



LUND UNIVERSITY
Faculty of Social Sciences

Graduate School

Course SIMV07

Master of Science in Development Studies

Spring 2015

Major: Political Science

Supervisor: Catarina Kinnvall

Sexuality, Gender empowerment and Development

A case study of clitoral rehabilitation of excision-
affected women in Burkina Faso

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Abstract

This qualitative case study explores the empowering potentialities of clitoral reconstruction for mutilated women in Burkina Faso. In this developing country of sub-Saharan Africa, historical high prevalence rates of excision leave millions of women in the most physical and mental ill being. This, as a consequence, causes their marginalisation from the development process.

The methodology is bond to the feminist empowerment theories. My feminist approach is critical to national and traditional structural mechanisms, which maintain mutilated women in subordination. Doing so, and influenced by a conception of development based on well-being for its intrinsic value, I mainly focus on clitoral reconstruction candidates striving towards more flourishing lives.

The analysis is partly drawn from observation and interviews performed during a short field research in the capital city Ouagadougou. Rehabilitated women, doctors and professional workers in women's support associations drove me closer to women's issues. This allowed an exploration of both the enabling practices of clitoral rehabilitation, and the constraining national and traditional conceptions of sexuality. This study partly relies on the analysis of secondary data including policy documents.

I conclude that genital reconstructive surgery of the clitoris has the potential to anatomically and psychologically rehabilitate a functioning sexuality to genitally impaired women. The contribution of the surgical treatment to women's individual empowerment rests on women's demands and entitlement to more fulfilling lives. This paper addresses public institutions and advocacy groups committed to fight feminine genital mutilation as well as women's movements in general. The findings provide material for informing individual choices and ultimately for policymaking.

Key words: clitoral reconstruction, empowerment, feminine genital mutilation, gender equality, genital reconstructive surgery, sexuality

Words: 19,945

Acknowledgments

First of all, I would like to express my gratitude to my supervisor, Catarina Kinnvall from the department of Political Science for her kind mentorship and for showing interest in my study; thank you for your advices and availability.

My infinite thankfulness also goes to the formers colleagues of Diakonia's country office in Burkina Faso, as well as all those whose readiness made possible my research in Burkina Faso. I think for instance, of Agnès, Sakina, and Solange whose experiences fed my reflection.

I am very grateful to my reviewers Emma, Étienne, and Nancy for their dedication. Many thanks to my friends, study fellows, and relatives for their unconditional moral and intellectual support throughout the process.

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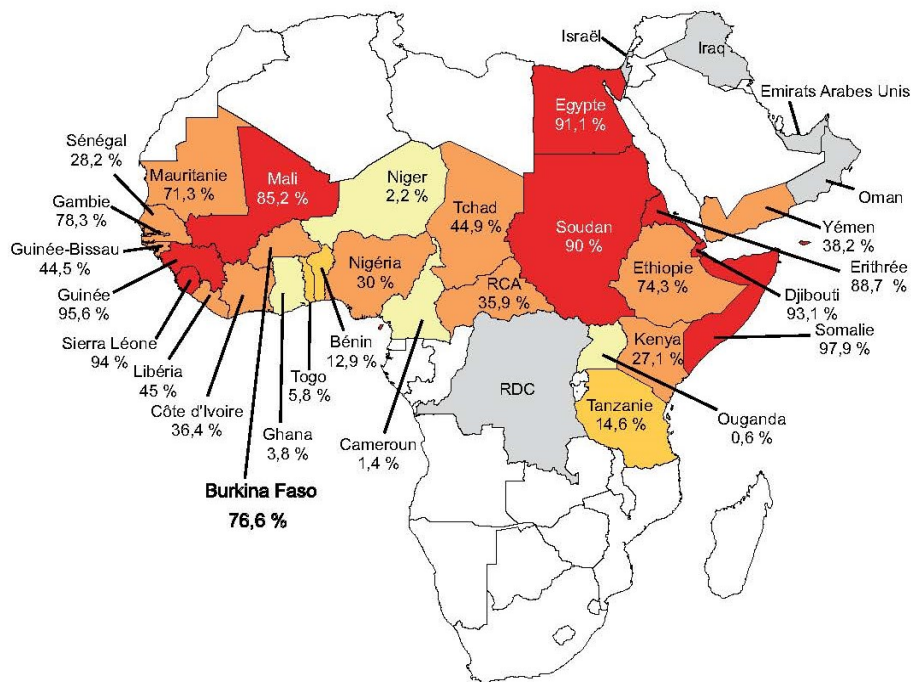
List of abbreviations

AVFE	Association voix des femmes pour
l'épanouissement	
APO	African press organisation
BF	Burkina Faso
CFA	Currency of the West African Economic
and Monetary Union	
CHU	Centre Hospitalier Universitaire
CHUYO	Centre Hospitalier Universitaire Yalgado
Ouédraogo	
CR	Clitoral repair
DHS	Demographic and Health Surveys
FGC	Feminine genital cutting
FGM	Feminine genital mutilation
FGM/E	Feminine genital mutilation/excision
GHI	Institut en Santé Génésique
MASSN	Ministère de l'Action Sociale et de la
Solidarité Nationale	
PNG	Politique Nationale Genre
UN	United Nations
UNICEF	United Nations Children Fund
SAEC	Société Africaine d'Études Conseils
SP/CNLPE	Sécrétariat Permanent du Comité
National de Lutte contre la Pratique de l' Excision	
WHO	World Health Organisation

1 Introduction

In a documentary released in 2013, *Femmes, entièrement femmes* (Being full women, my translation), Dani Kouyaté and Philippe Baqué report on clitoral repair (CR). Affected women share their experiences related to excision, its aftereffects on their sexual health, on their sexuality and on their psychological ailments. Experience sharing is carried out both on virtual platforms and in real life settings (ibidem). In their sense, excision turned them into ‘abnormal’ women – incomplete human beings. The movie’s insight into the lives of CR patients and potential candidates shows that the female characters see hope for improved living conditions in the few surgeons qualified to operate on CR (2013). More specifically, they solicit Pierre Foldès the French urologist who introduced this genital reconstructive technique. From France to Burkina Faso (BF), the documentary sheds light on the silent quest of women to recover a bodily part, which they have lost at a young age during ritual excision. This surgery seems to leave in expectation dozens of genitally mutilated women in BF, a

**Feminine genital mutilations types 1, 2 and 3:
Geographic repartition and prevalence rates in Africa
and the Middle East**



Prevalence of feminine genital mutilations
(women's age 15 - 49 years old)

- ≥ 80 %
- 25 à < 80 %
- 5 à < 25 %
- < 5 %
- Non available national data

Source: *SPF Santé publique et al. (2011: 2, my translation, my edition).*

landlocked West African country (see illustration above and Reference Map in APPENDICES).

In BF, background to women's journey through CR is the commonplace ritual practice of excision. Excision is a traditional practice consisting of cutting off young girl's genitalia (Akotiongga et al. 1998; WHO, 2014b). An important literature qualifies this harmful practice as "feminine genital mutilation" (FGM) (Akotiongga et al., 1998; Diop, 2006; WHO, 2014a). It is also usual and useful to describe the type of FGM concerned with the terms FGM/E alternatively with feminine genital cutting (FGC). In BF, excision is the most common type of mutilation (Diop, 2006) among others as mentioned by the map above and as elaborated in following chapters (see 4). As FGM type two, excision involves the removal of the clitoris and the labia minora of women's genitalia (Akotiongga et al., 1998; Diop, 2006; WHO, 2014a). Estimations of the prevalence rates remain over 50% over the last decade (MASSN & SP/CNLPE, 2014; SAEC for MASSN, 2006).

The operation is often carried out in very doubtful conditions and it exposes the victim to uncountable and potentially life-threatening aftereffects (ibid). The nature of the complications can be urologic, gynaecologic, obstetrical, or a combination of two or more of these aftereffects (Akotiongga, Traore, Lakoande, & Kone, 2001; Foldès, 2006) – the latter posing serious public health issues. Mutilating a woman because of her sex poses problems of gender inequality. High prevalence of excision (SAEC for MASSN, 2006) overlooks and denies well-being to millions of women mutilated over generations. The latest estimation of the total number of women with FGC is over two and a half million according to the Demographic and Health Surveys' (DHS) working papers (Yoder & Khan, 2008).

Social planners took note of the negative effects of such traditional practice on the country's development. Actually with a fast-growing demography, women make up more than half of the population estimated at seventeen and a half million in this country of the Sahel region (UN, 2011). Half of its mostly rural inhabitants are under fifteen (ibid). The country's illustrates itself with one of the lowest Human Development Indicator (HDI) (PNG 2009): the latest indexing ranks BF 181st of a total of 187 countries with the HDI of 0,388 (UNDP, 2014). With an average purchasing power of seven hundred and fifty dollars per habitant (World Bank, 2015), BF is considered a low income country (PNG, 2009). The general conviction is that "the fight against inequalities and the disparity gender is a central axis in order to reach the results of social and economic change" (PNG, 2009: 21). Adopted by presidential decree in July 2009, the National Gender Policy (PNG) sums up the national endeavour to "establish sex equality and the de-marginalisation of the woman" (PNG, 2009: 51). On such grounds, a nationwide campaign against the practice,

launched from the beginning of the 1990's on (Diop, 2006: 3; SAEC for MASSN, 2006: 23-34).

Since 1990, a multi-stakeholder group, the National Committee to Fight the Practice of Excision (CNLPE) is in charge of the eponym mission (ibid). The Permanent Secretariat (SP) of the CNLPE (SP/CNLPE) coordinates, monitors and evaluates the different actors' activities aiming at the progressive abolishment of excision "and of all other forms of practices affecting the health and flourishing of women and children" (Diop, 2006: 7, my translation).

1.1 Aim and research question

Foldès' clitoral rehabilitation addresses women who underwent excision (Foldès, 2014; Foldès apparition in *Priorité santé*, 2012). The surgical repair of the clitoris is also alternatively called "clitoral reconstruction" or "clitoral rehabilitation" (CR). In treating the ailment subsequent to genital mutilation, CR interplays with gender sexual equality, and women's sexuality, and is less concerned with reproductive health (Foldès, 2006; Foldès & Louis-Sylvestre, 2006). Refined, developed and shared (Foldès, 2014; *Priorité santé*, 2012), the surgical intervention became light and affordable (*Femmes, entièrement femmes*, 2013), thus allowing a growing number of women to access genital reconstruction since 2006 (C. Ouédraogo, 2015). However in the context of BF, only few qualified medical specialists and individuals within women support associations see real opportunity for victims of FGM/E to recover a sense of their lost dignity and human integrity.

The report aims to explore the opportunities for change introduced by clitoral reconstruction from an empowerment perspective while restricting the research to the case of Burkina Faso. By contributing to women's general development and well-being, especially those victims of FGM/E, CR appears interesting for women individual empowerment with an increased likeliness for them to engage in political institutions influencing the country's development agenda in accordance with the national priority of promoting a 'participatory' and 'equitable' development by ensuring both women and men's 'equitable' access to resources and decision-making arenas (PNG, 2009: 55).

In such context, the following research interest governs this project.

To what extent can clitoral repair empower women in their active role in the development process?

First, the purpose of this research is to inform debates within its academic disciplines provided that research on CR is limited (WHO,

2014a). Secondly, this study's moral stance is to emancipate, raise consciousness, and free affected women – potential readers – from the unrealised injustice they may be victims of. Beyond the academic work, this investigation has the ultimate purpose of providing material for policy-making: for instance, the CNLPE and related stakeholders might consider CR for complementing inclusive anti-FGM actions and advocacy for strengthening women's development. A less obvious but still very important intention of this project is to inform women's individual choices. Accordingly, this act is profoundly activist, in the sense that it enables improved decisions and provides guidance for action (Miles & Huberman, 1994).

1.2 Methods and material

I rely on accounts from doctors specialized in the technique's achievements and on the way women relate to it. Technical information regarding CR mostly stems from doctor Foldès' academic publications (Foldès, B. Cuzin, & A. Andro, 2012; Foldès, 2006; Foldès & Louis-Sylvestre, 2006; Foldès, 2008) and interview (Foldès, 2014) as well as apparitions in other sources (*Priorité santé*, 2012). He is a member of the French Urologic Association and is based in a clinic in Saint-Germain-en-Laye, France. He also co-created and runs the Institute en Santé Génésique (GHI) (Genesis Health Institute, my translation), a multisectorial support centre for women in distress.

Material from two Burkinabè gynaecologist-obstetricians respectively, Michel Akotiongga and Charlemagne Ouédraogo complete the previous technical information while providing evidence on the Burkinabè case more specifically. Doctors Akotiongga, now retired, and C. Ouédraogo are both professors at the Health Science Centre within the University of Ouagadougou in addition to being renowned surgeons in the capital city. Akotiongga collaborated with Foldès on issues related to genital reconstruction (Foldès, 2014). His publications (Akotiongga, 2014; Akotiongga et al., 2001; Akotiongga et al., 1998) and various interventions (IRIN, 2009; B. Ouédraogo, 2009; *Priorité santé*, 2012) are useful material for this study, likewise for C. Ouédraogo's contributions (Baqué & Kouyaté, 2013; IRIN, 2009; B. Ouédraogo, 2009). Four major public documents provide background information on the progression of excision practice in Burkina Faso and the institutional environment of anti-excision and gender policies. They include:

- two evaluation reports from the public body SP/CNLPE (MASSN & SP/CNLPE, 2014; SAEC for MASSN, 2006);
- another paper from the Population council (Diop, 2006);

- all framed into the broader National Gender Policy (PNG, 2009).

My empowerment theory draws from scholars of women and development field: the *Indiapolitan* Naila Kabeer (Kabeer, 1994; Kabeer, 1999) and the Canadian Jane Parpart (Parpart, 2008; Parpart, 2002; Parpart, Rai, & Staudt, 2002). Further contributions to the feminist thinking developed below include Nigerian Scholar Nkolika I. Aniekwu (2006), Sonia Corrêa (2008), and Alice Miller and Carole Vance (2004) for the analysis on sexuality. Sandra Harding (1997) offers a useful standpoint on feminism amongst others who frame my thought in this paper.

Now, after sketching out my intentions, the development proceeds in the following order: I first precise my feminist approach to empowerment theories with a special interest in the concept of individual empowerment and its interplay with sex issues. Then I discuss my choice of a qualitative case study with an incursion into standpoint feminist epistemologies. An account of the practical research processes complements the discussion of the methodology. In a final chapter, my analysis articulates the motives of women who underwent the surgery, and the hostile context in which they do it. I conclude that despite few shortcomings, CR allows these mutilated women victims of a harmful practice, to retrieve a part of their body, of their integrity, identity, and by that to reach sexual – and spiritual – emancipation. In that way CR contributes to women's individual empowerment.

2 A Feminist perspective on empowerment

Historically, empowerment was conceived as an alternative development model rooted in the local, in the needs of the ‘poorest of the poor’ i.e. women (and some men) (Parpart, 2008). Later on as the term became mainstream, alternative development practitioners and theorists furthered the reflection on its implications for women and gender equality in general. Their analysis purports to preserve the endangered transformative edge of the concept (Kabeer, 1994; 2008).

2.1 Capacitating the individual: a way to women’s collective empowerment

The gender and development debate is mostly concerned with empowerment of women. Starting from an original interest in involving women in development, theorists and activists moved their argument for empowerment to challenging gender inequality. In the process, they point to the patriarchy at play in the domestic domains of family and households considered as the cause of women’s marginalisation (Parpart, 2008).

Various strands of feminism unite in their focus on the causes of and the explanations for women’s subordination to men worldwide (Tong, 2009). From this point of view, the feminist empowerment approach is critical to conventional development activities where it pinpoints sexist patriarchal thought and practices (Kabeer, 1994; Kabeer, 1999; Parpart et al., 2002). The definition of development itself is subject to doctrinal debates (Cowen & Shenton, 1996). Nonetheless, a common assumption links development with positive social change. Feminist empowerment theorists and activists contend mainstream development methodologies, which are articulated by unsymmetrical power relations called *trusteeship* by Michael Cowen and Robert Shenton (1996). Trusteeship refers here to a top-down approach to social policies aimed at improving people’s lives in developing countries, which share a common historical past of colonization. This approach values an individualistic – egoistic – behaviour and production-oriented outcomes, whereas the present study stands by Kabeer (1994) to conceive development as more

relational and with a value for well-being. This post-colonial feminist critique argues that conventional development procedures privilege certain worldviews over others, hereby re-producing oppression and alienation. Therefore, empowerment aims at giving voice to the unofficial actors of development, to the unheard voices, namely women in this instance. Its methodology seeks to adopt the perspective of those denied voices and agency (Kabeer, 1994) for emancipation.

What does em(*power*)ment imply? It is necessary to take a closer look to the concept while critically using the term “power”. The following section explores the theoretical implications of empowerment, mostly according to Kabeer (1999; 1994).

2.1.1 A critical approach to disempowering social practices

Kabeer insists on the centrality of empowerment for the struggle to achieve gender equality. She contributes to this theoretical framework with her feminist analysis of power: rather than *power over* resources, she emphasizes the transformative potential of *power within* (Parpart, 2008, original emphasis). Her conception consists on ‘self-understanding’ and aims at identifying and challenging gender inequality both in the home and the community (Kabeer, 1994: 224-229).

Power lies not only in men’s ability to mobilize material resources from a variety of arenas in order to promote their individual and gender interests, but also in their ability to construct the ‘rules of the game’ in ways that disguise the operations of this power and constructs the illusion of consensus and complementarity. (Ibid.1994: 229).

According to this overtly feminist definition of power, men enjoy social privilege, authority and esteem that women are unlikely to enjoy; a fact that in turn shapes their lives. In an interesting way, Kabeer (1999) conceptualizes *empowerment* in terms of *resources*, *agency* and *achievements* all articulated by the *ability to make choices*. Empowerment implies disempowerment in the first place. Being disempowered means having been denied that ability to make choices. *Choice* can be broken down to few qualifications: a broad sense of access to material and non-material resources negotiated through multiple social relationships within the various institutional domains, which make up a society (such as family, market, community) (Kabeer, 1999: 437). At stake here are the rules and the norms, which entitle certain actors with the authority to allocate resources – with a secondary focus on the origin of these distributive principles. The second and most interesting dimension of Kabeer’s conceptualization of power relates to *agency* or *power within*. Being a quality of both individuals and collectivities, agency refers to

consciousness and understanding (Parpart et al., 2002). In relation to power, agency embraces a positive – *power to* – and a negative meaning – *power over*. As such, power can be disembodied because “[t]he norms and rules governing social behaviour tend to ensure that certain outcomes are reproduced without any apparent exercise of agency” (Kabeer, 1999: 438). The presence of the negative dimension of power results in non-decision making for the individual subjected to it.

2.1.2 Enhanced sense of dignity and self-esteem through positive sexuality

In contrast with the practical grassroots activism of Kabeer’s focus on collective action, Jo Rowlands (1997, cited in Parpart et al., 2002) has a more analytical perspective with an emphasis on the individual. She considers empowerment not only as participation in decision-making, but also as including processes that lead people to perceive themselves as able and entitled to make decisions (Parpart, 2008: 356). With its personal, relational and collective dimensions, empowerment is not only a gender issue but also a development issue concerning both women and men.

[T]here is a core to the empowerment process ... which consists of increases in self-confidence and self-esteem, a sense of agency and of ‘self’ in a wider context, and a sense of *dignidad* (being worthy of having a right to respect from others). (Rowlands 1997 quoted in Parpart, 2002: 340, author's emphasis).

Before linking dignity to a positive right, Rowlands refers to the mental quasi-metaphysical state in which the individual has a positive image of herself. This self-perception considerably enables agency. Rowlands’ position is interesting in that it adds another layer to the implications of empowerment. Her primary focus on the individual serves as a basis for exploring a woman’s relations with the social, political, and economic contexts in which she lives (*ibid*, 2008). In the same line as Rowlands, Caroline Moser (1993, cited in Parpart et al., 2002) prioritizes personal empowerment as a way to achieve collective empowerment. Indeed, empowerment should aim at enhancing self-reliance and internal strength, two keys for being able to “determine choices in life and to influence the direction of change, through the ability to gain control over crucial material and non-material resources” (Moser quoted in Parpart, 2002: 340).

All these conceptions of empowerment emphasize the need for collective action against unequal power structures that oppress women. Nonetheless, Moser and Rowland’s arguments contrast with Kabeer’s in that they explore the conditions of engagement into collective action at the individual level. Conversely, Kabeer brings out

the fragility of individual efforts and centralizes on collective empowerment.

However different they may be, these arguments are complementary. Indeed, in Kabeer's qualification of choice, the concern lies more on the *inequalities* of women's capacities to make choices rather than in the *difference* of choices they make. Thus empowerment works as the expansion of women's ability to make strategic life choices in a context where this ability was previously denied to them (Kabeer, 1999: 437). For empowerment to be this self-generated power, concepts of internal strength and self-esteem are conditions to capacitating and enabling women's agency. Lifting power *within* in Kabeer's sense, is necessary for participating in decision-making instances and beyond. In Parpart et al.'s (2002: 10-12) exploration, such agency factors individual political activity referring to David Marquand's notion of active citizenry (*ibid*). Achieved through formal or informal policies, such personal agency potentially leads to collective struggles of power *with* and power *to* challenge oppressive power structures (Desai, 2012). In sum, social change, and more specifically gender equality, can arise from the (political) activism of an individual whose agency is guaranteed. Impediment to the development of women's agency and overall well-being threatens their mobilization for achieving this ideal.

These conceptions also share the commonality of envisioning empowerment merely as a process. By that, the present theoretical approach steps aside another current of the empowerment debate. In the development field, practitioners and policy-makers have come to terms with the approach. When initial development policies fell short of alleviating poverty, policy makers started considering the approach as a necessary ingredient for women's promotion (PNG, 2009; Parpart, 2008). In spite of this acceptance, interventions have instrumentalized empowerment as a tool for development (Kabeer, 1999). Mainstream development institutions took up the empowerment methodology but their practice of the approach holds an underlying neoliberal economist assumption, which measures yields in terms of productivity and efficiency (Parpart, 2008). However on which factors could indicators be built so as to assess the outcomes of empowerment?

This question leads the discussion to a definitional point, one considering empowerment mostly as outcome (Kabeer, 1999; Parpart, 2008) disregarding the 'processual' dimension which this study argues for. Standing by Kabeer (1999), it is possible to argue that a measurement of empowerment is impossible. From her extended experience as an activist, she explored different practical measurable ways to empower women, and bases her conclusion on the assumption that human agency is unpredictable and the circumstances under which such agency is exercised are various (*ibid*: 442). Her approach highlights the tensions between agency and structures at grassroots

level. Kabeer's (1999) association of resources and agency draws from Amartya Sen's notion of *capabilities*. It allows a person to *be* and *do* in ways valuable according to her context as a way to attain *functioning achievements*; these further being conceived as "the particular ways of being and doing which are realized by different individuals" (Kabeer, 1999: 438). Kabeer thus attributes high value to welfare activities centred on the human being. By seeking to meet people's needs, welfare activities contribute to shape thriving communities including in the material sense dear to social planners (Kabeer, 1994: 84). In this construction, women would take their place as key actors in the development process because of their contribution to human survival and well-being. Such approach promotes gender equity (ibid). In this paper, I envision empowerment as a concept and practice for enhancing women's equality and gender equity for its intrinsic value rather than for its neoliberal instrumental use for productivity and efficiency purposes (Kabeer, 1999).

In this debate, sexuality holds a central place as it articulates physical and mental condition (Koso-Thomas, 1987) at all institutional levels because of its personal, relational and collective dimensions (Rowlands in Parpart, 2002). My view on sexuality is distinct from usual association with reproduction (Corrêa, 2008). Most feminists from the radical strand have a negative use of *sexuality* to prevent exclusion (ibid). Miller and Vance (2004) propose an interesting positive conception of sexuality, one valuing eroticism, pleasure and well-being. This projection also contrasts with that of most post-colonial African feminists (Aniekwu, 2006). Their conception of sexuality is marked by cultural continuity in the pro-natal aspect of the traditional culture (ibid). According to Aniekwu, 'new African feminism' is less assertive and distances itself from Western feminist debates about the female body, sexuality, autonomies, and sexual rights. "Rather the emerging African model is distinctively heterosexual, pro-natal and concerned with economic, social, cultural, and political empowerment" (Aniekwu, 2006: 148). I have discussed earlier the emotional – as opposed to material – empowerment affects the individual's ability to make claims with others over resources (see 2.1). I shall take this 'African' perspective into account when considering interactions between contemporary African feminism and the state (ibid, 2006).

It was this section's aim to clarify the conception of empowerment with a focus on power *within* and the first-hand need for emotional capacitating of the individual before aiming for material support. This premise hinges on a conception of power as both relational and as resources with a slight emphasis on the relational aspect when it comes to CR. The reflection moves on to the methodology of the inquiry in the following section.

2.2 Focus on the unheard voices: a qualitative case study

After elucidating my conceit of em(power)ment (see 2.1), it is necessary to articulate the theoretical debates with the more technical procedures of this inquiry.

Behind the idea of empowerment is the expression of the interest of the disenfranchised groups of society, e.g. women, necessitating shedding light on the confluence of experiences at the grassroots level (Kabeer, 1994: 223). In the occurrence, our categorizing focused particularly on genitally mutilated women. Despite Burkina Faso being a multi-ethnic country, criteria of ethnicity is irrelevant as CR addresses women from all ethnicities or religions touched by FGC. The practice of excision may be differently prevalent according to ethnicity and mostly, religion (Akotonga et al., 1998), but it affects most of the communities in large extents (Diop, 2006).

The preceding sections accounted on the ambition of this inquiry to foster political action (see 2.1) towards a more inclusive and participative development (PNG, 2009; Kabeer, 1999; 1994). Doing so means finding emancipating ways through for victims of FGC. Thereby, the intentions of the present search refer to Harding's action research (cited in Reinharz & Davidman, 1992) She conceives feminist action research as being oriented to individual and social change based on the feminist revolutionary thought of repudiating the *status quo* (ibid.)

These feminist motivations imposed the case study of a small category of women from BF's masses of unheard voices. This case was identified out of the 'naturally' occurring material conditions – physical and mental – (Harding, 1997) of genitally impaired women. As described earlier (see Introduction), this social reality transpires in *Femmes, entièrement femmes* (2013) the coproduction of the Burkinabè and French film-makers, Kouyaté and Baqué, experimental research according to Marthyn Hammersley's (2004) definition is excluded for this research project. The case study also rejects the idea of social survey considering its advantages in allowing collection of larger amounts of information across a wider range of features (Ibid.).

With this qualitative case study I commit to share and have empathy with the experiences of those – women – disempowered (Kabeer, 1994). For instance, penetrating the private and the personal sexuality is crucial to uncover the oppressive character of female genital mutilation (Letherby, 2003; Reinharz & Davidman, 1992). In this instance, the conduct of fieldwork is indicated because it allows the closeness sought for obtaining in-depth information. Robert Emerson states what fieldwork is based on “immersion” and “first-

hand familiarity” with the subject. By that it allows the discovery of “unappreciated” or “unacknowledged processes” (2001).

The above-mentioned political purposes also instruct the relation of this design with theory. The research is less engaged with “developing new theories (exploratory), but rather, seeks to describe and explain what is going on in a particular situation for its own sake” (Hammersley, 2004: 93). For that reason, the current case study’s orientation is primarily explanatory. I see things in the light of theory (Jackson, 2011) in this instance, in the light of a critical feminist theory. Facing the ubiquity of the term *theory* (Abend, 2008), it is necessary to precise how it is conceived. In Abend’s (ibid) semantic clarification of the different uses of *theory*, this analysis is concerned with observing women’s experiences through the normative lenses of critical post-colonial feminism (Abend, 2008: 180). From this position, norms and practices such as FGM/E that intend to control or manage women’s sexuality are critically scrutinised.

By looking at the grassroots level, the main aim of this inquiry is to capture the case of BF in its uniqueness, while conceding its use for wider empirical or theoretical conclusions in future research. This methodological position is closely connected to the use of theory. In the same way, this research does not seek to form overarching theories, it does not seek to generalise its claims about what is going on in the Burkina Faso context. According to Harry Eckstein (2009), this view is common in the study of micro-politics whereas macro-political inquiries may seek general conclusions. An idiographic position alike seems orthodox in political science where case study is commonly perceived as limited in objectivity and generalizability (ibid). Clarifying the epistemological assumptions of our standpoint, feminism also informs the implication of the scientific choices described above. It is the object of the next section.

2.3 A standpoint feminist epistemology

Why do objectivity and generalisability hold secondary places in the range of values and objectives of this standpoint feminist methodology? In response to these remarks, standpoint feminist claims take root on a conception of the social world as discursively constructed and mediated by language, technology and even theory (Adcock & Bevir, 2010: 88-89; Haraway, 1988; Harding, 1997; Schuetz, 1953a: 2). As an illustration, the common use of *excision* makes the practice appear value-neutral, apolitical. Conversely, the expression *Female genital mutilation* shows more empathy to the victims while emphasising the type of unnatural and unnecessary operation that women undergo only because of their sex (WHO,

2014b). Hence, a standpoint feminist would prefer the latter terminology, which creates space for struggles against such harmful practice. Instead of seeking truth and reality, which reflects the “absolutist standards of modernism” (Harding, 1997: 388), feminist standpoint seeks “knowledge that is more useful for enabling women to improve the conditions of our lives”. In that, Harding and Kabeer (1994) link power and knowledge in scientific activities. With scrutiny to relations in the process of knowledge making, Harding highlights andro-ethnocentricity in claims of radical objectivity and rationality in relation to the study of social reality.

Some have pointed to its missing account of truth and reality, thereby compromising the reliability of inquiries conducted by standpoint feminism (Hekman, 1997). Another downside is the tendency to overvaluing the agency of the marginalised while denying the phenomenon of “internalised oppression” (Grasswick, 2013). This renders the perspective of the oppressed unreliable because the forces of oppression have damaged their perspective (Grasswick, 2013). Some women do indeed internalise “damaging false beliefs”, for example that excision is a virtuous act (Abusharaf, 2001; Akotionga et al., 1998), which contributes to perpetuate the damaging tradition on other women (Koso-Thomas, 1987). In addition to these shortcomings, critics warn that the lack of coherence between the scattered experiences of oppression reported from situated locations not only introduce competition between feminists, but it also threatens the potential for a collective feminist struggle altogether (Grasswick, 2013; Hekman, 1997). Underlying this warning is the fear that an emphasis on different levels of oppression may stand in the way of a collective feminist struggle against alienating power structures.

A reference to the historical contexts in which standpoint feminism emerged (Harding, 1997) can answer Hekman’s (1997) and Grasswick’s (2013) critiques. This particular strand was articulated in opposition to the “all powerful dictates of rationalist/empiricist” (Harding, 1997: 383-384) of the positivist epistemologies and methodologies, common in the natural and social sciences, and in public institutions. It was also constructed in opposition to the anti-positivist critical interpretations of science (ibid, 1997: 383-384).

According to Harding (1997: 386-388) standpoints make up structural cultural differences. They are valuable in that they provide insights into actual experiences:

(...) standpoint theorists use the “naturally occurring” relations of class, gender, race or imperialism in the world around us to observe how different “locations” in such relations tend to generate distinctive accounts of nature and social relations. (Harding, 1997: 384).

Gender, class, or race are experienced daily and make up ‘privileged’ locations from which social relations can be studied. Albeit trivial, daily life activities involving the identities provide opportunities for

observing and explaining systemic relations between what is/can be known and what is done (ibid). Claims produced from such insights are not accessible to northern feminists who are differently positioned (Harding, 1997). Therefore, trying to build a unique feminist conceptual framework threatens to reinstate yet another system of domination. Embracing an attitude as the one Hekman's (1997) and Grasswick's (2013) refer to results in taking up an "administrator perspective". This implies looking down to and consequently overlooking locally situated – different – voices (Harding, 1997: 387). Ultimately this approach threatens the feminist very ambition of emancipation. Nonetheless, this statement does not deny the possibility of solidarity around common feminist struggles (Kabeer, 1994: 208).

This approach entails a redefinition of objectivity as illuminated by a reflection on the researcher's own values and assumptions, as well as and their impact on the research process. Providing more information on this position highlights the research in a better way, considering that these elements influence both observation and findings (Haritaworn, 2008:2-5). Subsequently to constructivist critics (Schuetz, 1953b), standpoint feminist researchers value biographies, especially that of the researcher in that they explain certain choices. Ensuring such transparency guarantees 'strong' objectivity rather than the 'weak' one generated by traditional 'malestream' inquiries (Kabeer, 1994; Harding, 1997).

The value of reflexivity and research ethics of this standpoint epistemology designate the researcher's position on the same critical level as the ones researched (Maynard, 2004). This allows the use of *I*. Clearly, this thinking motivated the choice of Burkina as empirical ground. As a *Fasopolitan*, I was born in Burkina Faso and raised in France where I mostly studied Political science as a major. Travelling also exposed me to European ways of doing and thinking. That biography and my Western academic curriculum certainly influence my use of post-colonial feminist concepts and references. *Femmes, entièrement femmes* (2013) met two of my major areas of interests i.e. gender debates and development issues in the Sub-Saharan Africa, particularly BF. In combination with my personal history, this stimulation indicated Burkina Faso as ground for the empirical study. This way my cultural familiarity with the environment established its accessibility for the purposes of the inquiry.

3 The methods for a qualitative inquiry

Provided the implications of the feminist standpoint approach, this methodology calls for sampling methods for the conduct of interviews – in-depth and open-ended. Combining interviews with observation, and secondary data analysis enhances the thoroughness of the inquiry. The premises discussed earlier inform not only the choice of methods for data collection, but also the way these methods are performed. It is the object of the present chapter.

The above-mentioned methodology (see 2.2 and 2.3) calls for a qualitative design but the research question necessitates including a quantitative data collection. However, this does not change the nature of the design. Indeed, if qualitative research designates both a domain of inquiry and “a site of protest and reconciliation” according to Margarete Sandelowski (2004: 894-895). It aims at understanding how human beings understand, perceive, experience, and shape their world (social). Hence a requirement is to adopt a certain attitude towards the issue and the people engaged with, with certain strategies (ibid). These strategies are developed in the sections below. In order to help the analysis process I kept a memo in which I held a diary of fieldwork and of the overall research. In this memo I accounted for my subjective experience of the fieldwork. This is a notable good support for reflecting on the ethics of field study (Lee & Fielding, 2004) as discussed in different passages of the present report.

Ethical issues related to the use of these various methods are object of reflection. Participants are key actors in the frame of this qualitative research and based on the study’s philosophical approach. Therefore, ethics are crucial because they bear the idea of respect for the studied. While conducting interviews, the qualitative researcher is guest in private spaces and shares an interest in personal views and circumstances. There consequently exists a moral obligation between the researcher and the researched. Issues of observation and reportage have to be discussed in advance, limits to data access have to be defined and the researcher is attentive to the concerns of the researched (Stake, 2005). Attitudes adopted especially in healthcare research ethics are considered since CR relates to sex and sexuality, both very private and delicate topics. Principles such as “being non-judgemental, empathic listening” are general attitude (Josselson, 2007). A guarantee of anonymity consists in assigning surnames to the three operated women I interviewed (Israel & Hay, 2008). Agnès, Solange and Sakina chose anonymity and were assigned these aliases.

I also decided to anonymise my informant from the SP/CNLPE with this eponym term because she seemed undecided when giving her consent for the audio recording of the conversation.

3.1 Interviews and observation

Interviews aim at understanding the meaning of CR from the respondent's viewpoint. Especially open-ended interview "allows researchers to make full use of differences among people" (Reinharz & Davidman, 1992: 19) in line with feminist standards. This method of data collection provides access to people's relations to CR with primary interest for three concerned women and their two doctors' point of views. Those of three representatives of development institutions – both governmental and non-governmental – are also included. Along with doctors, the latter happen to share some of women's most personal experiences due to their professions. Assumedly, concerned participants disclosed information with regard to their respective corporate code of ethics. Information from the total eight interviews permits to come to conclusion about the patterns and meanings observed in those interactions (Warren, 2004) (see Interviews list in References).

Limits of such methods reside in the actual faculty of getting valuable data from a so-called "speech event" by Warren (ibid), and the potential loss of information during transcription and translations. Nonetheless, "[i]nterviewing is an inexpensive and easy way to do research" (Warren, 2004: 54) when resources in this case, time and money constrain the multiplication of interviews. Moreover, the use of qualitative interviewing appears logical according to the present methodology. Field research and case studies traditionally associate interviewing indeed (ibid).

In practical terms, I planned this individual inquiry, with myself as the principal investigator. I decided in consultation with the respondent how and where the interview takes place. The conversation is recorded with a mobile phone audio recorder and check marks in a field notebook. I planned to run the interviews face to face but few were held over the telephone because of time and resource constraints both from my side and that of the respondents. The average length of dialogue was twenty minutes approximately.

This was conceived more as a guided conversation where I first extensively presented myself, and my motivations for requesting the discussion. After a three to five minutes presentation, I engaged with the questioning (see Interview guides in Appendices): it is this part which is recorded. Few times the respondents asked for clarifications about my personal background. This was particularly the case in the

interactions with reconstructed women. The overall aim with this attitude is to locate the researcher on the same critical plane as the respondent (see 2.3) (Maynard, 2004). The design planned only individual interviews, however a case occurred where a third participant came into play: it was the conversation with the civil servant representative of the SP/CNLPE. Despite the exclusion of focus group from the design, notably because of the sampling methods (discussed further below), the conversation at the headquarters of *Mwangaza Action* could also be referred to as a focus group (Bakouan & Sawadogo, 2015). Indeed it involved namely, the programme manager, Badjima Bakouan, and Seydou Sawadogo, the monitoring and evaluation assistant. That interview had the particularity of being more informal and unrecorded with audio device. I had taken care to transcribe the field notes in the hours following the meeting.

Ethics related to feminist research commended to obtain consent before recording. In all concerned cases, consent was given after being informed by the introductory presentation. Once recorded, interviews were later transcribed. Complementary to the audio recording, the memo documented context information and personal reflections about the different interviews or problems or issues encountered during the interviewing. For instance, the interviewing with Dr Foldès illustrates power relations clearly at his advantage. Everything was overwhelming from his status as specialist of reference to his high paced working schedule, which I observed after a few hours waiting time in the clinic in Saint-Germain-en-Laye. He commented on his constant business both in our discussion (Foldès, 2014) and in a radio broadcasting (*Priorité santé*, 2012). I obtained fifteen minutes in-between two consultations when I was expecting a one-hour discussion. I felt the tension during the interaction in Foldès' office where I finally got the privilege to be heard. Even within this short time incoming calls interrupted us. This could have clearly gone out of control if I had not prepared an interview guide and practiced ahead of time.

Despite the opportunity offered by audio recording, just as Svend Brinkmann (2008) warned for, the poor quality of the sound made the transcription process harder few times. Be it because of various sources of interruptions or the exposed setting, interruptions concerned the parts considered as not providing essential information. This assertion is motivated by the fact that the transcriptions intervened in a fairly short period after the actual recording time, and the memo was of valuable help to help exclude certain hypothesis. Moreover, in order to guaranty data quality, I exchanged contact information with the respondent – operated women and C. Ouédraogo – at the end of each interview in order to maintain communication and allow verifications afterwards.

In a second phase, the research design included participant observation for obtaining information on non-verbal elements of inquiry (Bottorff, 2004). At this stage, ethical issues embrace the possible exposure to anxiety for the researcher (Platt, 2004) given the topic at hand. In spite of this, participant observation potentially yields information on behaviours and mind-sets explicating the interviewee's relation first to excision and or to CR as far as operated women's are concerned. For instance, Agnès communicated with body language when mentioning her second excision or when she tried to explain how she could sit, walk or lay on the bed because of the pain she felt after the reconstruction surgery (Agnès, 2015). The very sensitiveness of the topic motivated me to seek proximity with the respondents in order to encourage them to share their experiences (Bottorff, 2004). I have sought the proximity by sharing personal information regarding a close relative who underwent mutilation and by seeking advices in her name. The first objective of the design was for observation to help in the collection of contextual data about how respondents react to certain topics and questions. However in fact, only the interview with Agnès was carried out face to face. On common ground with Solange and Sakina, we held the conversation over the phone. So such observation was not easy to perform. The tone of the voice could be the only basis for interpretation. In this respect, these interactions took place in a surprising serene and light-hearted ambiance often comprising laughter. As far as the photographing is concerned, surgery tools and operation rooms were not readily accessible but C. Ouédraogo (2015) assured that the necessary tools and facilities were unsophisticated. Foldès also mentions this in his articles (2006; Foldès & Louis-Sylvestre, 2006).

3.2 Purposive sampling

Sampling appears as a condition for proceeding with the interviews in this qualitative inquiry. It implies to identify people to interview, how many, then locate them (Warren, 2004). The sampling is very limited by the need to capture participants' experiences regarding CR and by the need to leave room for them to voice alternative claims in line with our methodology and its ethical underpinnings. The sample depends specifically on the purposes and goals of this research project (Morgan, 2008). Logically, this case study does not engage with the entire population concerned by CR ranging from women operated or candidates, to professionals - medical and women's support and advocacy groups. Therefore, and provided our methodology and scientific position, the sample of informants is small – eight persons –, systematically selected because the individuals composing it provide

information serving the purposes of the study well. They were approached face-to-face, by telephone, and email.

Purposive criterion sampling involves searching for the cases or individual who meet a certain criterion (Palys, 2008). The actual field research started in France where Foldès is based. His apparition in *Femmes, entièrement femmes* (2013) helped me find him for the interview (Foldès, 2014) during which he referred me to Akotionga.

Once in Ouagadougou, (see Reference Map of Burkina Faso), colleagues from the NGO *Diakonia* where I was interning referred me to Mwangaza Action. From the interview with Bakouan and Sawadogo (2015), I collected contact details of relevant institutions and professionals operating clitoral repair. Their first suggestion was to proceed with the SP/CNLPE. Secondly, they designated three major medical centres (public and private) where CR was performed in Ouagadougou. There the name of Akotionga surfaced again. In an informal conversation, the informants from Mwangaza Action introduced me to the networks of stakeholders concerned with the genital reconstructive surgery accordingly to Chaim Noy's (2008) suggestion. From one informant to the other, I approached C. Ouédraogo in his office in the University Hospital Yalgado Ouédraogo (CHUYO) in Ouagadougou. He then allowed me to reach Agnès, Solange and Sakina, three of his patients who had agreed to "answer questions for research purposes" (C. Ouédraogo, 2015). All over forty years old, the three women had undergone CR in 2014 and had just had their last post-operation check. All married with children, they had been living in Ouagadougou for decades: Solange (2015) and Sakina (2015) grew up there while Agnès (2015) did in Bobo Dioulasso, the second biggest city of Burkina Faso. Both Agnès and Solange are civil servants while Sakina is a retailer.

From the interviewing of an initial set of participants on the research topic, the final sample size was obtained through a process of interviewees serving as informants supplying information about other potential participants, and giving details about where and how to approach these people. This way, the sampling method draws very much on a snowball sampling method (Morgan, 2008). That form of nonprobability sampling is a particular purposive sampling method useful when no lists or patent ways of locating members of the population at study is available (Morgan, 2008). Snowball sampling yields dynamic qualities (Noy, 2008), which matches the feminist value of active involvement of participants (see 2.2 and 2.3) (Noy, 2008: 330). Few identified respondents could not be interviewed. One of C. Ouédraogo's patients, the second was Akotionga himself. Attempts to book an appointment with him proved vain insofar as he was busy dealing with ever more serious cases. Brahim Ouédraogo mentions this doctor's unavailability with a report on the case of a twenty-five-year-old woman who desperately and vainly sought a

consultation with Akotionga (B. Ouédraogo, 2009). Moreover, my waiting time in the cabinet allowed me to confirm Akotionga's activity despite his retirement from all official positions. Yet, he maintains occupation in a private clinic.

3.3 Secondary data collection and management

The major advantage of collecting and meta-analysing secondary data is that this type of material proves much readily available and less costly to obtain than primary data (Lewis-Beck, 2004). It would require too many resources (time and financial) to carry out a study so as to gather data for the specific purposes of this inquiry when even resourceful institutions such as the SP/CNLPE find it difficult to construct solid databases (SP/CNLPE, 2015). In this instance, the secondary data include quantitative material. For example, given the business of doctors, getting to tour an operation room was not easy so this is information tracked in secondary sources.

Many articles are sources of secondary data. They include newspapers articles such as (IRIN), (B. Ouédraogo, 2009), and (E. A. Ouédraogo, 2015). Amongst those discussing FGM issues at a more general level, many pieces are edited by institutions on their website, either as page content or as downloadable documents as is the PNG (2009). The book of Nigerian doctor Olayinka Koso-Thomas (1987) on female circumcision was a valuable source of contextual information. She worked largely with women patients and medical staff, advised and treated large numbers of women suffering from the physical and physiological problems directly attributable to FGC. Press releases are mostly available online from Burkinabè newspaper cluster website (LeFaso.net) and also from NGOs intuitional content (UNICEF Burkina Faso, 2015; UNFPA/UNICEF, 2013). Regarding the nature of the support, all are digital and most of them are written documents but the collected data includes sound recordings (Smokey, 2014; *Priorité santé*, 2012) Kouyaté and Baqué's motion picture was already mentioned (2013) with additional input from Bakary Ouattara's documentary (2014).

Managing the data according to its nature, authors, and sources eases the reporting process. Applying and making the management system explicit "enhances the transparency of research procedures" (Lee & Fielding, 2004: 533). Referring to MacQueen (2004), Lee and Fielding provide practical strategies for classifying while progressively moving into the interpretation (*ibid*). The online referencing programme, RefWorks supported the efforts to classify the data in thematic folders and subfolders.

Despite all this description, transparency is not granted in this process (Maynard, 2004). While reflexivity is a ‘laudable’ goal, it is not without inherent difficulties (ibid: 140). Difficulties include attaining full reflexivity without making an account on one’s own life instead of that on the study’s subject. Nonetheless, clarifying the process wherein mixed methods are used help answer the question of ‘reliability’ raised earlier (see 2.3). The combination of data collection methods described above aims at uncovering the subjugated experiences of women and indicating complementarity between the sources (Reinharz & Davidman, 1992). Indeed, “[m]ultiple methods increase the likelihood of obtaining scientific credibility and research utility” (ibid, 1992: 197). This strategy contributes to add complexity and understanding in women’s experiences and their environment. It involves the comparison and contrast of both qualitative and quantitative data in the analysis (ibid).

3.4 Ahead of the interpretation: a discursive psychology analysis

The analysis is linked to the methodology and theoretical perspective both resting on the feminist action research (Reinharz & Davidman, 1992). Feminist researchers regard analysis and interpretation as going along with other stages of the research, notably data collection (Maynard, 2004). This qualitative research mainly consists in describing while giving my own interpretation of the phenomenon in the light of theory (Firmin, 2008; Reinharz & Davidman, 1992) The methodology requires discerning the different perspectives, to define the case orientation, to be sensitive to the socio-historical context and be reflexive (Emerson, 2001). Finally, the overall emphasis on discourses – texts and talks – and practices within institutional contexts relate this analysis to discursive psychology (Poland & Potter, 2008). Hereby, I seize an opportunity to further intensify the qualitative purposes of this study.

The nature of the data collected, mainly semi-structured to unstructured, adheres to the same idea. After transcription and data management (Lee & Fielding, 2004) (see 3.3), the next phase consisted in translating the material into English. The in-built translator of the Microsoft editing programme provided an outstanding base for translating the passages relevant to the analysis. Since translating is not value neutral; the original version of each translation is made available for transparency purposes (see Original version in Appendices). Conducting interview is not self-sufficient; the process is completed with interpretation of the data. In this regard, the analysis process covers the following actions: describing, explaining,

prescribing, and evaluating the information (Gomm, Hammersley, & Foster, 2009).

Since this work is mostly about process, at this stage of the study, research ethics and the value of reflexivity demand sensibility to the power politics involved (Wheatley in Maynard, 2004). Now alone facing the data collected from the field, I can frame the participants framing into my own representation (Letherby, 2003: 117-120). However I have previously mentioned guaranties of accountability, which I left to participants in, order to allow them to have a say in the process (see 3.1, 3.2 and 3.3). Moreover, the extended account of my theoretical and methodological frameworks (see 2) intended to warrant transparency and open up the study for critical evaluation (ibid).

Instead of testing hypothesis, the aim here is to corroborate inferences (Bryman, 1992) and embracing the field data my feminist framework (Firmin, 2008). Instead of aiming to test theory, the analysis rather illustrates it (see 2.2). The concern is for plausibility and adequacy of the analyses produced with respect to the philosophical stand (Maynard, 2004). This position highlights the ability of the analysis to convince and persuade rather than on absolute validity (Maynard, 2004: 138). Hence, a deductive analysis can help sketch out in broad brush strokes patterns of institutional oppression in BF – both traditional and modern. In this instance, the intention is to create space for women's practical engagement with existing power structures by enabling them to be agents of their own development (Diane Elson cited in Kabeer, 1994).

In the next chapter I critically analyses the hostile context in which women seek and undergo clitoral repair in the light of my feminist approach to empowerment. At the same time, it envisions the opportunity for change introduced by that very practice in Burkina Faso. An analysis of CR politics requires that the reflection move from economic needs to welfare needs other than those conventionally assigned to women (Kabeer, 1994: 232).

4 Interpretations and conclusions

After this technical description of the analysis process, the following interpretation is formulated in accordance with the theoretical frame (see 2). The analysis follows the rationale of the feminist empowerment framework, which interlinks ways of thinking with ways of doing (Kabeer, 1994: 232). Ways of thinking imply inclusions and exclusions. These characterise ways of doing and determine what is worth doing (ibid) in a social world constituted of connected inter-subjectivities (Harding, 1997). At the same time, I envision the opportunity for change introduced by the practice of CR in BF.

The present chapter begins with a critical account of the context in which women seek and undergo CR. A first section scrutinises the institutionalised ways of thinking about the nature of gender relations underlying the ritual practice of excision and subsequent public actions to ‘eradicate’ this tradition. Then, I set to constructively nonetheless critically assess CR’s potential for strengthening women’s agency in this constraining environment. Its transformative edge upon ways of thinking could make ground for practices promoting women’s active participation into political activity for a more gender equal and equitable development. This reflection centres on welfare needs other than those – economic ones – conventionally assigned to women (Kabeer, 1994: 232).

4.1 Women disempowered by patriarchal managements of their sexuality

The framework suggests to historically analyse and situate women's struggles to gain power in contexts that are neither of their own making or choosing (Parpart, 2008: 358). The analysis finds that gender unequal rules govern the practices of the traditional and modern institutions having claims over women’s sexuality. With support from (Kabeer, 1999; 1994), this section first critically analyses how oppressive traditional gender norms can result in the perpetration and perpetuation of FGC. Then, I point to the shortcomings of development policies aiming to provide care to victims of FGM.

Ahead of the analysis it is necessary to clarify the use of certain terms, *SP/CNLPE* alternatively qualify the institution and the civil servant in charge of it, the secretariat permanent and or the secretary

permanent. *National* is often used to refer to the country level, *public* is preferred when it comes to characterise what the state or one of its institutions does.

4.1.1 With the clitoris, gone the power *within*

Taking a closer look at what goes on during the excision process allows an interpretation of this violent social act as carrying consequences for the individual's self-perception and sense of 'self' and 'dignidad'.

Excision consists of the removal of the organ responsible for the female sexual desire and response: the clitoris in association with the labia minora (IRIN, 2009; Diop, 2006; Akotionganga et al., 1998). It is the type two in the classification of violence perpetrated against women because of their sex (see map in Introduction).

However, the practice covers other types of mutilations across the country. They include clitoridectomy the FGC type one, consisting in the removal of the prepuce of the clitoris. Besides, infibulation is the most serious case because it entails excision of the clitoris, the labia minora and majora including a suturing of the vulva. This leaves a very small orifice to allow flow of urine and menstrual discharge (SPF Santé publique, 2011; Koso-Thomas, 1987). Potential life-threatening complications bring in violent suffering, bleedings, infections, tetanus, fistula, sterility and also HIV/AIDS (B. Ouédraogo, 2009). It is mutilation in that it takes away a healthy organ (Koso-Thomas, 1987; WHO, 2014b). Excision usually affects young women; their average age is situated between one and seven (Akotionganga et al., 1998). Prevalence rates vary from one document to another depending on the age range concerned: the average gravitates around 70%, 77% according to the 2010 DHS report (SP/CNLPE, 2015). This figure mostly includes the fifteen to forty-nine year-olds, meaning "women in age of procreating" (ibid). Besides, the evaluation study of the SP/CNLPE 2009-2013 action plan finds that excision prevalence rates increase with age range, from roughly 50% for the youngest to over 80% for the oldest women (MASSN & SP/CNLPE, 2014; SAEC for MASSN, 2006: 52). Albeit non-homogenous, these rates assess excision practice on average more than 50%. This is meaningful when transposed to the whole population of women: roughly three million according to the last DHS estimation based on statistics from 2003 (Yoder & Khan, 2008).

Beyond this technical and cold qualification, women's account of their personal experiences explains why excision is traumatising. Agnès recalls her experience in these terms:

I was circumcised at the age of five years. But I remember it as if it was yesterday. The image of the old woman who circumcised me, with the

knife that she... held in her hand, it remained etched in my memory. (...) My mom said we were excised at age five, me I remember as if it was yesterday, they caught us, I entered, I recall the scene! As if it was yesterday alongside. (...) so at this point the old one [father, *my note*] said to appeal to the old woman again. So the old woman came back, she looked [at the genitalia, *my note*], she said ‘ah! That it had re-grown’ so they... circumcised me a second time. That time they removed, all of the labia minora...and everything.... This pain, I can't explain it I HAVE IT IN MY HEAD! (Agnès, 2015, my translation, my transcription of her oral emphasis).

Two major observations can be made from the quote: the first is that genital cutting arises at a very young age; the second is that Agnès was victim of multiple interventions. This situation seems quite usual: the SP/CNLPE (2015) mentioned the fact that many women are affected by multiple excisions. I myself escaped excision; so did the majority of my siblings. However, I have discovered during the research that a close relative – a fifteen year-old – had three interventions in total. The last two failed to open up the desired space to allow proper urination and menstruation.

Koso-Thomas (1987) qualifies the torturing intervention as the crippling of women’s agency. Indeed it removes the very character of their *femaleness*, thus affecting women’s sexuality. This sexual characteristic determines both her sense of self and her sexual relationships (Koso-Thomas, 1987: 37-42). Excision is an injury to women’s being if we refer to Agnès’s (2015) testimony. Genitally impaired women “lost something and feel it at all levels” (C. Ouédraogo quoted in IRIN, 2009, my translation). Besides the pain of the initial loss, other health-and-non-health-related troubles drift women away from well-being. Félicité Medah is member of the NGO *Association voix des femmes pour l’épanouissement* (AVFE) (Association voices of women for self-fulfilment, my translation). She acknowledges the ailments related to FGM/E (cited in IRIN, 2009). These include psychological distress (Agnès, 2015; Foldès & Louis-Sylvestre, 2006; Foldès, 2008) affecting negatively her ‘self’ with a disempowering effect. The permanent troubles threaten the positive values of agency, indivisibility of the human (Kabeer 1999). The fact that excision happens at such a young age denies the victim a say although it impacts on her future strategic life choices regarding her sexual relationships. Therefore this practice also poses problems of accountability (ibid). If it violates human indivisibility (Kabeer, 1999), excision also violates the integrity of the human being therefore impeding the feeling of well-being in the sense of Jo Rowlands and Caroline Moser (in Parpart, 2002; 2008) (see 2.1.2). This statement comes against the national Constitution (1991): article two guaranties the protection of life, security and physical integrity (MASSN & SP/CNLPE, 2014: 27). Non-consented mutilation

breaches women's individual sense of ownership of their body and violates their human rights (Toubia, N. & A. S. Nowrojee, 1996). In short genital mutilation touches women in their very personality.

This harmful practice is carried out to the only benefit of men's sexuality, and furthers their domination *over* the extended social relations. It is holding ground because of its roots in patriarchal structures. An account of the beliefs underlying excision requires analysing the gender relations of the traditional society. Control over women's bodies and sexuality occurs in communities predominantly structured around polygamy (MASS & SPCNLPE, 2014: 22; Koso-Thomas, 1987: 37). The removal of the organs responsible for sexual stimulation (the clitoris) was vital in the fixation of certain values within the community, and to ensure the acceptance of rigid standards of conduct (Koso-Thomas, 1987: 37). Devising the brutal means of circumcision to curb female sexual desire and response, the traditional society established strong controls over sexual behaviour of women (*ibid*). Relations are conceived as making a family, and sexuality seen as a gift used for procreation and the reproduction of the community as Aniekwu (2006) discusses. In such context, the feminine being and personality is adulated as the mother figure existing to reproduce the species and ensure continuity of the community (Koso-Thomas, 1987: 39). Thereby, traditional lifestyles tend to suppress the personal gender role while enhancing the social gender role assigned to women by men's authority. For instance, the household gravitates around the husband, head of the family, who is allowed more than the wife (Koso-Thomas, 1987: 38). Love and emotional feelings are hidden from the public (Koso-Thomas, 1987: 38; Akotionga et al. 1998). Such ways refer to the gender hierarchy and dual sex roles, which Aniekwu refers to (2006: 148). They are evident in traditional African culture before and after colonisation. Further, these constructions reflect the continual hierarchical gender roles and division in politics, culture and religion (*ibid*).

Being a violence perpetrated against women based on their biological sex, FGC can be assimilated to a form of women oppression by a manly power expressed over the community (Kabeer, 1999; 1994). This oppression is so pervasive that women assimilated it and let their conduct be ruled by noxious norms. In this respect, excision is deemed for its important role in the traditional initiation of females into both womanhood and society (Akotionga et al., 1998; Koso-Thomas, 1987). In his movie, *Mooladé*, Sembène Ousmane (2004) portrays this initiation process entirely carried out by women. Mutilation is a tradition perpetrated and perpetuated by women on other women. Agnès (2015) mentioned her mother and the – usually – old and respected woman who acted to get her through this experience. The circumstance in which adolescent K.S. was mutilated also points to her grandmother's role in the intervention (UNICEF

Burkina Faso, 2015, anonymity original). She was nine years old and had come for the first time to Burkina from Ivory Coast. The grandmother planned the intervention with an “old woman” and took care of her after the mutilation (UNICEF Burkina Faso, 2015). In addition to the phenomenon of non-consented genital mutilation, Koso-Tomas (1987) and Abusharaf (2001) refer to a phenomenon of consented mutilation. Women of an advanced age let themselves be cut in the process of marriage. Be these women forced or not this further indicates how ubiquitous this tradition is. This situation also reveals that through socialization, mutilation entered in the women’s minds as a natural act of virtue (Abusharaf, 2001). The first consequence is that women leave this state of affairs unquestioned. Not only that but they also contribute to its reproduction. The violent practice reflects the disembodied power *over* referred to by Kabeer (1999: 438) (see 2.1.1). The expression of this negative dimension of power results in non-decision making for the individual subjected to it. This way guaranties the reproduction of a system of domination and exploitation of women, which starts in the beds (ibid). The latter are the type of social relations obscured by the intentional naturalisation and normalisation of FGM/E (Harding, 1997: 385).

Women’s assimilating unjust social norms as their own refers to the phenomenon of ‘internalized oppression’ (borrowed from Grasswick, 2013). Harding (1997) and Kabeer (1999) help interpret this state of affairs as the very reason why women should be heard and cared for instead of it being criteria of marginalisation. Reporting women’s experience from their point of view carves out the power relations within the social structures that women reproduce, thus, creating room for women’s engagement against these very structures of inequality (Kabeer, 1994; Parpart et al., 2002).

I have shown in previous passages that empowerment implies the recognition of disempowerment in the first place with support from Kabeer (1999; 1994). In the analysis above, FGM proves to be the result of sexist and patriarchal social norms, which disable women at many levels. The recognition of such detrimental practices, the contemporary state condemned these sinful proceedings (Diop, 2006; SAEC for MASSN, 2006). This became the base for a national commitment to eradicate the harmful practice incorporating so-called empowering strategies. Within these empowering actions is a plan of surgical repair of complications (ibid).

4.1.2 Actions towards ‘eradication’ of FGM/E: a failure to empower women

National efforts to ‘eradicate’ (SP/CNLPE, 2015) excision are described and critically analysed to unravel their shortcomings when it comes to empowering FGM affected women.

First, a quick overview of the awareness raising strategies from governmental and non-governmental institutions shows that they favour the educative approach. So are the actions of the SP/CNLPE consist of (see Introduction). Film projections, sensitisation campaigns in all imaginable supports are used to reach out to the populations (SAEC for MASSN, 2006). It is in this spirit that the local singer Smokey recorded *Tomber la lame* (2014) (Bring the blade down, my translation) calling on to stop this noxious custom. Besides this soft policies, the adoption of the 1996 law criminalising excision is ambitious as it calls for up to three years imprisonment and a fine of up to nine hundred thousand CFA (see Introduction) (Diop, 2006: 5). A complementary measure consisted in setting up a hotline (MASSN & SP/CNLPE, 2015: 28). However ambitious this rule was, its implementation was so flexible that in few cases, high profile public figures intervened to bypass the condemnation presumably concerning some of their relatives (Akotionga apparition in *Priorité santé*, 2012; Diop, 2006: 7). Hence in this context the legal tool was considered as merely an extension of the already existing educative ones. Besides these sensitization and educative activities mainly focus on community and religious leaders e.g. mostly men. So is it also when the broad awareness raising messages aim at everyone and at no one in particular; they only leave everyone unconcerned (Diop, 2006). This is equivalent to making change become dependent on men’s will. Kabeer (1999) reflected on the unlikelihood that those enjoying a privileged status in the community accept change to their immediate disadvantage.

Along with the educative interventions, the CNLPE members undertake additional empowerment strategies. Among these is capacity building at institutional and organisational levels of the anti-excision actions (MASSN & SP/CNLPE, 2014; Diop, 2006). I will not expand on that considering that these fail to focus on FGC affected women. However, this broad empowerment strategy encompasses a secondary plan entailing surgical repair for women subject to complications (ibid). Actions within this framework comprise training medical staff in reparative surgical techniques. Gynaecologists, anaesthetists, surgery assistants are qualified to operate on complications in the country’s thirteen administrative regions (SP/CNLPE, 2015). In theory, intervention on excision complications can be provided in any public medical centre equipped with a surgical facility. This way district and regional levels dispose both the human

resources and operation kits necessary to look out for women in need (ibid). This is valid not only for public medical centres. The CNLPE ensures that staff from private institutions also gets training to perform the surgery (SP/CNLPE, 2015). For instance gynaecologists as Akotiongga are involved in the training of other professionals (SP/CNLPE, 2015; Akotiongga, apparition in *Priorité santé*, 2012). District medical centres are able to provide such care. According to the national nomenclature, they are national institution of proximity administering general treatment. The head person of the SP/CNLPE (2015) clarifies whom this empowerment action is for:

Our priority is to help this woman who is unable to have sexual intercourse, the woman suffers who having extreme difficulties when comes her periods because her vaginal opening is too reduced for the blood to flow. This woman who has a so small hole, but germs could pass anyway and she could take pregnancy and will have problems during childbirth because the routes are really tiny... [we, *my note*] allow it to facilitate delivery for her. And this woman who has cheloids [cheloid scars, *my note*] downright clogging the entrance of the vaginal opening that could be treated, how called, cysts even preventing a man to approach her because she is seen as ... unlike the others. There are images here. Can you imagine a man who undresses a woman and who finds stuff like that, he will flee. It is to allow these women to experience their sexuality like the others. (SP/CNLPE, 2015, my translation).

Such attention is directed to women among the 10% undergoing clitoridectomy who are subject to complications as well as these among the 70% suffering from excision complications (Akotiongga cited in B. Ouédraogo, 2009).

The life story reported on by UNICEF Burkina Faso (2015) exemplifies the outcomes of the sensitization approach, in a technical and impassionate way. A campaign at her high school on the consequences and aftereffects of excision raised the young girl's awareness about her condition. Abnormality according to the report: "it was during a sensitizing sessions on the consequences and aftereffects of excision that I became aware that my genitalia had an anomaly" (UNICEF Burkina Faso 2015, my translation). Her mother brought her to SPCNLPE from where she went into a consultation with Dr Akotiongga. He eventually operated on her in the El Fateh Suka clinic, a reference when it comes to reconstructive surgery after genital mutilation (SP/CNLPE, 2015; Agnès 2015; Sakina, 2015; Solange, 2015). Her operation was coordinated and financially supported by the SP/CNLPE (UNICEF Burkina Faso, 2015). However from the source it was no possible get precision on the procedure up to the surgical intervention. What does it include, which parts are financed? Bakouan and Sawadogo (Bakouan & Sawadogo, 2015), and Kaboré (2015) only mention the intervention. With the grassroots anchor of their associations, they have contacts with women who are

potential candidates. Their association redirects aspirants to the local social services, which take care of the rest. By comparing the information provided by UNICEF Burkina Faso (2015) with that of Bakouan and Sawadogo (2015) and SP/CNLPE (2015), I can come to the conclusion that only the surgical intervention is supported, excluding potential side-consultations.

Since 1989, allegedly three thousand women and girls could benefit excision aftereffect reparation, which remains the priority for grassroots associations and the CNLPE (SP/CNLPE, 2015; IRIN, 2009; B. Ouédraogo, 2009). Among these women, supposedly seven hundred benefited the full support from SP/CNLPE (ibid). There is no clear statistics about the number of reconstructed women were they supported or not: the representative of the SP/CNLPE herself admitted that her institution had no database with disaggregated and reliable numbers (SP/CNLPE, 2015).

Yet from the description above, the first interpretation is that care policy is unequally distributed. First this development intervention leaves a gap of inequity defined by Kabeer (Kabeer, 1994) as an inefficient allocation. Since the framework is more interested in processes, this analysis leaves out a discussion of this national remedy's outreach by comparing numbers. Instead, I am concerned with the categories and their meaning. The SP/CNLPE welfare activity consists of an official preference for certain victims of FGC, thus leaving out other women affected by the tradition. What becomes of the remaining 90% of women who underwent clitoridectomy, and those 30% affected by excision? Do these women not deserve support because they do not develop medical complications in the official sense?

This selectivity amongst mutilated women introduces an opposition between them, by that, denying their shared experience of pain and ailments consecutive to genital mutilation. Disregard for the trauma women have in common does not challenge structures of inequality causing the very proceeding deemed inhumane. Underlying this welfare intervention is not the idea that care should be provided to women object of complications because they are victims of an oppressing and disempowering social practice. Rather, such intervention is motivated by the need to protect these women's reproductive capacities as the SP/CNLPE (2015) clearly stated.

As a matter of fact, complications – be they urologic, gynaecological or obstetric – affect mostly the reproductive health of women. Reproductive health is crucial in a state policy as it relates to demography. Therefore policing this field is crucial for states (Corrêa, 2008). In the last chapter of her book, Kabeer (1994) develops on inequitable women empowerment strategies in sexual and reproductive fields. Their default resided in that they only focused on women in age to procreate, which is unchallenging of the social order

(Kabeer, 1994: 264-304). In that regard the Burkinabè strategy gives priority to these women whose reproductive capacities are threatened: the national policy aims at “allowing women to enjoy their sexual and reproductive health” (SP/CNLPE, 2015). “So the reparative surgery actually consists in enabling organs to play their roles at that level...” (SP/CNLPE, 2015). This sentence can be completed in the following way: the reparative surgery actually consists in enabling organs to play their reproductive role. Further, according to the SP, “to cut off the clitoris does not necessarily prevent women to give birth. But complications do... there are for example keloids...” (SP/CNLPE, 2015). This specific statement clarifies the reason why the official strategy cares for certain mutilated women and not others. The SP/CNLPE (2015) mentioned women from fifteen to forty-nine years old but in reality, Kaboré (2015), Bakouan and Sawadogo (2015), and C. Ouédraogo (2015) report that candidates most often are young women who have not yet fully experienced sexuality in the reproductive sense. An implication of that is that the other category is ignored and considered undeserving because their reproductive functions are not affected. This group embraces older women sexually experienced, knowledgeable who also deserve protection and care. Backed with Miller and Vance (2004), my approach is concerned by the fact that the official remedy to women’s sexual disempowerment is honed with a certain innocent idea which marginalises a larger group compromised with harsh judgments of sexual respectability (ibid, 2004: 11). This second category of FGC affected individuals is deemed larger with reference to higher prevalence rates in older age ranges (MASSN & SP/CNLPE, 2014) (see 4.1.1).

A valuing of the woman for her reproductive capacities transpires through these statements from the official discourse. Such idea reinforces the traditional patriarchal conception of women through the lenses of motherhood useful for reproducing the population (Aniekwu, 2006; Corrêa, 2008). So in many aspects, the public intervention with surgical reconstructive surgery leaves the traditional views unchallenged.

The conception of empowerment pertaining the national plan of genital reparative surgery for victims of FGM/E shows limited success in terms of equity. Most importantly, it fails to address women’s demands in terms of individual sexual empowerment. Thereby the development interventions miss the transformative edge of empowerment and barely challenge the social order critically analysed in earlier (see 4.1.1). Congruent with my overall framework of analysis, the interpretation developed above highlighted the unbalanced gender relations pertaining the traditional practice of genital cutting. In these terms, this mutilating practice is considered disempowering for women and impacts negatively on their individual sense of self. The depicted constraining environment limits women’s

capacity to fully develop as active agents capable and willing to actively engage in public contention.

At this point, the overall framework of analysis suggests moving from looking at the gender “sub-text” of concepts and policies to considering the “political sub-text” of the CR practice as Kabeer suggests (1994).

4.2 Women empowerment through clitoral rehabilitation

The official action plan excludes surgical interventions for clitoral reconstruction in addition to undermining its empowerment potential for a large group of women. In my conception of empowerment, the notion of power *within* is more interesting than that of power *over*:

[i]t requires attention to the role of language and meanings, identities and cultural practices as well as the forces that enhance power to act with others to fight for change, often in hostile and difficult environments. (Parpart, 2008: 357).

This reminds us that empowerment focuses on the marginalised voices in society.

This section first explores CR as a practice while studying its implications with women’s individual sense of ‘dignidad’ (Rowlands 1997 cited in Parpart, 2008; 2002).

4.2.1 With the neoglans comes self-esteem

In this section, women’s accounts of their experience are completed with that of doctors to allow an analysis of the implications of clitoral repair. CR allows satisfaction of women’s immediate needs in terms of sexuality with impact on their sense of individual agency.

As a genital reconstructive surgery, CR emerged from Foldès’ experience on the field (Foldès, 2014; *Priorité santé*, 2012). The French urologist conducted mission across Africa and cited Mali, Senegal, Benin, and Ivory Coast where he lead awareness raising campaigns against FGM and more generally, sexual violence on women. While on the field the surgeon operated on various types of genital mutilation be they from ritual or wartime practices. From this experience with genitally mutilated women, he found out that “the clitoris is an as long organ as the male penis measuring between ten and eleven centimetres. Simply, it is not constructed the same way” (Foldès, in *Priorité santé*, 2012, my translation). CR is based on this finding.

(...) [E]specially in Bobo [Dioulasso, *my note*] and Fada [N’Gourma, *my note*], I met mutilated women. There I started to operate the first times before coming back to France to refine the technique. (Foldès, 2014, my translation).

In a radio broadcasting (*Priorité santé*, 2012) the doctor declared undertaking an existing issue that medicine had not yet taken up. He made his the mission to simply provide reparative surgery solutions to women in need. Without regard to the type, ritual mutilation always affects the emerged part of the clitoris and the labia minora (Foldès, in *Priorité santé*, 2012). CR uncovers the clitoral root untouched by mutilation (Höckel & Dornhöfer, 2004; Foldès, 2006; B. Ouédraogo, 2009). Then the affected genitalia is reconstructed the closest possible to a non-mutilated anatomy (Foldès, in *Priorité santé*, 2012).

Excised women now have hope because it does not matter any longer however cruel the excision was, they can get their organ back.

Now I have regained my physical integrity. I confess that I feel good and feel no more pain during sexual intercourse. (Abibata Sanou quoted in B. Ouédraogo, 2009, my translation).

Thirty-seven-year-old Sanou was restored after feeling her incompleteness successively to discussions she had with non-excised girls (B. Ouédraogo, 2009). Besides, in a press release published in *The Guardian* Monica Mark (2014) argues that clitoral reconstruction seems an opportunity for millions of little girls whose “genitalia [is] sliced off” still today. Foldès led prospective studies reporting on post-op follow up where he supplies criteria for evaluating the success rates of the operations (Foldès et al., 2012; Foldès, 2008; Foldès & Louis-Sylvestre, 2006). So did C. Ouédraogo for the women he operated on (C. Ouédraogo et al., 2012). The aesthetics, the anatomy, the sexual desire, and the functionality are the four distinct criteria used to assess women’s satisfaction rates (ibid). Their progressive cohort study concludes that “regardless of the anatomical and functional results, all women were satisfied with respect to body found” (C. Ouédraogo et al., 2012: 1). An interesting figure is that in about 90% of the cases, reparative surgery allows women to regain sensations during sexual intercourse (C. Ouédraogo et al., 2012; Akotonga cited in IRIN, 2009). This fact refers to Sanou’s declaration above. Agnès (2015) also agrees when she explains her encounter with CR:

Imagine, I am in my forty-ninth year. It is since September... 2014, that I know I am a woman! A woman in any sense of the word. Ohhh, I... unfortunately I no longer remember the word I had found to... to describe my current personality. I love life! Currently, I... I am happy. I intend to shout it to everyone. I love... I see life with a new eye, life in another way! (...) It was worth the trouble. I forgot the pain altogether when I had [my first sexual intercourse, *my note*]... Well, they had given us two months before having sexual intercourse, well I confess that my husband was

absent, but as soon as he came back ... I have spent six months eh [without my husband, *my note*], so I had time to actually forget the pain. He came home. The first day when he was home, well I did not recognize myself. I did not recognize myself! I said to myself 'Oh maybe you're being delighted to soon'. Second time, third time, until now that I am speaking to you. (...) My husband he is not here. Me I did not have reconstruction for hanging out [with other people, *my note*]... no-no-no. I did it for my husband and he is 100% satisfied. I did it for myself, and I did it for all women. To let you know that it is... I'm not against it, I say, really it's like someone who has appendicitis: you open her belly, you remove the appendix... the pain, and you throw away. The [clitoral, *my note*] repair is almost the same thing, except that instead of removing and throwing away, you reuse what remained inside you. (...) Sincerely Yes! I mean it honestly, I do not lie. I say what I feel. This is because it was so successful with me that I want to testify so that other people who are in my situation can come out... (Agnès, 2015, my translation).

“Rehabilitated” was the word Agnès had found to describe her actual situation but could not remember. She came up with it off record after the interview. Below, Agnès relates to Sanou, and K.S’ (UNICEF Burkina Faso, 2015) discovery of their alterity by discussing with others and further highlight the relational dimension of empowerment:

What people say ‘sexual intercourse is like this’, I don't know, I don't know! So I want to feel feminine, it's not to roam, it's to be myself first, and then to satisfy my husband. So each day I repeated this [to myself, *my note*]. When the pain was gone, really I... I was content. I am... (Agnès, 2015, my translation).

Both Solange (2015) and Sakina (2015) agreed that they would undergo the clitoral repair again. With their neoglans operated women recovered a sense of integrity. This is ultimately empowering in the sense of Rowlands. Monica Mark sees in CR an opportunity for “bolstering their [women victims of FGM, *my note*] self-image” (Mark, 2014). “The procedure restores normal appearances to women who have been mutilated - which can be an important step in restoring self-image” (ibid). Less trouble and more pleasure means that affected women become unencumbered and are more prone to experience well-being. Agnès’ term ‘rehabilitated’ is powerful in all senses: etymologically it means restoring a former capacity. It refers to an action of reinstating, re-establishing the former state of completeness. Rehabilitating means bringing back to a useful and constructive condition. In this respect clitoral repair contributes to strengthening women’s agency.

Based on women’s accounts of their sexuality ahead of the surgery, C. Ouédraogo et al. (2012) analyse their motivations in terms of a growing need to fully experience their sexuality and enjoy freedom. CR meets a quest for stability and sexual emancipation in the couple (for married women), as well as quest for a feminine identity

for many women who undergo the operation (ibid, 2012; SPF Santé publique et al., 2011). B. Ouédraogo (2009) alludes to the re-shifting in sexual preferences and practices as he quotes twenty-five-year-old Jeanine Sawadogo. The young woman is prone to frustration and despair because her condition prevents her from having sexual intercourse. This scares men off her so she cannot engage into serious relationships (ibid).

Ram Zongo, forty-two-year-old businesswoman from Ivory Coast gives another type of reason why women demand CR: “fashions were changing, and African men no longer wanted women who had been ‘excised’” (quoted in Mark, 2014). The formulation of her motivation is so straightforwardly put and is at the same time interesting, it indicates underlying social implication or women’s journey to CR. With the improvement of women’s education and the massive migration from the rural areas into the cities, women have been exposed to an unprecedented extent to a new thinking of female sex roles, fulfilment, and independence and security (Koso-Thomas, 1987: 37). It is mainly in Ouagadougou the capital city, and Bobo Dioulasso that CR intervention is practiced (IRIN, 2009). In relation to the people showing active interest in CR, C. Ouédraogo (2015) does not only cite educated and urban women:

That is to say, any woman coming to us, but women who have sexual experience. Women ... for the virgins, we do not reconstruct the clitoris. No. It is women who have a sex life, whether married or not. (...) It is women who are at least age twenty and over. (...) Well, we receive all categories between twenty and sixty years old of educated women as well as illiterate women..., here we have everybody. (C. Ouédraogo, 2015, my translation).

The doctor’s description matches the point made above about this large category of women unjustly left out the national intervention (see 4.1.2). Through the continuous flood of information in print, on radio and television, an awareness of the importance of sexual life has been created among women who have been taught to disregard this aspect of their lives (Koso-Thomas, 1987: 37). Women reported to C. Ouédraogo et al. (2012) having been informed on the possibility of reconstruction, in order of occurrence, through media: that was the case of Agnès (2015). The second source of information is women’s relatives: Sakina said a childhood friend who had undergone the surgery in France introduced her to CR. Medical staff are the third main informant (C. Ouédraogo et al. 2012). Despite a seeming liberation, serious obstacles effecting the psychological and social transformations required for maintaining joyful and a purposeful life. These barriers are greater in rural areas where this is related to spirituality (Koso-Thomas, 1987: 38).

Notwithstanding its potential for enabling mutilated women to have an enjoyable self and life (Agnès, 2015), it is unclear how many

women CR actually reaches out to. According to Akotionga “[t]here is a huge demand in Burkina Faso and in the neighbouring countries” (quoted in IRIN, 2009). However the demand is difficult to estimate.

Citing Akotionga, IRIN (2009) reported hundred fifty women who had this surgery between 2006 and 2009. C. Ouédraogo claims that about a hundred women are operated each year since 2006 (C. Ouédraogo, 2015). This would make up estimation between nine hundred and a thousand operated women. Here again information is not readily available as to how many institutions offer the treatment in order to compile their data. It is not granted that such institutions care to keep record of these types of interventions either. By C. Ouédraogo, about fifty qualified doctors potentially operate mainly in Ouagadougou and Bobo Dioulasso (C. Ouédraogo, 2015; IRIN, 2009). No public record is available on this either. Moreover, the Burkinabè association of gynaecologists (SOGOB) was out of reach to enable a tracking of this information. In sum, it is difficult to estimate the average number of operated women living in Burkina Faso. In making such estimations, it should be taken into account that among women accessing the surgery many come from abroad, Africa and Europe included (IRIN, 2009), and even Haiti (C. Ouédraogo, 2015).

Drawing on the little data available, the practice of CR seems to involve few individuals. The service supply is the doing of private initiatives of which the most renown involves Prs. Akotionga and C. Ouédraogo. They declare being motivated by the promotion of women’s rights (C. Ouédraogo et al., 2012; C. Ouédraogo, 2015). Akotionga uses the following line of defence for CR candidates:

Women are psychologically affected by their being deprived of their clitoris and they regain a balance after restoration; this is not a luxury, it is rather redressing an injustice. (Akotionga cited in B. Ouédraogo, 2009, my translation).

Later on, he defends the same stand in an apparition in *Priorité santé* (2012), the RFI broadcasting. One interesting fact is that Akotionga was vice-president of the CNLPE at the time (B. Ouédraogo, 2009). His view opposes that of the SP/CNLPE. Indeed as a social planner she may not have the same proximity with women’s issues as the gynaecologist. He and Foldès have record of collaboration in reparative surgeries in Burkina Faso (Foldès, 2014). Akotionga contributed to train medical staff in clitoral reconstructive surgery (IRIN, 2009). He was long based in the private clinic El Fateh Suka where he contributed to the renown of the institution as specialised in genital reconstructive surgery, both on complications and on the clitoris. It is within this institution that he led most of his activities within the national action plan against excision. Agnès (2015) and Sakina (2015) mentioned clinic Suka as the initial place where they sought the surgery, before turning to the public institution CHUYO.

CHUYO stands for the national hospital of reference located in Ouagadougou. It is there where women queue to have consultations with C. Ouédraogo, the resident specialist in gynaecology obstetrics (C. Ouédraogo, 2015). There he runs a joint venture with a French doctor, Sébastien Madzou based in Angers, France (ibid). Since 2006, this a collaboration between the two doctors has become a collaboration between two medical institutions including an annual campaign of a so-called “intimate surgery” (ibid, my translation). The offer consists in a ‘package’ of interventions including “the reconstruction of the clitoris, the injection on the G point, the repairing of the perineum of women who have had deliveries that traumatized perineum and then the repair of urinary incontinence sometimes” (C. Ouédraogo, 2015, my translation). It is condensed in few weeks in March when women are offered affordable interventions while allowing practical training of ‘foreign’ doctors (Agnès, 2015; Solange, 2015; Sanga, 2006) as well as Burkinabè doctors-to-be (C. Ouédraogo, 2015). The reciprocity between the two hospitals comprises a supply of CHUYO in basic surgical material by the corresponding University Hospital Centre (CHU) of Angers (ibid).

(...) [A]s part of our agreement with Angers, there are many things that are not prescribed to patients: compresses, son, and all that is provided by the University Hospital of Angers that is offered for free. Here, there is no special fee for us physicians. (C. Ouédraogo, 2015, my translation).

This substantially contributes to reduce the intervention’s costs for women. However this notion varies very much: C. Ouédraogo estimates to roughly ten thousand CFA the actual cost of the intervention (Agnès, 2015; Sakina, 2015; Solange, 2015). The affordable price being due to the simplification of the surgical act into an ambulatory care: it lasts average thirty minutes and requires no more than a local anaesthesia. As Agnès and Solange explain below, the mobility permitted by this light intervention was convincing for them.

Well, the intervention ... it only took thirty minutes. I was kept for two - three hours. (...) And after I got home. (Agnès, 2015, my translation).

And when we finished the operation around ten - eleven in the morning, it is from four in the afternoon on that the anaesthetic has left my body and I could move my legs. So I went to take my car myself, and got back home on my own. (Solange, 2015, my translation).

Combined with the short stay period, such support contributes to reducing the intervention for affected patients. However, for women the cost has to include additional fees for medicine prescribed during the healing process: anti-inflammatory, disinfectants among others. Depending on the length of this phase additional costs can be substantial. Doctors say it takes average two months: for Agnès it took three months. Solange healed in one month when Sakina did in two

weeks. During the interview they reflected on how this impacts the cost for each one of them who had undergone the surgery. Agnès especially mentioned some of her fellows whose healing took four months (2014). Nevertheless, the ambulatory care provided at CHUYO remains very affordable compared to that in clinic: Agnès and Sakina who intended to visit a clinic mentioned two hundred and thousand CFA (Agnès, 2015; Sakina, 2015; IRIN, 2009).

Apart from Akotonga and C. Ouédraogo's popular activities in Ouagadougou, Mark (2014) reports on another initiative in Bobo Dioulasso: the opening of a CR hospital to provide free care to women. The city has clinics offering the service comprising the uncommon enterprise of the local association AVFE (Voices of women for self-fulfilment). Mariam Banemane is a fifty-four-year-old who was restored in 2006 in Burkina after she was excised at age thirteen (B. Ouédraogo, 2009). In 2009, she was head of AVFE. With the centre, she intended to restore women's clitoris for free (Mark, 2014; *Femmes, entièrement femmes*, 2013; B. Ouédraogo, 2009) because, as she declares, "we haven't asked for excision" (in B. Ouédraogo, 2009, my translation). AVFE claims it has successfully operated on twelve women in a local private clinic (Mark, 2014). With this in mind the association built the centre with support from a USA-based association *Clitoraid*. The later was the object of public opposition (Mark, 2014; *Femmes, entièrement femmes*, 2013; B. Ouédraogo, 2009). Mark (2014) qualifies of "unlikely alliance" the fact that groups of women support the Clitoraid project. For instance, individuals directly linked with Raelianism support this venture. A religious belief depicted as "an ideology of sexual satisfaction" (Mark, 2014). It is implied that the cultural norms of these women are irreconcilably different from the beliefs, which motivate the Raelian actors of Clitoraid. Besides, Mark claims that, such alliance would have never been possible in other circumstances (ibid). This fact illustrates the case that a feminism of difference can be open to solidarity in certain battle-fields (Kabeer, 1994: 80-84). Authorities eventually opposed the initiative (APO, 2014; Ouattara, 2014):

[t]he operations they want to perform are a good thing. But it is not right to use medical issues as a cover to convert vulnerable people. (Spokesperson of the Ministry of Health at the time quoted in Mark, 2014).

Without expanding on the debate about and the opposition of Clitoraid's underlying religious principles, the framework of analysis underlines the general hostile social context in which women's struggle for more flourishing lives takes place (Parpart et al., 2002; Kabeer, 1994) (see 4.1).

In the above reasoning, women's experiences designate the boosting effect of the surgical intervention on their self-perception and sense of internal strength. CR implies to consider women as ends in

themselves rather than just as mothers of the nation's productive force – mostly men (Kabeer, 1994). CR meets to some extent women's longing for integrity and sexual pleasure, in other words, the very elements of their personality denied to them by the mutilation. CR repairs the anatomical damages of clitoridectomy or other more severe mutilations it does not aim to undo the trauma. However, a reference to Agnès' (2015) hymn to life suggests that more than just the anatomy is affected in the process. The commonality of all the initiatives cited earlier is that they take root on women's actual experiences. In these experiences, women share their strategic gender interests, which can be basis for identifying their needs. The implications of such practice on the level of the worldview challenges dominant discourses underlying sexuality – as the Clitoraid case illustrated – and broader gender relations. As empowerment with its personal, relational and collective dimensions, CR is not only a gender issue but also a development issue concerning the whole community (Parpart, 2008: 356).

4.2.2 Voices of the unheard: from margins to centre

In expressing the demand for CR, women seek to rehabilitate their sexual being. Critics addressing the achievements of CR further highlight a different opinion that is more attached to the *status quo*. The actors uttering these remarks consciously or unconsciously disregard women's need and undermine their entitlement to non-material development, one that cares and nourishes well-being and creativity of all members of society (Kabeer, 1994: 83).

This relates to my framework's value for welfare precisely that of the human being. "Activities which contribute to the health and well-being of people would be recognized as productive, regardless of whether they are carried out within the personalised relations of family production, the commercialised relations of market production, or the bureaucratised relations of state production" (Kabeer, 1994:84). Along Kabeer, I intend to reverse the allocation priorities by valuing activities, which seek to meet human, needs.

Some within the medical field disagree when Foldès claims that beyond anatomical reconstruction, CR achieves restoration of women's pleasure. In a press release published in *The Guardian*, Monica Mark (2014) reports: "[t]he campaign against FGM could be undermined by a false proposition that the ill effects can be reversed. Formation of a 'neoglans' cannot restore the lost or damaged innervation". This sceptic statement was raised in the evaluation process of Foldès et al. (2012) articles' in *The Lancet*. "A team of experts from University College hospital in London led by Professor Sarah Creighton" (Mark, 2014) contested Foldès et al.'s (2012) results

in a correspondence to *The Lancet*. The British team pointed to technical limitation of these results in terms of efficiency in restoring “clitoral sensation”. On such grounds they challenge the pretence of the technique to increase FGM/E affected women’s well-being. What seems to oppose technicians is whether to qualify CR surgery as a medical treatment or a plastic surgery.

The national care policy (see 4.1.2) bases the exclusion of CR on such classification. Officially considered as a plastic surgery, CR becomes an unnecessary intervention left to luxurious individuals.

(...) most of the times, it is for aesthetic needs... it is mostly aesthetics indeed, because when a woman..., when the clitoris is missing, she does not feel a full woman. (SP/CNLPE, 2015, my translation).

This statement from the SP/CNLPE associates a mutilated woman’s feeling of incompleteness with a secondary aesthetic matter. Interestingly, she recognizes that without their clitoris, women feel incomplete but the SP civil servant denied CR’s ability to even restore dignity to these women. So genitally impaired women are condemned by fate to remain in their condition. Moreover, according to such conviction, CR cannot be prioritized before more urgent matters. The outcome sought from CR appears meaningless compared to more pressing issues such as endangered livelihood, public health, and inadequate education system. This argument meets that of those – feminists included – prioritising political and economic issues over sexual ones (Aniekwu, 2006: 143-146; Tong, 2009: 215-217).

The SP/CNLPE at the time, Marie-Rose Sawadogo thought “it is a luxury” because the surgery is expensive to a point that too many women in BF cannot afford it (cited in B. Ouédraogo, 2009). B. Ouédraogo evaluated the cost between hundred and forty and four hundred dollars – in private clinics – in 2009 unchanged up to this date. Even Drs Akotionga and Ouédraogo believe the cost for the intervention is too “prohibitive” (cited in IRIN, 2009) compared to the average purchasing power (see Introduction).

For me it was worth it but knowing the living standards of Burkinabè, I think it relatively expensive. (...) It remains expensive for the Burkinabè women that I know. In any case, the majority cannot really... er afford this easily! So... especially since many do not have a job. (Solange, 2015, my translation).

Solange raises one interesting point as of women’s economic disempowerment. The theoretical framework of this study analyses this unequal access to resources as a result of women’s marginalisation from sources of power, which begins in their private lives. In this instance, they are kept away from the distributive authority to negotiate in the allocation of resources (Kabeer, 1999). The aim of empowerment activities is to enable them, individually to feel a collective entitlement to engage in these very social negotiations

in order to introduce more equity in the distributive processes at play in the community (Kabeer, 1999; 1994).

Besides, if average 90% women who undergo CR are satisfied, this leaves another portion unsatisfied. Indeed Akotionga points:

Average 10% of women do not regain sensations during sexual intercourse because it is not always linked to FGM. (Quoted in IRIN, 2009, my translation).

It is on such bases that contenders as the British opponents to Foldès could contest the efficiency of the surgery. Ram Zongo who I mentioned earlier did not feel any difference in terms of sensations but she also admits that doctors warned her that sensation was not restored in all cases. Below C. Ouédraogo explains how he receives newcomers:

(...) we receive them, we explain what the reconstruction of the clitoris is, we discuss their sex life, to understand their reason for the request. Thereby we discard a number of ambiguities and expectations a priori or ideas on the reconstruction of the clitoris in relation to phenomena like orgasm and everything; explain that if it's only for the purpose of having an orgasm, 'careful you can be disappointed' because there are women who are not circumcised who have never had an orgasm, there are women who are circumcised but who have orgasms. (C. Ouédraogo, 2015, my translation).

Being open about the intervention's (mis)achievements is crucial in the care offered to women (Foldès, 2015; intervention in *Priorité santé*, 2012). It informs women's choice and sets the base for confidence in for the rest of treatment if so is the case. Beyond this, the very fact of leaving the choice to women to decide whether to continue or not is empowering in itself. Further, C. Ouédraogo (2015) mentions a gap that Paterson et al. (2012) explore. They found out that, on one side research conducted so far has failed to assess and create a correlation between ritual FGM/E and decreased sexual pleasure, and on the other side, research fails to correlate increased sexual pleasure with surgical reconstructive surgery after FGM. A questioning lies beyond this debate that is whether such subjective quasi-metaphysical concept as sexual pleasure can be measured. Kabeer's (1999: 442-460) perspective suggests keeping distance from such temptation. The venture entails getting over locally situated questions of meanings and values (ibid), which are not easily accessible. C. Ouédraogo corroborates this thought with the following statement:

[p]leasure is relative because there are women who were not operated and yet have healthy sexuality. But others are so traumatized psychologically and physically, that surgery can benefit them. (Quoted in IRIN, 2009, my translation).

This shows us that practitioners are aware that sexual pleasure as well as orgasm is difficult to define (Paterson et al., 2012). As a

consequence, and in line with Kabeer's (1999) argument, it is not easy to measure the extent to which surgery improves women's sexual life and feeling of well-being (SPF Santé publique et al., 2011) in the natural scientific sense of having the certitude.

Nonetheless, does the acknowledgement of this conundrum mean that CR does not meet women's demands altogether? Here again it is crucial to carefully listen to affected women. Koso-Thomas indicates a psychological barrier remaining after girls had been conditioned to suppress any feeling that may develop during male's advances (1987: 39). It is important to acquaint that the treatment provided to CR candidates is not and cannot be limited to the surgical repair of the clitoris (SPF-Santé publique et al. 2011). This necessitates listening and understanding women's experiences ahead of and after the intervention. In the FGM guide to professionals SPF-Santé publique et al. suggest careful listening to and empathy with candidates (Ibid, 2011: 119-135).

Agnès (2015) insisted on this aspect because she considered that the couple of four-five post-operation consultations were insufficient. She admitted feeling the urge to talk and share her experience of pain during the healing process but did not get the support she wanted from the doctors. Instead, she turned to the group of women whom she had met the day of the surgery and started a sort of support group. In the absence of a professional psychological support, she suggested to C. Ouédraogo to institutionalise the type of support group she had formed with other women.

It was there we grouped the eight of us. And after we decided to establish (...). Our club is called the cli - for clitoris - club [laughter, *my note*]. We hang out together, after pain [the healing process, *my note*], we hung out for drink... we became friends. So I exactly said to Professor [C. Ouédraogo, *my note*] to create... The women's forum... (...)

We used to exchange on the moments of pain, how each one felt her pain. Anyway it has permitted us to cheer up a little, to bear the pain. And after the pain, [the meeting with the club allowed us to interact on, *my note*] how everyone experienced her first sexual intercourse, how... Well there are some who are less satisfied than we. Well, I thought I was lucky. Really I am... I thank God. Since ...so much, I am very very... So the pain was excruciating, each day that God made, I thought 'Oh my God, I'm not sick, I took my money and went for my own torment', but it is that... why have I done it? (...) Well our women forum - er women cli? We meet virtually every last Saturday of the month, we gather, and we chat. (...) I made the suggestion to the Professor [C. Ouédraogo, *my note*], I said 'it is necessary that you create it [a support group, *my note*] BEFORE and AFTER!' [my transcription of the oral emphasis]

(...) from the moment we created our circle of repaired women and met, then we saw really that we could endure the pain. Because you talk about

your pain, you see that the other (...) she has... her's is worse than yours...

(Agnès, 2015, my translation).

Along with her account of how the support group helped her, Agnès makes another point about the pain she has felt during her healing process. While acknowledging that one member of her 'cli-club' did not feel as much pain and could sit properly a few days after the operation, she admitted not having been prepared to so much suffering herself (Agnès, 2015). She suggested that doctors be more open about pain as well. Nevertheless she is so content with the intervention turned out in her case that she does not regret doing it (ibid). Getting back to the concern for psychological support, C. Ouédraogo calls for a "proper psychiatric follow up" deeming this dimension crucial in the rehabilitation process (C. Ouédraogo et al., 2012). Paying attention to women's demands is important in many regards: firstly to match their expectations with the results of the operation communicated by the medical referent because the reasons motivating a woman who wants to be reconstructed influence her level of satisfaction after surgery (C. Ouédraogo cited in IRIN, 2009). Secondly, and most importantly a psychological support helps the individual relate the rehabilitating process with the initial trauma that excision caused. Such support is more likely to dissipate the physiologic reaction during the CR conducted under local anaesthesia as women can unconsciously assimilate it a replication of the mutilating act (Akotionga et al. 2001). This support also includes the 3% of women who engage in the procedure but eventually drop out (C. Ouédraogo, 2015). C. Ouédraogo as well as Paterson et al.'s (2012) and SPF-Santé publique's report (2011) make a comprehensive statement on the value of a psychological support for all women engaging with an exploration of their sexuality. Such procedure provides an answer to the possible mental barrier mentioned earlier (Koso-Thomas, 1987: 39). SPF-Santé publique et al. (2011) suggests consultations with psychologists and sexologists more if possible. For example, in Saint-Germain-en-Laye, France, Foldès' ISG offers a wider range of support including that of jurists (Foldès, 2014). Such an inclusive approach requires moving from an exclusive focus on FGC affected women to take in those enjoying genital integrity as well.

With regard to the exploration of one's sexuality, one that is necessarily positive (Vance & Miller, 2004) as I showed in other passages, women express another need, which is social acceptance. Indeed, Sakina (2015) and Agnès (2015) declared having hidden their intervention to their relatives except a few ones including their husbands. Their children were not aware: Solange felt her sons were not concerned so she did not intend to tell them about it. On the opposite, for Agnès it was a matter of time to let her daughters know once they have grown mature. She further specified that given her extended healing period she had to pretend a back pain to others:

I did the intervention, even a single day I have not been absent from the office. I was going [to the office, *my note*]. But to the family I had them believe that I had had an intervention on the nerve, for back problems. As the seated position was a bit difficult I thought... I was obliged to say that I had undergone surgery. (Agnès, 2015, my translation).

Solange (2015) also declared having carried out professional activities without interruption after being operated. The effort to hide the intervention has an implication, which is straightforwardly illustrated by Agnès' report of her colleague's reaction when she share her experience:

I have a senior position [at job, *my note*], I have my colleague (...) I told her I had undergone reconstruction. She looked at me weird... "You offered yourself to these butchers?"... Well imagine, this is a lady of a higher level as me. The spirits are not prepared for this ... (Agnès, 2015, my translation)

She carried on saying that:

I do not like to talk about it. I dislike telling others because people see it with suspicion. (ibid).

The experiences point to a despising social environment that forces them to keep their experiences secret even when they would like to share it. Hiding CR behind the veil of privacy on the grounds that it is a matter of sexuality equals to taboo it. Marginalisation comes even from well-educated and prominent actors as state officials, and even workers from the women's defence movements. Their conception of sexuality is honed with a false sense of purity and innocence, which consequently leads them to actively marginalise women. This thought also brings them closer to a conservative androcentric conception of gender relations in the community. The fact that sex related issues – female ones – are excluded from the public domain (Akotionganga et al., 2001; Aniekwu, 2006) whereas excision is so commonplace appears paradoxical. Genital mutilation is overtly associated with an intervention on the young girls' sex with implications on her future sexuality (see 4.1). A hint is that it is not CR's general relation to sexuality that is in question. Rather, it is the type of positive sexuality it implies, which denotes from the traditional and official and pro-natal conception of sex (Aniekwu, 2006). The discourses held at the SP/CNLPE (SP/CNLPE, 2015) lay on this ground. This may seem paradoxical that women are amongst those holding this stance especially the very actors responsible for fighting this harmful tradition. I have discussed earlier, along with Kabeer (1999) how women can integrate and reproduce systems of oppression and how bringing them to reflect upon these structures can be liberating.

In such disabling context, women underline the need for a public understanding, which implies furthering their de-marginalisation. They utter this demand before making any other material request for example, for supplying more operation kits or reducing intervention

costs (Agnès, 2015; Solange, 2015). For instance, Akotionga points to the lack of material preventing qualified doctors from doing the intervention (cited in IRIN, 2009). Moreover, surgeons do not have the adequate/necessary material, otherwise C. Ouédraogo recommends they repair the clitoris of patients during genital reconstructive operations (cited in IRIN, 2009). This suggests a way public intervention can systematize a care policy addressed to all FGM affected women. Below, Solange expresses her advice to a potential candidate. Then Agnès explains why CR should be opened up for discussion:

It is in fact really not to be ashamed to do it [CR, *my note*] not listen to the... the... people's gossips because there are some who are even afraid to talk about it even in their own environment in order not to be criticized and for me this is not the case, I think that sexuality should not be as taboo nowadays. (Solange, 2015, my translation).

It [intervention, *my note*] is desirable but I would like that people accept clitoral repair first. Because at the moment, (...) it is as I said earlier, people have no... It is necessary that people, spirits, attitudes change. (...) It is necessary that people accept the thing as if it were an illness like appendicitis that is treated. There is otherwise ... many women who suffer from the after-effects of excision but who do not speak out: outright forbidden, taboo subject. (...) But the repaired women must first accept to testify...on the benefits of [clitoral, *my note*] repair. As it is necessary that... well it is as I said spirits are not prepared! (...) It must be that there is... a frank collaboration between operated, non-operated women that we say everything. The communication is important! (Agnès, 2015, my translation).

Hereby, both Solange and Agnès indicate the necessity of public debate. In this respect, the controversy fuelled by the Clitoraid initiative in Bobo Dioulasso had the merit to bring the subject to the public arena. It did not make up the headlines but there was at least media coverage of the issue. Committed actions such as *Femmes, entièrement femmes* (2013) shed light on women's experiences with(out) FGM/C or CR. From his social status, and provided the "importance" and "significance" of "these practices", Kouyaté the popular Burkinabè filmmaker felt a responsibility to act with his own means (Artiste BF, 2014). Lifting CR up as subject of public deliberation allows both men and women to explore sexuality with the possible outcome of them accepting a more its positive conception alike that of Miller and Vance's (2004). This democratic process has the quality of being both informative, and most importantly, inclusive.

4.3 Final reflexions

All in all CR does not only reconstruct women's anatomy it rehabilitates a whole person. The surgery bears the potential to bolster women's self-esteem, and allows them to recover a sense of integrity and dignity; it firmly settles their very agency as full human beings. In the process of the quest for CR, women gain skills, and develop consciousness about their sexuality and their related social status. However, the aforesaid does not state in numerical terms the extent to which CR empowers women into more active development agents. A reason for that is the difficulty to define such situated, individual and subjective conceptions as pain, sexual fulfilment, and well-being. In fact, conceding this presides over actions that take root on people's needs; so is the principal achievement of CR regarding FGM/E affected women. Beyond individual empowerment, a similar attitude is concerned with care nourishment and well-being of human life. As indeed, listening to women and caring for their well-being as ends in themselves is key to the development of their personal agency.

I have emphasised the constraining social environment wherein the journey takes place. In this regard, doctors' allegations can be basis for further reflexion: women from the West African sub-region and from as far as Haiti have come to Ouagadougou to undergo the operation. A comparison could be interesting between Burkina Faso and neighbouring country's reception and acceptance of the practice of CR albeit marginal. There is potential for a comparative study to explore the extent to which this phenomenon reflects a greater toleration from the Burkinabè national community vis-à-vis this ground-breaking modern practice that challenges local ways of being and doing.

On a theoretical level, the reflection explored instrumentalist conception of empowerment a more intrinsic one best serving the self-assigned feminist goals. Besides, a conception of empowerment as a qualitative process confronts one difficulty when it aims at being implemented. Quantitative measurement is not easily achieved although it is necessary for keeping social planners accountable. This is both a shortcoming and strength of this approach. Parpart suggests to elaborate frameworks for measuring empowerment outcomes while valuing the process with the belief that "[w]hile attempts to measure outcomes can focus the mind and encourage new thinking, an obsession with outcomes and measurement can endanger the very processes most apt to nurture women's empowerment, even if not apparent at the time" (Parpart, 2008: 358).

As concerns the methodology, the focus on national and local structures disregarded the influence on women's development of international discourses and practices as Sakina's experience with her

French friend evokes. The analysis also mentions the influence of high-tech communication means. An axis of reflection may be to consider the interplay between local, national and global dimensions of development responds to the urge to explore cultural assumptions and discourses, notions of human rights, laws and practices to see how the broader political and economic structures, enable or constraint marginalised women's – and men - quest for survival and flourishing lives.

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APPENDICES

Reference Map of Burkina Faso



Original version of quotes (in French)

Authors are classified in alphabetic order. Then quotes are sorted in order of apparition under each source.

AGNÈS (2015)

Cited in section 4.1.1, p.27-28 : « (...) j'ai été excisée à l'âge de 5 ans. Mais je m'en souviens comme si c'était hier. L'image de la vieille qui m'a excisée, avec le couteau qu'elle a... tenait en main, c'est resté gravé dans ma mémoire. (...) Ma maman dit on a été excisée à 5 ans, moi je m'en rappelle comme si c'était hier, on nous attrapées, je suis rentrée, je revois la scène! Comme si c'était hier à côté. (...) donc c'est là le vieux a dit de faire appel à la vieille encore. Donc la vieille est revenue, elle a regardé, elle a dit 'ah que ça a poussé' donc on m'a excisée une seconde fois. Là on m'a enlevé, toutes les petites lèvres (...et tout...). Cette douleur, je ne peux pas l'expliquer je l'AI DANS MA TÊTE! »

Cited in section 4.2.1, p.36-37: « Imaginez, je suis dans ma 49ième année, c'est à partir de septembre...2014, que je sais que je suis femme! Femme dans tout le sens du mot. Ohhh, je... malheureusement je ne vois plus mon mot que j'avais trouvé pour ... décrire ma personnalité actuelle. J'aime la vie! Présentement. j'ai... je suis heureuse. J'ai l'intention de crier ça à tout le monde. J'aime... je vois la vie d'un autre côté, la vie d'une autre manière!(...) Ça en valait la peine. J'ai oublié la douleur carrément lorsque j'ai eu (mes premiers rapports). Bon ils nous avaient donné 2 mois pour les rapports, bon moi j'avoue que mon mari était absent, mais dès qu'il est rentré – moi j'ai fait 6 mois hein, donc j'ai eu le temps d'oublier carrément la douleur. Il est rentré, le premier jour quand il est rentré, bon, je ne me suis pas reconnue. Je ne me suis pas reconnue. Je me disais 'ah peut-être que (là-là je rejouis un peu...)' 2e fois, 3e fois, jusqu'à l'heure où je vous parle. (...) Mon mari il n'est pas là. Moi je ne me suis pas faite reconstruire, reconstruite, pour sortir... non-non-non. Je l'ai fait pour mon mari et il est satisfait à 100%. Je l'ai fait pour moi-même, et je l'ai fait pour toutes les femmes. Pour vous dire que c'est ... Je ne suis pas contre ça, je dis vraiment, c'est comme quelqu'un qui a l'appendicite: on ouvre son ventre, on enlève l'appendice... le mal, on jette. La réparation c'est à peu-près la même chose, sauf qu'au lieu de l'enlever jeter, on enlève ce qui est resté à l'intérieur de toi.(...) ! Sincèrement oui! Je parle honnêtement, je ne mens pas. Je dis ce que je ressens. C'est parce que ça a tellement réussi avec moi que je veux témoigner pour que d'autres personnes qui seraient dans ma situation puisse sortir-eueh...(...) »

Cited in section 4.2.1, p.36 : « Ce que le gens disent 'les rapports c'est comme ça', moi je ne sais pas, je ne connais pas! Donc je veux me

sentir femme, c'est pas pour vadrouiller, c'est pour être moi-même d'abord, et puis pour satisfaire mon mari'. Donc chaque jour je répétais ça (quelque part). Quand la douleur est passée, vraiment je... j'ai été comblée. Je le suis... »

Cited in section 4.2.1, p.40 : « Bon l'intervention ça ... ça n'a pris 30 mn. On m'a gardée pendant 2 h - 3h. (...) Et après je suis rentrée à la maison. »

Cited in section 4.2.2, p.45 : « C'est là-bas nous nous sommes regroupées les 8. Et après on a décidé de fixer (...). Notre club s'appelle le club cli – clitoris - [laughter]. On se fréquente, après les douleurs, on se retrouvait, on a pris un pot... on se...on est devenu des amies. Donc je disais au professeur justement de créer... Le forum des femmes (...) C'est que on échangeait les moments de douleur, comment chacun chacune ressentait sa douleur. Ça nous a permis quand-même de remonter un peu, de supporter la douleur. Et après les douleurs, comment chacun a vécu son premier rapport sexuel, comment... Bon y'en a qui sont moins satisfaites que nous. Bon je me suis dit que j'ai eu la chance. Vraiment je suis ... je rends grâce à Dieu. Puisque tellement, je suis très-très... Tellement la douleur-là était atroce, chaque jour que Dieu faisait, je disais 'ah mon Dieu, je ne suis pas malade, j'ai pris mon argent aller chercher mon mal', mais c'est que ... pourquoi je l'ai fait? (...) Bon notre forum femmes-heu femmes cli-là? on se retrouve pratiquement, les derniers samedi du mois, on se retrouve, on cause. (...)J'ai fait la suggestion au professeur, j'ai dit 'il faut que vous créiez [un groupe de de soutien ou un psychologue] ça AVANT ET APRÈS (...) à partir du moment où nous avons créé notre cercle de femmes réparées-là et puis on se retrouvait, on a vu vraiment qu'on arrivait à supporter la douleur. Parce que toi tu parles de ta douleur, tu vois que l'autre ... anhanh... elle a... vit pire que toi ... »

Cited in section 4.2.2, p.46-47 : « J'ai fait l'intervention, même un seul jour ne me suis pas absentée du bureau. Je partais [ndlr: au bureau]. Mais à la famille j'ai fait comprendre que j'avais fait une intervention au niveau du nerf, des problèmes de dos. Comme la position assise était un peu difficile je me suis dis que...j'étais obligée de dire que j'avais subi une intervention. »

Cited in section 4.2.2, p.47 : « Moi je suis d'un niveau supérieur, j'ai ma collègue à qui je... (...), je lui dis que j'avais fait la reconstruction. Elle m'a regardé bizarre ... 'Tu es parties te donner à ces bouchers-là?' Bon imaginons c'est une dame d'un niveau supérieur comme moi. Les esprits ne sont pas préparés à ça...(...) Mais je n'aime pas en parler. Je n'aime pas en parler aux autres parce que les gens voient ça d'un mauvais œil. »

Ibidem: « Mais je n'aime pas en parler. Je n'aime pas en parler aux autres parce que les gens voient ça d'un mauvais oeil. »

Cited section 4.2.2, p.48 : « C'est [une intervention] souhaitable mais j'aimerais d'abord que les gens acceptent d'abord la réparation du clitoris. Parce que pour le moment, (...) c'est comme je le disais tantôt, (les gens n'ont pas ...) Il faut que les gens, les esprits, les mentalités changent. (...) Il faut que les gens acceptent la chose, comme si c'était un mal comme l'appendicite qu'on traite. Voilà sinon il y a aucun beaucoup-beaucoup de femmes qui subissent les séquelles de l'excision mais qui n'en parlent pas: sujet tabou, carrément interdit. (...) Mais il faut d'abord que les femmes réparées-là acceptent de parler, de témoigner ... des bienfaits de la réparation. Puisque il faut que ... bon c'est comme j'ai dit les esprits ne sont pas préparés! (...) Il faut qu'il y ait ... une franche collaboration entre opérées, non-opérées qu'on dise tout. La communication elle est importante ! »

AKOTIONGA, Michel

Cited in section 4.2.1, p.38 : « Il y a une très forte demande au Burkina Faso et dans les pays voisins. » (Quoted in IRIN, 2009).

Cited in section 4.2.1, p.39 : « La femme est psychologiquement touchée par le fait qu'on lui a enlevé son clitoris et retrouve son équilibre après la restauration; ce n'est pas un luxe, c'est plutôt la réparation d'une injustice. » (Quoted in B. Ouédraogo, 2009).

Cited in section 4.2.1, p.43-44 : « Environ 10 pour cent des femmes ne retrouvent pas de sensations pendant l'acte sexuel, car [l'absence de sensations] n'est pas toujours liée aux MGF. » (Quoted in IRIN, 2009).

BANEMANE, Mariam (quoted in B. Ouédraogo, 2009)

Cited in section 4.2.2, p.41 : « on n'a pas demandé à être excisées .. »

FOLDÈS, Pierre

Cited in section 4.2.1, p.35 : « Le clitoris est un organe qui est aussi grand que le pénis masculin (entre dix et onze centimètres), simplement il est construit différemment. » (Appearance in Priorité santé, 2012).

Ibid : « (...) donc je connais très très bien le pays, surtout de côté de Bobo, de Fada. J'ai rencontré des femmes mutilées. J'ai commencé à faire mes premières opérations là-bas avant de revenir en France pour mettre au point la chirurgie. » (Foldès, 2015).

K.S Life story in UNICEF Burkina Faso (2015)

Cited in section 4.1.2, p.32 : « c'est au lycée, lors d'une séance de sensibilisation sur les conséquences et les séquelles de l'excision, que

je me suis rendue compte que j'avais une anomalie au niveau de mon sexe. »

OUÉDRAOGO, Charlemagne

Cited in section 4.1.1, p.28 : « Elles [les victimes de MGF/E] ont perdu quelque chose et ressentent un manque à tous les niveaux. » (Quoted in IRIN, 2009).

Cited in section 4.2.1, p.38 : « c'est-à-dire toute femme venant, mais des femmes qui ont déjà l'expérience sexuelle. Les femmes qui...les filles vierges, nous ne reconstruisons pas le clitoris. Non. C'est des femmes qui ont une vie sexuelle, qu'elles soient mariées ou non. (...) On en a eu ici entre 20 et 60 ans. Voilà, nous avons toutes les catégories entre 20 et 60 ans, des femmes instruites comme des femmes analphabètes-euh, voilà on a tout. » (2015).

Cited in section 4.2.1, p.40 : « ...nous organisons une campagne, que nous appelons "campagne de chirurgie intime" qui prend en compte la reconstruction du clitoris, l'injection au point G, la réfection du périnée des femmes qui ont eu des accouchements qui ont traumatisé le périnée et puis la réparation d'incontinences urinaires des fois, c'est vraiment un package. » (2015).

Cited in section 4.2.1, p.40 : « (...) dans le cadre de notre convention avec Anger, il beaucoup de choses qu'on ne prescrit pas au malades : les compresses, les fils et tout ça qui est apporté par le CHU d'Angers qui est gratuitement offert. Voilà, il n'y a pas d'honoraires spécial pour les médecins que nous sommes voilà. »

Cited in section 4.2.1, p.44 : « Et les femmes qui entendent viennent en consultation, nous les recevons, nous leur expliquons ce que c'est que la reconstruction du clitoris, nous abordons leur vie sexuelle, pour comprendre leur raison de la demande. Ce qui permet de lever un certain nombre d'équivoques et d'a priori ou des idées attendues sur la reconstruction du clitoris par rapport à des phénomènes comme l'orgasme et tout ; leur expliquer que si c'est uniquement pour le but d'avoir un orgasme, attention vous pouvez être déçues parce que il y a des femmes qui ne sont pas excisées qui n'ont jamais eu d'orgasme, il y a des femmes qui sont excisées mais qui ont des orgasmes. »

Ibid, p.44 : « Le plaisir est relatif parce qu'il y a des femmes qui n'ont pas été opérées et qui ont malgré tout une sexualité saine. Mais d'autres sont tellement traumatisées psychologiquement et physiquement que la chirurgie peut leur être bénéfique. » (Quoted in IRIN, 2009).

PNG (2009)

Cited in Introduction, p.5: « la lutte contre les inégalités et les disparité de genre constitue un axe central si l'on veut atteindre les résultats escomptés en matière de changement économique et social. »

Cited in Introduction, p.6: « (...) et toutes les autres formes de pratiques affectant la santé et l'épanouissement des femmes et des enfants. »

Ibid : « (...) la lutte contre les inégalités et les disparités de genre constitue un axe central à explorer si l'on veut atteindre les résultats escomptés en matière de changement économique et social. »

SANOU, Abibata (quoted in B. Ouédraogo, 2009)

Cited in section 4.2.1, p.36 : « Les femmes excisées ont aujourd'hui de l'espoir car quelle que soit la cruauté de l'excision, on peut retrouver son organe. »

Ibid : « Maintenant, j'ai recouvré mon intégrité physique. J'avoue que je me sens bien et lors des rapports sexuels, je n'ai plus de douleur. Je me suis habituée à cela maintenant. »

SP/CNLPE (2015)

Cited in section 4.1.2, p.32 : « Notre priorité, c'est d'aider cette femme qui ne peut pas avoir des rapports sexuels, cette femme qui souffre au moment de ses règles parce que les orifices sont réduits et qui a des difficultés extrême pour l'écoulement des sang règles. Cette femme qui, elle a l'orifice est tellement petit, mais les germes ont pu passer quand-même elle a pris grossesse et à l'accouchement aura des problèmes parce que les voies sont vraiment chose...lui permettent de faciliter son accouchement. Et cette femme qui a des chéloïdes qui bouchent carrément l'entrée, l'orifice vaginal que on puisse soigner les, les comment on appelle, les chistes qui empêchent même un homme de l'approcher parce que elle est vue comme ...une pas comme les autres. On a des images ici. Vous vous imaginez un homme qui va déshabiller une femme et qui va trouver des truc comme ça il va fuir. Donc c'est pour permettre à ces femmes-là de vivre leur sexualité comme les autres. »

Cited in section 4.1.2, p. 33 : « de jouir de leur santé sexuelle et reproductive. »

Ibid : « Donc la réparation bon des choses-là, consiste vraiment à permettre aux organes de permettre de jouer leur rôle à ce niveau. »

Ibid, p.34 : « De couper le clitoris-là ça n'empêche pas forcément une femme d'accoucher. Mais ce sont les séquelles... il y a des chéloïdes... »

Cited in section 4.2.2, p.43 : « Voilà, la plupart du temps c'est pour des besoins d'esthétiques...c'est esthétique surtout hein, parce que bon quand la femme (...) quand le clitoris n'est pas là, elle ne sent pas pleinement femme. »

SOLANGE (2015)

Cited in section 4.2.1, p.40 : « Et quand on a fini l'opération vers 10h-11h, c'est à partir de 16h que le produit anesthésique a quitté mon corps et que je pouvais mouvoir mes jambes. Donc je suis allée prendre ma voiture, me débrouiller moi-même pour rentrer. »

Cited in section 4.2.1, p.43 : « moi ça en valait la peine, mais connaissant aussi le niveau de vie des Burkinabès je trouve que c'est relativement élevé. (...) Ça reste cher pour les femmes du Burkina que je connais. En tout cas, la majorité ne peut pas vraiment... ehh faire cette dépense-là facilement quoi! Donc... surtout que beaucoup ne travaillent pas. »

Cited in section 4.2.2, p.48 : « C'est surtout vraiment ne pas avoir honte de le faire, ne pas écouter aussi les... les ... les comérages des gens parce que y'en a même qui ont peur d'en parler dans leur milieu même pour qu'on ne les critique pas et moi ce n'est pas le cas, je me dis que la sexualité ne doit pas être aussi taboue que ça de nos jours... »

Interview guides

The nature of the information needed was written down in bullet points a memo. Below they are classified according to the informant. Prior to formulating the questions, I briefly introduce my research interest and myself. I end this presentation by demanding consent for the audio recording eventually followed by a discussion on anonymity.

To All

- Nature of intervention
- Motivations
- Period / Length of surgery/ period covered by the whole treatment.
- Costs (aggregated & disaggregated)
- Effects and benefits of surgery: what advice would you give to me if I were candidate?
- Support needed/Basis for state intervention (supporting supply-side or demand-side)
- Recommendation to another potential informant

Specific to operated women

- Location(s)/occupations/age
- Source information about CR
- Recollection from the treatment
- What about relatives?

Specific to Dr C. Ouédraogo

- Actions/procedure of CR surgery,
- Population concerned + age, patients motivation(s), location,
- Number & regularity of interventions/ number of consultations
- Number and type of required medical staff for doing CR surgery.
- Required qualification(s)/specialisations for CR surgery
- Number of Drs qualified in CR/ Number of those meeting the basic requirements but unqualified in CR
- Number of institutions equipped for reparative surgery (complications/CR)
- Characteristics of necessary material/tools, and infrastructure(s)
- Rate of candidates who complete the treatment
- Rate of women experiencing (or not) complications
- Number of women who underwent CR, since the 80's (estimation)

- Number of women potentially demanding CR
- Institutional structure /organisation and budget allocation of Health, gender equality, and social welfare sectors

Specific to Dr Foldès

- Genesis of CR
- Acceptance by/reaction(s) of institutions (public/local/international). Then/today
- Relation to (doctors in) Burkina/Africa/. Observations/recollections?

Specific to SP/CNLPE:

- Excision/type prevalence rate in BF
- Conditions for accessing free genital reparation surgery. Motivation(s) for supply/intervention
- Which policy for women who do not experience complications?
- Number of women who underwent genital reconstruction since introduction of technique in BF/ Average number per year
- Rate of women experiencing (or not) complications
- Number of women who underwent CR, since the 80's (estimation)
- Number of women potentially demanding CR
- Institutional structure /organisation and budget allocation of Health, Gender equality and social welfare sectors

Specific to Mwangaza Action and ADEP

- Activities/Area(s) of intervention
- Relation to excision/CR
- Relation to CNLPE