A Tradition in Transition:
Female genital mutilation/cutting

A literature review, an overview of prevention programs and demographic data for Australia

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A Tradition in Transition: Female genital mutilation/cutting
A literature review, an overview of prevention programs and demographic data for Australia

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We thank those who gave generously of their time and expertise in producing this resource, as well as those who provided invaluable feedback, advice and support.

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Language used in this report

The language used to discuss the practices of mutilating, cutting, stitching and altering the genitalia of women and girls has been the subject of highly emotional debate over the past four decades and has been discussed in some detail in this report. We have used the term female genital mutilation/cutting (FGM/C) throughout, except when quoting the writing of others.
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Introduction

There are over 109,980 people living in Australia who were born in countries known to practise female genital mutilation/cutting (FGM/C) (WHO 2008; ABS 2011). Migrants and refugees from countries with a high prevalence rate of the more severe forms of FGM/C have been coming to Australia in significant numbers since the late 1980s.

Family Planning Victoria contracted RMIT University to undertake a demographic audit and literature review in relation to FGM/C. The findings of this audit and review are presented as a three part report titled *A Tradition in Transition: Female genital mutilation/cutting - A literature review, an overview of prevention programs and demographic data for Victoria, Australia*. These documents were expanded and updated in 2014 to reflect a national view.

The first part comprises a literature review, including an overview of the cultural and traditional contexts in relation to FGM/C and the effects of migration to Western countries.

The second part comprises an overview of international prevention programs, including those established in countries known to practise FGM/C and among Western countries in response to the arrival and settlement of people from practising countries. Included is a discussion on how these programs impact on communities and ultimately contribute to the abandonment of the practice.

The third part provides broad demographic data on communities from practising countries residing in Australia, including extensive statistical information and in-depth analyses. This demographic profile was developed using data from the Australian Bureau of Statistics (ABS), the World Health Organization (WHO), the Measure Demographic and Health Surveys (MDHS) and the United Nations Children’s Fund (UNICEF).

The first of its kind in Australia, we believe that this report will serve as a useful resource for educators, academics, health professionals, policy makers and agency staff who work with communities from practising countries. Through this report, we have endeavoured to provide valuable data and analyses for the development of services and policies to benefit communities settling in Australia.

The collated demographic data in part three was initially sourced from the WHO estimates of FGM/C prevalence (WHO 2008) and the ABS 2006 *Census of population and housing* (ABS 2006). Relevant data from the subsequent ABS 2011 census was released in November 2012 and has since been incorporated into this report.

A guide to using *A Tradition in Transition: Female genital mutilation/cutting*

In acknowledging that different elements of the report will be more relevant and valuable to different audiences, we have divided the information into three parts. While each part can be viewed independently, they are also part of a larger report that, in its entirety, will provide the reader with a more comprehensive understanding of female genital mutilation/cutting (FGM/C).

The introductory section of this report includes broad demographic data, definitions of the different types of FGM/C, the global and local incidence and an analysis of the potential risk of the practice continuing in Australia.

We acknowledge that the information in this report is a guide. We believe it to be a valuable contribution to the existing body of knowledge that may benefit those seeking to improve their understanding of FGM/C.
This part presents a broad overview of the practice of FGM/C, outlining the cultural and traditional contexts, the effects on the health and wellbeing of women and girls and the impact of migration to Western countries. This information will be of particular relevance to educators, academics, health professionals, policy makers and agency staff who work with communities from practising countries.

This part examines local and international prevention programs, including how these impact on practising communities and ultimately contribute to the abandonment of FGM/C. This information will be of particular relevance to community agencies and all levels of government for the development of prevention programs.

This part presents comprehensive demographic data on communities residing in Australia who have come from countries known to practise FGM/C. The data can be searched by local government area (LGA) or country of birth and can be accessed at <www.fpv.org.au/a-tradition-in-transition>. This information will be of particular relevance to agencies involved in service planning and policy development.
Female genital mutilation/cutting definitions and terminology

Female genital mutilation/cutting (FGM/C), the practice of cutting, sewing and altering the genitals of girls and women, is a significant global human rights issue (UNICEF 2005). The World Health Organization (WHO), the United Nations Children’s Fund (UNICEF) and the United Nations Population Fund (UNFPA) use the term ‘female genital mutilation’ (FGM), which they defined in their Joint Statement 1997 as comprising ‘all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons’ (WHO 2008).

FGM/C is a highly emotional and contested issue. Activists and communities, including some from within practising countries, argue that it causes severe and irreparable harm to girls and women and as such, they use the term ‘mutilation’. Generally, the word ‘mutilation’ does not sit well with women and communities directly affected since, from their perspective, FGM/C is connected to beautification. The terms that tend to be preferred within practising communities are ‘female circumcision’ and ‘female genital cutting’. In recognition of community concerns about the language, the phrase ‘female genital mutilation/cutting’ (FGM/C) is generally used throughout this report.

The term FGM/C encompasses a wide range of procedures, which have been grouped into the following four types by the WHO:

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

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

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

**Type IV**: All other harmful procedures to the female genitalia for non-medical purposes, such as pricking, piercing, incising, scraping and cauterising (WHO 2008).

The global and national incidence

Research indicates that 130-140 million women worldwide have been subjected to one of the first three types of female genital mutilation/cutting (FGM/C), with an estimated 2-3 million girls undergoing the practice each year. This equates to as many as 7,000 girls every day (UNICEF 2007; 2005). Significant measures have been taken over past decades to eradicate FGM/C. Although international and local responses have resulted in some progress, with prevalence rates for younger women having declined in some countries (WHO 2011), the overall prevalence remains high. As such, there is an urgent need to intensify efforts if FGM/C is to be eliminated within one generation.

The global incidence is highly concentrated in 28 countries, 27 in northern Africa as well as Yemen. Countries with the highest incidence include Somalia, Egypt, Guinea, Sierre Leone, Djibouti, Mali, Sudan and Eritrea (WHO 2008), with FGM/C also occurring in other African countries. Table 1 shows the prevalence rates and types of FGM/C in the high prevalence countries.
Introduction

Table 1. Prevalence rates and types of FGM/C in the high prevalence countries

<table>
<thead>
<tr>
<th>Categories</th>
<th>Definition</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Almost universal FGM/C with substantial type III</td>
<td>Over 85% prevalence, with over 30% type III</td>
<td>Sudan (north), Somalia, Eritrea, Djibouti</td>
</tr>
<tr>
<td>2. High prevalence FGM/C types I and II</td>
<td>Over 75% prevalence, predominantly types I and II</td>
<td>Burkina Faso, Egypt, Ethiopia, Gambia, Guinea, Mali, Sierra Leone</td>
</tr>
<tr>
<td>3. Moderate prevalence FGM/C types I and II</td>
<td>Between 25-74% prevalence, predominantly types I and II</td>
<td>Central African Republic, Chad, Côte D’Ivoire, Guinea-Bissau, Kenya, Liberia, Mauritania, Senegal, Togo</td>
</tr>
<tr>
<td>4. Low prevalence FGM/C types I and II</td>
<td>Under 25% prevalence, predominantly types I and II</td>
<td>Benin, Cameroon, Democratic Republic of Congo, Ghana, Niger, Nigeria, Uganda, United Republic of Tanzania</td>
</tr>
</tbody>
</table>

FGM/C is not, however, solely an African problem. Particular ethnic groups practise FGM/C in regions of Middle Eastern countries such as Iran, Iraq, Saudi Arabia, Jordan, Oman and Israel (Occupied Territories of Gaza), in Asian countries such as India, Malaysia and Indonesia and in parts of South America (IOM 2009).

Over the past few decades, through migration and refugee flight, women and girls who have been subjected to FGM/C and many others who are at risk of undergoing the practice have resettled in Western countries including Europe, the US, Canada, New Zealand and Australia.

Figure A shows the total number of Australian residents within each state and territory, based on the Australian Bureau of Statistics (ABS) 2011 census data, who were born in countries where FGM/C has been documented as being practised. Compared with data collated from the ABS 2006 census, the general pattern has remained the same, with New South Wales and Victoria each being the residence for a third of the people born in FGM/C practising countries. There were some minor changes between 2006 and 2011, with the percentage in Western Australia having increased from 4% to 14%, the percentage in Queensland having decreased from 14% to 11% and the number of people from FGM/C practising countries in other territories having increased from 0 to 3 people, which is likely to reflect the refugees living on Christmas Island (ABS 2011; 2006).
Introduction

South Australia: 7,079 (6%)
Victoria: 34,823 (32%)
New South Wales: 36,714 (33%)
Queensland: 11,966 (11%)
Western Australia: 15,496 (14%)
Tasmania: 1,351 (1%)
Northern Territory: 668 (1%)
Australian Capital Territory: 1,848 (2%)

Figure A: Australian residents within each state and territory who were born in countries where FGM/C has been documented and the prevalence estimated. Data source: ABS 2011

Detailed information about each of the significant national groups can be found in part three of this report, accessible via Family Planning Victoria's website at <www.fpv.org.au/a-tradition-in-transition>. This demographic data can be searched by local government area (LGA), or by country of birth. Other information on communities is provided, including religious affiliations and educational qualifications and achievements.
Female genital mutilation/cutting in Australia

There are no estimates of the prevalence of FGM/C in Australia. In considering which populations may be at risk, we have extrapolated data about Australian residents who were born in countries who were born in countries know to practice FGM/C. Countries are grouped into those where FGM/C is documented and the prevalence is estimated and those where FGM/C is documented but prevalence is not estimated.

This section provides commentary on countries where FGM/C has been documented.

Australian residents who were born in countries where FGM/C has been documented and the prevalence estimated

Table 2 shows the numbers of Australian residents by state and territory, who were born in the countries where there are estimates of FGM/C prevalence among girls and women aged between 15 and 49 years. These estimates, as collated by the WHO (2008), are also shown. Figure B shows the locations of these countries.

Part of the data presented in this report has been generated from the ABS 2006 Census of population and housing using ABS CData, which is no longer available. This information can now be accessed using ABS TableBuilder.

The WHO determines the prevalence of FGM/C within nation-state boundaries as opposed to categories such as ancestry, religion or language. In keeping with this, population data has been collected within the ABS ethnicity classification of ‘country of birth of person’. It is important to note that all of the data generated from the ABS 2006 and 2011 census that has been used in this report has been randomly adjusted to avoid the release of confidential information (e.g. where the population from one country in one area is so small, the people may be recognised).

The ABS census data indicates that in 2011, 109,937 people in Australia were born in countries where the prevalence of FGM/C has been estimated, which is 21,095 more than in 2006.

For the purpose of this report, we have supposed that people from countries where FGM/C is practised, ‘FGM/C affected communities’, are those who may choose to have their daughters undergo the practice, either in Australia or by returning to their country of origin.

In determining the state, territory or local government area (LGA) of people born in countries where FGM/C is practised, we chose ‘place of usual residence’ rather than the alternatives of ‘location on census night’ or ‘place of employment’. In keeping with this, population data has been collected within the ABS ethnicity classification of ‘country of birth of person’. It is important to note the implications of this choice. Although
country of birth provides the most useful snapshot of people living in Australia from countries known to practise FGM/C, the figures are not entirely accurate because there is likely to be a considerable number of people whose ancestry is inaccurately recorded. This includes the target group of girls currently aged under 12 years who were born of parents from practising communities outside their original country, possibly in refugee camps, on the way to Australia, or in Australia, since 2006. These girls appear as Australian-born in the 2006 and 2011 census data. This is significant, because they are among the children potentially at greatest risk of FGM/C.

The suspected under-counting of certain national groups is another factor limiting the data. Despite the employment of specially trained, culturally sensitive data collection staff, there is likely to be mistrust of the census process among some communities due to past experiences of oppressive governments. As such, the data indicating country of birth in countries of high FGM/C prevalence is an approximation only.

In addition to the data presented in this section, further statistical information can be found at <www.fpv.org.au/a-tradition-in-transition> and includes:

- The number of Australian residents for each state and territory local government area who were born in countries where FGM/C has been documented and the prevalence estimated (Table 4).

- The number of Australian residents for each state and territory local government area who were born in countries where FGM/C has been documented, but the prevalence is not estimated (Table 5).
The estimated prevalence of FGM/C in Sudan is limited to the northern region, which became a separate country in 2011 but is still represented as one country in these statistics.

<table>
<thead>
<tr>
<th>Country</th>
<th>Estimated prevalence</th>
<th>New South Wales</th>
<th>Victoria</th>
<th>Queensland</th>
<th>South Australia</th>
<th>Western Australia</th>
<th>Tasmania</th>
<th>Australian Capital Territory</th>
<th>Northern Territory</th>
<th>Australian Capital Territory</th>
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<td>16.8</td>
<td>17</td>
<td>26</td>
<td>18</td>
<td>8</td>
<td>6</td>
<td>0</td>
<td>5</td>
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<td>9</td>
<td>0</td>
<td>0</td>
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<td>53</td>
<td>20</td>
<td>46</td>
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<td>13</td>
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<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
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<td>15</td>
<td>16</td>
<td>12</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>49</td>
</tr>
<tr>
<td>Cote d’Ivoire</td>
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<td>104</td>
<td>88</td>
<td>81</td>
<td>83</td>
<td>70</td>
<td>6</td>
<td>3</td>
<td>0</td>
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<tr>
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<td>76</td>
<td>6</td>
<td>3</td>
<td>19</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
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<td>0</td>
<td>0</td>
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<td>0</td>
<td>10</td>
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<td>2767</td>
<td>2849</td>
<td>2065</td>
<td>1166</td>
<td>4400</td>
<td>151</td>
<td>312</td>
<td>131</td>
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<td>505</td>
<td>453</td>
<td>544</td>
<td>496</td>
<td>41</td>
<td>10</td>
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<tr>
<td>Mali</td>
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<td>15</td>
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<td>374</td>
<td>206</td>
<td>420</td>
<td>97</td>
<td>111</td>
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<td>1045</td>
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<tr>
<td>Sudan*</td>
<td>90</td>
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<td>2726</td>
<td>406</td>
<td>364</td>
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<td>Tanzania</td>
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<td>721</td>
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<td>775</td>
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<td>54</td>
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<td>Uganda</td>
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<td>529</td>
<td>90</td>
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<td>2677</td>
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<tr>
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<td>24</td>
<td>97</td>
<td>3</td>
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<tr>
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<td>34823</td>
<td>11966</td>
<td>7079</td>
<td>15488</td>
<td>1351</td>
<td>1848</td>
<td>668</td>
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The estimated prevalence of FGM/C in Sudan is limited to the northern region, which became a separate country in 2011 but is still represented as one country in these statistics.
Figure B: Countries where FGM/C is documented and the prevalence estimated, as described in Table 2
Djibouti

The prevalence of FGM/C in Djibouti is very high. It is estimated that 93.1% of all women have been subjected to FGM/C. Of these women, 67% have type III (MICS 2012; UNICEF 2012; Yoder & Khan 2008) despite laws prohibiting FGM/C in Djibouti. Most of the 135 people in Australia who were born in Djibouti live in Victoria and New South Wales. The high prevalence, of mostly type III, and possible isolation, makes this community one to be focused on when developing and implementing programs.

Eritrea

There are laws against FGM/C in Eritrea but prevalence of FGM/C remains high, 88.7%, despite a decline from 95% in 1995. Younger women between 15 and 19 are less likely to have been circumcised than older women. This suggests the incidence will continue to decline, though change is likely to be slower where Type III is prevalent (UNICEF 2005). Religion and region are not indicators of prevalence, however, they are of FGM/C type. Type III is common among Muslims and regionally along the border with Sudan (US Department of State 2001a).

Eritrean born Australians have endured significant trauma and loss through civil war, drought, displacement, violence and famine (Pittaway et al 2009). Many arrived in the early 1990s with a steady arrival of 100 to 200 people a year since then. Of these arrivals half are women and more than half are under 40 years of age. Over half reside in Victoria with small communities in Western Australia, Queensland and New South Wales.

Eritrean born girls in Australia may be at risk of FGM/C. However, with 20 years of settlement, education and exposure to women’s rights Eritrean Australians may mirror their counterparts in Sweden. Research indicates that the more integrated people are, the less likely they are to uphold the practice of FGM/C. After a decade of African settlement in Sweden, Eritreans have generally abandoned the practice (Johnsdotter et al. 2009).

Ethiopia

Ethiopians first arrived in significant numbers in Australia in the late 1980s, increasing in numbers throughout the 1990s, peaking between 2000 and 2004 and continuing to the present time. Like the Eritreans, Ethiopians have a traumatic history of war, famine and refugee flight. More than half of the 8,452 Ethiopian-born Australians reside in Victoria.

There are laws against FGM/C in Ethiopia and some evidence that rates have reduced from 80% in 2000 to 74% in 2005. In 2005, 62% of women between 15-19 years said they had been cut compared with 81% of women aged between 45 and 49 and significant change of attitude has been reported (UNICEF 2010). There are hopeful signs of abandonment in response to widespread prevention programs.

There are significant differences in practices between ethnic groups and regions. The highest prevalence is in ethnic Somali in the west of the country. More than half of girls subjected to FGM/C are cut before their first birthday, mostly with Type I and II although there are some pockets where Type III is practiced. The length of time since leaving, and ethnic and regional differences within Ethiopia are relevant in estimating the risk of continuance of FGM/C by Ethiopian migrants in Australia.
Guinea

Despite being illegal the prevalence rate for FGM/C in Guinea is very high. The World Health Organization (2008) estimated that 95.6% of girls and women between 15 and 49 report have had some form of FGM/C. Most girls in Guinea experience FGM/C before they reached twelve years of age. The milder forms of FGM/C are gaining ground over the more radical forms (Yoder, Camara & Soumaoro 1999). There is a regional variation in the age at which a young girl undergoes FGM/C (US Department of State 2001b) and the prevalence of the type of FGM varies by socioeconomic group (Van Rossem and Gage 2009). Guinea is one of three African countries where more men than women want the practice to end (UNICEF 2013).

The number of Guinea-born Australian residents is low. Most people born in Guinea arrived in Australia between 2001 and 2010 and reside in Victorian, Queensland and South Australia.

Kenya

Kenya has become the latest country to ban FGM/C with the passing of a law in 2011 making it illegal to practise, procure, or take someone abroad for cutting. Kenya is considered a medium prevalence, 32.3%, country practising mainly Types I and II. There are significant ethnic and regional differences in the risk of FGM/C. Prevalence rates are very high for three tribal groups, the ethnic Somali (97%), Kisii (96%), and the Masai, (93%) Regional variations are significant with the highest prevalence in the North Eastern region (90%) (Yoder and Wang 2013, UNICEF 2010).

The large numbers of Kenya-born people residing in Australia has arrived since 2000. However, the Kenyan birthplace may obscure the number of people, from high prevalence countries including Somalia, Ethiopia and Sudan, who have spent time in Kenya awaiting refugee status and visas to Australia.

Mali

Mali is one of the highest prevalence countries with 91.6% of girls and women between 15 and 49 reporting that they have had some form of FGM/C (WHO 2008). FGM/C is most widespread in the regions of Bamako and Koulikoro, where prevalence rates reach 99%. The practice varies across ethnic lines from 41% among Sonrai women, to 98% among Barbara and Malinke women. Types I, II and III are practised in Mali, generally without anaesthesia, on girls under 10, some as young as 3 months old (UNICEF 2001). There are no laws against the practice in Mali (Equity Now 2008).

Only 50 people born in Mali live in Australia. They reside in Victoria and NSW. With the communities concentrated in two major cities, and with the long settlement of people since the 1960s, the practice may have been abandoned, but this is not known.

Sierrre Leone

FGM/C prevalence rate in Sierre Leone is very high, with estimates of Type III varying between 94% (Dorkenoo et. al 2007) and 60% (Yoder & Khan, 2008). There are no laws in Sierre Leone to stop FGM/C, so new arrivals may be at risk of continuing the practices in Australia. Most of the people residing in Australia from Sierre Leone arrived after 2000 and more than half of these people these live in New South Wales.
The World Health Organization (WHO) recognises that female genital mutilation/cutting (FGM/C) is practised in India, Indonesia, Israel, Iraq, Malaysia and the United Arab Emirates. Although the practice has been documented in various studies, the prevalence rates for these countries cannot be determined and no national estimates have been established (WHO 2008, p. 30).

Due to the lack of confirmation, these figures can be misleading if read without an understanding of the context of each country. For example, the figures indicate almost a doubling of the population born in India at national levels. However, the more detailed country profile in the third part of this report indicates that in India, FGM/C is only practised in a small hillside community. As such, the increase in residents from India does not equate an increase in the number of communities that are likely to practise FGM/C. For analyses of the different types of FGM/C and anecdotal or estimated rates of the practice in the countries listed below, as well as in other countries with unknown or low FGM/C prevalence, refer to part three of this report.

Table 3 shows the numbers of Australian residents by state and territory who were born in countries where FGM/C is documented but the prevalence is not estimated.

In addition to the 109,137 people residing in Australia who were born in countries where FGM/C has been documented and the prevalence estimated (ABS 2011), the Australian Bureau of Statistics (ABS) 2011 census also records 887,487 people residing in Australia who were born in countries where FGM/C has been documented, but the prevalence is unknown.
<table>
<thead>
<tr>
<th>Country</th>
<th>Estimated</th>
<th>New South Wales</th>
<th>Victoria</th>
<th>Queensland</th>
<th>South Australia</th>
<th>Western Australia</th>
<th>Tasmania</th>
<th>Australian Capital Territory</th>
<th>Northern Territory</th>
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<tr>
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<td>111784</td>
<td>60518</td>
<td>37486</td>
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</tr>
<tr>
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<td></td>
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<td><strong>185569</strong></td>
<td><strong>105172</strong></td>
<td><strong>58716</strong></td>
<td><strong>138038</strong></td>
<td><strong>6100</strong></td>
<td><strong>19278</strong></td>
<td><strong>7366</strong></td>
<td><strong>887487</strong></td>
</tr>
</tbody>
</table>

*Table 3: Total population born in countries where FGM/C has been documented, but the prevalence is not estimated.*
Commentary on countries with no estimates of prevalence /

Egypt

There has been steady migration to Australia from Egypt since the 1950s. In addition, to people who were born in Egypt, Egypt has been a transit and destination country for refugees and asylum seekers since the 1980s. The largest refugee groups in Egyptian camps are from Sudan, Somalia, Ethiopia and Eritrea (UNHCR 2013; Forced Migration 2004). Egyptian born residents make up a third of people from FGM/C practising countries living in Australia. The majority reside in New South Wales and Victoria with small communities in Queensland, South Australia and Western Australia.

FGM/C was prohibited in Egypt in 1996, but allowed an exception when FGM/C was required for medical purposes. This exception was removed from the law in 2007 and in 2008 the Egyptian parliament established a law prohibiting FGM/C. However, changing attitudes and behaviour is slow (UNICEF 2010) and most women, 95.8%, in Egypt have been subjected to FGM/C. The most common forms are Types I and II but over 30% of women have undergone Type III.

The lengthy settlement of Egypt-born migrants may mean that the practice has diminished since the risk of FGM/C continuing is highest in the early years of community settlement (Johnsdotter et al. 2009). However, the steady flow of African origin refugees born in Egyptian refugee camps means that these communities should not be overlooked in prevention and response program planning.

India

The practice of FGM/C in India is confined to a small ethnic Muslim community from Bohra in the Gujarat regions in the west. The Bohra are known to commonly practise Type I (DHS 2012). The Australian population of people born in India is large has doubled in five years. It is not possible to identify if any there arrivals are from the Bohra community. However, given the small numbers of people born in India and settling in Australia who identify as Muslim, Indian migrants are not considered a community at risk from FGM/C.

Indonesia

In 2006, Indonesia reversed its position from a ban on FGM/C to legislating for FGM/C to be permitted as long as it is carried out by health carers and following specific guidelines (Orchid 2011). The World Health Organization recognises that FGM/C is practised to some degree in Indonesia but no official prevalence rates have been established. There is evidence that girls undergo, mainly, Type IV by the time they were 12 years old (Budiharsana et al 2003). This practice appears to be confined to Islamic Indonesians and occurs in parts of East, Central and West Java, North Sumatra, Aceh, South Sulawesi and on Madura Island, as well as in many other parts of the archipelago (US Department of State 2001).

The majority of Indonesia-born Australian residents are in the student age group. It is not known if Indonesian-born Australian residents are from the areas in which FGM/C is said to be practised.

Iraq

Iraq is not identified, by the World Health Organization, as a country practising FGM/C. However, there is evidence that Kurdish women and girls in northern Iraq undergo FGM/C, typically Type I or II and that FGM/C is also practised outside the Kurdish Region in localised
areas in Central and South Iraq. The practice is denied by the Iraqi Central Government. In 2011, the Iraqi Kurdish parliament legislated in 2011 against FGM/C (WADI 2012).

Iraq has had increasingly high rates of migration to Australia over the past 15 years with a marked peak between 1995 and 2004. Most have come as refugees under humanitarian visas following invasion/war and oppression of minority groups including Christians and Kurds. It is unclear how many Iraqi-born people in Australia are from Kurdistan.

Israel

There are reports, but no clear evidence, of a limited incidence of FGM/C amongst some Bedouin women and it may be practised by Ethiopian Jews who have settled in Israel (FORWARD 2012). This is not a country of concern despite large numbers of Israel-born people in Australia.

Malaysia

The World Health Organization recognises that FGM/C is practised in Malaysia but no official prevalence rates have been established. Type IV FGM/C is prevalent amongst some Islamic communities in Malaysia but confined to small areas for example, rural women from the Syafiee Muslim sect living in the north (Isa et al. 1999).

Somalia

Somalia has the highest prevalence of FGM/C of any country, with the rate estimated at 97.9%, and more than 80% of women and girls have undergone Type III. The prevalence rate in Somalia means that irrespective of ethnicity, region, education or any other differentiating factors nearly all women are affected. There is no national legislation prohibiting FGM in Somalia. (UNFPA, 2004)

Most Somali-born Australian residents arrived after the late 1980s and migration continues to the present time. Settlement is predominately in Victoria and Western Australia. The key issue in the process of transition from FGM/C is the length of time of residence in Australia, and the degree of integration into Australian society.

Sudan

The FGM/C prevalence rate in northern Sudan, where Type III FGM/C is widely practised, is very high, 90%. The prevalence rate in southern Sudan is negligible. The Sudanese population in Australia is large and has grown quickly. Most live in Victoria, New South Wales, Western Australia, Queensland and South Australia. They are predominately for the south and Christian. Thirteen per cent of Sudanese residing in Australia identify as Islamic and it is likely that they are from the north and FGM/C, with a high incidence of Type III, would be part of their tradition. Sudanese in Australia are a young community and most arrived within the last 13 years. Some, will not show in the figures for Sudan because they were born elsewhere, will be at risk. (Landinfo 2008).

UAE

The United Arab Emirates is listed in some publications as practising FGM/C, Type I but no national reports or documented evidence was found regarding the practice in these countries (World Health Organization 1998).
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A Tradition in Transition: Female genital mutilation/cutting
Literature Review
Introduction

The World Health Organization (WHO) has estimated that female genital mutilation/cutting (FGM/C) occurs in 28 countries, 27 in northern Africa as well as Yemen. Countries with the highest prevalence rates of FGM/C (over 80% of women aged between 15 and 49 years) include Somalia, Egypt, Guinea, Sierra Leone, Djibouti, Mali, Sudan and Eritrea (WHO 2008).

In a third group, prevalence rates are between 1% and 24%. These are countries where only some ethnic groups practise FGM/C, including Nigeria, Tanzania, Ghana and Yemen (UNICEF 2005, p. 5). Nigeria, for example, has a national prevalence rate of 16%, but in the southern regions, it is almost 60% (UNICEF 2005, p. 3).

Ethnic and regional variations are of critical importance in countries where FGM/C is known to be present to some degree, but where there has been no systematic estimation of prevalence rates. There are significantly high numbers of people residing in Victoria and other Australian states and territories who come from some of these countries, including India, Iraq and Indonesia. In Iraq, for example, although there is no national prevalence estimate, FGM/C is known to occur within northern Iraqi Kurdistan. It is estimated that overall, 65% of Kurdish women in Iraq are affected, with regional variations occurring (WADI & PANA 2012). It is thought that FGM/C also occurs in Kurdish communities across the borders in neighbouring countries such as Iran and Saudi Arabia. In India, while FGM/C is not thought to be widespread overall, it is known to occur among the Bohra people in the western regions (Orchid Project 2011). In Indonesia, type IV, the least severe form of FGM/C, is practised widely among Muslim communities (Newland 2006).
The forms or types of female genital mutilation/cutting (FGM/C), with their associated severity and harm, are obscured in the prevalence rates of countries and are therefore often overlooked. The distinctions, however, are important because of the different physical and psychological consequences associated with each type. Classifying FGM/C is complex on a number of levels and in practice, the distinctions are not as clear as the definitions imply. There may be significant variation in the nature and extent of cutting due to particular local traditions, poor physical conditions such as lighting, or because, without anaesthetic, girls often struggle to resist. Further, in self-reporting, girls and women may not always be certain about which procedure was performed on them (Berg, Denison & Fretheim 2010; UNICEF 2005). Difficulties of classification aside, types I, II and III all involve serious abuse of human rights, are traumatic at the time and cause irreparable and enduring harm and damage.

**Type I**, clitoridectomy, is the partial or total removal of the clitoris and/ or the prepuce. This form is widespread in many practising African countries (including Egypt), with the practice also occurring among the Bohra in India and in Middle Eastern countries. In 2007, modifications made to the definition acknowledge that for almost all forms of FGM/C that remove tissue from the clitoris, all or part of the clitoral glans are cut, not just the prepuce (WHO 2008).

**Type II**, excision, encompasses a range of practices including the removal of the labia minora only, the partial or total removal of the clitoris and labia minora and the partial or total removal of the clitoris, labia minora and labia majora. As with type I, type II is found across many northern African countries including Egypt, Ethiopia, Sierra Leone, Gambia and Guinea, as well as in Middle Eastern countries such as Iraq and in India.

**Type III**, infibulation, is the narrowing of the vaginal orifice with the creation of a covering seal by cutting and appositioning the labia minora and/ or the labia majora, with or without excision of the clitoris. It is known in some countries such as Sudan and Somalia as pharaonic cutting and is the most serious and harmful type. In Africa, this constitutes 15% of FGM/C overall (Caldwell, Orubuloye & Caldwell 2000; Toubia 1995), affecting large proportions of women in the northern African
countries of Somalia, Sudan, Eritrea and Djibouti (UNICEF 2005). This form of FGM/C also occurs in other countries including Ethiopia and Mali and in small but significant pockets elsewhere. Many of these are countries from which Australia draws significant numbers of people as refugees and migrants.

**Type IV** is a category of FGM/C that subsumes all other harmful, or potentially harmful, procedures to the genitalia of girls and women for non-medical purposes, such as pricking, piercing, incising, scraping and cauterising (WHO 2008). Type IV is generally less well-known and studied than types I, II and III and there are ongoing debates about whether these practices constitute FGM/C, are actually harmful or constitute an abuse of human rights. Various forms of type IV are widespread in African countries (including where the estimated prevalence is not high) and are known to occur in Middle Eastern countries, as well as in Indonesia, Malaysia, Thailand and South America.

In some contexts, procedures categorised as type IV are practised as traditional forms of FGM/C (Budiharsana et al. 2003) and in other contexts occur as a replacement for more serious forms (Yoder & Mahy 2001). In southern and central African countries, stretching or elongation of the clitoris using herbs and oils to enhance sexual pleasure for both men and women has been documented. These practices may be conducted in hygienic or very unhygienic circumstances (UNFPA 2008).

In contrast to types I, II and III, it is not always clear which harmful genital practices should be defined as type IV. In some contexts such as in Malaysia and West Java, Indonesia, the practice of FGM/C is seen to inflict minimal or no harm on girls and women (Merli 2010; Newland 2006). It is conducted as a ritual blessing that involves ‘the removal of a piece of flesh the size of a grain of rice’ and is said to tie the souls of mother, child and community together (Newland 2006, p. 396). The World Health Organization (WHO) states that it is important to maintain the broad definition of type IV as it stands, despite its lack of clarity, ‘in order to avoid loopholes that might allow the practice to continue’ (WHO 2008). The guiding principle underpinning this is one of human rights, the rights of girls and women and the creation of an environment that facilitates and encourages eradication, especially of types I, II and III.

The age at which girls undergo FGM/C is another obscured aspect that is relevant to understanding what perpetuates the practice and may lead to appropriate prevention strategies. FGM/C can take place at any time from the first week of life. It is most commonly undertaken between the ages of 4 and 8 years, sometimes during pre-puberty and rarely later than 16 years. The age is usually related to the particular cultural and social meanings that the practice has for a particular community. Recent evidence suggests that the age of girls undergoing FGM/C is becoming lower in African countries (WHO 2011), while indications in Western countries are that the practice is being postponed to an older age, a change that may relate to avoiding surveillance (Poldermans 2006).

The underpinning cultural meanings, beliefs, social norms and associated rituals and celebrations are particular to, and vary between, ethnic groups and regions. At the heart of the meanings are questions of gender and sexuality in relation to honour or being a ‘good’ woman. These meanings are deeply and powerfully ingrained in identity and social life. Understanding the particular circumstances of a given situation provides an insight into not only how the practice is perpetuated, but also how a community can change.

**Health consequences of female genital mutilation/cutting**

Female genital mutilation/cutting (FGM/C) offers no health benefits to girls and women and can harm them irreparably in many ways (Banks 2006; Berg, Denison & Fretheim 2010; WHO 2011). The damage to and removal of healthy and normal female genital tissue interferes with the natural functions of girls’ and women’s bodies. Further, it is often carried out in unhygienic conditions without anaesthesia. Immediate complications can include severe pain, shock,
Language and discourse

The language used to discuss practices of cutting, stitching and altering women’s genitalia has been the subject of highly emotional debate over the past four decades. ‘Female circumcision’ was the term commonly used into the 1970s when the current wave of global opposition was instigated through a series of conferences honouring the United Nations (UN) Decade for Women, 1975-1985. The term ‘female genital mutilation’ (FGM) was adopted to reflect the severity and seriousness of the practices, as a means of ‘condemnatory advocacy’ (Shell-Duncan 2008, p. 20) and to break any parallel that could be drawn with male circumcision.

It fitted with the human rights framework, highlighting the violation and abuse of human (women’s) rights. ‘Female genital mutilation’ remains the language currently used by the UN in its relevant conventions and documents and is the language adopted in the legislation and policies of many countries, including Australia.

While acknowledging its power and usefulness, problematic aspects of this discourse have become evident since the debates and campaigns of the 1980s and 1990s. As previously indicated, the diversity of the practices is obscured under the one
term, ranging from extreme infibulation, through excision and clitoridectomy, to less invasive practices such as pricking and piercing. In light of this diversity, many people, especially from within countries where female genital mutilation/cutting (FGM/C) is practised, see the term ‘mutilation’ as misleading, exaggerated and racist (Khaja et al. 2009), especially when referring to the lesser forms, or offensive, alienating, disempowering, disparaging and stigmatising, especially among affected women (Swensen 1995). The term ‘mutilation’ can be a serious barrier to dialogue and activist work with affected communities. It can be deeply resented as a mechanism for the hegemony of the West, reinforcing lingering imperialism in a post-colonial world. It clearly distances the ‘they’ who conduct such practices from the ‘we’ who do not, highlighting the inferior and superior positions presumed by the West (Diop & Askew 2009).

When we first met with a group of African workers employed to raise awareness and educate communities about the harms and illegality of FGM/C in Victoria, Australia, we introduced ourselves as researchers about female genital mutilation. The women became silent, then someone spoke up:

‘If you are going to research our practices, we do not want you to call us mutilated. We see ourselves as having beautified ourselves according to our traditional practices and that there was no choice. We would have felt unclean and would not have been accepted in our communities if we had not been circumcised. Do not judge us about what was done to us or make us sad or guilty about what we did to our daughters. Now we are here, we realise there is a choice and we want to stop the practice of female circumcision without your judgement’ (FARREP meeting 2010).

The language of ‘female circumcision’ is often used in practising communities, possibly because it is a literal translation from their own languages. There is a strong sense, however, among people concerned with seeing an end to FGM/C (whether from within practising communities or the international community) that, while still commonly used, it is dangerously misleading language because it implies a parallel with male circumcision. FGM/C is not analogous to male circumcision.

‘Harmful traditional practices’ (HTPs) is another term used in reference to FGM/C. These often interconnected practices are seen to have some cultural legitimacy, but can be harmful to women and girls. In addition to FGM/C, these include forced marriage, early pregnancy, poor birthing practices, large families and some dangerous rituals and practices associated with FGM/C.

The alternative language of ‘female genital cutting’ is now widely used, especially when working with members of practising communities. It is seen as being factual and not carrying the loaded meanings and associations of ‘mutilation’, or the embedded power relations. The discourse and language of FGM, FGM/C, female genital mutilation/cutting (FGM/C) and female circumcision all have their own particular political and personal meanings. All have a place and purpose in a global campaign that needs to be multifaceted and multileveled, involving legislation, policy, advocacy and sensitive grass-roots community development work within practising communities. Discussion of FGM/C needs to be responsive to the horror and violence of the practices, strategic in advocacy and at the same time sensitive in engaging affected communities and people in a supportive and respectful manner.
underpin what is considered proper sexual behaviour of women, including ‘premarital virginity and marital fidelity’ (WHO 2012). FGM/C is associated with cultural ideals of femininity, chastity and modesty and is thought to reduce a woman’s libido. Girls are made ‘clean’ and ‘beautiful’. The particular and specific meanings, beliefs, myths and their associated practices vary between regions, localities and tribes. For example, a tribal belief in a region in Ghana is that the clitoris is a harmful organ that interferes with fertility and causes damage if a baby comes into contact with it at birth (US Department of State 2001). In Uganda, FGM/C was understood as a rite of passage into adulthood that was carried out when girls were of pre-pubescent age (Fulgieri 2010).

These cultural meanings are so deeply entrenched in practising communities that FGM/C is considered a normal and necessary aspect of raising a girl properly in preparation for adulthood and marriage (UNICEF 2005; Natoli, Renzaho & Rinaudo 2008). The social pressures to conform are very real. Failure to have one’s daughter circumcised will likely mean that the girl will be stigmatised, excluded and unmarriageable and she and her family may be shamed, ostracised, discriminated against and subjected to violence. It is difficult for one individual or family to challenge these pressures. In the eyes of families and communities, FGM/C is not motivated by malice or violence as outsiders may see, but by the family’s consideration of the best interests of the child (UNICEF 2010).

The underpinning cultural beliefs are understood in the global activist community as ‘a manifestation of deep-rooted gender inequality that assigns [women] an inferior position in society and have profound physical and social consequences’ (UNICEF 2005, p. 1). These beliefs are highly controlling of women and are responsible for terrible violence and suffering. Further, Caldwell, Orubuloye and Caldwell (2000) note that FGM/C practices have not been found in matrilineal societies.

While the cultural bases of FGM/C are deeply entrenched and strong, cultures are dynamic, complex and continually evolving over time and at any one time, people draw on more than one set of cultural meanings. Further, cultural group boundaries are blurred and changing and cultural groups are not internally homogenous. Significant differences occur according to other interacting social and personal factors including class, urban or rural location, education and family and political histories.

The enduring nature of FGM/C, despite efforts towards eradication over decades, is testament to how embedded these cultural meanings are. This has profound implications for programs aimed at eradication, including that respect be given to peoples’ motivation in the best interests of their children, that the focus of change be towards a community rather than individual families, that cultural change comes from within the communities or cultural groups concerned and that detailed and particular cultural knowledge is acquired in order to identify pathways to change. The United Nations Children’s Fund (UNICEF) Innocenti Research Centre reminds us that ‘the social dynamics that perpetuate FGM/C [female genital mutilation/cutting] can also help drive its abandonment’ (UNICEF 2010, p. 6).

**Female genital mutilation/cutting and religion**

When people from practising communities are asked about their motivation for perpetuating female genital mutilation/cutting (FGM/C), the most frequent answer given involves religion (Berg, Denison & Fretheim 2010). More widely, it is often assumed that the practice is linked to religion and debates surrounding this assumption are highly emotive. However, FGM/C is not formally sanctioned by any religion. In fact, theologians in Islam, Christianity and Judaism hold that FGM/C is not advocated in or consistent with their scriptures (i.e. the Q’uran, Bible or Torah). FGM/C is known to have ancient origins predating both Islam and Christianity and to
have been practised at the dawn of Egyptian civilisation or earlier, most likely evolving in sub-Saharan Africa (Caldwell, Orubuloye & Caldwell 2000, p. 236)

FGM/C transcends religious boundaries. Caldwell, Orubuloye and Caldwell (2000, p. 235) report that in Africa, just under 60% of women affected are Islamic and just under 40% identify as Christian, with FGM/C also found to occur in some small Jewish communities and among people practising traditional African beliefs. The most severe form of FGM/C, infibulation (type III), is practised predominantly in Islamic countries in Africa including North Sudan, Somalia, Djibouti and pockets in Eritrea, Egypt and Mali (Caldwell, Orubuloye & Caldwell 2000, p. 236). Possibly because of this, FGM/C has come to be associated with Islamic culture. While Islamic authorities assert that it is not a requirement of the faith or the Q’uran (Bedar & El Matrah 2005), FGM/C is frequently supported and required by imams and other religious leaders at the local or community level.

Apart from type IV being associated with Islam in some Asian countries, FGM/C is not generally practised in non-African Islamic countries including Bangladesh, Pakistan, Afghanistan and Iraq, Iran, and other Middle Eastern countries, and this reality further loosens the connection between FGM/C and Islam.

The United Nations Children’s Fund Innocenti Research Centre (UNICEF 2010) argues that it is because culture, tradition and religion are so interconnected that it has been incorrectly interpreted that FGM/C has a religious basis. In much of Africa, ‘life was an expression of religion and religion hallowed life’ (Caldwell, Orubuloye & Caldwell 2000, p. 245).

The message that FGM/C is not supported by any religion or religious scripture is of critical importance to prevention strategies.

The effects of female genital mutilation/cutting on health

The health consequences of female genital mutilation/cutting (FGM/C) have been referred to earlier in this report. In the African context, ‘conceptualising Harmful Traditional Practices as a public health problem and focusing on the associated risks has influenced many responses, including awareness-raising and legislation’ (Natoli, Renzaho & Rinaudo 2008, p. 111). The Ottawa Charter for Health Promotion (WHO 1986) has been significant for health promotion around the world. It offers a clear statement of action for health promotion based on a social model of health, which views health and wellbeing as interconnected with social and environmental factors.

In Africa, raising awareness of the harmful effects of FGM/C improved the conditions under which it was conducted, resulting in better hygiene and a lower risk of harm to girls and women, but did not stop the practice (Natoli, Renzaho & Rinaudo 2008; UNICEF 2005).

Contemporary health responses to FGM/C include preventative health promotion education and medical and health care for girls and women affected by FGM/C. Health promotion aims at influencing the determinants of health at all levels, namely the individual, group, family, community and policy level (Victoria DHS 2008). Family Planning Victoria (Jordan & Neophytou 2012) and the British Foreign and Commonwealth Office (GBFCO 2011) have developed practice guidelines for professionals who work with women and girls affected by FGM/C.

In the Australian study by Murray and colleagues (2010), African women who had given birth in Brisbane expressed feeling lonely and ‘different’ after disrespectful encounters with medical staff. Health professionals had asked them inappropriate questions, often without an interpreter. No-one had explained the Australian health care system to them and they were disappointed about the lack of continuity of care. Many
women still suffering from their refugee experiences found it frustrating dealing with health service providers with limited cultural competence.

Health professionals are constantly confronted by the complex medical, moral or ethical, cultural and legal complexities associated with FGM/C. They can readily find themselves in a difficult position where the law prohibits them from fulfilling the (culturally based) wishes of their patients (FGM day 2011). Dilemmas include:

› caring for infibulated women requiring de-infibulation for sexual intercourse or childbirth
› responding to requests of women for re-infibulation after childbirth
› responding to requests for the medical circumcision of girls
› monitoring and screening for FGM/C by enquiring about genital surgery (FGM day 2011).

Allotey, Manderson and Grover (2001) argue that discrimination and ignorance about FGM/C within health services result in women’s reluctance to present for antenatal and gynaecological care or treatment for urinary and reproductive tract infections. There is a challenge for health and other professionals to ensure that infibulated women and women with other types of FGM/C receive the medical care they need, and that this care is delivered in culturally competent and sensitive ways that respond to

Feminist debates about female genital mutilation/cutting

The practice of female genital mutilation/cutting (FGM/C) violates human, women’s and children’s rights. There are no evidence based health benefits and types I, II and III can cause irreparable physical harm to affected girls and women, at the time of occurrence, throughout their lives, and potentially for their babies at the time of birth. Feminists see FGM/C as a means to exercise social control over women in patriarchal and patrilineal societies, where the status and identity of women are heavily circumscribed, largely through marriage (UNICEF 2005; Patrick & Markiewicz 2000). The Royal Australian College of Obstetricians and Gynaecologists described FGM/C as ‘an expression of a misogynist culture that curtails female pleasure and freedom and expects women to be docile and compliant’ (RACOG 1997, p. 16). Hosken, who coined the phrase ‘female genital mutilation’ (FGM), described it as a ‘training ground for male violence … used to assert absolute male domination over women’ (Hosken 1982, p. 4).

Even if not intended as a violent act, FGM/C violates women’s rights. It is a manifestation of deeply rooted gender inequalities and is discriminatory in nature. From its early use for ‘curing women who suffer from … melancholia, nymphomania, hysteria, insanity … epilepsy … kleptomania … and truancy’ (Lightfoot-Klein 1989), FGM/C has been used to oppress women and curb female sexuality.

A feminist stance that depicts FGM/C as purely oppressive to women, however, can be hostile to the core values of those who practise it (Mangan 2007). Political and media attention surrounding FGM/C can humiliate affected women, making them feel like social outcasts. Feminist advocacy did, however, convince the World Health Organization (WHO) and other international agencies to lobby against FGM/C at an international level. A current role for feminists in efforts towards the abandonment of FGM/C is to ensure women from FGM/C backgrounds have a voice in policy and program decision-making (Khaja et al. 2009; Broussard 2008). Women of African backgrounds are often depicted as being unqualified to comment about their traditional practices because they are assumed to be too immersed in, and not aware enough of, their subjugation to male violence to take the lead in advocacy against FGM/C (Johnsdotter & Essen 2010). Many African-born migrant women, however,
have been active in their countries of origin in attempts to eradicate the practice, but are not given credit for their activism in their new country (Khaja et al. 2009).

Feminists challenge inconsistencies in legal responses to the rights of women, contrasting FGM/C and elective female genital surgery. Dustin (2010) and Shell-Duncan (2008) claim laws in Western countries are racist in that they, on one hand, prohibit adult women from being re-infibulated as part of their ‘custom or ritual’ but on the other hand, allow genital surgery for reasons of health and ‘beautification’ (Dustin 2010, p. 14). Elective cosmetic procedures including removal of the clitoral hood, reduction of the inner labia, or vaginal tightening are not subject to legal scrutiny. They are available to women who can afford the ‘designer vagina’ (Dustin 2010, p. 17) and are increasingly popular in Western consumer-driven societies.

Johnsdotter and Essen (2010) ascribe the rise of genital aesthetics to the influence of mainstream pornography, where there is a trend for women to have shaved genital areas (a Brazilian wax) and trimmed inner labia so that nothing protrudes (Johnsdotter & Essen 2010). The WHO (2008) acknowledges that some practices that are legally acceptable for adult women in Western countries fall under the definition of FGM/C.

In Victoria, female genital surgery can be performed only by medical practitioners when it is deemed necessary for health reasons, for medical purposes connected with labour or childbirth, or for sexual reassignment (Sullivan 2007). Some forms of female genital surgery qualify for Medicare rebate and are advertised via websites. As recently as 2010, debates about the medical profession’s participation in re-infibulation have occurred in the US, New Zealand and Australia (Mathews 2011).

Feminist advocates have a role to keep the issue of women’s rights at the forefront of debates about FGM/C. The practice contravenes women’s rights, though addressing their rights is complex. It requires sensitive and respectful engagement with affected women, whether they are mothers contemplating having their daughters undergo FGM/C, wives needing de-infibulation in order to have intercourse or give birth to a child, or grandmothers whose status depends on their role as traditional cutter. Further, girls need the protection of feminist and child rights advocates to prevent FGM/C from happening to them. This should be done in collaboration with women from affected communities who are anti-FGM/C activists.

Stopping FGM/C also needs the participation of men in changing the patriarchal constructions and promotion of these practices (Broussard 2008).

### Child rights

Children from practising countries are in a different position from that of women in that they may not yet have been subjected to female genital mutilation/cutting (FGM/C). Regardless of the intent of a parent who participates in the FGM/C of their daughter, a child clearly cannot give informed consent and is powerless to stop it from happening. As the immediate and long-term consequences of FGM/C for girls are severe, prevention and care of children who may be or have been affected are urgent requirements. It is difficult, however, to detect FGM/C among young girls because of its secrecy. In addition, there is minimal public awareness and scrutiny, and records identifying the physical, psychological and developmental impacts are scant (Patrick & Markiewicz 2000).

Patrick and Markiewicz (2000) outline the challenges for child protection and welfare responses to FGM/C in Australia. As FGM/C is performed without intending to harm the child, it falls into the category of parenting practices that are deemed abusive following migration to a different cultural context (Khaja et al. 2009).
Four principles apply to protecting migrant children from FGM/C practising countries. The first principle is to acknowledge the multiple constructions surrounding the practice; second, to provide information regarding prevailing parenting standards and expectations and to raise awareness of the negative legal, psychological and social consequences of FGM/C for children; and third, to work with migrant and refugee communities around their parenting challenges while responding to their settlement needs. The fourth principle is that practitioners become culturally sensitive and competent in their work with families from diverse backgrounds (Patrick & Markiewicz 2000).

Patrick and Markiewicz (2000) advocate humanist, systemic, strength based approaches to cross-cultural training for welfare professionals. These approaches aim to engage and establish credibility and trust with families through common human responses, reinforce the family’s strengths, and ensure preparedness and openness to families’ embarrassment, denial, defensiveness and anger. Training should include the cultural traditions of FGM/C to ensure welfare professionals know the signs to look for that could indicate risk. In addition, well informed, culturally sensitive approaches are of greater importance than sharing the same ethnicity as the client (Patrick & Markiewicz 2000).

Human rights and the law

Female genital mutilation/cutting (FGM/C) is a practice that violates human rights - ‘the right to life, the right to health, the right to physical integrity - including freedom from violence, the right not to be subjected to torture or ill treatment, the right to non-discrimination, and … children’s rights’ (Poldermans 2006, p. 81).


Various UN instruments provide universal statements that deem FGM/C a serious transgression and urge states to stop it:

- The Universal Declaration of Human Rights recognises that women and girls are entitled to sexual and corporal integrity. FGM/C constitutes a violation of their right to control their bodies and deprives them of their sexuality, health and bodily integrity.
- The Convention on the Rights of the Child guarantees the right of children to enjoy their culture (in minority situations) and requires the abolition of traditional practices prejudicial to their health.
- The Declaration on Violence Against Women specifically defines FGM/C and other harmful traditional practices (HTPs) as gender-based violence.
- The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) identifies examples of violence and discrimination based on inferiority.
- The Convention Relating to the Status of Refugees and the Protocol Relating to the Status of Refugees provide for protection owing to a ‘well-founded fear’ of persecution (Swensen 1995).
- The Maputo Protocol requires African states to ‘commit themselves to modify the social and cultural patterns of conduct of women and men … with the view to achieving the elimination of harmful cultural and traditional practices and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes’ (Maputo Protocol 2003).
These charters have become important platforms for pressuring states to take action against human rights violations, either through criminal legislation or other preventative measures. However, human rights are effective only if they are enacted in the lives of the people concerned (Ife 2001; Ierodiaconou 1996). On its own, human rights education is considered ineffective. This is illustrated in a World Vision project conducted in Africa in 2006 that addressed FGM/C as a violation of human rights. Seventy-five per cent of those interviewed subsequently stated that they were aware that FGM/C was a violation of human rights, yet less than half of them thought that FGM/C should be abandoned. Findings suggest that addressing FGM/C as both a public health issue and a violation of human rights still fails to recognise the strength of the underlying social, cultural and religious beliefs that have sustained the practice for generations. Promoting awareness of international human rights standards is of limited effect unless communities themselves determine that those standards are consistent with their own cultural and religious norms (Barber 2009).

Laws cannot stop FGM/C practices unless they are implemented, enforced and prosecuted, though laws are difficult to enforce (Dustin 2010; UNICEF 2010). When enforced, there is some evidence that court intervention deters the practice of FGM/C (in France and Sweden) (Guiné & Fuentes 2007; Johnsdotter 2009), but criminal proceedings and the threat of imprisonment of parents can have negative consequences for the children, families and communities concerned. Surveillance and monitoring is fraught with cultural and ethical complexities. Every girl returning to a ‘home country’ where FGM/C is practised would have to be subjected to genital examination by a health professional prior to leaving and on return (Ierodiaconou 1996). The child protection system in France actively monitors the first six years of all girls’ lives through systematic examinations of their genitalia, with an obligation to report suspicious findings to police (Poldermans 2006). To circumvent these coercive practices, some parents delay FGM/C until their daughter is past the age of physical examination at school, taking her overseas to be cut or finding other secretive ways to avoid detection. The Dutch rejected the practice of maternal and child health nurses mandatorily examining the genitalia of each girl, which means many cases go unreported (Poldermans 2006).

A second negative consequence of criminalising FGM/C is that genital examinations to monitor the practice can be considered discriminatory, racist and invasive in their targeting of certain minority groups (Ierodiaconou 1996). Further, legal prosecution can stigmatise and marginalise women and girls from the communities concerned.

A third negative consequence is that criminalisation can be a barrier to affected women and girls seeking medical care (Mangan 2007; Swensen 1995). Women from affected communities have expressed reluctance in taking daughters who have undergone FGM/C to doctors for unrelated illnesses because of the risk of being reported to police or child welfare authorities and of losing their daughters to welfare authorities (Ierodiaconou 1996).

Fourthly, affected communities have expressed concerns that the criminalisation of FGM/C can divide families, penalise women who are themselves victims of FGM/C and lead daughters to view their mothers and grandmothers as criminals (Ierodiaconou 1996). Legislation involves the imperative of signalling and reporting instances and potential risk of FGM/C at an early stage. Studies of African countries show that the expected loss of social rewards and family honour for no longer complying with a social norm can be a more persuasive motivator than legal sanctions (UNICEF 2010).

Despite the operational challenges of implementing legislation prohibiting FGM/C, migrants in Canada and Sweden have expressed an appreciation of the existence of laws and in fact encourage a stronger response (Johnsdotter et al. 2009; Daniel et al. 2009; Ahlberg et al. 2004). One (African
migrant) woman in Sweden said:

‘Many girls must have suffered before the law came. It should have come a little earlier and have been more severe’


A midwife who worked with women of African backgrounds in Sweden said:

‘… the existence of the law gives them security here in Sweden – their daughters have an opportunity to escape the tradition of FGM [female genital mutilation] … The law protects these girls. If they stay in Sweden, they will never be mutilated’


The above considerations indicate that criminal laws prohibiting FGM/C are an important backdrop to other prevention strategies, with prosecution a last resort. Prevention and the health and physical integrity of the girl should be the priority rather than punishment (CRR 2009 Guiné & Fuentes 2007; Poldermans 2006). Criminal law and actual court cases showing the effects of the law are well-used as a warning and deterrent to parents, traditional practitioners and the communities concerned (Poldermans 2006). The New York Center for Reproductive Rights (CRR) recommends that under no circumstances should governments criminalise the practice of FGM/C in the absence of a broader government strategy to change individual behaviour and social norms (CRR 2009).

Impact of migration to Western countries: A tradition in transition

Migration to Western countries from countries known to practise female genital mutilation/cutting (FGM/C), particularly over the past four decades, has meant that the practice is a concern in new places of settlement, including Australia. The United Nations Children’s Fund Innocenti Research Centre (UNICEF 2005) observes that the persistence of FGM/C in these contexts is evidence of how strong the social convention is within practising communities.

It is hard to know the exact nature and extent of this problem in Western countries. For a range of reasons, including its private nature, cultural taboos and its illegality, the practice is hidden. It is not easily verifiable or well-documented and limited qualitative and quantitative data exists (Berg, Denison & Fretheim 2010; Daniel et al. 2009; UNICEF 2005; Johnsdotter et al. 2009; Norman et al. 2009). The ‘limited data available suggest that FGM/C [female genital mutilation/cutting] is occasionally practised by immigrant communities in a number of Western countries’ (Berg, Denison & Fretheim 2010, p. 3).

Estimates of girls and women likely to have been affected by FGM/C and of girls and young women possibly at risk of being subjected to the practice have been established in some countries (including the UK, Sweden, Norway, Switzerland and the Netherlands) using data on prevalence in countries of origin and the numbers of people settled (Dorkenoo, Morison & Macfarlane 2007; Johnsdotter et al. 2009). This report provides extrapolations of such data for Victoria, Australia. However, some
researchers claim that while useful, figures derived from these processes do not take into account the changing attitudes and practices that occur with migration and resettlement in Western contexts and therefore tend to be exaggerated and alarmist (Johnsdotter et al. 2009). Further, as discussed earlier in this report, the disaggregations are limited in their usefulness because significant indicating factors are obscured in the data. Moeed and Grover’s 2012 survey of obstetricians and gynaecologists in Australia and New Zealand found no conclusive evidence of FGM/C being performed by medical practitioners, but anecdotal evidence suggests that people other than registered health practitioners are performing FGM/C either in the country that they migrated to or on return to their country of origin.

Understanding the impact that migration to and settlement in Western countries has on the continuance of FGM/C is critical to interpreting the data available for evaluating risk; planning policy; and designing, implementing and evaluating program responses. This section addresses this theme by drawing on research from various Western countries including Sweden, Norway, the UK and Canada. The overall conclusion is that cultural change is taking place such that in the long run, FGM/C is unlikely to persist and that in Western countries, it is a ‘tradition in transition’ (Berg, Denison & Fretheim 2010, p. 41). Migration to and settlement in Western countries presents a unique opportunity for people to reflect on, question and challenge their deep-seated cultural values, beliefs and practices in light of a different context. Further, laws and discourse opposing FGM/C and legal environments prohibiting the practice in the new country allow migrants to examine their personal experiences (Berg, Denison & Fretheim 2010; UNICEF 2005; Johnsdotter et al. 2009). In the Netherlands, a Somali woman explained:

‘Due to our migration and the passing of time, we have come to think differently, and we now see the harm caused by our tradition. However our parents could not have acted otherwise and it is out of the question to suggest any kind of abuse. They wanted the best for us, their children … We are now able to express the sadness and pain in our history and that the genital mutilation of girls is no longer appropriate in this day and age. We want to give our daughters a happy future, a future in which they can fully develop emotionally, and a future in which they can be allowed to play and feel protected’ (UNICEF 2005, p. 27).

The transition to abandoning FGM/C reflected in these words is a complex, and in some respects, contradictory process (Norman et al. 2009). Significant research from Western countries exploring this complexity is outlined below.
Sweden experienced significant migration from Ethiopia, Eritrea and Sudan from the 1970s onwards and from Somalia from the 1990s. By 2007, there were about 39,600 residents born in Ethiopia, Eritrea and Somalia living in Sweden (Johnsdotter 2009). Sweden has been wrestling with the issue of female genital mutilation/cutting (FGM/C) for decades and in 1982, it was the first Western country to legislate against the practice. Johnsdotter and colleagues have undertaken considerable research into the attitudes and experiences of migrant and refugee communities from countries with a high prevalence of FGM/C, including a high incidence of infibulation (type III). These researchers consider that now, the occurrence of FGM/C in Sweden is ‘probably low or nonexistent’ (Johnsdotter et al. 2009, p. 117). As contributing evidence, they contend that the law is well-implemented through an effective alert system involving police and social and health authorities who tend to over-report rather than under-report. Despite this, only two cases have ever been prosecuted (in 2006), both of which ended in custodial sentences. On analysis, these cases were seen to involve complex circumstances of family violence and custody disputes such that they were considered atypical of the communities concerned (Johnsdotter 2009).

Johnsdotter and colleagues (2009) described the major themes about FGM/C that emerged from their research interviews in Sweden with migrants and refugees from Eritrea and Ethiopia as ‘change’ and ‘absence of meaning’ (Johnsdotter et al. 2009, p. 121). The following quotations exemplify the theme of change:

‘Of course my view on circumcision has changed … Since I came here … I have seen many debates or social documentaries about different countries … I’ve improved my knowledge … So, of course it’s changed since I came here’

The new context brought opportunities to hear different discourse and perceptions on FGM/C and to hear about health risks and human rights perspectives.

‘I only heard about that after I moved to Sweden’

‘When I moved to Sweden I learned that you shouldn’t do this. You learn those things in Sweden, but not at home’

Other respondents indicated that changing attitudes had sometimes begun before people left their home countries where, in
both Ethiopia and Eritrea, there is a history of debate, campaigns, community programs and now legislation against FGM/C (Johnsdotter et al. 2009).

In reference to the second theme of ‘absence of meaning’ (Johnsdotter et al. 2009, p. 121), the researchers found few references at all in their research conversations to any aspects of FGM/C that could now be perceived as being positive. The absence of meaning about FGM/C, they wrote, ‘permeates the entire interview material’ (Johnsdotter et al. 2009, p. 123).

‘If it’s unimportant, then why do it? Neither for health reasons nor …’


All participants in the study were asked whether they knew of anyone (without naming names) who had FGM/C performed on their daughter after moving to Sweden. There were only a couple of instances shared, with the majority saying with certainty that FGM/C does not occur within their group. Some indicated a little uncertainty about whether this was true among Muslims, though the Muslim women involved in the study refuted this categorically (more women respondents were Christian than Muslim and more men were Muslim than Christian) (Johnsdotter et al. 2009). All respondents had been living in Sweden for several years.

While Johnsdotter and colleagues noted the low number of new arrivals interviewed, they did reveal a ‘rapid abandonment of FGM/C’ upon migration (Johnsdotter et al. 2009, p. 129). The researchers concluded that the research design provided a reliable indication of low risk, with interviews showing ‘that children of Ethiopian and Eritrean parents resident in Sweden run little risk of being subjected to FGM/C’ (Johnsdotter et al. 2009, p. 128). They concluded that where cases are suspected in Sweden, they ‘generally concern Somalis’ (Johnsdotter et al. 2009, p. 128). It is significant to note here that Somalis arrived in Sweden in the 1990s, more recently than Ethiopians and Eritreans, and did not have the same established social networks on arrival. Further, they came to Sweden at a time of economic recession and therefore had difficulty entering the labour market, which meant more difficulty integrating into social and economic life.

In contrast, many people from Ethiopia and Eritrea came to Sweden in the 1970s and 1980s for labour reasons during a time of economic expansion, and those arriving since have been able to benefit from existing family and community networks and therefore integrate into Swedish society more easily (Johnsdotter et al. 2009). This illustrates differences in the processes of transition between national and ethnic communities due to length of settlement and various socioeconomic factors in countries of settlement and countries of origin.

The claim that in Sweden, the overall occurrence of FGM/C is ‘probably low or nonexistent’ (Johnsdotter et al. 2009, p. 117) is supported in part by Ahlberg and colleagues (2004). Their research was focused on attitudes leading to the persistence of FGM/C in the Somali community in Sweden and was based on the assumption that there was a risk of families returning their daughters to Africa to be subjected to the practice. There has been some debate between the two research teams about the efficacy of the research design employed by Ahlberg and colleagues which, among other things, indicates how difficult it is to get a clear picture of the situation.

These two teams do agree on the robustness of the country’s alert system for detecting suspected cases of FGM/C, which is considered highly effective compared to other European countries, and that its continuance is necessary (Ahlberg et al. 2005, p. 593; Johnsdotter 2004; 2009; Johnsdotter et al. 2009). Ahlberg and colleagues stress the importance of always serving and meeting the people respectfully (Ahlberg et al. 2005, p. 593). It is also very important, according to Johnsdotter and colleagues, to acknowledge the vast potential for change in the migrant groups concerned and to bring a ‘healthy sceptical attitude toward exaggerations that can be present in societal perceptions, media coverage and in risk data’ (Johnsdotter et al. 2009, p. 131).
In the UK, research undertaken for FORWARD (Foundation for [African] Women's Health, Research and Development) by Dorkenoo, Morison & Macfarlane (2007) indicated that in England and Wales, nearly 16,000 girls aged 8 years or younger were at high risk of female genital mutilation/cutting (FGM/C) type III and over 5,000 at high risk of type I or type II. These estimates were based on extrapolations of the numbers of children born to families from countries with a high prevalence of FGM/C.

Norman and colleagues conducted subsequent research for FORWARD with the aim of 'investigating beliefs, perceptions and experiences' of women from countries with a high prevalence of FGM/C who were now living in London and Bristol (Norman et al. 2009, p. 6; Ohuntoye et al. 2009, p. 1020). Norman and colleagues adopted a 'PEER' approach methodology found to be particularly suitable for marginalised communities and sensitive topics. Trained women from communities affected by FGM/C contributed to the research design and conducted in-depth interviews within their networks. Interviews were carried out in the third person (e.g. ‘what do people think about …?’) (Norman et al. 2009, p. 9; Ohuntuoye et al. 2009, p. 1021).

The study concluded that there was very little evidence that FGM/C takes place in the UK:

‘this study did not uncover any evidence that FGM [female genital mutilation] is occurring in the UK, although this is not to say that it might be occurring. However, if it is, it is likely to be in the utmost secrecy. It may be unlikely that people with information about FGM occurring in the UK would share it with researchers, due to fear of prosecution’

(Norman et al. 2009, p. 46).

'Most accounts of [the] practice continuing describe girls undergoing FGM when taken to their parent’s home countries during holidays'


The PEER researchers reported that migration to the UK, where FGM/C is not the norm and is questioned more openly, ‘led to women sharing their opinions and experiences more readily, and led to growing opposition to the practice’ (Norman et al. 2009, p. 31).

‘If she had stayed in Sudan, there is an 80-90% chance she would have her daughters circumcised – her father’s family are from a very traditional area. But because she is here she chose not to, because of the amount of suffering she went through, the pain, during menses, pregnancy and problems during delivery and also because when you come here you see the different ways and realize there are other options. If she had stayed in Sudan, even though she would have still suffered, she would have suffered with everyone else so it is considered normal, so she would still have circumcised her daughters’

(PEER researcher, cited in Norman et al. 2009, p. 31).

Norman and colleagues (2009) found that women who were either at a young age when they arrived in the UK or were born in the UK had very little awareness of FGM/C. 'Those born in the UK have no idea at all on FGM, their families do not tell them of the practice, as they think they will not circumcise their girls and as such there is no need to know of this information, as they fear that it will mark their children as being different from others'
Factors identified by Norman and colleagues (2009) as relevant to the discontinuance of FGM/C include the age of women on arrival in the UK, the degree of integration into wider society and the strength of their connections ‘back home’. As FGM/C is not supported in the UK, people feel more able to talk about it and share their experiences and reflections and therefore feel more able to make the choice to discontinue the practice. Further, the community and family pressure to undergo FGM/C is so much less intense than ‘back home’, as communities and families are smaller and members of the extended family, including grandmothers and others who would normally be involved in the decision-making, are often still living in their countries of origin (Norman et al. 2009, p. 31).

‘Peer pressure is a critical factor. Because they are living in the UK, they are protected from the pressure: others have not had it done so they don’t have to do it either’

(PEER researcher, cited in Norman et al. 2009, p. 31).

‘… in Sudan your children belong to everyone, but a benefit of being here in the UK is that they are your children: if you say no, it is no’

(PEER researcher, cited in Norman et al. 2009, p. 31).

Although the pressure to have women and girls undergo FGM/C may be less intense in the UK than in practising countries, it can still be significant. One contributing factor is that older women will often hold on tightly to traditions and will influence their families. In addition, PEER researchers recognised that some people feel it is even more important to hold on to traditions when living outside their country of origin, particularly in a liberal country like the UK (Norman et al. 2009, p. 32). Discontinuance may also be linked to whether people see themselves as remaining in the UK or returning home at some stage.

Pressure to have daughters undergo FGM/C may also come from countries of origin, possibly on a holiday visit.

‘When people go back to Sudan on holiday, always the grandmothers pressurise them to have their daughters circumcised’


‘Grandmothers pressure their children into circumcising their daughters, but most mothers either avoid going to Sudan if the pressure is too much until their children get older. Or if they go they do not leave their girls alone …’


Norman and colleagues (2009) found that the length of time in the UK and the degree to which people were integrated into the wider society and experienced a sense of belonging correlated with women distancing themselves from FGM/C. The empowerment of women was also seen to be significant in allowing them to take a stand against any pressure from, for example, older women. In the Bristol research, one striking finding to have emerged as women talked about the contextual issues surrounding their family life was how ‘intricately interwoven the impacts of FGM were with their daily problems and experiences: “Female Genital Mutilation is with us every day” said one PEER Researcher’. Most interviews reflected this view (Ohuntoye et al. 2009, p. 1022).

An earlier study in the UK by Morison and colleagues (2004) investigated perceptions and experiences of FGM/C among young and older Somalis. The researchers found some support for the continuation of the practice among both women (18%) and men (43%). They found that older people, those most recently arrived and those least well-integrated, are likely to hold traditional views and that the intention to have a daughter circumcised reduced significantly with time of residence in the UK. As with Norman and colleagues (2009), age on arrival was found to have a significant impact on whether girls had undergone FGM/C and whether men wanted wives who had undergone the practice. The more integrated people were, the less likely they were to uphold the practice of FGM/C (Norman et al. 2009; Ohuntoye et al. 2009).
Canada

Between 2009 and 2011, a research and education project conducted by the Sexuality Education Resource Centre (SERC) in Winnipeg, Canada, sought, among other things, ‘to understand the reasons why people would continue the practice [of female genital mutilation/cutting (FGM/C)] after having migrated to countries in the Western world’ (Daniel et al. 2009, p. 4). Project workers engaged with community leaders, community members and health and other service providers. Their emphasis was on newly arrived people from a high prevalence country (undisclosed at the request of community members for confidentiality reasons). Most participants had been in Canada for less than 24 months, with the average time being 14 months. Each had between one and seven children and most had young children, some of whom were born in Canada. They were refugees displaced through war and they represented different ethnic groups from their country of origin.

The research involved focus groups with 30 participants (though more people had wanted to join) and individual interviews with three women, four female community leaders and five male community leaders. These activities were followed by feedback sessions. On the basis of the findings (Daniel et al. 2009), a community education program was developed (Daniel et al. 2011).

FGM/C was practised in this community at a very early age in girls’ lives, without celebration. There were differences of opinion and practice within the group arising from ethnic and religious differences. People were divided, too, about the continuance of FGM/C and generational differences were noteworthy, with older women supporting continuance. Most knew it was illegal in their country of origin, but, one person said, ‘rule cannot stop it, talk can not stop it’ (Daniel et al. 2009, p. 23). It was agreed that increasingly, it was becoming a hidden practice. Nevertheless, some people had already changed their opinion about FGM/C before moving to Canada.

Some participants thought that most new arrivals did not realise that FGM/C was illegal in Canada and this was indeed the finding of the facilitator of the education workshops that followed the consultation. In discussion about health cards and health care coverage, some participants asked ‘is circumcision covered? What do they do here?’ They expressed the view that it is ‘not anyone else’s business’, it is ‘our culture – everyone has this’ (Daniel et al. 2011, p. 23). Some community members considered that ‘in spite of the existence of a legal framework protecting children from FGM/C in Canada, there was some evidence that the practice continued’. Discontinuance, they thought, may not be easy (Daniel et al. 2011).

In the evaluation of the education workshops, however, participants expressed a high appreciation of the information received on FGM/C and for the opportunity for discussion. This was clearly an optimal forum for allowing people the opportunity to reflect on FGM/C, see it differently and make their own transitions.

‘I knew the health consequences [of female genital cutting] and how to go and ask for help with health problems and illnesses. It helped me to see the health problems and illnesses’ (cited in Daniel et al. 2011, p. 17).

‘There are different traditional practices and some might not be acceptable to be done here and therefore it’s good to come here and talk about it – I hope the information grows’ (cited in Daniel et al. 2011, p. 17).

‘There are some traditional practices that we do – not aiming to hurt or destroy – but because it is culture, the aim is to help or treat, e.g. bloodletting … or FGM/C. It is done because of culture, but because diseases are coming, like communicable diseases – and in other countries it is changing - and there are no benefits … I know now that to do this – it doesn’t benefit’ (cited in Daniel et al. 2011, p. 17).
The report on this research, titled *Our selves our daughters* (Daniel et al. 2011), draws attention to the multiple challenges and difficult adjustments facing participants as refugees and migrants. It is, of course, not just FGM/C that is ‘in transition’. People were struggling with differences in cultural meanings and ways, as well as social systems, and were trying to understand and negotiate those differences. For some, there was an ‘overload’ of information. This was despite the evident high degree of community ‘mobilization and organisation’ within this community (Daniel et al. 2011, p. 16). The most pressing matters for them were to ‘fulfill their basic needs’ (Daniel et al. 2011, p. 16). Employment and housing took precedence over everything else, including health.

In fact, settlement processes were taking their toll on health and wellbeing. People found the health care system difficult to navigate and the lack of cultural competence of health care providers and systems was a big issue. Daniel and colleagues (2011) stressed that men and women faced different challenges and pressures, with women having to step up and out in new ways to support their families and men experiencing many losses relating to changed roles.

Other concerns encompassed aspects of family relationships and child rearing, including discipline and protecting children and adolescents from the dangers of drugs, promiscuity and alienation (Daniel et al. 2011).

Some key factors facilitating the transition from FGM/C early in settlement in Western countries stand out from Daniel and colleagues’ (2009) research. These include enabling people to provide basic necessities for their families, particularly through housing and employment. Independence was seen as important. The provision of regular and safe forums early in the settlement process to explore and learn about health and wellbeing (including FGM/C) and other systems were also found to be of critical importance.

‘… we can talk about this in Canada. It is our right. We need women’s sessions so we can speak about it. [We need] to know more about [FGM/C] … In our culture it is important. But here, it is good and bad. What are the effects? We need to know the effects on our children. Do we need to circumcise here? We don’t know how it is seen in Canada’ (Daniel et al. 2009, p. 24).

In addition to this research by Daniel and colleagues (2009; 2011), a significant earlier study in Canada by Vissandjee and colleagues (2003) asserted the contention that FGM/C in Western contexts is ‘a tradition in transition’ (Berg, Denison & Fretheim 2010).
Literature review

There is a small body of literature on female genital mutilation/cutting (FGM/C) in Australia, though none directly addresses the aspects canvassed in this report, which are the likely prevalence of FGM/C across Australia; the possible risk of young girls being subjected to the procedure either in Australia, or more likely, when taken temporarily to a country of origin or other practising country; the effect of migration to and settlement in Australia on people’s attitudes and behaviour concerning FGM/C; and the factors relevant to the continuance or discontinuance of the practice. All of these are areas where research would be very useful in informing policy and programs.

The aspects of FGM/C that are evident in the Australian literature include policy and legal debates (Mathews 2011; Patrick & Markiewicz 2000), the application of relevant conceptual frameworks such as human rights and cultural relativism (Mangan 2007), the challenges and debates in the provision of sensitive and respectful health services for women affected by FGM/C (Allotey, Manderson & Grover 2001; Banks 2006; Guerin et al. 2006; Nur 2002; Ogunsiji, Wilkes & Jackson 2007; Rogers 2009), prevention and support programs (Neophytou & Adam 2011), child protection (OCSC 2008; Patrick & Markiewicz 2000) and the 2012 survey by Moeed and Grover of FGM/C practices by gynaecologists in Australia and New Zealand.

Other Australian writing, while not focused on FGM/C, is directly relevant as background information for policy and program planning and design in that it addresses broader questions of the settlement, integration and adjustment of migrants and refugees. This includes Bursian (2011), Pittaway and Muli (2009) and Westoby (2008).

Factors promoting and hindering female genital mutilation/cutting in the transition process

Berg, Denison and Fretheim (2010, the United Nations Children’s Fund Innocenti Research Centre (UNICEF 2010), Johnsdotter and colleagues (2009), Ahlberg and colleagues (2004), Daniel and colleagues (2009), Norman and colleagues (2009) and Ohunoye and colleagues (2009) all discuss the importance of identifying, in this process of transition, the particular forces that promote female genital mutilation/cutting (FGM/C) and those that hinder the practice. This enables the tailoring of effective prevention programs and activities and the evaluation of current programs, and highlights gaps and uncertainties in knowledge (Berg, Denison & Fretheim 2010, p. 19).

Berg, Denison and Fretheim from the Norwegian Knowledge Centre for the Health Services undertook a systematic analysis of the best research from Western settlement countries to answer the question ‘what are the factors promoting and hindering the practice of FGM/C, as expressed by stakeholders residing in Western countries?’ (Berg, Denison & Fretheim 2010, p. 7). From a large number of publications (5,998 in total), they selected, on the basis of their research focus and quality, 25 studies in 29 publications. Many were from Scandinavia, some from other European countries including the UK, some from North America, one from New Zealand but none from Australia (Berg, Denison & Fretheim 2010, p. 4).

Berg, Denison and Fretheim (2010) found that the complex factors perpetuating FGM/C in Western countries of settlement include ideological, material and spiritual dimensions. They exist at multiple levels, namely intrapersonal (e.g. health consequences), interpersonal (e.g. the enhancement of male sexual enjoyment), meso (e.g. cultural tradition) and macro (e.g. religion or legislation). These dimensions need to be understood in their connectedness rather than as discrete aspects. The factors enabling
discontinuance can be seen largely as a negated reflection of the factors supporting continuance. The ‘social dynamics that perpetuate FGM/C can also help to drive its abandonment’ (UNICEF 2010, p. 6).

Johnsdotter and colleagues state that it is ‘highly significant that these traditional practices, once a sign of conformity to social norms, are viewed in the opposite light in the new cultural context’ (Johnsdotter et al. 2009, p. 117).

Berg, Denison and Fretheim (2010) identified five main thematic categories of continuance factors expressed by women and men living in Western countries who come from countries where FGM/C is practised. In order of their frequency of occurrence in the literature studied, these are because it is cultural tradition, it decreases women’s sexual desires, protects virginity and increases marriageability and because of social pressure. Other factors that emerged less prominently included to maintain ‘honour’, because of religion, for hygiene reasons, because men want women to have undergone FGM/C, to fully become a woman, for social identity, to please men and to avoid shame (Berg, Denison & Fretheim 2010, p. 38).

Four thematic factors hindering the existence of FGM/C, that is, discontinuance factors, are the negative health consequences, because it is against the law, that migration changes conditions and that there is no requirement in religion.

These thematic factors were further synthesised to result:

‘in eight analytic themes that influence the practice at multiple levels, from the interpersonal level to the macro level. These themes include: cultural tradition, sexual morality, marriage, religion, hygiene, achievement of womanhood, FGM/C [female genital mutilation/cutting] being unlawful, [and] negative consequences of FGM/C’

(Berg, Denison & Fretheim 2010, p. 41).

International data shows a close relationship between women’s ability to exercise control over their lives and their belief that FGM/C should end (UNICEF 2005).

‘If my daughter finishes school, learns how to drive a car, and gets a job, she doesn’t need a man whether she is circumcised or not’ (Somali parent in the US for less than 27 months, cited in Berg, Denison & Fretheim 2010, p. 54).

Berg, Denison and Fretheim conclude that in instituting prevention programs, the particular belief sets of the communities concerned need to be explored and addressed and that although ‘our results suggest factors promoting and hindering FGM/C are fairly consistent across the many migrant communities in the West, to optimally inform prevention efforts research should be done locally because the factors may vary across locations as well as time. However, we believe that the findings here form a clear starting point’ (Berg, Denison & Fretheim 2010, p. 59).
Table 6: Factors promoting and hindering FGM/C, as expressed by women and men living in Western countries who come from countries where FGM/C is practised

<table>
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<th>Factors promoting FGM/C</th>
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<th>Factors hindering FGM/C</th>
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Source: Berg, Denison and Fretheim 2010
Summary and discussion

The research shows that female genital mutilation/cutting (FGM/C) in Western countries is a ‘tradition in transition’, with cultural and other changes taking place such that, in the long run, the practice of FGM/C is unlikely to persist (Berg, Denison & Fretheim 2010, p. 52). The process of change is complex and at times seemingly contradictory. The pace of change varies widely, reflecting the interplay of the diverse factors involved. Key enabling themes are also evident.

All researchers agree that the process of migration to and settlement in Western countries in and of itself creates change. It presents a unique opportunity for people to reflect on, question and challenge deep-seated cultural beliefs and practices in light of a different context. New prevailing discourse on FGM/C, dominant attitudes embracing democracy and rights, especially women’s rights and gender equality, and legal environments prohibiting the practice all encourage a re-thinking of people’s personal experience (Berg, Denison & Fretheim 2010; Daniel et al. 2009; 2011; Johnsdotter et al. 2009; Norman et al. 2009). Women and men become aware of the irreparable health consequences to girls and women and come to understand the many myths that have surrounded and perpetuated the practice, including that it is required by religion, that it is a means to virginity at marriage or that it is ‘natural’. Johnsdotter summarises this transition as ‘change’ and ‘absence of meaning’ (Johnsdotter 2009, p. 121).

Time is an important factor in discontinuance. Johnsdotter and colleagues in Sweden (2009) and Norman and colleagues in the UK (2009) conclude that over time, there is little or no evidence that FGM/C continues. In fact, Johnsdotter reports on the ‘rapid abandonment of FGM/C upon migration’ (Johnsdotter 2009, p. 128). A few years of settlement and exposure to Western culture and laws will have a significant bearing on loosening traditional cultural values, beliefs and practices. These are always dynamic and changing and as cultural beings, people are flexible and innovative in re-forming cultural meanings and practices.

It is evident from the research that there is considerable variation in the rapidity of change. Age on arrival in countries of settlement is one factor. People who are older on arrival are more likely to hold on to traditional attitudes, whereas younger people are more likely to see the practice of FGM/C as not relevant in ‘this country at this time’. Age will of course be mediated by other factors associated with integration and acculturation.

A process of ‘rapid abandonment’ is facilitated by the pre-existence of supportive family and community networks (Daniel et al. 2011; Johnsdotter et al. 2009; Norman et al. 2009). Somewhat paradoxically, Norman and colleagues (2009) found that where small communities were disbursed geographically, the relative absence of community pressure to conform gave space and opportunity for change. Other well-documented factors influencing the pace of change include the ability and means for people to ‘fulfil their basic needs’, especially through employment and housing, and the presence of favourable prevailing economic, social and political conditions. These include the particular local operations of racism (in Australia, these often impact negatively on people from African backgrounds) and the settlement policy and service environment (where Australia has a strong track record, though there are potential areas for improvement). Language remains a primary barrier. Guerin and colleagues (2006) write about the challenges of resettlement in Australia, referring to the ‘wider cultural chasm that impedes integration’. They note language difficulties in particular, but also problems relating to navigation and cultural sensitivity in the health, education and welfare systems (Guerin et al. 2006, p. 9).
The empowerment of women, including language acquisition and economic capacity, is seen to be of critical importance in influencing the speed of the transition to abandonment.

In exploring the process of transition in countries of settlement, several writers have stressed the importance of understanding the particular factors that perpetuate the practice and those that promote its discontinuance or abandonment. They contend that a sound understanding of these factors is pivotal to designing and evaluating prevention programs and for identifying gaps in knowledge. Berg, Denison and Fretheim (2010) have analysed these factors from existing research literature and summarised them as eight ‘analytic themes that influence the practise at multiple levels, from the interpersonal level to the macro level’. These are cultural tradition, sexual morality, marriage, religion, hygiene, achievement of womanhood, that FGM/C is unlawful and the negative consequences of the practice (Berg, Denison & Fretheim 2010, p. 41). They identified the four major factors contributing to discontinuance as the negative consequences or harm inflicted on women, that it is against the law, that migration changes conditions and that it is not required by any religion. Berg, Denison and Fretheim (2010) consider further research in this area to be important.

Global links between the widely dispersed communities from FGM/C practising countries are important to both the continuance and the discontinuance of FGM/C. Berg, Denison and Fretheim (2010) found that connectedness works both ways. Pressure to continue FGM/C can come from ‘home’ communities, yet some women have changed their attitudes before migration and attitudes do change following settlement in migrant countries. There are also many ways in which diaspora communities exert considerable influence in countries of origin, contributing to social change. These links are often utilised in prevention activities.

Finally, as Johnsdotter and colleagues advise, we do well to acknowledge the vast potential for change in the migrant communities concerned, maintaining a ‘healthy sceptical attitude toward exaggerations’ that can be present in societal perceptions, media coverage and in risk data (Johnsdotter et al. 2009, p. 131; Johnsdotter 2009). At the same time, we should maintain an environment that fosters and supports change towards abandonment, including effective and early prevention programs and alert systems.


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Prevention programs in Africa and destination countries

This report presents research on female genital mutilation/cutting (FGM/C) prevention programs in countries where FGM/C is practised, and in non-practising countries that host migrants and refugees from FGM/C practising countries (host countries).

There have been several waves of attempts to prevent FGM/C. When missionaries in Kenya first encouraged the abandonment of FGM/C practices in the 1930s, local communities saw this as a colonialist attack on their traditional custom aimed at hastening their ‘Europeanisation’ (UNICEF 2010, p. 45). A cultural relativist stance prevailed internationally until the later decades of the twentieth century (Caldwell, Orubuloye & Caldwell 2000) when human rights, child rights and particularly women’s rights, were promoted. FGM/C and other harmful traditional practices were understood internationally as not only very harmful to the health and wellbeing of women and girls, but also as an abuse of their human rights and a form of violence.

In the 1970s and 1980s, delivering health messages about the harmful consequences of FGM/C for women and girls became the dominant conceptual approach in combating its occurrence in African countries. By the 1990s, all major relevant international bodies and most governments had committed themselves to the eradication of FGM/C, and the human rights stance had been integrated into a health promotion approach.

At the community level, human rights and responsibilities are still constantly being negotiated and these complex processes form an important part of community development and health promotion work on the ground level.

The practice of FGM/C in Africa is showing some encouraging signs of declining. One key indicator is that in African countries, younger women aged 15-19 years are less likely to have been subjected to FGM/C than are women in older age groups, as illustrated in Figure C below (WHO 2011, p. 1).

Nevertheless, ‘in many countries the reduction in prevalence is not as substantial as hoped for, and in a few no decline can be noted’ (WHO 2011, p. 4). This is despite significant efforts by international bodies, non-government organisations and governments to eradicate the practice. In 2008, the World Health Assembly passed a resolution on the elimination of FGM/C, emphasising the need for concerted action in all sectors, namely health, education, finance, justice and women’s affairs.

![Figure C. Prevalence of FGM/C among older and younger women in Africa aged 15-49 years](attachment.png)

MDHS: Measure Demographic and Health Surveys; MICS: Multiple Indicator Cluster Surveys
Data source: WHO 2011

Family Planning Victoria 2013
The World Health Organization’s (WHO) efforts to eliminate FGM/C currently focus on:

› advocacy: developing publications and advocacy tools for international, regional and local efforts to end FGM [female genital mutilation] within a generation;

› research: generating knowledge about the causes and consequences of the practice, how to eliminate it, and how to care for those who have experienced FGM;

› guidance for health systems: developing training materials and guidelines for health professionals to help them treat and counsel women who have undergone procedures.

The WHO is particularly concerned about the increasing trend for medically trained personnel to perform FGM/C and strongly urges health professionals not to perform such procedures (WHO 2012).

The research literature reviewed below reflects a range of interconnecting and overlapping approaches to the eradication of FGM/C practices that have been adopted in various communities around the world.

Frameworks for female genital mutilation/cutting prevention

The key frameworks used for the prevention of female genital mutilation/cutting (FGM/C) are health education and promotion, legal and human rights, including women’s and children’s rights, and changes in the social dynamics of FGM/C through community engagement.

Health education and promotion

Health education involves informing people about female genital mutilation/cutting (FGM/C) and its harmful effects (Banks 2006; Knight et al. 1999; Mathews 2011). Three distinct but interconnecting levels of health education and promotion are addressed here as strategies in the campaign for abandoning FGM/C. The first is the migrant or settling community of people; the second, professionals interacting with practising communities in a multitude of ways; and the third, the societal level, a ‘whole of population’ approach.

For migrants arriving in new countries, there are many opportunities for change, with education playing a significant role. Particular examples described later in this report highlight, in part, the roles of immigration, settlement and other relevant workers engaging with and informing new arrivals about their new country’s health, housing, employment and services, as well as providing information about laws relating to compulsory schooling, visas, child protection, domestic violence and gender relations.

Professionals can raise awareness at the time of arrival, or later when people are more settled, about sexual and reproductive health and FGM/C and its harmful effects on girls and women. Many of the people arriving may never have discussed FGM/C (Steele 1995) and may have inadequate knowledge of their bodies and biological facts.

As such, health-related problems are well placed among the psychosocial issues discussed in settlement programs with new migrants (Knight et al. 1999). Educators can invite religious leaders to inform people of
Prevention programs

the mis-association of FGM/C with religion, and the laws against and consequences of performing the practice in the new country (Ierodiaconou 1996; UNICEF 2010). Further, support and counselling should be available. Founder of the non-government UK organisation FORWARD, Efua Dorkenoo, declared that "when genitally mutilated women, en masse, understand what has been stolen from them, there will likely be a period when they will need every possible psychological support" (cited in Steele 1995, p. 122).

Migrants who have experienced FGM/C programs in Africa are well placed to contribute to educating others for whom it has been a taboo or unquestioned topic. Women and men of African backgrounds who are activists against FGM/C are seldom given credit for their attempts to promote human rights (Khaja et al. 2009) and are often excluded from leadership, decision-making or policy making roles. This is because they have been depicted as being unqualified to comment about their traditional practices (Johnsdotter & Essen 2010).

The way in which education about FGM/C occurs is important. Adults are more likely to consider new ideas, attitudes and behaviours when they are part of a group that provides opportunities for safe discussion; respects and appreciates cultures, values and aspirations; draws on common experiences; and establishes agreement about change. The more supportive, accepting and caring the learning environment, the freer people feel to experiment with new attitudes and ideas. Adults retain and act on knowledge that they discover themselves more so than knowledge that is presented by others (Vella 2002). Educational approaches that use these principles can engage and empower people to make their own decisions to abandon FGM/C (Daniel et al. 2011).

Adult learners appreciate opportunities for debate (Vella 2002). Facilitators can invite religious and other leaders from the communities concerned, as well as health and community professionals, to discuss the conflicting constructions of FGM/C. Being of the culture, community and religious leaders can be ambassadors of new ways, working with community members to frame problems and solutions in the context of religion and culture, using metaphors, idioms of distress, and proverbs that are familiar and accessible (Al-Krenawi & Graham 2001, p. 677) to inform people of the mis-association of FGM/C with religion and the laws and consequences against the practice in the new country (Ierodiaconou 1996; UNICEF 2010).

The participation of migrants in higher education is likely to create openness to re-thinking cultural assumptions and practices. For example, exposure to international education and discourse on human rights has been seen to influence young men in Muslim communities in Southern Thailand. On their return home, these men opposed FGM/C, in contrast to local people who want FGM/C to remain part of their traditions (Merli 2010).

For health, welfare and legal workers, it is important to undertake training in FGM/C and its consequences, including the barriers to effective and responsive health care. Systematic training is needed for professional groups who may deal with women affected by FGM/C, including immigration officers, settlement and health workers, lawyers and English language and other teachers. Training should be targeted at programs that will assist women who have undergone FGM/C and support them in seeking assistance for gynaecological or psychosexual help or counselling (Ierodiaconou 1996). If health professionals are not informed about the physiology and cultural bases of FGM/C, they may not know how to establish rapport with women who have experienced the practice when they present at medical settings. With culturally appropriate education and the use of interpreters (Knight et al. 1999), health professionals can provide a thorough assessment at first presentation. Counselling and further management can then be arranged if necessary.

At the whole of population level, technology and media can be used as a powerful
Prevention programs
force for health promotion, mass education
and influence (World Health Organization
1986). Radio and television talk shows,
documentaries, films and educational
programs reach large segments of the
population and can provide the basis for
discussion and debate. Through the media,
positive news about public abandonments
can be widely disseminated. Media attention
can expose illegal FGM/C procedures
performed secretly, incidents of failed
attempts to cut girls and the physical and
emotional repercussions of the practice
(UNICEF 2010).

The use of films such as Moolaadé (2005)
by Senegalese director Ousmane Sembène,
and Alice Walker and Pratibh Parmar’s
Warrior marks (1996) can sensitively inform
people about FGM/C and its devastating
consequences (Steele 1995). Documentaries
extend the reach of abandonment movements
across geographical borders and explain
how and why communities made the decision
to abandon FGM/C. Such films have been
screened across Africa to stimulate reflection
and discussion in practising villages. When
movies about FGM/C practices were shown
in Senegal to men and women, an open
discussion forum followed. Women said
they learnt that other women in the world
were not cut and did not suffer the pain and
complications during childbirth that they did.
The men in the community said they were
previously unaware that their daughters and
wives were being subjected to such practices.
The new insights and ensuing discussion
contributed to the significant changes in
FGM/C practices in Senegal (Wellerstein
1999). Similarly, movies and books such as
Alice Walker’s Possessing the secret of joy
(1992) and Waris Dirie and Cathleen Miller’s
Desert flower (2009) are useful in raising
awareness of FGM/C in migrant settler
communities (Steele 1995).

Public exposure of FGM/C must take into
consideration the impact it has on the
affected communities. Swedes of African
backgrounds expressed ambivalence about
mass media coverage of the FGM/C issue
because they felt it depicted all Africans
as the same in relation to FGM/C, despite
the differences that exist between them
regarding practices (Johnsdotter et al. 2009). In
the 1994 public health campaign about
FGM/C in Victoria, Australia, which followed
the introduction of FGM/C specific laws
in Victoria, African communities resented
public discussion of their private parts and
the subsequent adverse responses from
health and community professionals (Allotey,
Manderson & Grover 2001).

For women in countries of settlement,
FGM/C remains an intensely private and
sensitive subject and public discussions are
considered disrespectful and embarrassing
(Patrick & Markiewicz 2000, p. 16). Due to
the veil of silence and secrecy surrounding
the practice, it is difficult for women to speak
up in their communities. As such, great
sensitivity is required in any health education
or health promotion campaign relating to
FGM/C.

Human rights, women’s and children’s rights and the law
In response to the Maputo Protocol, the
governments of twenty African nations have
introduced legislation against female genital
mutilation/cutting (FGM/C). These countries
include Benin, Burkina Faso, Central African
Republic, Chad, Côte d’Ivoire, Djibouti, Egypt,
Eritrea, Ethiopia, Ghana, Guinea, Kenya, Mali,
Mauritania, Niger, Senegal, South Africa,
Tanzania Togo and Uganda (CRR 2006).

Eighteen countries that host refugees and
migrants from FGM/C practise countries
have laws criminalising the practice. These
countries are Australia, Belgium, Canada,
Cyprus, Denmark, Finland, Greece, Italy,
Luxembourg, Portugal, the Netherlands,
New Zealand, Norway, South Ireland, Spain,
Sweden, the UK and the US. Other countries
such as France and Switzerland rely on
existing criminal legislation to prosecute
practitioners of FGM/C and parents procuring
Prevention programs

The law in relation to female genital mutilation/cutting (FGM/C) type IV in Indonesia is interesting in its condoning of medically conducted ‘circumcision’. A large-scale country-wide research project in 2003, funded by USAID, concluded that 92% of the 1,694 families interviewed expressed support for the continuation of FGM/C for their girls and future grandchildren (Budiharsana et al. 2003). The research reported that the practice of FGM/C in Indonesia violated the rights of the child under the Convention on the Rights of the Child, which Indonesia ratified in 1990. Under international pressure, the Indonesian government committed to a campaign of zero tolerance of FGM/C, but the government’s response was ‘relaxed’ (Newland 2006, p. 396). Despite Budiharsana and colleagues’ (2003) recommendation that Indonesia’s Ministry of Health take firm action to prevent the medicalisation of FGM/C, subsequent Indonesian laws specify how the symbolic and small-cut incisions of the clitoris should be performed (Kesehatan 2010). These laws condone the practice, as long as it is conducted by a qualified paramedic, preferably a woman, not a traditional healer. The legislation stipulates that the paramedic must wash her hands for 10 minutes before beginning, wear gloves, wipe the vulva with iodine before starting and register and monitor the procedure when finished. Only the hood of the clitoris should be touched. It is prohibited to scratch or cut the clitoris or labia. The procedure is to be conducted in a clean room with good lighting, running water, gloves and sterilised equipment (Menteri Kesehatan 2010; Pendak 2011). The girl should sign a letter of request and agreement and be warned of possible infection. This legislation directly contradicts the World Health Organization’s (WHO) guidelines for the service for their daughters (Rahman & Toubia 2000). The role of legal sanctions varies between countries, with some placing greater emphasis on criminal proceedings and others prioritising other prevention strategies such as community support and education (CRR 2006; Leye et al. 2007).

There have been a few FGM/C cases prosecuted in Italian and Swedish courts, but France is the only country where the systematic criminal prosecution of FGM/C practices takes place. France, in the absence of specific FGM/C legislation, relies on existing criminal legislation. Between 1979 and 2006, 40 cases were heard in the French court involving 120 children and 99 parents. Parents, mainly mothers, were charged and given (mainly suspended) prison sentences for subjecting their daughters to the practice (Leye et al. 2007; Poldermans 2006; Rahman & Toubia 2000). While criminal proceedings may be seen to do justice in individual cases (Poldermans 2006), their greater function is social marketing, raising public awareness through the publicity they evoke. Prohibitive legislation against FGM/C provides disincentives, sanctions and penalties (Steele 1995) and serves as a warning signal to the families and communities concerned.

While there are several organisations that are responsive to the needs of FGM/C affected African communities in France, there are few policy initiatives and little coordination for community education or health promotion (Poldermans 2006). In contrast, the UK’s specific FGM/C legislation, which involves penalties of five to 14 years imprisonment for performing or assisting genital surgery, focuses on child protection and child rights with an obligation to report to social services rather than to police (Guine & Fuentes 2007). By 2008, there had been no prosecution of parents and only two doctors had been expelled from the UK medical council (Dustin & Phillips 2008). In contrast to France, the UK locates its legislation within a well-integrated educational, human rights and local and international policy and research approach (Guine & Fuentes 2007).

Indonesia: Where laws condone the practice

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stipulating that under no circumstances should FGM/C be performed by health professionals or in health establishments.

Amnesty International notes the following:

› In 2007, the Committee on the Elimination of Discrimination Against Women (CEDAW) recommended that Indonesia develop a plan of action to eliminate the practice of FGM/C, including implementing public awareness-raising campaigns to change the cultural perceptions connected to it and provide education regarding the practice as a violation of the human rights of women and girls that has no basis in religion.

› In 2008, the United Nations (UN) Committee against Torture (CAT) recommended that Indonesia adopt all adequate measures to eradicate the persistent practice of FGM/C, including through awareness-raising campaigns in cooperation with civil society organisations (Amnesty International 2011).

› Amnesty International has called on the Indonesian authorities as state party to CEDAW and CAT, to:

› repeal the Regulation of the Minister of Health No. 1636/MENKES/PER/XI/2010 concerning female circumcision

› enact specific legislation with appropriate penalties prohibiting FGM/C

› implement public awareness-raising campaigns to change the cultural perceptions associated with FGM/C (Amnesty International 2011).

In 2010, a debate within the Australian medical profession about women who wanted to be re-infibulated (re-sewn after childbirth) resulted in a recommitment not to conduct female genital mutilation/cutting (FGM/C) practices (Mathews 2011). Australian law prohibits the performance of any type of FGM/C, with six out of eight states and territories (NSW, SA, ACT, NT, Victoria and Queensland) having legislated specifically against the practice. Western Australia uses its existing laws (Spencer 2002) and Tasmania has legislation planned, but not implemented. There is no coordinated legislation at the federal level, but FGM/C is prohibited nationally by the policy of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (Mathews 2011). Moed and Grover’s 2012 survey indicates that Australian obstetricians and gynaecologists adhere to these directives.

The relevant laws in Victoria are as follows:

The Children Youth and Families Act 2005 mandates certain professional groups (doctors, nurses, teachers, school principals and police) to report concerns if they form a belief on reasonable grounds that a child is in need of protection from physical or sexual abuse, including FGM/C (AFMW 2009).

The Crimes (Female Genital Mutilation) Act 1996 makes it illegal to circumcise a woman, young girl or any child under the age of 18 years. It is illegal to remove or cut off any part of the female genital area (excision), including any part of the clitoris or labia, stitch up the female genital area (infibulation), conduct any procedure to narrow or close the vaginal opening or damage or mutilate the genital area. Even if someone requests or agrees to have any of the above surgery or their parents have provided permission, it is still illegal. It is illegal to perform, help or find someone to perform or take a person out of Victoria to another state or country to have any of the above practices. The punishment is a prison sentence of up to 15 years.

Surgical procedures on the female genital area can be performed by a medical doctor when the procedure is necessary for the health or to relieve physical symptoms of a person and only performed by a doctor, when
it is deemed medically necessary during labour or immediately after the birth and is performed by a doctor or midwife in hospital, or is a sexual reassignment procedure (a sex change) performed by a medical practitioner (The Women’s 2010).

There appears to be no legislation against cosmetic genital surgery, piercing or tattooing of the genitalia. In 2010, 1400 women made Medicare claims for labioplasty operations (Stark 2010), with some aspects of sexual reassignment qualifying for Medicare health insurance cover (SMH 2010).

Practice guidelines for reporting a belief that a child may be or has been subjected to FGM/C in Victoria are found on the websites of the Royal Women’s Hospital (The Women’s 2010), the Australian Federation of Medical Women (AFMW 2009) and the Office of the Child Safety Commissioner (OCSC 2009). Each of these sites refers to the Victorian Family and Reproductive Rights Education Program (FARREP). The discovery in Victoria in 1993 of two Eritrean girls who had been infibulated led to Victoria’s amendment of the Crimes Act in 1996 to prohibit FGM/C (Rogers 2009; Ierodiaconou 1996; Swensen 1995). In the 1993 case, it emerged that the girls had undergone FGM/C prior to their arrival in Australia. Prosecution of the parents resulted in the family feeling persecuted for doing what they believed was in the children’s best interests (FARREP worker 2010). In a subsequent case in the north of Melbourne, a school reported to police and Department of Human Services Child Protection their suspicion that a family was planning to take their daughter overseas to undergo FGM/C. This again resulted in the family feeling condemned intentions being depicted as criminal, causing great distress to the family with no decisive outcome (FARREP worker 2011). In September 2012 in Sydney, Australia, The Sydney Morning Herald (Bibby 2012) reported that a sheikh, a nurse and two parents were charged with the genital mutilation of two girls aged 6 and 7 years.

FGM/C is unlike other forms of abuse that are known to harm such as rape or domestic violence. The practice is usually committed in the misguided belief that it is in the child’s best interests. Accordingly, information should be made available to parents about the harmful consequences of FGM/C and, when it is thought probable that a child is to be subjected to FGM/C, strong legal intervention is required (Ierodiaconou 1996). A young girl is not able to give consent because she cannot be cognisant of the physical, psychological, sexual and social ramifications. A child protection response, however, must be sensitive and culturally informed. In the case of FGM/C occurring, a child may need medical assessment and care, as well as counselling about the possible trauma she experienced. Further, the provision of family counselling is important to ensure the family understands the reasons for the state response (Patrick and Markiewicz 2000).

In conclusion, legal measures that are solely punitive and criminalise FGM/C can stigmatise affected communities, reinforce traditional beliefs and drive the practice underground. As it is difficult to detect FGM/C, legislation cannot be well monitored without taking steps that could be perceived as racist and intrusive. While legislation may act as a disincentive, its importance lies in underpinning an integrated, holistic framework for culturally affirming, engaging interventions that involve communities and health professionals, promote child protection and are based on human rights. As Mathews (2011, p. 141) said:

‘Australia has strong and clear prohibitions of FGM [female genital mutilation] in both law and medical policy, and possesses a generally enviable record of gender equality and health provision. With a small population and a small but growing number of residents born in nations where FGM is customary, the current context may offer a chance to contribute to new ways of investigating FGM, reducing its incidence and altering its motivating attitudes’.
We have noted that legislation, health promotion and human rights work that focuses on delivering health and human rights messages to communities that practise female genital mutilation/cutting (FGM/C) do not, on their own, bring about the desired attitude or cultural and behavioural changes. Experience across the world, some of which is described later in this report, has shown that a community engagement or community development approach to consciousness raising, health and human rights education and research is more effective in bringing about this change.

Implementing a community approach involves:

- the creation of trust and safe spaces for people to think and discuss at a deep level the harm and human rights abuses of FGM/C and to explore these within wider political, social and cultural contexts, examining complexities and contradictions (i.e. consciousness raising processes)
- culturally respectful public discussion of issues around FGM/C
- cooperation between government and non-government agencies, religious leaders, societal opinion leaders and health experts in dialogue and education of the public
- the involvement of men and community leaders in educational and awareness-raising efforts, including facilitating conversations between men and women who have undergone FGM/C
- education of girls concerning their bodies and their human rights, similar to the Protective Behaviours Program (PBA 2012)
- the promotion of awareness of key human rights instruments (Mathews 2011, p. 141).

These approaches are integral to programs that work towards the abandonment of FGM/C in Egypt, Ethiopia, Kenya, Senegal and Sudan. In these countries, abandonment is achieved through challenging gender relations and negative assumptions and stereotypes. Rather than fighting against local cultures with a negative view of their traditional behaviours, effective programs have promoted significant questioning and attitude change, thus changing the social dynamics of FGM/C (UNICEF 2010).

The United Nation Children’s Fund Innocenti Research Centre (UNICEF 2010) explores the process that mobilises communities to publicly abandon FGM/C in FGM/C practising countries. Abandonment initiatives take into account the complex social dynamics surrounding FGM/C, tapping into the same factors that motivate parents to decide to have their daughters undergo the practice (UNICEF 2010, p. viii). Mackie and Le Jeune (2009) draw on Shelling’s (1960) social convention theory to examine the reasons why harmful conventions endure for generations and how families, individuals and communities can be persuaded to abandon them. They emphasise the importance of discussion and deliberation about social sanctions, moral judgements and human rights (UNICEF 2010, p. viii).

Where a social convention or norm is in place, decision-making is an inter-dependent process whereby a choice made by one is affected by and affects the choices made by others. This is a result of reciprocal expectations. The social convention theory offers an explanation as to why communities continue to choose FGM/C and why it is so difficult for individual girls or families to abandon the practice on their own. The convention assumes that girls are cut as a pre-requisite for marriage. Parents make the decision to cut their own daughters to ensure they are prepared for adulthood, a proper marriage and their social and
Prevention programs

economic security. Failure to conform leads to social exclusion, ostracism, disapproval, rebuke or even violence. Conformity to FGM/C expectations meets with approval, respect, admiration and maintains social standing for a girl and her family in the community. Daughters of families that break the convention find it difficult if not impossible to marry and may become social outcasts. Where FGM/C is universal within the marrying community, girls themselves want to be cut to ensure their marriageability. Compliance with the norm seems to be in the best interests of everyone concerned (UNICEF 2010; Mackie & Le Jeune 2009).

In the social convention theory, the opposite also applies whereby if a sufficient number of families in a community choose not to have their daughters cut, cutting loses its power as a pre-requisite for marriage. Families will abandon the practice only when they believe that most or all others will make the same choice at the same time. The challenge is to garner enough abandoning families through community discussion, decision and public commitment. Conventional practices are only abandoned when there is a coordinated act undertaken by a large enough proportion of the group concerned to ensure that the shift is effective and stable. Families will not abandon FGM/C on their own. They will only act when they believe that social expectations have changed and that most or all others in their community will make the same decision (UNICEF 2010).

The process of community change begins with an initial core group of individuals who set in motion a dynamic of change. As this group becomes ready to abandon FGM/C, they seek to convince others to also abandon the practice. This is done through spreading the knowledge of their intention to abandon FGM/C through social networks until there is a large enough portion of the affected community ready to abandon. If this tipping point is reached and there is sufficient trust in the intention of others, new expectations not to cut their daughters emerge. Public declaration of the new attitudes and willingness to change indicates the community’s commitment to abandon the practice. As news of the community resolve spreads, social sanctioning shifts onto those who continue the practice (UNICEF 2010).

The United Nations Children's Fund Innocenti Research Centre’s (UNICEF 2010) research into prevention programs that have achieved community attitude and behavioural change in relation to FGM/C identified the following key elements operating in coordinated and comprehensive strategies:

1. Interdependent decision-making and readiness for change
2. Communities feel that change is in their best interests
3. Positive aspects of local cultures are reinforced
4. Human rights education is linked to values and aspirations
5. Engagement of the media to promote social change
6. Engagement of influential social networks and institutions at the local and national level
7. Interconnection between the national and local levels
8. Legislative reform as part of a broader transformative process
9. Links developed beyond national borders (UNICEF 2010)

The following section provides examples of programs, policies and processes that have been effective in preventing FGM/C in practising African countries and in countries of migration.
Prevention programs

Successful initiatives leading to the abandonment of female genital mutilation/cutting (FGM/C) lie within a broader framework of human rights, social justice and community development. The United Nations Children’s Fund Innocenti Research Centre (UNICEF 2010) provides examples of education programs in Kenya and Sudan, community dialogue and conversation in Ethiopia, human rights and democracy in Senegal and a sociocultural approach in Egypt. These programs examine practical concerns relating to daily life, associating human rights principles with local values and using familiar language and images. Programs ‘play an instrumental role in changing social expectations surrounding FGM/C [female genital mutilation/cutting] because they provide men, and women, girls and boys with tools to deal critically with the reality surrounding them. Experiences confirm that human rights deliberations are more transformative if they challenge established gender relationships and existing assumptions and stereotypes’ (UNICEF 2010, p. 47).

Senegal: TOSTAN

The female genital mutilation/cutting (FGM/C) eradication program in Senegal began in 1997 when a US educator, Molly Melching, and a political theorist, Gerry Mackie, worked with a revered imam from a Senegalese village. The imam said that the only way to change deeply rooted traditions was to persuade villagers whose young people intermarried to abandon the practice simultaneously. This became the defining idea for TOSTAN, meaning ‘breakthrough’ in the Wolof language. Seventy-seven year old imam Mr Diawar visited the 10 intermarrying villages of his extended family. He won over the village chiefs and convinced imams that there was no religious requirement for cutting. He was tactful, never using the term ‘female genital mutilation’, but he did explain its consequences. The villages agreed to give up the tradition and in 1998, held what is believed to have been Africa’s first collective abandonment (Dugger 2011). The principles established in this process inspired Melching and Mackie to develop the TOSTAN strategy of intervention (UNICEF 2005; Diop & Askew 2009). They contended that, unlike rape or other forms of violence against women, FGM/C was a convention that parents followed out of love and care for their children, similar to the foot binding of Chinese girls over centuries. Eradication would require a collective commitment and pledge to stop the practice (Dugger 2011).

Village women engaged in dialogue about human rights and the harmful health consequences of FGM/C and began to conduct public discussions in their villages to extend and reinforce the goal of ending the practices. They used a non-formal, educational, integrated approach embracing national languages, life and sociopolitical skills, as well as innovative pedagogical approaches influenced by African traditions and local knowledge. The program built on positive traditional practices such as breastfeeding and challenged others such as FGM/C and forced marriage, and was underpinned by a strong human rights component. It was a fairly typical community development approach that involved village development committees, trained health facilitators and participants and used peer education and ‘adopt a friend’ approaches based on traditional ways of sharing. Women and men were involved. Diop and Askew (2009) evaluated the project using pre and post evaluation and a comparison group design. Overall, ‘the prevalence of FGM/C [female genital mutilation/cutting] among daughters aged ten years and younger decreased significantly over time as reported by women who were directly or indirectly exposed to the program’ (Diop & Askew 2009, p. 307).

The TOSTAN behaviour change model highlights the ‘cultural embeddedness’
Prevention programs

Sierra Leone, Uganda, Ghana, Ethiopia and Tanzania:
Alternatives to FGM/C ____________________________ /

Because female genital mutilation/cutting (FGM/C) is deeply rooted in culture and tradition as ‘a rite of passage for all virtuous women’, it needs to be replaced with an alternative rite of passage (Steele 1995, p. 135). An effective strategy is that of encouraging communities to find healthy alternatives to FGM/C without giving up its social and ritual aspects. Examples include the Kenema Project in Sierra Leone that worked with opinion leaders of the secret circumcision societies to educate them about the harmful effects of FGM/C and to encourage adolescents to go through the ceremonies without the harmful operations. This project encouraged young men to pledge that they would not insist on marrying only circumcised women and young women to pledge that they would not circumcise their daughters (Kiragu 1995).

Past prevention programs in Uganda involved girls in health and human rights education and discussion, from which they were able to make their own decisions about abandoning the FGM/C aspect of the rituals, with the support of the program. The practice was replaced with ‘Circumcision Through Words’, a coming of age ritual of celebration for girls (UNICEF 2010; Wellerstein 1999).

In Tanzania, women elders said they maintained their practice of cutting girls because they had no other form of income to support their extended families. Health Integrated Multisectoral Services (HIMS 2010) set up a cleansing ceremony to replace FGM/C. The Maasai elders gave up the tools that they had used to cut young women for many years and pledged to give up their trade of female circumcision. With the support of HIMS, they trained in other skills areas, such as beauty therapy and shopkeeping, so that they could continue to financially support their families. The ceremony took place in a public space to encourage the community to support the women in their choice to end the tradition (Miles 2012).

A project in Ghana worked to reduce opposition from practitioners by giving them alternative employment as traditional birth attendants. Another project in Ethiopia trains traditional circumcisers in sandal making and bread baking (Kiragu 1995).

of FGM/C and the consequent need for communities to make shifts in their cultural practices and beliefs to enable behavioural change. The TOSTAN village empowerment programs extended into other regions in Senegal and have been replicated in eight other African countries. The following factors were important to the successes of this work:

› A strong government position (legislative and policy)
› An integrated (education, dialogue, consciousness raising and health care), holistic (focus on women’s issues, not on a single health issue) approach at the local level focusing on both health and human rights
› Deliberate examination of traditional and cultural practices, reinforcing some (e.g. breastfeeding) and challenging others (e.g. FGM/C), and adopting traditional processes and ways of sharing information (e.g. stories, drama, ‘adopt a friend’)
› A broad community development approach, bringing villages together for sharing, awareness-raising and collective action
› Public declaration to abandon FGM/C, which was most significant and powerful (UNICEF 2010)
Egypt: A ‘positive deviance’ approach

The Centre for Development and Population Activities (CEDPA) identified that most programs in Egypt prior to 1999 had previously focused on the root causes of female genital mutilation/cutting (FGM/C). In contrast, a ‘positive deviance’ approach was initiated in 1999 to understand the factors that led to some families ceasing to have their daughters undergo FGM/C. CEDPA partnered with four key organisations and communities in Egypt, involving both women and men. It organised training for staff about FGM/C practices and their associated harm and conducted in-depth interviews to sensitively identify ‘positive deviants’. Positive deviants are individuals, ‘who have “deviated” from conventional societal expectations and explored – perhaps not openly – successful alternatives to cultural norms, beliefs, or perceptions in their communities’ (CEDPA 1999, p. 1). Their responses about how and why they had changed their opinions were analysed to discover how best to work with communities.

The research process described above enhanced awareness of FGM/C and led to open conversations where there was usually secrecy. The interviews revealed that the emotional and psychological trauma associated with FGM/C is the most influential factor leading to the rejection of the practice. By understanding the reasons why people resisted FGM/C, more effective ways of combating the practice in communities were able to be developed. The CEDPA project exceeded expectations and led to awareness-raising and education campaigns. Key community members in decision-making roles were targeted, including young men, doctors, religious leaders and elder women. The principle that ‘solutions already exist in the communities’ was emphasised. The project strengthened the relationship between the communities and non-government organisations to one of equal partnership and trust, respect and reciprocity, re-affirming principles of sustainability and ownership (CEDPA 1999).

In order to be open to ideas that challenge long-held beliefs and traditions, families want to be confident that the new information will benefit their communities, improve their lives and be widely accepted. The most successful programs in Africa engaged respected community members to promote change, including religious and local leaders, representatives of local women’s and youth associations and others, rather than bringing in outsiders to initiate discussions on FGM/C. When the information came from their own credible sources and there were opportunities to reflect, discuss and act, communities considered and were able to choose viable alternatives. Trust was built through community development projects that addressed local needs identified by the communities themselves. The introduction of health centres, education programs, microcredit schemes and other development projects provided communities with tangible, credible evidence that the new information and ideas could improve their lives (UNICEF 2010). Similar life improving responses to migrants’ needs for housing, work and acceptance in Australia evoke a similar sense of goodwill, creating a platform for change.
Examples of effective program responses in non-practising countries of settlement

Berg, Denison and Fretheim (2010) identified factors perpetuating female genital mutilation/cutting (FGM/C) in non-practising countries of settlement. The factors that promote FGM/C exist at multiple levels, namely intrapersonal (e.g. health consequences), interpersonal (e.g. the enhancement of male sexual enjoyment), meso (e.g. cultural tradition) and macro (e.g. religion or legislation). More information on these findings can be found in part one of A Tradition in Transition - female genital, mutilation/cutting. These dimensions need to be understood in their connectedness rather than as discrete aspects. The factors enabling discontinuance can be seen largely as a negated reflection of the factors supporting continuance, reinforcing the United Nations Children’s Fund Innocenti Research Centre’s statement that the ‘social dynamics that perpetuate FGM/C can also help to drive its abandonment’ (UNICEF 2010, p. 6). Johnsdotter and colleagues state that it is ‘highly significant that these traditional practices, once a sign of conformity to social norms, are viewed in the opposite light in the new cultural context’ (Johnsdotter et al. 2009, p. 117).

This section provides examples of FGM/C prevention programs in countries of settlement.

Sweden’s legal and social alert system

Johnsdotter and colleagues have been researching female genital mutilation/cutting (FGM/C) in Sweden since 2000. They have described the situation for migrants from Ethiopia and Eritrea who came to Sweden in the 1980s for labour reasons at a time of economic prosperity and, as such, were able to integrate into Swedish society quickly. The researchers confidently conclude that they abandoned FGM/C within a decade of arriving in Sweden (Johnsdotter et al. 2009). On the other hand, people from Somalia came later in the 1990s and 2000s, fleeing civil war and arriving in Sweden at a time of economic downturn and unemployment. This made their active participation and integration in Swedish society more difficult. Johnsdotter and colleagues do not have the same level of confidence that Somali Swedes have fully abandoned FGM/C, with the prevailing socio-economic conditions seen as the key explanatory factor (Johnsdotter et al. 2009).

The strength of Sweden’s effective prevention approach is its strong child protection response to FGM/C that includes:

- educational programs about FGM/C for community groups, including internal debate within exiled African communities and interaction with other exiled Muslims who do not practise FGM/C (e.g. people from Arabic countries), giving rise to debates on Islam and FGM/C
- several long running state prevention programs, including cooperative networks that involve authorities and other relevant agencies
- mass media campaigns to raise awareness of FGM/C, then to promote its abandonment
- a Child Protection Alert system that prohibits
  - all forms of FGM/C
  - performances of, participation in, facilitation of, attempts at, or procurement of FGM/C for another person or child
Prevention programs

» failure to report information about performed or future FGM/C
» gives citizens, teachers, children’s day care, health care and social services staff and police the duty to report knowledge of performed or suspicion of future FGM/C to social authorities who may report to police
» enables a genital medical examination by a physician of a child who is believed to have had FGM/C performed or where there is a suspicion of future FGM/C, even if the child’s parents object to it (Johnsdotter 2004).

The alert system has a strong emphasis on prevention and searching activities. Professionals are well informed about FGM/C and the laws against the practice and alert to signs that may indicate intention or that it has occurred. There are clear guidelines or routines for dealing with cases of suspected FGM/C in schools and through social authorities. The person suspecting FGM/C is not expected to investigate or ‘know for sure’ before reporting it to social authorities who make the decision when cases are reported. There are cooperative networks between police, social authorities, school staff and health and social services. Only two cases in Sweden have reached court, with people receiving custodial sentences (Johnsdotter 2009). Both cases involved similar negative impacts on prosecuted children’s families that occur in other legal systems that criminalise FGM/C (Johnsdotter 2004).

The UK: FORWARD and the African women’s clinics

FORWARD (Foundation for [African] Women’s Health Research and Development) is a UK registered African women-led charity that is dedicated to advancing and safeguarding the sexual and reproductive health and rights of African girls and women. The foundation works in the UK, Europe and Africa to help change practices and policies that affect access, dignity and wellbeing, focusing on female genital mutilation/cutting (FGM/C), child marriage and related rights of girls and young women (FORWARD 2012, p. 1).

Specific clinics in the UK offer empowerment programs for women from affected communities (Ball 2008; Dustin & Phillips 2008; Poldermans 2006). Culturally trained maternal and child health nurses and midwives develop trust, carry out de-infibulation procedures and refer women to gynaecologists where necessary. Midwives document the intact genitalia of newborn girls as grounds for legal proceedings if FGM/C is then suspected to have been performed. In Birmingham, midwifery and obstetric staff are informed and aware of cultural practices to watch for as warning signs that a child may be at risk. They engage the parent/s through discussion, education and support programs in order to protect those at-risk children (Ball 2008).

Criticisms of the British response included a lack of inclusion of the affected communities in discussions and decision-making and gaps in programmatic responses, including the lack of interagency cooperation and inadequate community education for relevant communities and professionals (Guine & Fuentes 2007).

FORWARD has built strong connections between research, aid and advocacy in FGM/C affected countries and awareness-raising, training and education of medical professionals in the UK.
A community-based research approach was used in the US in 2005 to assess the health care needs of Somali women living there. A participatory research network involved the Somali refugee community, health professionals, representatives from community-based organisations, refugee resettlement agencies and immigration law experts. The network explored migrant women’s traditional health beliefs to determine how sociocultural norms and values influenced their perception of health. They examined the role of acculturation in influencing adaptation to health-related cultural norms upon migration to a non-practising context. They considered the interplay of host country’s cultural norms with migrants’ previous experiences with health care providers, with an emphasis on health beliefs, health-seeking behaviours, health care utilisation, motivation to follow-up with ongoing care and willingness to participate in research studies (Johnson, Ali & Shipp 2009). The partnership involved the Somali community in all stages of the process. Educational focus groups and interviews were conducted in women’s homes using an illustrated anatomical guide to female anatomy. A sense of privacy and security created an atmosphere where ‘women felt comfortable and unabashed in viewing the diagrams and asking intimate questions’. The inclusive study led to improved, culturally competent health care (Johnson, Ali & Shipp 2009, p. 235).

Daniel and colleagues (2011) described the activities and outcomes of a community-based education program addressing female genital mutilation/cutting (FGM/C) with newly arrived refugee and migrant African women in Winnipeg, Canada. Participants had, on average, been living in Winnipeg for nine months. The program comprised ten weeks of educational, health and sociocultural support sessions to discuss, compare and share stories about models of health care, reproductive health, gender analysis, culture, values, sexuality laws, marriage and intimacy in Africa and Canada.

The project team developed a manual of materials designed for services to use with migrant and refugee women in relation to sexual and reproductive health and FGM/C information and prevention. Community-based researchers, including men and youth from practising communities, were trained in community-based education and facilitation. They ran three hour workshops for service providers on FGM/C, constantly reviewing and updating the content and processes, and a FORWARD funded symposium on FGM/C.
not to circumcise daughters was easier’ (Daniel et al. 2011, p. 28). The qualitative feedback from the refugee women conveys rich information about how change occurs. For example:

‘Back home - they want change but don’t educate women. Here (Winnipeg) we’re talking and learning about it. We go home and tell our family and friends … this is how the change happens’ (cited in Daniel et al. 2011, p. 27).

This program appears well resourced and transferrable to the Australian context.

Ahlberg and colleagues (2004) argued that Swedish anti-FGM/C interventions should take greater heed of the values, meanings, organisation and contexts of FGM/C, including the dynamics within which migrants negotiate their identities. For example, one of the dilemmas Somali migrants in Sweden identified was their fear of bringing up an uncircumcised daughter in the context of the sexually liberal mores of Sweden. Honouring the community’s moral imperatives that underpin the practices of FGM/C is important in engaging practising communities in change (Ahlberg et al. 2004).

Since 1997, the New South Wales Education Program on Female Genital Mutilation (NSW EPFGM 2012) has been addressing the eradication of female genital mutilation/cutting (FGM/C) through an integrated community engagement approach. It incorporates legislative (Crimes (Female Genital Mutilation) Amendment Act 1994), educational, health and human and child rights. With funding from the federal government and the NSW Department of Health, the NSW EPFGM is a statewide program under the auspices of Sydney West Health Service. FGM/C is specifically identified as child abuse under the NSW Children and Young Persons (Care and Protection) Act 1998.

The program has a strong educational approach targeted at service providers and communities at risk. Four staff (2.5 full time positions) work with 14 contracted bi-lingual community workers, a Program Advisory Group and a Men’s Advisory Group to provide professional education for service providers on the effects of FGM/C on women’s health and on culturally appropriate services for affected women. The program provides education sessions to raise awareness of general health issues where specific information is provided on the local and global occurrence of FGM/C. Programs held around the state are facilitated by bi-lingual community workers with shared cultural and language backgrounds. The program aims to respect cultural diversity and create safe community spaces for women to discuss and explore the harm of FGM/C to women and girls. It also celebrates events such as Children’s Rights Days, holds men’s seminars, conferences, forums and camps, and in the global context, contributes to national and international advocacy work (NSW EPFGM 2012).

The NSW EPFGM is evaluated through a research partnership with Diversity Health Institute, a collaborative group of state and federally funded programs that focuses on people from culturally and linguistically diverse backgrounds (NSW EPFGM 2012). Data from the Australian Bureau of Statistics (ABS) and the Department of Immigration and Citizenship (DIAC) inform their target groups and comprehensive strategic plan and their annual report specifies and reports on targets and key performance indicators. Detailed evaluations of these programs and events are available on their website (NSW EPFGM 2012).
The Office of the Child Safety Commissioner (OCSC) established a Working Group in October 2007 ‘to facilitate intervention to prevent the occurrence of FGM [female genital mutilation] in children and ensure access to appropriate health care where required’ (OCSC 2008). With representation across government and from community groups, including the Department of Human Services, Centre for African-Australian Women’s Issues, Victoria Police, the Department of Education and Early Childhood Development, the Association of Independent Schools and CASA (Centres Against Sexual Assault) Forum, the group is well placed to work towards a coordinated response to female genital mutilation/cutting (FGM/C). The current status of this group is unclear. One of its 2007 goals was to seek clarification from the Department of Immigration and Citizenship (DIAC) regarding the information on FGM/C that migrants receive before arrival and upon settlement in Australia (OCSC 2008).

Their report, In our own words: African Australians report (OCSC 2010), indicated that community members want information on the child protection system, the Children’s Court, family law processes and Centrelink payment procedures, the role of the OCSC and the Working with Children Check, management of family violence, educational policies for children attending school and policies about racial discrimination. Members of African communities believe that workers could benefit from an improved understanding of African collectivist cultures and traditional child rearing practices in areas such as gender roles, views about sex before marriage and supervision of children (OCSC 2010).

The Family and Reproductive Rights Education Program (FARREP) has been involved in raising awareness to prevent female genital mutilation/cutting (FGM/C) since 1997 (Neophytou & Adam 2011; Adam et al. 1994). Workers facilitate aspects of the approaches that appear to be effective elsewhere and have sound views about effective ways forward.

‘We need a strategy or program to support parents, support people from affected communities which has nothing to do with the word FGM [female genital mutilation]. Legislation has forbidden FGM, in doing so something has been taken away from people who are traditional practice FGM. We need to recognize they are going through some difficulties there, broaden support for parenting issues, support to empower people to practise their culture as long as it is not harmful; perhaps some community funding to assist them [to] address health issues’ (FARREP worker 2010).

Formal partnerships with the Department of Immigration and Citizenship (DIAC), Red Cross, refugee and migrants’ rights advocates and settlement services create opportunities for experienced workers to raise awareness of Australian legal, general and maternal and child health, education and social systems, as well as FGM/C, through discussion and debate with communities as they arrive.
Effective programs use a ‘whole of community’ approach, working with women-only or men-only groups as required by the community’s culture or the personal and sensitive nature of discussions. Engaging boys, men and community leaders, male and female, breaks the myth that female genital mutilation/cutting (FGM/C) and its eradication is only ‘women’s business’. It enlists men as allies rather than spectators in the stance against FGM/C and addresses the fact that pressure for continuing FGM/C is likely to come from men as well as women. There is a need for discussion and debates between African Muslims and non-African Muslims whose interpretations of Islam differ in relation to FGM/C.

Timing of programs is significant, with arguments for both early and later intervention. The research of Johnsdotter and colleagues (2009) demonstrated that in Sweden, new arrivals, older generations and people less acculturated are more likely to hold on to traditional views. Over time, with opportunities for integration, migrants feel less social pressure from their extended family and community because of the distance from home. They begin to perceive themselves as belonging to a new society where girls do not undergo FGM/C. At that time, migrants can question traditional practices in light of their new cultural context (Johnsdotter et al. 2009). This perspective promotes an approach that waits until people have settled and are not in the early crisis of post refugee flight and struggles. The programs of Daniel and colleagues (2011) in Canada, on the other hand, engage new arrivals from FGM/C practising countries in education and awareness within their first year of living in their new country, assisting them with settlement and integration processes. Both programs are successful in the connections made between FGM/C education and awareness and community participation and settlement.

Community participation is an important aspect in mobilising prevention in countries of settlement, where key figures from affected communities play important roles facilitating dialogue between all parties concerned. Migrants who hold prestigious positions in their communities of origin and pay remittances to family members in their home communities may wield considerable influence (Hussein & Manthorpe 2012). Change is likely to be greater in scale and endure over time when influential people are part of the growing social consensus (UNICEF 2010).
Summary and discussion

With 7,000 women and girls worldwide subjected to female genital mutilation/cutting (FGM/C) each day, there is an urgent need to maximise opportunities for change to stop the practice when migrants and refugees come to non-practising countries. This research has reported efforts in Africa and countries of settlement in order to find effective program responses that may be transferrable to the Victorian and Australian context.

The World Health Organization (WHO), the United Nations Children’s Fund (UNICEF) and other international researchers use the social convention theory to explain the processes of abandoning FGM/C in Africa. The social convention theory says that when enough people in a community commit to a new set of beliefs and practices, the balance of beliefs tips towards the new norms, replacing the old ways. Once there are sufficient numbers, a community pledge is a significant step in a community’s decision not to have their daughters undergo FGM/C. There is strong evidence of abandonment of FGM/C practices in some parts of Africa, although it continues elsewhere in the continent.

Migrants arriving from FGM/C affected countries are likely to be influenced by the values of the new community. Traditional leaders, imams and influential activist women and men who have changed their views and practices are well placed to facilitate dialogue with new arrivals who may never have discussed the practice before. This includes men, who can benefit from being informed of the legal and financial costs and consequences of participating in any way in the practice of FGM/C in Australia.

The main strategies for eradication are health education and promotion, legal and human rights, including women’s and children’s rights, and culturally sensitive community engagement and research with cross-sectorial links between systems.

Legislation is an essential aspect, as it provides disincentives, sanctions and penalties. However, on its own, legislation does not stop FGM/C and can send the practice underground if introduced without other strategies.

FGM/C is a child protection issue that warrants a public health response. Australia’s legal, medical and welfare systems are robust and, with increased awareness of FGM/C practices, trends, indicators and effective prevention approaches, health, legal and welfare professionals are well placed to work in collaboration with newly arrived and settled communities in their efforts to stop the practice.

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A tradition in transition: Female genital mutilation/cutting
Demographic data online

Demographic data online at www.fpvc.org.au/fgmc