

INTEGRATING CULTURE, GENDER, AND HUMAN RIGHTS: SUPPORTING COMMUNITY-LEVEL STRATEGIES TO ERADICATE FEMALE GENITAL MUTILATION/CUTTING (FGM/C) IN AFRICA

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This narrative shares the author's reflections on international efforts to support community level strategies that promote the abandonment of female genital mutilation/cutting (FGM/C) in Africa. The author's perspective is informed, in part, by her former position as a United Nations Population Fund (UNFPA) program officer in Yaoundé, Cameroon, and many years of international social work experience. The author aims to share how international organizations and community grassroots efforts have addressed the controversies surrounding FGM/C, in order to implement culturally sensitive programs for the abandonment of the practice, advocate for legal and policy reforms, and build local capacity to address all forms of FGM/C. Lessons learned from an international roundtable event will highlight how culture, gender and human rights intersect and inform innovation in Africa.

"Unity is Strength" - Ganda (Uganda) Proverb

Introduction

Despite diverse histories, circumstances and cultures, almost every country in the world has agreed on the eight Millennium Development Goals (MDGs) for achieving a better future. Some of these goals affect the most sensitive and intimate spheres of human existence, such as our reproductive health and rights, gender relations and population issues. According to the United Nations Population Fund (2010) "success, we have learned, requires patience, a willingness to listen carefully and a respect for cultural diversity. This is part of what we mean by a culturally sensitive approach." It is my perspective that different social and cultural realities create both challenges and opportunities for achieving internationally agreed upon goals in the United Nations Millennium Declaration. For example, work to change attitudes, behaviors, and laws, especially those touching upon reproductive health and gender relations, is a long-term and complex task. Practitioners have sought to mainstream culturally sensitive approaches into programming efforts by placing a greater emphasis on working with communities and local agents of change that engage in dialogue, listen, share knowledge and insights, and jointly plan the way we can move ahead.

In this article I share my reflections on the importance of understanding cultural dynamics in society and the positive, as well as the negative, cultural values, assets, expressions and power structures based on many years of international social work experience. Specifically, I will discuss international efforts to support community level approaches and strategies to end harmful traditional practices, specifically female genital mutilation/cutting (FGM/C), by considering culture, gender and human rights. As a social worker and former program officer of the United Nations Population Fund (UNFPA) in Yaoundé, the capital city of Cameroon, in Central Africa, I will share my reflections on how international organizations and community grassroots efforts are addressing FGM/C that include implementing culturally sensitive programs for the abandonment of the practice, and advocating for legal and policy reforms, while building national capacity to stop all forms of FGM/C.

Controversies on the Term "Female Genital Mutilation" (FGM)

There is no consensus among researchers and feminist activists on the correct term to designate the practice of cutting the female

genital organ (Kassam & Lalise, 2006). Some authors prefer the term “female genital cutting” (FGC) rather than “female genital mutilation” (FGM) because FGC is viewed as non-judgemental and makes discussion of this practice easier to facilitate at the local community level, particularly in using a human rights perspective. I have found that language is important because it frames the nature of the debate. Similarly, the term ‘abandon’ is used by some rather than ‘eradicate’ because FGC is not a disease but a social practice that can be abandoned (Ford, 2005). However, according to the International Planned Parenthood Federation (IPPF) (2008), a leading international organization, female genital cutting and female circumcision are not acceptable terms for the practice of female genital mutilation.

IPPF argues that neither of these terms reflects the true horror and impact of the procedure on the girls and women who are subjected to it. Additionally, “female genital cutting” is believed to over-simplify the procedure. The term “female circumcision” is considered misleading because it may incorrectly align the procedure with male circumcision, which is a relatively harmless process that has been linked to positive health outcomes (IPPF, 2008). Some groups argue that female genital mutilation is an inappropriate term as some audiences may infer that the intent to mutilate extends to the cultures and contexts in which this practice is prevalent.

IPPF (2008) disagrees that FGM is a culturally insensitive term. IPPF (2008) argues that female genital mutilation is the most accurate description of the procedure and thus, continues to use this term in the hopes of broadening a deeper awareness of the procedure and its implications.

In this paper I have chosen to refer to the practice as female genital mutilation/cutting (FGM/C) because the term FGM appears to have a greater impact at the international level and FGC for discussions at the local community level. Both levels are important given the urgent need to work towards achieving the Millennium Development Goals.

Some United Nations agencies also use the term ‘female genital mutilation/cutting’ in

order to reflect the importance of using non-judgemental terminology with practising communities (World Health Organization, 2008). Both female genital mutilation (FGM) and female genital cutting (FGC) refer to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons (World Health Organization, 2008). Surprisingly, these practices have been reported to occur in all parts of the world, but are most prevalent in the western, eastern, and north-eastern regions of Africa, some countries in Asia and the Middle East, and among certain immigrant communities in North America and Europe (Jaeger, Caflisch, & Hohlfeld, 2009; World Health Organization, 2008;). The countries reported to have the highest rates of FGM/C include Egypt, Eritrea, Sudan, Somalia, Yemen, Guinea, Mali, and Burkina Faso. Both terms emphasize the fact that the practice is a violation of girls’ and women’s human rights (World Health Organization, 2008).

The Context of Female Genital Mutilation/Cutting (FGM/C)

According to the World Health Organization (WHO), an estimated 100 to 140 million women and girls worldwide have undergone female genital mutilation (FGM), and approximately 3 million girls are at risk of being cut every year (WHO, 2008). This is a significant number, and it is surprising that so many girls and women continue to undergo the practice. Traditionally, the procedure is carried out by women with no medical training. Anaesthetics and antiseptic treatment are not often used and the practice may be carried out using basic tools such as scissors, knives, scalpels, pieces of glass and razor blades. The risks associated with the practice are shocking. The type of cutting varies widely by ethnic group and/or region.

Today health practitioners are engaged in debates as to whether they should perform FGM/C in hospitals under sanitary conditions (Jaeger, Caflisch, & Hohlfeld, 2009). FGM/C can range from a nicking of the clitoris to partial or complete removal of the external female genitalia and closing of the vaginal opening.

Many research studies have documented the adverse impacts of FGM/C on girls' and women's health (Adam, Bathija, Bishai, Bonnenfant, Darwish, Huntington, & Johansen, 2010; Ellis, 2004; Jaeger, Caflissch, & Hohlfeld, 2008; Kassam & Lalise, 2006). The World Health Organization (2008) has identified the immediate and long term health risks and complications of FGM/C. Every major international health and human rights consensus document of the last decade condemns FGM/C on the basis that the practice is a violation of girls' and women's rights to bodily integrity.

International and regional human rights treaties and consensus documents provide protection and contain safeguards against female genital mutilation/cutting. The set of international legal instruments and consensus documents that supports FGM/C abandonment efforts includes the Universal Declaration of Human Rights; 1951 Convention relating to the Status of Refugees; 1967 Protocol relating to the Status of Refugees; International Covenant on Civil and Political Rights; International Covenant on Economic, Social and Cultural Rights; Convention on the Elimination of All Forms of Discrimination Against Women; Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; Convention on the Rights of the Child; Committee on the Elimination of All Forms of Discrimination against Women; Human Rights Committee; African Charter on Human and Peoples' Rights; African Charter on the Rights and Welfare of the Child; Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa; as well as the Beijing Declaration and Platform for Action, among others. In addition, the Programme of Action of the International Conference on Population and Development (ICPD) calls on governments "to prohibit female genital mutilation wherever it exists and to give vigorous support to efforts among non-governmental and community organizations and religious institutions to eliminate such practices" (Paragraph 4.22). In addition, the Inter-Africa Committee on Traditional Practices adopted a Common Agenda for

Action on Zero Tolerance for FGM/C by the year 2010 and declared February 6 as the International Day of Zero Tolerance against FGM/C. A significant amount of international interest has fuelled these developments over the past several decades.

Female genital mutilation/cutting was adopted as a major health concern by WHO in 1982 and recognized as a human rights issues in the 1990s (Easton, Monkman, & Miles, 2003). Strategies for promoting the abandonment of the practice include legislation, medicalization (training health professionals to perform the procedure under sanitary conditions), religious condemnation, information, "just-say-no" campaigns, educational efforts, and attempts to institute alternative rituals (Easton, Monkman, & Miles, 2003). "We know that past efforts of colonial and national governments to legislate FGC out of existence have not only failed miserably but at times have had the unintended consequence of further entrenching adherence to the practice" (Martinez, 2005, p. 33). Many of these approaches failed because they did not recognise the need for locally generated initiatives to change social norms or social conventions (Mackie, 2000, cited in Easton, Monkman, & Miles, 2003). In fact, external intervention is perceived as cultural imperialism by practicing communities, and strengthens resolve to continue FGM/C in some contexts (Mgbako, Saxena, Cave, Farjad, & Shin, 2010).

Ford (2005) explains that UNICEF has tried several approaches to end the practice, including alternate rites of passage, alternate livelihood strategies for circumcisers, laws prohibiting FGM, and health messages and public awareness campaigns. As I learned recently at the International Conference on Health Promotion held in Geneva in July 2010, the UNICEF country offices, along with UNFPA, UNDP, and UNIFEM in Cairo, Egypt continue to support programs in this area, as does the national government. However, in the past many of these approaches were led by experts from outside the affected communities, often with little input or support from community members themselves (Ford, 2005).

I believe there are important lessons to be drawn from these experiences. While these

efforts have produced an increase in awareness, which is important, they have not changed practice nor produced large-scale abandonment of FGM/C (Mackie, 2000, cited in Ford, 2005). Consequently, the prevalence of FGM/C has remained more or less constant in the 28 countries where it is practised (Ford, 2005).

As a Western human rights activist and feminist involved in organizing an international roundtable event, I began to understand some of the practices associated with certain forms of FGM/C as horrifying for girls and women. At the time I was convinced that the practice had to be eliminated. Female genital mutilation served in some respects as “an icon of “oppressed Third World womanhood” to be waved as a rallying flag to the cause of a universalist, individualist political philosophy whose cross-cultural validity might, upon deeper reflection, seem more deeply problematic” (Martinez, 2005, p. 33).

Feminist theories and perspectives have influenced the debates on development across disciplines, and this historical trajectory has changed the way we consider the centrality of gender in shaping every aspect of social life (Drolet, 2010). I was aware that female genital mutilation/cutting (FGM/C) is a reproductive health and human rights concern, with devastating short- and long-term impacts on the lives of girls and women. The procedure itself is risky and life-threatening for girls undergoing it and throughout the course of their lives. This practice touches every aspect of the mandate of the United Nations Population Fund (UNFPA), including reproductive health and rights, gender equality and women’s empowerment, as well as adolescent reproductive health. And yet, despite the severity of its impact, FGM/C has been practiced for thousands of years.

UNFPA, and other United Nations agencies, have drawn public attention to the importance of ending FGM/C, advocating specific actions including the need to work with communities in order to prevent the practice. At the country level, in Cameroon, I was involved as UNFPA formed partnerships with relevant stakeholders, including government ministries, particularly ministries of health,

social affairs, finance, gender, youth and education. UNFPA also developed relationships with non-governmental organizations (NGOs), safe motherhood projects, community and faith-based organizations and religious leaders. In the legal arena, UNFPA undertook joint action with local human rights groups and governments in several countries in the region to develop legislation in an effort to end the practice.

As a former participant, I assisted with the organization of an international roundtable on eradicating FGM/C. More than 50 participants from Africa and the Arab world came together to discuss innovative and action oriented approaches for culturally sensitive community level actions at this event. I supported UNFPA’s position to address the practice of FGM/C not only because it has a harmful impact on the reproductive and sexual health of women and girls, but also because it is a violation of their fundamental human rights. According to the World Health Organization (2008) FGM violates the human right to health and to freedom from torture or cruel, inhuman or degrading treatment and, in some cases, even the right to life. The basis for a human rights approach is the affirmation that human well-being and health is influenced by the way a person is valued, respected and given the choice to decide on the direction of her or his life without discrimination, coercion or neglect.

The country program in Cameroon funded a group of female doctors to identify positive and negative cultural practices affecting women’s reproductive health. Dialogues were sponsored with women in local communities to discuss these practices and their impact on women’s reproductive health. The female medical doctors I met with were dynamic, outspoken, and a convincing group of women who drew from their medical background and health practice experience. In this process positive cultural practices are encouraged and negative cultural practices are discouraged. Because FGM/C was considered by the international community to be a negative cultural practice affecting women’s reproductive health, it was widely believed that it could be changed without disrupting the

positive underlying social value that the practice represents.

One of the most common explanations for continuing the FGM/C practice is local custom. Women themselves are sometimes unwilling to give up the practice, as they see it as a long-standing tradition passed on from generation to generation. Women carry out the practice but they do not have the power to avoid or end the practice, or even bring it forward for negotiation. Some have argued that the practitioners are often unaware of the real implications of FGM/C and the health risks that it poses. Values include family honour, cleanliness, protection against spells and the insurance of virginity and faithfulness to the husband; these values are used as rationales to continue the practice, according to the Cameroonian female medical doctors. However, the persistence of FGM/C as a practice goes beyond simply understanding the harmful effects on girls' and women's health. It is for this reason that efforts have started to focus on how to create a process that addresses culture, gender and human rights to improve women's social and economic situation. It is important to consider the complexity of these inter-related factors if we are to improve our understanding of the sources of human rights abuses in the world.

The International Roundtable Event

I assisted with coordinating an event entitled "International Roundtable on Eradicating Female Genital Mutilation at the Community Level: Overcoming Constraints with Culturally-Sensitive Approaches." This event brought together more than 50 participants from Africa and the Arab World working at the community level or with groups at the grassroots in Yaoundé, Cameroon. Participants included representatives and staff from UNFPA, UNICEF, and WHO, International Planned Parenthood Federation's Secretariat in London (UK) affiliate family planning associations in the Africa and Arab Work regions and representatives from a wide range of grassroots NGOs working on innovative programs out in the field. The roundtable was organized into plenary presentations by keynote speakers, and

discussion of the issues was held in working groups. All of the participants agreed that FGM/C has attracted much attention over the years at the international level, and the intention was not to duplicate earlier efforts. The focus of discussions was on culturally-sensitive or culturally-appropriate methods to operationalize previous recommendations to eliminate the practice. Recently there has been a shift in language focusing on "ending" rather than "eradicating" these cultural practices, which implies the role of outsiders rather than social change from within the community.

The roundtable assumed that community level approaches are paramount to the eradication of FGM/C. The working sessions focused on action-oriented approaches geared to the development of culturally sensitive, community level action. Participants had the opportunity to review, assess, and learn from other programs. The creation of channels of communication and coalition building between grassroots organizations, and national and international organizations was considered vital to this roundtable. Considering the complexity of FGM/C and the resistance usually encountered within communities, grassroots activists indicated that they often felt extremely isolated. At the community level forum it was important for those attending to develop strong links with others working in different settings on the same issue, and to receive mutual support, exchange experiences and expertise, and share lessons learned.

Throughout the sessions, it became apparent to me that just as the type of FGM/C varies, so do the reasons given for the practice. Some of the reasons shared in the roundtable included control of female sexuality, religious beliefs, aesthetic preferences, honour, hygiene, tradition, social definition of gender, appropriate sexuality, livelihoods, and improving marriage prospects. The age at which girls are cut also depends, I found out, on the country and culture. In some places, girls are cut as infants, and in others, girls are cut during adolescence as a rite of passage into womanhood. All of the participants were knowledgeable about the emotional trauma of the procedure, which is almost always done without anaesthesia, and the seriousness of the health impacts and

medical problems resulting from infection and complications presented during childbirth.

Many personal stories were shared describing the pain and suffering experienced. As a participant in the roundtable and working sessions I listened to these personal stories and narratives that transformed and grounded my own commitment to fostering a practice of change. But I was unsure what this would look like. It emerged that both men and women participants developed their own commitment to abandoning the practice based on the experiences of family members. Some of the women participants had undergone the practice themselves and were committed to preventing others from experiencing it.

Despite these challenging realities, participants explained to me that the vast majority of members in their community did not think that FGM/C was wrong. Campaigns and messages from those outside of the community were generally not proven effective in ending the practice. I began to seriously question what I could do as a white, Western feminist woman. Stories were told about adopted laws and legal frameworks that had the result of driving FGM/C underground. These laws tended to carry no weight because most people did not support them. Participants explained that there are limits to law as an agent of social change. Legal reforms require local support from people for them to produce change. I learned in this roundtable that the law can be an important, but not a self-sufficient, component of social and cultural change.

Discussions were held on the need for FGM/C to be considered in an integrated and holistic program that supports girls' and women's education, health and empowerment in the community, given women's subordination in society. The discourse of "oppression" was not favored and efforts are required to develop programs with a better understanding of the socio-cultural context in which FGM/C occurs (Mgbako et al., 2010). The important question remained: how to bring about social and cultural change? I questioned my role in the process. What can an outsider do to facilitate this change?

Strategies for Abandoning FGM/C

In order to develop effective strategies for the abandonment of FGM/C, we need to understand the local community context in which FGM/C is practiced. Many decades of prevention work have been undertaken by local communities, governments, and national and international organizations and have contributed to a reduction in the prevalence of female genital mutilation in some areas. Communities that have employed a process of collective decision making have demonstrated that they have been able to abandon the practice. National and international organizations have played a key role in advocating against the practice and generating data that confirm its harmful consequences.

"Community education workshops are the foundation of successful initiatives in Africa" (Mgbako et al., 2010, p. 123). New communication strategies were developed to engage communities in a respectful way (Ford, 2005). Instead of condemning FGM/C as a "harmful traditional practice" the dialogue approach to communication starts with an understanding that FGM/C occurs because parents love their daughters and want the best possible future for them (Mackie & LeJeune, 2009; Mackie, 2000). Human rights principles such as self-determination, participation and inclusion are relevant in strategies for FGM/C abandonment (Ford, 2005). Effective strategies need to go beyond why the practice is harmful and then they must persuade individuals to stop it. They must help them discover how they can stop, by facilitating a process to take collective action.

The behavioral changes required to abandon FGM/C are complex and are embedded in cultural practices through which families and communities define gender relationships, express sexuality, negotiate marriages and maintain or improve social standing (Ford, 2005). Information about FGM/C is necessary but not sufficient to produce change (Ford, 2005). For example, the "Reproductive, Education, and Community Health" (REACH) programme of the United Nations Population Fund in Uganda developed a culturally sensitive programme aimed at

supporting the efforts of the community to discard the practice. My former colleague, Dr. Francois Farah, former UNFPA country representative in Uganda, in a respectful and non-judgmental way, encouraged the local Sabiny people to be proud of their culture while questioning the legitimacy of some of its practices. The community proposed to celebrate the ceremonial aspects of the initiative rites for girls into womanhood, but to relinquish the practice of cutting. Members of the community jointly developed a non-cutting alternative ritual that has the same significance as FGM/C. The process of facilitating social change is highly relevant where people are brought together to discuss issues so that they can collectively define the best development pathway for their community. It also has important implications for health promotion strategies.

There is another approach that has shared knowledge of female genital cutting and its adverse consequences, resulting in a decrease in adherence to the practice following implementation of an educational program aimed at empowering adolescent girls and women and promoting health throughout Senegal and eight African countries (Melching, 2010). *Tostan*, an international non-governmental organization, discussed the negative aspects of female genital cutting as part of a broader three-year educational Community Empowerment program with curriculum that covered democracy, human rights, problem-solving, hygiene, health, literacy and management skills. The effectiveness of the program was magnified through successful dissemination of information through extended African social networks in intervention villages (Ball, 2010; & Melching, 2010). Participants learn, discuss, and come to consensus on issues. They share topics with family, friends, neighbors, and the community at large, as well as surrounding communities. *Tostan* facilitates inter-regional gatherings allowing for critical discussion and consensus building on social norms. Returning to their own communities, participants engage in meetings, and together these social mobilization meetings lead to transformation. This process can take 2-4 years, and, in many cases, has led to a public

declaration for the abandonment of FGM/C in the community. For example, 4,888 in Senegal; 364 in Guinea; 76 in Mauritania; 48 in the Gambia; 34 in Somalia; and 23 in Burkina Faso. It is a necessary process because FGM/C is a social norm perpetuated by the intra-marrying group. Reflections on a variety of social norms take place through critical discussion in the context of human rights, the human right to health, and the right to be free from all forms of violence and discrimination. *Tostan* learned through program participants that one community alone cannot stop harmful accepted norms (Melching, 2010). Complex networks exist through intra-marriage, family ties, and extended kin. An individual alone is unable to change deeply entrenched social practices because the consequences will be too great. Attitudinal and behavioural changes achieved as a result of the program have contributed to a mass grassroots movement for public declaration to promote health and human rights through the abandonment of female genital cutting. The communities themselves reach out to their relatives in other African countries as well as in Europe and America as all members must be included in the decision to abandon the practice. *Tostan* offers a comprehensive model for sustainable development and positive social transformation based on human rights, leading to improved general well-being of girls and women by starting where they are and giving value to what they consider important. The education program has led to improvements for African girls and women by using their preferred ways of learning and knowing, and reinforcing what they already do well (Melching, 2010). The abandonment of FGM/C was initially not an objective of the program. According to *Tostan*'s executive director, Molly Melching, who presented on the program at the International Conference on Health Promotion, it is "a process of self-discovery and engagement as a necessary precursor to any meaningful social change" (Melching, 2010). The program has led to improved health outcomes such as increased vaccination rates, increased pre- and post-natal consultation, creation of dynamic health committees that include women and adolescents, significant

reduction of child/forced marriage, birth registration, and higher enrolment of girls in school; it has also led to the creation of income generation projects which improve nutrition and health in the community.

Discussion

“FGM/C remains a hotly debated human rights issue among scholars, activists, and practicing and non-practicing communities” (Mgbako et al., 2010, p. 114). Many Western human rights activists have paid insufficient attention to the cultural importance of FGM/C within communities that observe the practice (Krotoszynski, 1997).

It is not for us in the West to decide whether FGM/C is a human rights abuse, but to support women and community members in a process to critically discuss and reconsider the practice, given the context of women’s subordination and economic dependence on men (Martinez, 2005; Monagan, 2010).

The Economist recently reported that many health practitioners are debating how best to stop FGM/C in the West (“Ending a Brutal Practice,” 2010). FGM/C highlights the importance of understanding the social, economic, cultural and historical contexts before taking action. We are reminded that cultural practices and social norms make sense in the context of their social function. Practices such as FGM/C will continue unless beliefs and social expectations can be separated from cultural practices (Easton, Monkman, & Miles, 2003). Abandoning FGM/C as a practice that negatively affects women’s health is important, but it does not necessarily dismantle other gender-based practices that are harmful to women psychologically, economically, and/or socially (Easton, Monkman, & Miles, 2003; Mgbako et al, 2010).

Workshops that promote community involvement and women’s empowerment are shown to foster dialogue on religious and medical considerations in the ending of FGM/C, the cultural significance of the practice, legal aspects that consider modern and traditional law, and the importance of placing community approaches at the center of international efforts. Previous work tended to focus on mothers and grandmothers, while current

efforts have expanded to include male family members and young people in social change. Other innovative strategies to end FGM/C in Africa include “positive deviance” to identify local, community role models who have stopped the practice and are empowered to discuss with neighbours, community members and friends; finding alternative sources of income for FGM/C practitioners; economic and social empowerment for women; the promotion of alternative rites of passage; group discussions and media campaigns aimed at raising awareness; promoting the abandonment of FGM/C as part of a development package that includes a reduction of poverty and of inequities and inequalities between the sexes; and an increase in access to education and health services (IPPF, 2008).

Importance of FGM/C for Social Workers

“We now have more knowledge about the practice itself and the reasons for its continuation, as well as experience with interventions that can more effectively lead to its abandonment. Application of this knowledge through a common, coordinated approach that promotes positive social change at community, national and international levels could lead to female genital mutilation being abandoned within a generation, with some of the main achievements obtained by 2015, in line with the Millennium Development Goals.” (WHO, 2008)

Considering that UNFPA and UNICEF recently launched a joint initiative that aims at reducing FGM/C by 40 per cent in 16 countries by the year 2015, “...the question is how to act effectively, not whether to get involved” (Martinez, 2005, p.42).

It is becoming increasingly important for social workers to understand the complexity of addressing diverse cultural practices, social norms, faith organizations, and ethical aspects of various human rights abuses around the world. There are many ways in which social

workers may encounter human rights abuse issues in their practice. The context and current status of female genital mutilation/cutting in the world presents an interesting case for our consideration. Some Diaspora communities experience a reinforcement of traditions, even though living abroad can be an opportunity to change and abandon harmful traditions (Jaeger, Caflisch, & Hohlfeld, 2009). There is evidence that some migrants may hold onto their traditional practices as a means of maintaining their identity in new communities. Social workers working with refugee and immigrant populations need to be aware of the populations' diverse views of this practice.

In an article on pediatric cases where there is a suspicion of imminent FGM/C, the authors recommend that pediatricians inform child protection groups or the authorities (Jaeger, Caflisch, & Hohlfeld, 2009). Allied health professionals (such as physicians and nurses) are not educated on FGM/C and may not know how to respond to a patient who has been cut. Social workers in hospitals and medical clinics may be able to help doctors and other health care providers respond appropriately and act in a culturally sensitive manner. Child welfare workers must also understand the practice and learn how to help children who have undergone the procedure or are at risk.

According to the World Health Organization (2008) a number of countries have declared the applicability of child protection laws to female genital mutilation/cutting, while others have enacted and applied specific provisions for the elimination of harmful practices, including FGM/C. Child protection laws provide for state intervention in cases in which the State has reason to believe that child abuse has occurred or may occur. These laws focus on ensuring the best interests of the child.

As international efforts continue to support community level strategies that promote the abandonment of female genital mutilation/cutting (FGM/C) we are reminded of the need for innovation to address the complexity of integrating culture, gender and human rights, and promotion of social and economic justice for all. Social norms and

conventions can be discussed in the context of social movements that include community development work, political will, engaging government action and involving the media. A combination of approaches such as education, public discussion and public declaration are showing to be most effective in ending FGM/C in Africa (Mackie, 2000).

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