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# SPECIAL ISSUE PAPER

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## Belief Systems Enforcing Female Genital Mutilation in Europe

### ABSTRACT

**Purpose:** Despite numerous studies on FGM, little is known about belief systems that support FGM in the EU. This paper explores the dynamic nature of belief systems and enforcement mechanisms that perpetuate FGM among three African migrant communities in the EU.

**Design/methodology/approach:** This paper is based on data collected through community-based participatory action research in three communities: Eritrean and Ethiopian community in Palermo, Italy; Guinea Bissauan community in Lisbon, Portugal; and Senegalese and Gambian community in Banyoles, Spain. A total of 24 FGDs and 70 in-depth narrative interviews were conducted for the research.

**Key findings:** The research finds that belief systems supporting the practice of FGM among African migrants in the European diaspora are similar to those in their home countries. Beliefs structured around religion, sexuality, decency, marriage and socialisation are particularly significant in perpetuating FGM in the study migrant communities. These are enforced through sanctions and social expectations from the migrants' home and host communities.

**Research limitations:** Members of the migrant communities that were the focus of this research are ethnically diverse; therefore it is possible that differences in the practice of and views on FGM by various ethnicities may have been masked. Also, due to close linkages between the migrants and their home countries it was hard to delineate beliefs that are specific to the host countries. In addition, it was difficult to assess the level of education of the migrants and how this may have impacted on their beliefs due to their contrasting and inconsistent educational backgrounds.

**Originality/value:** This paper provides evidence to show that the practice of FGM among migrants in the EU is driven by both social norms and individual (parent) behaviour and therefore there is a need for interventions to focus on individual behaviour change and social norm transformation techniques. It also suggests that beliefs around FGM have remained socially significant among migrants despite their exposure to European culture because such beliefs are used to promote the moral standards of girls, marriageability of women, respectability of families, and the assertion of cultural and religious identity in the migrants' new environment. The paper further underscores the role of migrants' European context as well as the home country in strengthening beliefs that perpetuate FGM in the EU.

**Keywords:** Female genital mutilation, African migrants, social norm, belief system, enforcement mechanism, Europe.

**Paper type:** Research paper

## INTRODUCTION

FGM is internationally recognised as a human rights violation and a public health issue (WHO, 2012). Traditionally, the practice was thought to be common only in Africa and the Middle East, but the increase of emigration from these regions has resulted in a growth in prevalence rates in many western countries. The European Commission (2013) estimated that about half a million women and girls living in Europe have been subjected to the practice and a further 180, 000 are at risk every year. FGM is most common in European countries with high migrant populations from countries where FGM is commonplace, including Italy, Portugal and Spain, the focus of this paper (The European Institute for Gender Equality, 2013).

Despite numerous studies on FGM (Mackie, 1996; Schelling, 1960), little attention has been paid to the values and belief systems that perpetuate the practice among migrant communities in Europe. The influence of the 'dominant' culture of a host country over migrants' 'home' culture suggests that traditional belief systems that support FGM in the home country should not apply with the same level of significance in the host country of the migrants. Based on a study in Norway, Johansen (2007) posited that migrants living in the diaspora often reflect upon and challenge their home countries' values and belief systems leading to the abandonment of cultural aspects that are deemed to be irrelevant. Despite being illegal in all countries of the EU and numerous campaigns to end FGM, the practice still continues. This underscores the need for a nuanced understanding of the belief systems and enforcement mechanisms that support the continuation of FGM in migrants' new environs.

This paper provides evidence to deepen understanding of the belief systems that shape FGM practice among three African migrant communities in Italy, Portugal and Spain. Such evidence is significant for both academic discourse and policy intervention. Gruenbaum (2005) argues the need for FGM interventions in migrant communities to be informed by a good understanding of the socio-cultural dynamics of the communities in order to maximise respect, appropriateness and effectiveness of the intervention. Using information and results from a large EC Daphne III funded project entitled REPLACE2 (JUST/2011-2012/DAP/AG3273)<sup>1</sup> this paper explores the belief systems and enforcement mechanisms that perpetuate FGM in the EU. The paper argues that the perpetuation of FGM practice amongst migrants in the EU is facilitated by belief systems whose social significance is partly shaped by the migrants' new environment in Europe as well as social expectations in home countries. An in-depth understanding of these belief systems and their social significance is imperative to the appropriate design of FGM interventions as well as

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<sup>1</sup> See the REPLACE toolkit (Barrett *et al.*, 2015a) and the REPLACE community handbook (Barrett *et al.*, 2015b) for further details.

enabling frontline professionals working with FGM affected communities to engage in a culturally sensitive and effective manner.

## **METHODS**

Given the culturally specific nature of researching FGM with affected communities, the methodology of the research adopted a community-based participatory action approach (Barrett *et al.*, 2011; Barrett *et al.*, 2015a, 2015b; Brown *et al.*, 2013). This involved training community-based researchers (CBR) who led in the design, sampling, data collection and data analysis of the research. The CBRs included adult males and females chosen from the migrant communities where the study was conducted. They had good knowledge of the local language and culture of their communities and were supported by a team of experienced researchers on the REPLACE project. The approach not only enabled effective community engagement and in-depth data collection on this sensitive topic, but also provided culturally informed understanding of the beliefs perpetuating FGM.

### ***Study location***

This paper focuses on research conducted in Italy, Portugal and Spain which have large migrant populations from countries with high FGM prevalence rates. The FGM affected communities participating were: the Eritrean and Ethiopian community in Palermo, Italy; the Guinea Bissauan community in Lisbon, Portugal; and the Senegalese and Gambian community in Banyoles, Spain. The Eritrean and Ethiopian community was made up of largely transient political refugees and asylum seekers. They mainly practiced Christianity, Islam and Judaism and belonged to the Tigray and Ahmara ethnic groups. The Guinea Bissauan community was made up of mainly economic migrants and mostly lived together in a common neighbourhood. The majority of them belonged to the Balanta, Fula and Mandinka ethnic groups and comprised both Christians and Muslims. The Senegalese and Gambian communities also consisted of economic migrants and comprised the Mandinka, Fula, Sarahule (Soninké), Wolof and Bambara ethnic groups. Traditionally the Wolof do not practice FGM (Kaplan, *et al.*, 2013). The Senegalese and Gambians were predominantly Muslims.

### ***Sample***

Research participants were purposively selected from each study community by the CBRs. Participants were selected to reflect differences in gender, age and length of stay in Europe as these characteristics were deemed to be likely to influence a migrant's belief system concerning FGM. Participants were selected if they were: aged 18 years and above; willing to participate in the research; and they or their parents originated from the designated FGM practicing country (e.g. Eritrea/Ethiopia, Guinea Bissau and Senegal/Gambia). Thus, the research sample included male and female, recent and less recent migrants, and young and older adults (see Table 1).

### ***Data collection***

A combination of in-depth narrative interviews and focus group discussions (FGDs) were undertaken to collect data on both individual and community level beliefs concerning FGM. Recognising the sensitive nature of the topic of FGM and the fact

that it is regarded as a taboo subject in the study communities, the FGDs were designed to enable the research participants to openly debate the cultural underpinnings of the practice while the in-depth narrative interviews were used to provide an opportunity for those who wanted to discuss FGM in detail to do so in private and with anonymity. Both the FGDs and in-depth narrative interviews were informed by a topic guide that was shaped by input from the CBRs. The guide covered a range of topics including: terminologies used by communities and individuals for describing FGM, belief systems and enforcement mechanisms; access to FGM related services, and socio-economic and cultural life of affected communities.

A total of 24 FGDs and 70 in-depth narrative interviews were conducted across the three communities (See Table 1). Each FGD consisted of between six to ten participants. The age range of the participants was between 18 and 65 years while their length of stay in the host country was between one year and 30 years. Details of the characteristics of the participants are presented in Table 1.

**Table 1 Characteristics of research participants**

	<b>Ethiopian/Eritrean community (Italy) (N=96)</b>	<b>Guinea Bissau community (Portugal) (N=83)</b>	<b>Senegalese/Gambian community (Spain) (N= 96)</b>
<b><u>Age group (total)</u></b>			
Young adults (18 – 30 years)	28	10	35
Older adults(31 – 65 years)	68	73	61
<b><u>Length of stay in the EU (total)</u></b>			
Recent migrants (less than 2 years)	75	23	35
Less recent migrants (More than 2 years)	21	60	61
<b><u>FGD</u></b>			
<b>Gender</b>			
Male	4 (39 participants)	4 (28 participants)	3 (16 participants)
Female	4 (37 participants)	4 (30 participants)	5 ( 55 participants )
<b>Age group</b>			
Young adults (18 – 30 years)	4 (31 participants )	4 (25 participants)	3 (21 participants)
Older adults (31 – 65 years)	4( 45 participants)	4 ( 33 participants)	5 (50 participants)
<b><u>In-depth narrative interview</u></b>			
<b>Gender</b>			

Male	10	13	15
Female	10	12	10
<b>Age group</b>			
Young adults (18 – 30 years)	12	10	12
Older adults (31 – 65 years)	8	15	13
<b><u>CBR</u></b>			
	2	2	2
<b>Males</b>			
<b>Females</b>	2	2	2

Source: REPLACE fieldwork 2014 -2015.

Both the FGDs and in-depth narrative interviews were conducted in the preferred language of the participants, which was either their native language or the national language of the host country, and also at a venue chosen by the participants. During the FGDs, males and females as well as young and older adults were separated into different groups in line with the values of communities and to prevent gender and intergenerational domination and influence. The gender of the participants was matched with that of the CBRs. Each FGD and in-depth narrative interview lasted for between one and half and two hours. All were recorded, transcribed and translated into English for analysis by the REPLACE team.

### ***Analysis***

Transcription and analysis of the data began during the data collection. This allowed for all the relevant data to be collected until a saturation point was reached (Glaser and Strauss, 2009). Thus, a decision on when to stop collecting data was based on judgement by the researchers that any further FGDs or interviews would not yield any new data.

Data was analysed using Nvivo10 software. Each country partner analysed their own data separately to identify preliminary key themes. These findings were compared with a parallel analysis of all the data by the Coventry University REPLACE team for triangulation. To minimise the influence of preconceptions and uncover new insights in the data, the analysis was based on a grounded analytic approach (Gibbs, 2002). Preliminary open coding was first conducted to provide an initial framework for the data to be recoded into meaningful codes. The coding process was repeated several times to develop categories and eventually themes and sub-themes. Where the meaning of a portion of the data could not be understood, clarification was sought from the relevant country partner and CBR. Identified themes were constantly compared across the genders and study communities. The preliminary findings of the research were shared with the project partners and CBRs for verification and feedback.

## RESULTS

The findings of the research are presented below. These are structured around three interrelated themes: practice and description of FGM; belief systems supporting FGM; and FGM enforcement mechanisms.

### Practice and description of FGM

In all three communities the dominant types of FGM practiced were Type I (clitoridectomy) and Type II (excision), with all the communities agreeing that Type III (infibulation) was less common in their communities in Europe. Among the Eritreans and Ethiopians girls were cut in the first few months after birth whereas with the Guinea Bissauans and Senegalese/ Gambians FGM was mostly performed during adolescence. Apart from six female participants who openly expressed support for the practice, the majority of participants were unwilling to reveal how it operated. Some respected community members noted that FGM was still 'substantial' in their communities and that girls were mostly sent to be cut in the home country.

Thus, while there were differences in the manner that FGM was practised across the three communities, the FGM types that were performed were similar. Each community had a unique terminology for describing FGM which reflected the type it practiced. These terminologies are summarised in Table 2. Most participants across the communities disapproved of the use of the words 'mutilation' and 'cutting' to describe FGM. They perceived them to be 'scary', 'horrific', 'aggressive', 'barbaric', and 'culturally insensitive'. However, nearly 15 percent of the interviewees thought such 'negative' terminologies were needed to reflect the abusive nature of FGM and to persuade parents to stop the practice.

**Table 2** Community terminology for describing FGM

<b>FGM affected community</b>	<b>Terminology</b>
Eritrean/Ethiopian	Girz, mekhnishab, sunna
Guinea Bissauan	Fanadu
Senegalese/Gambian	Londindeh or sunnadeh (sunna)

Source: REPLACE fieldwork 2014 - 2015.

## Belief systems supporting FGM practice

The practice of FGM in the migrant communities was supported by belief systems around religion, sexuality, marriage and socialisation. While these beliefs were common across the communities, the detail did sometimes vary.

### **Religion**

Religious beliefs supporting the practice of FGM were pervasive across the communities and participant groups, especially the Guinea Bissauan and Senegalese/Gambian communities who were predominantly Muslim. The most cited religious beliefs were related to the Islamic faith, even though there were other participants who practiced Christianity and African traditional religions that also supported FGM. Most Muslim participants perceived FGM as a Sunnah (an approved practice of the Prophet Mohammed) and a good deed for Muslims. The source of this belief was attributed to a narrative in which the Prophet Mohammed is purported to have sanctioned a woman (an excisor) “to cut [a girl] slightly, but not to overdo it.” Although nearly all the 41 Muslim interviewees were aware that FGM is not mentioned in the Quran (and therefore not mandatory), about 60 percent still perceived that it was a good deed that would earn them divine reward. Most parents supported the practice, not due to a fear of divine retribution for non-performance, but to attract divine reward.

*“If a girl is submitted to fanadu it is “Sunnah” which means that she complies with the orders of the prophet that are not compulsory. Whoever does not do it will not be punished. But you will be rewarded if you do it.”* (Male FGD participant, Guinea Bissauan community, Lisbon)

It was commonly mentioned across all the focus groups that FGM is required for women to cleanse themselves so that they can properly undertake Islamic rituals. Women who have not been cut were commonly deemed to be impure and unfit to perform the Muslim prayer (*salat*) or undertake fasting (Ramadan). FGM was commonly perceived as a virtue that strengthened women’s faith and brought them closer to God. Women who were cut were generally perceived to be more religious:

*“The thing about the cleanliness is that even when you rinse the thing [clitoris] it is dirty. So it [clitoris] has to be removed so that we will be cleaned. If a girl is not circumcised her prayer will not be accepted....”* (Female FGD participant, Senegalese/Gambian community, Banyoles)

Participants categorised FGM into two types: Types I and II, excision/clitoridectomy (little/big *sunna*) and Type III infibulation (pharonic). The Muslim participants were of the view that not all types of FGM are Islamic. They generally agreed that Type III infibulation was *haram* (forbidden and sinful). Nearly 20 percent of the Muslim participants, largely young adults, opposed all types of FGM on religious grounds. They argued that the religious texts used to support FGM in Islam are weak and poorly authenticated. They asserted that FGM is annulled by a higher injunction in the Quran which abrogates all practices that are regarded to be harmful:



*Most people in this community think that the prophet want us to cut our daughters. But this is not true. That hadith is weak. Allah says in the Quran that we should not do anything that harms us. (Male FGD participant, Guinea Bissauan community, Lisbon)*

Among the Eritrean/Ethiopian community, FGM was reported to be practiced by Muslims, Christians, and the Falashas (Jews). The Christian and Falasha interviewees perceived FGM as a religious ritual that ensured women's sexual purity, even though they often could not indicate the specific religious text that prescribed it. They appeared to be persuaded more by the instrumental value of FGM rather than the religious beliefs associated with it.

*"In my country everyone does it [FGM], whether Muslim, Christian or the Jews we all do it especially in the villages.... Now it is better. In my religion [Judaism] once a baby is born whether boy or girl, the religion expects that they are circumcised .... I don't know if this is true or not. But it [FGM] is good because it protects our girls." (Male interviewee, Eritrea/Ethiopia community, Palermo)*

Among the participants who practiced African traditional religions the belief that FGM is required by ancestral spirits was widely reported. They believed that a person could be punished by the ancestral spirits if they failed to perform FGM on their daughter:

*"Our ancestors did it and they expect us to do it in their absence. They are always watching over us. If you disobey them, it does not matter where you are they can send the punishment to you." (Female FGD participant, Senegalese/Gambian community, Banyoles)*

### **Sexuality, Virginity, Chastity and Decency**

It was widely believed among both the recent and less recent migrants that FGM reduces sexual drive in women. Consequently, most parents perceived FGM as essential for helping girls preserve their virginity and abstain from pre-marital sex, which was deemed to be both sinful and shameful. Girls were believed to be too weak to overcome the pervasive sexual temptations around them in the over-sexualised cultural environment of their adopted country and needed to be protected through FGM:

*"We do it to reduce the sexual obsession of our girls, and not to maltreat them. You know we women are very weak so if we don't protect our daughters they cannot resist... they will become prostitutes." (Female FGD participant, Senegalese/Gambian community, Banyoles)*

*"... this place [Lisbon] is rotten. It is sex everywhere.... The children see this and think it is OK to have a boyfriend or sex at that early age.... If you are not lucky you lose them to prostitution. So we have to protect them...." (Male FGD participant, Guinea Bissauan community, Lisbon)*

Another commonly held belief in the communities was that FGM helps girls to preserve their premarital virginity and remain chaste and decent, which enhances their marriageability. A third of male interviewees expressed a preference for circumcised women for marriage, mainly because they perceived them to be faithful:

*“When I am ready for marriage I will like to go back to my village and find a wife. Here it is difficult to find a good wife. They are not cut so they are not pure.... Women who are cut are faithful to their husbands (Male interviewee, Guinea Bissauan community, Lisbon)*

Across the study communities, when a man wanted to marry a woman he typically did not enquire specifically about her FGM status, but rather whether she was ‘decent’. The ‘decency’ of a woman was based on community perception about her in terms of respect for elders and sexual abstinence, which FGM was deemed to enhance.

FGM was perceived by men to curtail women’s sex drive. Interestingly about 40 percent of female interviewees also held this belief. The majority of male participants who supported FGM shared the view that uncircumcised women were too sexually sensitive and likely to be unfaithful if their husband was unable to meet their sexual desires. Among the Eritrean and Ethiopian community, uncircumcised women were commonly perceived to be sexually promiscuous. Many of the young newly arrived male migrants (including seven interviewees) who had left their wives behind in their home countries believed that FGM was important to ensure that their wives did not commit adultery:

*“If you see a restless girl it is because she’s not circumcised! An Eritrean girl, if she has several relationships, even if people don’t know if she’s circumcised or not, they automatically assume that she is not circumcised.” (Male FGD participant, Eritrean/Ethiopian community, Palermo)*

### **Socialisation**

FGM was commonly perceived as a rite of passage that imbues good cultural values in girls and prepares them for adulthood. This view was near universal among all participant groups across the communities.

*“In Guinea, we know fanadu as a practice of emancipation, training, and a transition from one level to another, from child to adult, and a way to learn all the skills you need to become a good adult.” (Male FGD participant, Guinea Bissauan community, Lisbon)*

The education rituals associated with FGM in these cultures were believed to enable girls to learn about the etiquette of culturally acceptable ways to behave towards their peers, husband and elders. Most parents perceived such education to be essential for transferring their cultural values to their children. Parents expressed anxiety concerning their children over-assimilating into western culture which was blamed for moral decadence in the host countries. Consequently, FGM was perceived as a mechanism for countering the influence of western culture and to instil discipline in their daughters:

*“Fanadu is good for our girls. When your girl is subjected to it she learns the culture which is good for her.... She becomes a good girl after that. We need it [FGM] because our girls here are not disciplined.”* (Female interviewee, Guinea Bissauan community, Lisbon)

Most parents believed that a key cause of disobedience in young girls was excessive sexual awareness and drive. As a result, it was common practice for a parent to recommend to another parent to send their daughter to Africa to be “taught a lesson” (cut) if she was considered to be “naughty”:

*“...circumcision of girls is very good. Uncircumcised girls are very disrespectful. When you have high feelings for men you cannot be respectful.... if you have a girl and you don’t want her to be stubborn you send her home to be cut.”* (Male FGD participant, Senegalese/Gambian community, Banyoles)

The Eritrean and Ethiopian participants mostly expressed scepticism about the effectiveness of FGM for instilling cultural values in children, given the young age at which they submit girls to the practice, even though they also believed that FGM enabled girls to become disciplined through the reduction of their sexual pleasure:

*“I think there is no benefit to it [to FGM].... the best way to educate children is at home and not to send them to be cut. If a child is cut when she is only a few weeks old what will she learn? Nothing! For our people it is not about the learning but because the sexual drive is reduced.”* (Female FGD participant, Eritrean/Ethiopian community, Palermo)

### **Cultural identity**

Participants perceived FGM as a practice that defines women’s cultural and religious identity. This view was common amongst less recent migrants. Over half of interviewees from the Guinean Bissauan and Senegalese/Gambian communities believed that FGM is an identity marker which separated them from non-Muslims:

*“If she is circumcised nobody will mistake her for a non-Muslim. We are Muslims and circumcision is good because that is what all Muslims do. Wherever we are we have to make our identity known.”* (Female FGD participant, Senegal/Gambian community, Banyoles)

Fourteen percent of older adult interviewees expressed fears of being accused of abandoning their culture if they did not subject their daughters to FGM. Such accusations were thought to have adverse implications on their reputation both in the host and their home countries:

*“Those of us from Africa hate to be accused of abandoning our culture... Even though I know it is not good, I can’t criticise it publicly otherwise they will say I have abandoned my culture and become a European....”* (Male interviewee, Guinea Bissau community, Lisbon)

Among the Ethiopians and Eritreans, FGM was not identified with any particular religion as it was common among all the major religious groups. However, infibulation was generally associated with Muslims and clitoridectomy and excision with Christians and Jews.

*“Infibulation is not our type. It is only the Muslims who do it. For us it is just a small cut of the clitoris”* (Female interviewee, Eritrean/Ethiopian community, Palermo)

## **FGM enforcement mechanisms**

The factors that were identified by the communities as being the drivers and enforcement mechanisms of FGM are located at both the family and community levels.

### ***Family level***

Participants across all the communities unanimously agreed that parents were primarily responsible for their children and therefore were the ultimate actors that enforced FGM at the household level. Within the patriarchal household setting of these communities, mothers were reported to be primarily responsible for instigating girls to be submitted to FGM, while fathers were the main financiers. The father was also reported, mostly by the female interviewees, to be the ultimate decision maker on FGM given his role as head of household:

*“The women are the ones who push for it, and then the men will accept. But the man is the boss. If a woman says that her daughter must be cut and the husband says no, it will not happen.... ”* (Female FGD participant, Eritrean/Ethiopian community, Palermo)

Other key enforcers of FGM at the family level were paternal grandmothers. Although many lived back in the home country, they were reported to wield enormous influence by applying pressure on the girl’s mother during their regular telephone conversations.

*“If you don’t do it, there is trouble. Her father’s family back home will not leave you in peace.... it is the grandmothers who promote it [FGM] most.”* (Female FGD participant, Guinea Bissau community, Lisbon)

Over a quarter of female interviewees said they felt under pressure to conform to requests by their mothers-in-law to submit their daughters to FGM in the home country:

*“...My mother-in-law insisted that my daughter should be circumcised. I couldn’t stop it because she is their grandmother.... she belongs to them. So they can do whatever they want to do to her”* (Female FGD participant, Senegal/Gambia community, Banyoles)

Thus despite living in the European diaspora the decision of migrants over their daughters’ circumcision was substantially influenced by social expectations in the home country.

### **Community level**

An important community enforcement mechanism that was widely mentioned by participants across the study communities was the use of social sanctions. In the home countries, women who have not undergone FGM are stigmatised and marginalised from participating in key family and community decision-making and ceremonial activities. Even though such marginalisation was not universal in the migrants' communities, FGM-related stigmatisation was commonplace in those communities. Among the Senegalese/Gambian community in Spain uncircumcised girls were known as *solima*, which means 'rude', 'ignorant', 'immature' and 'uncivilized'; and among the Guinean Bissauans they were called *blufo*, meaning 'stupid' or 'promiscuous'. Although these negative labels were not extensively used in the migrant communities, parents (especially mothers) were conscious of them and did not want their children to be associated with such labels, especially when they visited their home country.

*"if you don't go to fanadu you are insulted, you are "blufo". You feel ashamed.... Even here [Portugal] some people still use those words...."* (Female FGD participant, Guinea Bissauan community, Lisbon)

*"The thing is you don't want your daughter to be called solima when she goes home... some people do it [FGM] because of that."* (Female interviewee, Senegalese/Gambian community, Banyoles)

Also, it was a collective perception among the Eritrean/Ethiopian community that uncircumcised women are prostitutes. Nearly all the participants in this community were aware of this stereotype and agreed that it was not good thing to be associated with it:

*"In our culture a woman who is not circumcised is called a prostitute. They say her feelings are too high and so she goes after men.... It is not good to be called a prostitute. Here in Italy when a woman is promiscuous our people say it is because she has not been cut."* (Female FGD participant, Eritrean/Ethiopian community, Palermo)

Participants noted that both parents and girls who have participated in FGM are respected and honoured, especially when they visited the home country. Parents who reject FGM were likely to be accused of under-valuing their culture and be stigmatised by some members of their community in both the home and host countries:

*"I have four daughters and all of them have been submitted to fanadu. I really wanted them to go to fanadu because when you have a daughter there is nothing more important than the day she is going to be submitted to fanadu... everybody respects you... If you want to be happy and have peace you have to submit your daughter to fanadu."* (Male interviewee, Guinea Bissauan community, Lisbon)

Most participants noted that the pressure to conform to expectations on FGM was greatest in the home country but that there was also pressures in communities in the host countries as well. They feared that even if their girls managed to escape the sanctions of non-compliance in the diaspora they are still likely to face it when they visit relatives in their home country:

*“If you don’t do it [FGM] she will not be respected when she goes back home. They will treat her like a minor. Her colleagues will harass and poke fun on her.”* (Female FGD participant, Senegal/Gambian community, Banyoles)

Older women were noted to be very instrumental in enforcing FGM at the community level. They were said to be particularly proactive in instigating and persuading parents to submit their daughters to the practice. Seven (20 percent) of the 36 older adult interviewees supported FGM because of their perceived role as custodians of culture. Older people were generally regarded in their communities as the embodiment of wisdom and respect, and their decisions must be followed:

*“The elders in this community are well respected. They are those who protect our culture. They have a lot of experience and we respect them. So when they recommend that you subject your daughter to FGM you have to respect that.”* (Male interviewee, Guinea Bissau community, Lisbon)

Religious leaders were also noted to be influential in enforcing FGM. Most participants perceived religious leaders as a credible source of knowledge and information concerning FGM. It was reported that even though not all religious leaders supported FGM, those who did used the *hadith* of the Prophet Mohammed to support it. The three Islamic religious leaders who participated in this study perceived FGM as Sunnah. The Eritrean and Ethiopian participants who practiced Judaism also reported being influenced by their religious leaders to subject girls to FGM, even though they noted that such influence was less intense in their community in Italy.

*“Back home our [religious] leaders expect that the girl is cut before or during baptism. If she is not, he will not allow the baptism to take place. Over here that pressure is not there. But back home it does...”* (Male interviewee, Eritrean/Ethiopian community, Palermo)

The findings reveal a complex decision-making process over the submission of girls for FGM in the study communities. Such decisions occurred at the household level, made jointly by the girl’s parents. Although fathers often denied having any role to play over their daughters’ FGM, they were the ultimate decision makers in light of the patriarchal social relations of the migrant communities. Thus, unlike many of the home countries where multiple actors are involved in direct decision making over girls FGM (Shell-Duncan *et al.*, 2011) parents were largely the primary decision makers in the diaspora communities. However, parents were exposed to extensive social pressures from friends and family relations both from the host and home

countries. The external social pressure from family relations in the home country appeared to be substantial.

## **DISCUSSION**

This study explores the belief systems and enforcement mechanisms that support the continuation of FGM among three migrant communities in Europe. Many community members supported FGM and described it as a functional and socially significant cultural and religious practice that should be continued. This finding reflects that of Berg and Denison (2013) in a systematic review of FGM in western countries showing beliefs about FGM remain strong. However, it contradicts modernisation theory which suggests that an increase in modernisation, economic development, education and communication should reduce the practice (Hayes, 1975 in Yount 2002). Continuation of the practice appears to be influenced by regular communication and links to friends and families in the home country. The close connection between the migrants and their home countries made it difficult to separate FGM-related beliefs that are pertinent to just the host countries. However, it was clear from the findings that the migrants continue to be influenced by social expectations in the home countries. In addition, most communities (particularly, the Guinea Bissauans and Senegalese/Gambians) lived in insular, culturally isolated neighbourhoods which provided a conducive environment to enforce belief systems that support FGM.

Although numerous belief systems have been attributed to the practice of FGM in different cultural settings (WHO, 1999; Berg and Denison, 2013; Johansen, 2007; Berggren *et al.*, 2006), this study found that beliefs around religion, sexuality, chastity, socialisation and cultural identity were particularly instrumental in shaping people's motivation towards continuing FGM among the Eritrean/Ethiopian, Guinea Bissauan, and Senegalese/Gambian communities living in Europe. These beliefs appear similar to those that perpetuate FGM in the migrant's home country as noted by the WHO 'mental map' (WHO, 1999). Berg and Denison (2013) identified similar belief systems and aesthetics as important factors for perpetuating FGM in Europe. However, the present study did not find evidence to support aesthetics as a driver of FGM among the study communities. While these belief systems are part of the cultures from which the communities originate, the data provides evidence that they have been adapted to support the continuation of FGM within a European context. It emerged the European context that the migrants lived also serve to strengthen some of the beliefs that perpetuate the practice in several pathways:

First, the belief that FGM honours the prescribed deeds of Prophet Mohammed and facilitates religious purity as well as virginity is strengthened by the need to enhance the moral standards of girls in a host environment perceived to be morally decadent. In these communities FGM enhances the marriageability of the girl as well as respect for her family. Similarly, Allag *et al.* (2001) found that girls in France who

were not cut were considered bad Muslims, which reduced their social reputation and marriage potential.

Secondly, it emerged that the main motive behind the belief in the suppression of girls' sexual desire through FGM is due to the need for parental control. High sexual drive was widely deemed to be responsible for adolescent delinquency. Most parents in the migrant communities felt that they lack control over their children's upbringing and attributed this to incompatibilities between certain aspects of western parenting and the typically stricter traditional African parenting style. Western parenting styles were perceived to be responsible for children engaging in promiscuity, and alcohol and drug use. Therefore, the reduction of sexual drive of girls was seen as a way for parents to maintain control in an over-sexualised environment.

Thirdly, many of the beliefs around FGM can also be related to the need for the migrants to assert their cultural identity in their new environment. This was deemed to be necessary for cultural and religious preservation and feeling of purposefulness and pride among the migrants. Some felt that their culture and religion were under threat in their new host country and therefore used FGM as a way to assert their identity. Also, the assertion of cultural identity had an instrumental value by enhancing social networks and access to social capital which were essential for effective daily living in a European context. Bhugra and Becker (2005) argued that migrants often suffer mental health problems associated with socio-economic issues in the host country such as unemployment, financial hardships, poor housing and racism, and as result need greater social support from the communities that they live with. Thus, FGM was seen by the migrants as a means for them to relate with the collective body of their communities in order to guarantee their social and economic security in the diaspora.

While there are similarities in the belief systems and enforcement mechanisms that support FGM among the three communities, there are also differences in the dynamics of these beliefs and enforcement mechanisms. The recognition of these differences is important so that FGM interventions are adapted to the unique characteristics of each community. The findings show that beliefs around socialisation and religion are particularly influential in supporting FGM practice among the Guinea Bissauan and Senegalese/Gambian communities. These two communities live a relatively settled life with their families in culturally isolated neighbourhoods and with close connection to relatives in the home country which fostered the enforcement of FGM. In contrast, the Ethiopians and Eritreans who are relatively transient with limited community structures (e.g. leadership, close geographical living arrangements) showed greater affinity to the need to reduce female sexual drives as an argument for the continuation of FGM. The transient lifestyle and refugee status of most members of these communities (Ethiopians and Eritreans) seemed to further add to the appeal of FGM as a means of preventing unwanted pregnancies in girls that could exacerbate the precarious living conditions of the refugees.

The findings underscore the role of families and community level actors in enforcing the belief systems that sustain FGM. While parents are the primary decision makers, their actions are largely influenced and constrained by other family relations and



community members both at home and in the host country. Thus, the continuation of FGM within the migrant communities is driven by both individual (or family) decisions and community norms (Shell-Duncan and Hernlund, 2006; Mackie, 2000). Yount (2002) noted that, in most African societies, families and communities are central institutions whose interest overrides those of the individual. Although the migrants lived far away from their kinsmen based in the home country, the regular transnational communications between them ensured the application of pressure that sustained FGM practice within the diaspora. This is congruent with findings by Gilette-Frenoy (1992) who noted that pressure from extended family in home country was a strong driver of FGM practice among migrants in France.

## **CONCLUSION**

This paper has argued that the perpetuation of FGM among African migrants in the EU is supported by belief systems constructed around religion, sexuality, chastity, socialisation and cultural identity. These beliefs remained influential despite the migrants' new socio-cultural environment in Europe. They are used to enhance the moral standards of girls, marriageability of women, respectability of families, and the assertion of cultural and religious identity. An in-depth understanding of these belief systems and their social significance as well as the social, cultural, economic and local political context of migrants' new environment (diaspora context) will contribute to the appropriate design of FGM interventions. Interventions thus need to recognise the heterogeneity of the practice and belief systems of FGM across different communities in the EU, and work to address and change relevant beliefs rather than take a 'one-size fits all' approach to tackling the practice. In addition, the transnational connections between migrants and their home countries suggest that without tackling FGM in the home countries, there will always be pressure on communities in the diaspora to perform FGM.

While this paper has demonstrated the complexity of the numerous belief systems and enforcement mechanisms that perpetuate FGM in migrant communities in Europe, it is important to recognise that these beliefs are dynamic and can be adapted to bring about positive changes concerning FGM practice in migrant communities. This requires effective engagement and training of 'influential' individuals in affected communities in order to identify, challenge and modify FGM-supported beliefs and to bring about the needed social norm transformation.

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