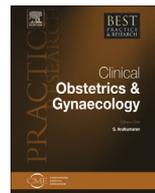




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Cultural change after migration: Circumcision of girls in Western migrant communities

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This paper reviews the current knowledge on cultural change after migration in the practice of female circumcision, also named genital cutting or mutilation. Explorative studies show trends of radical change of this practice, especially the most extensive form of its kind (type III or the 'Pharaonic' type). The widespread interpretation that Islam would require circumcision of girls is questioned when, for example, Somalis meet other Muslim migrants, such as Arab Muslims, who do not circumcise their daughters. The few criminal court cases for circumcision of girls that have taken place in Western countries corroborate the conclusion that substantial change in the practice has occurred among migrants. In this literature review, an absence of reports is identified from healthcare providers who have witnessed circumcision after migration. Concurrently, a substantial knowledge exists on how to take care of already circumcised women and girls, and there is a system of recommendations in place regarding best practices for prevention. There is a great potential for healthcare providers to encourage this development towards general abandonment of circumcision of girls. The challenge for the future is how to incorporate culturally sensitive efforts of prevention on the one hand, and the examination of suspicious cases of illegal circumcision on the other. We recommend using – in a cautious way – the existing routines for identifying child abuse in general. Experiences from African contexts show that

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failure to generate significant change of the harmful practices/tradition may be due to the lack of multidisciplinary collaboration in different sectors of the society. In Western societies, the tendency toward abandonment of the practice could be reinforced by professionals who work toward better inclusion of men and women originally from countries where circumcision is practised.

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Circumcision of girls

Among academic researchers, circumcision of girls is often labelled 'female genital cutting' (FGC) or 'female circumcision', but the term is usually designated as 'female genital mutilation' (FGM) among activists and legislative documents in Western countries and the World Health Organization (WHO).

The practice of circumcision ranges from pricking the clitoris or clitoral hood in order to draw a drop of blood to more extensive procedures in which tissue is removed. These practices are categorised into four types: [1]

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

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

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

Type IV Unclassified: All other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping and cauterisation.

Type I and II are the most common forms globally, whereas type III (infibulation or 'Pharaonic circumcision') amounts to about 10% of the world's circumcisions [2]. Yet type III is being treated in Western media coverage as the typical form of 'female genital mutilation'.

Among girls, the age of circumcision varies. Christian Ethiopians, for example, are reported to circumcise newborn girls to ritually purify them before they go through the christening ceremony; however, more commonly among other groups, girls go through the procedures as toddlers, preadolescent girls or teenagers. There are also reports of groups in which the procedure is optional, where the teen girl can choose to go through the procedure with or without parental consent [3,4]. In nearly all societies where girls are circumcised, the boys are too [2].

Circumcision of girls is historically linked to religion. The practice is found among many Muslim and Christian groups in Africa, and among some Muslim groups in the Arabic peninsula, Malaysia, India and Indonesia. One Jewish group, the Beta Israel of Ethiopia, is known to have practised circumcision on girls of their community. These are known as the 'Falasha Jews', who, during the 1980s and 1990s, were transferred to Israel by the Israeli state.

In many groups, religious obligation is stated as an important motive for both female and male circumcision. However, whether female circumcision is required by religion is a much-debated issue, as is the type of procedure. Neither the Koran nor the Bible mentions female circumcision, and the majority of the Muslims and the Christians in the world do not practise female circumcision. Traditions of female circumcision existed in Africa before the region was Christianised or Islamised – the earliest mention of the practice is in an Egyptian papyrus from 163 BCE [5]. When these world religions reached Africa, the imported religious norms were intertwined with local customs and previously existing practices, which resulted in the introduction of religious motives for female circumcision.

Not all groups practice circumcision of girls for religious reasons, and there are no universal motives behind the various traditions. Each group has its own rationale, which is often a blend of motives. For

example, among the Somali girls, circumcision is generally seen as the ‘normal’ and ‘natural’ state of a woman’s genitals, which also carries an aesthetic value. There is widespread interpretation that Islam requires it. Furthermore, some parents fear that an uncircumcised young girl will be exposed to ostracism, considering that all her peers are circumcised, and that she will have problems finding a husband in the future [6].

Issues related to sexuality also vary widely. In some groups, for example, among groups in Ethiopia and Eritrea, circumcision is meant to moderate sexual urges [7], whereas in others, group motives are not linked to sexual behaviour at all. Girls in some groups are often sexually active before they go through circumcision and are not expected to be sexually impaired afterwards [8,9]. A large number of West African groups practise female circumcision within an initiation rite, in which the young girls are being prepared for the life of adult women [10,11]. The most prominent motive in such cases could be social pressure: In contexts where all or most girls are being circumcised, the social cost for those refraining will be high [12]. The practices of female circumcision are upheld by women and generally also strongly supported by women.

Female circumcision has some immediate complications. The long-term medical complications of pain, bleeding, urine retention and risk of infection have been debated since the end of the 1990s, and critical scholars argue that such adverse health effects have been exaggerated in campaigning and media coverage [2,13–15]. Long-term sequelae demonstrated through research concern mainly type III (infibulation) and include an increased risk of chronic pain and dyspareunia [1]. Because of the small orifice created after sealing of the vaginal opening, it may be difficult to pass urine, and this leads to a higher risk of such urination problems as leakage and urinary tract infections (UTIs) [1,16].

Despite the vast reporting of negative circumcision-related effects, a paradox was noted by Norwegian evaluators of their government’s FGM action plan: While it is stated that >80% of the Somali women in Norway are expected to suffer from chronic physical affliction and pain as a result of female circumcision, this is the immigrant group reporting overall best health, especially the women [17,p.27]. Studies in settings with high prevalence of FGC and low resources have shown associations between FGC and adverse obstetric and perinatal outcomes [18,19]. However, studies on circumcised women (type III), who have given birth after migration in high-resource settings, indicate no causal relationship between circumcision and such adverse obstetric outcomes as maternal and perinatal mortality [20–22]. Current international campaigns to prevent circumcision of girls focus on human rights and the right to bodily integrity, rather than on medical consequences [13,23].

In addition, studies aimed at establishing the effects of female circumcision on sexuality show disparate results. Some studies show minor differences in sexual function between circumcised and uncircumcised women in controlled studies, while other studies fail to establish any differences at all. Studies have found that there is a general difficulty in operationalising aspects of sexuality: It is complicated to measure sexual desire, enjoyment or satisfaction, sexual problems or dysfunction and even orgasm in exact ways [24,25]. Although most studies have been criticised for methodological flaws, overviews of studies on sexuality among circumcision tend to show that female circumcision appears to have little negative effect on sexual function on a statistical level [13,19].

Female circumcision is often described as a ‘deeply rooted’ custom [26–28], and a seminal book on the subject is entitled *Prisoners of Ritual* [29] as though proponents have no way of ever changing their minds. However, the following description of current research demonstrates that people’s attitudes and behaviour may change rather drastically under favourable conditions, and this knowledge might be useful in healthcare encounters with families originating from areas where circumcision of girls is practiced.

This literature review includes qualitative and quantitative studies as well as grey literature on the subject. Systematic searches in databases were conducted using search strings such as ‘female circumcision’, ‘female genital mutilation’ and ‘female genital cutting’ in combination with terms such as ‘migration’, ‘cultural change’, ‘court cases’ and ‘care encounters’. Furthermore, the reference lists of the latest publications found were checked for further references to relevant literature.

Circumcision of girls in Western countries

In Western countries, circumcision of girls is prohibited by law, either through specific criminal law provisions or as a criminal offence of mutilation or grave bodily harm in the penal codes. In 1982, the

first specific law against female circumcision in the West was launched in Sweden and many countries followed [30,31]. Most Western countries with FGM legislation apply the principle of extraterritoriality, which makes it possible to prosecute offenders when the act has been performed abroad, such as during trips to countries of origin [32].

Criminal court cases for circumcision of girls have taken place in nearly ten Western countries: Denmark had one conviction in 2009, Spain has had some cases in court but only one conviction, Italy has had two court cases and Sweden two convictions, both in 2006 [33–35]. Switzerland had two criminal cases in 2008. In one of these cases, in which the prosecuted parents were from Somalia, the act was said to have been performed on Swiss soil [36]. France stands out with 29 cases in court in the 1990s, all concerning West African immigrants. Germany is one among the Western countries that has not had any criminal court case so far [37]. In the UK, an obstetrician was charged for FGM in 2014 as he had stitched a circumcised woman in order to stem blood during a delivery, but he was acquitted in 2015 [38]. In the US, there was a conviction in 2006, when an American Ethiopian man was sentenced to 10 years in prison for FGM [39].

These figures of criminal cases in Western countries – all in all fewer than 50 court cases – are surprisingly small in view of the fact that there are, in European and other Western societies, hundreds of thousands people from countries where circumcision of girls are practised. The key question is whether illegal female circumcision takes place on a large scale, but goes unnoticed and thus unreported to authorities: Are there bountiful unrecorded cases among migrants who uphold their traditions in secretive manners? Although these claims lack empirical evidence to support them, the issue is sometimes presented as if this were the case [1,40–42]. Another possibility is that the scarcity of confirmed cases reflects substantial cultural change after migration – a view that is gaining ground at the international level, especially in the context of attempts to estimate prevalence and incidence of circumcision in girls of the Western host societies [6,35,43–48].

Cultural change after migration

One of the first studies highlighting cultural change in relation to circumcision of girls was a qualitative study among Somalis in Canada and London, showing how a growing opposition toward circumcision of girls to a high extent revolved around new interpretations of an Islamic point of view [49]. Similar processes of change after migration to other Muslim countries have been reported regarding Sudanese people migrating to Cairo [50], and on Sudanese and Egyptians abandoning the practice at migration to the Gulf States [51]. Morison et al. [52] render a more complex picture on Somalis in London but confirm largely that migration gives rise to changed attitudes.

On views of female circumcision among Swedish Somalis, Johnsdotter's [6] qualitative study, including both women and men, demonstrated how migration gives rise to cultural reflection: All the motives for circumcision in Somalia are turned in and out in exiled life in Sweden. What was once largely seen as 'normal' and 'natural' about the own cut and sewn genitalia was questioned in Sweden, when the women were met with shocked reactions among healthcare providers in maternal care and delivery rooms. A hitherto strong conviction that circumcision of girls was required by religion was questioned when Somalis met Arab Muslims, who do not circumcise their daughters, in Sweden. The fear that their daughters would be rejected at marriage if uncircumcised disappeared in the light of the immense Somali diaspora in the West, where Somali men can be expected to accept and even appreciate uncircumcised wives. In addition, the risk of stigmatization and ostracism disappeared when living in an environment where most girls are not circumcised. Finally, informants were well aware of the legal ban on circumcision of girls and testified that few Swedish Somalis would dare, even though they, in principle, might approve of female circumcision, to have their daughters circumcised. While Somalia offers a an environment where circumcision of girls is widely accepted, many Swedish Somalis express fear of the Swedish social authorities and their right to take custody of children by force. Thus, practically all informants testified that they were opponents of the practice, and they cited religion as the main motive: According to the Koran, man should not change what God has created [6,53].

This is consistent with other data. For instance, a quantitative survey investigating Swedish healthcare providers' experiences supported the view that there is no abundance of unreported cases

within the healthcare sector in Sweden [54]. Very few healthcare providers had seen a newly performed circumcision in a patient, and the few cases reported may date back to early and mid-1990s, when large groups of Somalis had first arrived in Sweden. In Denmark, in 2003, it was reported that some cities had implemented a general screening of (undressed) children when first attending school since 1995. A school physician who was interviewed said that while most Somali girls examined during many years had been circumcised, their younger sisters who had been born in Denmark were not [55]. Of note is that these school physicians did not find evidence of circumcision among the younger girls, although their parents had the opportunity to have circumcision legally performed abroad, had they wanted – Denmark did not introduce the principle of extraterritoriality in their FGM legislation until 2003.

In addition, a qualitative study on attitudes to circumcision of girls, including 33 interviews with Swedish Eritrean and Ethiopian men and women, showed no support for the practice, and the interviewees could not cite any positive aspects of this tradition. These migrant groups arrived in Sweden during the 1970s and 1980s, and they are well integrated today. Many looked upon their children as ‘Swedes’; thus, placing their children in the category ‘at risk for circumcision’ was as absurd to them as it would be to any Swedish parent [7].

Yet another study discussing cultural change concerned Ethiopian Falashi Jews in Israel. In qualitative interviews, the informants claimed they had abandoned the practice at once after migration to Israel, and the researchers could not see any signs of distress or nostalgia. The study was followed up by genital examinations, including 113 fertile women, and these examinations confirmed abandonment of female circumcision [46,56]. In a study from 1995, 21 Bedouin Arab women in Israel were interviewed about female circumcision, and a genital examination was conducted on 37 other women. In the interviews, the women related that they themselves, their sisters and female relatives had all been circumcised, and a vast majority of the interviewees displayed a strong support for the continuation of the practice. Although no clitoridectomy or removal of labia was observed, the genital examination showed some kind of scars in most of the women (type IV). In addition, these 37 women showed strong support for female circumcision. In a follow-up study in 2008, women under the age of 30 were targeted, as physicians in the area reported that the custom seemed to have been abandoned among the Arab Bedouins previously practising it. Of note, genital examination was carried out on 132 women and none of them showed any traces of genital cutting. Six of the women reported that they had heard by word of mouth that female circumcision was still practised, but the researchers could not identify a single case that they could be referred to [46].

In a qualitative study including 162 Canadian immigrants from regions in Africa, where circumcision of girls is practised, the authors describe a picture of changing attitudes due to migration, rendered by their interviewees who talked about reduced social pressure from extended family because of the distance [57].

A mixed-methods study in Germany further corroborates the importance of migration for cultural change. The qualitative study included 91 key informants living in Hamburg, Germany, and they all originated from countries where girls are circumcised (21 sub-Saharan countries; among them Ghana, Ethiopia, Cameroon). The quantitative survey included 1767 participants (the largest groups of respondents from Ghana, Nigeria and Togo). Both the qualitative and the quantitative surveys gave evidence to widespread opposition to circumcision of girls. Only 3% advocated continuation of female circumcision [37].

In a cross-sectional study using a respondent-driven sampling, structured questionnaires were filled out by 214 Somalis in Oslo, Norway. Abandonment of the practice was favoured among 70% of respondents. It is not clear what forms were preferred by the remaining 30% favouring a continuation of the practice [58]. Many may have been proponents of the milder form called ‘sunna’, which includes everything from a pricking with no tissue removed to removal of some flesh. However, many Somalis who still support female circumcision favour a mild form which they say causes no harm [6,48].

A qualitative study among Somalis in Oslo, Norway, was conducted by the same research group. Overall, four focus group discussions included 22 Somalis, and individual interviews were conducted with 16 Somalis. A majority of the interviewees and FGD participants viewed circumcision of girls as ‘harmful, barbaric, and un-Islamic’ [59,p.14], and they found that the uncut state now had a higher

status than that of being cut, shown also by the fact that a majority of the male respondents would prefer to marry an uncircumcised woman.

Expectations that people adhere to traditions blindly are based on a poor concept of culture. American anthropologist and circumcision expert Ellen Gruenbaum points out that when 'reformers assume that people follow "tradition" for no conscious reason, they overlook the complexity of decision-making processes within a culture' [60,p.456], and she emphasises how culture is always dynamic. It seems that many people who have the ability to escape the practice of female circumcision – when the social pressure disappears in a new social context – choose to do that, when the possibility presents itself after migration [6,61].

Theoretical perspective

The possible reasons behind this process have been discussed in terms of 'social convention theory' by political scientist Gerry Mackie, [62–66] who compares the case of female circumcision with the abrupt abandonment of the 'deeply rooted' practice of foot binding in China a century ago. Mackie claims that one of the key factors behind the abrupt abandonment of the 1000-year-old tradition of foot binding in China was the belief that 'everybody else' had abandoned the custom. His starting point is that parents all over the world love their children and want to do what is best for them. Female circumcision is to be understood as a strategy, and mothers choosing female circumcision for their daughters in a specific situation are doing this to optimise their daughters' future prospects. This means that mothers will refrain from having their daughters circumcised, when the option to give it up will lead to a better life, all aspects regarded, for their daughters. When the number of people openly opposing a certain practice reaches a critical mass, the rest will follow. Both foot binding and female circumcision provide advantages only as long as they are considered the conventional and obvious things to do. Social convention theory might be useful as a tool for healthcare providers and social workers to understand the processes of cultural change and increasing opposition to circumcision of girls among migrant communities in Western societies.

Encountering concerned girls and women in the health care system

Encountering circumcised girls and women, or families in which girls might be at risk for circumcision, entails some consideration for healthcare providers. Many countries in Europe and US have developed best practices [6,35,43–47]. When it comes to inquiry into complaints and symptoms that might need to be addressed with proper treatment, scholars have introduced a more holistic 'maternal migration effect' approach for obstetric care, in which underlying socio-cultural factors related to adverse outcome among Somali infibulated adult women are conceptualised and highlighted. Pre-migration-related factors that influence on pregnant women's post-migration care-seeking and consistent usage of available care are thus vital for optimal treatment at maternity level [67,68]. However, when to best perform proper treatment may still be difficult for providers who meet infibulated girls and unmarried young women. In clinical practice, in general, the patient's history and a proper clinical examination are the gold standard in handling the symptoms of an individual. The best time for defibulation (opening the scars in the vulva) must be decided upon after thorough consultation with each and every woman and, thus, cannot be based on general guidelines sometimes emanating from stereotypical ideas of circumcised girls or women.

There are reports that female circumcised patients are frustrated when there is too strong a focus on their genitalia while they may have sought care for some other problem [69–71]. For instance, in a qualitative study by Khaja et al. [69], 17 Somali women living in Canada and the US were interviewed about their circumcision experiences. Their encounters with the North American healthcare systems were brought up by some interviewees who expressed that they were concerned about many healthcare providers focussing on the woman's circumcision rather than on the complaint or problem which was the reason for the visit. Another concern aired by many interviewees was the lack in the acknowledgement of Somalis' efforts to deal with the practice of female circumcision and instead, as a group, were portrayed as child abusers through the sensationalist female genital *mutilation* discourse.

The public discussion about female genital mutilation is usually tinted with sensationalist views and exaggerations when it comes to the scope of long-term medical and sexual consequences [2,15]. If healthcare providers are influenced by mass media discourse rather than familiarity with research perspectives, this may distort communication with circumcised patients [69].

Through focus group discussions and interviews with Swedish midwives, Leval et al. [72] studied how these medical professionals discussed circumcised female patients' sexuality. They found that midwives not only experienced encounters with circumcised women as stressful due to strong and mixed emotions about female genital mutilation but also held assumptions about erased sexual pleasure as a result of the procedure despite negligence on their part to openly ask their patients. Such assumptions not only are contrary to current research on circumcised women's capacity to enjoy sex and orgasm but may also have serious implications for circumcised patients if communicated during the healthcare encounter. This is especially relevant in encounters with young sexually inexperienced women who may have their self-esteem damaged as a result of statements about their being 'mutilated' and unable to enjoy sex [73].

Medical doctors Hearst and Molnar [70] call for a culturally sensitive discussion approach with circumcised women, give suggestions on how the issue can be brought up with patients in a respectful manner and emphasise the importance of knowledge of cultural context and best practices. They advise that the terminology 'female genital mutilation' be avoided in the encounter with patients who are generally more comfortable with the 'circumcision' term.

There are competing demands on healthcare providers when it comes to female circumcision. However, they need to identify the medical issues and symptoms at hand on the individual level and plan for the best treatment available, whether or not the reason for the visit is related to a previous circumcision. They need to be prepared to give counselling on a range of matters; among them, possibly, sexuality and sexual health. With current anti-FGM campaigns going on in most Western societies, many young women are led to believe that the circumcisions they had to go through during childhood will inevitably result in flawed sexual lives. It is here that healthcare providers have a key role to play in explaining what research actually shows, in order to improve these young women's self-esteem and counteract possible feelings of body shame [74,75].

Concurrently, they must take into consideration that the practice itself is illegal in Western societies. The patients they are seeing might have been illegally circumcised or be at risk of becoming so. A patient in front of them may have daughters who are at risk of circumcision, and an intervention during the healthcare encounter may protect these young girls. The healthcare providers have to take the legislative framework into consideration and possible duties to report suspected performed or pending child abuse. They may need to take measures – but not in ways that can be deemed discriminatory [76].

Among migrant communities, current research demonstrates a strong tendency of cultural change in views and behaviour regarding circumcision of girls; it is reasonable to expect that most patients stating their opposition toward the practice are trustworthy. Yet, there are families where young girls are at risk of being subjected to circumcision. These families are more likely to be newly arrived migrants in the host society [52,61].

There have been some attempts to eradicate the practice in African countries through interventions [77,78]. The engagement of Muslim leaders and an active participation by and with the target group communities seem to be crucial factors for successful interventions. No anti-FGC interventions with designs including a comparison group have been performed in a Western setting resulting in a knowledge gap regarding how to best tackle the issue of FGC in non-practising societies. However, there is reason to believe that professionals who encounter the concerned immigrant group have a key role to play in supporting the ongoing process of cultural change toward complete abandonment in these groups.

Summary

This paper reviews the current knowledge on cultural change after migration in the practice of female circumcision, also called genital cutting or mutilation. Exploratory studies show trends of radical change in this harmful practice, especially the most extensive form of its kind. The widespread interpretation that Islam would require circumcision of girls is questioned when, for example, Somalis

meet other migrants, such as Arab Muslims, who do not circumcise their daughters. The few criminal court cases for circumcision of girls that have taken place in Western countries corroborate the conclusion that substantial change of the practice has occurred among migrants. In this literature review, an absence of reports was identified from healthcare providers who have witnessed circumcision after migration. Concurrently, a substantial knowledge exists on how to take care of already circumcised women and girls, and there is a system of recommendations in place regarding best practices for prevention. Experiences from African contexts show that failure to generate significant change of the harmful practices/tradition may be due to the lack of multidisciplinary collaboration in different sectors of the society. In Western societies, the tendency towards abandonment of the practice could be reinforced by professionals who work towards better inclusion of men and women originally from countries where circumcision is practiced.

Conflict of interest

None.

Practice points

- A multidisciplinary approach to evaluate criminal acts is recommended. The team could possibly include general practitioner, gynaecologist, nurses/midwife, paediatrician, paediatric urologist, social worker and medical anthropologist. When it comes to examination of genitals, senior paediatric urologists/surgeon and gynaecologists are the evident experts.
- Female circumcision is a rare phenomenon in the West, but, at present, there are centres of experts and on-line guidelines in nearly all countries in Europe and North America.
- In clinical practice, the patient's history and a proper clinical examination are the gold standard in handling the symptoms of an individual – circumcised girls and women do not constitute an exception for this routine.

Research agenda

- Most prevalent studies on female genital cutting (FGC) in Europe are based on prevalence figures from the pre-migration areas in Africa. It is a methodological limitation, as they have not taken cultural change after migration into consideration in the analyses.
- There are few intervention studies on cultural change, and all these studies were carried out in African countries. There is a lack of knowledge on how best to implement results from African countries with high prevalence of circumcision to low-prevalence countries.

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