“An Investigation into Internal and External Conflicts in relation to the practice of Female Genital Mutilation/Cutting, and possible strategies for social convention shifts”

by

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I would like to express my deepest gratitude and compassion on doing this research to all of the women that, daily, need to experience the most cruel and patriarchal forms of pain, in many levels, in order to be heard and accepted inside their groups. The practice of Female Genital Mutilation/Cutting is just one of the many symbols that wish to control and withhold the power of women.

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I truly hope that after these hard times the world have been living we are able to reassess how we take for granted the amount of privilege we possess and maybe this can cause the world and the people to act with the collective mindset that freedom and access to equal gender opportunities is the only way that our path in this world will be lead more gracefully.

Abstract

The purpose of the research presented is to investigate internal and external conflicts in relation to the traditional practice of Female Genital Mutilation/Cutting (FGM/C). The research also proposes to investigate possible tools that could create an environment to produce shifts in the perceptions that FGM/C is a social norm.

In this paper the author proposes to use a mixed method approach using secondary qualitative and quantitative data and ethnographic methodology to attempt to gain an understanding of the implications and interpret the data from the analysis of the qualitative and quantitative data.

Using the above methods this thesis will analyse the origins of FGM/C and its incidence in African countries. It will assess theoretical studies and the reasons for its continued endurance. This thesis will concentrate on the conflicts surrounding the practice which were observed. The conflicts surrounding the practice were observed after diaspora movements, from Somalia to the United Kingdom.

Introduction

For most people, the word culture carries a sense of recognition and identity. When one thinks about "culture" one's mind tends to focus on the country/area/region/customs from where we grew, family beliefs and relationships and the social patterns and expectations we have brought with us into the current society in which we live. Some of these patterns/ habits are so ingrained in our societal norms we do not take the time to question or reflect on why this is the case. These patterns and habits are formed in an automatic way and passed automatically from parents to children through the generations.

The Oxford Language Dictionary defines culture as "the arts and other manifestations of human intellectual achievement regarded collectively"; "the ideas, customs, and social behaviour of a particular people or society"; and, [biological meaning], maintain (tissue cells, bacteria, etc.) in conditions suitable for growth" (Oxford Dictionary, 2020).

Following this sense of logic, it is generally accepted that groups living in the same community will make decisions based on ideas that they share as a collective, this forms parts of culture. However, when moving to a different location this automatic perception of culture will bring about change. Conflicts of perceptions are observed when different cultures clash their lines of thoughts or simply when their social norms differ from each other.

This thesis will focus on comprehending how the practice of Female Genital Mutilation/Cutting originated and analyze the scope of internal and external conflicts caused within the context that the practice was understood as a social convention by traditional communities.

To understand the processes explained above Chapter 1 aims to cover the history and concepts of Female Genital Mutilation/Cutting and demonstrates reasons for its endurance inside many communities due to its strength as an institutionalized social norm between these groups. Numerical incidences of the practice will also be considered. Finally, as part of the History and

Concepts an examination of the diaspora process will demonstrate incidences of FGM/C on western countries, which caused processes of conflict surrounding the recognition of the practice as a social rule in western society.

Chapter 2 will focus on theories based on cultural conflicts in relation to FGM/C, social norms, culture shock and, the management of the conflicts surrounding the practice, culminating on the demonstration of tools for social convention shifts.

Chapter 3 aims to focus on demonstrating the enforceability of the practice of FGM/C on the international level. It also aims on the extent to which law and enforceability can change the perception of groups in relation to the practice.

Within this chapter the author will also focus to raise an awareness of the internal conflicts that the enforceability of the practice can cause, thus appointing for the creation of a system of significance that needs to work in conjunction with legal prospects focusing on holistic approaches in order to experience social changes of behaviour. As an aside to the changes in social behaviour, it may also contribute to the endurance of the recognition of FGM/C as an act that goes against female's basic rights.

Chapter 4's aims will gather the data findings and the discussions in relation to FGM/C and its incidence. In relation to the migration movements and the international mobilization and the results that these promoted in relation to change of behaviour and management of the many conflicts surrounding the practice.

Chapter 5 concludes the research with the author's views aims to conclude with a discussion on how a mixed approach joining legal enforcement and communitarian holistic views can produce a change in future perceptions in relation to the practice of FGM/C

Aims and Objectives of this Research

The aim of the research presented here, is to examine the practice of Female Genital Mutilation/Cutting and analyze the scope of internal and external conflicts caused within the context that the practice is understood as a social convention by traditional communities.

In order to achieve understanding this research will focus on the following objectives:

- Examine the origins of the practice of FGM/C and its importance within the cultural context of the communities where it is practiced. Analyze the prevalence of the practice throughout African countries
- Assess how a migration movement from Somalia towards Western countries caused the practice to become an International issue forcing International laws to qualify the practice as a Human Rights issue
- Demonstrate the scope of internal and external conflicts existent within the processes above mentioned
- Identify the solutions encountered in order to shift the understanding of the practice as a social convention and examine the possible results in relation to this change of mindset.

Research Methodology and Methods

The thesis here presented will be supported by a mixed method approach using the analysis of secondary qualitative, quantitative and ethnographic research in order to support the aims presented throughout this piece of work.

Analysis of secondary quantitative data will be used to assess the prevalence of the practice of Female Genital Mutilation/Cutting in African countries, as well as the prevalence of such in Western territories after diaspora movements, specifically focused on numbers from Somalia and United Kingdom.

Secondary qualitative research will be used to assess the power of FGM/C as a social convention between these groups and the conclusion of the reasons why the practice has a quality of social norm between the communities that is performed. The same method will be used to evaluate the provisions of laws inputted towards the practice of FGM/C in specific groups and the mixed reactions that this enforceability caused on the focal occasioning on conclusions in relation to the effectiveness of FGM/C's prohibition laws in relation to social behaviour.

The use of this methods is necessary to demonstrate the extent of conflicts, internal and external, in relation to the practice of FGM/C.

Ethnographic methodology mixed with qualitative method analysis will demonstrate the tools necessary for shifts on social convention or social behaviour in relation to the practice of FGM/C.

Chapter 1 - Concepts of Female Genital Mutilation/Cutting (FGM/C)

Female Genital Mutilation/Cutting (FGM/C) is a term commonly understood as any procedure involving the "partial or total removal of external female genitalia, or other injuries to the female genital organs for non-medical reasons" (World Health Organization, 2020, p.1). It is a process generally carried out by a circumciser that possesses central roles inside the social hierarchy in the communities where it is performed (Boyle, 2002).

Some scholars argue against calling the practice with different vocabulary than genital mutilation. It is also termed as genital circumcision once there is also a comparison with the male tradition of circumcision, some call it female surgeries or female genital cutting. African scholars usually defend the last name once they believe the term mutilation has an ethnocentric[1] vein. In their view, the used term "female genital surgeries" emphasises the similarity of the practice with the western culture of plastic surgeries and cosmetic procedures (Boyle, 2002).

In this research, however, the term female genital mutilation/cutting will be used, and therefore the above definition.

There are four different types of FGM/C, and its usage varies from culture to culture (Boyle, 2002):

1. Type 1 or **Sunna**: Consists of the circumcision or excision of the clitoris prepuce.
2. Type 2 or **Clitoridectomy**: This encompasses the removal of some part or all the clitoris and labia minora. This category of excision is the most popular between countries in Africa.

[1] evaluating other cultures according to preconceptions originating in the standards and customs of one's own culture. Or: based on the ideas and beliefs of one particular culture and using these to judge other cultures.

Source: Oxford Dictionary, 2020.

3. Type 3 or **Infibulation** - practised in the horn of Africa, it is the complete excision of the external part of the genitals - clitoris, labia minora and majora. The left pieces are sewed together leaving a small space for urine and menstrual fluid to exit. The process of deinfibulation[2] happens before intercourse after marriage.
4. Type 4 is, generally, any other type of procedure that can injure the women's genitals for non-medical reasons.

Usually not respecting medical standards, in most of these countries the circumcisions are made outside of medical premises, in family households, and other locations, and the cutting is made with sharp non-sterilised material for example razor blades, pieces of glasses or scissors The person performing the practice or *circumciser* (as identified by most of the cultures) does not need to have a medical background to do so (National Health Service, 2020).

Western, Eastern and North-Eastern African regions concentrate most numbers of the FGM/C (World Health Organisation, 2020a). It varies inside territories on the west coast of the continent between Nigeria and Senegal going towards the African horn as well as Egypt and the northern region. The Middle East also reports countries with incidences of the practice (UNICEF, 2013).

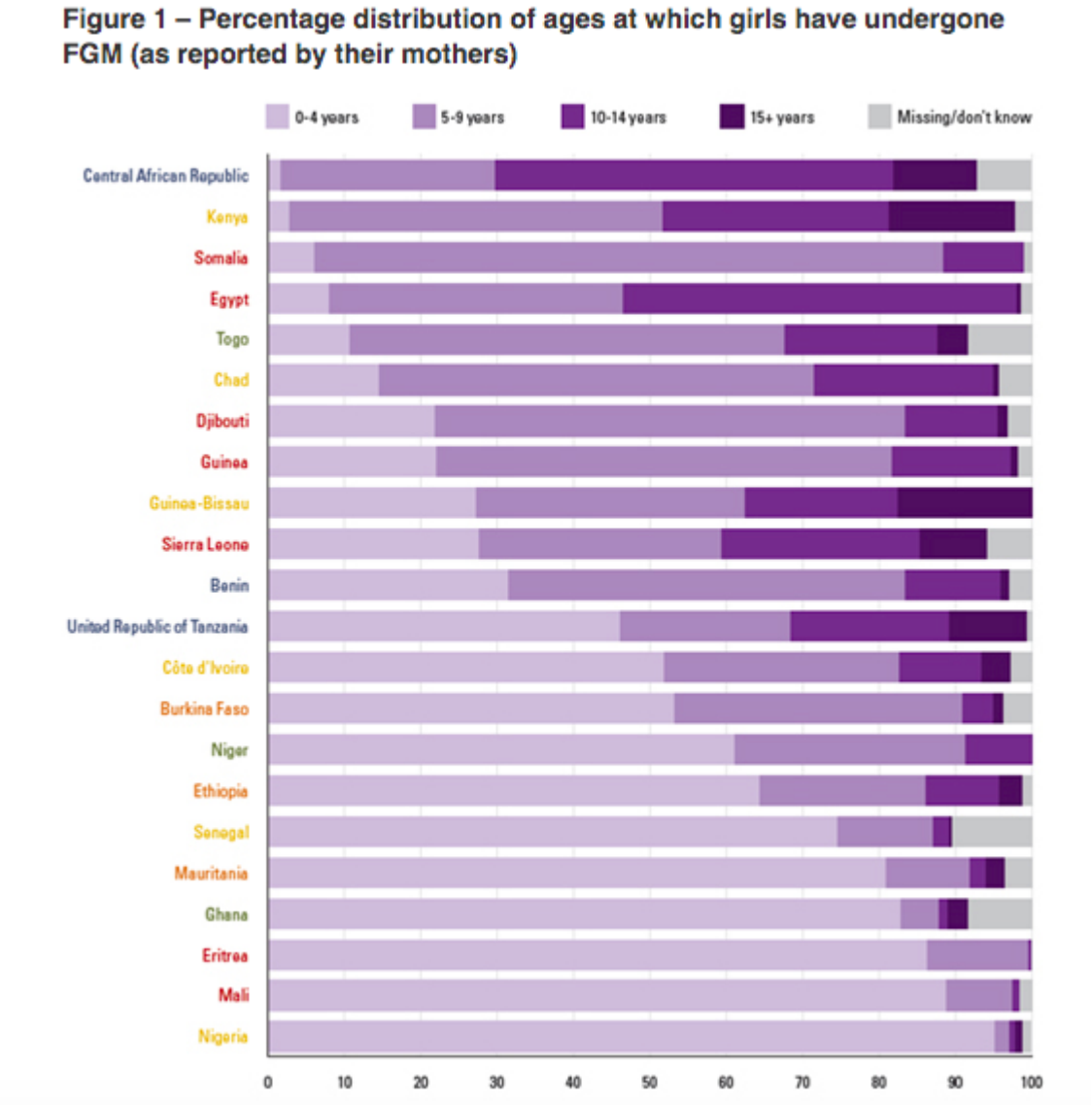
African diasporas and migration movements were responsible for bringing the practice to other continents on the globe, which made the FGM/C a global concern within a variety of countries. (Such phenomena will be further discussed in the next sections of Chapter 1).

According to the World Health Organization, over 200 million women and girls have undergone the practice worldwide, with 3 million girls annually being at risk of enduring the

[2] **Deinfibulation**, according to the World Health Organization (2020b) 'refers to the practice of cutting open the sealed vaginal opening of a woman who has been infibulated, which is often necessary for improving health and well-being as well as to allow intercourse or to facilitate childbirth'.

practice of being circumcised every year (World Health Organisation, 2020). It is mostly performed on girls between 4 and 12 years old (Center for Reproductive Law & Policy, 2006).

Figure 1 - Percentage distribution of ages at which girls have undergone FGM (as reported by their mothers)



Source: World Health Organisation, 2020a.

1.1 - History of FGM/C

According to Historians the practice of Female Genital Mutilation/Cutting dates from remote times. Indications of its appearance are embedded in old eras of Egyptian culture as well as the Arabic Community and inside the cultural rituals and social understanding of many African Societies. Since the twentieth century, its prevalence is mostly observed in African and Asian cultures (Boyle, 2002).

The African groups or communities shared a common view where they would tend to progress with the practice basing themselves in specific 'social laws' or belief systems.

There are many reasons, already studied and researched by scholars in order to create a general understanding about the origins of FGM/C and where this belief was rooted. One of the beliefs that lead African Communities to follow the idea of FGM/C was a ritualistic, mystical and Pharaonic belief related to the bissexuality of the Gods: Humans would represent a reflection of this quality, possessing both female and male souls. In order to achieve a level of healthy gender development, the female soul should be excised from the men, and the male soul should be excised from the women through circumcision. These groups believed that their souls were located in the male and female genitals. The healthy development then would only happen if the female part were circumcised from the men and the male part circumcised from the women. (Boyle, 2002).

Some argue that the practice arose in ancient Egypt among tribes located near the western part of the Red Sea around 200 BC. They would perform infibulation or clitoridectomy. Other versions indicate that it originated on the continent following the arrival of Arab populations in the Sub-saharan African region or possibly after the arrival of black slaves into some Arab societies (28 Too Many, 2013).

Additionally, FGM/C can happen not only in Muslim communities but as well as Christians (Catholic and Protestants). (UNAIDS *et al.*, 2008). There is not a specific religion practised between communities that can lead to the act of FGM/C. According to Boyle (2002), there have been reports of it being connected to Islamism in some African countries as well as being coincident with the rise of Islam in the continent. The Islamic law, or *sharia*[3], mentions the practice of FGM/C on one of their *hadith*[4]. Mohammed would attest that the practice should happen with caution, but it could still bring honour to the women also being more positive to the husbands. The origin of this *hadith*, however, is contested by numerous scholars.

Moreover, the adoption of the practice of FGM/C could reportedly have been started in these regions. Slavery originated from the region of Egypt comes before the rise of Islam in the area. Egyptians enslaved part of the Sudan population exporting those to areas near the Persian Gulf. Similar slave trade started being observed around the Islamic area and the captured population would move from Sudan to designated areas of Egypt and Arabia. FGM/C started to happen with the idea that such action would increase the value of the female slaves as well as control sexual acts and fertility between them. "Reports from the fifteenth and sixteenth centuries suggest that female slaves sold for a higher price if they were 'sewn up' in a way that made them unable to conceive" (Boyle, 2002, p.28).

The explanation for the spread of the practice around the African areas can as well be explained in the context of Harems. Common in Egypt, harems were commonly populated with women

[3] Sharia law represents the legal system of Islam. Its origin comes from the Koran, Islam's central text, and fatwas - the rulings of Islamic scholars. Its literal translation means "the clear, well-trodden path to water (BBC, 2014, p.1)".

Sharia law is a code of conduct that Muslims must follow, for instance, prayers, fasting and others. It is a way of clarifying life and existence to Muslims, and the way they are meant to live their lives following God's wishes (BBC, 2014).

[4] "a collection of traditions containing sayings of the prophet Muhammad which, with accounts of his daily practice (the Sunna), constitute the major source of guidance for Muslims apart from the Koran (Oxford, Reference, 2020,p.1)" .

previously infibulated. After the Egyptian region became Islamic - they were not allowed to enslave the Muslim population - they went ahead with slave trading towards Africa looking for non-Muslim slaves in order to populate harems keeping up with the circumcision (infibulation) in between the enslaved women (Boyle, 2002).

1.2 - FGM/C as a cultural tradition within the African culture and its impacts

Between most of the communities that accept the procedure, Female Genital Mutilation/Cutting occurs as a way of controlling the female body as well as their sexuality. With the excision of the women's genitals, it is generally comprehended that their desire for sex is prevented thus, keeping the wives faithful to their husbands. These communities based their social interactions on raising their daughters towards marriage. In this sense the practice needed to be performed to prepare girls for the next phase of their life: the wedding. With such reality surrounded by the idea of marriage, men hold the leadership and are seen as the most important figures in their social structures - men themselves would understand women's bodies as their own property being able to control their power by performing the practice of infibulation (Boyle, 2002).

For these communities, FGM/C is a social **convention or norm** that conforms a pressure to be socially accepted inside these cultures.

Fear of rejection and a necessity to be an active part of these groups within communities are mainly what constructed the unquestioned idea that FGM/C needed to be performed in all women and girls inside these groups (World Health Organisation, 2020).

Numerous reasons were studied and identified in order to explain the prevalence and continuance of the practice in many countries. They usually vary from region to region and overtime present different characteristics and are based on a series of morals entrenched in social norms (Berg and Denison (2013).

Their choice in relation to choosing the way towards the practice would also be based in the collective scope. According to Berg and Denison, (2013), *community mechanisms* were responsible for creating an atmosphere of constant social pressure where the community would have opinions and make decisions in relation to one family circumcising their daughters.

The tradition surrounding the practice is so dominant inside these communities that its understanding has an institutional emphasis, socially speaking. Families consider the act a vital aspect of parenting, where they are expected to do so in order to be accepted inside their own groups (Boyle, 2002). The education of girls is based on the idea that they need to be prepared for marriage and adulthood. These societies hold a patriarchal construct where the positions for men and women are well defined. Maintaining such beliefs, the practice of FGM/C is then performed as a demonstration of accepted social behaviour. Premarital virginity needs to be ensured as well as their ability to remain faithful to their future husbands.

In this sense and in accordance with Berg and Denison (2013), sexual morality and marriage, together, are strong holders of the continuance of the practice.

> FGM is in many communities believed to reduce a woman's libido and therefore believed to help her resist extramarital sexual acts. When a vaginal opening is covered or narrowed (Type 3), the fear of the pain of opening it, and the fear that this will be found out, is expected to further discourage extramarital sexual intercourse among women with this type of FGM (World Health Organisation, 2020, p.1).

The communities that recognize the practice usually organize themselves with the idea that the circumcisions on their daughters will guarantee, not only the future marriage ceremony but as well as their own acceptance as a whole family unity. In most of these countries, and as referred by Boyle (2002), if in the course of their teenage years a girl that have never been circumcised is to be discovered between other teenagers, they would often suffer backlash and discrimination. Much like the celebrations surrounding male circumcision, ceremonies are held around the practice when a girl from the family undergoes the procedure. It is one of the only times where a woman/girl is celebrated inside their community (Boyle, 2002).

Religious beliefs are also considered to perpetuate the practice of FGM/C and, for most of research studies by Khaja (2004), and as mentioned sections above, the practice is connected to the Muslim faith. However, the same religious belief holds a hindering factor in relation to

FGM/C, once there are parts of muslims that believe that the type of pharaonic circumcision goes against Islamic principles.

The last factor highly mentioned in the researche studied by Berg and Denison, (2013) demonstrates that FGM/C is also connected with female hygiene. Cleanliness of the female body and genitals would only be achieved after circumcision. Other than this, uncircumcised women are considered unclean and, in some cultures, they are not allowed to handle water or food (Akidwa, 2020).

In conclusion, the word *tradition* seems to be what better explains the continuance of the practice inside so many countries. The incidence of the FGM/C is mostly mounted in the idea that women will be chosen by men as their wives only if they were circumcised. These cultures usually are socially divided with men taking a position of power, which means that the woman - the wife - is the men's property. The practice is understood as a pivotal event in a woman's life once it is a preparation for marriage. Not only men hold the belief in the practice, but generally, women also agree that they must endure such. According to Boyle (2002), 74% of Egyptian married women believed that men held a preference for circumcised versus uncircumcised women in the country.

Moreover, a systemic change of behaviour was later observed after migration movements - from African countries towards western countries - started to occur.

> Due to exposure to Western thought models, migration allowed the participants to question doxic cultural models, including those of FGM/C, a reassessment that helped slow the continuation of the practice. Participants in Berggren and colleagues' study (2006) explained, "because of migration, they got rid of most of the female peer pressure to continue all forms of FGC" (p.55)' (Berg and Denison, 2013, p.845).

Once finding themselves in another society with a new and divergent discourse in relation to the FGM/C, internal and external conflicts started to occur in between those groups. With the predominance of the practice now being observed in other continents beside African

communities, the fight against the practice would later become a global issue once it would go against girls and women's rights.

International Agencies and governments started to generate pressure in countries where the practice was legal and incorporated between their populations with the creation of laws enforcing the illegality of the practice, once again, creating a new conflicted atmosphere inside groups that kept practicing the FGM/C between their cultures despite new laws atesting the ilegallity of such. In this paragraph alone, two major conflicts are observed: Internal conflicts and conflicts between groups and governments.

Another scope of cultural conflict would later be observed between traditional immigrant groups that would keep the practice intact between their beliefs and the western society that would not recognize FGM/C as a social rule inside their own social comprehension. International Organisations and NGOs became the main actors responsible for attempting to change the belief system and managing the cultural conflict surrounding the practice of FGM/C with the creation of reeducational programs, female empowerment focal groups, guidelines to health professionals, and law enforcement (inside each especific country) in response to the assimilation of acception and diversity of cultures in relation to the practice.

1.3 - Diaspora and Family Systems

As already understood in the section above, FGM/C became an ongoing social tradition inside the groups where it was performed. This quality, however, started to present changes of perception by certain groups that started moving from their main land towards different countries. These groups changed their understanding on what the practice carried around in terms of acceptability and social ruling after they started migrating from one place to another. Identified as *diasporas*, these consist of 'a group of people spreading from one original country to other countries (Cambridge Dictionary, 2020, p.1)'.

The International Organization for Migration (IOM) identifies the features inside these diasporas (Migration Data Portal, 2020), which can explain the endurance of the FGM/C between migrating communities even after they moved to Western countries, as well as explain the other way around: how a change in their environment was able to produce a new mindset in relation to the weight that the practice of FGM/C possessed inside the social construct of African immigrant families.

Another definition of the word identifies diasporas as groups of migrants and descendants of migrants that constructed their identity and sense of acceptance by their experience as being migrants as well as the background brought from the places they emigrate from In this regard the features that characterize diaspora groups are identified by the Migration Data Portal (2020) as:

Migrations: In order to escape conflicts or to seek asylum, these groups disperse to other parts of the globe looking for better opportunities.

Collective Memory: A collective idea, a myth or social norm, an idealized memory shared between them and in relation to their ancestral home.

Connection: a connection to a country of origin.

Group Consciousness: these groups create a strong collective consciousness that is usually sustained over time;

Kinship: the sense of sharing characteristics with diaspora members from other locations; (Migration Data Portal, 2020)

Taking into consideration that the practice of FGM/C encompasses a cultural tradition, research already presented has shown that this tradition functions as a way of social control being 'deeply rooted in their social systems' (Berg and Denison, 2013, p.846). These communities then perceive the practice as a norm inside their own groups and, consciously they follow each other's path on perpetuating this idea because they share the same identity. Comparatively, the *group consciousness* presented in the features of the diasporas could explain the persistence of immigrants to sustain the usage inside of western territories even when these would not recognize the practice of FGM/C. Inside their own communities the practice still connects them to their own countries, and can also be identified as a *collective memory* that would draw them together to their ancestors, their national social norms and the importance that FGM/C held inside their own social construct.

Furthermore, an interesting link that can explain the strength of the practice is related to the power in which these communities are sustained around the concept of family. A single family by itself would not be able to reassess the importance of the practice inside their society once the construct of the practice of FGM/C is reinforced by the social necessity to to conform to circumcision and the tradition that maintain the family status inside the whole community.

When these families decide to follow a different path, they encounter themselves inside social stigmas. For girls to be recognized as members of their society they need to undergo the practice which will also guarantee that the whole family unit will be well positioned inside their own social groups. In conclusion, the social dynamic and the pressure input inside these

groups to obey to certain rules keeps the practice of FGM/C going even between families that do not agree with the way it is carried out.

For migrants, even though they are already residing in different locations, they will be consequently presented with a new set of laws and beliefs. However, they will still migrate holding their own story, as well as their social, economic and environmental health beliefs (International Organisation for Migration, 2008).

> Migration can thus create situations where cultural and ethnic reproductive and sexual health practices differ from and sometimes causes conflict with the practices of the host community. A well recognized example of this phenomenon is the issue of Female Genital Mutilation (International Organisation for Migration, 2008, p.1).

Generally coming from a local process of civil wars and looking for better opportunities of life, many diaspora groups originated from African countries going towards the European continent. These groups are generally running away from failed governments where their countries couldn't or wouldn't provide a basic way of living for its population due to war, religion, power and greed.. Whether searching for destinations that could provide families and communities with the potential of a healthy way of living, or even departing from countries in constant civil wars and other conflicts, many African groups would constantly move in diaspora in order to reach a better life. One of the diasporas that can explain the incidence of FGM/C outside of African countries - into western countries such as the United Kingdom - originated from Somalia. This section of the research will cover the incidence of the practice in this country and discuss the historical facts that caused the Somalian Diaspora towards Europe, leading to the incidence of FGM/C inside the new continent.

1.3.1 - Cultural History of the practice of FGM/C in Somalia

Somalia is located in the horn of Africa bordering countries such as Djibouti and Kenya (Putman and Noor, 1999). Having just recently recovered from a status of a failed state, the UN alleged that the country had a significant development in the last three years but it is still a 'recovering fragile country' (The Guardian, 2015).

60% of the country's economy is based on agriculture despite its unexplored natural reserves. Most of the population have Somalian descendants and practice Islam, although there are some minorities that have Bantu descendants living in the south of the country. It is known that the country was first populated around a thousand years ago and the country's conversions to Islam could have started somewhat between the 11th and 12th century (Putman and Noor, 1999).

A failed state and a major difficulty to survive without a centralized government led Somalia to become a country with constant refugee and asylum seekers groups. Diasporas are a common reality in the country and these groups migrate constantly towards other regions of the world. From the end of the 1970s an estimation of 1.2 million Somalians was living in diaspora. 500.000 are identified living in neighbouring countries such as Kenia, Yemen and Djibouti. In western regions the European country is the most popular destination for these populations (Al-Sharmani, 2007).

Strong beliefs held the practice of FGM/C intact within the Somali community and many other groups around the African continent. The maintenance of these patterns started being observed outside their countries as a result of these African Diasporas.

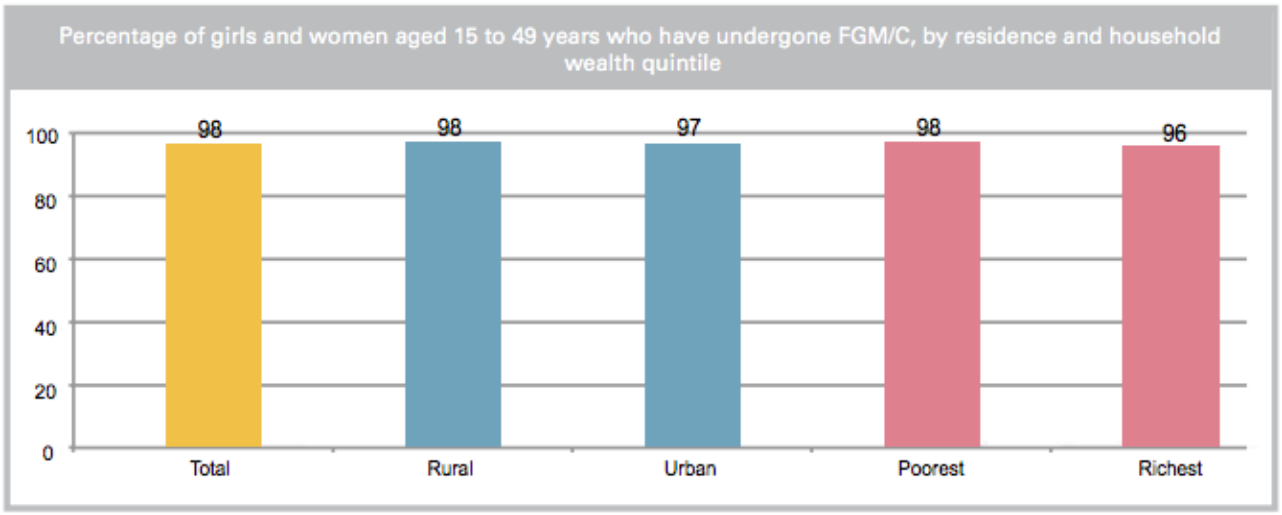
Until 2018, an estimated 108.000 Somali-born immigrants were living in the United Kingdom, being the largest Somalian community inside Europe (Hassan *et.al*, 2013).

Surrounded by the same cultural and traditional roots that accept the continuance of FGM/C in other African countries, Somalia has one of the highest incidences of the practice inside the

continent. 98% of females between 15 and 49 had already suffered the practice with the majority of such being held into girls between 4 and 11 years of age. Infibulation[5] is the most common type of procedure in the country with 80% of the women undergoing such (UNICEF, 2013a).

Somalia is the African country with the highest number of FGM/C incidences in its territory. It is nearly universal the number of girls and women that have undergone the practice. Comparatively with other African countries, Somalia leads in the percentage of women and girls who had undergone the practice. Girls between the ages of 5 and 9 experience the mutilation of type 3, infibulation. It is the most severe form of FGM/C. 63% of females between 15 and 49 years have already suffered the practice of infibulation (UNICEF, 2013a).

Figure 2 - Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, by residence and household wealth quintle



Source: UNICEF, 2013a

Commonly known as "*Sunna"* the procedure is made by traditional circumcisers (*Guddaay)* that would usually perform the practice in a non-sanitized way, which can cause serious health consequences, including fatal risks. Due to the seriousness of the risks several families choose

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to hire a professional circumciser instead. After Somalia's independence, Lebanese doctors would agree to perform the practice alleging that such actions could then minimize the negative impacts of the practice on the girls (World Bank, 2004).

As already stated, the beliefs surrounding the practice are religious, ritualistic, sociological, and sexual. The Somalians share the common idea that the female genitalia holds the impurities of the women which can withhold their growth and some of them even believe that if the clitoris is not circumcised it can cause midwives to go blind, the husband to become insane or the new born to die - if they touch the mother's genitals during birth (Ali, Mohamaud & Yinger, 1999).

Even though not all Somalians hold such beliefs, there is a common pressure for the practice to be continued. Uncircumcised girls cannot find husbands and the ones that get married can suffer from divorce if discovered not to be circumcised. Moreover, families fear being socially rejected or punished by God and their ancestors, strongly holding to the idea that a tradition can never be broken (Ali, Mohamaud & Yinger, 1999).

1.3.2 - Incidences of FGM/C outside of the African continent

The Somali migration flow started in the 1970s growing in strength after a civil war in 1991. The groups migrating from the country would go towards many parts of the globe, such as Europe and North America. Escaping from war and bankruptcy of their state these groups kept the tradition of FGM/C between their families, which can explain the incidence of the practice and many other ethnical practices inside the European Continent. Somalian communities live in a state of constant migration towards different regions of the globe. The nature of the migration caused the practice to become an international issue once it was introduced in other parts of the world.

The practice of FGM/C started being observed between immigrant women residing in the European Continent, specifically in the United Kingdom and Switzerland. The generation of girls born from these families also ended up suffering from the practice (Dokernoo, Macfarlane, 2015)[6].

In 1999 it was estimated that about 15000 Somali women living in the British territory had already undergone the practice (Forward, 2002). In 2011, the estimated number of children and women living in the country who had already endured the practice, or were at risk of suffering the practice, and originated from countries where it was ostensibly performed was approximately 137000 (Dorkenoo, Macfarlane, 2015).

[6] Further incidence of the practice in Europe will be discussed on chapter 4 - Data Findings

Figure 3 - Incidences of FGM/C in European Countries

Country	Number of girls at risk	Annual new cases	Number of girls/women with FGM	Number of girls/women from FGM risk countries
France	4,500 (Délégation Régionale aux Droits des Femmes, 1998)		13,000 (Délégation Régionale aux Droits des Femmes, 1998)–27,000 (Gillette, 1997)	40,000 (Gallard, 1995)
Germany	5,500 (Utz, 2000)		21,000 (Gleissner, 2002; Utz, 2000)	
Italy	4,000—5,000 (girls with FGM) (Grassivaro Gallo et al., 1998)		27,000 (Grassivaro Gallo et al., 1995)	30,000 (Bosch, 2001)
Sweden				27,000 (Andersson, 2001)16,000 (Widmark et al., 2002)
Switzerland			(incl.# of girls at risk): 6,711 (Jäger et al., 2002)	
Netherlands				13,313 (Somali women) (Central Bureau voor Statistiek The Netherlands, 2003; Jäger et al., 2002)
UK	10,000 (British Medical Association, 2004; Jager et al., 2002)–15,000 (Levin, 2001)	3,000–4,000 (British Medical Association, 2004; Levin, 2001)	10,000–20,000 (Momoh et al., 2001)	

Source: Leye et.al, 2006

There is a common understanding between authors and organizations on how the data is important in order to map the incidence of the continuity of the practice. However, local actors can encounter many difficult aspects of gathering such data once talking about the practice lies in an intimate issue. The challenges presented are connected with the difficulty of the Western society to understand why FGM/C carries a deep sense of social behaviour between migrant communities. Because of the difficulty in understanding such behaviour, other sources of conflict can be identified in such aspects: European health professionals lack knowledge on the subject - due to a lack of training on information in relation to the practice - and on the approach they should follow in order to give assistance to women that suffered the practice (End FGM, 2020).

As discussed in chapter 2 FGM/C is a foreign tradition not recognized by Western doctors and Western society which leads to the lack of information on the preferred form of treatments in medical assistance to those victims. Moreover, there is a lack of systematic and holistic approach on the services related to FGM.

This occurs because these professionals in relation to the practice and the reasons for it to be sustained between those groups. These services should involve the aspect of sensibility toward cultures, whereby services have access to possible tools for changing their understanding. There should be an educational element to training in relation to the diversity of cultures and the diversity of beliefs they carry (End FGM, 2020).

In further chapters the research presented will cover the issue of how, even after migrating to a different country, diaspora groups kept the source of the practice of FMG/C between their communities. Incidences of the practice inside Western territories caused the local Western society to perceive the practice as a negative thing, excluding social behavioural aspects. The

cultural conflict of FGM/C is explained in the sense that the origin and the reason for the practices itself are not sustained inside the European continent. This has caused numerous international actors to act in relation to the practice, culminating in programs and tools for management of the conflicts surrounding FGM/C in order to re-evaluate and re-educate the practice between traditional groups and achieve eradication of the procedure.

Internal conflicts between these migrants were also perceived. With the support of a new society - with a new setting of social construct and beliefs - these communities started to create a new understanding in relation to the practice of FGM/C hindering the idea that the tradition was a necessity to be carried out. The next chapter will cover theories related to Cultural Conflict as well as the concept of Cultural Conflict in relation to the practice of FGM/C.

Chapter 2 - Cultural Conflict

The author wonders if the practice of FGM/C is fully understood by the groups where it is performed as a cultural tradition.

Firstly, excluding external pressures once unknown or not considered by these communities, they would follow their tradition accepting FGM/C as a natural passage of their own way of living without questioning it. In other words, one could agree then that the practice is an active part of their cultural archetypes. African communities based their realities in accordance with rules existent in their own groups.

Moreover, it is correct to affirm that cultures vary and differ from community to community, and this assertion can be even more confirmed when we think on a macro level: different societies, residing in different geographic spaces will go about their lives in different ways. To deepen this discussion, it is paramount to understand the concept of culture and its direct connection with **social conventions**.

This section will evaluate the depth of the understanding of the practice to the communities that institutionalized such inside their own culture, and because of the strength of the practice between these communities, the FGM/C started being observed in western countries after migration movements causing a series of internal and cultural conflicts that will be later discussed and demonstrated. The cultural conflict that existed was observed after the social norms lived by African communities clashed with the Western's understanding of the practice. Studies here represented will sustain the idea that this conflict can only be managed with the construction of support that would engage in 'social convention shifts'. This means that the eradication of FGM/C can only be achieved if organisations focus their work on reeducation and reintroduction - or social re-significance - of new social norms between communities' beliefs (UNICEF, 2005).

In order to understand the source of conflicts surrounding the practice of FGM/C is necessary to assimilate the concept of culture and how the practice is embedded in these communities' perception as a valid and necessary cultural tradition.

Giddens and Sutton (2013) understand culture as a reference to habits and behaviours or ways of living that a group experiences inside a specific society. In this regard, culture and society are intimately connected in a reflexive way - for a society to exist, culture will exist at the same level. Society can be understood as inter-relations systems that connect people and inside of these societies a range of cultural variations can occur. Culture, as presented in the societies, includes diverse aspects. Intangible aspects are the beliefs, ideas, values that constitute the nature of culture and the tangible aspects are related to objects, symbols or technology responsible to represent such content (Giddens, Sutton 2013).

Another concept of culture is based on the system of symbols shared on the social level. Ann Swidler (1986) defines culture as the symbols available on a social level, these being identified as tools for symbolic interpretation. These tools are identified as simple actions practiced in our everyday life. 'These symbolic forms are the means through which social processes of sharing modes of behaviour and outlook within a community take place (Hanners, apud Swiddler, 1986, p.273).'

According to Swidler (1986), there are a diversity of symbols presented in many cultures. This diversity can create a divergence of point of views and these different perceptions will conflict, for instance, the divergence of religions or even tribal practices that differ from those accepted by the Western cultural framework. Therefore, culture cannot be considered a homogeneous or unified system. The author claims that culture cannot drive individual action towards a consolidated direction. In this sense, it works more as a tool system where 'actors select differing pieces for constructing lines of action' (Swiddler, 1986, p. 277).

In this sense, a conflict with a basis in a cultural sense can be perceived as a divergence between the symbols that certain groups share socially. Behaviours, values and beliefs are set in accordance with these symbols and, when confronted with a different culture, a clash of these perceptions can occur once the symbols may not be socially recognized by a different culture. This clash can be classified as culture shock.

2.1 - Cultural Shock

Migration movements, in addition to promoting the dispersion of people from one environment to another can also maintain the cultural archetypes of such groups, also virtually migrating their perception to a new society they have moved to. Some of these archetypes, however, are not recognised by their new host society.

This sense of estrangement or non-recognition of a certain way of living can be understood as cultural shock. Even after a change in social environments, Swidler (1986) claims that culture can explain these continuities in behaviours even if there are structural changes. These individuals or communities maintain their habits, as they usually act according to their own culture, preserving "(...) traditional habits in new circumstances [...] culture accounts for any observed continuities in the way of life of particular groups." (Swiddler, 1986, p. 277-278).

Bellini, (2005) states that the cultural shock phenomenon has four stages: the honeymoon stage, frustration stage, adjustment stage and acceptance stage. They are more related to the psychological effects imposed on individuals who move from one social environment to another.

The period prior to the change of environment is the **honeymoon** stage and it is the phase where one sees the positive sides of moving to a new location (Bellini, 2005).

The **frustration** stage consists of an overwhelming feeling regarding change. This period is usually temporary but, as time goes by, the adaptation process presents complications due to cultural divergences in relation to everyday practices and diverse behaviour. It consists of a sense of rejection. There is an understanding in relation to the habits presented in the new environment, difficulties with a new language and other aspects observed in the new cultural arrangement in which the individual is encountered. Due to the high expectations previously created by these individuals in relation to this new environment, these barriers of cultural

estrangement cause a disappointment that leads to a phase of regression where they start to idealize the culture in which they migrated from (Bellini, 2005).

This stage connects with the thought proposed by Swiddler (1986), who claims that certain individuals, even after migrating from one location to another, maintain certain habits, act according to their own culture, the one they were previously inserted in. The rejection phase ends after a certain time and gives rise to the period of **acceptance** and **adjustment** to the new social environment (Bellini, 2005).

In relation to the research proposed here, the cultural shock phenomenon is effective in demonstrating that processes occur due to groups maintaining habits related to their culture of origin, more specifically the practice of FGM/C. This practice, disseminated after the migratory process of populations from Somalia to some countries in Europe, did not correspond to the habits or cultural reality of western countries.

The change in relation to FGM occurred, as these groups started to adapt socially to the culture or the system of symbols presented in the social environment of the Western societies. The network of symbols and cultural habits presented in these European countries provided a new behavioral model for these individuals, which may contribute to the changes of perceptions in relation to the practice.

In addition, Western perceptions in relation to the practice also resulted in a series of conflicted scenarios surrounding FGM/C. Considerations on what would be an effective approach that would generate changes of behaviour - both for the western society and the migrant communities began to be discussed at both National and International Levels (UNICEF, 2005). Cultural conflicts can occur in between negotiation processes and are generally also perceived by the same issues. Cultures are diverse and present themselves with a different set of

communication styles, norms and ways of behaving. Consequently, unequal perspectives are brought to the negotiation and this can result in misunderstandings (Shonk, 2020).

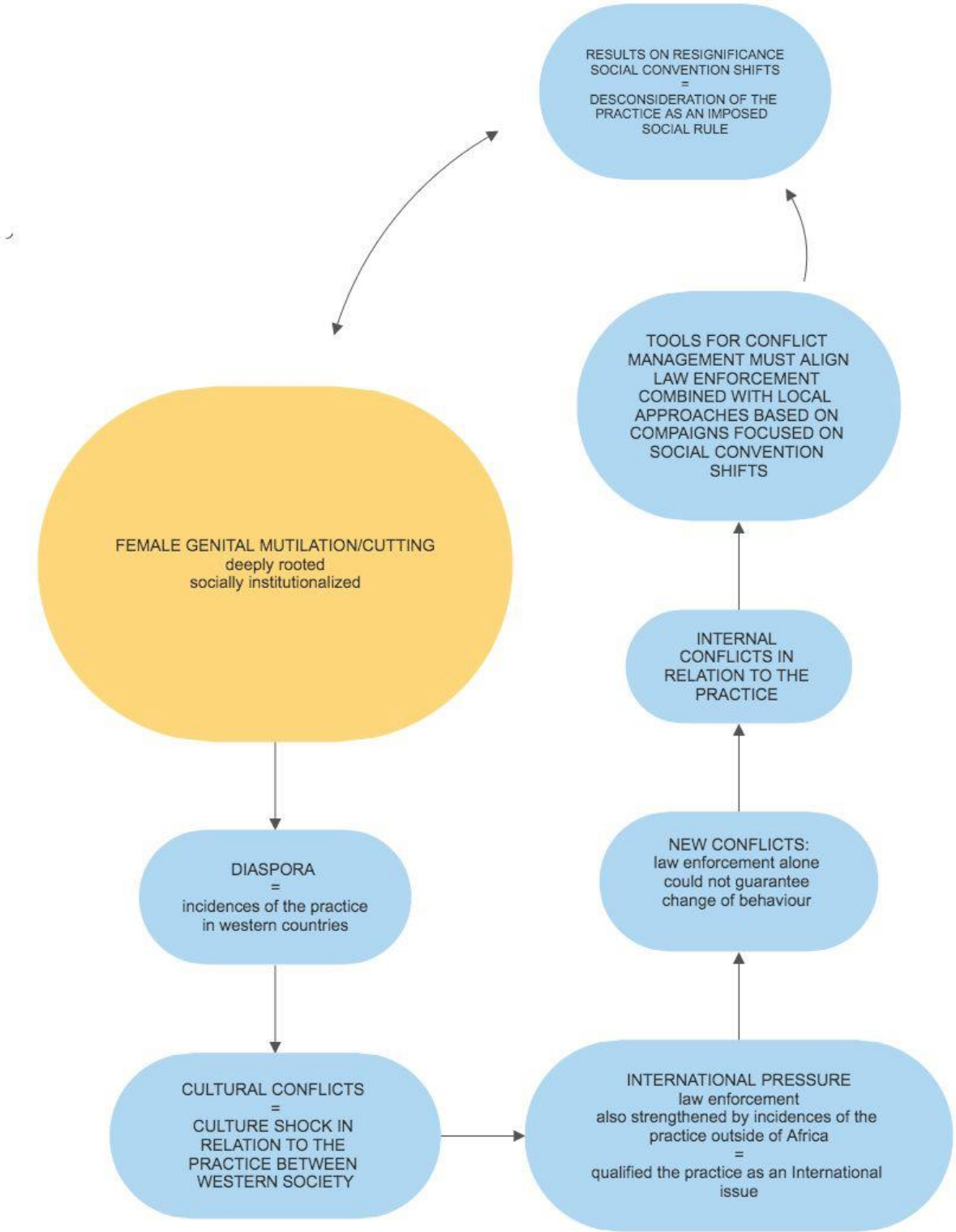
2.1.2 - Conflicts in relation to FGM/C

How to perceive and visualize the movements that caused scopes of conflict surrounding the practice of FGM/C?

The diagram bellow illustrates a flow chart in regard to the social process surrounding FGM/C that will be studied by this research[7].

[7] The further discussion surrounding this chart will be presented in the chapter 4 - Data Findings and Discussions.

Figure 4 - Comprehensive flow of research



2.2 - Family Social conventions in relation to Marriageability in the context of FGM/C

In order to comprehend the most effective way to reestablish a new vision in relation to the FGM/C between the groups that perform the practice, it is interesting to visualize how are the social dynamics surrounding such in order to later demonstrate strategies based on social convention shifts which will base the sources of management in relation to FGM/C.

Research on the organizational quality of the practice of FGM/C traced that the strength of it as social convention lies on the extent to which these groups are organized in the concept of marrigeability[8] that will guarantee the social success of the family as a unity between a collective group. The traditional vein of these groups are based on the premise that the practice is 'necessary for proper marriage and are believed to be sanctioned by tradition (UNICEF, 2007, p.3)'.

In this sense, the practice of FGM/C it is a self-enforcing social convention and the actions of one family are based on the general social actions of the other families from that specific society. The procedure holds value in guaranteeing status for the daughters through marriage. The decisions in relation to social behaviour are directly entrenched to reacting to what the other families will pursue. Albeit 'no one family can abandon the practice on its own; to do so would ruin the marriageability and status of that family's daughters. To change the convention, it is necessary to coordinate abandonment by the intermarrying community as a whole (UNICEF, 2007, p.13)'.

The idea is that if one group of families decides to abandon the practice - based on the principles that health issues and human rights hold greater impact on their daughter's lives - they will recruit other families and persuade them in the interests to abandon the practice. Finally the knowledge perpetrated by one family or the groups of family will spread towards the rest of

[8] Suitable for marriage. Source: https://dictionary.cambridge.org/dictionary/english/marriageable

the families characterizing a process of social network that makes itself effective if it is based on an organized and coordinated collective abandonment of the practice (UNICEF, 2007).

The idea is well explained with a comparative example proposed:

> To understand how a social convention might be transformed, it is helpful to use a simple metaphor. A group has a convention whereby audiences (at the cinema, at plays, at recitals) stand up rather than sit down. An outsider comes along and explains that elsewhere audiences sit. After the shock of surprise wears off, some people begin to think that sitting might be better. If only one person sits, that person can't see anything on the stage. However, if a critical mass of people in the audience can be organized to sit, even a group of people who are less than the majority, they realize that they can sit comfortably and have a clear view of the stage (UNICEF, 2005. p.22)

Social conventions based on traditions like FGM/C should always engage on collective approaches. The collective decision of abandonment should follow both the population's decision itself but as well as the coordinated work of competent authorities - governments, statutory laws, community organisations such the NGOs, health professionals and other social instances - that can back up a group's decision of breaking boundaries with their core belief system.

2.3 - Conflict Management Approaches in relation to FGM/C

The shift of a social convention needs to encompass a series of approaches that will guarantee a permanent change of behaviour. There are six main elements confirmed by UNICEF (2005) that can guarantee the permanent re-significance in relation to the practice and change their perceptions that circumcision is a means for social acceptance. They are shown below and will be discussed on section 4 of this research:

1 - Approaches free from coercion and prejudice focusing on Human Rights issues as well as processes empowering women.

2 - Programs of local awareness explicating the harm cause by the practice

3 - Collective choices of groups that are connected by the social norm surrounding marriageability and its relation to the practice of FGM/C

4 - Explicit demonstration/affirmation by groups of their decision to abandon the procedure of FGM/C

5 - Organized diffusion of the will to change the perception in relation to the practice, that should spread throughout the communities

6 - An atmosphere that creates means to sustain models of behavioural change

2.3.1 - Communitarian and local Approaches promoting social convention shifts - NGOs

According to the Center for Reproductive Law & Policy (2006), the fight against the practice of FGM/C occurs with the participation of many actors but, in order to achieve social change or social convention shifts the work of NGOs is paramount once it is made directly with the population facilitating the eradication process on the community, national, Regional and International levels. Together with International Organisations, the NGOs were responsible in creating International pressure inside the global scope in order for FGM/C to be discussed as a practice that would go against the rights of women and girls.

NGOs in Europe started to act in order to change the reality surrounding the FGM in the early 1980s. Their approach was based on dealing with the problem of FGM itself but also on understanding the population and women's reality surrounding such a theme. In that sense, the NGOs were responsible for following up on refugee and migrant issues as well as women's health issues. These organizations were responsible for educating and informing, as well as working for lobbying and advocacy. Their local work would primarily focus on African communities inside the European territory and also the western audience (Leye, 2005).

Organizations such as *Terre Des Femme* (created in Germany in 1981) and the *Groupment pour l'Abolition des Mutilations Sexualles* (created in France, 1982) had an approach based on producing professional programs like information leaflets and educational programs and researches and supporting African organizations. All this work was paramount in order to raise awareness inside the population, both groups that would suffer from the practice as well as health professionals and the Western society that didn't possess cultural knowledge in relation to the practice (Leye, 2005).

The work of the NGOs is essential once it also provides data related to the prevalence of the practice in many countries and works inside the local communities, raising awareness. The

organization “FORWARD” works with data publications and it is essential to show the reality of the practice in numbers.

According to Momoh and Rymer (2005):

> “During the 1980s FGM resurfaced with the arrival of immigrants, students, refugees, and Asylum seekers from countries that had continued FGM on their daughters, for example, Somalia, Ethiopia, Djibouti, Sudan, and Eritrea. Health professionals were undoubtedly ill-prepared for managing the care and treatment of these women and this was compounded by the fact that there was little or no understanding of the multiplicity of gender-related socio-cultural and economic factors underpinning FGM. (p.21)”

The NGO named FORWARD was founded in 1981 by Efua Dorkenoo. Her advocacy work in relation to the practice of FGM/C was pivotal in conceptualising and identifying such as a violation of women and children’s rights in the International scope inside the United Nations. The year 1985 formalised the NGO as a charity, and this was of paramount importance in the process of the organisation’s participation in the first UK law against the practice of FGM: *The Prohibition of Female Circumcision Act.* The organisation continues its work with the creation of data surveys and also partnership with other leaders in the creation of new NGOs, such as the”Organisation End FGM”.

Chapter 3 - FGM/C in the International Agenda

This chapter will follow the International steps identified and characterised with the practice of FGM/C. Not only as a traditional practice between the groups that would practice it, but also as a Human Rights issue once it caused physical and psychological scars to women and girls. The following sections will cover the process of enforcing laws that would prevent the practice of FGM/C from happening inside it's territories and the conflicts and ineficacies identified in the process.

Before the appearance of NGOs and other organisations that would research and demonstrate the greater impact of FGM/C on women and girl's rights, the practice had a different worldwide perception. Firstly being considered a cultural tradition, there was a general reluctance on imposing universal values on an act that was considered to contribute to a collective identity of communities practising such. Most of the International actors would consider the practice of FGM/C as an individual-led practice. It was perpetrated by groups only and it was not led by state actors. In this sense, it was considered to be a private action (UNICEF, 2005).

In the 1950s FGM/C was placed on the International agenda of the United Nations and addressed within the UN Commission on Human Rights. The World Health Organisation was invited by the Economic and Social Council of UN in 1958 to manage a study in relation to the persistence of traditional ritual practices inflicted on women and girls.

The International scope of action in relation to the practice of FGM/C remained limited and other milestones were achieved later in the 1960s and 1970s (UNICEF, 2005).

The decades mentioned above were identified by a significant step in the movement to end the practice of FGM/C. The increase in raising awareness programs mainly focused on women's rights advocating on the harmful effects of FGM/C on the health of girls and women was identified and it contributed on the process of the erradication of the practice worldwide.

In 1979 the regional seminar on *Harmful Traditional Practices Affecting the Health of Women* was created by the World Health Organisation in Khartoum, Sudan. In this sense the practice of FGM/C was condemned in all its sources and even when it was performed respecting medical and hygiene conditions. Later, the *Inter-African Committee on Traditional Practices Affecting the Health of Women and Children* introduced the FGM/C in an international scope, guaranteeing the enforcement of the understanding of the practice as a harmful social convention in relation to rights of women and children (UNICEF, 2005).

In that same year *The Convention on the Elimination of All Forms of Discrimination Against Women* promoted the perspective of recognition of the FGM/C as a violation of girl's and women's rights following such reinforcement in other numerous international conferences.

The decades of 1980 and 1990 were the most prominent times in which guaranteed that the talkings surrounding the FGM/C would already classify the practice as an important subject affecting Human Rights issues. The *UN World Conference on Human Rights* in 1993 in Vienna followed the reinforcement on understanding the practice as a Human Rights issue. Other conferences that would focus FGM/C on a Human Rights dimension: *The International Conference on Population and Development* (Egypt, 1994), *The Fourth World Conference on Women* (Beijing, China, in 1995). (UNICEF, 2005).

Until 1990, FGM/C (and other practices that denoted violence against women) were not considered relevant in an International sphere:

> 'Before the 1990s, the international community did not view violence against women in general and more specifically FGM as a major issue. If violence against women was recognized as an issue at all, it was seen as under the purview of national governments, not a subject of International law. Violence against women was widely viewed as a private act or a domestic matter carried out by private individuals. For this reason FGM was initially placed beyond the scope of international human rights law' (Middelburg, Desiderio, 2014 p.8).

Moreover, the movement of diasporas from African communities towards western countries (this research focus will be in African diaspora towards European countries, most specifically

United Kingdom) also contributed to International considerations of the practice, once incidences of FGM/C started happening inside Western territories, originating from families or groups that were now residing in the European continent. The process increased both International and communitarian campaigns working in direct contact with migrant populations and the Western society in order to create an environment of awareness and knowledge in relation to the practice. These processes will be discussed placing emphasis on the importance of community groups in the fight against the practice, for instance, the local work of Non-governmental Organisations.

With a movement that focused on fighting the violence against women, changes to that perception were observed. In 1990 the adoption of General Recommendation No. 14 on Female Circumcision1 and the General Recommendation No. 192 on Violence Against Women in 1992 focused on including the subject under the CEDAW or *The Convention on The Elmination of All Forms of Discrimination against Women*. Any type of female circumcision would then be understood as a possible breach of International Human Rights Law (Middelburg, Desiderio, 2014, p.8).

The practice of FGM was, for the first time, recognized as a form of violence against women in 1993 at the World Conference of Human Right with its declaration stating that FGM/C and other traditional practices were harmful practices against women. Moreover, 'although not legally binding, this declaration strengthened the growing international consensus that gender-based violence is a human rights violation (Middelburg, Desiderio, 2014, p.9)'.

These world conferences were responsible for creating a joint engagement of countries with the potential to work internally to fight the practice of FGM/C inside their territories. The Human Rights implication that was now input towards the FGM/C created a scope that

pressured nations to recognize the practice with a negative impact on female's rights inside their traditions.

In 1994, The *International Conference on Population and Development* held in Cairo created a programme of action adopted by 179 countries that agreed on taking measures to fight the practice of FGM/C inside their territories. Prohibition and enforcement should be the lead measures implemented and they should focus on Community Based Engagement by village and religious leaders. Education, raising awareness and counselling victims of the practice as well as local people should engange in order to reeducate on the harms of the FGM/C, leading their population to change the perceptions focusing on eliminating the practice of FGM/C between these groups (Middelburg, Desiderio, 2014).

Accreditation to NGOs work is once again sustained once it was advised that States should support the effort of these organisations inside their territories. The discouragement of the practice should also be perceived in the health system. (Middelburg, Desiderio, 2014).

Considerations on Health consequences x Human Rights approach

Before the classification of FGM/C as a Human Rights issue, the first engagement on understanding the practice as a harmful procedure and lead its focus into International erradication campaigns, focused on classifying FGM/C as a health issue which unintentionally was responsible for promoting the medicalization of FGM/C. The erroneous classification created an environment for the continuation of the practice, now being exercised and normalized by health professionals inside numerous countries (Middelburg, Desiderio, 2014).

It is then interesting to pinpoint the first atmosphere of conflict in relation to the FGM/C: just claiming the practice as a health issue was not enough to erradicate and demonstrate its impact in the life of women and girls. The health classification didn't rule out FGM/C, on the contrary, opened a precedent for the practice to become medically institutionalized inside the territories that would practice it.

The health classification of the practice enhanced the importance of understanding and classifying the practice not only as a health issue but as well as a Human Rights issue:

> 'From a human rights perspective, medicalization of the practice does not in any way make FGM more acceptable. The International community has since recognized that FGM is not only a health issue but also a matter of human rights. The International campaign to eliminate the practice has subsequently embraced the human rights framework, acknowledging that, while parents do not intend to hurt their children, FGM violates a number of recognized human rights. (Middelburg, Desiderio, 2014, p.9)'

It was clear from an eradication perspective that only the medical classification itself would not stop FGM/C from being practiced inside these territories.

Although the health classification could not impose a reality that would erradicate FGM/C as a harmful procedure and stop its incidence, the harmful impacts of the practice were itself a prerrogative in the violation to achieve a standard of health, presenting long and short-term risks: severe pain that can cause shock, excessive bleeding (can occur during the procedure if a clitoral arthery is cut), inflammatory responses to the procedure, infections with the

possibility to contract sexually transmitted infections such as HIV, urination problems (World Health Organisation, 2020c).

Mental health complications are also noted (most of the women describe the practice as a traumatic event in their lives. post-traumatic stress disorder is also connected to the experience of being mutilated), sexual health problems, obstetric complications (the practice increases the risk of caesarean section, postpartum haemorrhage, difficult labour and other birth-related complications), and, neonatal death (World Health Organisation, 2020c).

The assimilation of FGM/C as a Human Rights issue additionally with many of its health impacts created a space for the inauguration of internal laws in each country that would practice it.

3.1 - FGM/C and International Law

This section will cover the steps taken by each country in their law enforcement towards the practice of FGM/C. It will provide general information of enforceability in relation to the FGM/C, following the legal implications in relation to the practice inside African countries.

For the research presented here, the author has chosen Somalia as the country studied as its incidence in relation to FGM/C is the highest in the African Continent. The author also choose Somalia as this was the focused population studied in chapter 1 that migrated to European countries in diaspora, leading the practice of FGM/C to become a reality in Europe.

Numerous International conferences above mentioned were responsible for creating a scope of action surrounding the practice of FGM/C. These milestones caused International pressure and led the procedure to become questioned not only as a cultural tradition, but as a form of violation of women and girl's rights in many aspects, including a reflection on the inequality of the sexes and the female's rights to physical integrity. With the International consideration of FGM/C now demonstrated, the next step was to legally enforce that it couldn't be carried out as a normal social passage between the groups that would perform it.

The entrance of the FGM/C issue inside the International scope (as mentioned on the first section of chapter 3) were the first Western resolutions in relation to the later creation of enforcement laws inside the European continent. The scope of coverage of this research focuses on the European and African legal actions towards FGM/C once the considerations in relation to the practice in these locations (Somalia and United Kingdom) are the main areas being studied.

International texts and resolutions were important to stipulate FGM/C as harmful practice, creating a basis to reject such as an acceptable social behaviour. Many countries had ratified the International Conventions and other conferences were talking about FGM/C which caused

the increasing of European policy in relation to the practice and the following creation of National Laws (Leye, 2005).

A research study performed on legal provisions identified European National Laws in relation to FGM/C. Some countries legal decisions as shown below:

Table 1 - Specific criminal law provisions applicable in former EU Member States

Table 8.1 Specific criminal law provisions applicable in former EU Member States[1]

	Austria	*Belgium*	*Denmark*	*Spain*	*Sweden*	*United Kingdom*
Specific criminal law provision	Section 90 of the Penal Code	Article 409 of the Penal Code	Articles 245–246 of the Penal Code	Article 149 of the Penal Code	Act Prohibiting Genital Mutilation of women, 1982:316, changed in 1998 and 1999	PFC Act 1985 and changed in the FGM Act in 2003
Date of entering into force	01/01/2002	27/03/2001	01/06/2003	01/10/2003	01/07/1982, modified in 1998 and 1999	1985, modified to FGM Act 2003 on 03/03/2004
Applicable on genital mutilation of boys	Yes	No	No	Yes	No	No
Which forms of FGM are forbidden?	Clitoridectomy Excision Infibulation All other forms	Clitoridectomy Excision Infibulation All other forms, except tattoos and piercings	Clitoridectomy Excision Infibulation –	Clitoridectomy Excision Infibulation All other forms	Clitoridectomy Excision Infibulation All other forms	Clitoridectomy Excision Infibulation All other forms, except tattoos, piercing and stretching of the labia
Is re-infibulation mentioned?	Not specifically stipulated as illegal	Not specifically stipulated as illegal	Not specifically stipulated as illegal, national guidelines are provided	Not specifically stipulated as illegal	Not specifically stipulated as illegal, national guidelines are provided	Not specifically stipulated as illegal, health professional guidelines are provided
Aggravating circumstances	Loss of essential body parts/ Permanent and incurable corporal lesions/Permanent loss of working capacity/Offence causes death	Offence is committed against minor/Offence is performed by a parent, person having custody/ Permanent and incurable corporal lesions/Permanent loss of working capacity/Offence causes death	Loss of essential body parts/ Permanent and incurable corporal lesions/Offence endangers life of victim/Offence causes death	Offence is committed against a minor/Offence is performed by a parent, person having custody	Offence endangers life of the victim/ The crime involved particularly reckless behaviour	Not mentioned in the 1985 Act, or in the 2003 FGM Act
Does the consent of the victim affect the legal qualification of the act?	No	No	No	No	No	No
Applicability of the principle of extraterritoriality	Yes	Yes	Yes	Yes	Yes	Not in the 1985 Act, but in the 2003 FGM Act
Criminal prosecution of FGM?	No	No	No	Yes (in these court cases FGM was still treated under general criminal law)	No	No

PFC: Prohibition of Female Circumcision

Source: Leye, 2005.

The enactment of laws inside many countries was perceived as an important step in the fight against the practice. However, here another sphere of conflict began to be observed: the legal enforcement towards the practice could not guarantee its eradication because the communities[9] that would practice the procedure would still perceive and understand FGM/C as their tradition and as a social rule that still had major importance inside social participation in their groups (Middelburg, Desiderio, 2014).

The legal side of FGM/C was considered but the social convention ruled out the illegality of such inside the understanding of these groups. In this sense the only way to change the communities' mindset in relation to the practice was the adoption of a holistic approach that would incorporate Human Rights to the conversation. The practice of FGM/C would then be brought to an agenda focused on social justice where governments should be alligned to a human right's approach that would focus on the realization of female's rights[10] (Middelburg, Desiderio, 2014).

Although there is a necessity to coordinated work, not only legally enforcing FGM/C, the countries that had already made efforts to criminally legislate the practice in their territory represented a step forward in the management of the erradication of the procedure:

[9] This conflicted reality is mostly identified between African communities in which the FGM/C was perceived as a conventional social rule, understood as cultural tradition - both communities residing inside African territories as well as the African groups that had migrated to western countries.

[10] A further discussion on the changes of the perception of FGM/C between traditional communities promoted by external influences - results of the migration movements discussed in prior sections of this research - will be later proposed.

Table 2 - National Efforts to Eliminate FGM

NATIONAL EFFORTS TO ELIMINATE FGM

Criminal Legislation/Decree (year enacted)

AFRICAN NATIONS

Benin (2003)
Burkina Faso (1996)
Central African Republic (1966)
Chad (2003)
Côte d'Ivoire (1998)
Djibouti (1994)
Egypt (2008)
Eritrea (2007)
Ethiopia (2004)
Ghana (1994)
Guinea (1965, 2000)
Kenya (2001)
Mauritania (2005)
Niger (2003)
Senegal (1999)
South Africa (2005)
Tanzania (1998)
Togo (1998)
Nigeria (multiple states, 1999-2002)

INDUSTRIALIZED NATIONS

Australia (6 of 8 states, 1994-97)
Belgium (2000)
Canada (1997)
Cyprus (2003)
Denmark (2003)
Italy (2005)
New Zealand (1995)
Norway (1995)
Spain (2003)
Sweden (1982, 1998)
United Kingdom (1985)
United States (Federal law, 1996; 17 of 50 states, 1994-2006)

Source: Center for Reproductive Law & Policy. 2006

Additionally, with the communitary perception of FGM/C still not suffering major changes with the creation of laws, another conflicted scenario could be perceived, especially in African countries: gaps on the implementation of the laws.

> 'While some form of legislation against FGM exists in most of the 28 African countries of focus, there are serious challenges to implementation and enforcement of those laws. Some of these challenges are systemic; for example, there are often few police or other government officials in remote rural areas, where FGM is most prevalent, and those who are in these areas may have limited knowledge or understanding of the law. There are also cultural challenges and conflicts of interest where police and local political and community leaders continue to support the practice (for reasons of 'tradition', status and/or financial gain). (28 too Many, 2020, p.1)'

Moreover, the absence of prosecutions in these countries shows the imbalance of laws in the efficacy of eradicating the practice. National laws banning FGM/C are presented in 22 of the 28 African countries that practice the procedure in their cultures. These laws lack in

enforcement and there are rarely prosecutions documented inside African countries which can demonstrate how the enforcement itself is not able to defeat FGM/C as a reality in these territories. In a communitarian level FGM/C is, once again, justified as a costumary tradition also being backed up by religious laws (28 Too Many, 2020).

Although 22 countries hold laws banning FGM/C inside their territories, 6 countries still hold FGM/C as a legal practice: Chad, Liberia, Mali, Sierra Leone, **Somalia** and Sudan. The lack of the FGM/C legal aspect in the countries aforementioned can explain the strength of the procedure as a social convention even after diaspora groups emigrate to other continents. The research presented here will focus on the Somalian perspective of FGM/C and its legal challenges in order to later demonstrate the incidences of such inside the European continent after the diaspora - mostly concentrated between Somalian communities living in UK and other european countries.

Although some articles of the country's constitution[11] set out some level of prohibition: under article 15(4) circumcision of girls is appointed as a 'cruel and degrading customary practice, and is tantamount to torture. The circumcision of girls is prohibited' (28 Too Many, 2018, p.3) the domestic legal framework of Somalia lack in providing a National legislation that expressly criminalises FGM/C. 2015 demonstrated some effort on passing a new Bill that would criminalize FGM/C but such bill has yet to be proposed in the country.

What demonstrates a weakness in the legal enforcement in relation to the FGM/C in Somalia has to do with the fact that the Somalian constitution does not specifically define the FGM/C - article 15(4), it only mentions the circumcision of girls. This limitated statement of restrictions in relation to FGM/C makes it almost impossible to identify whether the prohibitions cover

[11] 'Somalia's legal system is a mixture of civil law, Islamic law and customary law (referred to as Xeer). The Constitution of Somalia (2012)1 states at Article 4, 'After the Shari'ah, the Constitution of the Federal Republic of Somalia is the supreme law of the country' (28 Too Many, 2018. Somalia: The Law and FGM, p.3)'.

FGM/C performers only, or people that directly or indirectly assists and perpetrate acts of FGM/C and/or people who fail to report a possible procedure from happening. There are currently no penalties set out in the constitution of Somalia in relation to practitioners of FGM/C, except for penalty in case *hurt* is cause towards another person. In this case the penalty is imprisonment for 3 months to three years (28 Too Many, 2018. Somalia: The Law and FGM, 2018).

Difficulties in implementing laws in relation to the practice of FGM/C are also perceived inside Western countries but now with a different layer within the conflicted scenarios surrounding FGM/C. In addition to legal technicalities - law provisions in relation to the practice could not guarantee court cases and enough evidence whether to prove a procedure that had already happened or one that would still be performed - were just not enough to build a case and bring it to court (Leye, 2005).

It is interesting to note the main factors that lead to the difficulties within the legal aspect of FGM/C: they are intimately linked to lack of knowledge in relation to the practice. This factor has deep connection with the problems perceived inside societies that do not recognize the FGM/C socially. Authorities that should be aligned to recognize the practice lack on achieving expected solutions towards the problem.

> The implementation of laws is further exacerbated by the fact that in some countries those health professionals, authorities and police officers who need to be alert to the problem of FGM have a lack of knowledge about the practice in general and about the legal provisions and procedures to follow in particular. Furthermore, all these actors have their own attitudes towards migrant populations and towards the practice of FGM. In the UK, for example, fieldwork showed that several professionals are paralyzed into inaction because of fear of being labelled 'racist' (Leye, 2005, p.89)

The limitations of the competent authorities surpass problems that demonstrate that the reality surrounding the FGM/C should be analyzed and worked from a myriad of possibilities and not lie in only one alternative for change. The creation of laws itself cannot guarantee that the

practice will be suddenly forgotten from a cultural archetype rooted and based on a complex social system.

Lack of knowledge in relation to the practice within Western societies can be seen as a significant disadvantage. Without a strong support network, traditional communities will not be able to resignificate the practice of FGM/C and understand its impact from a new light. ‘Westerners working with FGM are often viewed with suspicion, seeking to impose their Western ways upon people’ (Momoh, 2005, p.11). Culture shock and aversion to foreign systems can be perceived in both ways.

Researches demonstrate that the progress in relation to the erradication of FGM must be aligned with education and prevention programs and must be based on a non-prejudice and non-directive approach where all participants in this issue should feel open to dialogues and discussions that can create the necessary space for learning and changing. Both health professionals and all other interested parties as well as the migrant community may then feel safe to talk about their issues and look for medical and social assistance (UNICEF, 2007).

The next sections will demonstrate how the creation of laws had built the first basis on the fight against FGM/C but alone, enforcement law could not achieve total changing of the perception and behaviour towards the practice. Collective work in many societal spheres (law enforcement, education, awareness, and other communitary approaches) must be engaged in order for the management of the practice between the groups that it is still performed.

3.2 - Impact of International laws on ritualistic tradition and religious beliefs - Mixed responses and Internal Conflicts

The process of the creation of legal enforcements in relation to the practice FGM/C layed first in the technical prospects of classifying FGM/C within a legal context. Studies indicate the depth of laws and their power to hinder the incidence of the practice between the groups that would perform it.

This section will demonstrate such studies, that focused on observing the context of law between groups performing FGM/C in African territory and as well as Western countries that became a home for migrant communities familiar with the practice.

The first study focused with community groups in a rural area of Senegal after an anti-FGM/C law in 1999 was imposed in the area attested for mixed results and perceptions in relation to FGM/C. Parts of the focal group attested a variety of views in relation to the enforceability and power of the law. The authors of the study based the theoretical perception of social norms versus legal norms.

According to the research general behaviour is mainly guided on a first extent by local norms - as discussed in previous sections FGM/C represents a major norm for leading to a certain behaviour - certain parts of the population had no knowledge of law provisions (legal norms) which led them to not recognize the law as enforceable (Shell-Duncan, *et al.* 2013).

However, even having the knowledge about the law and the consequences of perpetrating the practice, the illegality of such was not a guarantee of hindering the result for certain portions of the focus group. Instead, these groups followed performing FGM/C in the country but the existence of the law generated anxiety issues related to fear of criminal sanctions (Shell-Duncan, *et al.* 2013).

Coercive approaches or a virtual coercive feeling guaranteed the abandonment of the law,

> 84 percent of respondents agreed with the statement, "The law banning female circumcision is more powerful than we are, so we must change the practice," and 80 percent agreed with the statement, "Someone who openly breaks the law banning female circumcision needs to worry about being punished" (Shell-Duncan, *et al.* 2013, p.11)

In addition the coercive interpretation of the law was followed by the social consequences of not practicing the FGM/C between their groups. One mother alleged that not having their daughters circumcised caused her psychological effects and fear for the non-acceptance of their uncircumcised daughters in between their social groups. The 'law trap', as appointed by the mother, shows the extent to which the tradition rules play a bigger part, still stronger than prospects of the law in between women that fear social rejection and inability to continue the familiar role in their society (Shell-Duncan, *et al.* 2013).

The extent to which families carry a considerable weight in the process of abandonment is also demonstrated. The research showed prospects of behavior change in relation to the law classifying the groups (Shell-Duncan, *et al.* 2013):

Willing Adherents - the ones that favoured the continuance of FGM/C and kept the procedure happening between their families.

Reluctant Adherents - subjects that were favour to the discontinuance of the practice but felt pressured to keep it happening due to the influence of other participants in the decision of abandonment that had not yet themselves became persuaded to abandon FGM/C

Contemplators - subjects that kept practicing FGM/C but now they wouldn't agree with the whole extent of practicing such (sense of ambivalence)

Reluctant Abandoners - the ones that support the continuance of the procedure but external pressures and other people coerced them to discontinue such.

Willing Abandoners - people that personally favors the eradication of the practice and had space to act in accordance to it.

The research concludes that the extent of the law on banning FGM/C presents mixed responses with variable perspectives. Parts of the society will challenge the law and find ways of keeping the practice going - reports of extraterritorial trips in order to circumcise girls on borders where the practice was not legally enforced were demonstrated. Others will feel coerced and obey to the legal solution but still, the strength to which culture and tradition clashes and conflicts with the abandonment is still vastly observed.

In conclusion:

> legal norms are variably weighed against social, moral, and religious norms that serve to uphold the practice of FGM/C. We find that threat of criminal sanctions is weighed against the effects of defying local norms, and this calculus is strongly influenced by the degree to which the cultural value has been called into question (Shell-Duncan, *et al.* 2013)

Imbalances between legal enforcement and rooted cultural archetypes such as FGM/C can be brought to the prospect of the research proposed on this thesis: To what extent can a change of cultural scenery cause changes to a deeply rooted social behaviour?

Different scenarios demonstrate the extent to which laws perpetrated in subjects' decisions to abandon the practice. Berg And Denison (2013) state, in their study with focal groups that FGM/C is a system socially constructed around deep cultural roots and that it holds major expectations within the social norm of these communities. Even in between exiled members of such communities the continuity of the practice is perceived and they still base their argument on the extent of treating the practice as a cultural tradition. On the other hand there is a duality in relation to the perception of migrant communities: they perceive with more clarity the illegality of FGM/C in the Western countries they reside in and, according to the research:

> 'the law was not just a deterrent but for many was also a support in their decision to abandon FGM/C. Second, many participants stated that FGM/C was not an Islamic duty and put this forth as an important

> reason why they would not follow the tradition. The last key factor tempering FGM/C also influences the first three factors: migration presented individuals in exile exposure to other cultural models, models that opposed FGM/C, thereby allowing sharper scrutiny of the practice (Berg and Denison, 2013, p. 848).

The existence of migrant communities show that there is a mixed perception and a process of acculturation[12]: balancing the two cultural extents to which these communities are living. While residing in Western society they accommodate considerations of both the Western culture and the culture they are coming from. Berg and Denison (2013) research shows the same extent of mixed responses to the law extent that the one reported in the first research. However, the prominent change lies in the perception of migrant communities.

There are similar factors weighing hindering and continuance of the FGM/C causing a mixture of discourses in the migrants' mindsets but also demonstrating that exiled communities contribute to the change of perception and anti-FGM/C laws in Western countries are an 'important macrolevel factor(s) slowing its continuation', (Berg and Denison, p.851).

In relation to laws enforced in their own countries the research shows positive effects in accepting the law where they have started questioning if the practice needed to keep happening, 'migrating to a new social, political, and cultural context with specific laws seems to have led some to question the normalized practice of FGM/C (Berg and Denison, 2013, p.851)'.

The extent to which the practice of FGM/C holds strength lies in cultural norms. Institutionalized by their communities, these families accreditate the position of their daughters in preparation for marriage so that in the end the family, as an organized group, can follow the social lead and prosper between their society. The recognition of FGM/C as a criminal act

[12] 'those phenomena, which result when groups of individuals having different cultures come into continuous first-hand contact with subsequent changes in the original culture patterns of either or both groups' (Ahmed, 2005, *Attitudes towards Somali women living in the UK* p.95).

‘outlawed’ the practice and it was a result of an international mobilization movement that started to position questions in relation to its existence.

However, the enforcement of law alone still causes conflict. Inside the communities that, as a strong group, perceive the importance of a rooted norm and fear become social outcasts in case they disagree to this shared rule. At the same extent, the fear of legal prosecution causes them to abandon the practice pressured by coercion.

Comparatively, another portion of these groups, led by the weight of their own experiences and with the assistance of legal prospects re-defined their beliefs in relation to the practice and fought against the continuance of such. Their personal experiences were documented and were another aspect in the work of fighting the practice.

The story of women that had suffered from FGM/C was responsible for the articulation of groups of pressure that led to the creation of laws and, with a familiar holistic view, approached the work that envisioned the creation of an empathetic re-definition and re-education process of looking at the practice not only as an unchangeable social rule but a procedure that would decrease females access to their basic human rights.

3.2.1 - Re-definitions of beliefs in relation to the practice of FGM/C

This section covers stories of FGM/C suffered by women that contributed to the re-definition of the practice between their social groups. Combined with the process of enforcement law, new perceptions visualized after migration movements, and a conjunction of holistic and community approaches (provided by invested parties such as NGOs) strengthened the process of management of the practice perceived as a social/cultural conflict, these seem to be the most effective method that, aligned, can support the discontinuation of the strong source of cultural beliefs.

The following story in an extract from Joshi (2016): *The brave Women Fighting to End FGM/C*. As told by a woman that had undergone FGM/C, the extract denotes how she believes that the practice can be descontinued with the advance of laws to protect women as well as the creation of a support net for girls that can undergone the procedure:

‘ “My message is that we must continue to educate and support women and girls in their fight against female genital mutilation. The numbers are reducing and people are now more fearful of the government law that has made it illegal.

“I tell other girls that they shouldn’t do it and to tell their families that there is now a law to protect them. And tell them about my experiences and how painful it was and the problems it can cause them later on in life. I tell them that if they are mutilated they will be married off to an old man like I was and they won’t be able to finish school. My hope for the future is that no girls in Pokot have to go through what I went through. I think this is possible – we just need more time and education.”

When Christine was 15 her family were preparing for her to undergo Female Genital Mutilation/Cutting (FGM/C). She asked her mother and brothers why she had to have this done. They answered that it was for *her* future. She was kept in seclusion after undergoing this harmful cultural practice, a much older man came to see her brothers. He was 60 years old and wanted to marry Christine. Her brothers agreed and gave him 15 cows to marry her. She asked them why they had agreed to this arrangement – with an old stranger – they told her she had to follow him even if she didn’t want to.

At the marriage ceremony, his relatives and some guards carried her away. She cried. She was forced to stay inside his home for a week. Seeing children playing outside she asked if she could go and play with them but the old man refused as he was afraid that Christine would escape.

Christine was not this man’s only wife. His first wife, also much older than Christine, also lived there and treated her like one of her children.

During Christine's first night in this house, the old man forced himself on her. She cried with pain. Because of the type of FGM/C Christine was subjected to, this meant that Christine has been sown closed – with only a small hole for urine and menstrual release. The other wife was waiting at the door. He asked her to come in so that she could "make her bigger" using a cow's horn. The eldest daughter of the man also came in to help.'

When arguing in relation to tell her story to other girls, Christine demonstrates how a humane approach plays the cards on familiarizing communities that assimilate the FGM/C in the same extent as her community did. When she urges them to tell their families that there is a law that now protects them against the practice, she empathises with other women's stories, and creates a familiar and safe approach that can make other girls identify their own stories with her passage and maybe consider the harder consequence of FGM/C in contrast with its normative quality. Her message also pinpoints the importance of the creation of the laws in the sense of legally protecting women that underwent the practice and they feel safe to report the issue from happening in their communities.

Figure 5 - Challenges faced by those who begin the process of change

Box 5 - A mother's story: Challenges faced by those who begin the process of change

Khadija is a devout Ansar Sunna Muslim from the Beni Amer tribal group in Eastern Sudan. She lives with her extended family. When she leaves the house, she covers herself in a black *abaya* (garment) and face veil to be properly modest. As a girl, she underwent infibulation, known in Sudan as "pharaonic" cutting, according to Beni Amer tradition.

Now she has a six-year-old daughter who has not yet been cut. Khadija attended a program about harmful traditional practices, where she learned about the health complications associated with FGM/C. Along with other women, she registered her daughter with the group of uncircumcised girls. Yet Khadija is troubled. Although she doesn't want her daughter to suffer from the health complications she heard about, she knows that men favour the practice for religious reasons. She also expects that her mother-in-law will have something to say about it. "If I don't cut her, there won't be anyone to marry her," says Khadija. "I wish I didn't have daughters, because I am so worried about them."[17]

Source: UNICEF, 2007

The story above denotes how a shift in the perception, alone, can still not be strong enough to resignificate the practice in the FGM/C on a larger scale. As explicit in chapter 3 the social convention shift in relation to the practice holds greater strength when all the community

understands and re-engage their social values in order to change. The mother still has conflicts internally with the norms that her family still feel coerced to follow.

> 'Individuals within the group who have opted to abandon the practice will still face social pressure to cut their daughters, [...]. For this pressure to disappear, the number of people who have expressed their intention to abandon the practice must reach a "tipping point". At this point, those who still consider following the practice recognise that the status and honour it brings to a girl and her family no longer outweigh the risks involved.
>
> Once the new convention of valuing a girl's physical integrity is established, it becomes, like the old convention, self-enforcing. For those who have abandoned FGM/C, there is no incentive to revert to the practice, while the few individuals who continue to support FGM/C will face the disapproval of the community (UNICEF, 2007, p.22)'

Chapter 4 - Data Findings and Discussion

At the beginning of this thesis, evidence was presented that the slave culture was one of the factors that contributed to the introduction of FGM/C to these populations:the African enslaved and the slave traders themselves. The existence of FGM/C was/is based on considerations of women's sexuality and male dominance. It encompassed the idea of female sexual control as well as high value to the slave profit and the cleanliness of women.

Other studies also identify origins prior to Egyptian and Muslim slavery of African groups:

> Though the exact reason for the origin of Female Genital Cutting (FGC) is unknown due to the dearth of conclusive evidences, multiple theories revolve around how the practice began. FGC precedes both the start of Islam and Christianity and is practised predominantly because of cultural traditions. FGC is not limited to a single community, religion or ethnicity. Rosemarie Skaine mentions that there are archival documentations indicating a Greek papyrus to have recorded women to get circumcised while receiving dowries around approximately 163 BC. In fact, there are several Greek scholars mentioning its prevalence before the advent of Christianity (Charterjee, 2018, p.1).

As the origin of FGM/C has been covered the understanding of the persistence of the practice is paramount in order to assess what are the main factors that lead groups to create a common sense and a belief system surrounding the practice.

Berg and Denison (2013) studied the main factors responsible for perpetuating the continuance of the practice inside these groups. With mixed method research, consulting and interviewing African Nationals and African exiled communities it was concluded that religion, tradition, marriageability[13], sexual morals, health benefits, male preference, aesthetics and social pressure are the general beliefs surrounding the persistence of the FGM/C between these communities. Encompassing all of the studies held, the practice was mentioned by the participants as a ‘highly meaningful and cultural tradition (Berg and Denison, 2013, p.845).

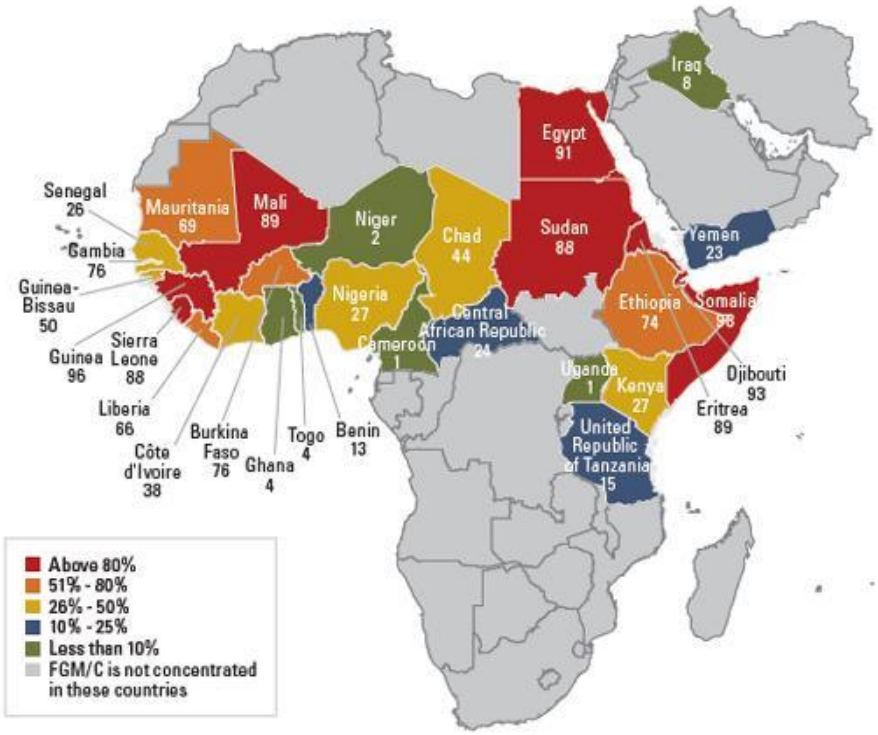
[13] The concept of marrigeability in relation to FGM/C was discussed in Chapter 2

To these communities FGM/C has the capacity to ensure and protect the women's virginity once it would decrease female sexual desires. Virginity, as commonly understood inside these traditions, is a prerequisite for marriage and it affects the families relationships within the general society in which they live. Local families usually would judge the families that do not circumcise their children and consider the act of not doing so as 'poor parenting' (Boyle, 2002, p.29).

In this sense it was comprehended that the practice held major weight on what was socially expected and accepted inside of these groups. Social status conforms the actions of these groups and the FGM/C is the means that will guarantee their acceptance throughout their community.

The World Health Organisation (2020), in conformity with the researchers studied in this thesis, stated that the practice of FGM/C is a social convention where there is a pressure in between the societies to conform to what they all do collectively thus causing the necessity to be socially accepted. The motives that perpetuate the practice also lie in the fear of social rejection by families of families within the communities, and these factors are the reasons why FGM/C is still universally performed in a number of countries:

Figure 6 - Percentage of girls and women aged 15 to 49 years who have undergone FGM, by country



Source : UNICEF, 2013

Following analysis of the practice of FGM/C in African countries and its persistent endurance, migration movements were responsible for the appearance of incidences of the practice in many other reagions of the world. This research, however, is focusing on the Somalian groups migrating to the United Kingdom. Diasporas are a common reality in these countries and as a result these groups migrate constantly towards other regions of the world.

The movement of Somalian[14] groups travelling towards Europe - and most specifically the United Kingdom - was responsible for bringing a foreign tradition to the western culture, resulting in incidences of the practice never before seen in Western territories:

[14] The diaspora movement from Somalia towards United Kingdom was discussed on Chapter 2

Table 3 - Figures of the most recent FGM prevalence studies in the EU

Country	Title of study	Year of publication	Number of women and girls victims of FGM	Number of women and girls at risk of FGM
Belgium	Estimating the number of women with FGM in Belgium[v]	2011	6,260	1,975
France	Quantitative chapter of the 'FGM and disability' project[vi]	2007	61,000	Not available
Germany	Statement of Terre Des Femmes e.V. – Human Rights of Women at the Public Hearing of the Committee on Family Affairs, Senior Citizens, Women and Youth on the subject 'Fighting FGM'[vii]	2007	19,000	4,000
Hungary	FGM prevalence in Hungary, estimation	2012	Between 170 and 350 women affected	
Ireland	International Day of Zero Tolerance to FGM[viii]	2011	3,170	Not available
Italy	Quantitative and Qualitative Evaluation of the FGM phenomenon[ix]	2009	35,000	1,000
UK	A statistical study to estimate the prevalence of FGM in England and Wales[x]	2007	65,790	30,000

Source: European Institute for Gender Equality (EIGE), 2013.

The incidence of FGM/C inside United Kingdom unites disagreggated data due to the extent which it is still an intimate issue. As already stated by this research, lack of knowledge and the extent to which the communitarian assistance can be weak are related to the diversity of social behaviours persisted by Western society and immigrant communities. However new data on the FGM/C inside the country is being gathered to some extent.

Until the late 1990s, 86000 immigrants and refugee women originated from the African Continent lived in the United Kingdom and had already suffered from FGM. The number of children at risk of undergoing the practice was 7000. The refugee flow was originated from countries such as Somalia, Sudan, and Sierra Leone and occurred due to the population

escaping civil wars and these countries presented a high incidence of FGM practice in their territory (Forward, 2002).

Other countries with survivors of the FGM/C gather 125,000 in Germany, the second highest incidence of FGM in Europe followed by Italy, 70,469, Germany, 70,218, and Sweden, 38,939. An estimation of 600,000 currently are living in the Europe with the consequences of FGM/C. The United Kingdom is the European region with the highest number of incidences of the practice in its territory (End FGM, 2020).

Table 4 - Comparison of numbers of women aged 15-49 born in FGM practising countries, England and Wales Censuses, 2001 and 2011

Country	Enumerated number of women aged 15-49, 2001	Enumerated number of women aged 15-49, 2011	Difference 2011 - 2001	Group
Djibouti	93	204	111	1.1
Eritrea	2,804	7,071	4,267	1.1
Somalia	15,744	43,558	27,814	1.1
Sudan	3,200	5,412	2,212	1.1
1.1	**21,841**	**56,245**	**34,404**	
Burkina Faso	33	81	48	1.2
Egypt	3,698	4,463	765	1.2
Ethiopia	3,421	6,930	3,509	1.2
Gambia	1,387	4,236	2,849	1.2
Guinea	101	911	810	1.2
Mali	41	140	99	1.2
Sierra Leone	6,625	8,903	2,278	1.2
1.2	**15,306**	**25,664**	**10,358**	
Central African Republic	163	75	-88	2
Chad	44	121	77	2
Guinea Bissau	155	970	815	2
Iraq	7,546	18,344	10,798	2
Ivory Coast	1,082	3,625	2,543	2
Kenya	45,396	31,740	-13,656	2
Liberia	555	1,234	679	2
Mauritania	13	64	51	2
Nigeria	33,485	68,727	35,242	2
Senegal	264	701	437	2
Yemen	1,092	5,062	3,970	2
2	**89,795**	**130,663**	**40,868**	
Benin	99	242	143	3
Cameroon	1,353	4,227	2,874	3
Democratic Republic of the Congo	1,199	8,783	7,584	3
Ghana	22,116	33,059	10,943	3
Niger	39	76	37	3
Tanzania	10,512	7,729	-2,783	3
Togo	174	586	412	3
Uganda	19,640	15,715	-3,925	3
3	**55,132**	**70,417**	**15,285**	
Africa - East (not otherwise stated)	3,626			
Africa - North (not otherwise stated)	276			
Africa - West (not otherwise stated)	896			
Africa (not otherwise stated)	4,232	4,028		
Total, ignoring not otherwise stated	**182,074**	**282,989**	**100,915**	

Source: ONS

Extracted from: Dorkenoo, Macfarlane, (2014)

Datasource from MICS (2006 - 2011) demonstrated that the prevalence of FGM/C in the Somalian territory was 97.9%. Staggeringly, 64.5% of women believed the practice should continue. The highest incidence can be explained by a law-enforcement perspective. (28 Too Many, 2018)

Chapter 2 focused on identifying the sources of conflict surrounding FGM/C. Theoretical approaches on conflict were covered to identify that culture shock from Western society was perceived when dealing with the cases of FGM/C now reported in Europe. The cultural shock observed has generated International pressure towards the practice of FGM/C - in this case International Organizations and NGOs that protect Human Rights that systematically work to change the perception of these populations regarding the practice.

The NGO's needed to identify and explore effective ways to perceive the intimate, personal, communal and cultural conflicts in relation to the practice of FGM/C when the incidence lay on strong social conventions.

It was later demonstrated that the prospect of international pressure based on law enforcement itself was not able to discontinue or promote a shift of social behaviour towards the practice. According to qualitative research promoted in Senegal[15] on measuring the extent to which law enforcement discontinued the practice between traditional communities showed mixed responses on the extent of the law.

According to the research provided by UNICEF (2007), in order to access the discontinuation of FGM/C as a social convention, more than the law, prospects on social convention shifts must be addressed in order to guarantee the abandonment of the practice and re-significance of such as a social norm.

[15] The research is appointed on section 3.2 of chapter 3.

As listed on section 2.3 of chapter 2:

- Approaches free from coercion and prejudice focusing on Human Rights issues as well as processes empowering women: The increasing of awareness is capable of promoting the understanding of FGM/C as a Human Rights issue and guarantee the progress in relation to the areas that are considered of immediate concern such as human issues like education and health.
- Programs of local awareness expliciting the harm caused by the practice: discussions surrounding the practice must be non-judgemental and its reflections should be non-directive. When subjects that suffered any type of harm in relation to the practice tell their own stories the negative costs of FGM/C become more evident.
- Collective choices of groups that are connected by the social norm surrounding marriageability and its relation to the practice of FGM/C: descontinuation of the practice will only be achieved if there is a collective decision on abandon such. Members of these societies must organize in order to successfully transform the social convention on a generational communitarian level.
- Explicit demonstration/affirmation by groups of their decision to abandon the procedure of FGM/C: Public statements on the abandonment of the practice should be done in order to create an authoritative statement towards descontinuation of the practice fortifying their decision on a public level.
- Organized diffusion of the will to change the perception in relation to the practice, that should spread throughout the communities: Once the decision of hindering the practice is already sustained and diffused between communities,

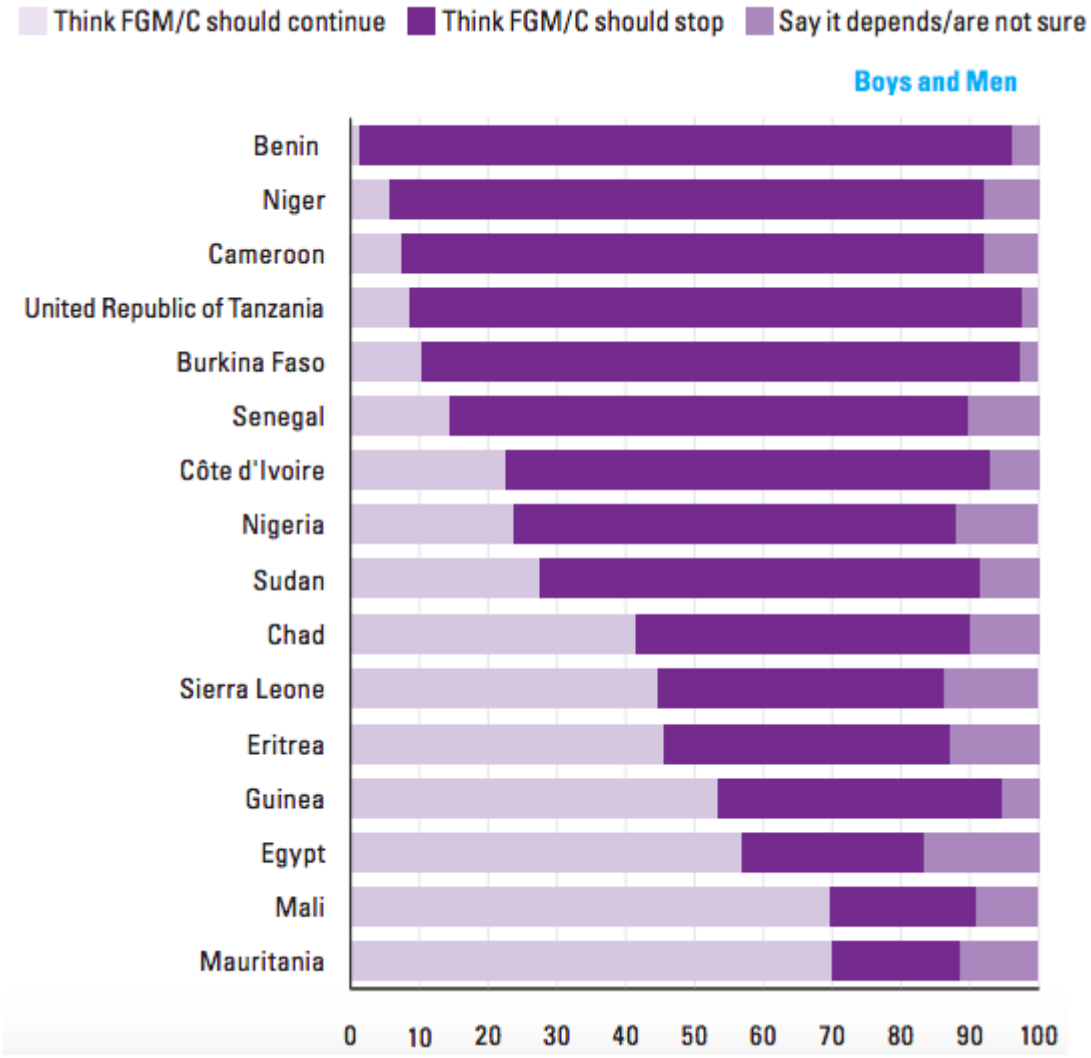
> ‘the social dynamics that originally perpetuated the practice can serve to accelerate and sustain its abandonment. Where previously there was social pressure to perform FGM/C, there will be social pressure to abandon the practice. When the process of abandonment reaches this point, the social convention of not cutting becomes self-

> enforcing and abandonment continues swiftly and spontaneously (UNICEF, 2007, p.23) ’

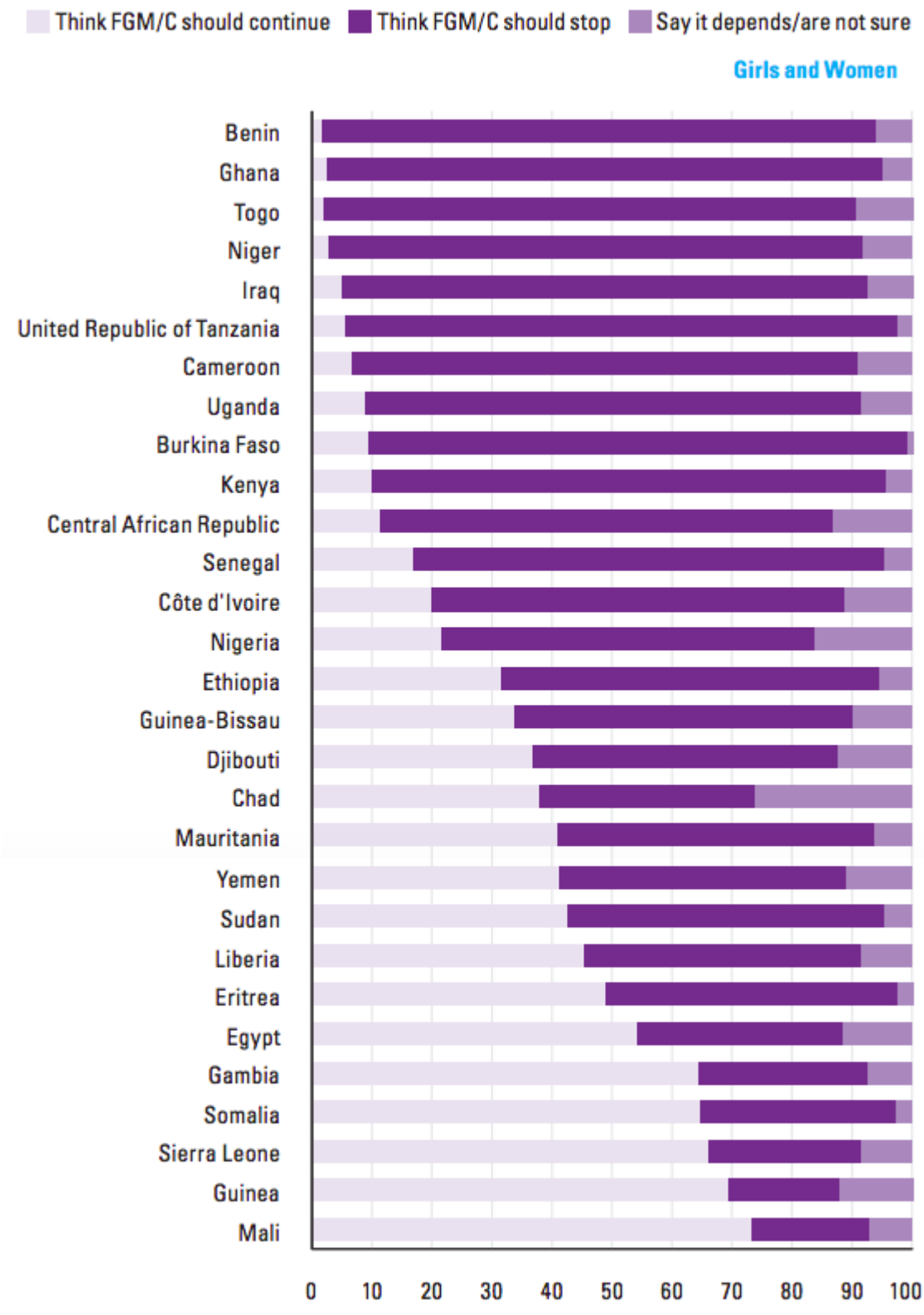
- An atmosphere that creates means to sustain models of behavioural change: The last step studied by the Technical Note provided by UNICEF (2007) appoints that, in order for all the other 5 stages to work, governments need to be aligned in all levels supporting the social shift: legislation, effective advocacy and awareness approaches.

Since this research was based on the possible approaches that should be considered in order to change the perception in relation to FGM/C, a quantitative look on the results of international work in the fight against the practice can aggregate to this piece of work:

Figure 6 - Percentage distribution of girls and women aged 15 to 49 years and percentage distribution of boys and men aged 15 to 49 years who have heard about FGM/C, by their attitudes about whether the practice should continue



Source: UNICEF, 2013



Source: UNICEF, 2013

Conclusion

In the beginning of this research it was aimed to analyze the practice of Female Genital Mutilation and the internal and external conflicts caused within the context that the practice was understood as a social convention by traditional communities. The origin, history and incidences of the practice in Africa were analyzed through secondary qualitative research studies in order to understand the factors that perpetuate the practice between traditional groups.

On a second moment I assessed how migration movements called diasporas - most specifically Somali diasporas migrating towards Europe (I have investigated this movement towards the United Kingdom), have caused international pressure towards the practice.

The movement of diaspora (from Somalia towards the United Kingdom) caused culture shock - both in the diaspora groups living in Europe and the european citizens themselves. That atmosphere of shock enhanced the scope of conflicts surrounding FGM/C.

Considerations on the enforceability of the practice, after international pressure that caused the creation of laws were also perceived. They were discussed in order to evaluate the extent to which the law was effective to re-define or discontinue the practice and the internal conflicts which enforceability towards FGM/C have caused in a societal and internal logic.

The law itself could not enforce the discontinuation and re-education of the practice at a communitarian level and the social conflicts surrounding the knowledge and understanding of the practice caused the following conclusions.

The international movement towards the re-significance of the traditional practice of FGM/C needs to align a series of tools enganged on focusing in a holistic approach towards the community level. General knowledge in relation to this procedure needs to be provided to health professionals so that they know how to assist groups that have suffered from the FGM/C

in the past. Moreover, this same knowledge needs to be spread throughout western and immigrational levels, assessing the harms that the practice can cause, the institutions that can provide assistance to women and how the law is just one of the steps that can 'back up' subjects that decide to abandon the practice.

The understanding of the practice as a Human Rights issue needs to be credited and interpreted through a communication system that is free from judgement, empathetic and non-coercive. The work of NGOs was cited in this research because these organisations are led by African women that can empathise with women and girl's stories and create a safe atmosphere that will engage freedom of speech and will later be backed up by other prospects of civil society (governments and law enforcements).

The communitarian work on the processes of re-significance of the practice need to engage the whole body of a group or society once it was already proved that, in the case of FGM/C, its quality of a social convention based on a familiar system makes it more dificult to be changed in case only one subject of a group decides to change.

The social convention shifts tool then, represent a *collective* approach that needs to look at the practice of FGM/C not judging such for the subject that practice it but, understanding that the strength of a traditional rooted norm goes over the single and personal right of one to choose.

The research presented here, followed these 7 steps, this comprehensive flow can be accessed on section 2.1.2 of the chapter 2:

1. Before external pressure, FGM/C was considered a social convention deeply rooted and unquestioned by the groups that would perform it.
2. The external movement (diasporas) cause the practice to start being observed in other continents of the globe, specifically the migratory flow from Somalia towards the United Kingdom

3. The practice was not socially recognized in western countries, which caused cultural shock and estrangement in both ways (western societies and diaspora groups)
4. Strengthened by the incidences of FGM outside Africa the practice gained international attention which caused international actors to create pressure in order for the practice to be forbiden/descontinued. It was then qualified as a Human Rights Issue and followed by the creation of laws enforcing the practice in many countries.
5. The sphere of conflicts were then observed: laws itself could not guarantee that these communities would consider the practice as a harmful issue, as it was still rooted and based on social norms between them. These groups kept practicing the FGM/C and also the enforceability of laws in many countries was weak and unguaranteed.
6. Illegality of the practice caused internal conflicts in relation to the practice: Families would keep practicing and fear being prosecuted, the ones that discontinued the practice were still perceived as outcasts by their social groups and internal issues would appear (anxiety, PTSD, fear of being prosecuted or rejected)
7. The management of the conflicts surrounding FGM/C should align law enforcement with local approaches based on campaigns focused on social convention shifts

Reflections

This research reflected in myself deep feelings and questions. I believe that society perceives the positions of power in a very patriarchal way, and I believe that, both women and men, tend to lead their stories virtually in this matter. FGM/C is 'lead' by women. It is a patriarchal construct but the women believe that they need to do it/undergo it. Because they are mothers and are constantly being asked on what they must do and how to act. It is a vicious cycle because their mothers suffered from their own mothers, because they all believed that if they didn't do it, their daughters would suffer and be socially abandoned and forgotten. Marriage is not the means to all ends. But when there is access to only one tool and only one line of thought it is natural that one will think that they need it.

Shifts of behaviour are also reached when something new comes to picture, for better or worse.

I believe that FGM/C, more than a traditional practice, it is a practice moved my fear and peer pressure. There is no light at the end at the tunnel if you are trapped on a cycle and if you are trapped, in the literal geographical way. The extent to which people moved from one place to another opened doors to new perceptions. These movement does not need to be a literal movement. Changes of perceptions can happen with the right set of materials that, without prejudice and assumption, and with empathy and respect can show these communities an easier way of perceiving their place at the earth. Men should not be the ones making such decisions.

These women will slowly start to realize that, if they have coordinated support between themselves and their own strength, they can envision a different and brighter life.

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