Literature Review

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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, Sierre Leone, Djibouti, Mali, Sudan and Eritrea (WHO 2008).

Ethnic and regional differences

The World Health Organization (WHO) prevalence figures for female genital mutilation/cutting (FGM/C) obscure ethnic and regional differences, including those within and those transcending national boundaries. Ethnic and regional social and cultural norms have been found to have the most determining influence in explaining the incidence of the practice (UNICEF 2005).

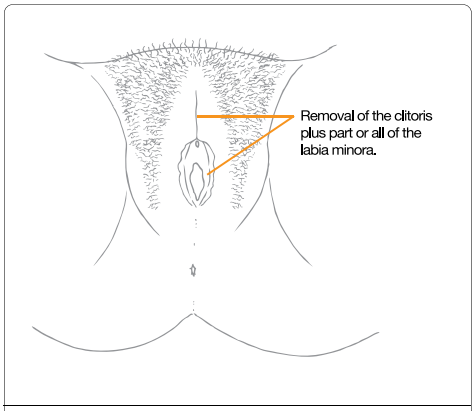
A second group of countries has been identified, where prevalence rates have been estimated at intermediate levels of 25% to 79% (UNICEF 2005, p. 5). This includes Ethiopia, Kenya and Liberia. Only certain ethnic groups within these countries practise FGM/C, with intensities varying according to ethnicity and tribal practices. In Ethiopia, for example, the overall prevalence rate is 74%, but for the ethnic Somali in Ethiopia, it is almost 100% (43% Gambela and 34% Tigrayans). Regionally, prevalence is very high in the east of Ethiopia, where the ethnic Somalis mostly reside, and relatively low in the north-west. Similarly, while the overall prevalence rate is 32% in Kenya, which provides refuge for people from neighbouring countries, there are significant variations according to ethnic differences, with the Somali at 97%, the Kisii at 96% and the Maasai at 93%, compared with the Kikuyu at 34%. Regionally, the prevalence is 99% in the north-east and 4% in the west, again reflecting the diversity of ethnic and tribal groups (UNICEF 2005, p. 5).

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).

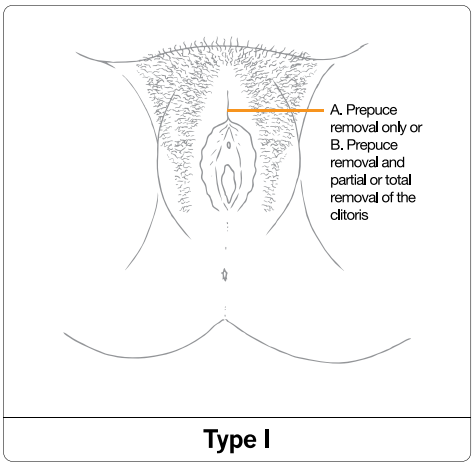
Types of female genital mutilation/cutting

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.



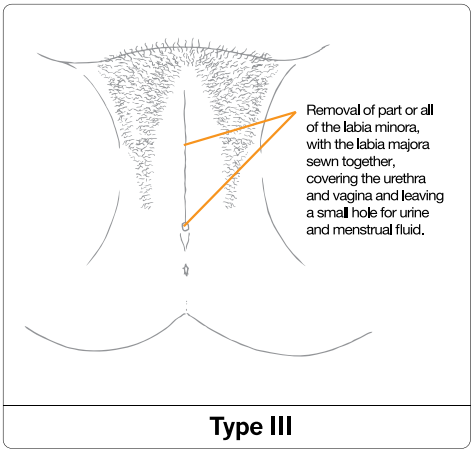
Type II

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 I

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 III

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,

haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue (WHO 2011).

African and international researchers from Australian National University's National Centre for Epidemiology and Population Health undertook a large study into the deleterious effects of FGM/C on the birth outcomes for 28,393 mothers and their babies in Burkina Faso, Ghana, Kenya, Nigeria, Senegal and Sudan. The study established a correlation between women who had undergone FGM/C and significantly higher likelihood of difficulties during childbirth and infant mortality (Banks 2006).

An earlier, smaller study in Melbourne found similar outcomes. Knight and colleagues (1999) interviewed 51 women (average age of 25 years) from Somalia, Ethiopia, Eritrea and Djibouti who had a history of FGM/C and had attended hospital for antenatal or gynaecological care. Of these women, 77.6% had undergone infibulation and 29.4% requested surgery to facilitate intercourse. More than 85% of the women in the study reported complications such as dyspareunia, apareunia and urinary tract infections. The procedures had been conducted in Africa when they were at an average age of 6 years, with a range of 1-14 years, mainly by respected, older, traditional midwives from their villages (60.8%) or by doctors (39.2%). In 51% of cases, no anaesthetic was used. The study found that the types of FGM/C differed according to the country of origin. Procedures such as clitoridectomy and excision of the labia minora were more common in women from Ethiopia, with infibulation more common in Somalia (Knight et al. 1999).

These and other studies demonstrate that the long-term consequences of FGM/C can include recurrent bladder and urinary tract infections, cysts, infertility, reduced sexual pleasure, an increased risk of childbirth complications and newborn deaths and the need for later surgeries (e.g. to be cut open to allow for sexual intercourse and childbirth and, in some cases, re-stitched and re-opened several times, further increasing both immediate and long-term risks) (WHO 2011).

In addition, FGM/C is associated with psychological and psychosomatic disorders such as disturbances in mood, cognition and sleep patterns in girls, which can extend into womanhood with a loss of self-esteem, depression, chronic anxiety, panic attacks, psychotic disorders, sexual dysfunction and reduced sexual sensitivity (Patrick 2001).

The level of harm from FGM/C varies according to the extent and severity of the type of procedure undertaken, the level of hygiene, and community expectations (Banks 2006; Knight et al. 1999).

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.

Cultural and social bases of female genital mutilation/cutting

Female genital mutilation/cutting (FGM/C) is deeply entrenched in cultural and societal meanings and beliefs that relate to gender, sexuality, marriage and family and

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 the specific needs of these women.

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).

The 1993 United Nations (UN) Conference on Human Rights, declared FGM/C a violation of human rights. The 1994 UN Conference on Population and Development in Cairo urged governments 'to prohibit FGM [female genital mutilation] wherever it exists and to give vigorous support to the efforts among non-government and community organisations and religious institutions to eliminate such practices' (UNICEF 2010, p. 241).

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’

(cited in Johnsdotter et al. 2009, p. 123).

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’

(cited in Johnsdotter 2004, p. 38).

The above considerations indicate that criminal laws prohibiting FGM/C are an important back drop 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.

Examples

Sweden

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) focused on the perspectives on FGM/C of women and men from Ethiopia and Eritrea living in Sweden. With the exception of two men, all 33 informants strongly rejected FGM/C. The vast majority declared that their own girls had not undergone the practice.

> 'My children are Swedes and will grow up exactly like Swedes. It's not just the language, but the whole way of thinking that has to be adjusted to the society you live in'

(Man from Eritrea, cited in Johnsdotter et al. 2009, p. 122).

> 'We are two different generations, you know … They are Swedish. Us parents are neither Swedish or Eritrean, you know … We are sort of stuck between'

(Woman from Eritrea, cited in Johnsdotter et al. 2009, p. 128).

Johnsdotter and colleagues 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'

(Man from Eritrea, cited in Johnsdotter et al. 2009, p. 126).

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'

(Woman now opposed to FGM/C, cited in Johnsdotter et al. 2009, p. 126).

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

(Woman in group interview, cited in Johnsdotter et al. 2009, p. 126).

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 …'

(Woman from Eritrea, cited in Johnsdotter et al. 2009, p. 121).

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).

The UK

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; Ohuntoye 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'

(PEER researcher, cited in Norman et al. 2009, p. 51).

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'

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

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'

(PEER researcher, cited in Norman et al. 2009, p. 32).

'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 …'

(PEER researcher, cited in Norman et al. 2009, p. 32).

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).

Australia

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 Ohuntoye 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).

These themes, as reported by women, men and health workers, are summarised in Table 3 below (Berg, Denison & Fretheim 2010, p. 37). The factors in parentheses are those that the stakeholders indirectly expressed as promoting or hindering FGM/C.

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 3: 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

Source: Berg, Denison and Fretheim 2010

Women	Men	Health workers
Factors promoting FGM/C		
» Religion » Tradition » Marriageability » Sexual morals » Health benefits » Perceived male preference » Aesthetics » Perceived social pressure » (Positive feeling about own FGM/C) » (Intention to continue practice) » (Think practice should continue) » (Believe it is important) » (Don't know the health implications)	» Want circumcised wife » Intention to continue practice » Think practice should continue	» Tradition » Religion » Hygiene » (Willing to perform FGM/C) » (Believe should not engage) » (Believe should encourage) » (Believe should respect practice)
Factors hindering FGM/C		
» Negative health issues » Negative personal experiences » Illegal » There's no need to do it » Not religious requirement » It's not natural » Husband is against it » (Disapprove of practice) » (Don't think uncut women are promiscuous) » (Positive expectations regarding not performing FGM/C on daughters)	» Think practice should stop » Not religious requirement » Don't think uncut women are promiscuous	» Negative health issues » Oppose the practice » Believe it is violence » Believe it is violation of human rights » Believe should educate/ report

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 'fulfill 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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