In the Best Interests of the Child: Preventing Female Genital Cutting (FGC)

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Abstract

Female Genital Cutting (FGC), the practice of cutting, sewing and altering the genitals of girl children, is a significant global human rights issue, with two to three million girls subjected to it annually. Prevalence is concentrated in twenty-seven northern African countries and Yemen, and, with migration, it is also present in Western countries. It is a highly emotionally charged and contested issue. Globally, activists and communities, including those within practising countries, argue that it causes severe and irreparable harm to girls and women. It is understood as abuse and a violation of the ‘best interests of the child’. Yet, within practising communities, FGC is generally believed to be ‘in the best interests of the [girl] child’. The writers contend that social workers, child welfare and health professionals in Western countries should be equipped to assist residents from practising communities to recognise the harm, change attitudes and practices, and together ensure the protection of their girls from this form of abuse. Drawing on international literature, this article addresses FGC prevalence and harm, its cultural and social bases and effective prevention strategies internationally, together with strategies for practitioners to harness communities’ commitment to their children’s best interests by abandoning FGC.

Keywords: Female genital cutting, female genital mutilation, circumcision, FGM/C prevention

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Introduction

Despite several decades of efforts to eradicate Female Genital Cutting (FGC), 7,000 young women and girls worldwide are subjected each day to FGC, the practices of cutting, sewing and altering the genitals of girl children (UNICEF, 2005). There is no evidence of any health benefits from FGC. Rather, it can cause irreparable physical harm and all types invade a child’s body without their informed consent, potentially causing psychological harm. Harm can occur at the time of surgery and throughout the lives of girls and women, causing recurrent bladder and urinary tract infections, reduced sexual pleasure and interference with bodily functions. In aseptic conditions, often without anaesthetics, girls can suffer extreme pain, shock, haemorrhage, tetanus, sepsis and open sores (Banks, 2006; Knight et al., 1999). Some women suffer psychological and psychosomatic disorders such as sleep, mood and cognition changes, depression, chronic anxiety and panic attacks (WHO, 2011; Banks, 2006). Infibulated women require surgery to allow for sexual intercourse or childbirth, and face significantly more difficulties in childbirth, and higher rates of infant mortality and infertility (Banks, 2006; Knight et al., 1999). Even milder forms of FGC such as ‘nicking or pricking’ an infant girl’s clitoris (Merli, 2010) are still an unconsented invasion of a child’s body with unknown psychological and emotional impacts. FGC violates the health, well-being and ‘fundamental human rights’ of women and girls (WHO, 2008, p. 9).

Implications for social workers

The International Federation of Social Workers commits social workers to promote human rights, including ‘the elimination of all forms of gender-specific discrimination and violence’ (IFSW, 2012). Despite important debates about ethical tensions between respect for cultural diversity and individual human rights (Burson, 2007), FGC is clearly a form of discrimination against a vulnerable group—girl children—and it is illegal and identified as a child protection risk in many countries (Dustin and Davies 2007). However, FGC has been identified as a ‘blind spot’ for social workers and child protection workers (Kriz and Skivenes, 2010). From our experiences as practitioners in community, family and child protection social work, we believe FGC is often overlooked in social work curricula and child protection training. Reasons given for this include its comparatively low prevalence, the lack of FGC knowledge and skills, and misconceptions about culture and racism (Guine and Fuentes, 2007). There is little research on the role of social work in relation to FGC or how lessons from FGC prevention programmes in African countries can be applied in countries of migration. This article breaks new ground in addressing these issues. We argue that social workers...
and health and welfare professionals have responsibilities in three response areas: to protect girls from being cut; to advocate for services for affected women that address the physical, psychological, identity and cultural consequences of FGC; and to engage with practising communities in processes to stop the practice. To fulfil these responsibilities, social workers need to become informed in four areas: FGC practices, prevalence and harms; the cultural complexities and social bases of cutting girl children; effective international prevention strategies and programmes; and culturally respectful strategies to engage sensitively with children considered at risk of being cut, women who have been cut and their communities. We recommend that this issue be included in social work curriculum and continuing professional development as has occurred effectively for obstetricians and gynaecologists in Australia and New Zealand (Moeed and Grover, 2012). These four knowledge areas are described next, drawing on international and local knowledge.

FGC practices, prevalence and harms

Female Genital Mutilation (FGM) is the term used by the World Health Organisation (WHO) to describe ‘all procedures involving the partial or total removal of the external genitalia or other injury to the female genital organs for non-medical reasons’ (WHO, 2008 p. 1). WHO categorises it into four broad types:

- Type I: The partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
- Type II: The partial or total removal of the clitoris and the labia minora, with or without the excision of the labia majora (excision).
- Type III: The cutting of the labia minora and/or labia majora, with or without the excision of the clitoris, and sewing the cut labia to close the vaginal opening to a small hole sufficient to pass urine and menstrual blood (infibulation).
- Type IV: All other harmful procedures to the female genitalia for non-medical purposes, such as pricking, piercing, incising, scraping, cauterising.

FGM is the term used in UN documents and conventions, and in legislation in many countries, as a form of ‘condemnatory advocacy’ (Shell-Duncan, 2008, p. 20). It is a contested term, especially by women from FGC-practising communities. They do not see themselves as ‘mutilated’ and find the term offensive, alienating, disempowering and racist (Khaja et al., 2009). In their eyes, FGC is linked to beautification and female identity. This was well expressed in the course of our research into FGC by one of a team of African-background workers engaged in raising awareness of the harms and illegality of FGC in Victoria, Australia:
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 (Family and Reproductive Rights Education Program meeting, 2010).

The terms used in practising communities are ‘Female Circumcision’ and ‘Female Genital Cutting’, or expressions that convey that meaning. We have chosen to use FGC in this article.

FGC is usually carried out on girls between infancy and puberty, most often between the ages of four and eleven years (WHO, 2008). The global prevalence of FGC, shown in Table 1, is concentrated in twenty-seven countries in northern Africa and Yemen, and within particular ethnic groups and regions in the Middle East and Asia. The prevalence rate is estimated from data gathered in National Demographic and Health Surveys and Multiple Index Cluster Surveys based on the percentage of girls and women between fifteen and forty-nine years of age who report that they have been cut when asked by researchers (WHO, 2008, 2011). The figures represent national averages and do not identify variations within countries or particular regions or ethnic groups.

Through migration and refugee flight, FGC is practised to some extent in a number of Western countries. Because of its private nature, cultural taboos and illegality, the scope and exact nature of prevalence are difficult to determine. In some countries such as Australia, Norway, Sweden and the UK, researchers have tried to estimate the risk to girls of FGC using extrapolations based on numbers of migrants from FGC-practising countries, and prevalence in those countries (Dorkenoo et al., 2007; Johnsdotter et al., 2009). Johnsdotter and colleagues warn of the potential for these extrapolations to be exaggerated and stigmatising, so practitioners should use these statistics only as a starting point to indicate where there may be children at risk of FGC and women requiring sensitively informed and respectful services.

Cultural, religious and gendered bases of FGC

To work effectively with these children, women and communities, practitioners need to understand the socio-cultural contexts of the countries of origin. FGC has occurred for nearly 2,500 years, and infibulation, FGC in the most radical form, has been traced to ancient Egypt (Slack, 1988). Where it is practised, FGC is deeply entrenched in cultural values relating to gender, identity, beautification and inclusion. It is intertwined with ‘family honour, virginity, chastity, purity, marriageability and child bearing virtues’ for girls and women (Mudege et al., 2012, p. 243). The particular
<table>
<thead>
<tr>
<th>Categories</th>
<th>Prevalence and Definition</th>
<th>Countries (with laws against FGC)</th>
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</thead>
<tbody>
<tr>
<td>1. Very high, almost universal FGC</td>
<td>75.1% and over and 30% Type III</td>
<td>Djibouti, Egypt, Eritrea, Gambia, Guinea, Mali, Sierra Leone, Somalia, Sudan (north)</td>
</tr>
<tr>
<td>2. High prevalence FGC</td>
<td>Between 50.1–75% and predominantly Types I and II</td>
<td>Burkina Faso, Ethiopia, Mauritania</td>
</tr>
<tr>
<td>3. Medium prevalence FGC</td>
<td>Between 25.1–74% and predominantly Types I and II</td>
<td>Central African Republic, Chad, Cote D’Ivoire, Guinea Bissau, Kenya, Liberia, Senegal</td>
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<tr>
<td>4. Low prevalence FGC</td>
<td>Between 25–10% and predominantly Types I and II</td>
<td>Benin, Nigeria, United Republic of Tanzania</td>
</tr>
<tr>
<td>5. Very low prevalence</td>
<td>Below 10%</td>
<td>Cameroon, Ghana, Niger, Togo, Uganda, Yemen</td>
</tr>
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and specific meanings, beliefs, myths and their associated practices vary between regions, localities and ethnic groups. They are so deeply entrenched that FGC is considered a normal and necessary aspect of raising a girl properly (Innocenti, 2005).

The motivation for FGC is not malice or violence, as outsiders might assume. Parents decide to subject their daughters to FGC in the belief that it is in their daughters’ best interests and that the benefits outweigh the risks. The Best Interests of the Child Principles articulated in the Convention on the Rights of the Child, whilst particularly applicable to policy and law makers, have implications for families:

> The best interests of children must be the primary concern in making decisions that may affect them. All adults should do what is best for children. When adults make decisions, they should think about how their decisions will affect children (UNICEF, 2013, p. 1).

In practising countries, FGC can be seen as the only pathway to economic and social security for women, such that girls themselves want to be cut (Innocenti, 2010). The drive to belong and conform is powerful. An African-background woman in Melbourne, Australia, told how, as a child in Africa, she defied her parents’ refusal to have her circumcised by sneaking off to the traditional circumciser so that she was the same as her eight-year-old girlfriends. Breaking the convention exposes girls and families to serious repercussions including exclusion and possible violence from their communities, and it is very difficult for an individual or family alone to challenge FGC.

Adherence to religious practices is one of the most frequently given reasons for FGC (Berg et al., 2010). Yet FGC is not sanctioned formally by any religion or sacred text (WHO, 2008). It pre-dates Christianity and Islam, and transcends religious boundaries, with estimations that nearly 60 per cent of women affected in African countries are Muslim, 40 per cent are Christian and a small number are Jewish or practising traditional beliefs (Caldwell et al., 2000). Some religious leaders do support, even demand, the continuance of FGC in their communities, while others reject it and participate actively in its prevention (WHO, 2008, p. 6). Innocenti (2010) and Caldwell et al. (2000) suggest the incorrect association of religion and FGC occurs because religion, tradition and culture are so intertwined. Exposing the myth that FGC has its basis in religion is an important aspect of prevention and change.

FGC violates women’s rights and manifests deeply rooted discriminatory gender inequalities. It can be understood as the unquestioned continuation of traditional patriarchal cultural practices to curb and control women’s sexual behaviours. Hosken (1982, p. 4), who coined the term ‘FGM’, described it as ‘male violence . . . used to assert absolute male domination over women’. Somewhat paradoxically, women do the cutting and sustain the practice in many ways, including decision making. Men also are complicit in its perpetuation. Both women and men have important roles in eradicating FGC.
What can be learnt from international FGC prevention strategies?

After several decades of prevention efforts, there are indications that FGC is declining in parts of some African countries. One of the hopeful signs is that relatively fewer younger women are reporting being cut (WHO, 2011), indicating a trend away from the practice. Overall, though, prevalence remains high, and the challenge to eradicate FGC remains urgent. The three main strategies for eradication are legislative responses, health and human rights education, and community empowerment. These are discussed in turn, in relation to African and migration countries and the roles social workers can play in working with communities to prevent the practice.

**Legislative responses**

FGC was publically declared a violation of human rights in 1993 (Innocenti, 2005). Ten years later, at the UN World Conference on Human Rights twenty-eight African states committed to prohibit all forms of FGM through legislative measures and supportive sanctions (Maputo Protocol, 2003). In December 2012, the UN General assembly banned FGC and made a commitment to intensify global efforts to end it (United Nations, 2012). Such conventions and legislation are, however, only as effective as their implementation. Sudan, for example, was a signatory to the Maputo Protocol, yet there are still no laws against performing FGC (USDS, 2012) and North Sudan remains one of the highest FGC prevalence countries. Eighteen African nations have legislation against FGC (see Table 1), as do eighteen Western countries of migration (Leye et al., 2007).

The role of legislation and legal interventions in deterring FGC is not straightforward. FGC is difficult to detect because of its private, taboo nature, and types I, II and IV cannot always be detected through observation, particularly in young girls. The process of monitoring selected girls’ genitalia is intrusive and racist (Johnsdotter, 2009). Prohibition risks increased secrecy with families delaying FGC until girls pass the age of surveillance (Poldermans, 2006). Prosecution can penalise women who are themselves victims of FGC and divide families (Ierodiaconou, 1996). Criminal processes and imprisonment of parents have negative consequences for the child, family and communities concerned, including stigmatising and marginalising women and girls (Ierodiaconou, 1996). Despite these concerns, many migrants in affected communities appreciate the existence of laws (Johnsdotter et al., 2009; Daniel et al., 2009). ‘Many girls must have suffered before the law came. It should have come a little earlier and have been more severe,’ said a woman in Sweden (Johnsdotter et al., 2009, p. 123).

France and the UK host the largest migrant communities from FGC-practising countries. France uses its highest criminal court to penalise families and practitioners when community education and preventive
campaigns fail (Guine and Fuentes, 2007). Between 1979 and 2006, forty cases involving 120 children were prosecuted, with sentences including fines or ten to fifteen years in prison. Parents, mainly mothers, were charged, and given prison sentences (which were mainly suspended) for subjecting their daughters to the practice (Leye et al., 2007). There is some indication that trials have been a deterrent, contributing to a declining incidence of FGC in France (Guine and Fuentes, 2007). The ensuing publicity and awareness raising are arguably the greater function.

In contrast, in the UK, prosecution is the last resort after social services’ responses have been exhausted. Specific African Women’s Clinics train maternal and child health nurses, midwives and obstetric staff to carry out de-infibulation procedures, refer women to gynaecologists, and be aware of warning signs indicating children who may be at risk (Ball, 2008). The intention is to educate parents and prosecute doctors and traditional circumcisers in order to prevent FGC surgery (Guine and Fuentes, 2007). By 2008, there had been no prosecutions of parents and only two physicians had been expelled from the medical council (Dustin and Phillips, 2008).

The Swedish system combines preventive education with well-integrated child protection surveillance and legal intervention. Professionals are well educated about FGC and laws, alert to signs that may indicate intention or occurrence, and know the processes for reporting. The child protection system operates in conjunction with community education and debate about FGC amongst practising migrant groups. Mass media campaigns raise awareness and promote abandonment of the practice (Johnsdotter, 2004). Only two cases in Sweden have resulted in custodial sentences, both of which were associated with other issues of risk (Johnsdotter et al., 2009).

Australia has strong and clear prohibitions against FGC in legislation and medical policy. All states and territories have laws making it illegal for anyone to perform or procure any type of FGC, take a child out of the country for that purpose or re-infibulate a woman even if she requests it (Dreyfus, 2013). Moeed and Grover’s 2012 survey of obstetricians and gynaecologists in Australia and New Zealand found no conclusive evidence of FGC being performed by medical practitioners. There have been few prosecutions overall, but, as in other countries of migration, anecdotal evidence suggests that FGC is still being performed either in Australia or New Zealand or on return to countries of origin. In 2012, four parents, a Sheik and a nurse were reportedly charged with procuring FGC for three girls aged one, six and seven (Bibby, 2012; AAP, 2012).

In summary, while there is some evidence of deterrence of FGC through well-publicised and implemented laws and prosecutions, the most effective aspect of legislation is to convey its unacceptability. Combined with an alert child protection response, legislation sends a strong public message that girls are entitled to protection. Social workers need to be aware of the complexities associated with implementation of laws and prohibition, and
work in ways that minimise potential harms whilst ensuring the wholistic safety of girl children and women.

**Education and health promotion**

Community education and empowerment should accompany legal responses to FGC. Education about the harms, laws and consequences of FGC has been a key strategy in the prevention of FGC for decades and much has been learnt about what is effective. In the African context, health education on its own has been found to have limited impact on reducing prevalence, though it has led to improved hygiene (UNICEF, 2005). Evaluations of preventive programmes indicate that broad social media health promotion must be accompanied by local culturally based empowerment approaches to education. We address this further in the following section.

In countries of migration, such as France (Guine and Fuentes, 2007), whilst educative public media campaigns have been effective in communicating the legal repercussions of performing or arranging FGC, they can also have negative impacts on affected communities causing shame and embarrassment through public discussion of women’s genitalia, blurring different practices and people, inciting racist responses from the public (Johnsdotter et al., 2009; Allotey et al., 2001) and creating barriers to affected women and children seeking medical care even for unrelated matters (Ierodiaconou, 1996). Awareness-raising strategies can be sensationalised, ‘insensitive and inaccurate’, depicting only the most severe form of female circumcision—in-fibulation (Khaja et al., 2009, p. 735)—and failing to address its complexity.

The most effective health education programmes in African and migration countries provide broad education about sexual and reproductive health, gender, culture, values, sexuality, marriage and intimacy, human rights, women and children’s rights and the laws that protect them (Daniel et al., 2011; Innocenti, 2010). Education can transform beliefs and attitudes when it is participatory and includes dialogue and debate. One newly arrived migrant to Canada remarked:

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

**Community and cultural engagement**

Research about FGC prevention approaches in both African and Western contexts indicates that community engagement, empowerment and support are key factors in creating leverage for the abandonment of FGC.

In Africa in 1991, the NGO Tostan (meaning ‘breakthrough’ in Wolof) began a significant community education programme (CEP) in Senegal which has now expanded into many other countries. It begins with the
selection and training of facilitators with high social status and knowledge of the community’s cultural traditions—‘cultural mediators’ (Al-Krenawi and Graham, 2001, p. 665). They in turn work with men and women in the community delivering education on human rights, literacy and mathematics, using traditional ways of sharing information such as storytelling, drama and friendship. The curriculum includes women’s health and hygiene, leadership, management, problem solving and negotiating skills. Discussions challenge culturally based gender relations and harmful traditional practices such as FGC and early marriage, and reinforce positive practices such as breastfeeding (Wardlaw and Landgren, 2008; Tostan, 2013). Central to the CEP is the formation of Community Management Committees, trained to implement community-initiated income generation and empowerment projects (Tostan, 2013).

Following the first Tostan CEP, the community decided with their new knowledge and skills that they no longer wanted their daughters circumcised. They approached village leaders to engage the entire community in stopping the practice and to make that declaration public. With credible sources of information and opportunities to reflect, discuss and make decisions together, communities developed alternatives to FGC such as ‘Circumcision Through Words’ (Innocenti, 2010); young men pledged they would not insist on marrying circumcised women; women pledged they would not circumcise their daughters (Population Reports, 1995); and circumcisers found alternative employment as traditional birth attendants (HIRDA, 2013). To date, over 6,000 communities in African countries have abandoned FGC and child marriage (Tostan, 2013). With a certain proportion of community ready to abandon FGC, a tipping point is reached and new expectations not to circumcise girls emerge. Public declaration extends community resolve and social sanctions requiring FGC lose their power (Innocenti, 2010).

In Western countries the processes of migration and settlement in new cultural contexts opposed to FGC are significant levers for change, but they do not automatically lead to abandonment (IOM, 2009). Families and communities experience pressures that can reinforce commitment to traditional values and practices to preserve their threatened identity (IOM, 2009). Pressures include managing the trauma experienced through civil war: loss, grief, displacement, hunger, violence and rape (Khaja et al., 2009) and fear for family remaining in conflict areas (Bernard and Gupta, 2008). They also include structural barriers to integration and settlement, and Allotey and colleagues (2001) refer to the triple discrimination experience arising from migrant or refugee status, skin colour and FGC.

The general socio-economic conditions of settlement countries have been found to be significant in migrants’ adoption of new values, such as abandoning FGC. This is evident in Johnsdotter and Johnstodder et al.’s (2004, 2009) research, which indicates that migrants from Ethiopia and Eritrea coming to Sweden for labour reasons in the 1980s, a time of economic prosperity, were able to integrate into society quickly. Researchers are confident they have
abandoned FGC within a decade. On the other hand, people fleeing civil war in Somalia later in the 1990s and 2000s, arrived in Sweden at a time of economic downturn and unemployment. This made their active participation and integration in Swedish society more difficult. The prevailing socio-economic conditions are seen by researchers as the key explanatory factors for less confidence that FGC is fully abandoned by Somalian Swedes. Enabling effective integration into the new society, especially through employment and housing which generate independence, dignity and connection, is critical in leveraging change to abandon FGC (Johnsdotter et al., 2009).

Where positive settlement conditions, with effective, timely support and education programmes underpinned by legislation and robust alert systems are in place, FGC can be considered a ‘tradition in transition’ in Western countries (Berg et al., 2010, p. 41). Mindful of the vast potential for change within migrant communities, we now address the critical roles of health, welfare and social workers in ensuring the best interests of children and the eradication of FGC in Western countries.

Culturally sensitive strategies to engage and work with families affected by FGC

Many of the complexities and dilemmas surrounding FGC are familiar to social workers, who, working in situations such as child protection, criminal justice or mental health, and guided by values of social justice and human rights, continually mediate tensions between providing care and protection and asserting control. The situation of FGC similarly requires practitioners to engage respectfully with FGC affected communities, assist settlement and integration, and take steps necessary to protect girls from FGC (Patrick and Markiewicz, 2000). This article has identified areas in which social workers must be informed if they are to engage and work respectfully with communities from FGC-practising countries: FGC practices, harms and prevalence; the cultural complexities of the practice; and effective international prevention strategies.

This knowledge on its own does not indicate how to talk with people about such a personal, private and culturally specific issue. Drawing on the literature review and the authors’ practice experience, we now discuss practical skills and strategies to assist practitioners to implement these ideas in effective, respectful, empowering and informed ways.

First, inter-cultural practice requires a high capacity for critical self-reflection to challenge one’s inherent ethnocentrism and privilege. Conversations with women affected by FGC are likely to be far more daunting for them as they also deal with trauma, grief and loss, discrimination and uncertainty than for educated, salaried, middle-class and, often, locally born social workers. Practitioners, including interpreters, need to recognise and manage their reactions to unfamiliar cultural practices and minimise everyone’s discomfort to create a safe, confidential environment for women and girls to
discuss their personal issues (Jordan and Neophytou, 2012; GBFCO, 2011). Professionals from FGC-practising backgrounds and traditions may also struggle with having conversations against the practice and may appreciate collegiate support.

Second, as international research indicates, effective interventions occur through collaborative engagement and supportive relationships with community members. Cultural sensitivity matters more in establishing relationships than shared ethnicity as the client (Patrick and Markiewicz, 2000). Such relationships require awareness of the structural, emotional and practical barriers that refugees and migrants face as they settle, including displacement, economic hardship, racism, unemployment, uncertain and unsuitable housing, and mental illnesses. As Khaja and her African colleagues (2009, p. 736) say, ‘Western women need to put themselves in the other’s shoes. They need to be compassionate . . . Ask questions. Listen, don’t judge . . . Did you ever speak to us? Did you ask us?’.

Listening for migrants’ likely fears and confusion about the new country’s laws and rights, such as children’s and women’s rights, social workers can provide creative opportunities for conversation, debate, support and advocacy about the issues identified: What are the difficulties you face being here? Have you found accommodation, work and friends? What are you missing most about your home country? What do you know about laws and practices relating to domestic violence, compulsory schooling for children, parenting discipline practices and child protection? Are there local health professionals who are aware of and sensitive to your cultural background? General health, legal and community conversations that are engaging, safe and respectful may engender questions and discussion about FGC with community members.

People from FGC-practising countries may never have openly discussed FGC prior to settlement (Steele, 1995). Affected women may want to know where to go to be unstitched or for treatment for damage from FGC surgery, without being judged. They may have inadequate knowledge of their bodies and biological facts (Banks, 2006) and may be shocked and angry when they learn that FGC is not a universal practice, and is illegal. ‘[W]hen genitally mutilated women . . . understand what has been stolen from them, there will likely be a period when they will need every possible psychological support’ (Dorkenoo, as cited in Steele, 1995, p. 122).

Third, when, practitioners encounter FGC, they must find ways to discuss it sensitively: with affected women who may need specific health care; with young women cut before arrival and caught between two cultures as they discover what has been done to them; with families considering cutting their daughters; and with men, boys, religious and other leaders who can play a part in stopping the practice.

Khadija, a young Australian woman from Sierre Leone, described her grief and horror when a doctor declared her ‘mutilated’, and she discovered that her clitoris had been cut off. Khadija understood that her mother had
arranged her circumcision in her best interests, but she was angry with her for having taken from her the essence of ‘Being a Woman’, as portrayed by women’s magazines. How, she asked, do we ask our mothers about what was done to us? How do we talk with our boyfriends about that? The good counselling Khadija received helped her channel her personal rage into political activism against the practice, inspiring her compatriots and outsiders alike (Gbla, 2013).

Social workers have a responsibility to be available and ready to respond to young migrant and refugee women who want to make sense of what was done to them, without blaming and judging. Who is talking with young people about their views on life in their new country versus their traditional contexts? Are girls being informed of their rights not to be cut and given the names of safe people with whom to discuss their fears of FCG? Are school staff informed about warning signs and responses if they feel a girl is at risk of being cut? Are young men being included in conversations about the harms of FGC so that they can publicly state that they do not need women to be cut in order to marry them?

In situations where a girl is considered at risk of FGC, for example, when there is information that a family is planning a trip ‘back home’ with their daughters for ‘a special occasion’, someone, usually the relevant child protection service in the country, needs to investigate. The way that professionals approach parents about suspected risk or abuse significantly affects parents’ reactions and actions in response to the allegations (Turnell and Essex, 2006). It is important to give families clear information about the laws prohibiting FGC, the consequences of cutting, together with transparent sensitive explanations about suspicions held of risk of FGC. Conversations should be conducted with sensitivity to the pressures on the family, rather than confronting them about their suspected intended harm to their child. For families with experiences of oppressive authoritarian regimes, the demand to break with a culturally prescribed practice believed to be in their child’s best interests can cause fear, anger, humiliation and resistance, and denial and defensiveness. Turnell and Essex (2006) advocate focusing on establishing future safety rather than forcing admissions of guilt. They suggest recruiting and working with cultural mediators, known for their opposition to FGC, to act as protective resources while the parents are engaged around their care for their child. ‘The same factors that motivate a parent’s decision to have their child cut may also spur a decision to stop the practice’ (Innocenti, 2010, pp. viii).

FGC is an issue of children’s rights and child protection (Dustin and Davies 2007). The rights of the child take precedence over the right to practise harmful cultural traditions, but social workers can prioritise the safety and well-being of girls at risk, and engage their families and communities with cultural awareness, sensitivity and respect. What are your thoughts about circumcision of your daughter now that you are in a country whose laws forbid it? Are you aware of the harms caused by FGC that led to the laws? How are
other families in your community dealing with this decision? What are your hopes and fears for your daughters growing up in a country with a liberal approach to women’s sexuality? (Daniel et al., 2009). Without the ‘security’ of FGC, parents face dilemmas as locally born parents: how can our daughters be prevented from being promiscuous or becoming pregnant or being infected with sexually transmitted diseases? (Daniel et al., 2011) Further research is needed to establish how migrant communities navigate these complex cultural, moral and legal dilemmas.

Social workers also need to be alert to the importance of coordination and advocacy. Coordination between child protection workers, law enforcement officials, other practitioners and services, and representatives of affected communities is essential to the good management of these situations, and sadly is often difficult to achieve. With knowledge of the cultural contexts of FGC practices, social workers can advocate for culturally sensitive medical assessment, counselling about the possible trauma a girl may have experienced and promote family counselling to ensure the family understands the reasons for the state response.

**Conclusion**

FGC is a complex, emotionally charged and contested issue that persists because of its deep culturally embedded meanings. It causes irreparable harm to girls and women and violates their fundamental human rights. Despite several decades of prevention programmes and strategies, thousands of girls are cut every day. In Western countries, FGC is understood to be a tradition in transition. The challenge to end this form of abuse and realise the ‘best interests of the child’ is urgent.

To that end, we have outlined key learning from research about prevention programmes in African countries and countries of settlement, which can inform policy, programme design and practice approaches. The main strategies for eradication are legislation, education and community empowerment.

We have identified areas where practitioners can strengthen their knowledge and skills for practice in this sensitive context. Practitioners should be informed about FGC and the contexts in which it may be practised, be critically self-aware and able to engage inter-culturally; be respectful in developing collaborative relationships with cultural mediators and communities; and be inclusive in facilitating settlement processes to help migrants to participate and integrate into new societies. Acknowledging the shared commitment to children’s best interests between practitioners and practising communities can enhance their capacity to embrace abandonment of FGC.

Practitioners, organisations and government departments should take up these challenges and work to ensure that no more girls are subjected to FGC. The best interests of the world’s girl children will be served by the eradication of FGC.
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