conditions, such as maternal near miss or maternal death, especially in high maternal mortality settings[22]. While interventions to improve emergency obstetric care are important, preventive measures such as improving postpartum contraceptive uptake for women and couples, who choose to use it, should be instituted to further reduce the burden of severe maternal morbidity and mortality.

Conclusions

Postpartum family planning is one of the recommended evidence-based interventions to improve maternal health[7,23,24]. However, further evidence on how to better integrate family planning into maternal health services is still urgently needed[16]. Further research should consider integrating postpartum family planning consultations by linking available services such as reproductive health clinics at the facilities. This would alleviate the burden of rather than including additional tasks for the midwives and the doctors in the wards, and could be a sustainable solution in

such urban, high-volume settings. Such environment would also be more conducive to comprehensive counseling as well as inclusion of partners in the decision-making processes.

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Conflict of Interest

The authors have no conflict of interest.

Contribution of Authors

OT and MJH conceived and designed the study in collaboration with RMA and KAB. OT and KAB collected the data and OT and MJH conducted the analysis. OT prepared the first draft of the manuscript and MJH, RMA and KAB provided input.

References

1. Firoz T, Chou D, von Dadelszen P, et al. Measuring maternal health: focus on maternal morbidity. *Bull World Health Organ* 2013; 91(10): 794-6.
2. Ashford L. Hidden suffering: disabilities from pregnancy and childbirth in less developed countries. http://www.prb.org/pdf/hiddensufferingeng.pdf (accessed December 4, 2012.
3. Say L, Souza JP, Pattinson RC. Maternal near miss--towards a standard tool for monitoring quality of maternal health care. *Best Pract Res Clin Obstet Gynaecol* 2009; 23(3): 287-96.
4. Storeng KT, Drabo S, Ganaba R, Sundby J, Calvert C, Filippi V. Mortality after near-miss obstetric complications in Burkina Faso: medical, social and health-care factors. *Bull World Health Organ* 2012; 90(6): 418-25B.
5. Tuncalp O, Hindin MJ, Adu-Bonsaffoh K, Adanu RM. Understanding the Continuum of Maternal Morbidity in Accra, Ghana. Maternal and child health journal. 2013.
6. World Health Organization. Report of a WHO Technical Consultation on Birth Spacing. Geneva, Switzerland: WHO, 2005.
7. Ahmed S, Li Q, Liu L, Tsui AO. Maternal deaths averted by contraceptive use: an analysis of 172 countries. *Lancet* 2012; 380(9837): 111-25.
8. World Health Organization, UNICEF, UNFPA, The World Bank. Trends in maternal mortality: 1990 to 2010. WHO, UNICEF, UNFPA, and The World Bank Estimates, 2012.
9. Ghana Statistical Service (GSS), Ghana Health Service (GHS), ICF Macro. Ghana Demographic and Health Survey 2008. Accra, Ghana: GSS, GHS, and ICF Macro., 2009.
10. Eliason S, Baiden F, Quansah-Asare G, et al. Factors influencing the intention of women in rural Ghana to adopt postpartum family planning. *Reprod Health* 2013; 10: 34.
11. World Health Organization, . Evaluating the quality of care for severe pregnancy complications: the WHO near-miss approach for maternal health. Geneva: WHO, 2011.
12. Tuncalp O, Hindin MJ, Adu-Bonsaffoh K, Adanu RM. Assessment of maternal near-miss and quality of care in a hospital-based study in Accra, Ghana. *Int J Gynaecol Obstet* 2013; 123(1): 58-63.
13. Tuncalp O, Hindin MJ, Adu-Bonsaffoh K, Adanu R. Listening to women's voices: the quality of care of women experiencing severe maternal morbidity, in Accra, Ghana. *PLoS One* 2012; 7(8): e44536.
14. Tuncalp O, Hindin MJ, Adu-Bonsaffoh K, Adanu RM. Assessment of maternal near-miss and quality of care in a hospital-based study in Accra, Ghana. *Int J Gynaecol Obstet* 2013.
15. Hindin MJ, McGough LJ, Adanu RM. Misperceptions, misinformation and myths about modern contraceptive use in Ghana. *The journal of family planning and reproductive health care / Faculty of Family Planning & Reproductive Health Care, Royal College of Obstetricians & Gynaecologists* 2013.
16. Speizer IS, Fotso JC, Okigbo C, Faye CM, Seck C. Influence of integrated services on postpartum family planning use: a cross-sectional survey from urban Senegal. *BMC Public Health* 2013; 13(752).
17. Ganaba R, Marshall T, Sombie I, Baggaley RF, Ouedraogo TW, Filippi V. Women's sexual health and contraceptive needs after a severe obstetric complication ("near-miss"): a cohort study in Burkina Faso. *Reprod Health* 2010; 7: 22.
18. Borda MR, Winfrey W, McKaig C. Return to sexual activity and modern family planning use in the extended postpartum period: an analysis of findings from seventeen countries. *Afr J Reprod Health* 2010; 14(4 Spec no.): 72-9.
19. Campbell M, Sahin-Hodoglugil NN, Potts M. Barriers to fertility regulation: a review of the literature. *Stud*

Fam Plann 2006; 37(2): 87-98.
20. Schwandt HM, Creanga AA, Danso KA, Adanu RM, Agbenyega T, Hindin MJ. Group versus individual family planning counseling in Ghana: a randomized, noninferiority trial. *Contraception* 2013; 88(2): 281-8.
21. Becker S. Couples and reproductive health: a review of couple studies. *Stud Fam Plann* 1996; 27(6): 291-306.
22. Gipson JD, Koenig MA, Hindin MJ. The effects of unintended pregnancy on infant, child, and parental health: a review of the literature. *Stud Fam Plann* 2008; 39(1): 18-38.
23. Department of Reproductive Health and Research. Medical Eligibility Criteria for Contraceptive Use, 4th Edition. Geneva, Switzerland, 2010.
24. Tsui AO, McDonald-Mosley R, Burke AE. Family planning and the burden of unintended pregnancies. *Epidemiologic reviews* 2010; 32(1): 152-74.

ORIGINAL RESEARCH ARTICLE

Reflections on Female Circumcision Discourse in Hargeysa, Somaliland: Purified or Mutilated?

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Abstract

In communities where female circumcision is carried out, increasingly large segments of the population have been exposed to strong arguments against the practice. This study aimed to explore diverse discourses on female circumcision and the relationship between discourses and practice among informants who have been exposed both to local and global discourses on female circumcision. A qualitative study was carried out in 2009/10 in Hargeysa, Somaliland, employing interviews and informal discussion. The main categories of informants were nurses, nursing students, returned exile Somalis and development workers. The study findings suggest that substantial change has taken place about perceptions and practice related to female circumcision; the topic is today openly discussed, albeit more in the public than in the private arena. An important transformation moreover seems to be taking place primarily from the severe forms (pharaoni) to the less extensive forms (Sunna). *(Afr J Reprod Health 2014; 18[2]: 22-35).*

Keywords: pharaoni, sunna, FGM, infibulation,

Résumé

Dans les communautés où l'excision est pratiquée, de grandes parties de la population ont été exposées à de forts arguments contre la pratique. Cette étude vise à explorer les diverses discours sur l'excision et la relation entre les discours et la pratique parmi les informateurs qui ont été exposés à la fois à des discours locaux et mondiaux sur l'excision. Une étude qualitative a été menée en 2009/10, à Hargeisa, au Somaliland, en utilisant des entrevues et des discussions informelles. Les principales catégories d'informateurs étaient des infirmières, des étudiants en soins infirmiers, des Somaliens qui revenaient de l'exil et des agents de développement. Les résultats de l'étude suggèrent que les changements importants ont eu lieu sur les perceptions et les pratiques liées à l'excision; le sujet est aujourd'hui ouvertement discuté, mais plus dans le domaine public que dans le domaine privé. Une transformation importante semble d'ailleurs avoir lieu principalement à partir des formes sévères (pharaoni) jusqu'aux formes moins vastes (de sunna). *(Afr J Reprod Health 2014; 18[2]: 22-35).*

Motsclés: pharaoni, sunna, MGF, infibulation

Introduction

Although powerful global campaigns against female genital mutilation (FGM) have been in place for a number of years, the practice of what we in this paper will refer to as female circumcision continues to be customary in a large number of countries and communities globally, with a majority found across Africa from the north eastern coast to the west coast[1]. Increasingly large segments of the population in Somaliland, where female circumcision is carried out on a considerable scale, have been exposed to both strong arguments for the continuation of female circumcision and strong arguments against the practice. This paper focuses on discourses on female circumcision in Hargeysa, Somaliland, as encountered among categories of people who to a substantial extent have been confronted with the strong global anti-FGM discourse but, who are moreover well acquainted with local discourse in favour of the practice. Indeed, the inhabitants of Hargeysa increasingly live their lives with a fundamental knowledge of both positions. Circumcised women who have been strongly confronted with arguments against the practice

have potentially important roles to play in the fight against female circumcision. The paper sets out to explore how people in Hargeysa, Somaliland, perceive and relate to the diverse positions of this practice.

Background

We will start with a brief commentary on the somewhat confusing terminological landscape around the practice before we turn to the background for and some implications of female circumcision. Female genital cutting (FGC), female genital mutilation (FGM) and female circumcision (FC) are all commonly employed terms in English when referring to the practice. The term female genital mutilation (FGM) is the term most often used in English. With its clear derogative connotation, FGM was found to be problematic to use in the present study, which aimed to explore the practice in an open manner. Rather, 'female circumcision' – which emerged as the concept located closest to the terms in use in Somali – was employed in the present study[2]. Female circumcision will however be employed in combination with 'infibulation', the form of circumcision which is most common in this part of Africa, along with local terms. Female genital cutting (FGC) is not in common use in Hargeysa.

The World Health Organisation offers a revised (2008) description and classification of various forms of female circumcision, and presents four main types with sub-categories: types I and II correspond to what is labelled *Sunna* in Somaliland. This is an operation implying anything from a pricking of the clitoris to the cutting and sewing with one or two stitches in the labia minora. Type III in the classification corresponds in broad terms to infibulation, or to what would be labelled *gudnin pharaoni* in Somaliland, and implies the cutting of the labia minora and/or the clitoris. This practice commonly involves quite elaborate stitching of the labia major a, leaving a small orifice for urine and menstrual blood to pass. Type IV is described as 'all other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization'[3]. Due to the multitude of local variations, a well-recognized challenge has been to incorporate these variations of female circumcision in a standardized classification system[4,5].

According to the Norwegian anthropologist Aud Talle, who has studied female circumcision in diverse 'non-Western' as well as 'Western' contexts, *sunna* has come to mean among Somalis all ways of female genital cutting that do not classify as infibulation or as being 'closed'[6]. '*gudninp haraoni', 'gudnin sunna'* and *'halalays'* are all common terms in use in the Somali language to describe female circumcision. Broadly speaking, *gudnin pharaoni* or just *pharaoni* corresponds to infibulation, while *gudnin sunna* or just *sunna* largely corresponds to clitoridectomi. *'Halalays'* has the stem *halal* in Arabic – referring to what is permitted in Islam – and is used for all forms for circumcision. Talle writes that, in a Somali context, both women and men are considered to be impure at birth and need to be purified in order to become true women and men and to reproduce. The purification process partly takes place through the act of circumcision for both women and men. For women, the purification takes place by cutting the clitoris, which is considered the 'hard' and masculine part of a woman, and is connected with childhood and with dirt[7].

Female circumcision has been presented somewhat stereotypically as a practice in which men control female sexuality and female reproduction. The manner in which women have been depicted as victims of a brutal male practice has created sharp reactions, not the least from circumcised women. They have not commonly perceived themselves as victims of a violent male practice but have seen female circumcision as a female custom that is necessary to maintain in order to make or create true women. Female circumcision has been described in the anthropological literature as part of a gendering process carried out to create a moral, marriageable and fertile woman[5,7,8]. Infibulation, moreover, has been described as a protection for women against rape, for example in connection with women who were herding alone or were alone in their huts[2,7,9]. Female circumcision was barely mentioned in either the historical or the anthropological

literature until the last half of the twentieth century. Written sources tell of female slaves from Sudan who were 'closed', that is, were circumcised in order to protect their virginity and thus ensure a higher price on the slave marked in Egypt. The term *pharaoni* is believed to have its origin from this time[2,6]. From being a rather muted issue, the debates concerning female circumcision surfaced between the national movement in Kenya and missionary communities in the last part of the 1920s as the 'female circumcision controversy'. The missionaries made attempts to raise a protest against the practice. From the local and national perspective, female circumcision at this early point emerged as a case symbolizing African resistance against colonization[6,10,11]. The controversy over female circumcision did not however end with the Kenyan confrontation. The issue returned with full force during 'UN' women's decade' and the feminist movement in the 1970s. The debates at times became very emotional. Body and Gruenbaum have pointed out that a lack of understanding about the complexity of the practice has characterized the discourse ever since the seventies[2,12-14]. Female circumcision has been increasingly debated in global forums, not least because circumcised women have migrated to all parts of the world, and the challenges related to how to perceive and deal with the practice have increasingly become central issues in settings that find the custom unacceptable. With processes of globalization, female circumcision has become a phenomenon known worldwide, with increasing emphasis on and demands for the eradication of the practice[2,5,6,15,16].

Female circumcision has e.g. for a number of years appeared in Norwegian official debate, and Talle in particular has voiced concern about what she has described as a 'tabloid' view of the practice. She has attempted to give a more nuanced and informed picture, and to minimize the stigma that such simplified views have produced[1,6]. According to Talle, it is almost taboo in Norway to discuss female circumcision in terms other than of disgust[1]. A documentary from Hargeysa shown on Norwegian TV in 2007 held that as many as 185 Norwegian-Somali girls could have been circumcised over the last couple of years in Somaliland[17]. Talle, who at the time was involved in a study among Norwegian-Somalis in Oslo and Hargeysa, strongly questioned the reported numbers, arguing that the number was much lower[1].

The demand for eradication of the practice has been based on gender and human rights arguments and health related arguments respectively. A number of studies have scrutinized the health implications of female circumcision. Acute complications of the operation are reported to be excessive bleeding, pain and infection[1]. Pain and sometimes occlusion related to menstruation, prolonged urination time due to the small outlet, and both acute and chronic urinary tract infections proportional to the anatomic extent of the circumcision have been reported[18]. Urogenital complications have been found to be of a significantly higher risk among circumcised girls (Type I, II, III) compared to uncircumcised girls[19]. Morison et al. for example concluded that there was a significantly higher risk of bacterial vaginosis for circumcised compared to uncircumcised women, while there was a lack of other significant possible health outcomes for Type II-circumcision[20]. A WHO study carried out in six countries in Africa moreover concluded that there was higher risk associated with delivery among circumcised women[21]. Small's study, comparing Somali post-immigrant women and women in the 'receiving' countries, found that Somali women were more likely to have a Caesarean section, and had a higher risk of perineal trauma. Children born to Somali women showed in the same study a markedly higher risk of a low Apgar score, still births and neonatal deaths. Delayed care-seeking combined with lack of interpreters for circumcised women in a foreign setting were explained as other possible reasons for the poor birth outcomes[22]. The results, however, have varied starkly: Vangen et al. found no explicit connection between female circumcision and maternity complications for Somali immigrants in Norway, although the relation was not entirely excluded[23]. A case-control study on infertile women found that the prevalence of gynaecological pathology was higher among infertile women with a more extensive form of circumcision than in the control group, indicating that the more extensive the

circumcision, the greater the chance of complications leading to infertility[24]. According to Obermeyer, there are many challenges for health research related to female circumcision, not least the lack of specificity and detailed knowledge about the different types of circumcision[25]. What is more, the reliability of self-reporting of forms of female circumcision, which is a commonly employed method, has been questioned, as women tend to under-report the degree of their circumcision[26].

Debates related to whether or not female circumcision has implications for female sexuality has also emerged. The review article by Obermeyer suggests that studies concerned with female circumcision and sexuality demonstrate that many circumcised women experience sexual sensation and desire despite the clitoris being damaged[4,25,27]. Other studies suggest that women with female circumcision have less sexual sensation and, again, that the extent of the removal of tissue is of importance for the potential of sexual arousal[28,29]. However, very few if any studies have been able to explore any difference in sexual sensation among women who have been sexually active both before and after female circumcision, hence uncertainty remains regarding the impact of female circumcision on sexual sensation[13,28]. Pain in connection with coitus has been reported, especially pertaining to infibulated women[25]. Less research has been carried out on the potential effects of female circumcision on male sexuality, but a study by Almroth et al. among married Sudanese men found infibulation to be associated with both physical and psychological sexual stress for men[30].

In Somaliland, the custom of female circumcision has commonly been associated with the Muslim religion, and some of the leading Muslim schools interpret the religious scripts (*Hadiits*) in the direction of an acceptance of *sunna* circumcision, despite the lack of a clear link to the Koran[31]. Female circumcision has not in fact been described as a required practice in the Koran or by Islam, which has been used as one of the main arguments against the practice by many Muslims. Female circumcision is not customary in central Muslim countries in the Middle East, while a large number of non-Muslim societies in Africa practise female circumcision[1,5,31]. Within Somali society, however, female circumcision is said to 'purify' girls for religious practice; i.e. becoming Muslim[7,32].

Study setting, aims and objectives

The present study was carried out in Somaliland, a de facto state and the northern autonomous region of Somalia. The capital Hargeysa found itself in the midst of reconstruction at the end of the civil war in the late 1980s. The war led to a continuous flight from the Somali populated area on the Horn of Africa, and resulted in exiled Somali populations located in neighbouring African countries as well as in a number of western countries. Hargeysa has remained safe compared to southern Somali and has, for a number of years, been a melting pot and meeting place for Somali society and the Somali diaspora. This background makes Somaliland and Hargeysa a particularly interesting and important location for a study of potential transformation of this culturally-embedded practice. In Somaliland, female circumcision is normally carried out well before the onset of puberty, commonly between the age of five and ten[1]. The information available indicates that more than 95% of all women are circumcised, of whom more than 95% are infibulated[33-35].

In a context of massive FGM eradication campaigns, this paper sets out to explore discourses on female circumcision among categories of people who are familiar with local discourses that argue for a continuation of the practice but who, simultaneously and to a substantial extent, have been exposed to or are working within the anti-FGM campaigns. The more specific objective of the paper is to study the present discourses on female circumcision among nurses, nursing students, returned exile women, and development workers engaged in FGM eradication work with the aim of informing the FGM eradication campaign. Furthermore, the paper aims to explore the relationship between the discourses on FGM and the practice of female circumcision in Somaliland.

Drawing on the discourse concept in the analysis of the material, a brief mention of