Female genital mutilation

Challenges for child welfare in an Australian context

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This article addresses the challenges facing the child welfare system in general, and child protection practice in particular, in responding to female genital mutilation (FGM) in an Australian context. Policy and programmatic responses to FGM are analysed to identify how child welfare concerns may be addressed in a culturally sensitive manner. FGM is depicted as a multi-dimensional phenomenon, related to a complex of inter-connected cultural, social, economic, religious, gender and migration issues. An appropriate response is one that acknowledges these antecedents through the utilisation of a holistic, multi-disciplinary approach. Legal and child protection responses to FGM are inadequate if operating in isolation and are most effective as adjuncts to community development strategies that are aimed at education, information dissemination and consciousness raising among affected communities. More work needs to be undertaken to develop frameworks for practitioners in a cross-cultural context, particularly in the light of continued settlement within Australia of migrant and refugee communities from countries with different child-rearing practices and beliefs.

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The practice of female genital mutilation (FGM) on children has serious physical and psychological consequences. The issue has become increasingly controversial following the arrival of refugees and migrants in Australia, particularly from northern African countries, and also from parts of the Middle East and Asia where the practice is found. The deleterious effects of FGM are instrinsically identified in the notion of 'mutilation' which infers that the practice is an infringement on the physical and psychosexual integrity of girls and women and a form of violence against them. Such a notion is supported in the World Health Organisation (WHO) definition of female genital mutilation as 'all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons' (WHO, 1997:3). FGM represents a significant exemplar of the challenges facing the child welfare system in general, and child protection practice in particular, in responding sensitively and effectively to culturally embedded parenting practices which may result in risk for children.

In Australia, and other countries of settlement, there is a tension between affirming cultural diversity in family life, whilst simultaneously protecting children from risk of harm. When parenting practices cross the threshold of what is regarded as acceptable risk and intervention is required, there is a danger that child protection measures can exacerbate harmful and neglectful situations, rather than alleviate them (Mason, 1993:15). In responding to practices such as FGM, the challenge is to intervene in a manner that does not unduly increase family stress and heighten the alienation and exclusion that families may already experience as migrants (Korbin, 1981:206). This article identifies the policy and programmatic responses to the above dilemmas, and provides broad principles to guide practitioners working with culturally and linguistically diverse families where children are 'at risk'.

Child protection responses are placed in the context of other initiatives addressing FGM operating in Australia, and also internationally. These include legal, health, and community development activities. Overall, FGM can only be effectively understood and addressed through consideration of intrinsically linked gender, cultural, migration, health and human rights issues.

CONTEXT OF FGM

FGM is a deeply embedded cultural practice that predates Islam, Christianity and other major religions (Walker & Pratibha, 1993). The practice is predominantly found in northern and central Africa, in a total of 28 countries. There is also a very low incidence of FGM among Muslim communities in the Gulf States, India, Indonesia and Malaysia. Although FGM mainly occurs within Muslim communities, it is also practiced by some Christians. Some Muslim groups believe that the practice is endorsed by Islam, but Islamic religious leaders both internationally and in Australia have condemned FGM and stated that it has no basis in Islamic teaching (WHO, 1996(a); Al Naggar, 1995). FGM is increasingly found amongst immigrant populations in Europe, Canada, the United States, Australia and New

Zealand following political and civil turmoil in Africa and increasing resettlement of refugees and migrants (WHO, 1996b:3).

There are four different kinds of FGM, as identified by WHO (WHO, 1996b:6). The first type involves removal of part or all of the clitoris and surrounding tissues; while with the second type part or all of the labia minora are additionally removed. These two types are the most common forms of FGM and make up around 80% of instances. The third type, commonly referred to as infibulation, is the most extreme and comprises about 15% of instances. It involves removal of part or all of the external genitalia and stitching/narrowing of the vaginal opening. The fourth type encompasses a set of unclassified operations on the external genitalia such as pricking, piercing or incision of the clitoris and/or labia.

The age at which FGM is carried out varies widely but most commonly occurs on girls between the ages of 4 and 10 (WHO, 1996b:2). Globally, there are an estimated 100 to 132 million girls and women who have been subjected to FGM, with an additional 2 million at risk every year. However, assessment of the exact prevalence of FGM has been limited by the lack of systematic surveys undertaken. This, in turn, reflects the lack of priority given to the issue, and its cultural sensitivity (Dorkenoo, 1996:144; WHO, 1996(b):3; WHO, 1998:37). In African countries where the practice occurs, the incidence ranges from between 5% and 98% of the female population. In over 60% of these countries the incidence is 50% or greater. Countries with the highest estimated incidence of FGM are Somalia (98%), Djibouti (98%), Eritrea (90%), Sierra Leone (90%), Sudan (85%), Egypt (80%) and Gambia (80%) (Hosken, 1993; Toubia, 1993).

The incidence of FGM within Australia is difficult to establish. The number of migrants coming from Africa and other countries with affected communities is low; therefore the incidence of FGM is also likely to be low. Anecdotal evidence from institutions having contact with children such as schools and the police, indicates that some forms of FGM are probably being practiced in Australia (Family Law Council, 1994:17).

CONSEQUENCES FOR FEMALE CHILDREN

The consequences of FGM for female children are severe and likely to have both immediate and longer-term effects. However, the lack of visibility of the practice, as compared with other forms of abuse, has resulted in relatively little public scrutiny and a dearth of data or records that identify the distress or dangers associated with it (Dorkenoo & Elworthy, 1994:14). The literature that is available is more informative on the short and longer-term physical effects, with much less known about psychosocial impacts, and their effect on child development (Baker et al., 1993; Toubia, 1994; Kiragu, 1995; American Medical Association, 1995, WHO, 1996b,1996c,1998; Nyinah, 1997; Elchalal, 1997; American Academy of Pediatrics Committe on Bioethics, 1998).

FGM is usually carried out without anaesthesia and with crude instruments. Immediate physical complications include severe pain, possible haemorrhage and shock. Further complications are the possibility of urinary retention, a failure to heal and possible transmission of tetanus and HIV. The longer-term physical complications of FGM, especially in the case of infibulation, include bleeding, particularly if the wound becomes infected. Other common problems are the formation of cysts and tough scar tissue around the wound, difficulties with urination, reproductive tract infections and chronic pelvic pain. The chances of infertility are heightened, together with problems with menstruation, pregnancy and childbirth. Repeated de-infibulation and re-infibulation at childbirth can cause blood loss and anaemia (American Medical Association, 1995; Kiragu, 1995; WHO, 1996b, 1996c, 1998).

The psychological and emotional consequences of FGM can include disturbances in sleep patterns, mood and cognition. In the longer term, this may lead to loss of self-esteem, depression, chronic anxiety, phobia, panic or even psychotic disorders (WHO, 1996b:10). Sexual dysfunction can result as a consequence of painful intercourse and reduced sexual sensitivity following removal or damage to the clitoris (Toubia, 1994:714; Dorkenoo, 1996:143; Knight et al., 1999). FGM is not necessarily perceived as a health issue or problem by affected communities, even some years after settlement. Some women do, however, express varying degrees of disquiet about having been subjected to FGM, but without readily suggesting that it has resulted in psychological or emotional ill-health.

FAMILIAL AND CULTURAL CONTEXT OF FGM

The belief systems that have perpetuated the practice of FGM are highly complex and entrenched. While reflecting specific historical and ideological conditions in each country in which the practice is found, there are also common characteristics. FGM occurs in societies that are strongly governed by social obligations to the family, clan and society. Expectations of conformity are pronounced and participation in shared cultural practices is a condition of membership.

The practice of FGM is considered to be a defining 'rite of passage' and required as part of the transition of a girl into acceptable womanhood. Great social importance is placed upon the marriageability of women, and virginity prior to marriage is considered mandatory. Males carry an expectation that their marriage partners have been subjected to the practice. FGM is therefore strongly linked to notions of female identity and self worth, and considered part of the defining characteristic of a virtuous woman.

The motive for FGM may specifically equate the practice with reducing the girl's or woman's sexual urges. Conversely, FGM is often perceived to increase the sexual pleasure of a husband and also increase fertility (WHO, 1996b). Both of these characteristics may reinforce marriageability. FGM is also often considered to improve the health of women and reduce problems in childbirth (Dorkenoo & Elworthy, 1994:13-15; Family Law Council, 1994:9; Morris, 1996).

A feminist perspective on FGM sees it as a means to exercise social control over women in patriarchal and patrilineal societies, where women's status and identity are heavily circumscribed, and largely derived from that which they obtain in marriage. FGM can be viewed as an expression of a misogynist culture that curtails female pleasure and freedom, and expects women to be docile and compliant (RACOG, 1997:16). Other explanations for the occurrence of FGM include the economic motivations of the older women operators, who both profit financially from the practice, and obtain power and status from it. They may pressure families through networks of older women in the community to subject girls to the practice (Aldeeb Abu-Sahlieh, 1994).

Within the countries of settlement, FGM remains an intensely private and sensitive subject, with public discussion of the practice discouraged, and considered disrespectful and embarrassing for the whole community (Morris, 1996; Eyega & Conneely, 1997; Maggi, 1995; Nkrumah, 1995). In this climate, there can be distrust of the views of those outside the community regarding FGM, together with a sense of disquiet in relation to affected women being portrayed as 'victims' of the practice (Eyega & Conneely, 1997:178).

MIGRATION CONTEXT OF FGM

The processes of migration and settlement have significant ramifications for responding to FGM. Policy and programmatic initiatives need to be sensitive to this context, particularly with refugee groups where torture and trauma have occurred and intense settlement needs are prevalent.

Many of the women affected by FGM in Australia have been resettled as refugees from Africa under the Department of Immigration and Multicultural Affairs (DIMA) Women at Risk Program. These women comprise 'female heads of families, single mothers, widows and abandoned or single women' who are 'often exposed to great risk of serious abuse, sexual assault, victimisation or harassment where traditional support and protection has broken down' (DIMA, 1997:14). They arrive from countries such as Somalia, Ethiopia, Eritrea and Sudan that not only have very low living standards, but also have a history of civil conflict, drought and famine (DIMA, 1997:18). They may have spent considerable time in refugee camps and may be survivors of torture and trauma. In addition, they may have experienced the loss of many close family members, and possibly sexual assault as refugees (Ssali, 1998:20).

The deleterious effects of FGM are instrinsically identified in the notion of 'mutilation' which infers that the practice is an infringement on the physical and psychosexual integrity of girls and women and a form of violence against them.

In Australia, African refugee groups suffer multiple levels of disadvantage. They share with other refugee groups problems of inadequate resources, and pressing needs for housing, financial and material support (Munro et al., 1992; Viviani et al., 1993; Junankar et al., 1993). Refugee groups are often socially isolated, and suffer from a lack of interpreters and poor provision of information in relevant languages (Cox, 1996:18-21).

The specific needs of African refugees and migrants in the Australian context have been examined in one substantial research project (Batrouney, 1991) and in other articles and reports largely based on welfare practice with African communities (eg, Maggi, 1995; Buechler & Talarico, 1998; Ssali, 1998). Batrouney (1991) identified major settlement needs of African communities to be in the areas of employment, accommodation, provision of interpreters and translators, a more culturally sensitive education curriculum, child-care, financial services, and information and reception services. African communities in Australia can be described as:

> ... now among the most marginalised and vulnerable groups in Australia, a highly visible community that suffers a considerable degree of racism. The refugee experience has left them with an enormous fear of authorities including the state, the police and the legal system (Marshall, 1994:70).

Given the experience of African refugees, the process of acculturation, where ethnic minorities learn, incorporate, and integrate cultural characteristics of the mainstream culture, may be delayed. Acculturation is slower where communities are more isolated, and where language is a barrier to accessing information (Ruzzene, 1998:18). This has implications for efforts to curtail FGM as there is a causal relationship between the decline of the practice and acculturation (Webb & Hartley, 1994:443).

While some families may alter their belief patterns following arrival, others may react to the dislocation of resettlement by attaching greater emotional commitment to traditional cultural practices such as FGM (Owen & Pritchard, 1993:89). Specifically in relation to attitudes to FGM amongst African communities in Australia, Dorward (1998:8) comments:

> Customs and rituals often assume a significance in migrant communities long after they have begun to disappear 'back home'. Many of the Horn of Africa communities in Melbourne are more strident in their self-identity than back in Africa. To excise the practice of female circumcision from a broader cultural totality can be seen as a challenge to the cultural survival of the society.

The tensions between acculturation and the adherence to traditional practices are indicative of the complex factors impinging on policy and program development for FGM.

RESPONSES TO FGM IN AUSTRALIA AND OTHER COUNTRIES OF SETTLEMENT

In countries of settlement, responses to FGM have incorporated two broad elements, community development and legal/child protection. The responses made broadly reflect the approach to FGM advocated by WHO and other UN agencies (WHO, 1996b;1996c;1997; 1998). A holistic and integrated approach where community education is backed by clearly identifiable human rights instruments and supportive legislation is advocated. The aim is to prevent the occurrence of FGM where the practice is being transferred to the new context, and provide assistance to women and children who have already experienced FGM.

In Australia, the Commonwealth Department of Health and Family Services coordinates the National Education Program on Female Genital Mutilation (1995-2000) that is implemented through the states. The program incorporates community development initiatives such as community and professional education, and community health responses. These initiatives run alongside separate state legislation and child protection practice addressing FGM. The following discussion places these activities in context in terms of community development and legal/child protection responses in other countries of settlement.

COMMUNITY DEVELOPMENT

The community development response to FGM is widely advocated, emphasising collaboration, participation and empowerment of affected communities through information dissemination, awareness-raising and responses to associated settlement issues. This approach locates the FGM response within an overall strategy to improve the health and well-being of the target group.

Projects implemented, which are often small and of a pilot nature, may be community-based and work directly with affected communities. Other projects may work through mainstream service providers, particularly local authority social service departments and health centres, and provide education and other services to both affected communities, and the community in general (Dorkenoo, 1994:142; Ortiz, 1998:126-127).

Training, information and education strategies for health and welfare professionals are important elements of a community development response, targeting professionals who are likely to have contact with women where FGM has taken place, and equipping them with the knowledge and skills to respond sensitively and appropriately (WIN News, 1994;1997).

LEGAL AND CHILD PROTECTION RESPONSES

The issue of FGM raises questions as to whether cultural diversity can accommodate a range of parenting practices, or alternatively whether fundamental principles of human rights should be applied to children across all cultures. There is an additional question as to what, if any, corrective and punitive measures should be imposed if FGM takes place. In industrialised countries, there are well established public child welfare agencies, and associated child protection legislation in place to respond to defined incidents of child abuse and neglect. In addition, in some countries, there is specific criminal legislation directed at the practice of FGM. These measures will be briefly reviewed.

Specific FGM legislation exists in countries such as Britain, Sweden, Norway, Canada and the United States. This legislation remains largely untested, but in France legal proceedings under the criminal code have addressed FGM (Gallard, 1995; WIN News, 1998). In Australia, there is no national legislation, but the states of New South Wales, South Australia, Victoria and the ACT all have specific FGM legislation. In the remaining states and territories current criminal codes are believed to cover FGM. The Queensland Law Reform Commission has, however, recommended and drafted FGM legislation which has not yet been introduced (Queensland Law Reform Commission, 1994). Within Australia, as in other countries of settlement, the legislative approach to the prevention of the practice of FGM is viewed as a course of last resort.

Critique of the legislative approach to FGM suggests that it could be interpreted by communities as a hostile response and consequently drive the practice underground (Aboud & Johnson, 1994; Liverani, 1994a; Schinella & Aboud, 1994; Ierodiaconou, 1995). Some commentators argue that a tolerant multicultural society does not legislate against a culturally embedded practice (Buhagiar, 1997). Other commentators claim that the issue of FGM underlines the need to adopt limits to community tolerance of cultural diversity (Hartley & McDonald, 1994). The predominant view advocated is that publicly endorsed legal standards which signal the inappropriateness of FGM as a form of abuse should accompany ethical, humane and culturally responsive services for migrants (Liverani, 1994b; Hughes, 1995; Ortiz, 1998; Gibeau, 1998).

Many countries of settlement respond to FGM through existing child abuse and neglect statutes. In the UK, for example, the *Children Act 1989* provides protection for children, but local authorities regard proceedings under the act as less effective than sensitive community education and family support (Webb & Hartley 1994:443). In Australia, all states and territories have jurisdiction under their child protection legislation to respond to incidences of FGM as a matter of physical abuse. In Victoria, Interim Practice Guidelines on FGM (DHS, 1997b) suggest that all forms of FGM fall into the definition of physical injury, and thus warrant notification to Protective Services (DHS, 1997b:13). In addition, the guidelines recommend interagency collaboration with a view to effective monitoring of children at risk. The guidelines stress that the main purpose of intervention is to educate parents about the practice and that removal of the child should be avoided. Such guidelines represent an important initiative, but the area of risk assessment for children and young people within specific cultural contexts is under-developed and requires further consideration (English & Pecora, 1994:465).

Although FGM has serious physical and emotional consequences, in cultures where it is found it is performed without intention of harm to the child. It is an approved practice within such communities, and is usually only deemed illegal following migration to a new country (Black & Debelle, 1995:1591). The conceptual framework developed by Korbin (1981) can be usefully applied to discriminate between parenting practices that may be considered abusive according to the cultural context. There are three categories with the first involving practices that are regarded as acceptable in one culture but abusive in another. Initiation rites are an example which, if not completed, compromise the status or identity of the child in the original culture. The second category involves parenting practices that even within the culture would be outside the norm and considered abusive. The third level involves abuse of children that stems from structural conditions such as poverty, poor health and nutrition. FGM sits in the first category and because of the cross-cultural context involved does not fit into a neat traditional definition of child abuse, and therefore requires tailored interventions (Dorkenoo, 1997:7; DHS, 1997b:13). This culturally sensitive approach to FGM has applicability more broadly to the child welfare context. This is elaborated upon below.

CHILD WELFARE RESPONSE IN A CULTURALLY DIVERSE CONTEXT

There is growing recognition of the need to develop sensitive and appropriate cross-cultural policies and programmatic responses in child welfare, as a result of historically poor practice with indigenous and immigrant communities in industrialised countries (Scott & O'Neil, 1996). Due to the level of attention given to the issue of FGM and innovative programs mounted, there is a considerable body of experience and learning with applicability to cross cultural child welfare practice. This forms the basis for identification of key principles supporting an effective response to cultural diversity.

The first principle for practice in child welfare is to contextualise the occurrence of neglect or abuse in families within a cultural frame of reference. In the situation of FGM, this involves the development of a sophisticated appreciation of the context in which FGM has developed, and its role as a socially constructed practice or initiation rite germane to a specific culture.

Responding to culturally bound parenting practices which come to the attention of the child welfare system will be more effective if it incorporates an empowering approach, with a focus on the role of women in the family structure.

The second principle involves giving priority to the provision of information and education in relation to prevailing parenting standards and expectations within the country of settlement. In responding to FGM, community education and community development strategies are of critical importance in addressing the issue. This includes consciousness raising regarding the practice, and its deleterious effects for women. Curtailment of FGM relies on communities understanding the legality and health consequences of the practice. Child protection and specific FGM legislation are required as a complement to community based initiatives rather than the converse.

The third principle in working with migrant and refugee communities is to respond to identified parenting issues within the context of impinging settlement needs and issues. This requires a holistic, multi-disciplinary and integrated approach to service provision. In Australia, the communities affected by FGM have an array of settlement needs spanning the areas of health, accommodation, financial issues, education and employment. Programmatic responses to FGM are most effective where they complement other settlement programs, work collaboratively with families and communities, and adopt an empowering approach which increases the ability of both genders to access information and services.

The final principle is for practitioners in child welfare to develop culturally sensitive and culturally competent practice in their work with families from culturally diverse backgrounds. This involves the development of an understanding of the specific culture and the families' place within it, whilst simultaneously recognising that family members are unique individuals who will benefit from empathic, non-judgemental and competent practice. In the example of FGM, the challenge is to appreciate the differences that exist within the African continent between countries, language groups and religions.

IMPLICATIONS FOR PRACTITIONERS

The notion of 'cultural sensitivity' logically emerges from the analysis of the response to FGM in countries of settlement. In the most expedient of situations, culturally sensitive practice can appear as little more than a 'politically correct' statement of intent. Considerable work is required to define and realise such practice, translating good intentions into the daily work of a human service practitioner. There is a shortage of relevant literature that can guide such development, especially regarding inter-cultural child welfare practice in an Australian context. Much of the available material originates from the USA and UK and concerns ethnic groups not commonly found in Australia. Some aspects of effective cross-cultural practice are, however, identified from the literature, and related to the case of FGM.

Cross cultural child welfare work needs to address a range of interconnecting social, political, economic, religious and gender variables impacting upon the family and its parenting practices. One useful framework for incorporating these variables is the ecological model

of child development (Bronfenbrenner, 1979; Garbarino, 1982). This perspective focuses on the impacts upon the child from a constellation of influences in the immediate environment, the social setting and the community. The ecological perspective places the child and family at the epicentre of a complex web of social relationships, which need to be identified and addressed in assessment and intervention processes.

Two contrasting, but also complementary approaches predominate in cross-cultural work with families, termed 'emic' and 'etic'. The emic approach is culturally specific and relies upon culturally relevant interventions, based on accurate knowledge and information about the culture in question (Adams & Gilbert, 1998:38). In the example of FGM, preparation is needed in relation to African culture in general, but more specifically acknowledging individual communities and traditions. Adopting the emic approach can be onerous for practitioners, and confusing if the individual situation is not consistent with the norm. There is also the danger in the emic approach of stereotyping by drawing inaccurate inferences from specific cases.

The etic approach, in contrast, involves the use of techniques that are universal to counselling and other interventions, such as engagement and establishing credibility with the family (Adams & Gilbert, 1998:37; Paniagua, 1998:8). This approach assumes that there are commonalities in human responses and needs. In the example of FGM, the development of a trusting counselling relationship with family members is paramount requiring a non-judgemental approach and respect for client self-determination. Professional assessment and intervention processes need to be based on verifiable factual information rather than conjecture. The practitioner should be aware that discussion of parenting practices may lead to sensitivity and defensiveness, if not feelings of threat and persecution. Finally, it is important to reinforce the family's strengths where parenting skills are evident to offset the possible feelings of parental failure (Adamson, 1998).

There are limitations in using either the etic or the emic approach exclusively, and a blend of both is recommended.

The emic and etic approaches combine to provide an integrated framework which both contextualises and universalises family circumstances, while providing an individualised response based on the unique characteristics of the family members.

'The challenge is to recognise the commonalities between families and individuals across cultures, as well as the uniqueness of different cultural backgrounds' (Hartley & McDonald, 1994:12).

For the practitioner, operating in both a credible and culturally sensitive manner is critical and is of greater importance to successful outcomes than sharing the same ethnicity as the client (Paniagua, 1998:8).

CONCLUSION

This article has specifically addressed the issue of FGM and more generally examined the area of cross-cultural practice with migrant and refugee communities in a child welfare context. The case of FGM has provided key areas of learning to guide child welfare initiatives. Policy and practice responses in child welfare are most effective if they are broad based, placing the family within its cultural context, and operating in concert with other programs addressing settlement issues. An educative approach incorporating information dissemination is critical in preference to more punitive and corrective measures. For the practitioner, the development of culturally sensitive practice involves a combination of emic and etic approaches, utilising an ecological perspective.

Responding to culturally bound parenting practices which come to the attention of the child welfare system will be more effective if it incorporates an empowering approach, with a focus on the role of women in the family structure. This involves collaboration with communities to ensure that responses are appropriate and likely to achieve the desired outcomes.

The challenge of further developing a comprehensive framework for multi-cultural practice in a child welfare context lies ahead. It is hoped that this article will stimulate further discussion and writing which examines child welfare practice with culturally and linguistically diverse communities in an Australian context. The issue is particularly topical given continued settlement within Australia of migrant and refugee communities from countries with diverse child-rearing practices and beliefs. □

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