

**Overcoming female genital mutilation
and internalised social norms in the
context of migration:
Turning points and explanatory
mechanisms**

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AUGUST 2021

Thèse présentée en vue de l'obtention du grade
de docteur en sciences de la santé publique
Secteur des sciences de la santé



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Thesis submitted in fulfilment of the requirements for the
degree of Doctor in Public Health Sciences



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*“Each time a woman stands for herself, without knowing it possibly...,
she stands up for all women”.*
Maya Angelou

This thesis is dedicated to:

all women,

my parents: Togbui Agokoli IV and Dogbe Ameyo Agnès,

my siblings,

my husband Simon-Pierre Schumann.

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Poem

'I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel'. Maya Angelou

*Just like moons and like suns,
With the certainty of tides,
Just like hopes springing high,
Still I'll rise.*

*Did you want to see me broken?
Bowed head and lowered eyes?
Shoulders falling down like teardrops.
Weakened by my soulful cries.
...Out of the huts of history's shame
I rise
Up from a past that's rooted in pain
I rise
I'm a black ocean, leaping and wide,
Welling and swelling I bear in the tide.
Leaving behind nights of terror and fear
I rise
Into a daybreak that's wondrously clear
I rise
Bringing the gifts that my ancestors gave,
I am the dream and the hope of the slave.
I rise
I rise
I rise.*

(Maya Angelou)

Acknowledgements

I was very fortunate that once I discussed my research plans with Prof. Isabelle Aujoulat, she was interested, and her encouragement spurred me on. When I was faced with difficulty in securing a place on the doctoral programme, Prof. Jean-Marie Degryse kindly accepted my proposal. I still remember what you said: *“It is a misunderstanding to think that a targeted research project mainly based on qualitative research is less rigorously formulated than a research that uses quantitative methods”*. Thank you!

This research would not have been possible without the willingness, cooperation, and support of the women participants and some Activists ‘*norm leaders*’ I met personally, therefore, my sincere appreciation goes to each and every one of them for volunteering to take part in this research and for sharing their personal stories and sensitive or intimate experiences. Without the courage of these women, this research would not have happened, but above all, their motivation to make a change where FGM is concerned provided me with endless energy to see this research through to the end.

I am incredibly grateful to all the members of my steering committee:

Prof. Jean Macq: your listening ears and encouragements are well appreciated.

Thank you, Prof. Mylène Botbol-Baum for your continual moral support throughout this research. You strengthened my rapport with the capabilities approach association and community. I will always appreciate your kindness and financial input at the conference in London.

Prof. Olivier Schmitz, I thank you for all your help and input in this work. I owe you the term ‘norm leaders’ attributed to women who publicly reported their stories in books.

My supervisors Prof. Isabelle Aujoulat and Dr Fabienne Richard: you are the best. I am grateful for having you on this journey, for diligently guiding me through the research process, for reading my thesis and for giving me constructive feedback. Thank you.

Prof. Aujoulat: your encouragement and support are very much appreciated. Even hiring me towards the end for a few months contract, thank you!

Dr Fabienne Richard: you gave me access to GAMS Belgium, welcomed me, and accepted me as part of the GAMS family. Thank you also for always being there for me.

Prof. Susann Wolff-Hennen: thank you. You gave me insight on life story methods, and I would have loved to have you among my examiners... anyway, I hope to collaborate with you on future occasions.

I am also grateful to the Centre of Health, Economics, Law, Ethics and Social Issues (HELESI), for allowing me to participate in seminars on capabilities and vulnerabilities.

A big thank you to IRSS for your support, especially with financing my second paper.

Prof. Dominique VanPee: I thank you for your listening ears.

To Nathalie Chaidron: You have always been there for me. Thank you for all your help.

To Prof. William D’Hoore: thank you for your continuous moral support.

Dr Pablo Nicaise: thank you for your encouragement.

Nathalie Malevé: A big thank you for the last arrangements before the printing.

Djamila Taimount: A big thank you.

Thank you to Moustafa Berdii and Alaa Mahboub for always being there when I have issues with my computer.

Alaa Mahboub: your advice, help and support are well appreciated.

A big thank you to my friend and colleague Dr Nathalie Maulet, Sakhina, Zouleika, (I always have fun with you when I babysit you, you are my girls!).

Dr Sarah O’Neill: Thank you so much, you are a great colleague and friend.

Thank you to my friends and colleagues: Marie Friedel, Chiemeka Onyeze-Joe, Suzanne Mbaka, Loveness Dube, Nora Mélard, Segolène Malengreau, Maria Rodrigues Leal Moitinho de Almeida, Thomas Ogbu for your support and encouragement.

Marie Friedel: You are really special. Thank you.

Dr Nathalie Djeufa, Dr Marie-Chantal Manguem, Dr Augustin Ntambwe, Pauline Ikhongo, Pauline Umba, Vicky Boulingui, Duestine Arlette Mawekam, Rachel Ngouozong, Dr Marie-Cécile Muyer, Aicha Inès, Ismatou Bah, Rosario, Olivier, Dr Sonia Lawson, Dr Viviane Bawa, Simbi Makumbe: you are true friends.

My appreciations also go to Dr Rex Obeng: thank you for your prayers and encouragements, you are a wonderful mentor.

My friends Laetitia Yannick Kpenou, Severine Marie-Luce Owolaju, Joshua Ozi. God bless you all!

Thank you to my colleagues on the Gynaecology ward at Homerton Hospital-London.

Thank you to my friends and colleague nurses in Belgium: Myriam Windey, Adeline, Ghislaine, Célia, Fiona, Kessia, Diane, Sandra, Fabienne.

My friends: Ismatou, Fos, Chafika, Kadra, Halimatou, Nassou.

Mrs Khadidiatou Diallo, president of GAMS, Khady Koita, Diaryatou Bah: thank you for being role models to our generation.

To my family:

A big thank you to my husband Simon-Pierre Schumann for his patience, understanding and support throughout this project.

I would like to express my deepest gratitude to my parents: Son Excellence Ewefiaga Togbui Agokoli IV *Roi des Ewés*; and Agnès Améyo Dogbe.

My siblings: Dr Essi d'Almeida, Mr Hope Agboli, Mme Solange Maurey, and Mme Suzanne Dossou. You were inspirational and supportive from the start to the completion of this research project.

I am very grateful to my cousins Doris, Philippe, Laura, Hope, Dr Mama Attiglah, Lucie, Jean-Luc, Maurice, Da Betty, Steeve and Jean Mensan for helping and supporting me throughout this long journey.

To all my nieces, nephews and godchildren: Edwina, Jojo, Crépin, Emmanuel, Merveille, Michel, Aurélien, Nolaan, Arielle, Bébé Nicole, Nasya, Hélène-Gabrielle, Noah. Thank you.

Finally, I am grateful to God Almighty who, I am sure, made this journey possible and always is my source of strength.

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List of Abbreviations

BNIM: Biographical Narrative Interview Technique

CA: Capabilities Approach

EMDR: Eye Movement Desensitization and Reprocessing

FGM: Female Genital Mutilation

FC: Female Circumcision

FGC: Female Genital Cutting

FGCS: Female Genital Cosmetic Surgery

GAMS: *Groupe pour l'Abolition des Mutilations Sexuelles*

GT: Grounded Theory

NBA: Narrative Biographical Approach

NGO: Non-Governmental Organisation

PTSD: Post-Traumatic Stress Disorder

SQUIN: Single Question Inducing Narrative

TP: Turning Point

TTM: Transtheoretical Model

UNICEF: United Nation International Children's Emergency Fund

UNFPA: United Nation Population Fund

WHO: World Health Organisation

List of appendices

Appendix 1: Article:

Agboli A, Botbol-Baum M, O'Neill S, Richard F, Aujoulat I. Transforming vulnerability into power: exploring empowerment among women with FGM/C in the context of migration in Belgium. *Journal of Human Development and Capabilities*. 2019; 21(1): 49-62. DOI: 10.1080/19452829.2019.1661981

Appendix 2: Prevalence of FGM in the world

Appendix 3: A reconstructed vignette of a typical life story and lifelines

Appendix 4: Interview guide with general questions

List of published articles in relation to the thesis

Agboli A, Botbol M, O'Neill S, Richard F, Aujoulat I. Transforming Vulnerability into Power: Exploring Empowerment among Women with Female Genital Mutilation/Cutting (FGM/C) in the Context of Migration in Belgium. *Journal of Human Development and Capabilities*, 21:1, 49-62. Doi:10.1080/19452829.2019.1661981(presented in Chapter 2, section 2.5.2)

Agboli A, Richard F, Aujoulat I. "When my mother called me to say that the time of cutting had arrived, I just escaped to Belgium with my daughter": identifying turning points in the change of attitudes towards the practice of female genital mutilation among migrant women in Belgium. *BMC Women's Health*. 2020; 20(1):107. doi:10.1186/s12905-020-00976-w. (presented in Chapter 5, section 5.1)

Agboli A, Richard F, Botbol-Baum M, Brackelaire J-L, D'Aguanno A, Diallo K, Mikolajczak M, Ricadat E, Aujoulat I. Changing attitudes towards female genital mutilation. From conflict of loyalty to reconciliation with self and the community: the role of emotion regulation Submitted to PloS One, under review (presented in Chapter 5, section 5.3)

Oral and poster presentations in relation to the thesis

Oral:

Agboli Afi; Richard Fabienne; Aujoulat Isabelle. Identifying Turning points in the process of changing attitudes towards FGM among migrant women in Belgium. **2nd International Expert Meeting on Female genital mutilation/cutting: Sharing data and experiences, improving collaboration.** (Montreal Canada, 28-29 May 2018). J. Obstet. Gynaecol. Canada. 2020; 42(2): E16-E17, <https://doi.org/10.1016/j.jogc.2019.11.018>

Agboli Afi, Richard Fabienne, Aujoulat Isabelle. Understanding turning points in the process of changing attitudes towards the practice of Female Genital Mutilation/Cutting. **European Association of Social Anthropologists (EASA) Conference** (Stockholm Sweden, 14-17 August 2018).

Agboli A, Schmitz O, Aujoulat I, Richard F. Récit de vie et Analyse par théorisation enracinée comme méthodologie dans le processus de changement d'attitude envers les MGF chez les principales concernées en Belgique. **Colloque International, AISLF: La Mécanique de l'Analyse Qualitative** (Brussels, 29-30 Oct 2018).

Poster:

Agboli A, Botbol Baum M, O'Neill S, Richard F, Aujoulat I. Transforming vulnerability into power: empowerment among women with female genital mutilation/cutting in a context of migration in Belgium. **2019 Human Development and Capabilities Association Conference: 'Connecting Capabilities'** (London- UK, 9-11th September 2019).

<https://hd-ca.org/conferences/2019-hdca-conference-london-uk>

Summary of the thesis

Female genital mutilation (FGM) remains a global public health issue with harmful consequences on women's health. Migration relocates women from FGM practising communities to Belgium and other western countries for various reasons including war, persecution, religious discrimination, politics, or seeking protection from sexual and gender-based violence and structural gender inequalities. FGM is a complex social norm that is difficult to change because of its deep roots in tradition, the interdependency, and expectations from practising communities. Change is a complex matter which occurs slowly from the bottom up with individuals involved making particular choices through a long process of transition. We asked ourselves what caused migrant women to change their attitudes towards the practice of FGM at an individual level and how the change was experienced by them?

We used a qualitative methodology through a sequential design of narrative biographical approach and elements of grounded theory. In two empirical studies, we demonstrated the 'what' and the 'how'. The first study identified critical life events which prompted *turning points* to occur. *Turning points* were defined as significant events that challenged their norms and other norms associated with the practice of FGM which led to their change of attitudes and their decision to leave their community. We conducted in-depth interviews with fifteen women twice using the biographical narrative interview method (BNIM). The findings revealed different *turning points* related to an encounter with health professionals and education, to name but a few. These *turning points* were also related to feelings and conflicts based on which we hypothesised that emotion regulation and the resolution of conflicts of loyalty might be two common mechanisms involved in the empowerment of the women as they decide to take action against FGM for themselves and their daughters and changed their attitudes towards the social norm.

Thus, in the second study, we sought to better understand how emotion regulation and conflict of loyalty resolution interact with each other to explain the change of attitudes by the migrant women towards the practice of FGM.

We explored the literature, and we used three sources of data to help us theorise the process of change experienced by women as they turn their backs on the practice of FGM and take action to protect future generations from the practice: the transcripts of the 15 women interviewed twice from our first study; we included the life stories and public testimonies (books) of 10 women referred to as ‘norm leaders’; and also the transcripts of interviews we conducted with six experts from different fields of expertise, including one expert with lived experience. The analysis enabled us to theorise and to propose a model of five phases (*the suppression, the awakening, the clash, the reappropriation of self and the reconciliation*), which explain the process of change of attitudes towards FGM, as women move from being full members of their community at the cost of suppressing their emotions and denying selves, to becoming fully selves while symbolically remaining members of their communities of origin.

Our study contributes to the body of knowledge and provides avenues to be explored by health professionals working with migrant women once subjected to FGM in order to support their processes of reconciliation with themselves and their communities. This may also help to develop strategies to promote the abandonment of FGM.

General introduction and thesis outline

I first developed an interest in the topic of Female Genital Mutilation (FGM) when I was a newly qualified nurse working on a gynaecological ward in a hospital in London. I also had the opportunity to start my training in women's health at the same time. My interest in FGM grew when, as a health professional, I encountered female patients from Somalia and Ethiopia who were suffering from the physical and psychological consequences of the practice. My experience caring for these women boosted my curiosity to learn more about it, not only because of the health issues associated with it, but also because of the controversy and challenges involved in the attempt to abolish the practice despite the palpable negative consequences on women's health. I pondered over the justification of FGM and regarded it as a specific culture of the practising communities only. I subsequently decided to focus my public health Master's dissertation on FGM and examined the empowering effect of health promoting activities organised by GAMS (*Groupe pour l'Abolition des Mutilations Sexuelles*) on the wellbeing of migrant women who have undergone FGM.

This introductory chapter outlines the structure of the thesis.

Thesis outline

To better understand the psychosocial processes by which the migrant women change their attitudes towards the social norm involved in the practice of FGM, the first chapter of the thesis provides a contextual and conceptual overview of FGM. It begins with the definition of FGM according to the World Health Organisation (WHO), before outlines the nuances in terminology and justifying our rationale around the selected terms of reference. The chapter considers the prevalence of FGM worldwide and summarises the common reasons for continuing the practice and the public health implications (i.e. the consequences of FGM on women's health). It furthermore considers the role of culture and patriarchy in understanding why the practice of FGM continues to be maintained, as well as various debates, dilemmas and controversies

surrounding FGM. A significant number of feminist scholars and activists have put forward their response to many of these debates and discourses and these will be briefly considered here. Chapter 2 reflects on FGM as a social norm embedded in other norms such as those of marriageability and considers how the concept of a norm is defined much more precisely in relation to how it influences behaviour and attitudes of these women. Additionally, this chapter shows how the norm are constructed which brings out the concept of primary socialisation. It also outlines that change is possible and demonstrates the power of secondary socialisation, but it also sets out the difficulty in changing norms and discusses how they are changed through various empirical research conducted by scholars. Based on our previous work in this area, (Paper1: Agboli *et al.*, 2019), women can change their attitudes towards the practice of FGM. Furthermore, this chapter considers the relational link of FGM with the capabilities approach in the sense that it undermines and interferes with women's fundamental human capabilities (Nussbaum, 2011).

This chapter addresses the situation of FGM in Belgium and the respective laws and regulations in the country. This chapter also considers the different agencies and support available to help women who have undergo FGM. However, some questions remained unanswered, which led us to set out the problem in Chapter 3.

Chapter 3 explains the problem and outlines the research questions.

Chapter 4 presents the **research methodology** and discusses the procedures undertaken during the data collection including the recruitment process and analysis. The choice of the design, the qualitative approach using a sequential approach of narrative biographical approach (life story) and grounded theory is explained. This chapter positions the research within the epistemological and philosophical context that underpins our choice of methods and describes our process of data collection and data analysis. Other issues relating to fieldwork are also explained in this chapter. We examine how a biographical narrative (life story) approach helps to understand and identify when the turning points occurred in the lives of the migrant women. The chapter also explains how the study is divided into two parts and how the first part has led us to ask a more refined question and which in turn has set the foundation for the second part of the study.

In Chapter 5, we present the **main findings (results)** of the study. In the first part, we identified *turning points* together with the women participants. The identification of the turning points enabled us to refine our objective in the second part of our study, that is to examine the mechanisms that explain the change of attitudes towards FGM and other related norms (looking at the role of emotions regulation and the resolution of conflicts of loyalty and interest when one makes a choice not to perpetuate the practice of FGM).

Chapter 6 draws together the different themes identified into a critical discussion and highlights the study's unique contribution to the field. It outlines the strengths and limits and discusses the issue of validity and reliability in this study. It also articulates the overlap with other fields, the research perspectives, and the practice implications. This chapter discusses our own personal position (reflexivity) and ideas for further research. The final section sets out the general conclusion of the thesis.

State of the art review

CHAPTER 1

Understanding Female Genital Mutilation

Introduction

Female Genital Mutilation (FGM) is a global issue that stems from gender inequality. It is an intimate, bodily experience for women and girls who undergo the practice. In this chapter, we look at the definition of the practice of FGM, the different terminology and the reasons the practice continues as well as the health consequences. We also discuss the various debates, discourses and controversies surrounding the practice. Finally, the chapter ends with our stance on FGM from the public health perspectives.

1.1. Definition and terminologies

Female Genital Mutilation is a public health concern and it is defined as intentional procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons (1). There are regional and ethnic variations of the practice (2,3). The classification by World Health Organisation is given in the table below:

Table1: Different types of FGM, WHO (2008)

Type I (or Sunna¹): Known as clitoridectomy, this is the partial or total removal of the clitoris and/or the prepuce of the clitoris. Type II: This refers to excision as the partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora. Type III (or pharaonic): Also known as infibulation. This is the narrowing of the vaginal orifice through creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris. ‘Pharaonic’ is accepted terminology of WHO. Type IV: This covers all harmful procedures to the female genitalia for non- medical purposes, for example: pricking, piercing, incision, scraping and cauterisation.
--

¹ Type I is sometimes called ‘Sunna’ by the practising communities, but this terminology does not form part of the WHO classification because it is a religious term, and it can reinforce the fact that people link FGM and religion.

Type I and II are the most frequently practised forms of FGM in West African countries (4) while type III is the most common in East African in countries such as Djibouti, Somalia, and Northern Sudan (5).

The terminology surrounding the issue of FGM can be challenging. Three separate terms have been widely used to describe the practice: female circumcision, female genital mutilation, and female genital cutting. All these terms have their limitations and fall short of accurately describing the practice because of the different types and perspectives of FGM among different communities (3,6). The practice of FGM is also termed as female genital surgery by anthropologist such as Obermeyer (7) or female genital alteration by Earp (8,9). The debate around the terminology implies the defence of universal human rights, with women's rights being especially contested, and reflects on the concepts of body and sexuality. Choosing the right terminology to describe these practices is full of '*political land mines*' and one of the most heavily scrutinised controversial issues (10). The term female circumcision is considered too 'tolerant', and 'relativist', while female genital cutting is less judgmental and value-laden by practising-communities (3). Moreover, referring to our field work and also in practising communities, women themselves are more comfortable with the term 'cutting' (11). Since 1990, the Inter-African Committee (IAC) has referred to the practice as FGM, followed by WHO in 1991, and they have subsequently reaffirmed their use of the word '*mutilation*' in 2005 stating that the term FGM is not judgmental, but rather it is a medical term that reflects what is performed on the genitals of girls and women and it is a cultural reality (12). However, some scholars suggest the term FGM is highly contentious (7,8), as it assumes that parents intentionally 'mutilate' their children, despite extensive research showing that the practice is embedded in socio-cultural norms that are perceived to save and protect daughters from debauchery and temptation and to preserve the honour of the family (13,14). Moreover, the growth of the feminist movement and public concern from international health organisations resulted in objection to the term as actually de-emphasises the severity of the practice by comparing it to the removal of the foreskin of males (10). For Meyers (15), any other term condones the practice and sustains male dominance. Thus, throughout this thesis, we refer to the practice as FGM to conform with the WHO terminology and also because of my background as a health professional in public health.

1.2. Prevalence and geographical distribution

It is estimated that more than two hundred million women and girls are living with FGM worldwide. More than half of these girls and women live in Egypt, Indonesia and Ethiopia. Furthermore, it is estimated that more than three million girls globally are at risk of undergoing FGM each year (16–18). Within the same country, the prevalence differs from region to region and according to ethnic groups. Despite the general decrease of the prevalence in the age group 15 to 19, the total number of girls subjected to the practice is increasing because of the population growth. In Europe, it is estimated that migration has increased the number of girls and women who have undergone FGM living in the European Union or who are at risk of being subjected to the practice. The European Parliament estimated that approximately 500,000 women victims of FGM are living in Europe and 180,000 girls and women living in the EU are at risk of FGM every year (19).

The practice is performed mainly in sub-Saharan Africa as well as in the Middle East, Indonesia and Malaysia (20). In Africa, there are 29 countries across the whole continent in which FGM is practised. Some Asian countries including India (specifically the Dawoodi Bohra community), Indonesia, Philippines, Malaysia, Pakistan and Sri Lanka are also practising countries (21). Middle Eastern countries such as Oman, Yemen, Iran, Iraq, Palestine, Israel and the United Arab Emirates have also been documented as areas that practise FGM. Some communities in South America also practice FGM and these include Ecuador, Panama, Peru and Colombia (17). Cases have also been reported in the upper Amazon tribes, the Arunta tribe in Australia and throughout the Russian federation (17,18). However, the data is not clear for all countries and in some cases, the data has not yet been published; neither they are reported by Non-Governmental Organisations as no national surveys have been done. The majority of published statistics are from countries in Africa (see Appendix 2).

1.3. Reasons for the continuation of the practice

The reasons for FGM are complex, interrelated and woven into the beliefs and values of practising communities (22). Religion is sometimes used to justify FGM (3,23). Nevertheless, the practice predates both Christianity and Islam and it is not recommended in the Bible or the Quran (17,22).

One cultural reason is the ‘rite of passage’ from childhood to womanhood. This can include a celebration with traditional dancing and food, the girl may also receive money, clothing, and gifts (3,24). FGM is part of the cultural heritage, and it defines who belongs to the group. The fear of losing the psychological, moral, and material benefits of ‘belonging’ is one of the greatest motivators of conformity (25). Indeed, the fear of the social and cultural consequences that might ensue if women do not undergo FGM. These consequences can range from isolation from family, friends and the community to being outcast and viewed as dangerous or dirty. As such FGM provides social integration and ensures the maintenance of social cohesion (3). The rite of passage demonstrates group affiliations as well as marriageability. FGM is based on a belief system, and a code of honour which depends on a girl’s or a woman’s virginity and chastity (26). The preservation of virginity before marriage, and marital fidelity, are all linked to the underlying expectation that women’s sexuality needs to be controlled (3,14).

Aesthetic reasons involve the ugliness of the clitoris where FGM is practised to ensure cleanliness, and this makes it beautiful (17,24,27). Cultural ideals of femininity and the idea that girls need to remove unclean, unfeminine, or male body parts in order to be beautiful and clean (WHO, 2018). Another reason linked to gender inequality is that it is deeply entrenched in social, economic and political structures (2). FGM represents society’s control over women and perpetuate normative gender roles that are unequal and harmful to women (24).

Finally, social pressure is the main reason the practice continues. Communities themselves create an environment in which the practice of FGM is performed due to social conformity and expectations (2,3,25). The common nature of the practice creates a perception of acceptance and normality. In these circumstances, non-conformity could carry significant social costs such as ostracism, enforced unmarried life and rejected by peers (3,28).

1.4. The consequences of FGM: physical, psychological, and sexual

From public health perspectives, FGM violates women's bodily integrity and causes women and girls several health complications: physical, psychological and sexual. The health consequences reported to result from FGM are said to vary according to the type of the practice undertaken.

1.4.1. Physical

The physical consequences include pain, urine retention, infection, painful sexual intercourse, haemorrhage, shock, and sometimes death (1). The healing period is also painful. Shock can be caused by pain and/or haemorrhage. Excessive bleeding (haemorrhage) and septic shock have been documented and death can be caused by haemorrhage or infections, including tetanus (29). The long-term consequences include reproductive difficulties, obstructed labour and fistulas (3,30), psychological trauma, flash back, post-traumatic stress disorder (31,32). Studies of labour and delivery problems indicate significantly higher risks of self-reported perineal tears (33), foetal distress (34,35) and general difficulties (34). Other studies performed in African practicing countries concluded that women with FGM were more likely than those without to have adverse obstetric outcomes such as prolonged labour, caesarean section, infant resuscitation and perinatal death (36). Similarly, Banks (34) confirms in her comparative studies that deliveries to women who have undergone FGM are significantly more likely to be complicated by caesarean section, postpartum haemorrhage, episiotomy, extended maternal stay and important perinatal death than deliveries to women who have not undergone FGM. Concerning gynaecological effects, controlled studies indicate increased risks of reporting abdominal pain, dysmenorrhea and dyspareunia (33,37).

1.4.2. Psychological effects with reference to traumatic memory

Whitehorn *et al.* (23) and Behrendt *et al.* (30) suggest that the focus of research on physical complications has detracted from the psychological damage associated with FGM. Despite the

lack of data related to the psychological impact of FGM, psychosomatic and mental health problems have been observed (4,31,38). These include mood and thought disturbances, sleeplessness, recurring nightmares, and loss of appetite, panic attacks and Post-Traumatic Stress Disorder (PTSD) (29). The psychological complications of FGM may be buried in the child's subconscious and may trigger behavioural disturbances. In the longer term, women may suffer feelings of incompleteness, anxiety, depression, loss of trust, chronic irritability and frigidity. Many women and girls, traumatised by their experience, but with no acceptable means of expressing their fears, suffer in silence. It is evident that the severe pain experienced during the procedure can result in deep psychological wounds, leaving painful memories and emotional scars and psychological trauma (30,39). Toubia (26) maintains that during her clinical experience in Sudan many infibulated women had chronic anxiety and depression, arising from worry over the state of their genitals, intractable dysmenorrhea, and the fear of infertility. A qualitative study of the psychosocial impact of FGM among *Bedouin Arabs* in Israel reveal that, women with FGM had various emotional struggles and psychosocial problems, such as a loss of trust in the mother-daughter relationships. Women have reported feelings of fear, helplessness, and anger related to FGM (40) as well as anxiety, bad memories, and stress (31). Anxiety prior to the procedure, terror of the moment of being seized by a family member, unbearable pain during and after the procedure, a subsequent sense of humiliation and feelings of betrayal by parents have also been reported (2,4). Penn and Nardos (29) highlight the emotional and psychological impact of FGM associated with cultural prohibition, whereby women are forbidden from discussing concerns regarding their sexuality. High levels of psychological impacts have been reported in countries where the practice is illegal (41).

1.4.3. FGM and women's sexuality

FGM potentially causes a host of sexual problems. It is difficult to assess the impact of FGM on women's sexual fulfilment as each individual woman with FGM will be affected differently. The type of FGM, the amount of tissue removed, the degree of scarring, the experience of the initial procedure, cultural and social expectations, and affection and bonding in sexual relationships will all directly affect women's sexuality and sexual functioning. Many women who have undergone FGM experience various forms and degrees of sexual instinct, reporting

altered mental states or emotions. These include fear of their first sexual intercourse; pain associated with sexual intercourse; difficulty with, or an inability to have, sexual intercourse; and decreased sexual pleasure and fulfilment. Emotional or physical pain during intercourse diminishes the enjoyment of both the woman and her partner (23), which could have implications for intimacy in the relationship. FGM removes the erogenous genital area as well as the sexually responsive vascular tissue. Therefore, the excision of the clitoris coupled with damaged nerve- endings and the development of scar tissue reduce women's capacity for sexual enjoyment (42). For example, some research indicates that the sensitivity and integrity of the clitoris and labia minora are essential for experiencing sexual satisfaction. It is also likely that a woman's sexuality is affected according to the extent of the FGM and the degrees to which other social messages inhibit sexual expression are internalised (43). Sexual dysfunction in both partners may be the result of painful intercourse and reduced sexual sensitivity on the side of the woman. Sexual dysfunction adversely affects quality of life, and it may often be responsible for psycho-pathological disturbances, yet the subject remains taboo in many countries (44).

1.5. Debates and discourses

Understanding FGM through the lens of feminism and cultural relativism

This section outlines different approaches and arguments which make FGM a controversial issue. Tensions emerge when culture dictate norms that undermine women's advancement. The different approaches result in the women's bodies to become '*battlegrounds*' for discursive conflicts, whilst the women themselves are reduced to the status of their genitals (45). The arguments of Western feminists who support anti-FGM discourses and argue against the practice, and those who prioritise the cultural relativism and cultural identity are discussed below. The Western feminists focus mainly on universal human rights and the patriarchal system which cause gender inequality. Thus, Western feminist discourse frames FGM as a form of oppression and abuse within the patriarchal system.

1.5.1. The Western feminist discourse: Patriarchy and the female body

The focus on patriarchy by feminists is essential in understanding the perpetuation of FGM. This is because the practising communities are still male dominated. Patriarchy is more than just a term and feminists employ it as a concept, and, as all other concepts, it is a tool which in this case helps to understand women's realities in FGM-practising communities (46). The Western countries frame FGM as an expression of patriarchy under the umbrella of violence against women and girls. It also queries whether or not women have a choice in the practice and whether this choice is informed and free from pressure and social consequences, as well as whether and to what extent women's agency and autonomy have been involved (15,47).

Patriarchy broadly refers to societal structures which favour men by assigning them more privilege than they assign to women. The word 'patriarchy' refers to the rule of the father or the 'patriarch' and was originally used to describe a specific type of male-dominated family and the secondary status of women (46). It is referred to as a kinship system in which men exchange women (46) and also it is a system of social structures and practices in which men dominate, oppress and exploit women (48). Monagan (49) argues that FGM is a matter of survival and not a choice for women in patriarchal systems, which implies that women do not have much agency and autonomy in these circumstances. They are subordinate and are therefore, reduced to the second sex (50). Women's subordination means the social situation in which they are forced to stay under the control of men. In this way, to keep women under men's control, patriarchy propagates some social customs, traditions and social roles (46). For example, women in FGM-practising communities, are simply viewed as inferior and not able to control their own sexuality in a socially acceptable manner and so it must be externally controlled by mutilating their bodies (51). Therefore, women are often assigned roles such as childbearing and rearing and satisfying men sexually, consequently placing them into an inferior position (51). The trauma caused by the mutilation often diminishes women's dignity and self-worth and undermines their self-confidence (51).

FGM is designated as a harmful traditional practice that undermines the rights of the child, and the right to bodily and sexual integrity (52). Violation of the rights of a child is another justification for eliminating FGM championed by advocates of children's rights (5). However,

in a society where FGM is the norm, girls who do not undergo the practice are the exception and consequently face the risk of being cast out from the community as well as losing prospects for marriage. The right to bodily and sexual integrity is breached by the patriarchal system through FGM, as women's sexuality is being controlled. Despite the consequences of FGM on women's health, beliefs held by women and men are reinforced by gender roles and cultural identity. All these Western feminist approaches have been critiqued by postcolonial feminists who focus on cultural relativism and cultural identity and ethical relativism (53).

1.5.2. Cultural relativism and ethical relativism: the role of culture

Viewing FGM through the lens of cultural relativism is significant as cultural relativism holds that no particular culture is superior to another when examining issues of ethics, morality, law or politics (54). Adams (55) reports that many proponents of FGM argue that applying Western concepts of feminism, sexuality and human rights ignores the cultural values of the societies that practise FGM. There are arguments that FGM provides cultural identity, cultural cohesion, role clarification and a sense of pride. Pressure from outside the culture to abolish the practice are evidence of ethnocentrism, cultural imperialism, and cultural imposition. Hicks (56) claims that FGM is one of the ties that binds communities, a means by which they have chosen to define roles and identities. Cassman (57) discusses the concept of honour in society as central to FGM and linked closely to the motivations of continuing the practice. The cultural significance of the clitoris in the practising communities is also sometimes seen as a danger to men and new-born babies as the clitoris is believed to grow to the size of a penis if left intact. Bishop (58) highlights how Western critiques of FGM map Western beliefs about the clitoris and sex onto African women's bodies. The woman's body can also provide a critique against the Western feminists. Some scholars acknowledge the existence of natural dimensions to the body but recognise the mechanism by which the body bears cultural meaning (59,60). The body is seen as an active part in embodying cultural and historical aspirations. Thus, gender entails a performance which implies that it has a social audience and thus a woman's performances are compelled and enforced by historical social practice (61,62). This is a crucial point when considering FGM as an initiation into womanhood, embodiment, and cultural identity.

It is crucial that we understand FGM as a lived, bodily experience of women and girls. The practice and its different types represent physical enactments of cultural norms and belief systems. The body, in this sense, is a symbol of culture upon which values are inscribed (63). It is important to understand how women's bodies become sites of conflict and debate for cultural, social and political arguments between ethnocentric universalism and cultural relativism.

In contrast to cultural relativism, ethical relativism makes a much stronger and more controversial claim. Salmon (64) holds that ethical relativism appears to accord with anthropologists' determination to reject ethnocentrism and maintain a non-judgmental stance towards alien cultural practices. Salmon also seconds criticisms of ethical relativism as a position that had seemed to offer anthropologists a way to profess tolerance and avoid criticising the morality of some practices including among other, FGM (64). Even though anthropologists abandon relativism in favour of a morality based on principles of justice and fairness, tolerance should not be put aside (64). Ethical relativism cannot be justified by simply comparing different cultures and noting the differences between them; researchers in anthropology for example, Gruenbaum (13) assert that ethical relativism has held an important place in anthropology and criticisms from outsiders are simplistic and fail to understand the diversity of cultural contexts and the complex meaning behind them. She argues that human rights came into the picture to safeguard people from government that were violating their rights. However, in some situations (like that of FGM), the governments of practising countries are not the perpetrators. Instead, women themselves violate such rights. Njambi (65) even presents FGM as a 'means of empowerment and suggests that the practice provides access to social, political and economic power and status in an undeniably patriarchal society'. In her analysis of culture and the body, Njambi (53) suggests that bodies do not exist in a 'vacuum' but rather that they are made and negotiated through everyday rituals and performances. Cultural context is essential; the body and culture are not separated entities (53).

Cultural identity and social conformity mainly account for the motivators for FGM-practising communities to continue the practice. The role of FGM in the construction of cultural and gendered identities highlights the role of social pressures to perform FGM. The fear of what

other people in the community think and the role of FGM in cultural identity appear to contribute to a strong sense of social pressure and a desire to belong to the group. Social expectations of compliance are major contributing factors to whether or not norm change occurs (66).

1.5.3. Female genital mutilation and female genital cosmetic surgery (FGCS): exploring the similarities and differences between these two practices

There are also similarities between FGM and FGCS in that the practices involve an intentional excision of women's and girls' genitals for the purpose of conforming to an 'ideal' standard defined by minority or majority cultural and social norms. A key argument for undergoing FGM or FGCS is that women's bodies in their natural state are unattractive and are in need of surgical intervention (67). FGM is performed due to a cultural belief about beauty and smooth genitalia, which is similar to the justification for FGCS, where women seek to replicate the prepubescent aesthetic genitalia featured in mainstream advertisements (67). Like FGM, cosmetic surgeries are carried out to make women fit a '*cultural norm*' (67). However, the domains of FGM and FGCS have been construed as opposites. It is nevertheless important to identify the obvious differences between the two practices, such as the demographic of women and girls undergoing the practices, the context in which the practices are performed, and the purpose and the meanings ascribed to the practices by society. A Western woman is conveyed as superseding the influence of culture, making an autonomous, empowered and authentic choice to undergo FGCS (68). In contrast, the question of choice for the non-Western ethnic minority woman choosing to undergo FGM is seen as overdetermined by culture and therefore not a true choice at all (69).

African women and cultural relativists group FGM and FGCS together as a means of arguing for the decriminalisation and medicalisation of FGM to mirror FGCS. They have compared the practices and argue that neither practice is oppressive because the resulting appearance is considered by Western and African women as an improvement of normal genitalia (70). Some African women do not consider FGM as mutilation just like many Western women do not view cosmetic procedures as mutilation and yet both procedures involve excision. African women

argue that if women in the West have a right to express their sexuality, then African women should also have the right to choose how they express theirs (70). Some scholars argue that FGCS is a choice, liberating and empowering for the individual woman. Instead, feminists use the same facts to support their argument that FGM and FGCS are oppressive to women and both practices should be criminalised. They draw analogies between FGM and FGCS to show that the issue is not just about ‘*barbaric*’ Africa and the control of African women’s sexuality, but it is about the abuse of women’s bodies on a global scale, suggesting as above that both practices are oppressive to women (71,72). Both practices are considered patriarchal practices imposed on women to ensure they conform to what is considered the ideal body type within their communities.

1.5.4. Understanding male circumcision vs FGM

The male circumcision refers to the cutting of male genitals, usually done for cultural or religious reasons (3,73). Male circumcision also varies from removing the foreskin of the penis to a cutting in the urinary tube; from the scrotum to the glans (74). It is worth noting that male circumcision is still legal in most countries while FGM is illegal. The two practices are commonly compared by both people inside and outside of affected communities; often believing they are similar and in particular in relation to human rights and autonomy over the body (75). Male circumcision is often seen as having health benefits and no negative impacts. However, Earp (9) notes that there are actually similarities between the two and should therefore be considered within an ethical discourse as opposed to a gendered or sexed one. These similarities include the procedures being carried on the genital area for non-medical reasons, the lack of consent and both involving incisions being made. Moreover, the motivation for carrying out the two procedures is to prepare girls and boys for joining religious or adult communities, for aesthetic purposes (76,77). Other motives of FGM are to control women’s sexualities and expressing male power and domination while male circumcision has nothing to do with controlling male sexuality. Male circumcision might confer health benefits, whereas FGM has no health benefits, and only causes harm. The quest to curtail the harm of FGM induce to thinking other way through to keep the continuation of the practice.

1.5.5. Medicalising FGM

Medicalisation is defined by the World Health Organisation as situation in which FGM is practiced by a healthcare professional, whether in a public or private clinic, at home, or elsewhere (3). Despite the emergence of international consensus that FGM is a violation of human rights, FGM continues to be performed by healthcare professionals and this may be impeding progress toward abandonment of the practice. WHO (3) has rejected propositions for the medicalisation of the practice in its recommendation that FGM should not be performed by health professionals under any circumstances. Dorkenoo (2) suggests that the public might also view the medicalisation of FGM as giving a ‘green light’ for its continuation, even if it presupposes harm reduction. Shell-Duncan (78) inquires whether medicalising female circumcision through a harm-reduction approach might help to protect women’s health. She suggests that by considering a wide range of alternatives to the procedure that are still viewed to be culturally acceptable (e.g. nicking of the clitoris with a blade) the risk to women might be minimised. This proposition has been put forward in response to the fact that FGM has continued despite legislation prohibiting the practice. Harm-reduction strategies aim to minimise the health hazards associated with risky behaviours (e.g. intravenous drug use) by encouraging safer alternatives, including, but not limited to abstinence (78). However, opponents of FGM fear that medicalisation might legitimise a practice that is not only dangerous but serves to subordinate women within patriarchal societies. Moreover, there has been no evidence to show that policies promoting the less drastic forms of FGM have resulted in the eradication of more severe forms of the practice (2). She draws attention to a policy in Sudan forbidding infibulation but permitting clitoridectomy and reports that 89% of women still undergo infibulations despite such legislation. Whilst it might be accepted by some that harm-reduction programmes serve to address the health-hazards facing women it might not address some of the psychological and social consequences of the practice. Feminist opponents might argue that medicalisation would do little to address the gender imbalances that perpetuate and are perpetuated by FGM.

What this chapter adds:

This chapter has provided an overview of what FGM entails. It also outlines critical discussion of key concepts and perspectives which have been applied to FGM by academic scholars, including Western feminist perspectives and patriarchy, cultural relativism, and cultural understanding of the body.

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CHAPTER 2

FGM as a social norm is difficult to change

'If you do not like something, change it. If you can't change it, then change your attitude'.

Maya Angelou

Introduction

This chapter reflects on FGM as a social norm embedded in other norms such as those of marriageability and considers how the concept of norm is defined much more precisely in relation to how it influences behaviour and attitudes of women affected. Additionally, this chapter shows how norms are constructed, which brings out the concept of primary socialisation. It also outlines that change is possible and demonstrates the power of secondary socialisation. The chapter sets out the difficulty in changing norms and discusses how they are changed through various empirical research conducted by scholars.

2.1. Construction of norms and the power of primary socialisation

2.1.1. Norms

Norms are influencing mechanisms aimed at directing the future conduct of the individuals subjected to them (1). They reside in individuals' heads (2). Types of norms include prescriptive norms, descriptive norms and subjective norms. Prescriptive norms (or injunctive norms) refer to moral values and societal standards concerning behaviours. For example, a nurse who works in a hospital would abide by the hospital's dress code regulations and expect the same of their colleagues. Dressing differently for work in a hospital would be unprofessional and would result in the nurse being judged negatively or even sacked. In this case, what they are expected others to wear as uniform has an influence on their decision about the clothes to wear while on duty.

at a hospital. There is a consensus that everyone is supposed to behave in an appropriate way by wearing the uniform. There are different types of norms; descriptive, prescriptive and subjective norms.

A descriptive norm is only described as such when an individual conforms to the norm based specifically on the expectation that a sufficiently large subset of other people conforms to the norm as well (3). Descriptive norms provide information on the typical behaviours of others and can serve as a potential policy tool to push individuals towards norm compliance (4). The subjective norms are determined by the perceived social pressure from others for an individual to behave in a certain manner and their motivation to comply with those people's views (5). They refer to the belief that an important person or group of people will approve and support a particular behaviour.

Paryavi *et al.* (6) suggests that norms encourage conformity regardless of social desirability. To understand what motivates the conformity, there is a need to clarify the meaning of social norm. They are complex concepts since the elaboration of a norm is a long collective process which make it inherently social (7). Social norms studies are defined as the process by which people look to others consciously or unconsciously, as a guide for how to act or think. They demonstrate the power of normative influence (8) and are an integral part of life, where we find ourselves constantly facing them. As emphasised by Stangor (9), they are also defined as 'a way of thinking, feeling or behaving that is perceived by group members as appropriate or normal' (9) (p.20). They are informal, socially shared and relatively stable guides for behaviour or attitude, which are enforced by social impacts, such as social approval or disapproval (either real or perceived) and can be specific to a group or society. This definition of social norm emphasises three of their characteristics. First, the informal character of a norm implies that one has a certain freedom to follow or violate the norm, because social norms 'guide and constrain social behaviour without the force of law' (10). The non-obligatory character of social norms differentiates them from legal norms or laws, which involve any rule that is explicit, formal, applies to all members of society, and has strict sanctions for violation. Second, social norms are socially shared, as there is a target group (reference group) to which a norm spread (7,10). The collective relevance of social norms differentiates them from personal norms, where individuals are subjected to self-induced personal limitations which they consciously and

voluntarily decide to follow. Third, social norms are usually ‘enforced by sanctions, which are either rewards for carrying out actions regarded as correct or punishment for carrying out those actions regarded as incorrect’ (11). The presence of sanctions differentiates social norms from habits, which are a form of goal-directed regular and automatic behaviour, which do not require conscious planning (12), and require minimal attention and deliberate action (13).

Social norms have received considerable attention in academic research, revealing their substantial power to affect the behaviour of individuals and even of a whole community. They were explored in different fields and contexts such as anthropology, politics, law, ethics and public health to name but a few. In the field of ethics, the focus is on how norms are constructed, and attempts to explain why certain behaviour is perceived as ethical in some cultures and unethical in others and investigates the consequences of social norms on societies (3,14). Social norms have the power to direct our actions and behaviours. Bicchieri (3) asserts that the understanding of social norms is like a kind of ‘grammar’ for social interactions. This means that social norms are similar to a collection of linguistic rules that are implicit in and define a language. Social norms are implicit in the operations of a society and make it what it is. Like ‘*grammar*’, a system of norms specifies what is acceptable and what is not within a social group (3). Thus, people have conditional preferences for observing or respecting norms: they choose whether to observe a norm or not based on their expectations of what the (relevant) others will do (3). Social norms sometimes play an important role in perpetuating harmful practices especially practices affecting women and girls (7,15). To understand the meaning of ‘*practice*’ and ‘*norms*’, we consider Bicchieri’s (3) definition of social norms because it clarifies how norms come into being and how they are held in place. They are behavioural rules supported by social expectations. The expectations underlying the obedience to a given norm are twofold in nature: empirical and normative (3). An empirical expectation is ‘the belief that a sufficient number of people will observe a norm in a similar situation, the belief about what we expect others to do’ (3). For example, I would expect all women to cut their daughters if I were from an FGM-practising community. A normative expectation, in contrast, is ‘the belief that a sufficient number of people believe that they should, or ought to, observe the norm in the given situation, and are ready to reward those who observe it and punish those who do not’ (3).

For Bicchieri, the conformity to a social norm also involves ‘normative expectation’ which is our belief of what others think we should do (3). For instance, women should submit to their husband. In other words, social norms are related to beliefs about others within a particular reference group and maintained by social approval and disapproval, i.e. what is typical action or appropriate or both (16). People sometimes have false beliefs about the beliefs of others. They lack proper information about what people really believe and support. For example, research confirms that migrant women thought men support FGM while they do not (17,18). This is a ‘pluralistic ignorance’ (15,19). Thus, the concept of expectation is important because it helps to understand that our expectations about what others do or will do are important in explaining why we choose to behave in a certain way. The reasons people follow these rules are yet to be identified. Cialdini (2) suggests distinguishing between descriptive norm (doing what others do) and injunctive norm (doing what others think one should do). For further clarity on these overlapping concepts, see the table next page for the terminology (1).

Table 2: Terminology adapted from Cislighi and Heise (1)

Terminology	What it means
Descriptive norm= collective behavioural norm= Empirical expectation	What is typical within one’s reference network
Injunctive norm= collective attitudinal norm= Normative expectation	What is appropriate within one’s reference network

When norms, values and beliefs are taken on by an individual of a particular culture who adapts them as part of their own personality in order to function within that culture, this is known as socialisation (20). The next section discusses primary socialisation and its power in the internalisation of norms.

2.1.2. The power of primary socialisation

The concept of socialisation is a process by which social norms are incorporated by individuals (21). Norms start to be internalized during primary socialization and maturation is reached in adulthood (22). Primary socialisation refers to the internalisation of what is fundamental culture by shaping norms, values and beliefs at the time when the child has little understanding of the world (23–25). Internalisation is understood as the process by which people develop a psychological need or motive to conform to a set of shared norms. When norms are internalised, norm-abiding behaviour will be perceived as good or appropriate, and people will typically feel guilt or shame at the prospect of behaving in a deviant way. Through repeated socialisation, individuals come to learn the common values embodied in the norms. These values and beliefs show that individuals acquire language, knowledge, social skills, norms, values and customs as well as the rules that are necessary for participating in and integrating into a group or community. Thus, the combination of willed conformity and externally imposed rules, mediated by the expectations of others are part of socialisation (20). Primary socialisation (or basic socialisation) allows for learning the rules of behaviour, norms and values that can be assimilated at early ages and which form the informational and emotional make-up of individuals (26). The process of transformation of children into true social human beings is achieved from childhood and within the family. It is a process of forming an emotional character with a strong maternal influence.

In case of the practice of FGM, girls are taught in their childhood. Primary socialisation ensures that the social meaning of FGM is related to and interwoven with initiation rituals. In some practising communities, FGM historically takes place the context of such initiation rituals and as one of the gradual steps in the transformation from childhood towards adulthood, the initiation involved an instruction period where girls are taught about their culture and gender roles (27). For example, Boddy (28) explains that Sudanese children are circumcised when they are old enough to have achieved a minimum understanding of reasons or ‘social sense’; thus, they are expected to realise that their bodies are being ‘purified’, made discreet by the social group (28). Here a requirement for the practice of FGM is that the child should be cognitively mature enough to understand the procedure. However, in other communities, FGM is performed

on infants, which means that the instruction of the child and the meaning-making take place long after the procedure itself (29). The goal is to for them to develop an identity as a cut, proud, and honourable woman (29). It is the mother's responsibility to emphasise to her daughter the importance of being an honourable woman in order to be married and what this means when it comes to sexuality. When a girl has received and internalised this information, she has attained the educational goal of knowing how to behave honourably. As soon as she reaches the right age, she is ready to be married; a suitable husband is selected, and then the mother becomes a grandmother and is responsible for making sure the procedure is done appropriately on her grandchildren. Primary socialisation results in the meaning-making process of FGM for girls being carefully monitored by their mothers, older sisters, grandmothers, and other women. The educational goal is that the girl becomes a clean and honourable woman. This is achieved when the girl has undergone the ritual, has understood and accepted its importance, and finally passes it on to the next generation (29).

2.1.3. The social practice theory and FGM

Theories of practice have their roots in the works of Giddens, Bourdieu, Foucault, Heidegger, amongst others (30). Despite important differences of orientation and ambition, one common theme is that social practices are taken to be the site of social order and change. Indeed, social practice theory can be applied in understanding FGM as it explains both action and social order through highlighting significance of shared symbolic structures of knowledge and the dynamic processes in other realms of everyday life (31). As a social norm practice, FGM fits well in the definition of social practices. Practices are defined as anything social, shared and which persists across time and space (32). They depend on the on-going integration of elements including materials (objects, consumer goods and infrastructures); competence (practical know-how); and symbolic meaning (embodied understanding of the social significance of the practice and past experiences of participation) (31). In the case of FGM, the practice depends on the integration of materials (knives, blades etc) used; competence (knowing when and where to do the cutting) and the meaning attached to the practice (the compliance of all families and the wider communities).

Bourdieu (33) asserts that the body is the embodiment of society or culture that we live in. His concept of 'habitus' forms a social and cultural heritage which is expressed in practices, to give cultural affirmation and social identity with bodily expression. FGM as a bodily modification is a fruit of a cultural practice that is learnt and passed on. Bourdieu concurs that people tend to represent and to recreate the social condition that they were taught. In gender relations, FGM represents a culture of the domination of a patriarchal power over women's bodies.

Bourdieu's (33,34) other concept, that of field explains social reality and assists in the analysis of cultural products in relation to an identifiable network of relationships that take into consideration institutions as well as social agents.

A field is a network, a structure or a set of relationships which may be intellectual, religious or cultural. The practice of FGM can thus be regarded as a field since it sets its own rules and regulations for behaviour. According to Bourdieu (35), as we enter the field, we are more or less aware of the rules of the game and/ or have great capacity to manipulate these rules through our established capital appropriation. *Habitus* refers to the way we are and the way we act. Thus, habitus is acquired. Within the field, there is a '*habitus*' that is likely to predispose the practising communities to think and act in particular ways; it is a product of the environmental conditions that individuals encounter in their development. We, as social agents, Bourdieu (34) explains, are endowed with habitus, inscribed in our bodies by past experiences. In essence, *habitus* supplies the action with a certainty that is innate in practice and only materialises later as if it had been planned beforehand. Due to *habitus*, social structures become installed within each one of us, at the same time as we contribute to their reproduction. We are simultaneously products of, and productive of the societies in which we live in, and it is impossible to separate us from our society (34).

One of the key features of habitus is that it is not composed entirely of mental attitudes and perceptions, it is embodied (33). To illustrate the importance of habitus, some social groups are more capable of mobilising their own deeply held beliefs on the value of a cultural practice. The concepts of habitus and field can facilitate the understanding of the relationships between the practice of FGM and its representations among practising communities. The FGM-

practising communities have framed their understanding of reality of everyday life through the representation of their own bodies in the face of cultural practices.

2.2. FGM as a social norm embedded in other norms

What makes FGM a social norm?

As mentioned earlier in section 2.1, people comply with social norms because they have internalised the values embodied in those norms. They do so to avoid sanctions (36,37). The practice of FGM is performed because individuals and families believe their communities expect it and to ensure honourable and worthy womanhood for their daughters (38). There are various reasons that motivate people to continue the practice, some of which were discussed in Chapter 1. Support for the practice comes from mothers, mothers-in-law, fathers, other family members, and indeed from the whole community on the basis of the girl's future role as a wife and a mother (39). In other words, FGM has some strong meanings and reasons attached which explain why it is practised and maintained: FGM preserves virginity, bestows beauty and purity, enables the rite of passage to womanhood, makes the girl ready for marriage (marriageability), secures ethnic identity and controls the girls' sexual desires.

The practice of FGM is maintained not only because of these reasons, but also by other related norms surrounding the practice, which give it more weight and have contributed to making it a stronger and wider norm than just FGM itself. The other related norms are embedded in the patriarchal system of practising communities. Addressing issues of patriarchy is akin to addressing issues of identity and culturalism. In some FGM-affected communities, FGM is a celebratory rite of passage which reinforces cultural identity and a sense of belonging in the community (37,40). The procedure is a secret matter and girls are not aware of the event; often they are lied to and taken aside to have it done (37,40). FGM reduces girls' sexual desires and ensures that they remain chaste and virgin, marriageable and faithful after marriage (17,40).

Cultural cues reinforce the social significance of FGM, and Bourdieu argues that people tend to represent and to recreate the social condition that they were taught (33). For example, a woman from an FGM-affected practising community may internalise the representation and values of the practice to the point that even when having migrated to another country where

these values do not exist, she could still take her daughter back to her country of origin and subject her to the practice. Uncut girls are not allowed to serve in meetings or prepare food because they are perceived to be unclean and are teased or ostracised by peers in the playground (29,41). Having FGM performed is a sign of social solidarity and strengthens bond between women (39,42,43).

In the past, girls would spend days with the exciser being instructed in the norms of womanhood and would be rewarded with gifts and public recognition. Through this process, some girls develop a sense of pride, cultural identity, social acceptance and belonging (29). Nowadays, the practice is performed even on babies. Thus, mothers and grandmothers gain respect for having done the duty placed on them by their cultural and heritage to produce an ideal, virgin, young woman ready for marriage through FGM (29,37).

Female Genital Mutilation, like other practices including foot-binding and breast-ironing, is practised in communities and the common denominator is in the harm inflicted upon women and girls, often by other women (the perpetrators and the guardians of the tradition). Women do not engage in these practices for their own benefit but rather for the benefit of men (44). In some practising communities, girls are taught to be brave and endure the pain inflicted by it.

Ayaan Hirsi Ali, along with other activists or '*Norm leaders*' describes her experience as a woman from Somalia in a patriarchal society of her sexuality belonging to her father or uncles, the owners of the family. She was a virgin when she married, because to do otherwise would have damaged the honour of her father and his whole clan (uncles, brothers, male cousins etc) irretrievable and forever. The space between her legs was sewn up and to be broken only by her husband (45). Unfortunately, her story is not uncommon. Kanko (46) noticed how she was treated differently to her brothers at the age of five; she underwent FGM and when she queried it, she was told: 'because you are a girl'. Other activists and '*Norm Leaders*' report similar experiences such as: Bah (47); Koita (48); Dirie (49) and Diallo (50), who was told that 'you will be a good and pure Muslim'. The practice impacts women everywhere as it reinforces male dominance and women's subordination: a situation based on a power dynamic, and men dominate women and have control over their bodies and their sexuality (51). Thus, the other related norms and associated meanings which contribute to giving FGM greater significance and making it stronger as a norm are embedded in the patriarchal system (e.g. *It is the father*

who decides; the roles assigned for women within communities; enduring pain and suffering; the duty to bear and rear of children; subordination (i.e. that they must obey husbands)). The table next page shows the meaning and reasons behind FGM, and other related norms embedded in the patriarchal system which contribute towards making it a stronger social norm.

Table 3: List of meanings/reasons for FGM and the patriarchal system

FGM (meaning and reasons)	Patriarchal system (other norms contributing to give FGM more weight)
Tradition and culture	Forced marriage
Rite of passage to womanhood	Gender roles:
Ensure virginity and chastity and fidelity afterwards	Father who decides
Marriageability	Woman's role in the community
Aesthetic, purity, beauty	Bearing and rearing of children
To preserve ethnic and gender identity	Subordinate, must obey husbands
Honour	Suffering and endurance of pain

Female genital mutilation is further connected to men in society through marriage. In many cultures, women who did not undergo FGM are not considered 'marriageable' (40,52). However, Shell-Duncan found in one of her studies that FGM is not a prerequisite for marriageability, but mainly a way to facilitate entry into a social network and have access to social support and resources, with peer pressure playing a major role in its perpetuation (53). Marriageability is connected to FGM's role in preserving the chastity and virginity of women and the male lineage of families (17). Parents will therefore have their daughters undergo FGM to ensure marriageability and FGM has become accepted as a social norm as parents do not want to be stigmatised or ostracised for having their daughters be unfit for marriage.

The practice of FGM is embedded and reinforced because decisions made about performing FGM are interdependent on decisions made by other intra-marrying families within the communities around them (15). FGM is thus maintained to keep young girls pure and married

women faithful. It is taboo to discuss the subject openly and girls who undergo it are taught to keep their experiences secret (40,54).

In some cultures, the practice is said to create and sustain the image of a woman as docile, asexual, obedient, and fertile (42). It adheres to local ideas of womanhood, femininity, and proper female behaviour (40,42). The practice of FGM is also viewed as a beautification technique that enhances feminine beauty (42,52,55). Aesthetic notions are therefore linked to the conception of purity (17,56). Thus, similar hygienic and aesthetic meaning and an analogous power are used to preserve ethnic and gender identities (57,58). The clitoris and other parts of the female genitals are seen as ugly, dirty, unrefined, and non-human, as a result, FGM is used to attain a more culturally feminine, ideal body (42).

Support for the practice comes from mothers, mothers-in-law, fathers, other family members, as well as religious and community leaders (39). Women who were socialised in a cultural context where FGM is highly valued receive and process information that contradicts and devalues the meaningful norms and traditions they internalised as children. As has been described by Schultz and Lien (29), norms and values related to the practice are deeply internalised by children through metaphors in a meaning-making process that deals with morals, knowledge and aesthetics. The interdependence of expectation from communities makes FGM, as a social norm stiffly resistant to change.

2.3. Change is possible

Change in any context is a process and takes time. Changes in norms can sometimes be achieved through challenge and debate. For example, human rights activists attempt to transform practices despite publicly refusing to conform to accepted norms about how things should be done. They also advocate new and unconventional practices by disrupting ‘the logic of appropriateness’ (59). Other changes in norms happen when people seek to weaken a norm and outline the ways in which it is unreasonable, harmful, inconsistent with other norms or inappropriately applied to a particular issue (60). However, even weakened norms persist unless alternatives are offered. Therefore, successful norm change requires pairing a weakened norm with promoting a new norm in an organised way. This may consist either of a reframing of an

existing norm, or of a new norm altogether. Activists attempt to reframe norms by drawing on other widely agreed norms, such as human rights, justice, or fairness to argue for change. As mentioned previously, girls and women internalise the meaningful norms and the traditions within which they have been socialised as children. In the case of FGM, there has been an increased commitment to reducing and one day ending the practice (29). The WHO, United Nations (UN), UNICEF, and other anti-FGM organisations have adopted various strategies in order to raise awareness and work towards ending FGM and making change possible. Moreover, there is evidence of change over time in attitudes and in the prevalence of FGM (61). Indeed, the prevalence of FGM has declined; and in almost all countries, girls and women are less likely to have undergone the practice than older women (62).

2.3.1. The power of secondary socialisation

Secondary socialisation takes place outside of the family in other social frameworks, including school, peer groups, the media, religion, workplace etc (23,24,63). The socialisation experienced by adults generally falls into the category of secondary socialisation, building on the socialisation experiences from childhood. Much of this is acquisition of role-specific; that is, learning the knowledge and skills required for the performance of specific adult roles (e.g., career, marriage, parenthood) (23,64,65). As individuals become committed to the roles they play, they come to think of and identify themselves in terms of these role identities (21). Secondary socialisation requires the acquisition of role-specific vocabularies which means the internalisation structuring routine interpretation and conduct within a specific institutional area (64).

It is of great importance as to whether individuals begin to think differently about the practice of FGM. An understanding of the learning process and the type and quality of girls' acquired knowledge of the ritual is of relevance to the key education component of behaviour-change programmes targeting both in FGM-performing countries and those living in exile in non-performing countries. Where women who have undergone the practice of FGM and have migrated in Western countries, the empowering nature of their environment has motivated their rejection of the tradition (Lien, 2010). The literature reveals that the environmental factors in

contexts where the practice is against the law influence the change of attitudes among migrant people (15,66). O'Neill et al. (17) assert that the length of time spent in host countries is associated with the likelihood of a change of attitude towards the traditional practice. In a study where activists were interviewed after seminars and conferences, they reported that what were taught in the seminars about FGM changed their views and caused them to abandon the practice (65).

2.3.2. Review of selected literature on the change of attitudes towards the practice of FGM

Despite this normative system making the change difficult, some women still succeed in changing their attitudes towards the practice. Most research studies about the change of attitudes towards FGM were conducted at a community level, and, to a much lesser extent, an individual level. These studies considered different perspectives to understand how communities may succeed in changing attitudes towards the norm and describe the main approaches used, such as the human rights approach and anti-FGM campaigns (67); the legislative perspective (40,61,68,69), the social convention perspective (15,53) and the behavioural approach to change (53,67,70).

2.3.2.1. *Human rights and anti-FGM campaigns perspectives*

Approaches based on the human rights perspective and anti-FGM campaigns have been mainly adopted by Non-Governmental Organisations (NGOs). The firm grounding of FGM as a violation of human rights that contravenes international human rights treaties and conventions has, however, attracted strong criticism from a camp of legal and human rights scholars. They have challenged the application of the human rights argument to FGM on a number of counts. The practice of FGM impacts three basic rights: the right to health, the rights of the child, and the right to bodily and sexual integrity (71). The right to health approach has been the most frequently used and perhaps the easiest to integrate into messaging, as it is objective in nature and does not challenge the belief structure of practising communities. However, the health rights argument may backfire as it attacks practices in Western countries that are potentially

life-threatening but nonetheless conducted for aesthetic reasons (the female genital cosmetic surgery, which women undergo although it is not socially necessary) (72). It was through emphasis on the negative health effects of FGM that the practice came to be seen not in terms of a ritual of socialisation but as a grave violation of the physical integrity of the women who have undergone it. Thus, they provide grounds for analysis from a human rights perspective (54).

The human rights messages combined with communication about negative health consequences of FGM emphasising the harmful consequences of the practice convinced communities to change their attitudes and stop cutting their daughters. The health messaging that reveals the negative consequences of the practice can also motivate communities to carry out less severe forms of FGM due to the medicalisation of FGM. For example, WHO (40) reports an increase in the number of parents seeking out medical practitioners to carry out the procedure. This represents the efforts of communities to balance the social expectations with the human rights and well-being of girls and women. The campaigners focused on the immediate and long-term health consequences of FGM and the irreversibility of the procedure by holding informational workshops aimed at ending FGM. However, such campaigns failed to make a distinction between the specific health consequences from different types of FGM, and communities did not view all types of FGM as responsible for adverse consequences (67,72,73). As a result, their efforts to eliminate all forms of FGM were undermined.

2.3.2.2. *The legislative approach*

Laws against FGM are an important step and create an environment suitable for abandoning the practice (74). The legislative approach was used to criminalise the practice of FGM either as a specific criminal act in itself or as a general act of bodily harm. The legislation was a step forward and a great milestone for the protection and promotion of the rights of women and girls worldwide. It is seen as a tool to fight a wide range of perpetrators through the judicial system. The legislative approach aims at a preventive effect (75). This official platform which offers legal protection for women can discourage excisers and families for fear of prosecution and supports health professionals to oppose requests to perform FGM (76). For legislation to be effective and win the public support that is crucial to facilitating the implementation and support

for the law, it is imperative to take into account the extent of the consensus around the social acceptance of FGM and the reality of the lives of women and girls. Stopping the practice by providing women with the information and freedom of choice to abandon FGM cannot be achieved by the simple act of drafting or interpreting a set of human rights principles or laws, even though such steps are necessary to enhance the process of change (77). However, the difficulty with this approach is that families will not report members of their own family, and parents may carry their daughters to countries where the law is not against the practice.

2.3.2.3. *The social convention approach*

The social convention theory has been applied to understand harmful traditions and cultural practices such as FGM and foot-binding amongst Chinese communities (15). Mackie and LeJeune (15) highlight the wider inequalities in society that perpetuate such practices and how factors such as gender, class, and the desire to improve one's access to social and economic resources may contribute to the establishment and continuation of the practice. In many FGM-affected communities, women who have been cut are considered to have maintained their virginity, which is desirable for marriage. Mackie and LeJeune argue that the potential problem of marriageability will be solved if a few people abandon the practice and suggest shifting from a point where everyone cuts (in the case of FGM) to one where nobody cuts. This approach was used to suggest that the eradication of these practices may be achieved through public renouncement (15,36). Communities publicly renouncing FGM was meant to make families believe it not to be detrimental to their status and indeed acceptable not to cut their daughters (67,78).

There is some evidence that this approach may be successful in the short-term. For example, in Senegal, a whole community collectively declared their renunciation of FGM (78). In the long-term however, only minimal change has been sustained, as some of the women excisers, even though they had renounced the practice as part of the public declaration, 'had gone back to their scissors' some years later to avoid losing their economic status (77,79).

2.3.2.4. *The behavioural change approach*

As efforts to eliminate FGM have intensified the social norms theory has become a prominent framework for understanding the dynamics of behaviour change. In recent years, there has been influential in the design of interventions aimed at accelerating the abandonment of the practice. Social norms theory sees FGM as held in place by interdependent normative expectations, as, what one family chooses to do is linked to the expectations of (important) others and reinforced through social sanctions. With reference to the behavioural change approach, intervention programmes have applied the stages of change or Transtheoretical Model (TTM) (80) to FGM, with the aim to achieve a change of attitudes at the community level. The stages follow the sequence of *precontemplation*, *contemplation*, *preparation*, *action* and *maintenance*, with relapses possible at any within the process. In the *precontemplation* stage, the individual is conditioned by pre-existing knowledge and beliefs, and there is no intention of changing a particular behaviour (80). *Contemplation* is the second stage, where the individual becomes aware of a problem and considers the possibility of taking action to address that problem. A multiplicity of triggering events may lead to this stage, from a death in the family caused by FGM as an extreme to the cumulative effect of several less individually impactful factors. Direct experience, such as witnessing the pain the daughter suffers after the procedure and exposure to new information about FGM may be two factors that trigger contemplation. Societal changes, such as immigration or wars that grant women greater independence much stronger influencing factors than any intervention programs (77). However, feelings such as confusion, fear, and guilt of going against one's tradition may relapse into strong resistance. By the third stage, *preparation*, the individual experiences a change in attitudes. The individual displays some behaviour that reflects the intention to change. Possible threats may be pressure from the individual's social network to forego her decision. The fourth stage, or *action*, involves modification of one's behaviour in order to follow through with the decision to change. This stage may be implemented by participating in an alternative ritual ceremony or making a public pledge not to circumcise. The final stage, *maintenance* is where stabilisation of behaviour occurs, and individuals sustain the behaviour change without turning back to their former behaviours.

For all the above stages, a supportive social environment is a crucial factor in maintaining one's decision not to circumcise (77). The changing of attitudes remains challenging, as the decision to cut a girl is beyond the immediate parents' power, and often involves several individuals, including the father, mother, grandmother, aunts, and potential in-laws (77). According to some authors who have applied the TTM of change to FGM at a community level, their approach failed to address important individual dimensions in the dynamics of community change (76). The process involved in the change of attitudes towards the practice of FGM which has been around for several centuries is clearly more complex because the decision to cut a girl is beyond just the mother and involves cooperation between individuals and families (81). In addition, change does not simply occur in a '*top-down*' manner, but rather, change occurs from the '*bottom-up*' via individuals making particular '*choices*', making them capable of doing and being (82).

In all these approaches, the impact of interventions aimed at changing attitudes towards FGM was mostly studied at the community level. How change occurs at the individual level remains an under-investigated issue, which this present study aims to address by researching critical events in the lives of women that led to a change of attitudes towards the practice of FGM at the individual level. To date, the different approaches discussed in this section have not led to a reduction of the practice as such due to the insufficiency of strategies that work.

2.4. The capabilities approach in relation to FGM

The claim that the capabilities approach defends a concrete universality of emancipation for all women can be extended to the debate concerning the practices of FGM. The approach defends the freedom to attain complete well-being and the ability to attain well-being through the capabilities of humans. The capabilities approach has the advantage that functionings and capabilities are properties of individuals (82). Developed by Nussbaum (83), the approach is a conceptual framework which embodies a new approach to defining and assessing progress in wellbeing and social arrangements. Nussbaum (83) adopts a philosophical point of view based on Aristotle's ideas of human being as a rational animal. Nussbaum's perspective of the capability approach reasons that the well-being of people greatly depends on their freedom to

do and to be whatever they desire. This approach constitutes a life where people have the choice, the resources and the opportunities to give them a life they can lead themselves based on their own terms. In this sense, she defines both the body and reason in functional terms and draw up a list of capabilities that she explains would enable human beings to function and fulfil their potential in a given community. See Agboli *et al.* (84) in chapter 2 under section 2.3, for more details on FGM undermining some of women's capabilities from Nussbaum's list (83). In this section, we discuss Nussbaum's claim that making the practice of FGM illegal is necessary to protect the central human capabilities and opportunities for functionings for women who have undergone FGM as well as choosing the life they value. For example, a woman who chooses not to partake in sexual satisfaction or who chooses celibacy is very different from one who is forced into FGM to prevent her from going astray and fulfil herself sexually (85). Nussbaum, through her capabilities' list, speaks against the practice of FGM because it deprives women of the opportunity to decide what their sexual life may entail and also completely nullifies a woman's decision to attain celibacy if that is what the woman considers a life of value for her. The practice of FGM undermines the respect for agency which requires that people control their own lives, choose their own goals, and contribute to those of the community and larger society through a process of public reasoning (86).

The capability of Emotions according to Nussbaum says that: being able to have attachments to things and people outside ourselves; to love those who love and care for us, to grieve at their absence; in general, to love to grieve, to experience longing, gratitude and justified anger. Not having one's emotional development blighted by fear and anxiety, or by traumatic events of abuse or neglect. (83). FGM can cause a woman's Emotion to be affected psychologically and influence her ability to properly feel love for her family if she is angry with those who have forced her to undergo the practice. This could impair her attachment to those whom she trusted before the procedure.

2.5. Addressing FGM in Belgium

FGM is not traditionally practised in Belgium. Due to migration, the practice has become host countries' concern including Belgium. Women fled from different countries in sub-Saharan Africa and from difficult situations, persecutions, and wars. In Belgium, the recent arrival of African families from Somalia and Eritrea (countries with high prevalence of FGM) as well as Iraq and Syria, enabled to update the data in order to develop strategic actions and interventions to protect girls and support women already affected by FGM. Recent research on the prevalence enabled information-gathering on migrants' date of arrival in Belgium and estimated that 17,273 women and girls had already undergone FGM, and that 8,644 women and girls were intact but at risk of being excised (87).

2.5.1. Legal provision and extraterritoriality

Legal provisions that apply to FGM can be found in criminal laws and child protection laws as FGM is considered as a form of child abuse in Europe. In 2001, Belgium passed a specific law punishing the perpetrators of FGM (Article 409 of the Penal Code). The problem has several components, because it is not only a question of protecting girls who are at risk of this practice, but it is also a case of taking care of the gynaeco-obstetrical and psychosexual complications of those who have undergone the procedure (87).

The principle of extraterritoriality is a criminal provision applied when girls and young women undergo FGM whilst on holiday visiting relatives in their country of origin. This means that Belgium can prosecute for the practice of FGM when it is committed outside the borders just as if it were executed in the country (88,89).

2.3.2. Empowerment support for women affected by FGM in Belgium

In 1996, GAMS Belgium (*Groupe pour l'Abolition des Mutilations Sexuelles*) was founded. It is a Non-Governmental Organisation (NGO) that stands against FGM and harmful practices against women and girls. GAMS Belgium is a group of African and European women and men that are fighting for the abolition of FGM. The organisation works with various groups

including women affected by FGM (through social, medical and legal assistance), girls at risk, religious and community leaders, the wider African communities affected, schools and parents' organisations, the federal agency for the reception of asylum seekers, asylum centres, professionals of the social, legal, law enforcement and health professionals, the Belgian authorities and the public. This is done by raising awareness, championing individual cases, political and legal lobbying, and leading projects in Africa.

Survivors of FGM or children at risk can benefit from a national protection scheme (with reference to youth laws or civil laws) or an international protection scheme (concerning asylum). Because the law prohibits FGM in Belgium, it can be subject to criminal proceedings. Since 2019, GAMS follows up the cases of national protection and international protection and takes legal action to combat the practice of FGM. The NGO follows up applications for asylum, supports professionals that are confronted with child victims or children at risk, and organises training and symposiums on FGM, etc.

The support given to migrant women in Belgium by GAMS has several dimensions:

Prevention: For prevention, GAMS-Belgium supports the community by working to raise awareness and involves other institutions such as ONE (*Office National et de l'Enfance*) to ensure that parents are aware of such concerns during their routine visits.

Holistic care: In terms of care and support for women who have undergone FGM, a holistic care is given at the accredited centres (*CeMAViE at the St Pierre University Hospital and the Vrouwen Clinic at the Ghent University Hospital*) for psychological, surgical and sexual care. Since 2014, clitoral reconstructive surgery has been funded by Belgian social security in conjunction with multidisciplinary care (90).

Advocacy: GAMS Belgium provide advocacy on a political level based on daily liaison with the communities concerned and various professional sectors. Their political demands involve the prevention of protection for all girls and women from of FGM, and the provision of high-quality and continuous multidisciplinary support to women and girls who have undergone FGM throughout Belgium. It also provides effective protection for women who have fled forced marriage.

Empowerment support: GAMS Belgium offers workshops for people from communities affected by FGM. These workshops aim to facilitate the autonomy and decision-making capacity of the participants through animations structured around different themes related to

gender and gender-based violence (including problematic masculinity) which can lead to the creation of tools to raise awareness and to encourage sharing and empowerment. The empowerment supports are based on health promotion charter and framework. The charter introduced a focus on health and its determinants for individuals to increase control over and improve their health (91). Providing information and education to women and girls living with FGM, they are in line with international human rights and of course empowering. Thus, it can be an important influence on how the communities affected may change their attitudes towards the practice. Such interventions, which include information on women's health as well as the health effects of FGM, can have positive effects on women, girls, and other community members by helping them to overcome the shyness to discuss the procedure due to the taboo around it. Thus, enhancing their capabilities and supporting their empowerment. The relation between empowerment and reinforcement of capabilities following participation in health promoting interventions by GAMS Belgium was evidenced in a qualitative exploratory study we conducted in collaboration with GAMS Belgium (84). See Appendix 1.

Our study however raised further questions, such as what happens at individual level?

What this chapter adds:

FGM is a social norm internalised through primary socialisation and embedded in the patriarchal system which in turn encompasses other norms. These norms and the associated meanings of FGM contribute to making it a stronger norm rooted in the tradition of practising communities and thus, resistant to change. However, change is possible and various approaches have been attempted to stop the spread of the practice including the empowerment and capabilities reinforcement at the community level. Thus, we hypothesised that it is a complex individual process which we look at in this study (knowledge gap).

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Chapter 3

Problematism and Research questions

3.1. Significance of the study (problematism) and knowledge gap

What makes some women change their attitudes towards the practice of FGM?

The practice of FGM is a complex social norm difficult to change because of its deep roots in tradition and its interdependency on the expectations of practising communities. The practice is also difficult to change because FGM is not an isolated social norm; many other varieties of norms embedded in the patriarchal system contribute to making FGM a stronger, more complex social norm and therefore more resistant to change. Older women who are also the perpetrators and guardians of the tradition maintain and perpetuate the practice. Support for the practice comes from mothers, mothers-in-law, grand-mothers, aunts and even other female family members as well as from the wider community on the basis of the girl's future role as a wife and a mother (1). To illustrate, in many FGM-practising communities, women who have been cut are considered to have maintained their virginity, which is highly desirable for marriage and married life. Consequently, practising FGM becomes accepted as a social norm, as no family wants to suffer the stigma associated with having a daughter considered unfit for marriage (2,3). In this study, we argue that some women changed their attitudes towards the practice and its related norms, and, as a result, did not have it undertaken on their daughters. Other women, through their own personal experiences of the consequences of FGM on their own health, changed their attitudes towards it and became agents of change as well as activists, even if they had no daughters of their own. The question is, what caused them to change their attitudes towards the practice of FGM? A growing body of literature as discussed in Chapter 2 has researched the change of attitudes towards FGM at a community level using different approaches, including the human rights approach and anti-FGM campaigns (4), the legislative approach (5–7) and the behavioural approach (8). For example, social convention theory was used to understand harmful practices (FGM, foot-binding), and was also suggests that these

practices will finally be ended when communities publicly renounce the practice. The renouncement of the practice by communities makes families believe it not to be detrimental to their status and indeed acceptable not to cut their daughters (3,9). These studies overlooked the transition process and the mechanisms by which the change of attitude towards FGM and other related norms occurs at individual level. We know from Chapter 2 that change is a complex matter which does not occur in a top-down manner. Rather, it occurs slowly from the bottom up with the individuals involved making particular choices, through long processes of transition; but this has not been studied in the field of FGM at the time of our research. Our study seeks to address this knowledge gap by investigating and analysing the transition that has led to a change of attitudes towards the practice of FGM at individual level.

3.2. Research questions

3.2.1. General research question

The general objective of our project is to better understand how migrant women who have undergone FGM and who were socialised in a cultural context where the practice is valued and deemed normal have changed their attitudes towards the practice and speak out against it. Thus, the question that we have attempted to answer in this research is as follows:

- What are the psychosocial processes by which migrant women change their personal attitudes towards the practice of FGM?

Because our project is about a change of attitudes towards a social norm, we seek to explore life events which introduce the concept of turning points that can lead to a change. Furthermore, we strive to understand the mechanisms that influence the women's change of attitudes with regards to the events that have happened in their lives. Thus, in order to answer this research question, we propose two objectives as follows:

3.2.2. Objectives

3.2.2.1.Objective 1

To identify critical life events in relation to what makes the change of attitudes towards the practice of FGM to occurs.

3.2.2.2.Objective 2

To better understand mechanisms and factors that explain the change of attitudes towards FGM and other related norms.

These two objectives will be addressed in a sequential design. This means that the two studies are not parallels but the specific objective for Study 2 is derived from the results of Study 1.

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Empirical part

Chapter 4

Methodology

A sequential approach of narrative biographical approach and grounded theory methods to explore the process of changing of attitudes towards the practice of FGM

Introduction

This chapter introduces the general objective and research questions. This chapter also provides the philosophical underpinnings of the research design chosen for this study.

4.1. General objective

The general objective of this project is to better understand how migrant women who have undergone FGM and were once socialised in the FGM-cultural context where the practice is valued and considered normal may change their attitudes towards the practice and speak out against it. Thus, the question that we have attempted to answer in this research is as follows:

What are the psychosocial processes by which migrant women change their personal attitudes towards the practice of FGM?

4.2. Qualitative sequential method design and rationale

The exploration of both the philosophical and practical perspectives in this study provides evidence of a rigorous approach to the research process. The methodological choices made throughout research are core features of credible robust research (1). This research has used a sequential, qualitatively driven methods design which combines two qualitative approaches: the narrative biographical approach and elements of grounded theory. The qualitative method design known as ‘QUAL-qual’ research model design by Morse and Niehaus (2) refers to the incorporation of one or more methodological strategies drawn from a second method, into a

single research study. The aim is to access some part of the phenomena of interest that cannot be accessed using the first method alone.

The design consists of a main core study (i.e. '*the QUAL*'), a complete study in itself that could be published alone. However, it is complemented by another supplemental component ('*the qual*') that cannot be interpreted or utilised alone (2,3). Qualitative health researchers are interested in individual experiences and processes linked to a particular phenomenon as well as experiences and processes that are common across a group of participants. This interest can be pursued by a combined methodological approach that harnesses the strengths of narrative approach and grounded theory. In this research, *the QUAL* is the narrative biographical approach (NBA), and *the qual* is the grounded theory (GT) approach (constant comparison). See the diagram for the design next page.

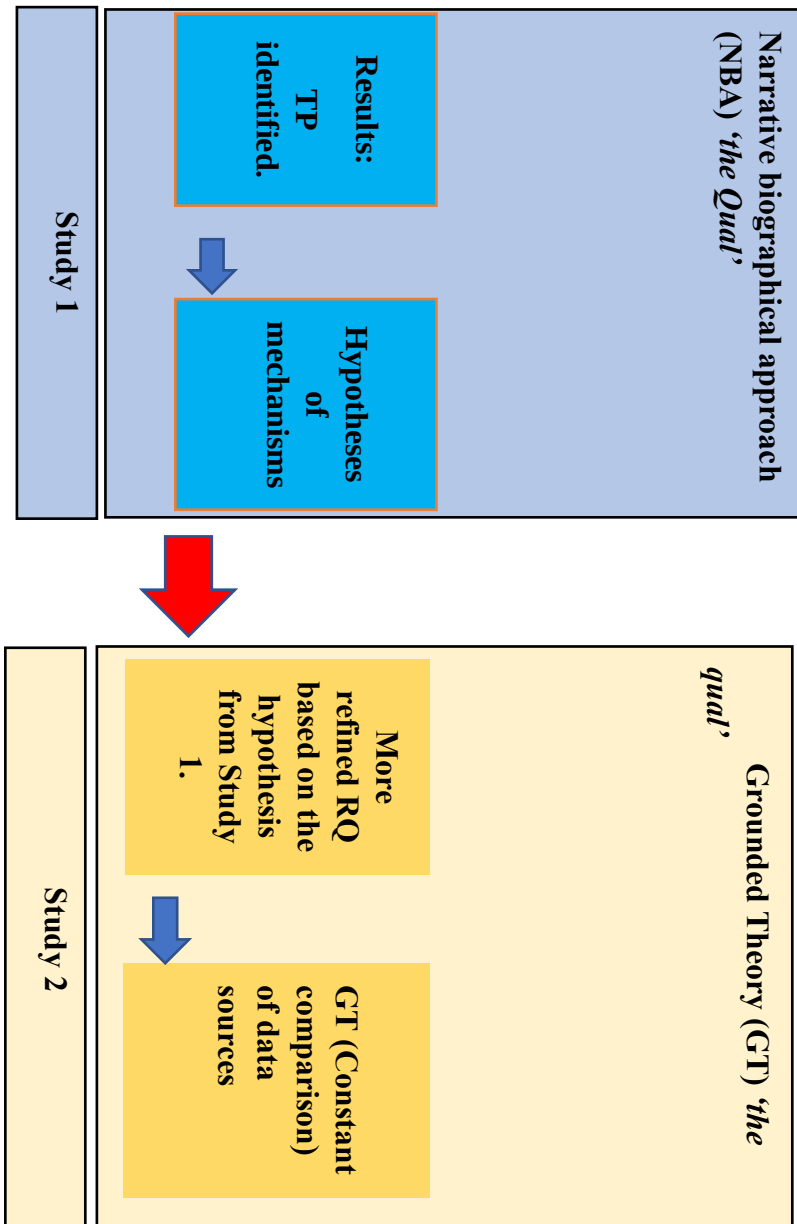


Figure 1: The qualitative sequential design of the study

4.2.1. The rationale for choosing to combine qualitative methods

This method was chosen because of its closed association with the paradigm adopted (narrative) and to explore the dynamics of the relationship between life stories and the change of attitudes towards FGM. Riessman (4), suggests that contributions to knowledge can be provided by studies adopting both grounded theory (GT) and narrative approaches. For the purposes of capturing themes, categories and patterns across subjective perception and meanings ascribed to the change in the representation of the practice of FGM, a combined method was thought most suitable for this study. Charmaz (5) advocates that the power of GT lies in its tools for understanding empirical reality. The life stories of the women generate detailed stories of their experiences (4) and thus can be seen as an opening for analysing this specific group through constant comparison to allow the emergence of categories (6). Several researchers have already combined the two methodologies. For example, (i) Drew (7) combined GT with narrative analysis to explore the impact of childhood cancer on social and personal wellbeing in early adulthood.

The combination was useful to provide a deeper analysis and better understand the importance of cancer in identity development and the expression of the experience of survivorship. The analysis was done firstly breaking the data into smaller units using coding steps according to grounded theory, then the analysis moved on to draw on aspects of narrative analysis in order to facilitate a better understanding of the core category, as grounded theory alone was not sufficient for explaining the relationships between the themes identified.

Floeresch *et al.* (8) also used a combination of qualitative methods to produce an integrated framework for understanding adolescent experiences of psychiatric medication. By inter- and intra-comparison of the participant responses, they developed a conceptual framework for understanding the medication experience. Then, they drew on narrative methods from each of the participant responses that resulted from the ground theory analysis into one story about medication, allowing for a better understanding of it through concepts of plots and temporality.

4.2.2. The choice of the narrative biographical approach (life story approach) in our study

The overall aim of this project was to explore the psychosocial processes by which migrant women change their attitudes towards FGM. In the first study, the narrative biographical approach was used to investigate the critical life events experienced by the women. A crucial factor in choosing the life story approach as a method was its sensitivity towards the multiplicity of contextual and cultural determinants which influence storytelling (8,9). Riessman (4) identifies stories as not only personal but part of the social aspects of our lives. Storytellers narrate their stories within the framework of their culture, beliefs and values (10). Narratives are co-constructed between the teller and the interviewer. Life story offers a way which enables to step inside the personal world of the storyteller (11). It expresses our sense of self and is an important means by which we communicate and negotiate this sense of self with others (12). Life stories function to give our daily experience an understanding of time dimension (8). They are a relation between events, and one's identity through which we discover ourselves and reveal to others (13). Narrative is about interpersonal relations, human experience, chronology of events as well as temporality of existence (14). Riessman (4) asserts that the purpose of narrative and life story is to see how the participants impose order on the flow of experience as a way of making sense of actions and events in their lives.

Humans are often storytelling people who individually and socially lead storied lives. Bertaux (15) stresses that life story is the account given by people of their whole lifetime or part of it, but it is written by another person. Thus, life story approach is a useful research tool to explore the lived world and to reveal how people experience everyday life, for example, their turning points, daily rituals, relationships with other people etc (9,16). This approach helps to make sense of changes in social character, in individual lives, and in society. Chamberlayne *et al.* (16) highlight an emphasis on self-construction, life review and the fashioning of identity impacting the biographical work. Narratives of each life event are, at least, double-interpreted by the storyteller and the interpretation began when the event was first experienced and then re-interpreted when it was narrated to the interviewer (17). Stories are the subjective, interpreted version of accounts remembered and the meaning reconstructed by storytellers (9,12). Each storyteller decides how he or she wants to remember the events and how and what to share with

the researcher. There is no absolute or single truth in life story inquiry, and the stories are considered to constitute the narrative truth (9) or subjective reality (12).

The life story approach has been influenced by philosophy, anthropology (18) as well as in health (19) and social sciences (4,16). The process of telling stories is believed to have the potential to transform participants' experiences (20). Several studies have supported life story and its development as a methodology within health-related fields research. In this context, life story has become increasingly perceived as vehicles through which illness experiences and critical turning points in life could be understood (21,22). They represent important tools that humans use to make sense of biographical disruptions related to illness and other challenging life circumstances (4,23).

The advantage of doing life story research is that stories are significant for representing and analysing identity in its multiple guises in different contexts. It allows the individual to construct the content of their experiences as the researcher does not impose a structure on their story (15). The type of data collected in life story research are diverse in nature such as personal oral accounts, in-depth conversational interviews, a brief story in response to a single question, archival documents including diaries, and letters (4). Life story research is often perceived as a joint work in which findings are co-constructed and co-negotiated between the researcher and the researched (9,12).

4.2.2.1. *Rationale for using the life story approach*

The choice to use the life story approach in this study is based on its advantages when exploring the literature on immigrants and their contexts. We drew on this approach with women who linked their change of attitudes with stressful events. Hence, 'life story' in this study involves the personal experiences of migrant women and is considered an integral part of how understanding is reached where the women themselves are the narrators of and experts in their stories (24). It enables the depth of the researched lived experiences to be better understood (4). The migrant women who have left their country of origin and have come to host countries in a western world have different trajectories and different experiences. The approach places the focus on the ways in which the women participants construct their own narratives about their experiences in relation to what made them to change their attitudes towards the practice of

FGM. Life stories research has been found to facilitate the exploration of *turning points* in the trajectories of individuals (25).

4.2.2.2. *Turning points in life story research*

The first word '*turning*', implies a change of direction. The event itself seems to trigger a shift in direction, thereby influencing the series of events that follows it, although this causal relationship may be subjective rather than objective (26). It could be a single event or several linked events within a temporally extended unit of time and the specific episodic experiences within the larger timeframe must be cited in order to create causal links between the turning point and one's current life direction (26). Thus, *turning points* may be defined as specific events that are perceived to change the direction of one's life (25,26). The second word '*point*' implies that it is a specific moment in time; they have a source and a point in time at which they begin (26,27). *Turning points* involve life event experiences, critical moments when there is a change of trajectory. They can only be identified in hindsight, after the event and they are subjective and retrospective reconstructions of life story narratives (28). Embedded in life stories, *turning points* are shifts that force individuals to recognise that they are no longer who they used to be (29). The concept of *turning points* in life story research is recognised as transformation of identity where the individual is not the same, '*as he or she was and he or she used to be*' as a result of events (30). In our study, the life story approach is therefore a suitable tool for identifying *turning points* which occur in the lives of women and have led them to change their attitudes towards FGM. *Turning points* reflect the social norms of both the social contexts in which they have emerged and individuals' own definitions of the significant experiences that define their lives within a shifting sociohistorical context (27). The life story concept therefore results in *turning points* being viewed as salient events important to individuals or as realisations that influence positive movement along the stages of the change continuum (31,32). Furthermore, *turning point* are viewed as an experience or a period of time of time that changes one's life perception and allows one to maintain a sense of self-continuity (33). Wheaton and Gotlib (34) claim that *turning points* can only be found in the context of life trajectories, and they define them as specific events perceived as changing the direction of one's life (26). These can only be identified in hindsight after the event has passed, and thus are

subjective and retrospective reconstructions of life story narratives (28). In the life course perspective, the events are revealed as something that helps people to change status ‘*from disadvantaged to successful, from criminal to non-criminal, from abused and battered to breaking out of the relationship and becoming free*’ (35).

In this study, we focused on *turning points* as significant events which create an awareness that challenges existing internalised norms in relation to the practice of FGM. The understanding of *turning points* provides a valuable insight into the factors and processes involved in the change of attitudes towards FGM.

4.2.2.3. *The theoretical and philosophical basis of Biographical Narrative Interviewing Method (BNIM)*

The use of narratives has not only been of interest to psychologists, anthropologists and philosophers, but has also gained the attention of health researchers. This research drew from the Biographical Narrative Interviewing Method (BNIM), a life story approach developed by Wengraf (36). BNIM is concerned with the exploration of subjective experience in historical and social contexts and examines life narratives in a structured way. Temporality is embedded in the meaning of a narrative (4) and analyses events which occurred chronologically. BNIM facilitates a systematic and retrospective exploration of individuals’ whole life story (*Biography*) and how they tell it (*Narrative*). Narratives are subject to social world, and BNIM follows social constructionist philosophy which entails the social nature of knowledge and the construction of reality (37). Thus, narratives are like vehicles by which socially mediated knowledge is manifested. This approach is informed by other theoretical perspectives, including grounded theory (38,39).

Within the BNIM approach to data collection, the interviewee is seen in two phases and sometimes three, with the first interview being unstructured and the consecutive interviews building on the previously collected data.

Phase One offers an open structure led by the interviewer. It starts with a single statement which has been described as ‘*a single question aimed at inducing narrative (SQUIN)*’ (36). Interviewees are encouraged to talk freely about their life stories in the way they decide and

without interruption, allowing memories to surface and connections between thoughts to develop.

In Phase Two, researchers review their field notes for all topics mentioned by the participants to develop further narratives around them. The second phase generates rich data around incidents prompted by the researcher from which the respondent could choose. Phase Three within BNIM is not always present in studies but does allow an opportunity for the researcher to follow up on more specific points (36) and to be more structured with questioning, should this be appropriate.

4.2.2.4. *The data collection process and description of the sample*

The recruitment process took place between December 2016 and April 2017. Ten women were recruited through gatekeepers from a non-profit organisation, GAMS-Belgium (*Groupe pour l'Abolition des Mutilations Sexuelles féminines*), which strongly opposes FGM. This initial convenience sample was followed by a snowball procedure that led to the inclusion of a further five women. As a result, a total of fifteen women who self-reported that they had once undergone FGM and now stood against it were included in the sample. They were considered eligible to participate if they had self-reported to have undergone FGM, were 18 years or over, had been living in Belgium for at least one year, were from an FGM-practicing community from East or West Africa, spoke either French or English and self-reported as being against the practice of FGM. All the women participants who were recruited came from five different countries in sub-Saharan Africa and provided written informed consent in order to participate. The informed consent process included an overview of the objectives of the study and the women were also informed of their ongoing rights as participants and were reassured that they were free to stop without having to explain why. Given the sensitivity of the topic, the women were informed that they could give a pseudonym when signing the consent form, but they all gave their real names. The description of the women participants is presented in the table next page:

Table 4: Summary of participants' characteristics at the time of the interview (n=15)

Variables	N (%)	Median/Range
Age of the woman at time of interview		39 years [23-53]
Age when FGM was performed		7 years [5-14]
Region of origin:		
East Africa	5 (33%)	
West Africa	10 (66%)	
Level of education:		
Primary school	1 (1%)	
Secondary school	7 (46%)	
University	7 (46%)	
Occupation		
Unemployed	5 (33%)	
Voluntary work	4 (27%)	
Student	6 (40%)	
Length of stay in Belgium at time of interview		6 years [1-15]
Method of entry to Belgium:		
Asylum	13 (87%)	
Family reunion	2 (13%)	
Marital status at the time of the interview:		
Married to an African man (same community)	6 (67%)	
Married to an African man (other community)	1 (11%)	
Married to a Belgian man	2 (22%)	
Married once, but divorced and cohabiting with a Belgian man at time of the interview	6 (40%)	
Total number of children at time of interview	25	
Number of children per woman		2 [1-4]
Number of children born in Belgium	15	
Woman giving birth to at least 1 girl	11	
Woman with 1 child left in the country of origin	1	

Because FGM is a sensitive topic, we have decided not to give too much information about the women to avoid them being recognised. However, for a better understanding of who these women are, we constructed, based on the different women's experience, a fictive typical woman's case which is presented in Appendix 3.

4.2.2.4.1. *Location and the conduct of the interviews*

Prior to conducting the interview, we read Patton's (40) 'informal conversational interview' model which we found interesting as it motivates and guides the researcher to follow the interview in a more naturally occurring conversational manner. We wanted to exert as little control as possible over the narrative. However, Patton (40) suggests that during an interview, the researcher remaining entirely non-directive does not necessarily always serve the function of creating space for narratives or allowing the participant to have control over their own stories. We arranged the interview and suggested the date, time and location with the participants through a telephone call. We introduced ourselves as a student doing a research on women from countries with high prevalence of FGM and their life trajectories. The women participants were given options for the location of their interviews: in their homes or in another comfortable location of their choice. Some women chose to be interviewed at GAMS-Belgium in Brussels, others in their homes. This led the researcher to travel to different places in Belgium: Brussels, Liege, Gembloux, Antwerp and Ghent.

The first interviews lasted from 30 minutes up to an hour and a half, with an average of 45 minutes and the second interview lasted from 50 minutes to one hour and 40 minutes with an average of one hour and fifteen minutes.

4.2.2.4.2. *First interview: One question was asked*

Our first interviews were conducted either at the GAMS offices (n=8) or in the women's own homes (n=7), according to the women's preferences. An explanation of the objectives of the study was provided to the women before the beginning of the interview so that they would know that FGM would be discussed. Then, at the start of the interviews, the women were all asked this one, broad question as suggested by Wengraf (36) and Bertaux (15): *Could you tell me about your life experiences, and in doing so, include any story in your life that you think important?*

Then, the women were let to narrate their stories and experiences without interrupting them too much as they are the experts of their lived experiences. The particularity of the SQUIN is that it enables the participants to say what they want to say. This is in contrast to other more

structured interview techniques that may have made participants talk about what interviewers wanted to hear. The importance of empowering the women participants to structure their own narratives was a key consideration, particularly in relation to the sensitive nature of the subject. The first interview which corresponds to phase 1 in BNIM method ended with the women's own closure expression such as: '*this is it*' or '*that is my story*'.

The women's stories were audio-recorded, and their consent was sought beforehand. Only one woman refused to be recorded, therefore, notes were taken.

4.2.2.4.3. *Second interview: based on personal story and experience.*

Two weeks after the first interviews and their transcriptions, we conducted the second interviews in the women's own homes. The women were able to: (i) confirm the hypotheses of *turning points* raised after the first interview, (ii) narrate more events and complete the lifelines, and (iii) identify further relevant *turning points*, if any. The second interview was guided by semi-structured questions that were unique to each woman according to their initial narratives. This enabled the completion and validation of the lifelines with every woman, with a visual representation of the significant events (*turning points*) that led to a change of attitudes towards the practice of FGM.

The first and second interviews are summarised in the table next page:

Table 5: Overview of the nature of the BNIM interview technique used in our study

	Interview 1 SQUIN (the single question)	Interview 2 Follow up from SQUIN (Two weeks after Interview 1)
Purpose of the questioning	To elicit a narrative in which the participant controls the beginning, end, timing, and structure of the narrative.	To obtain more in-depth data about a particular incident narrative mentioned by the participant. The purpose of the second interview is for the women to confirm the hypotheses of turning points, to narrate more events, to identify other relevant turning points and to complete the lifelines together with the women. The second interview was guided by semi-structured questions that were unique to each woman according to their initial narratives.
Nature of questioning	‘As you know, I’m researching on the change of attitudes towards FGM. I understand that you have had such experiences. So please can you tell me the story of your procedure of FGM as well as events and experiences that were important for you, personally up till now. There’s no rush, you can start wherever you like. I will listen first; I will not interrupt I will just take some notes in case I have any further questions for after you’ve finished telling me about it all’.	-Please could you confirm the hypotheses of turning points raised after the first interview? -Could you tell me more of any event you think that has contributed to any awareness towards the change? ‘You said (...) do you remember any more about that particular event, how it all happened?’ or ‘you said (...) Do you have any thoughts (or feelings) about that time? Based each woman’s life story: - What led you to question excision? -Growing up, what do you think the reason was? -How do you position yourself regarding FGM now? -How do you feel about it now?
Tools and methods	Interview guide (SQUIN) in the hand of the researcher	Interview guide in the hands of the researcher and visual lifelines, prepared by the researcher after the first interview and shared with the participant during second interview, to further allow co-construction of the lifelines and the visualization of the critical life events and turning points.

4.2.2.5. *How the data was analysed*

After the first interviews, the first level of analysis began. We transcribed the interviews and started the coding process. The transcribed data was read and re-read several times to familiarise myself with the data. This process of repeated reading and the use of the recordings to listen to the data results in data is highly immersive and results in the researcher's gaining a very detailed familiarity with the data (34). We moved from the transcripts to the construction of lifelines by identifying life events in the stories that are likely to make the women question the practice of FGM, or even to take action against it. If a woman specified or emphasised an event during the interviews, that event was considered significant. The construction of lifelines enabled the validation and understanding of what is likely to be a significant event for the women themselves (see Appendix 3). During the interviews, the women told their stories in a non-chronological way. The lifelines offer a visual display to observe life events in chronological order (35). Hypotheses of *turning points* were thus inferred from life stories in relation to existing norms embedded in the patriarchal system and associated with FGM. We saw in chapter 2 that FGM is associated with other norms. These norms (*keeping virginity, beauty and purity, ensuring the rite of passage to womanhood and marriageability, ethnic identity, being subordinate, and the acceptance of pain and suffering women must endure without complaint*) were used as an initial list of predefined categories in this first level of analysis.

The second interview enabled us to involve the women in the analysis by completing and validating their respective lifelines with each woman with a visual representation of the significant events (*turning points*) that had led to a personal change of attitudes towards the practice of FGM.

After the confirmation and further elucidation of their individual *turning points*, we persisted with a comparative analysis between the transcripts, case sheets and lifelines in order to identify common categories of *turning points* across the range of life narratives. In doing so, we noticed that some of the *turning points* overlapped, so we grouped them again in accordance with those similarities. We moved back and forth to rearrange the groupings, until consensus was reached on six categories of *turning points*. The results of this process of analysis are presented in Chapter 5, section 5.1.

4.2.3. The choice of Grounded Theory (GT) in our research

Based on the results of our first study, we conducted a second study to address our second objective, which was to investigate possible psychosocial mechanisms that would explain the change of attitudes towards FGM and other related norms. Grounded theory (GT) involves integrated conceptual hypotheses systematically generated to produce an inductive theory about a substantive area (41). It has several distinct methodological types: *traditional* GT associated with Glaser (38); *evolved* GT associated with Strauss, Corbin and Clarke (42); and *constructivist* GT associated with Charmaz (43,44). Each type is an extension and development of the original GT by Glaser and Strauss (38). The goal of traditional GT is to generate a conceptual theory that accounts for a pattern of behaviour that is relevant and problematic for those involved. *Evolved* GT relies on the subjective meaning people ascribe to the processes of social interaction (45). *Constructivist GT* focuses on how participants construct meaning in relation to the area of inquiry (46). *Constructivist grounded theory* emphasises the importance of the multiple perspectives of participants and the researcher and the influence of social structures and processes during analyses. In our study, grounded theory was appropriate as it involved explaining processes and aimed to generate an original theory.

4.2.3.1. *Data sources for our second study*

Three sources of data were used to help us theorise the process of change experienced by women as they turned their backs on the practice of FGM and took action to protect future generations from it: (a) the 30 transcripts from the interviews conducted with the 15 women of study 1 (47); (b) the life stories and public testimonies of 10 women referred to as '*norm leaders*'; (c) consultation with six experts (including one expert with lived experience) who were chosen for their complementary fields of expertise to discuss the emerging concepts and theory generated by our study as highlighted in Chapter 5, section 5.2. These discussions and exchanges ranged from 45 minutes to one hour with an average of 50 minutes. Notes were taken during the interviews, which were conducted as videoconferences, with the exception of one interview which happened face-to-face in accordance with the preference of the participant. Prior to the meeting, the experts had had the opportunity to read and comment on a

document which presented the draft results of our analysis, and therefore a first version of our emerging theorisation.

4.2.3.2. Data analysis of our second study

The data analysis occurred in three steps, following the three data sources and through constant comparison: (a) a secondary analysis of 30 transcripts from the first study; (b) and original analysis of the ten books; and (c) the analysis and integration of the results from the consultation with experts, and review of the further literature they had suggested. For the 30 transcripts, we verified that the *turning points* from the first study were associated with the emerging categories related to the two mechanisms that were hypothesised to be linked with change (i.e. emotion regulation and resolution of conflicts of loyalty: see Chapter 5, section 5.2). The original analysis of the ten books identified the turning points in the women's lives and subsequently examined them in relation to the same two hypothesised mechanisms of change.

Based on the results of these two first stages, a first draft of a theoretical model to explain the change was produced and discussed with the experts, who enriched our understanding of the process of change and suggested further relevant literature. We iteratively pursued this theorising and integrative process, until we came up with a model of five phases (*i.e. the suppression, the awakening, the clash, the reappropriation of self and the reconciliation*: see page 105 and in Chapter 5, section 5.2). Throughout the process of analysis, we simultaneously generated memos on concepts triggered by the experts and the participants' story lines. Charmaz (39) advises that advanced memos start to be written after initial coding. We also followed Saldana's (48) suggestion to appreciate the prioritisation of analytical memos as: '*whenever anything related to, and significant about the coding or analysis of the data comes to mind, stop whatever you're doing and write the memo*'. We took notes whenever we had discussion with either supervisors or experts. The whole process was iterative and always on-going.

The constant comparative method was an important analytical tool within this thesis to allow all our data units to remain continually under review. It involved going back and forth between

data, coding, further defining the codes and writing memos, all while our understanding and interpretation developed.

4.2.4. Ethical considerations

Ethical approval to conduct the study was obtained from the Ethics Committee (*Comité d’Ethique Hospitalo-facultaire*) of Saint Luc University Hospital- Brussels with reference number: 2013/21NOV/522; dated July 10, 2017.

The sensitive topic of our study raised some ethical challenges and questions. Eligible women participants who had received oral and written information about the study and given their informed consent were included in the study. The participants were informed the interview would be tape-recorded, but their identity would be kept strictly confidential, and kept locked in our office and would be destroyed after completion of the thesis. No identifying information was used from the interviews. However, the women decided to give their real names even though we told them to give a fake one. Some questions that we thought might trigger painful memories, we made sure to inform the women to withdraw from the study at any time without providing any reason. Also, we assured them that they could talk to a psychologist at GAMS to assure follow-up. We also ensured to inform them that the research would be published in a scientific journal, but their identity would be kept strictly confidential.

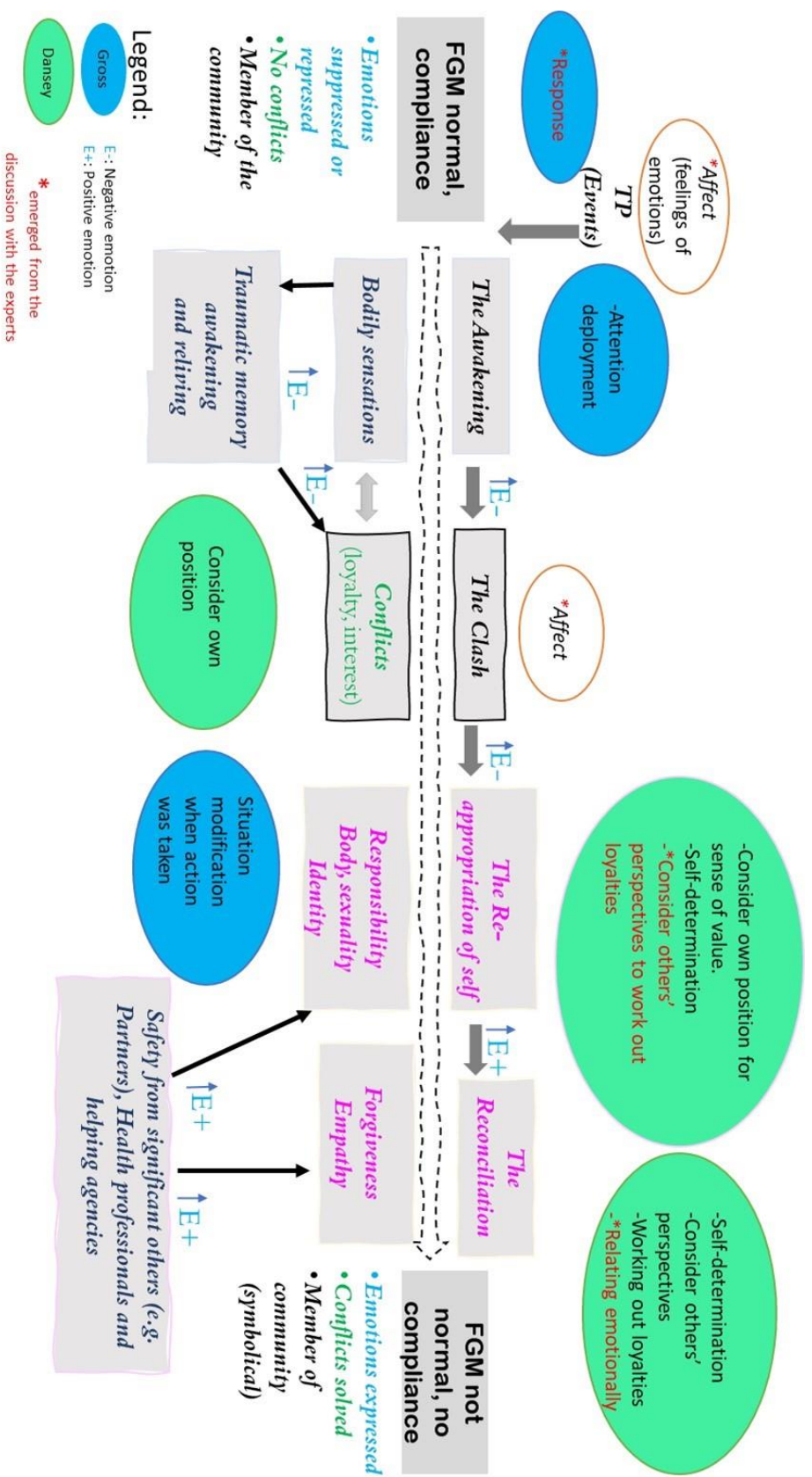


Figure 2: A woman's journey: From compliance to FGM and community norms to non-compliance to FGM and community norm.
From suppression of emotions to reconciliation with self and community.

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Chapter 5

Results

5.1. Critical life events in relation to what makes the change of attitudes towards the practice of FGM to occurs.

These results have been published as:

Agboli A, Richard F, Aujoulat I. *“When my mother called me to say that the time of cutting had arrived, I just escaped to Belgium with my daughter”*: identifying turning points in the change of attitudes towards the practice of female genital mutilation among migrant women in Belgium. **BMC Women’s Health**. 2020; 20 (1): 107

DOI: 10.1186/s12905-020-00976-w

RESEARCH ARTICLE

Open Access

“When my mother called me to say that the time of cutting had arrived, I just escaped to Belgium with my daughter”: identifying turning points in the change of attitudes towards the practice of female genital mutilation among migrant women in Belgium



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Abstract

Background: Female Genital Mutilation (FGM) is a public health concern with negative consequences on women's health. It is a harmful practice which is recognized in international discourses on public health as a form of gender- based violence. Women are not only victims of this, but also perpetrators. The practice of FGM remains a social norm which is difficult to change because it is deeply rooted in tradition and is embedded in the patriarchal system. However, some women have managed to change their attitudes towards it and have spoken out against it. This study identifies and describes turning points that have been defined as significant and critical events in the lives of the women, and that have engendered changes in their attitudes towards the practice of FGM.

Methods: We have conducted an inductive qualitative study based on the life story approach, where we interviewed 15 women who have undergone FGM. During the interviews, we discussed and identified the turning points that gave the research participants the courage to change their position regarding FGM. The analysis drew on lifeline constructions and thematic analysis.

Results: Six common turning points relating to a change in attitude towards FGM were identified: turning points related to (i) encounters with health professionals, (ii) education, (iii) social interactions with other cultures and their own culture, (iv) experiences of motherhood, (v) repeated pain during sexual or reproductive activity, and (vi) witnessing the effects of some harmful consequences of FGM on loved ones. **Conclusions:** The turning points identified challenged the understanding of what it means to be a 'member' of the community in a patriarchal system; a 'normal woman' according to the community; and what it means to be a 'good mother'. Moreover, the turning points manifested in conjunction with issues centred on emotional responses and coming to terms with conflicts of loyalty, which we see as possible triggers behind the shift experienced by the women in our sample.

Keywords: Female genital mutilation, Turning points, Migrant women, Patriarchal system, Emotions

Background

Female Genital Mutilation is defined as all procedures whereby the external female genitals are removed for non-therapeutic reasons [1]. The practice is performed mainly in sub-Saharan Africa as well as in the Middle East, Indonesia and Malaysia [2]. It is estimated that two hundred million women and girls have been subjected to the practice worldwide [2]. International migration brought the practice to other parts of the world, and it has become a global public health concern to host countries [3]. FGM is a harmful practice due to: (i) its consequences on women's health; (ii) the violation of women's bodily integrity, as a healthy organ is cut without a medical reason. Complications related to FGM vary from both immediate to long-term concerns and sometimes require interventions from health professionals [4]. Several studies have looked at the negative consequences of FGM on the lives and health of women who have undergone it [1, 5, 6]. The immediate consequences include pain, severe haemorrhage, urine retention and urinary tract infections. The long-term impacts include depression, Post-Traumatic Stress Disorder (PTSD), and difficulties in relation to painful sexual intercourse [1].

The practice of FGM suggests gender-based violence, a violation of women's health rights and of human rights generally [1, 7]. As FGM is mainly performed on young children, it violates the rights of children and undermines those of girls to health, security and physical integrity [1, 8].

The practice of FGM involves a whole community, making it a social norm that everyone is expected to comply with [1]. In some FGM-practicing communities, FGM is a celebratory rite of passage which reinforces cultural and ethnic identity and a sense of belonging in the community [1, 9]. Individuals and families believe their communities expect them to do it in order to ensure an honourable and worthy womanhood for their daughters [1]. Cultural cues reinforce the social significance of FGM, and the practice is maintained for the strong meanings attached to it: virginity, beauty and purity, rite of passage to womanhood, and marriageability [1, 10]. The practice as a norm is also reinforced through several other norms that are embedded in the patriarchal system. These norms include the submissiveness of girls throughout their childhood, roles of childbearing and rearing as well as the sexual satisfaction of men [11].

Grandmothers and mothers have the responsibility to uphold the tradition and to perpetuate the practice on their daughters. Girls are taught to be brave, endure pain, and not to express their emotions. The practice is often perpetrated upon women and girls by other women [10, 12]. The related norms embedded in the patriarchal system together with the associated meanings of performing FGM make the practice resistant to change.

The change of attitudes towards the practice of FGM

Despite the normative system that makes the change difficult, some women still succeed in changing their attitudes towards the practice. Most research about the change of attitudes towards FGM has been conducted at a community level, and only to a much lesser extent at individual level. In order to understand how communities may succeed in changing their attitudes, these studies used different perspectives, such as the human rights approach and anti-FGM campaigns [13]; the legislative perspective [1, 14-16], the social convention perspective [17, 18] and the behavioural approach to change [13, 17, 19].

Approaches based on the human rights perspective and anti-FGM campaigns have been mainly adopted by Non-Governmental Organizations (NGOs). They used human rights messages and communicated negative health consequences of FGM to emphasize the harmful repercussions of the practice, and to convince communities to change their attitudes and stop cutting their daughters. However, such campaigns failed to make a distinction between particular health complications associated with different types of FGM, and communities did not view all types of FGM as responsible for adverse consequences [13, 20, 21]. As a result, their efforts to eliminate all forms of FGM were undermined.

The legislative approach was used to criminalize the practice of FGM either as a specific criminal act or as an act of general bodily harm. Studies found that environmental factors in contexts where the practice is against the law influence the change in attitudes among migrants [18, 22]. O'Neill et al. [23] assert that the length of time spent in host countries is associated with the change of attitudes towards the traditional practice.

The social convention approach was used to suggest that the eradication of these practices may be achieved through renouncing it publicly [18]. The public renouncement of communities was meant to make families believe it to be acceptable and not detrimental to their status not to cut

their daughters [13, 24]. There is some evidence that this approach may be successful in the short-term. For example, in Senegal, a whole community collectively declared their renunciation of FGM [24]. In the long-term however, the change is hardly sustained, as some of the women excisers, although they had renounced the practice publicly, ‘had gone back to their scissors’ some years later in order not to lose their economic status [24, 25].

With regards to the behavioural change approach, intervention programs have applied the stages of change or the Transtheoretical Model (TTM) [26] to FGM, with the aim of achieving a change of attitudes at the community level. This remained challenging, as the decision to cut a girl is beyond the parents’ power, and often involves several individuals, including father, mother, grandmother, aunts, and potential in-laws [25]. According to some authors who have applied the Transtheoretical Model of change to FGM at a community level, their approach failed to address important individual dimensions in the dynamics of community change [27].

And thus, in all these approaches, the impact of interventions aimed at changing attitudes towards FGM was mostly studied at the community level. How change occurs at the individual level still remains an under-investigated issue, which our study seeks to address by researching critical events in the lives of women, that led to a personal change of attitudes towards the practice of FGM.

Researching critical life events or turning points to understand changes in personal attitudes has proven particularly relevant when studying sensitive issues, such as overcoming intimate partner violence [28-30], quitting drug use [31], or criminal offending [32].

Through the identification of common turning points, this paper looks at what makes individual migrant women in Belgium, who were once socialized in the FGM cultural context where the practice is valued and normal, change their attitudes towards the practice and speak out against it.

Methods

Qualitative methodology informed by the life story narrative approach was used to investigate, identify and describe critical life events experienced by the women in their change of attitude towards the practice of FGM. Life stories research uses the concept of turning points to describe changes in the life trajectory of individuals [32]. Wheaton and Gotlib [33] claim that turning points can only be found in the context of life trajectories, and they define them as specific events perceived to change the direction of one's life [34]. These can only be identified in hindsight after the event has passed, and thus are subjective and retrospective reconstructions of life story narratives [35]. In the life course perspective, the events are revealed as something that helps people to change status from disadvantaged to successful, from criminal to non-criminal, from abused and battered to breaking out of the relationship and becoming free [36]. Embedded in one's life story, turning points are shifts that force individuals to recognize that they are no longer who they used to be [37].

This study focuses on turning points as significant events which create an awareness that challenges the existing internalized norms in relation to the practice of FGM.

Sample (participants)

Fifteen women who self-reported that they had once undergone FGM and now stood against it were included in the sample. They were considered eligible to participate if they self-reported to have undergone FGM, were 18 years or over, had been living in Belgium for at least one year, were from an FGM-practicing community from East or West Africa, spoke either French or English and self-reported as being against the practice of FGM. Ten women were recruited through gatekeepers from a non-profit organization, GAMS-Belgium (*Groupe pour l'Abolition des Mutilations Sexuelles féminines*), which strongly opposes FGM. This initial convenience sample was followed by a snowball procedure that led to the inclusion of a further five women. All the women participants we recruited came from five different countries in sub-Saharan Africa and provided written informed consent in order to participate. The informed consent process included an overview of the objectives of the study, and an appointment was set by mutual agreement for an interview at a place that suited each woman. We also mentioned their ongoing rights as participants and reassured them that they were free to stop without having to

explain why. Given the sensitivity of the topic, we had anticipated the possibility that they could give a pseudonym when signing the consent form, but they all gave their real names. The recruitment process took place between December 2016 and April 2017.

The age of the women participants varied from 23 to 53 years old, with a median age of 39. The age when FGM was performed varied from 5 to 14, with a median age of 7. There was a range of women from across East (33%) and West (67%) Africa. They had been living in Belgium for a median duration of 6 years. The other characteristics are presented in Table 4 (Chapter 4 under section 4.2.2.4).

The iterative process of data collection and data analysis

In-depth interviews were conducted by the first author, and each woman was interviewed twice in the Biographical Narrative Interview Method (BNIM) developed by Wengraf [38] in order to produce narratives relating to life events. BNIM draws on several theoretical perspectives to take a case-based approach to narrative analysis [38]. Within the BNIM approach to data collection, the interviewee is seen in two phases and sometimes three, with the first interview being unstructured and the consecutive interviews building on the previously collected data.

Phase One starts with a single statement which is known as '*a single question aimed at inducing narrative (SQUIN)*' [38]. Interviewees are encouraged to talk freely about their life stories in the way they decide and without interruption, allowing memories to surface and connections between thoughts to develop. In Phase Two, researchers review their field notes for all topics mentioned by the participants to develop further narratives around them. The second phase generates rich data around incidents prompted by the researcher from which the respondent could choose. Phase Three within BNIM is not always present in studies but does allow an opportunity for the researcher to follow up on more specific points [38] and to be more structured with questioning, should this be appropriate.

First interview

Our first interviews were conducted either at the GAMS offices (n=8) or in the women's own homes (n=7), according to the women's preferences. The interviews lasted from 30 minutes up to an hour and a half, with an average of 45 minutes. An explanation of the objectives of the

study was provided to the women before the beginning of the interview so that they would know that FGM would be discussed. Then, at the start of the interviews, the women were all asked this one, broad question as suggested by Wengraf [38] and Bertaux [39]: *Could you tell me about your life experiences, and in doing so, include any story in your life that you think important?* The women were encouraged to talk freely about their lives and to tell as much or as little of their story as they wanted. The women's stories were recorded, and their consent was sought beforehand. Only one woman refused to be recorded, so notes were taken.

This first interview enabled the analysis to start by constructing lifelines for each woman. If a woman specified or emphasized an event during the interviews, that event was considered significant. A 'lifeline' is a visual depiction of a life story which displays events in chronological order and also shows the importance of events [40]. We drew along an x axis with events entered in chronological order, in such a way that the main events were visually represented along with the link to any environmental context. Appendix 3 shows a 'lifeline' from a fictive vignette of a typical reconstructed story from different participants after the first and second interviews.

Hypotheses of turning points were thus inferred from life stories in relation to existing norms embedded in the patriarchal system and associated with FGM, such as: keeping virginity, beauty and purity, ensuring the rite of passage to womanhood and marriageability, ethnic identity, being subordinate, and the acceptance of pain and suffering that, women must endure without complaint. These represented our predefined categories.

Second interview

The second interview was conducted in the women's own homes and lasted from 50 minutes to one hour and 40 minutes with an average of one hour and fifteen minutes. Within this length of time, the women were able to: (i) confirm the hypotheses of turning points raised after the first interview, (ii) narrate more events and complete the lifelines, and (iii) identify further relevant turning points, if any. The second interview was guided by semi-structured questions that were unique to each woman according to their initial narratives. Appendix 4 shows the interview guide with general questions. This enabled us to complete and validate the lifelines with every woman, with a visual representation of the significant events (*turning points*) that

led to a change of attitudes towards the practice of FGM. After the confirmation of individual's turning points, we pursued with a comparative analysis of all the transcripts, case sheets and lifelines in order to identify common categories of turning points across the range of life narratives. In doing so, we noticed that some of the turning points overlapped, so we grouped them again in accordance with those similarities. All emerging themes were discussed throughout between the first and last author, involving the second author whenever possible without breaking confidentiality. We moved back and forth to rearrange the groupings, until consensus was reached on six categories of turning points. These are as follows: Turning points related to encounters with health professionals; education; social interactions with other cultures and their own culture; motherhood and the urge to protect daughters; repeated pain during sexual or reproductive activity; and witnessing the effects of some harmful consequences of FGM on loved ones.

Ethical considerations

During the recruitment and before the beginning of each interview, the women were verbally given information, including the objectives of the study. We stated to them that their participation in the study was voluntary and that because we were aware of the sensitivity of the topic, they may withdraw from the study at any time. They were also told that the information obtained in this research might be published in a scientific journal, but that their identity would be kept strictly confidential. They were assured that all data would be kept locked in the student's office and destroyed after the PhD thesis would be completed.

They agreed, and all signed the written consent form in their own names even though an option was given to them to sign with a pseudonym. The study received approval from the Ethics Committee (*Comité d'Ethique Hospitalo-facultaire*) of Saint Luc University Hospital- Brussels with reference number: 2013/21NOV/522; dated: July 10, 2017.

Results

In reporting our results, we shall first illustrate how the women in our study had internalized the practice of FGM as a social norm, before reporting on the turning points that led to a change of attitude and the decision to take action in their lives.

Attitudes towards FGM as a mandated social norm before the turning points

The women in our sample confirmed that FGM is indeed a powerfully enforced norm, which they used to be forbidden to speak about. It was considered taboo, and they could not discuss it with their siblings. They reported that they were forbidden by their grandmothers to look down at or touch their private parts. However, their mothers were proud to show off to new members of the community after the procedure. Some women reported that they had asked to undergo FGM, to avoid being mocked by peers and to be allowed to serve men tea and food. They also believed they would be considered clean, hygienic, more beautiful and likely to keep their virginity for marriage. This was believed to preserve the family honour and morality of girls and women.

“...At home we did not talk about it; it was taboo. We were forbidden to tell others what had happened ... Nobody spoke about how it happened ... a girl must be excised otherwise she will not be a virgin, so she will always run after men. She cannot control herself; she will run after all the men she will meet and so we must go through that to preserve our virginity and not be unfaithful after marriage ... So, virginity has a lot of weight in that sense.” Interv_6

“I have undergone female circumcision and I asked for it because I was fed up with being excluded from playing with my friends...it was normal, because your mother, grandmother, your aunt, and neighbours have all undergone it and everything is normal” Interv_8.

The other related norms embedded in the patriarchal system were for the elders to be obeyed and the grandmothers to be the guardians of the tradition, forced marriage, the way women ought to behave in the community, and that women must endure pain and suffering without complaining. Most women explained that after FGM, forced marriage would follow. Gender

roles were carefully reinforced, either by their mothers or their grandmothers: for instance, how a woman ought to behave in the community and be submissive to her husband, and how they should endure pain and be brave.

“We were told all sorts of things, such as how to behave later with our husbands, how to respect them, the good manners that a good wife should always have and always listen to them. We were told that a girl has to go through that, and we should pass it on to the next generation. They have gone through it, so we have to go through it too. That’s how it is, it’s a custom to be respected...” Interv_2.

One woman recounted how she was given a white sheet by her father as a gift on the day she was cut, despite expecting sweets and toys as she was only six years old. When she asked about it, she was told that it was for her wedding. She was later forced to marry an old man whom she met only on the wedding day.

“My dad chose someone I did not even know, an old man, far older than me and I was forced to marry him ...it's very difficult, (silence) because it's something that stays with you ... because you are being raped. I do not call that marriage, it’s a rape...” Interv_1

The main turning points that led to changes in women’s lives

Turning points related to an encounter with health professionals

These turning points concerned events where the women encountered a health professional: a gynaecologist, a psychologist, or a social worker. For example, during gynaecological visits, the women reported that they were shocked to be told that they did not have a normal vulva and were shown the intact anatomy of the vulva of their daughters, which was different from their own. This led them to understand the difference between an intact vulva and one that has been mutilated, as well as some negative consequences of the practice of FGM. They also mentioned that this shock led to the awareness that what they had thought was a ‘normal’ vulva (one that was “pure and beautiful” after FGM) was not. Other women mentioned that they were surprised, confused, and felt anxiety at the news of what an intact vulva looked like. One participant had been persuaded that all women, including white women, were like her. The

picture shown by the doctor brought on an understanding of the organ that had been lost and led participants to question what it means to be a 'normal woman'. For some women in our sample, this led to taking action for a defibulation procedure. Others, at the time of the interview, were considering having a reconstruction of the clitoris.

"So I went to see a gynaecologist at a family planning clinic. She put me on the table and examined me and said you're cut and closed ... She put my daughter on the table too and showed me, you see she is not cut, she is intact not like you ... So, for the first time I saw the difference between my daughter and myself" Interv_11

"... When you visit a gynaecologist, you are surprised when the doctor tells you that you are not 'normal'. With the expression of his face ... he looks and looks; he closes his eyebrows and says to you like this: you're not normal ... and I was confused and anxious ... And you realize, after explanation with photos, the difference between the normal and abnormal private part. So, I say, I have never seen the thing between the legs..." Interv_8

Turning points related to education

This type of *turning point* involves events such as lectures on anatomy and sexuality at school and university, where some women, enrolling at medical school and attending anatomy lectures, started changing their views. Schools and universities have been eye-openers. The knowledge gained resulted in the feelings of shock and anger experienced by most women, and this made them change their attitudes towards the practice. The anatomy lectures contributed to the knowledge of the consequences of FGM and what the normal anatomy of a woman ought to be.

"But during my studies, I realized some things and it was a shock ... The first time I saw the genital organ of a woman, I said ah ... so I lost this part of me in the excision ... But hey, it's a bit what like I looked as well. But it must be said that this operation is very traumatic. We only perpetuate the tradition of our ancestors. All you gain is pain and sorrow." Interv_13

Turning points related to social interactions

These turning points relating to social interactions are two-fold. One is in relation to interactions with other cultures and involved events where the women heard the noise of urine at refugee centres, got married, or had a relationship with a European man when they came to Belgium. Migrating from their country of origin to Belgium contributed to raised awareness of differences between cultures, and a sense of not being defined exclusively by FGM. The shock provoked by the noise of urine coupled with the women noticing that *“women are urinating like men”* made them question something that they had previously thought was normal. They no longer viewed women as having to endure pain and suffering when men from other communities made them aware of the possibility that their sexual lives could be experienced without pain or complication during intercourse.

“When you come here, you discover that not all women are like you. Because you see women go to the bathroom, and their pee makes a noise ... (laughs). So, I asked myself ‘What have they got there?’ And I asked my doctor once, ‘You’re not circumcised?’ She says ‘No’ ... then I understood why their pee makes noise.” Interv_8

The second interaction was within the women’s own culture when they were told of the reasons why FGM is performed, for them not to be promiscuous before marriage, and they saw the opposite happening around them in the community. This made them realize the lies and the deceit.

“On the one hand I saw that it was false, that we were told lies because I saw Fulani women who prostituted themselves, and I asked myself some questions ... these circumcised girls prostitute themselves – how does it happen? ... I also saw some circumcised girls who became pregnant before marriage and brought shame upon their families.” Interv_2

Turning points related to motherhood and the urge to protect their daughters

The women in our sample wanted the best for their children. Those of them who had girls reported that at some point or other they had been put under pressure by mothers, mothers-in-law and grandmothers or aunts, the keepers of the tradition, to put their own daughters through

FGM. The pressure from other women in their families made them recall their own experiences and brought back vivid memories of the whole procedure. Some talked about pain in the womb, anger, nightmares and the urgent need to fly away to escape the danger. The prospect of perpetuating the tradition on to the next generation through their own mothers, mothers-in-law and grandmothers triggered a change in views about the practice for several women, creating a sense of apprehension as well as a duty to protect their daughters, which in turn changed their views of what it means to be a good mother. According to their previous beliefs, a good mother would put her own daughter through FGM. After becoming mothers, themselves, they did not want to put their daughters through what they had experienced. They were caught in a dilemma of loving both their mothers and their daughters, and therefore, disappointing their mothers by not wanting to destroy their daughters' lives through FGM.

"...My husband could not say 'no' to his mother, and it had become very serious, something had to be done to protect my daughter from the influence of my mother-in-law ... I tried to tell him we shouldn't listen to his mom for everything, and he answered me, "Aren't you yourself excised? So why not your daughter? You see?" And I did not want that for my daughter..." Interv_4

"I was destroyed by my mother and my grandmother. I can say that since they have done something horrible to me ... I love them but when my in-laws wanted to excise my daughter, as was usual. But I opposed." Interv_15

Another woman reported that she lied to her mother, telling her that she had performed FGM on her daughter at the hospital. However, the grandmother found out three years later and informed the mother. The mother pressured the daughter over the phone. As a result, the daughter fled abroad.

"My mother called me to say with a lot of pressure that the time for her daughter has arrived to be made pure and clean, ...I took a radical action without thinking and escaped abroad" Interv_11

Turning points related to repeated pain during sexual and reproductive activity

The sexual and reproductive aspects identified as turning points were mainly associated with repeated pain, childbirth and sexual activity: pain felt during the procedure of FGM when the participants were little girls; painful monthly periods as adolescents; pain during their first experience of sexual intercourse after their marriage; and pain during childbirth. The repeated pain during sexual intercourse implied that the women took part in it out of duty towards their husbands, rather than for pleasure. They used to think that experiencing pain during the sexual intercourse was *normal* until they developed an awareness of what sexual activity could be. They then came to understand the real consequences of FGM.

“But then what we do not understand is how much it hurts ... it's horrible, and it follows you everywhere ... even in adulthood, in your teenage years when menstruating, when you get married, when you have sex with your husband, if you give birth, if you go through a caesarean...you see? The pain follows you everywhere, and it's horrible.”

Interv_8

“I had convinced myself that I would not be able to have a fulfilling sex life, and I was right because when I got married, it opened the door to another phase of a woman's life of suffering ... It gives no benefit, just suffering and I find that men also suffer, not only women.” Interv_10

Turning points related to witnessing the effects of some harmful consequences of FGM on loved ones

These turning points are related to events that happened to the women's loved ones and that gave rise to stressful emotions for them. For instance, the participants in our sample reported events such as the death of a sister after the procedure, witnessing their husbands being battered by their own families for not wanting to comply with the tradition and the death of a sister in childbirth. Such events made the women realize the harm caused by FGM.

“... Because after our excision, we stayed with an old woman for 20 to 30 days, but my sister only made it for six days. She had a high fever, and she bled a lot and the old

woman kept changing cloths and made her drink various concoctions until she died the following day...” Interv_12

Discussion

Understanding the significance of turning points (TPs) in the changing of attitudes towards the practice of FGM

This paper identified and described turning points defined as significant and critical events which created an awareness that challenged the norms embedded in the patriarchal system and associated with the practice of FGM. The turning points in the lives of the women who participated in our study occurred as a result of events where the women either encountered health professionals or attended educational settings and through that education became aware of the normal anatomy of the female genitals. Moreover, experiences of motherhood were reported when pressure from their mothers-in-law, their mothers and grandmothers made them question what it meant to be a good mother to their daughters. How the experience of fearing for one’s children is associated with making decisions to change correlates with other studies on turning points but is related to other forms of violence against women, for example, intimate partner violence (28, 41).

Another type of event related to turning points was found to be linked to social interactions within one’s own culture or with other cultures. The events related to reproductive and sexual activity included pain during menstruation, childbirth, and repeated pain during sexual intercourse. As other authors have reported about turning points associated with issues other than FGM, the turning points found in our study created either ‘*sudden*’ awareness from a single event or ‘*gradual*’ awareness from repeated events [28, 42, 43].

Challenging what it means to be a member within the community and a normal woman

The different turning points that led to a change of attitudes towards FGM in our study frequently challenged the norms of what it means to be a ‘*normal*’ woman in the eyes of the

community, and what it means to be '*a member of the community*' in a patriarchal system. The community dictates what a 'normal woman' is supposed to be and do. For example, a '*normal woman*' is supposed to be cut, to behave in a certain way in the community, to be a virgin before marriage, to endure pain and suffering, and not to show emotions. Also, a '*normal woman*' does not experience any sexual desire or pleasure. If a girl is cut, she is a full member of the community.

The norms related to FGM, which were embedded in the patriarchal system, and which were challenged by the women, made them more conscious of the gender roles their communities had projected on them. Challenging these interconnected norms is somehow challenging the "*invisible cage*" imposed by the gender roles the patriarchal system has established [10]. They came from communities where both girls and boys were taught these gendered relationships to power throughout their lives. This explains why the women used to see the practice of FGM, as well as other related norms, as 'normal'. However, their consciousness of these gender roles evolved through events in the women's lives that caused them to begin to question the legitimacy of what they used to consider '*normal*'. The realization of what the women considered to be simple everyday life was challenged and changed by what now constitutes for them a '*normal woman*'.

Their consciousness of gender roles gave them a platform from which to acquire new knowledge through turning points, which was added to the knowledge gained during childhood. For Lawrence and Valsiner [44], new information integrated into an individual's previous understanding makes the individual either focus on or reject the new information. The women in this study focused on the new information and came to learn, for example, the normal anatomy of female genitals (new information); they then processed it and internalized it into new knowledge (normal anatomy). The new knowledge, in this case, helps to challenge what has been internalized in childhood. Lien and Schultz [45] researched the internalized knowledge with the change of attitudes about FGM among migrant women in Norway. They found that some women activists had undergone FGM and seen it as *normal* yet had later changed their attitudes towards the practice. What they had internalized as normal was processed into a new knowledge through exposure to negative consequences of FGM and preceded an attitudinal change [45].

While recalling critical events associated with turning points in their lives, the women in our study expressed emotions. Thus, it appears that new knowledge happened through the recognition of experiencing certain emotions such as anger, shock, and astonishment when they acknowledged the normal anatomy of female genitals. They experienced the same in various educational settings. Moreover, astonishment, surprise, and loss of trust were seen in their social interactions. At the same time, empathy, flashbacks of their own experiences and sadness were identified in the turning points related to experiences of motherhood as well as when they witnessed the effects of some harmful consequences of FGM on their loved ones. Yet, the right to the recognition and expression of their own emotions is something that had until then been denied to these women, as they were raised and taught in their communities as young girls that it is normal for women to endure pain and suffering without complaining.

Challenging what it means to be a good mother within the community

The turning points in our study also challenged the norm of what it means to be a ‘good mother’, as good mothers according to the norms in the community are expected to ensure their own daughters meet all requirements of the patriarchal system, including the practice of FGM. In this case, being a ‘good mother’ meant that they did not want to put their daughters through FGM. As they wanted to do good by their daughters by not putting them through FGM, the desire to protect their daughters made them experience ambivalent and uncomfortable feelings towards their own mothers. Indeed, they wanted to hate their mothers for putting them through FGM, but at the same time, they understood that their mothers had wanted somehow the best for them.

We therefore hypothesize that turning points that generated some emotions may be associated with conflicts of loyalty which the women needed to come to terms with if new values and norms were to be internalized. Being a ‘good mother’ is therefore connected to the existing core value of caring for children. Mackie [46] put it well in saying that the most important, fundamental, and personal value of parents worldwide is to take good care of their children and protect them from harm. When, in our case, mothers were put under pressure (for example, phone calls to put a daughter through FGM, or the decision of a mother-in-law to excise the

woman's daughter), they did not necessarily change what Mackie identifies as their basic values [46]. Instead, the basic value, e.g. 'being a good mother' was reinforced but took on a new meaning and therefore, a new outcome.

Strengths and limits

There are several limits to our study: our sample of 15 women is relatively small, and some sub-groups of women may be under-represented or over-represented. For instance, none of the women in our sample were single mothers, and half of them were cohabiting with or were married to a Belgian man at the time of the interviews. Due to our snowball procedure, there might have been a selection bias in our sample, and we cannot disregard the possibility that other turning points might have emerged from further interviews with other women. Moreover, although the main researcher (who is also the interviewer) originates from an African FGM-practicing country herself, difficulties and challenges were still encountered in the recruitment of the women and even during some of the interactions, as we felt that the women had probably censured themselves at times. For these reasons, we cannot be sure that we have reached saturation in our results.

Another source of bias may be linked to our initial recruitment procedure through GAMS-Belgium, and the fact that the first interviews for some women were conducted on GAMS-Belgium premises. However, the second interviews for all the women were conducted in their own homes, thus minimizing the risk of desirability bias. As far as the process of analysis is concerned, all emerging themes were discussed throughout between the first and last author, involving the second author whenever possible without breaking confidentiality. This collaborative process of analysis is one of our study's strengths. However, the main strength of our research lies in the co-construction of the findings with the women themselves, as these women were involved in the meaning-making process and were invited to confirm the turning points that had made them change their attitudes. Due to our rigorous analytical approach and the fact that we allowed the women to co-construct our findings with us through repeated and participative interviews, we believe that our results are trustworthy and transferable enough to be shared with the scientific community.

Conclusions

This study confirmed that FGM is indeed a social norm through the women's own words. It also identified turning points which enabled the researcher to find norms embedded in the patriarchal system, which went on to be challenged. Coming to terms with the taboo of having emotions and feelings on the one hand, and on the other, the conflict of loyalty that inevitably arises when one questions the legitimacy of the rules and norms of one's own community, are major challenges that may be seen as common mechanisms for succeeding in changing the attitudes of women who originated from FGM-practicing countries and communities towards FGM. These hypotheses merit further investigation as they may pave the way for further applied research into better understanding the mechanisms by which the women change their attitudes towards the practice of FGM in the context of migration. This might in turn help the women stop perpetuating the practice of FGM and become agents of change within their own communities.

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5.2. Mechanisms and factors that explain the change of attitudes towards FGM and other related norms.

These results have been submitted for publication as:

Agboli A, Richard F, Botbol-Baum M, Brackelaire J-L, D'Aguanno A, Diallo K, Mikolajczak M, Ricadat E, Aujoulat I. Changing attitudes towards Female Genital Mutilation. From conflict of loyalty to reconciliation with self and the community: the role of emotion regulation. **PLoS One**, under review.

Abstract

The practice of female genital mutilation (FGM) is a social norm embedded in the patriarchal system and is resistant to change due to its roots in the tradition of the practising communities. Despite this difficulty in change, some women succeeded in changing their attitudes towards the practice. In trying to understand what made these women change their attitudes, we identified in a previous study, involving their life trajectories, critical life events at which change occurs (turning point). These turning points were described with emotions and conflicting feelings based on which we hypothesised that emotion regulation and the resolution of conflicts of loyalty might be possible mechanisms that explain the change of attitudes by the women. In this article, we sought to investigate how the mechanisms interact and how they were at play to explain the change. We therefore triangulated our previous data, fifteen women interviewed twice with the published life stories and public testimonies of 10 women with FGM, and interviews of six experts chosen for their complementary fields of expertise to discuss the emerging concepts and theory, generated by our study. The data were analysed using framework analysis and an element of grounded theory approach (constant comparison). As a result of our emerging theorisation, we propose a model of change in five stages (the suppression, the awakening, the clash, the re- appropriation of self and the reconciliation). This describes the process of a journey of a woman from compliance to FGM and community norms to non-compliance. Our study reveals how the women whose stories were analysed, moved from being full members of their community at the cost of suppressing their emotions and denying their selves, to becoming their whole selves while symbolically remaining members of their communities through forgiveness of their mothers.

Keywords: Female genital mutilation; change; emotion regulation; conflict of loyalty; migrant women; trauma; identity; empowerment; affect.

Background

Female Genital Mutilation (FGM) is a public health concern with harmful consequences on women's health [1,2]. FGM is a gender-based violence which violates the bodily integrity of the women and girls. The practice which is an intentional partial or total removal of female external genitals [1,3,4], contributes to the cultural identity of the woman who receives a mark in her body. This mark is a perfection of physical appearance within the culture [5]. Elderly women, guardians of the tradition, always strive to ensure that the practice is passed on from generation to generation. Consequently, the fear of seeing other members of the community performing the practice on their daughters results in women fleeing and migrating to western countries, at times in very difficult conditions, in order to protect their daughters.

The health consequences that are reported to result from FGM vary according to the type of the practice undertaken. The physical consequences include pain, urine retention, infection, pain during sexual intercourse, haemorrhage, shock, and sometimes even death [3,6]. Psychological consequences include feelings of incompleteness, anxiety, depression, loss of trust, chronic irritability and frigidity. FGM creates psychological trauma and is a potential cause of Post-Traumatic Stress Disorder for the women [7–9]. From Toubia's work, infibulated women suffered from chronic anxiety and depression, arising from worry over the state of their genitals, as well as intractable dysmenorrhea, and the fear of infertility [10]. The shocking experience of FGM comes from the girls being unprepared for the excruciating physical and emotional experience that the practice entails. Evidence shows that the severe pain experienced during the procedure can result in deep psychological wounds, leaving painful memories and emotional scars [3,11–13]. Women who have undergone the practice have had various emotional struggles and psychosocial problems, such as a loss of trust in the mother-daughter relationships [14]. Thus, it results in social consequences too; and besides the psychological impact of FGM, women and girls also suffer emotionally. Girls and women, traumatised by their experience but with no acceptable means of expressing their fears, suffer in silence. Feelings of fear, helplessness, and anger were also related to FGM as well as anxiety, bad memories, and stress [8]. Fear and helplessness are associated with having experienced the procedure [15]. Even years after the procedure, girls and women experience feelings of loss and incompleteness, anger, shame, and depression, as well as a sense of betrayal [15]. However, through

socialisation, women have been taught to remain silent about the procedure and their feelings. The practice of FGM is a social norm held in place by individual attitudes of parents and other family members' decisions of performing FGM on girls [2]. The cultural values imparted [16] and other related norms embedded in the patriarchal system together with the associated meanings of performing FGM make the practice resistant to change [17]. Despite the practice of FGM remaining a social norm that is difficult to change because of its deep roots in the tradition of the communities, some migrant women succeed in changing their attitudes towards it and do not perpetuate the practice on their daughters. Attitudes change after migration regarding FGM have been reported in other European countries [18,19]. Changes in the social norm towards FGM among migrants as a result of living in settings where FGM is not the norm have also been evidenced [19–22].

In a previous study [17], we identified and described specific significant events (*turning points*) which played a role in the lives of the women that were interviewed. *Turning points* were defined as significant events including social interactions that challenged their norms and any other expectations associated with the practice of FGM, leading to women changing their attitudes towards it, and to take action to quit their community in order to protect themselves and their daughters from the practice. In relation to these *turning points*, we had hypothesised that emotion regulation and the resolution of conflicts of loyalty might be two common mechanisms involved in the empowerment of the women as they decided to take action against FGM for themselves and their daughters. This paper seeks to further explore how these two processes may interact to explain the change in their attitudes towards traditional norms.

Methods

A qualitative methodology informed by the grounded theory approach was used and it allowed us to generate the hypotheses mentioned above [17]. The approach inductively helped to consolidate these hypotheses through constant comparison [23], taking into account the narratives of the women who had participated in the first study (n=15) and comparing them with published testimonies (n=10), while further exploring the literature and consulting experts including one expert with lived experience to discuss and consolidate our emerging theorisation.

Data sources

In addition to the continuous exploration of the literature, three sources of data were used to help us theorise the process of change experienced by women as they turned their backs on the practice of FGM and took action to protect future generations from it: (a) The 30 transcripts from the interviews conducted with the 15 women of our previous study [17]. The 15 participants in this study had all undergone FGM in their countries of origin during childhood, originated from Sub-Saharan African countries and were living in Belgium at the time of the interview. Full details of the sample can be found in our publication. (b) In addition to the 30 original interview transcripts, we included the life stories and public testimonies of 10 women referred to as '*norm leaders*' (Table 6).

Table 6: Table of the books of norm leaders

Names of NL	Title of the book	Year of publication	Country of origin	Host country
Thiam, A	La parole aux négresses [The voice belongs to the negress]	1978	Senegal	France
Diallo, K	Mon jardin dévasté [my devastated garden]	1991	Senegal	Belgium
Dirie, W. & Miller C.	The desert flower	1999	Somalia	Austria
Barry, M	La petite peule [The little polar]	2000	Senegal	France
Abdi, N	Larmes de sable [Tears of sand]	2003	Somalia	Germany
Koita, K	Mutilée [Mutilated]	2005	Senegal	France
Bah, D	On m'a volé mon enfance [My childhood has been stolen]	2009	Guinea Conakry	France
Miré, S	The girl with three legs	2011	Somalia	USA
Kanko, A	Parce que je suis une fille [Because you are a girl]	2014	Burkina Faso	Belgium
Bowin, L	Swimming in the red sea	2018	Guinea Conakry	Canada

(c) The third source of our data comes from interviews we conducted with six experts, including one expert with lived experience) who were chosen for their complementary fields of expertise to discuss the emerging concepts and theory, generated by our study: lived experience (Khadidiatou Diallo), philosophy, bioethics, norms and capabilities approach (Mylene Botbol-Baum); sexual health and identity issues (Elise Ricadat); psychology and traumatic memory (Annalisa D'Aguanno); transcultural clinical psychology and anthropology (Jean-Luc Brackelaire); and emotional competence and regulation (Moïra Mikolajczak). Due to COVID-related restrictions, regarding all but one, the experts were met individually through videoconference by the first and last authors. The consultation with the lived experience was done face-to-face by the first author alone.

These discussions and exchanges ranged from 45 minutes to one hour with an average of 50 minutes. The duration of the face-to-face interview was 45 minutes. Notes were taken during the discussions. Prior to the meeting, they had had the opportunity to read and comment on a document which presented the draft results on the applicability of the concepts of emotion regulation and the resolution of conflicts of loyalty to understand the process of changes in attitudes towards the norms associated with FGM. During the process of generating and enriched theory, based on their complementary initial comments, all experts had the opportunity to further contribute by commenting on draft versions of this article. Eventually, all were invited to choose to co-author the article for their contribution.

Ethical considerations

First source of data: The women from the first data source were recruited from our previous study [17]. During the recruitment and before the beginning of each interview, the women were given oral information about the study prior to the interviews and the objectives of the study were given. We stated to them that their participation in the study was voluntary, and because we are aware of the sensitiveness of the topic, they may withdraw from the study at any time. The sensitive topic of our study raised some ethical challenges and questions. Eligible women participants who had received oral and written information about the study and given their written informed consent were included in the study. They were also assured that the information obtained in this research may be published in a scientific journal, but their identity

will be kept strictly confidential. They were assured that all data will be kept locked in the student's office and destroyed after the PhD thesis is completed. No identifying information was used from the interviews. However, the women decided to give their real names even though we told them to give a fake one. Narrating some life events in their life stories might trigger painful memories, we made sure to inform the women to withdraw from the study at any time without providing any reason. Also, we assured them that they could talk to a psychologist at the non-governmental organisation called GAMS-Belgium to assure follow-up. They agreed and signed the written consent form.

Second data source: for the books, they were already published testimonies of the life stories of women who strongly oppose the practice of FGM. No consent was needed for this data source.

Third data source: The experts

Verbal consent was received from the experts. Prior to meeting the experts, we sent a mail to each expert to describe the objectives of the study and requested their expertise in process of our emerging theorisation regarding the mechanisms that explain the change of attitudes towards the practice of FGM. They agreed on having their names and their expertise to be reported in the article and they agreed to co-author the article.

The study received approval from the Ethics Committee (*Comité d'Ethique Hospitalo-facultaire*) of Saint Luc University Hospital Brussels with reference number: 2013/21NOV/522 dated 10th July 2017.

Data analysis

The data analysis occurred in three steps following a sequential design and through constant comparison.

Secondary analysis of the 30 transcripts from the first study

The objective for this first step was to systematically screen the 30 transcripts from the first study again, which had initially been inductively analysed to reveal specific turning points in the lives of the participants. In this secondary analysis, we aimed to examine how the emerging categories of emotion regulation and conflict of loyalty resolution were represented in the data.

The *turning points* revealed in the first study constituted the starting points for the secondary analysis of the transcripts. More precisely, we verified that the *turning points* were indeed associated with experiences and the expression of emotions as well as conflicts of loyalty, as we had hypothesised at the end of our first study. The data were synthesised using a framework analysis approach, a process which involves a systematic indexing of responses in line with a given framework [24]. This was based on the dimensions of Gross' model of emotion regulation [25] on the one hand, and on the model of the processes of informing loyalty on the other [26]. The two theories referred to for this framework analysis may be approximately presented as follows:

Emotional regulation

Emotion regulation is a key contributor to social functioning and refers to the processes by which individuals influence what emotions they have, when they have them, and how they experience and express them [25]. Such control processes may be conscious or automatic [25,27] when responding to environmental demands and may take effect at one or more points in the emotion generative process. An umbrella term for emotional state which is '*affect*' is viewed by Gross [25], as stress responses, emotions such as anger, sadness, and mood such as grumpy, down. Affect refers to individual's life and beliefs which preclude the understanding of social life as a system of rules and norms [28]. Gross [25] develops a process model of emotion regulation which allows for the identification of when regulation may be understood to have occurred. The model has five major points of focus (*situation selection, situation modification, attention deployment, appraisal and response modulation*). Emotion regulation is goal-oriented. Goal-oriented emotion regulation strategies related to bodily expression include emotion suppression, in which people actively try to inhibit their emotional expression [25]. Expressive suppression is defined as the inhibition of emotional expression, such that an outside observer would be unaware of an individual's internal emotional experience [25]. The suppression does not always lead to the desired changes in emotional experience but can lead to a negative emotional experience instead.

Conflicts of loyalty

Loyalty is a feeling or an attitude of devoted attachment, even where it may not be deserved [26]. Loyalty conflicts occur when a person feels trapped in a disagreement between two people, and they expect the trapped person to support them over the other. The literature describes mainly children's perceptions of one parent's pressure to side against the other and the conflict is expressed by the feeling of being trapped, torn, or 'caught between parents' [26,29]. Research on children in foster care presents a model of processes informing loyalty to help to understand the experience of children in foster care and how they negotiate living with a new family while retaining their place in their birth family [26]. The model which emerged from their results encompassed seven theoretical categories that enable different relationships children have with their parents' loyalty to be distinguished: *new realities*; *considering position*; *making sense*; *relating emotionally*; *working out loyalties*; *considering others' perspectives*; and *self-determination*.

Loyalty conflicts have generally been the focus of attention in the literature on children of divorced parents [29,30], as well as in foster care literature [26]. It has not been applied to adults much; however, the concept seems essential in our study because the women felt trapped between what the community expects from them and what they want for their daughters.

Original analysis of the books (n=10)

All 10 books were read by the first and second author to identify the turning points in the women's lives that had prompted them to change their views and attitudes toward the practice of FGM, and other related norms. Then the two theoretical frameworks mentioned above were applied by the first author to systematically screen for expressions of emotions and conflicts of loyalty resolutions in relation to those *turning points*.

Consultations with experts

In the third stage, after having confirmed that aspects of emotion regulation and conflicts of loyalty resolution were indeed present in the women's narratives as they reported turning points in their lives, we submitted our results to several experts from different disciplines in order to discuss our emerging theorisation, and to help us refine it, by collaboratively working out the

interrelations between the two hypothesised mechanisms of change, i.e. emotion regulation and conflicts of loyalty resolution.

The notes taken during the different discussions were compared and analysed by the first and last authors to further clarify our emerging theorisation, which was also discussed with co-author FR on several occasions and enriched through review of some published material suggested by the experts. For instance, in order to understand trauma and its impacts on the body, we read the literature of Van der Kolk [31]; Rothschild [32]; Salmona [33] and Hoschild [34]. To become more familiar with narratives and the capabilities approach, we read the books of Botbol-Baum [35] on '*Bioethics dans les pays du Sud*' [Bioethics in the southern countries] and Nussbaum [36] on women and human development, the capabilities approach. We iteratively pursued this theorising and integrative process, until we came up with a model with five stages (*the suppression, the awakening, the clash, the reappropriation of self and the reconciliation*), which we present hereafter in our results section, to explain the process of the change of attitudes in women with FGM as they move from being full members of their community at the cost of suppressing their emotions and denying their selves to becoming their whole selves while symbolically remaining members of their communities of origin. The results hereafter are presented according to the five stages of our proposed model, and integrate the findings from all three steps of our analysis.

Results

From suppression of emotions to reconciliation with self and community

The model that emerged from our findings consists of the five stages mentioned above. Each stage refers to the processes that were found to explain the women's attitudes towards change. The theorisation that emerged from our work is summarised in the model we propose. In the diagram next page (Fig 2), the five stages are depicted as parts of a linear process, but we are aware that these stages might not always be linear, as there may be overlap and a woman may move through and between stages of the model numerous times or simultaneously.

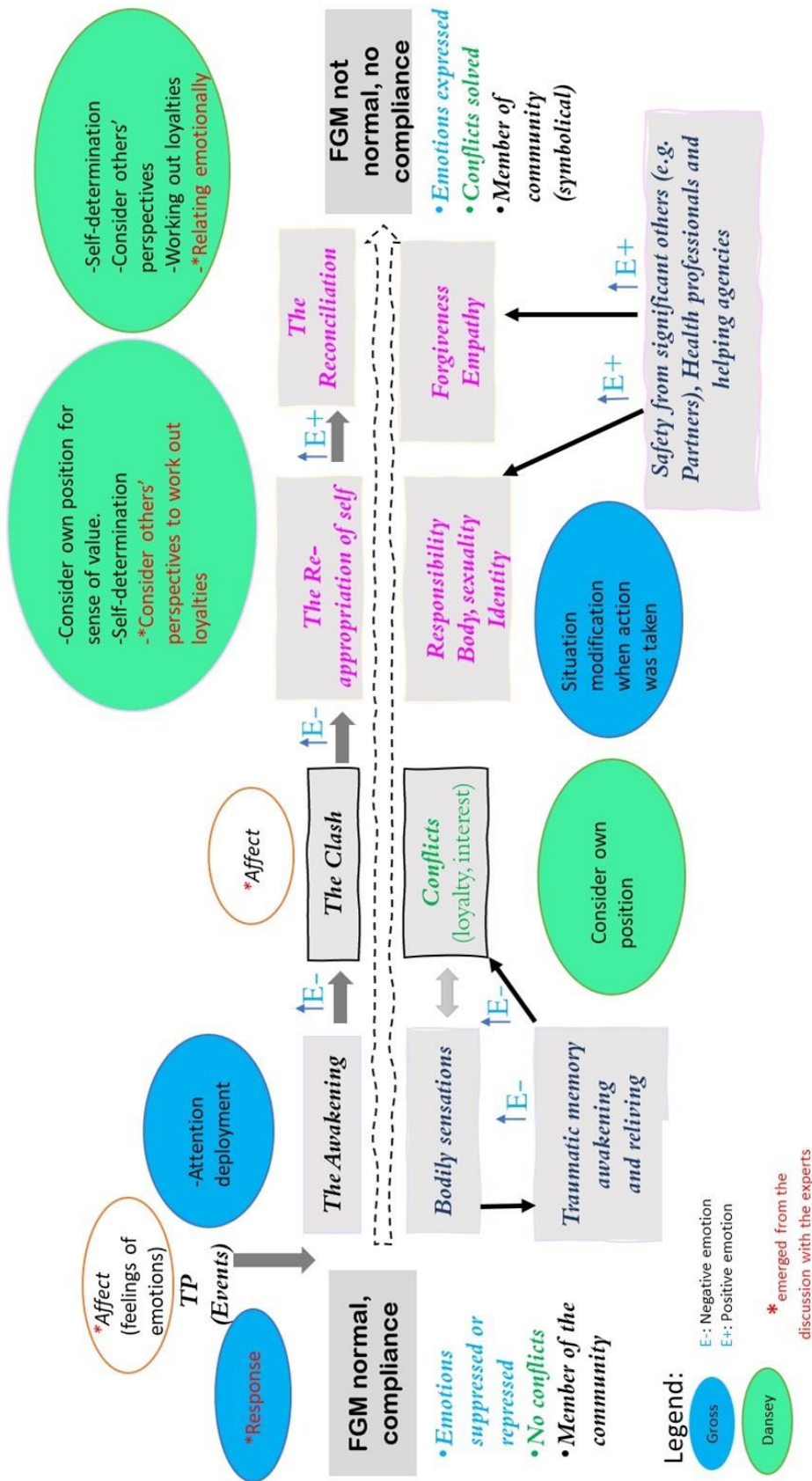


Figure 2: A woman's journey: From compliance to FGM and community norms to non-compliance to FGM and community norm.

From suppression of emotions to reconciliation with self and community.

Emotion suppressed or repressed

Our results show that women's emotions were often repressed and suppressed before the *turning points*. Emotions are socially constructed so culture has an impact on the expression of emotions. Girls are taught to be brave and not to cry during the procedure to prevent bringing shame upon their family.

“Afterwards, we are told you must remain courageous, never complain, you have passed the first stage, there will be others that will come with pain too, but do not forget that a good woman must always bear the pain and must suffer.” Interv_2

“... I got used to being in pain; not crying anymore but clenching my teeth...later on, I continued clenching my teeth as I was always told...” Kanko [39]

Before the occurrence of the *turning points*, the suppression of emotions was associated with the acceptance and internalisation of the practice of FGM. The women used to comply with the social norm as prescribed by the patriarchy. The patriarchy system determines and prescribes how individuals ought to behave in regard to certain feelings (*affect*) and emotions. The cultural grounding of emotional expression is reflected in the whole procedure when at times, women are instructed to be brave and endure pain and sufferings without complain. This is a norm in the patriarchal system. Even though, the women were not allowed to express any emotion, they felt them, and they were affected by them. Some women described their initiation stage as being taught about their gender roles by the older women who are the guardians of the tradition. They were guided by the instructions from the older women to endure pain and sufferings as their accepted fate. Fear was what generally drove women to comply with the social norm to avoid being ostracised and isolated from the community and have their daughters unmarried.

“I was constantly in fear and felt the anger, but I did not know where they were coming from. Because something tells you why ‘you’? And during all the initiation phase, they talked about your recognition as part of the community, you are going to become a woman, you are going to serve the cakes, you are going to be pure and say good prayers but they will never tell you the intensity of the pain, just to bear it and not talk about it.

It's like you are being plunged in the unknown which is unbearable and that's the problem." Expert with lived experience.

The suppression of emotions which results in the inhibition of the emotional expression, is one of the response components according to Gross' model [25]. It represents the last stage on Gross' model while it is the starting point on our model. Suppressing emotions ensures community membership and the women usually do as they are instructed from respect to the elders. Silence is also imposed by the patriarchy and the women are trained socially to bear pain at important moments of their lives (for instance, first sexual intercourse on the wedding night, as well as at childbirth and not screaming during labour).

"The patriarchy uses violence to assign identity and thus, construction of cultural identity is through the bearing of pain without complaint, so involving suppression of emotions" Expert in psychology and traumatic memory.

The awakening

At the second stage of our model, which we call *the awakening*, emotions are expressed in relation to the *turning points* described in the narratives of the women who participated in our previous study, as well as those from the norm leaders whose testimonies we analysed.

"The emotions that were expressed evolved with the process of emancipation and questioning of norms. These were affects that were acknowledgement which precede the change of norms. Turning points are as a normative conversion, allowing the capability to act against one's community beliefs, which is also a definition of emancipation. This conversion of self is indeed a turning point for it allows to go beyond the conflicting emotions between community and self" Expert in philosophy and bioethics

At this stage, the emotions are felt and acknowledged. In Gross' model, the acknowledgement refers to the *attention deployment* stage, and to the events and emotions it generates. As they recalled the *turning points* in their lives, most women described sensations in their bodies in

the form of pain in the womb and goose bumps. These prompted them to reflect on their own experiences of the procedure of FGM, which in turn awakened their traumatic memories. They described these *turning points* as events causing them to relive the procedure of FGM, thus experiencing emotions of fear, helplessness, and betrayal.

“[...] then on the skype, my mother-in-law had called me...soon you will be with us, I have prepared everything, and the circumciser is ready to purify the little one like this, she will be clean and everything. Baf! It was like a slap! I felt something in my belly”.

Interv_1

“My stomach sank as I recalled the sound of scissors, the horror and the fear that overwhelmed me when I faced the men in white coat...” Miré [37]

We know from our previous study [17] that there might be different types of events leading to *turning points* and thus the awakening of emotions. In some narratives, an encounter with a health professional (a gynaecologist or psychologist) was key in provoking the awakening. The role of others when old memories are stirred up and emotions relived and expressed by the women, sometimes for the first time is crucial. Indeed, the women need to experience a sort of ‘safety net’ while their negative emotions are relived as they reconsider their own experiences of the procedure of FGM.

At that stage, most of the women reported vivid emotions such as anger, fear, despair, and suffering, which they had been used to conceal not only from others but also from themselves. With external help, the traumatic nature of their experience would be acknowledged, thus allowing their emotions to be integrated as part of their experiences and selves, rather than suppressed again.

“The dimension of trauma should be considered here as there is violence against women’s bodily integrity. Also, in their traumatic experience, the women’s sense of identity may have split due to their emotions and stress (traumatic cleavage). Being supported by a professional who is used to dealing with trauma when they relive it, could therefore be considered the starting point to building their new identity and a way to foster it in a personal and subjective way” Expert in psychology and identity issues

An expert considered how the acknowledgement and expression of negative emotions was crucial at that stage to help the women move forward in changing their attitudes towards the practice of FGM as they enabled the up regulation of these negative emotions. Negative emotions are not to be down regulated at this stage but up regulated instead.

“The rising up of negative emotions is important for women to acknowledge and accept them, and thus, the up regulation of these negative emotions will push the women to do something and act” Expert in emotion competence

The negative emotions relived by the women interviewed in our study as well as those whose published testimonies were analysed. These emotions were derived from the consequences of FGM and brought a lot of trauma into the women’s lives. For example, trauma made one woman bleed in any painful circumstances, even when unrelated to FGM.

“Anything that upset me makes me to bleed...I can’t believe I am bleeding again, at hearing about the Brussels’ attack.” Bowin [38]

The clash: the conflicts of loyalty experienced

In the third step of our model, which we refer to as *the clash*, we looked at how the awakening and up regulation of negative emotions, that were associated with the acknowledgement of trauma led to inner conflicts of loyalty. Women experienced conflicts of loyalty when they wanted to protect their daughters as they did not want them to go through the same experiences. This gave them to have some mixed feelings as they became aware of different norms and values that would define them in different ways, in their own eyes and that of their community of origin. The feeling of being trapped between the two constituted a conflict of loyalty. As they experienced such conflicts of loyalty, the women became further aware of their bodily sensations and emotions such as embarrassment, shock, fear etc.

“I was constantly in fear and felt the anger, but I did not know where they were coming from[...] your own community has fooled you, you feel bad because you want to be a good Muslim woman” Expert with lived experience

At this stage, the negative emotions are still present. This makes the women try to come out of that state. However, the conflict of loyalty generates in turn new sufferings and negative emotions and needs to be solved to gain peace. According to the model's informing loyalty Dansey *et al.*[26], *considering one's own position* is a key stage to moving past this when trapped in a conflict of loyalty. In our study, the women at this stage would consider their positions as mothers and the devoted attachment to both their daughters and their communities would conflict, thus prompting them to work out how to prioritise those loyalties. This was the stage where a need was perceived to weigh up and choose, in order to emerge from the conflicts, they were experiencing. Indeed, choosing to protect their daughters by not perpetuating the practice would isolate and even ostracise them from their communities of origin. The women therefore reported experiencing conflicting representations of motherhood: what made them believe they were a good mother in their own eyes and that of the society in their host country by protecting their daughters from the practice of FGM, would make them bad and irresponsible mothers instead in the eyes of their own mothers and their communities of origin. Deciding to protect their daughters, meant the death of their affiliation with their original communities because they were defying the prescribed norms established by the patriarchal system.

“I think of my daughter...but I want to be a good mother in my community also »
Interv_15

“...I was convinced that I was born free, not with a pot in one hand and a broom in the other...I couldn't understand how a hand that caressed you, wiped your tears, reassured you, comforted you, could hurt you...I was confused...but I had a commitment to my sister and brothers, not to abandon them.” Barry [39]

Along with conflicts of loyalty, conflict of interest might be experienced, as women may be trapped in the feeling of losing the status that they gained through the procedure of FGM.

Moreover, when women oppose a norm, their opposition becomes an element that disturbs and endangers the patriarchal system as a whole.

The re-appropriation of self

The next step in our model that we named *the re-appropriation of self* suggests that as they move forward, the women need to actively engage in processes of self-re-appropriation whereby they accept the need to reconsider their positions and see and value themselves for what they are. This is different then, from what is valued in their communities of origin. This is what Dansey *et al.* [26] call the recognition of new position and re-conceptualisation of sense of value.

The re-appropriation of self is an important stage in the women's journey. It entails their own identity re-appropriation as well that of their bodies and sexuality. The women explored their responsibility to themselves and sought to re-appropriate their identity and rebuild their self-esteem and self-confidence. Some women became aware of their inner internal agency and were able to identify and express personal qualities by being curious and stubborn in response to the patriarchal system that see women as subordinates. Developing such personal characteristics enabled them to preserve their sense of self. One woman reported:

"I'm a bit stubborn, there are things I didn't accept. For example, I couldn't stand the veil before the wedding and after the wedding, I wore it in my own way, that's me."
(Interv_4)

This stage also entails women starting to think by and for themselves so as to discern their identity as distinct from the one imposed by the community. At this stage, the participants in our study as well as the women who shared their testimonies through published material started to value what they wanted for themselves instead of what the community wanted for and from them. There was an awareness of their internal drive to claim back what they had lost and therefore, their bodies could be reclaimed. The women recognised that some aspects of their future were within their control by wanting to undergo the reconstruction with regards to the lost physical part of themselves (the clitoris) and so to regain their sexuality. The control over

their own lives placed more responsibilities on them to make changes to improve their lives. This was a shift from the powerlessness they felt before the *turning points* and as while they were dealing with conflicts of loyalty. As a woman participant reported:

“I wanted to gain something but rather I lost something and that they never told me I felt betrayed; so, I want it back, I want to do reconstruction of the clitoris” Interv_3

The issue of responsibility is an important part of the journey at this stage. Accepting responsibility for themselves and making their own decisions for their wellbeing and that of their daughters gave them control over their own lives. The women’s sense of self-worth increased as the positive emotions were released in this resolution of the conflict of loyalty.

An expert asserts that:

“The re-appropriation of the body and sexuality implies the responsibility towards oneself and others; responsibility and identity are articulated. This re-appropriation seeks to (re)define and (re)delimit not only identity but also the roles between oneself and others; that is to say the power and the competencies belonging to each, entering into the transaction by allocating responsibilities in relation to their duties with respect to others” Expert in transcultural, clinical psychology and anthropology.

In addition to the help or advice received from professionals, those women who had a partner from a different cultural background stated how they had been helped by their partner to understand that sexual intercourse ought not to be painful and that they had a right to be satisfied with their sexual lives. This is an important role played by the others in the women’s change of attitudes.

“The fact that my partner supports me, encourages me, and has offered to help me with the reconstruction, and that he will pay the costs has also given me strength to move forward and I feel valued” Interv_12

The women acknowledged the viewpoints of the professionals and partners but made their own decisions, which signals out the phase of *considering others' perspectives* in Dansey *et al.*'s model as important for influencing individuals' position and loyalties. In Gross' model, this stage refers to the *situation modification* which in our study was materialised by actions such as fleeing with their daughter, going forward with clitoris reconstruction or defibulation or writing of a book (becoming an activist). They made sense of their situation by realising that they did not have to suffer without saying anything. Women also reckoned that the assistance from the safety net of helping agencies (for example the non-profit organisations and some health professionals such as psychologists), was important in this phase of dealing with their emotions of fear, anger and the accompanying traumas. This is an empowerment experience for the women, and they saw these relationships as positive contribution to their wellbeing. Some positive emotions were brought up when the women felt supported by significant others. At this stage of their journey, *self-determination* was established by the choice the women made in another context which enabled them to prevent further FGM. The women reported their ability to be assertive and make plans for themselves for the future, for their comfort and independent lives. This encouraged them to have positive feelings about themselves and think positively for their future. They also made plans for their relationships with their children, families, and new romantic partners.

"You see, I have plans, a lot of plans for the future, first of all I tell myself that after my nationality I'm going to move to France so that I'll be close to my parents and then do something else, like going back to school and furthering my education" Interv_4

The reconciliation: with mother and community

In the last stage of our model, women have managed to not only reappropriate themselves and their bodies, but also to reconcile themselves, even if sometimes just symbolically, with their mothers and communities. At this stage, the women expressed being able to identify with their mothers, understood that they could not have acted differently, and ultimately forgave them for what they were once subjected to. They did not apportion any blame to their mothers.

“And when I think that my grandmother certainly underwent this in a more archaic way ... I say to myself that we need to understand them...” Interv_9.

At this stage, the empathy the women feel towards their mothers enabled them to overcome their sense of blame towards them. They become able to *relate emotionally* again to their mothers. Many participants reported of their struggle to understand why their mothers made them undergo FGM. But they also thought of the fact that their mothers went through the procedure in a more violent way than they did. Some women reported anger towards their mothers but later did not want to blame them.

At last, the women at this stage report to be able to forgive since their mothers for what they have once been subjected to, as they acknowledge their mothers did probably not have a choice to act differently because of the social pressure inherent to the context and time at the moment. By contrast, they see themselves as having a choice, especially in the context of their Western host countries where the practice of FGM is prohibited by law.

Forgiveness towards their mothers led to a symbolic reconciliation with the community. Some women participants depicted a transformation in their perspective through their acceptance and forgiveness of themselves and their mothers. By forgiving their mother, the women did not condone their mothers' actions but rather they freed themselves from the anger and the negative feelings that threatened their own wellbeing. As one woman put it: *“I love my mother and my people” Interv_13*. They understood that, forgiving their mothers was part of the process that would enable them to move forward and be part of the community again, even if just symbolically. They let go of both anger and blame towards their mothers.

“Letting go allowed me to live my life so that I don't live other people's lives. Then, I gradually learned to regain confidence in my parents. I undertook not to judge my mother anymore...But I wouldn't want her story to be really mine, nor that of my children” Kanko [40]

“Our mothers, my grandmother, they are the bearers of this tradition to please the men but in fact it is ignorance. And when you realise that, your anger fades away, you just

know that you can't be like them...I have to protect my daughter and other little girls who undergo the practice during the school holidays. I am less angry today" Bah [41]

At this stage, by seeing themselves as different from their mothers yet being able to identify with them and forgive them, the women may be seen as having *self-determination* management despite their powerless position and successfully *work out their conflicting loyalties* as Dansey *et al.*'s model [26] suggests.

"I first began to reconcile myself with the part of my body that was ignored, and then with my community so as not to blame anyone" Koita [42]

Discussion

The main aim of this study was to generate a better understanding of the mechanisms and factors that might explain the change of attitudes towards the practice of FGM in the context of migration in relation to *turning points* that occur in the life trajectories of the women who challenge the practice of FGM. Emotions such as fear and helplessness were reported in our study as relating to the patriarchal ideals of what a normal and good mother should be. Negative emotions tend to be suppressed before *turning points*, as according to patriarchal ideals, women should endure pain and suffering without complaining. Therefore, anything that the women felt but were not able to express because there was nobody to hear them, tended to transform into fear that would hinder their emancipation and freedom. Conflicts of loyalty inevitably arise when the women question the legitimacy of the rules and norms of their own communities. In our study, the women reported to have felt torn apart by conflicts of loyalty as they sought to be themselves while being part of the communities. They challenged the prescribed norm when the lives of their daughters were at stake, which made them think back on their own experiences and feel the urge to protect them.

Our findings illustrate that as they were socialised in a patriarchal system, the women were not permitted to express their emotions especially pain in three crucial moments of their lives i.e. at the procedure, on the wedding night and during childbirth. These findings confirm other

research findings for example Abdalla [43]; Malstrom [44]; Fisaha [45]; and Morgan [46] in that, women were not allowed to express their suffering verbally during the procedure and in the social interaction of their everyday lives. Suffering and pain were understood as ‘*normal*’ and as expected parts of a woman’s life. This socialisation-based learning includes acts that demand silence without complaint. Verbal complaints were understood as a failure and also as shameful, since these acts were connected to sexuality and reproduction. Silence and secrecy guard against the making of the feminine self [47], while the painful experiences are continuously engraved on the inside of the body. For them, being silent or silenced about one’s trauma signifies the loss of power and self [48].

The women acknowledged that the FGM experience creates psychological trauma and is a potential cause of Post-Traumatic Stress Disorder (PTSD) for the women [7]. The trauma is considered a psychophysical experience where the traumatic event has a damaging impact on the mind and the body, and the bodily injury can result in fear of annihilation [32]. The results of this trauma invade the consciousness (flashbacks, sensory illusions, nightmares) and means all or part of the trauma is relived identically, with the same distress, the same terror and the same physiological, psychosomatic and psychological reactions as those experienced during the violent event itself [33]. Van der Kolk [31] asserts that the re-experiencing in the present moment of the physical sensations of past traumatic events triggers the experience of uncontrollable intense feelings. The impact of PTSD on the mind and body has been discussed by Rothschild [32]. She examines a normal response to that of a PTSD response and concludes that the most severe consequences of PTSD result from *dissociation*. Women who have undergone FGM manifest PTSD as well as trauma-related complications, shutdown dissociation, depression, and anxiety [7,11,12].

In the literature, suppression of negative emotions is thought to lead to poor long-term health outcomes [49,50]. In our results, the rising of the negative emotions in women triggered sensations in their bodies, causing them to relive their own personal experience of the procedure of FGM. These personal experiences brought some negative emotions to surface which led to feelings of vulnerability in the women and the awakening of the traumatic memory. In theory, the negative emotions are to be down regulated by positive emotions in order to minimise the

consequences of emotional experiences [51,52]. However, the up regulation of the negative emotions was key in prompting the women to move forward, as they started to question the norm in the process of becoming aware of the responsibility they have towards their daughters' safety as well as to their own personal lives. As the traumatic memory was awakened, the women in our study became more aware of their negative emotions (fear, betrayal, helplessness, pain, and a sense of being overwhelmed) and this triggered sensations in their bodies. The acknowledgement and acceptance of these emotions, called *the attention deployment* in Gross' model [25], represents the explanatory mechanism of up regulation of negative emotions in *the awakening* stage of our proposed model. It also led the women to move through and reach the next stage, *the clash* (conflict) stage even though this was uncomfortable for them. That is the stage when most of them took action and fled from their countries of origin meaning that they were able to step out of the normativity of the social community. Thus, the awakening of their emotions foster their possibility to take agency of their suffering body over the social expectations. This is an articulation of individual experience and the capacity of modifying a social norm. In the context of migration, these women were exposed to a variety of norms and were affected by conflicting norms that allowed them to make a choice to be agents and questioned the norm. The choice offered in the new context, their mothers and grandmothers did not have because they were only participating in the patriarchal model which was the only narrative available. However, making the choice and act on it implies the capacity to rewrite alternative narratives and also implies the concrete realisation of freedom as a transgression of their own norms while they respect the law of the host country [53]. The choice was also an important part in *working out their loyalties* [26], which enable the women in our study to be able and determined to choose their daughters and take control. Dansey *et al.* [26] stress that this *self-determination* is understood as being underpinned by empowerment. They created their own sense of meaning and acted to make their own decisions for themselves and their daughters.

The body as a vehicle for empowerment and capability

The changes in their sense of self the women described in our study while they re-appropriated their bodies and sense of identity and responsibility towards themselves and their daughters, constitutes a gain of empowerment. This is consistent with other studies on violence against women where women experienced changes in themselves through a change in their power and

their concrete actions to take control over their own lives [54,55]. This process includes recognition of their power to make choices about their own lives and take steps to embracing that power. Fahs and Swanks [56] suggest that embodied resistance is when the body is used to contradicting cultural norms; as for example, the women resisted and decided to go ahead with the reconstruction of the clitoris or de-infibulation. Their bodies gave them the means to act on their decisions about themselves. This is a *capability* according to Nussbaum [36]. These parts of their bodies appeared meaningful to them, and they thought of protecting their daughters' bodies as well. Before the *turning points*, what the norm imposed was contrary to what they felt. After the turning points, they were able to disclose their feelings and express their emotions. This was consistent with previous studies [17]. Under the practice of FGM, there was a sense of communal body. However, after the *turning points*, the women have a sense of a more individualistic body, where their rights are promoted in terms of their decisions concerning their bodies. Their emancipation or empowerment is therefore seen as from the bottom-up, from an individual body towards a community. The narratives of the women enable them to gain the strength of internal resistance that comes from self-confidence by becoming responsible for the sequence of events experienced [35]. Furthermore, the capability to preserve oneself as a person within the community and acting against own community beliefs represent the definition of concrete freedom [35].

A sense of agency and responsibility to take their own decision and to protect their daughters was a source of relief that acted as a counterpoint to their own memories and pain. This is consistent with the findings of Koukoui *et al.* [57] that mothers were appreciative of the opportunity to raise their daughters in an environment that offered protection against FGM and took comfort in knowing that their daughters would know another destiny.

The role of significant others in this process

The significant others played an important role in the change of attitudes of the women. Migration in the host country contributed to raising the awareness of differences between cultures and not being defined exclusively by FGM. The safety net of helping agencies and the assistance of significant others and health professionals were determining factors in the stage

of resolution of conflicts of loyalty. They can help to identify women in all stages of the process in order to provide assistance to their needs at that stage.

When they had partners from another culture, this was also significant because the women understood that one could be a member of a community without being cut. They no longer believed that women must endure pain and sufferings when their partners made them aware of the possibility of living their sexual life openly without pain during sexual intercourse which was a clear difference to the expectations of their own culture. In the host country, the different interactions with others also helped in the construction of their identities. Identities are relational socially constructed [58,59].

Women were able to shift and exercise their internal agency as an empowering means to achieve the stages of re-appropriation and reconciliation. This demonstrates their direction in moving forwards which reinforces the women's self-esteem, security and freedom. It also appears to enhance their determination to move through all the stages and to advocate against the practice.

Forgiveness and empathy in the process of changing attitudes towards FGM

The women represent themselves within their communities by identifying themselves with their mothers. They can be themselves and, also, they can be part of the community. The identification is a form of empathy they felt for their mothers which enabled them to reconcile with their mothers and see themselves as being part of the community again through the process of forgiveness. This correlates with other findings on the study of childhood abuse where forgiveness of parents was found to have good impact on emotional health [62]. Forgiveness refers to the process of the voluntary waiving of resentment, hatred and blame towards others so that not only the person not only forgets the hostility and hatred but also wishes the best for the transgressor [60]. This forgiveness requires a deliberate act of giving up anger and resentment toward the offender while also not requiring a response from the offender [61]. The offenders in this case are the mothers in the communities, and the women succeeded in seeing them as not having a choice in a pressurised community. This is empathy they demonstrated when they put themselves in the shoes of their mothers.

Strengths and limits of the study

The study is strong in various areas. An important one is the use of the inductive approach in analysing the data and the triangulation of different sources of data. Secondary analysis was done from interviews conducted with 15 women [17], which we compared with the experience of 10 further women with publicly available narratives (see list of books in methods section). The rich dialogues with experts from different fields including an expert with lived experience, also contributed to bringing out concepts that were relevant in enriching the interpretation of the results. The contribution of the expert with lived experience was valuable to enriching the trustworthiness of our results.

The study also presents some limits. First, our emerging theorisation was not tested through further interviews with a theoretical sampling methodology. Therefore, we cannot be certain that we have reached saturation. Moreover, our proposed theorisation might have been enriched through interactions with experts in presential seminars, as we had initially intended. Such seminars could unfortunately not be organised due to the sanitary situation in 2020-2021 in context of the COVIS-19 pandemic.

Conclusion

Building on hypotheses generated from an earlier study [17], this study examined possible mechanisms which might explain the change of attitudes towards the practice of FGM in migrant women. The model of change which emerged from our analysis gives us an insight into the journey of the women towards changing their attitudes after some self-reported *turning points* in their lives drove them to change. Re-appropriating their own self and identity as well as reconciling themselves with their communities of origin were both valuable in the women's perspectives in order to move forward with their lives. Trying to protect their daughters from going through the same experience led them to identify FGM as a violation of a woman's right to bodily integrity.

The importance of acknowledging the emotional work and painful traumatic memories awakened during the journey has significant implications for the assisting agencies and health

professionals who are in contact with migrant women who originate from countries where FGM is practised. Our model describes several stages including the stage of *the clash*, where the women find themselves trapped in the conflicts of loyalty and which in turn generates very uncomfortable and painful feelings. Thus, our study contributes to the body of knowledge and provides avenues to be explored by health professionals working with migrant women subjected to FGM, in order to support their processes of reconciliation with themselves and their communities.

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Discussion and conclusion

Chapter 6

Discussion and Conclusion

Introduction

The main goal of the thesis was to explore the psychosocial processes through which migrant women change their attitudes towards the practice of FGM. In the first stage of our study (1), we identified turning points which we defined as significant events in the women's lives. These events raised their awareness and influenced how they changed. The second stage of the study explored and examined emotion regulation and conflicts of loyalty, which we hypothesised play a key role in these turning points, and act as mechanisms that could explain the change.

In this chapter, we review the key findings in relation to some of the theoretical perspectives discussed in Chapter 2, and we also attempt to provide a theoretical contribution to the process of change at the individual level when women turn their back on the practice of FGM. We discuss how the model generated by our study could help in developing effective approaches to prevent the practice of FGM among migrant women in Belgium. The final section of this chapter discusses the strengths and limitations of this study, issues of validity and reflexivity, and provides recommendations for future research and practice.

6.1. Discussion of main results

In an exploratory work (2), we examined the empowerment of migrant women who had undergone FGM and also participated in health promotion activities in relation to the reinforcement of their capabilities in lines with Nussbaum's central human capabilities (3,4). From that study, we found the capabilities that were reinforced through those activities facilitated the birth of other capabilities in the women. These results prompted us to reflect on the journeys of women who have been affected by FGM in order to better understand the psychosocial processes involved in those journeys.

In the first stage of our study, we identified and described specific turning points in the lives of the women who were interviewed. Turning points were defined as significant events that

challenged their norms and any other expectations associated with the practice of FGM. The events were specific to each woman yet could be grouped into several common *turning points*: *encounters with health professionals; education-related processes; social interactions with other cultures and within own culture; experiences of motherhood and the urge to protect their daughters; repeated pain and sexual and reproductive health aspects; witnessing the effect of harmful consequences of FGM towards loved ones* (1). These results are presented in detail in Chapter 5 section 5.1. As awareness of emotions and mixed feelings toward themselves and their communities were expressed by the women in relation to those *turning points*, we hypothesised that emotion regulation and conflicts of loyalty might be common processes involved in the change of attitudes towards FGM.

These hypotheses were further investigated in a second stage of our study through secondary analysis of the transcripts from the first stage, and through triangulation with books of *norm leaders* and consultations with Experts. This allowed us to generate an original model which represents the typical journey of the migrant women post turning points, to better understand the mechanisms involved in the change of attitudes towards the practice of FGM. This model of change is presented in Chapter 5, section 5.2 and the main stages were as follows: the suppression, the awakening, the clash, the re-appropriation of self and the reconciliation (1).

Our results highlight the importance of the process of up regulating negative emotions in pushing the women moving towards change, as well as the importance of identity issues and the role of forgiveness and empathy in the empowerment process. These important concepts are further discussed hereafter.

6.1.1. The importance of up regulation of negative emotions in conflict of loyalty and the change of attitudes towards FGM

From the up regulation of negative emotions identified in our study, it appears that emotional reactivity accounts for a wide range of reactions from the women. The emotional reactions are from the acknowledgement and the acceptance of the negative emotions which activated heuristic processes; hence their attitudes could be affected (5,6). The acknowledgement of emotion is also called the '*affect*'. The '*affect*' refers to 'individual's life and beliefs which

preclude the understanding of social life as a system of rules and norms' (7). It is the acknowledgement before the knowledge. It is the feeling of an uneasiness of suffering or sadness that enables to take a step. In this sense, the acknowledgement, acceptance, and up regulation of negative emotions by the women are to be seen in the context of the process of '*attention deployment*' in the model of Gross (8). The women paid attention and acknowledged well the emotions they had. Thus, the explanatory mechanism of the *awakening phase* in our proposed model is the up regulation of negative emotions, which is when the women come to understand and are aware of their emotions. The up regulation of these negative emotions is related to the experiences of FGM.

In our thesis, the concept of *affect* in the change of attitudes towards the social norm is important in the sense that it precedes the change. The fact that the individual woman is affected is a vulnerability and at the same time a capacity to step out of the vulnerability, so it gives the strength. When women have the knowledge that the norm is not right for them, then through agency, they can take into account their own narratives instead of the narrative of the patriarchy. Thus, being *affected* becomes a capacity for the women to act and take a step to be agent of change.

According to Gross' model (8), when one is conscious of a negative emotion, the regulation is usually a down regulation of these negative emotions and up regulation of positive emotions. By contrast, in our model, it is the up regulation of negative emotions that pushed the women into motion, thus representing an important mechanism involved in their process for change. Working out loyalties to solve the tension experienced in relation to conflicting self and community expectations was a key to the women's journey of change. One interpretation could be that the women made sense of all the mixed feelings they experienced. At this stage, being able to acknowledge negative emotions was key to coming to terms with the conflicts of loyalty between wanting to maintain affiliation to one's community and making the decision to choose to protect one's daughters. The decision to oppose to the community bonds, which once appeared to indisputable, represents the bereavement of the affiliation.

6.1.2. Assigned identity through patriarchal system vs constructed identity in the host country

Our research confirmed FGM as a practice which gave women their cultural identity. Identity refers to one's notion of self and has an important influence on human behaviour (9). Identity gives an overall unity and purpose to one's life and defines how one is similar to and different from others (10). The self is conceptualised as a process instead of as a thing (11). The dynamics of identity were clearly described by the women as what they thought was normal for them and this was associated with their marriage as well as childbirth. The role of FGM in assigning ethnic identity, is crucial to understanding of the practice (12). This was demonstrated in our study as it strengthens both the individuals' identity and the groups' identity as it gives status within the community. The study illuminates how primary socialisation impacts girls and women from an early age, so much so that the practice is important in the broader community. For instance, women are taught at a very early age how they should behave according to the culture and tradition and most of them are pressurised and bullied by their peers and some request the practice to avoid stigma and mockery. From the evidence, the practice, in its rituals and in its execution, is typically a female activity, for women only; the male remains on the side-lines if not altogether excluded (13). However, this does not necessarily mean that men are not taking part in the decisions to have their daughters cut, or complicit in the continuation of the practice. It is clear, however, that it is women who take care of the preparations and who accompany the girls to the ritual, during which they play the active role. Likewise, because of the deep-rooted and internalised social constraints, it is women who defend the continuation of the practice, required by families to protect their daughters, and assure them a future, since it is also this ritual that defines their social status within the community (13).

Older women who have themselves undergone the procedure have the marks on their bodies but continue to serve as guardians of the tradition although they are in the best position to comprehend the pain and health issues associated with the practice (14). The effects of harmful consequences on women's health results in the practice being recognised as a violation of women's bodily integrity. This violence is often perpetrated by the older women facilitating it being re-inflicted on generations as part of their identity. This identity is assigned to the women

and controlled mainly by the patriarchal system, as '*a good mother*' is often tied to her daughters' participation in the FGM practice. For example, the identity of 'a good mother' according to the prescription of the patriarchal system, ensures that daughters participate in FGM. This identity may be threatened by a child who resists participation in the tradition. As part of that assigned identity, there is also a requirement of non-expression of the emotions that women feel.

Our study also exposed a change when the women reconstructed their identity in the context of migration. In terms of body ownership, the women's bodies used to belong to the community. The women tried to reconstruct their identity by challenging and resisting the requirements of the social norm. The resistance to the control of the body is described through the women's narrative as a feeling of disconnection from both their own bodies and their experience of FGM. For example, when they healed from the physical wound following the procedure of FGM, they forgot about it until something else triggered the experience again. This could suggest that they had embodied the practice of FGM. The embodied resistance refers to when the body is used to contradict cultural norms, such as when women resist cultural expectations through reconstruction of the clitoris and defibulation. This resistance to rationality pretends that all narratives are the same, and women should endure pain and suffering without complaining. Their bodies give them the tools to act, whether through reconstruction of the clitoris or defibulation or the urge to protect their daughters. The women believe in their desires, their feelings, and in short, their *affects*. Their body parts appeared meaningful to them, and they also thought of protecting those of their daughters'. Before, what the norm imposed was contrary to what they felt. While FGM used to make them part of a communal body, the refusal of FGM allowed them to gain a sense of an individual identity and body, along with the right to make their own decisions on their bodies. The practice of FGM as a rite of passage to womanhood in the patriarchal model used to give them an assigned identity. The feeling of suffering has meaning in the women's subjective narratives, but they were excluded from being heard by the patriarchal system that did not take their interests into account. When they found themselves in another context, with the law against FGM as well as other norms, they were faced with conflicting norms, which in turn led them to transgress their own norms. This transgression occurs when individuals behave outside social expectations (15). The confrontation with an

alternative norm in Belgium represents also a conflict for the women participants as they expressed it as '*being normal in their country of origin*' and '*not normal here in the host country*'. However, this conflict enables them to make a choice. These women have the advantage that the new context offers them a choice which their mothers and grandmothers did not have, because they were only participating in the patriarchal model and therefore the only narrative available.

6.1.3. The role of forgiveness and empathy in the process of empowerment

Our findings show that forgiveness and empathy were mechanisms and a means at *the reconciliation phase* of the journey of the women in their change of attitudes. Forgiveness is defined as a process whereby the victim gradually releases negative emotions, thoughts, and actions toward the offender and replaces them with neutral or positive emotions, thoughts, and actions. This definition emphasises both empathy and compassion (16). Forgiveness and empathy in our study as means in exercising the women's choice confirmed other findings (17). Individuals forgive when they rationally determine that they have been unfairly treated but choose to abandon the resentment and related responses toward the offender (17). Identifying with the offender on an emotional level and fostering a willingness to show compassion compels the victim to forego his or her right to negative thoughts and feelings (16).

Forgiveness was conceptualised by Enright (16) who proposed a process model of forgiveness which has four phases: *the uncovering phase*, *the decision phase*, *the work phase* and *the deepening phase*, and found that forgiveness is associated with better emotional health (16). During the first phase (*uncovering phase*) of the forgiveness model, the person who is hurt experiences negative emotions and pain resulting from the offence. Enright (16) asserts that the individual must confront his or her negative emotions and understand them deeply before the process of healing can begin. The women in our study acknowledged the negative emotions and accepted them which enabled them to be able to move on to the next stages of the change process.

In the second phase (*decision phase*), the hurt person realises that continuing to think about and feel angry about the harm serves only to prolong their suffering (16). When the victim begins

to engage in forgiveness the victim begins to let go of thoughts, feelings, and intentions of revenge. However, it is in the third stage (*work phase*) that the process of forgiveness actively begins (16). During this stage, victims seek to change their perception of the offender through such means as developing a better understanding of the offender's life, and consequently why he or she may have committed the offense. This explains how the women thought about the choices they had available in the host country and were able not to blame their mothers and did not feel angry with them.

The goal is not to excuse the perpetrator but to induce empathy for the offender by viewing him or her as human and fallible. It is also during the third stage that the victim acknowledges and accepts the pain created by the offense but makes a conscious decision not to project the pain onto others. In the final phase (*deepening phase*) of Enright's forgiveness model, the victim experiences the positive emotional benefits resulting from forgiveness and indeed the paradox of forgiveness where one bears the unjust pain, grants undeserved mercy to another, and, in so doing, is healed. During the final stage, the hurt person chooses to restore the relationship with the offender by '*letting go*' (17). The '*letting go*' also refers to a greater sense of empowerment on the part of the victim or forgiver and requires the ability to detach and separate from the traumatic event and the offender (17). The women manifested this sense of empowerment when they experienced a reduction of anger towards their mothers and grandmothers. This confirmed what authors called '*abandoning resentment*' or '*responding to the offender with empathic understanding through increased understanding and acceptance of the other and self*' (17).

From public health perspectives, forgiveness has been found to lead to a reduction in the risk factors associated with cardiovascular problems, as those with a disposition to forgive were found to have lower indices of blood viscosity (18). Furthermore, forgiveness is also positively correlated with improvements in the immune system (19). Thus, there is some evidence that a personality prone to exercising forgiveness in the face of an interpersonal offense is beneficial to one's physical and emotional health and overall wellbeing (19,20).

6.2. Implications of our study

6.2.1. Contributions to theory and knowledge

The main contribution of our study is the innovative part of our suggested model that impacts the process of a journey towards change post turning points. The model also advances the understanding of the journey of the change in attitudes of the women affected by FGM in the context of migration. It has generated new knowledge about how the up regulation of negative emotion can set an individual woman to move towards a resolution. This demonstrates ways of ascribing meaning to the change at an individual level before being extended to a community level.

Our study also highlights the role of the capabilities approach in the change of attitudes towards FGM in the host country. The women who participated in the study are women who had undergone the practice of FGM in their country of origin, and who self-reported as having already taken up a position against it when we met them. This in a context where the law prohibits the practice of FGM, enabling them to make a choice for themselves, which was different to what their communities would expect. The capabilities approach defends the concrete universality of emancipation for all women, and this can be extended to the practice of FGM. In considering the argument that while the capabilities approach emphasises people's freedom to choose the lives they value; we understand in our research that patriarchy is founded on prescriptive norms that de-subjectify women and dismiss their emotions by suppressing them. The main emotion that alters the women's emancipation and freedom is fear. However, Nussbaum (3) stresses that, having one's emotional development blighted by fear and anxiety thwarts the capability of *Emotions*. She suggests that having a choice is empowering (3,4). Thus, the women choose what is more in line with their subjective feelings by deciding to protect their daughters and themselves. Forgiving and not blaming their mothers preserves their freedom. When the women change from their own norms to the norms of the host country without relating to them, this makes them even more alienated. This explains how a woman can still take her daughter from a host country to her country of origin in order to have her cut. By contrast, the women in our study realised that they had been 'fooled' by a social norm which

did not take their well-being and interest into account. When, a norm only takes into account the will and need of the prescriber, it is usually in his own interest. The women in this study prevented their daughters going through FGM to protect them from the experience they had had themselves. This demonstrates an empathy as a capability they exercise towards themselves, their daughters, and their mothers.

6.2.2. Further developments

Our snowball procedure in the recruitment phase has led to a sample that was quite homogeneous. Our proposed model therefore reflects the experience of women who had all gone through each of the phases we presented, and who had arrived at *the reconciliation phase*. We are therefore missing the voices of those women who have not yet gone through all the phases, and who deserve further attention.

In asking ourselves '*What happens when a woman does not go through all the stages of our model of change?*', we hypothesise that the resolution phase could involve a *going back phase*, instead of just the *moving forward* stage, which in our model leads to *the re-appropriation of self*, and *the reconciliation phases*. Similarly, the conflict resolution stage might involve a *going back* instead of just the *moving forward* phase. Indeed, *going back* to the starting point may be another way for some women to solve their conflicts. By '*going back*' at the stage of experiencing the conflicts of loyalty, means to do as they were taught, in order to avoid the inner conflict. The women who *go back* to the starting point probably lack the capacity to up regulate their negative emotions, and may resign themselves to believing that, after all, they were cut themselves and had learnt to suppress the emotions, and that therefore their daughters would manage. Another explanation for *going back* could be that the consequences for challenging the system by not complying are significant and symbolic: you could be ostracised, and your daughter might never marry. The social pressure of compliance is also immense. As a result, women could once more repress the emotions they feel by down regulating their negative emotions according to Gross' model (8), and so not expressing them; just like before the *turning points*.

Instead of *going back* to the starting point, some women may be *stuck* and remain in the conflict. At this stage, they might require help from health professionals. Helping women move from

one phase to another instead of *going back* or remaining *stuck* at a precise phase, has important implications for practice which will be detailed hereafter. Importantly, it should be acknowledged that our model should not be seen as linear, although it is presented that way.

6.2.3. Implications for practice in terms of prevention and health promotion interventions

Our proposed model provides an inclusive framework to assist health professionals and other professionals in their work with women who have undergone FGM and who are at any one of the defined phases. The life story approach we used in the first part of our study may help as a health promotion strategy to frame women's progress and help them make sense of their experiences. This approach may help the women's voices to be heard. The change at the individual level that our study highlights can make women start sharing their experiences in the context of migration within their small group of '*tontine*' at the grassroots level in order to raise awareness among other women. This might also help to dispel the taboo associated with the practice.

Our proposed model may help to define self-management strategies for emotion regulation which would benefit women in the process of changing their attitudes towards FGM. Professionals working with women with FGM need to develop clear strategies for each stage proposed. Hereafter are some suggestions especially for stages after the *turning points*:

- The *awakening phase*: Professionals working with women may help them to work on the turning points in order to put together the emotional sphere and the cognitive sphere with care so that the reliving of their trauma will be under control. They can also help in screening women to identify in what stage they are to offer the proper assistance associated with the stage. Women may also benefit from the help of professionals to remember, reflect on and learn from their experience as opposed to being reduced to silence while having emotions. They may be prepared for the past to resurface in order to have anticipatory guidance.
- The *clash* in the conflict of loyalty: Guidance can be offered to the women as how to come out of the conflict without being *stuck* or *going back*. The dilemma women

experience around their loyalties to their mothers and to their daughters can be solved by giving support in this regard.

- The *re-appropriation of self*: Health professionals can build on the effort and decisions of the women to take a new image by using language that resonate with their orientation for the future. Here, efforts need to be put on the women's self-esteem, strengths and their capabilities in order to foster their new *self*. The principle of do no harm can work here for the women even though some professionals might not know what the trauma of FGM entail.
- The *reconciliation phase*: Our findings concerning this stage offer direction for professional working with women to give appropriate support to be proactive in forgiveness and empathy; by giving them voice enabling the women to feel free of the link with their mothers.

Other implications for practice include training healthcare professionals to use the right terms. First, regarding the use of FGM or other terminology, such as female circumcision, female genital cutting, we would advise as a health professional to stick to the term FGM, though the women themselves sometimes use the term '*cutting*' as it happened when we were doing the field work. Moreover, there might be an issue with the terms '*normal*' or '*abnormal*'. Indeed, some women in the study themselves as *normal* in their home countries as they thought all women in the world were like them and yet in the host country, they were considered *abnormal*. This idea needs to be deconstructed as well. Due to the sensitiveness of the topic, the label '*normal*' or '*abnormal*' should be avoided in order not to stigmatise the women and not cause more harm than good by labelling. Thus, there is a need to adapt it and use the term '*intact*' as even anatomically, there is no '*normal vulva*'.

Labelling all forms of violence against women such as forced marriage, rape, an act without consent may have an impact on the perception of the women with their lived experiences. Indeed, these three cases are found in FGM and child sexual abuse and there are common denominators: silence and the long-term psychological impacts (PTSD, depression, anxiety, flashbacks). However, a difference between FGM and child sexual abuse lies in the fact that FGM is perceived positive and empowering sometimes by the women themselves (2,22).

Whereas the child sexual abuse is seen negative as far as shame is concerned (54,55). Therefore, in terms of prevention, labelling all violence the same may be dangerous and can jeopardise some women's perceptions of the violence and their lived experiences. How professionals handle the different terms determines how survivors of FGM may perceive the gravity of their experiences.

Thus, we think that considering the perceptions of the women as far as the violence is concerned is important to increase the efficiency and effectiveness of prevention and intervention programmes. In the case of FGM, prevention programmes should include all types of FGM and also consider it a form of sexual violence according to WHO's definition, to avoid the danger of promoting a perception of tolerance for some type of FGM (e.g. medicalisation of type 1 FGM). However, considering FGM a sexual violence, a rape and an act without consent as well as FGM being a harmful cultural practice can impede some women's response to prevention. This could bring a form of colonialist assumption by universalising the Western culture (21,22).

In terms of health promotion, programmes may also contextualise the type of violence as sociocultural contexts often surround violence issues.

Further perspectives on treating Post traumatic stress disorder (PTSD) generated by FGM in childhood.

The post-traumatic stress disorder is one of the harmful long-term consequences of FGM which often leads to severe changes in women's psyche. Emotional trauma, with time alone, cannot heal on its own. We discuss below some therapies which can be applied to women or girls, survivors of FGM.

Eye Movement Desensitization and Reprocessing (EMDR) therapy

It is a therapeutic approach that emphasizes the brain's intrinsic information processing system and how memories are stored (23–25). The main aim is to relieve psychological stress. Research has shown the therapeutic efficacy of adapting a cognitive set in which negative thoughts and feelings are seen as passing mental events rather than as aspects of self (26). The importance of moving from identifying with the emotion to viewing the thoughts and emotions can enable to

relate to negative experiences with a wider field of awareness. This can enhance a sense of efficacy and mastery (23). EMDR therapy is already used in Belgium at '*Centre medical d'aide aux victimes d'excision*' (*CeMaVie*) on women patients who have undergone FGM. It has proved to be helpful. Thus, our proposed model describing the journey of a woman from compliance to the norm to non-compliance, evidenced that traumatic memory, negative emotions, and affect were present and played a central role. This suggests that as EMDR therapy is used in the treatment of PTSD, it may be an interesting option to consider by healthcare professionals as treatment in different stages of the model, as negative emotions are strongly present. Because FGM is performed in childhood, girls that had undergone FGM, may be treated earlier with this method which could enhance their well-being and quality of life and also reduce cost for public health. Moreover, the early treatment on girls earlier may benefit to prevent the long-term psychological consequences of the practice of FGM.

Forgiveness as a therapeutic intervention

Therapists have considered the role of forgiveness in resolving trauma (27,28). Experts distinguish between two types of forgiveness. Forgiveness can involve forgiving the offender for their wrong-doing and forgiving the self for the traumatic event and holding the perpetrator accountable for the harm. Forgiving the offender as well as the self, have been found to resolve past interpersonal issues (16,20,28).

Most women in our study chose not to blame their mother, manifested empathy towards them and forgave them in order to move on with their lives. Thus, the model presented in this thesis may be useful to help health professionals to develop strategies around stages of *re-appropriation of self* and the reconciliation to reinforce forgiveness as a therapeutic intervention to help women with the trauma due to FGM.

6.2.4. Further avenues for future research

A need is clearly evident for more research that will explore these avenues:

- Investigation of the role of emotion as a capability in the change of attitudes towards FGM among migrant women.
- The exploration of the impact of narrative therapy on women's wellbeing after they have engaged in disclosing their story to the public.
- The examination of the experiences of women with FGM raising daughters who have not undergone FGM.
- The social practice theory can give insight to understand the empowerment possibilities for the women as it has an impact on the social dynamics of the women. The feeling of connection to others, the relationships with others and promotion of mother/daughter relationships are also important. Further research is needed to better understand the implication and the importance of the social interaction with others in the change of attitudes towards the practice of FGM.
- *The intergenerational dialogue approach*

The intergenerational dialogue approach is another avenue worthwhile to be considered as a potential tactic for social norm change. The intergenerational dialogue approach is a participatory approach to engaging members of the community across sexes and generations to feel empowered to change behaviours (52,53). The intergenerational dialogue is developed to promote constructive and consensual change of harmful practices, such as genital mutilation and forced marriages. The goal of this approach is to build people's communication skills and confidence to articulate viewpoints in a community-based dialogue where young and old women discuss controversial themes such as gender roles, sexuality, traditional values and practices, with mutual respect (52,53). This intergenerational dialogue could be therapeutic in fostering the bond between them and also sharing knowledge and support for each other, hence promote reconciliation and forgiveness. Further research is needed to examine this avenue to better understand how this intergenerational dialogue could reinforce the change of the social norm and if transferable in another context rather than the context of migration.

6.3. Strengths and limits

6.3.1. Strengths: Discussing the issue of validity and reliability in this study

Validity, the process through which we make claims for the trustworthiness of our interpretations, is a crucial issue (29). The assumption underlying this research is that reality can be interpreted in many ways and the understanding is dependent on subjective interpretation. Reissman (30) posits that, traditional applications of reliability standards do not and should not apply to narrative study.

We address the trustworthiness of our data through triangulation, member checks; thick description and clear exposition of methods of data collection and analysis (29,31). We assessed the accuracy of our data, but we could only rely on what the women narrated to us as authentic (32). Their life stories remain the material of truth we have to work on and cannot be disapproved. The whole process of data collection from the women participants and the difficulties we encountered in the field were described in detail. The life story and the grounded theory approaches were also described thoroughly as recommended by Mays and Pope as research methods used to influence the researched (33). Ayres and Poirier (34) assert also that a clear and transparent description of all methods and means used to come to the final presentation is the best evidence for demonstrating the trustworthiness of the work, given the potential for multiple interpretations and meanings.

Credibility in qualitative research occurs when we document the experiences of each participant by checking the accuracy of what each participant revealed during the interview (35–37). Some of the techniques that can be used to establish credibility include prolonged engagement with each participant, peer-debriefing, member-checking, and reflexive journaling. We used member-checking and reflective journaling to enhance the credibility of findings from this study by asking the women participants to confirm the *turning points*, and thus, the *turning points* were co-constructed. We presented the transcripts and the *lifelines* (see Chapter 5, section 5.1) to the women and recorded the defined events on sticky note pads, asking them to classify them according to the significance in terms of turning points. We also asked them to add new events or delete anything they felt they did not want on record anymore or anything they felt was not relevant (as explained in Chapter 5, section 5.1. In addition to member- checking, we

jotted down any reflective notes and advice received from supervisors. We found it deeply important to maintain reflective awareness during interviews because of cultural constructions exhibiting both similarities and differences between us and the women (38).

6.3.2. Limits

The thesis has some limits also. Our proposed model has some limits as it focused on the intrapersonal dimension of an individual while the interactions with others are also useful in the change of attitudes towards a social norm. The context of migration creates an empowerment and freedom environment as well as a new culture for the women. However, in the European context, the empowerment in terms of freedom is not something the women who have undergone FGM in their country of origin would automatically gain. In this context, the conformity to norms in the host country could be a real pressure for them. They transgressed their own while respecting the laws of the host country.

6.4. Reflexivity and positionality

6.4.1. Reflexivity

In this section, we will use the '*I*' pronoun instead of '*we*' to highlight our personal reflection on the whole journey of the thesis. Reflexivity entails that the researcher's personal and professional backgrounds, beliefs and feelings contribute towards the construction of knowledge and how these impact on the research (39). It encourages researchers to be mindful of both their position as researchers and the position of their respondents (39). This helps us to identify how the research process and questions are shaped and influenced by various factors, such as our assumptions.

As a young activist on the issue of FGM and a health professional, it was easier for me to understand the health problems, the rights of women and children; and also, it was instinctive for me to put myself in the shoes of a woman whose perception of wholeness and maturity is tied to the excision of a body part, and whose life is embedded in a culture that rewards or punishes her actions. While writing this thesis, it has become evident to me how the topic of

FGM makes women's body a debating ground for the fields of anthropology, sociology, psychology and public health.

Hesse-Biber (20) adds however that it would be illusionary to believe that reflexivity alone can bridge the differences that both the researcher and participant bring to the interview (20). Thus, being reflective consists of the awareness of my role in the research process and making conscious efforts to ensure that my subjective input is minimised. Keeping a research journal throughout the research process allowed me to reflect on how my thoughts, opinions, and emotions evolved over time and how these might have affected the analysis and write up of this sensitive topic. Being reflective also raised questions for my research such as: *Where do I place myself?* Can I be a researcher and have a social relationship with my women participants? What is the justification for my interest in the research topic and will it be viewed or accepted as legitimate to women it affects when I have no first-hand experience of it? Do I use terminology that suits affected communities such as '*cutting*' rather than '*mutilation*' as recommended by WHO (which is FGM)? Creswell asserts that the extent of involvement and the amount of time invested can raise strategic, ethical and personal issues (40). In this study, personal issues arose as when hunting for an interview with a woman participant, I ended up becoming her babysitter, looking after her children and picking them up from school when she was busy. In the end, she never let me interview her; she always made excuses that she was busy. Even though she was a nice lady, I had to put a stop to the researcher-participant relationship. The extremely sensitive and emotional nature of the topic and the time I put into the interviews and transcriptions represent another investment. Due to the intensity of involvement, it is becoming common practice that researchers are reflective throughout, clearly setting out their personal reasons for the research amongst other things, such as, any biases they have, values and their personal background, as these contribute towards the interpretations researchers make (40). These reflections also enable the reader to clearly see the participants' views and for their voices to be heard without my direct discussion attached to it. However, I acknowledge that my selection of quotes and authority over the data analysis and process holds some of my own meaning and interpretation, even when consciously minimised.

6.4.2. Positionality

My identity and position as a researcher were crucial, especially after I was pushed out of the circle of women that I had been in, and how these may have impacted my research was taken into consideration. My primary intention was to use the community-based participatory approach. I assumed that I had some characteristics which could give me a privileged position for my fieldwork: being a black African female, originated from a country where FGM is practised in the northern part of the country (though I come from the south).

However, I was in a tricky position because in the beginning, I did not disclose to the women why I was with them and what my intentions were. As a result, I was expelled from their group. I soon realised that it was rather a matter of being a young researcher with not much experience in research on sensitive topics. I was really disappointed that my own assumptions let me down. These experiences in the field taught me to be, right from the start, completely honest and clear to the women I intended to invite to be part of the study and not to assume that they would agree at a later stage.

I have gained their trust in the end, and I would not do it the same way if I had to do it again.

I have learnt that coming from an FGM-practising country was not enough for them to accept me as I was still an ‘outsider’ to them. In feminist research, sometimes just being a woman is not enough to give you an ‘insider’ status and it is simplistic and inaccurate to suggest gender can override all differences between women, as there are many other fixed and non-fixed characteristics that play a role (39,41). Moreover, my ethnicity and work on the role of emotion was important to reflect on as a researcher who is from outside the FGM-practising communities in Belgium. In my situation, being an outsider had some implications to consider. I was often asked what my own position and opinion on FGM was and whether I had undergone it myself. Another question that I was faced with was why I was interested in researching FGM and whether I was a medical doctor. Indeed, my position had changed from when I was expelled from the women’s group, and I took my stand as a public health professional and used the term FGM as defined by WHO. Later on, I also learned that using the term ‘practising communities’ implied blame and stigma for many women and communities. Johnsdotter (42) supports

research academics not declaring a position when trying to research from a place of neutrality as this can blur the roles between academic and activist.

There have been great discussions around women interviewing women and the advantages and disadvantages associated with this relationship. Researchers have questioned the assumptions of the literature produced by feminists on women interviewing women, highlighting its influence on the researched. Several black and South Asian women have written about their experiences of conducting research on other black and South Asian people (43–46). They had further illuminated the complexities of the research process, highlighting issues from minority ethnic perspectives, such as insider/outsider status which may arise with sensitive research topics. For instance, Phoenix (44) confirmed that being a black researcher did not guarantee her access to all the black respondents that she approached to take part in the research. In this study, I acknowledged that giving a voice to the women was not a simple task and needed to be done with respect and humility. I continue to be grateful to my women participants for entrusting me with their stories.

Scholars, such as Okumus et al. (47), Patton (48) and Shenton and Hayter (36) stress that one of the most significant pitfalls in conducting any research well is the inability to obtain access to the research field. This study was just as tricky. Gaining access to my research field was not easy and involved a lot of negotiations back and forth. The gatekeepers were of utmost help in gaining trust and acceptance.

Studies reveal that sensitive topics may unleash painful memories and emotions during fieldwork (49). However, others suggest that feelings of grief, anger and fear in response to remembering the trauma may not be harmful (50). Thus, rapport-building and trust were necessary for this study, and the gatekeeper strategy was a key element prior to interviews.

I endeavoured to be an empathic listener and not judgemental. The expression of empathy was necessary for the women participants to fully engage, and sometimes I voiced something like *'I am very touched to hear this'*. I was aware that asking a woman to recount her experiences of FGM may induce some strong feelings and emotions. It was a challenge as to know how to respond appropriately to the women's silences and indeed to manage my own emotions. In this

case, I respected the women's silences and, where necessary, suggested counselling to them at GAMS, which offers psychological support to women victims of FGM. Wengraf (2008) suggests not to rush to 'rescue' the informant by changing the topic but instead to give the informant the impression that we accept them and their expressed emotions in an empathic way (11). I noticed that the women expressed their gratitude to me because I listened to them even though the topic was sensitive and taboo.

In managing my relationship with the women who had undergone FGM, I set out my position as a researcher and at the same time, worked to establish trust with them, as the women and I both co-constructed the narrative story (51). I was comfortable myself with the topic and did not feel shy talking about sexuality. However, the women did not want to discuss further my results with them but promise to come the day I will defend the thesis. In the interest of personal wellbeing, I always discussed the process of the interviews with the psychologist of GAMS, with supervisors and with PhD colleagues.

6.5. General conclusion

This thesis has demonstrated the changing of attitudes' experience of women who have undergone FGM as they changed their attitudes in the context of migration to Belgium. This journey of changing attitudes towards the practice of FGM is complex, mediated by turning points and emotion regulation and conflict of loyalty as well as some other factors such as partners from other communities, health professionals and the women's own internal agency. Our objectives were to identify turning points that influenced the change and we strived to better understand how emotion regulation and the conflict of loyalty explain the change.

Women were primarily confronted with significant events that gave them the awareness to challenge the practice of FGM and other related norms. They made sense of the cultural identities assigned to them by the patriarchy through primary socialisation. They had been taught to suppress their emotions especially pain and view it as part of a woman's fate. However, our results indicate that the various encounters the women experienced through the events made them to experience turning points and engage in their journey towards the change. Novel findings emerged from this study regarding mechanisms that may explain the change of women's attitudes towards the practice of FGM. The journey towards the change of attitudes towards the practice of FGM was developed through 5 stages as proposed by our model (*the suppression, the awakening, the clash, the reappropriation of self and the reconciliation*). Each of the stages consists of the women's processes that were found to explain the women's attitudes to change after the turning points.

Our discussion has drawn on the capabilities approach as informed by Nussbaum. This has been broadly woven into the concept of empathy and forgiveness in the stages of re-appropriation of self and reconciliation to highlight the complex experience of change.

The *re-appropriation of self* encouraged the women to take responsibility by seeking to reconstruct their identities reconstruction and rebuild their self-esteem and self-confidence. The identification with mothers through which the women tried to reconcile with their community and could see themselves as part of the community again is culturally mediated. The forgiveness and empathy enabled this reconciling stage to be experienced.

As a process, our model is not linear. The up regulation of negative emotions which was found to be an important mechanism that prompted the women to move through this complex journey, has a mainly painful impact on them.

The implications for this thesis are pertinent to both health professionals and other professionals working with women affected by FGM to help them through their journey in the changing of their attitudes towards the practice of FGM. This is strengthened and enhanced by the combined use of the life story and grounded theory approaches in our study. This thesis has the potential to inform and support health promotion programmes which aim to produce change in attitudes in a culturally sensitive way.

“Each time a woman stands for herself, without knowing it possibly..., she stands up for all women”.

Maya Angelou

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Appendices

Appendix 1:

Agboli A, Botbol M, O'Neill S, Richard F, Aujoulat I. Transforming Vulnerability into Power: Exploring Empowerment among Women with Female Genital Mutilation/Cutting (FGM/C) in the Context of Migration in Belgium. **Journal of Human Development and Capabilities**. 2019; 21(1): 49-62.

DOI: 10.1080/19452829.2019.1661981



Transforming Vulnerability into Power: Exploring Empowerment among Women with Female Genital Mutilation/Cutting (FGM/C) in the Context of Migration in Belgium

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To cite this article: Afi Agboli, Mylene Botbol, Sarah O'Neill, Fabienne Richard & Isabelle Aujoulat (2020) Transforming Vulnerability into Power: Exploring Empowerment among Women with Female Genital Mutilation/Cutting (FGM/C) in the Context of Migration in Belgium, Journal of Human Development and Capabilities, 21:1, 49-62, DOI: [10.1080/19452829.2019.1661981](https://doi.org/10.1080/19452829.2019.1661981)

To link to this article: <https://doi.org/10.1080/19452829.2019.1661981>



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ABSTRACT This paper discusses an aspect of empowerment in relation to the central human capabilities for women with FGM/C in the diaspora. Many women who have undergone the practice of FGM/C come from societies where gender inequalities and gender-based discrimination between men and women persist, which compromises their capabilities, and many find themselves in vulnerable positions in their relationships with men, at work and in their everyday-life. The participants in this study however appeared somehow to have been empowered through certain health-promoting activities where they exercised agency in the western social context, they reside in. This paper examines the empowerment gained by the migrant women with FGM/C after participating in health-promoting activities. We compared this form of empowerment to the reinforcement of their capabilities according to Nussbaum's central human capabilities. Drawing on Nussbaum's list as a starting point we explore the relationship between capabilities and empowerment. We found that some central human capabilities appeared to be reinforced through health-promoting activities, whereas issues relating to asylum seeking became a determinant of empowerment in the women's own terms. Although the activities aimed to empower women, the participants themselves felt that they would only truly be empowered if they obtained full citizenship.

KEYWORDS: Asylum, Female genital mutilation, Capabilities approach, Empowerment, Freedom, Migrant women

Introduction

The World Health Organization (WHO) defines female genital mutilation (FGM) as a harmful practice whereby the female external genitals are removed for nontherapeutic reasons (WHO 2008). Since 1990, the Inter-African Committee (IAC) has referred to the practice as FGM followed by WHO in 1991, and they have subsequently reaffirmed the term “mutilation” in 2005 stating that: “The term FGM is not judgmental. It is instead a medical term that reflects what is done to the genitalia of girls and women. It is a cultural reality”, (IAC declaration on the terminology, 6th general assembly, 2005). However, some scholars suggest the term FGM to be highly contentious (Earp 2016; Obermeyer 1999), as it assumes that parents intentionally “mutilate” their children, despite extensive research showing that the practice is embedded in socio-cultural norms that are perceived to save and protect daughters from debauchery and temptation and to preserve the honour of the family (Gruenbaum 2002; Shell-Duncan and Hernlund, 2006). Moreover, in practicing communities, women themselves are more comfortable with the term “cutting”. Thus, throughout this paper we refer to the practice as FGM/C, on the one hand in line with the WHO classifications, which guides health practitioners in their daily practice, and at the same time showing awareness of the sensitive nature of the issue and the ethics in referring to this practice as “mutilation”.

Migration relocates women from FGM/C practicing communities to Belgium and other high-income countries for various reasons, such as war persecution, religious discrimination or politics, but also to seek protection from sexual and gender-based violence and structural gender-inequalities (i.e., forced marriage). Even though FGM/C gives women status and recognition within their family and community, in host countries like Belgium, the practice is officially prohibited and frowned upon by the general public as barbaric and savage. Therefore, women lose any positive status and recognition associated with the practice in comparison to their country of origin. The new situation they find themselves places women in a situation of disempowerment. Many women, who seek asylum in Belgium while undergoing longwinded administrative and legal procedures, attend the activities of GAMS Belgium (*Groupe pour l'Abolition des Mutilations Sexuelles*), which is the only recognized non-profit organization that offers support to women with FGM/C in Belgium. The organization also refers these women to social workers or immigration officers. GAMS uses a women-centred approach through health

promoting activities that are based on the Ottawa Charter (WHO 1986), which empower and reinforce the women by positioning them as agents of change of their own lives. Their main goal is to empower women and girls living with FGM/C and to reduce the impact of FGM/C on their health and psycho-social well-being (GAMS 2015). The objective of these health promoting activities in general is to give these women grounds to exercise their agency (strengthening capabilities to act) in Belgium. This paper focuses mainly on two activities developed by GAMS, namely group discussion and psycho-corporal workshops, which are meant to support and reinforce the empowerment of these women. Hereafter, we call health promoting activities GAMS activities.

Group discussion workshops are an opportunity for migrant women to gain awareness and reinforce learning on specific themes regarding FGM/C-related subjects. The aim of these workshops includes promoting reflective discourse among the women and encourages them to respect the opinions of others; it also provides general knowledge and social skills, as well as building the capacity and emancipation of women participants in the perspective of combating violence against women (GAMS 2015). The main idea is therefore to promote the sense of equality between women and men. The topic of FGM/C is not directly at the centre of the discussions, but other things are discussed first, therefore enabling the women to understand at a social level, their rights as foreigners, and discovering ways to find support groups which aim to raise awareness of various situations in their country of residence.

Other topics related to their personal life trajectories include the role of religion in the practice of FGM/C, the consequences and complications of genital mutilations/cutting, and various other topics that facilitate an understanding of the implications of the practice of FGM/C. The aim of these workshops is to help the women to become aware of their conditions within their family and society, to improve their self-esteem and to develop critical thinking (GAMS 2015). The women are also encouraged to appraise their daily lives and improve their living conditions and those of their entourage.

Psycho-corporal workshops deal with the acknowledgement of one's own body, the experience of its pleasure and its movements, where dance, drama, stretching, relaxation and breathing exercises come into play (D'Aguanno 2015). This leads to a familiarization and the awakening of sensations in the body and thus to awareness of their body. It is hoped that through the workshops, the women's creative forces will strengthen, and their confidence will increase as

they interact with each other and with others. The group discussion and psycho-corporal workshops of GAMS are therefore viewed as fundamental resources aiming at empowering these women. These workshops are opportunities offered to the women to live a life that they have reason to choose and value (Otto and Ziegler 2006). It could be argued that GAMS Belgium represents an opportunity for the migrant women to accomplish what they value. However, does this empowerment have the same merit from the women's own point of view? This study's aims are twofold: first, to describe the aftermath of disempowerment caused by FGM/C of the migrant women in relation to the central human capabilities, and second, to use Nussbaum's (2005) "central human capabilities" as a framework to discuss the process of empowerment for the women as experienced through the activities organized by GAMS.

Empowerment in Relation to Capabilities

The empowerment that the women experience through GAMS activities is understood as the process whereby women acquire an ability to make strategic life choices in a context where this ability has been hitherto denied to them (Kabeer 2010). This empowerment can give the opportunity for greater freedom from oppressive gender norms (Gaetano 2015). It refers broadly to the expansion of choices and actions to shape one's life (Botbol-Baum 2016; Kabeer 2010). Likewise, power is also thought of as the ability to make choices. From Kabeer's argument, the ability to make choices leads to empowerment, which can be thought of in terms of three critical elements: resources (the preconditions), agency (the process), and achievement (the outcomes of empowerment). Of these elements, agency is when power within is operationalized in relation to resources and made visible in valued achievements (Kabeer 1999). Women's empowerment is not a question of taking sole control in power relations previously held by men but transforming the nature of power relations into a situation of equality (Kabeer 2010). This empowerment of the women is exercised in opposition to a prior condition of subordination in the women's lives. When the women with FGM/C are empowered, they gain freedom to make choices in the pursuit of better influencing the course of their lives and decisions which affect them. These interrelated dimensions of empowerment together constitute capabilities, the potential that people have for living the lives they want, of achieving valued ways of being and doing (Kabeer 1999). Taking this into consideration, the importance of the concept of capabilities in relation to empowerment is significant for women seeking to attain

true autonomy and becoming the agents of their own liberation and freedom (Botbol-Baum 2016).

Empowerment then has been recognized as an important aspect of human development by Sen (1999) and Nussbaum (2011), the pioneer philosophers of the capability approach. The core characteristics of this approach is its focus on what people are actually able to do and to be (Nussbaum 2005; Sen 1999). The concept of capability conceptualizes freedom, inequalities and justice, while empowerment is widely used in areas such as education, public policy and democracy (Otto and Ziegler 2013). The capability approach is not only related to empowerment but also enables a relationship between action, reflexivity and context through the conditions required to empower individuals and to exercise their agency (Zimmerman 2006). Sen's contribution to the capability approach associates both the concept of freedom, the valuable beings and doings (functionings) and the concept of "agency-freedom", which is the freedom to bring about the achievements one values (Sen 1999). Agency-freedom is concerned with the freedom of the individual and how to augment this freedom by having further opportunity to achieve the things that one values and has reason to value (Sen 2002). Our capabilities then, tend to mirror the opportunities we have to achieve valued objectives, and expanding choices is to include valued capabilities, which involves an empowerment process (Ibrahim 2014; Keleher 2014). Thus, GAMS Belgium seeks to offer opportunities for the migrant women to achieve what they value, and what they think they should do or be; that is, their valued capabilities. The more valuable the capabilities we have, the more power we have to decide about and achieve valuable functionings (Keleher 2014). Nussbaum holds that Sen's agency-freedom can be represented entirely within the category of capability (Keleher 2014). The role of empowerment in both Sen's and Nussbaum's capability approach can be understood in terms of agency and expansion of capabilities (Ibrahim 2014). In other words, a person's capabilities can reflect the level of empowerment he or she is experiencing. The more valuable the capabilities he or she has, the more empowered he or she is. Similarly, if a person lacks certain basic capabilities, he or she may be poor, oppressed, or disempowered. Thus, Sen's capability approach offers an understanding of empowerment as the process of expanding an individual's agency-freedom or a set of valuable capabilities (Keleher 2014). As far as women's empowerment is concerned, therefore, the focus should be placed on their capabilities as their real freedoms for leading a valuable life (Robeyns 2003). Because people are essentially

different, the focus should be on what someone is able to be and to do, due to personal, social or environmental factors, such as physical and mental handicaps, talents, traditions, social norms and customs, and legal rules (Robeyns 2003). Gender inequality therefore, is to be taken under consideration when contemplating women's empowerment as a whole and particular attention should be given to each individual woman. Within the setting of this study, the capabilities framework can be used further for the analysis of empowerment and freedom when taking into consideration the experiences of the women in the context of migration.

The Disempowering Impacts of FGM/C in Terms of the Central Human Capabilities

FGM/C is globally recognized as a public health issue with damaging consequences to women's health (WHO 2008). The short and long-term physical consequences of FGM/C include severe pain, haemorrhage, infection, urinary problems, dysmenorrhea and dyspareunia (Banks et al. 2006; Behrendt and Moritz 2005; Berg, Denison, and Freitheim 2010; Vloeberghs et al. 2012; WHO2008). The procedure can sometimes lead to death or lifelong health problems, such as depression and post-traumatic stress disorder and increased risks during childbirth (Banks et al. 2006; Larsen and Okonufua 2002), and the severity of the consequences depends on the type of procedure. As with other types of violence against women, these consequences are disempowering to women and thwart their human capabilities, limiting their choices for living their lives in a "dignified way" (Nussbaum 2005). In spite of the health consequences, not all FGM/C-practicing communities see the practice as disempowering. Within their communities, FGM/C gives women and girls an identity, a certain social and adult status as well as strength and power (Ahmadu 2000; Koso-Thomas 1987). In FGM/C-practicing communities, the practice gives women a sense of pride and mothers and grandmothers gain respect for having done their duty of cultural heritage to foster an ideal, virgin young woman ready for marriage. However, in Western countries where FGM/C is not a social norm, it is argued that this puts girls and women in an inferior position and that they are discriminated against and humiliated. The inequality between the sexes is stressed as FGM/C suppresses, destroys and interferes with fundamental human capabilities because their membership in a group is defined on the basis of sex (Alavi 2003; Nussbaum 1999). In fact, the daily lives of many women and girls involve submission, hard labour and deprivation, without the possibility of participating in decision-making. Some central human capabilities such as *Life, Bodily Health, and Bodily Integrity* are

affected as a result of the consequences listed above and are found to be diminished. Trauma and post-traumatic stress disorder associated with FGM/C, such as memories of the cutting, first sexual intercourse and other health consequences resulting from FGM/C can impact on women's relationships with their partners and can lead to avoidance of sexual intercourse (Obermeyer 2006; Whitehorn, Ayonride, and Maingay 2002). Thus, women's sexual and reproductive health may be jeopardized as they cannot have full sexual satisfaction because their *Bodily Integrity* is intentionally compromised by FGM/C. This puts the women in a disempowering situation in which men strive to exert their control over the women by granting themselves the exclusivity of sexual pleasure (Black and DeBelle 1995; Gruenbaum 2002; Obermeyer 2006; Penn and Nardos 2003). According to Nussbaum's list, the capability of Affiliation also requires the social bases of self-respect and non-humiliation (Nussbaum 2005). The practice of FGM/C is performed on girls between the age of 4 and 12 and even on babies (Yoder, Wang, and Johansen 2013), without consent, depending on ethnic differences and local custom. In Western countries where FGM/C is not a social norm, it is argued that this puts girls and women in an inferior position and that they are discriminated against and humiliated.

Methods

A qualitative study was carried out with the collaboration of GAMS Belgium among migrant women seeking asylum in Belgium who had undergone FGM/C and participated in the activities of GAMS at the time of the study. They were aged between 18 and 50. Out of the 55 women who participated in both activities, 35 women met the inclusion criteria (age above 18 years old and able to speak French or English) and were approached for individual interviews by the first author who also participated in the activities. Twenty-five women initially agreed to participate in the interview between January 2014 till March of the same year. However, 16 later dropped out: six women did not attend the arranged date and time for the interviews; six women found their asylum procedure stopped and were no longer available, and four women had a trust issue relating to the asylum-seeking formalities, because they feared that the interview could jeopardize their application for asylum. As all the women were living in refugee centers at the time of the interview, it was conducted in their own room and it was related to the activities they had participated in at GAMS.

Prior to data collection, ethical approval was sought and granted by the Ethics Committee of the *Université Catholique de Louvain* (2013/21NOV/522).

The analysis focused on a thematic analytical approach based on the 10 central human capabilities. Through the participation in the health promoting activities, one or several capabilities were reinforced among the participants, and participation was thus considered to be an empowerment experienced by the women. Different capabilities were found to be reinforced throughout different workshops. Practical Reason, Affiliation were reinforced through the group discussion workshop and Emotions and Play were identified to be reinforced through psycho-corporal workshops. In addition, the asylum issue emerged as a relevant theme in relation to the women's sense of disempowerment and refers to a capability called Control over one's environment.

Findings and Discussion

The results below are presented according to the capabilities reinforced through the workshops and in the context of seeking asylum.

The Capabilities of Practical Reason and Affiliation reinforced Through Group Discussion Workshop

The capability of *Practical Reason* refers to “being able to reflect on the good and engage in critical thinking about one's life” (Nussbaum 2005). Through the activity of group discussion, the women gained insight into the consequences of FGM/C and related women's health issues. They suffered from lower abdominal pain and urinary tract infections, which they had not previously linked to FGM/C. They were empowered in the sense that they gained knowledge linking the practice to its negative consequences on women's health, which they could relate to, and by the realization that they did not have to cut their daughters. They refuted and spoke out against the tradition, and the social norms. The fact that they expanded their understanding of FGM/C better enabled them to reflect on their position in their new context, which they desired to become a part of. For example, the women became aware that contrary to what they thought before, not every woman in the world undergoes FGM/C. The group discussion workshop enabled the women to gain critical awareness of their rights, which has an

empowerment effect on them. This reinforced their *Practical Reason*, as mentioned above. Most of the women talked about having plans for their own lives and even further pursuing education. For instance, the decision to improve their level of French and computer literacy was expressed after participating in group discussion activities. Some women stressed that girls' education was not much encouraged in their country of origin. Their understanding of the importance of education was boosted. This empowerment was found to be protective (Schuler et al. 2017) in the sense that education remains the main force that enables women to have expanded choices and therefore enhances their capabilities (Arends-Kuenning and Amin 2001). According to Freire (1997, 2000) dialogue generates a critical attitude and true dialogue cannot exist unless the dialoguers engage in critical thinking. In this study, the interaction between the activity moderators and the women in the workshop setting developed critical consciousness, which generated some sort of liberation (Freire 2000). The practice of FGM/C itself is often a taboo subject, which places women in a culture of silence; as a result, most women with FGM/C are not aware of the negative consequences of the practice. They learnt to disclose their feelings and the learning they acquired, supported the reinforcement of the capability of Practical Reason. This capability is about engaging in critical thinking about one's life and critical thinking is at the heart of empowerment.

The capability of Affiliation refers to: "(a) being able to engage in social interactions, (b) to be able to be treated in a non-discriminative way and as equal to others" (Nussbaum 2005). Affiliation involves appropriate interactions with other people including interactions with people who are different from us. It also involves caring for other people and attempting to protect their well-being (Nussbaum 2005). Women engaged in social interactions and this capability was reinforced as most of them emphasized that the group discussion workshop at GAMS helped them to enlarge their circle of acquaintances. Through these workshops the women acknowledged that they were equal to the other participants; meeting other women from their own country or other countries allowed them to exchange on an equal basis and to make friends. This helped to alleviate other problems they were facing. Seeberg and Luo (2018) found in their study on rural migrant Chinese women in the city that social relations were an important resource which generated new functionings.

The women's capabilities were enhanced through their relations and friendships. Looking at gender inequality, Robeyns (2003) suggested that capability of *Affiliation* is an important

capability for social networks. In our study, the women's sense of independence was developed through a "*sisterhood-bonding*" effect as they tried to have some fun together. Some women became friends with women from other ethnic backgrounds from non-FGM/C practicing communities and even though they had not undergone the practice, they accepted each other with respect. Such interactions allow the exercise and development of *Practical Reason* and the making of more inclusive and informed decisions (Nussbaum 2000).

The *Capability of Emotion and Play* reinforced through the Psycho-corporal Workshop

The capability of *Emotion* indicates: "to be able to love, care, grieve and experience longing, gratitude and justified anger; not to have these emotions inhibited by fear, abuse, anxiety or neglect" (Nussbaum 2005). Through the psycho-corporal activity, the women in the study were able to reconcile with their own bodies through touch, which helped them to become more comfortable with their body. They were able to express their understanding of the cleanliness and purity with regard to their genitals. They learned to challenge the internalized conception that uncut genitals were impure. The participants talked about their limited opportunity to love, as most of them were forced into a marriage, some mentioned fear and sleeplessness. The capability of Emotion was explored among migrant women in a study where the term love was not part of the women's language, because romantic love was shameful and disgraceful (Uyan-Semerci 2007).

Showing love was inappropriate for these women; however, they expressed feelings towards their parents and children, which were socially acceptable (Uyan-Semerci 2007).

Some women reported feeling relieved through the psycho-corporal workshops as they were able to speak freely and were encouraged to feel free to talk, or to be silent and were able to manifest any emotion they wanted. Some were able to sleep better at night after relaxation exercises and participating in the psycho-corporal workshops and they reported that they saw changes in themselves. They indicated that they were doing things they could not do before, such as "sleeping well without fear" and "being able to have eye contact when talking to someone".

The capability of *Play* refers to: "*being able to laugh, play and enjoy leisure activities*" (Nussbaum 2005). The women compared their lives before applying for asylum with the difficulties they were encountering during the asylum procedure. They described their loss of

joy and the ability to laugh. However, they were able to engage their bodies and express joy and laughter during and after the psycho-corporal workshops. Similarly, Robeyns (2003), mentioned leisure activities to be an important means of relaxation, pleasure and intrinsic aspect of well-being. Even if they did not speak French accurately, their embarrassment decreased through the interactions of drama play. The women danced and enjoyed role-play and painting activities. One woman expressed her feeling as:

I'm so well and laugh at ease and even my daughters see that I can laugh when telling them what I have been doing at GAMS...sometimes I play the drama for them.

The engagement of the body manifested itself in self-confidence and in a change in their bodily attitude during and after the psycho-corporal workshops. Most of the women interviewed reported feeling more confident in their bodies and their self-esteem was boosted.

The physical exercises performed during the sessions enabled them to feel and recognize their own bodies, and to be aware of the anatomy of the body. The acknowledgement that their bodies belonged to them was reported by all the women. The workshop sessions enabled them to make peace with their body by touching and feeling the body as it is. The self-confidence that had been lost and the confidence in others were regained by learning that they had the right to say "no" if they did not want something. It could be argued that having gained confidence in one's body is significant and may represent the beginning of change of one's perception that could influence one's own body image. Studies on vulnerable women who have a disability found an association between gender, body image and confidence (Calogero and Thompson 2010; Peuravaara 2012). Regaining confidence in one's body indicates changing one's position in society (Peuravaara 2012). Women's self-esteem in this study was more closely tied to their body esteem and they showed their satisfaction by being part of this workshop. This is a sign of empowerment experienced through self-confidence and self-esteem (Botbol-Baum 2016). Njambi (2004) considers the gender differences as well as the lived experiences of women in a patriarchal culture and suggests that women's bodies can be very important to their sociocultural well-being. In this sense, the participation in the psycho-corporal workshops provide a different way to view the body as a tool to promote a healthier body image (Brennan, Lalonde, and Bain 2010). Women with FGM/C in this study reported feeling good in their

bodies after each psycho-corporal workshop. Similarly, evidence supports outdoor activities as an avenue for women and girls seeking to realize their goals and gain a sense of self-worth (Angell 1994).

The Capability of Control Over One's Environment Diminished Because of the Asylum Issue

The capability of Control over one's Environment refers to: *"being able to participate effectively in political choices that govern one's life; having the right of political participation; and also being able to hold property (both land and movable goods), and having property rights on an equal basis with others; having the right to seek employment on an equal basis with others"* (Nussbaum 2005). The women with FGM/C in our study found themselves in migration context. Some had fled their country of origin to protect their daughters, others fled from war and some because they wanted to be reunited with their family in the host country. For this reason, migration makes it possible for migrants to extend their cultural practices in their host countries (Leye and Sabbe 2009). Many migrants find themselves in some vulnerable situations because of their immigration status, gender or ethnicity (Askola 2010). This vulnerability corresponds to the experience of being affected by the difficulty to act for oneself and, as a result, places the individual in the situation of being for others, in order to find *"the I am as well as the I can"* (Botbol-Baum 2016). Their vulnerability requires special protection, acknowledgement and fulfilment of their needs. In Belgium, the process of immigration allows for women who report a risk of the mutilation/cutting for their daughters, re-infibulation for themselves or gender persecution to apply for asylum at the Immigration Office in accordance with international, European and Belgian standards (Dieleman 2010). Girls or women who are at risk of or who have been subjected to FGM/C with a well-founded fear of persecution qualify for the status of refugee according to the Geneva Convention of 1951, article 1A as, "persons who have left their country of origin because they were persecuted for their nationality, race, political or religious beliefs or membership of a particular social group". In the case of FGM/C, which is gender-based violence, the particular social group is "being a woman" (Chevalier 2016). After registration at the Immigration Office, the girls and women asking for asylum are sent to a reception centre for asylum seekers (GAMS 2018). Their application for international protection is examined by the Commissioner General for Refugees and Stateless Persons (CGRS) and they will have to go through one or several interviews. The CGRS pays particular

attention to situations and realities that especially affect women. The women must convince the asylum authority, which requires a detailed account of their life events that led to their exile and where contradictions in their stories may lead to a refusal of asylum. Furthermore, women have difficulties to consistently reveal what they have suffered. Indeed, sometimes there are limitations posed by the memory of traumatic events because women are not used to discussing this aspect of their life. Contrary to other Western countries, where the legal system is not gender-sensitive, the number of women aged between 14- and 64-years seeking asylum on the basis of FGM/C has risen sharply in Belgium since 2008 (584 in 2008 against 1605 in 2011), and the granting of asylum on this basis has increased from 154 positive decisions in 2008–360 in 2011 (Chevalier 2016). The stress about the asylum procedure and the difficulties encountered while living in reception centres are also disempowering for them. Almost all the women in our study emphasized that they wanted to be helped with their asylum applications. The women interviewed mentioned that getting refugee status could give them the opportunity to seek employment. At the time of the interviews, this therefore appeared to be a priority, more so than FGM/C in itself, because women saw FGM/C as something that had happened to them in the past and which could no longer be changed. The current uncertainty of their refugee status in Belgium, however, was something that the women judged to be disempowering according to their own sense of empowerment. The refugee status also symbolized their integration into Belgian society. This represents a form of Control over one's Environment on the central human capabilities' list, as it would give them the right to seek employment on an equal basis with citizens as well as other residents. It would give them the ability to earn an income, enjoy a rewarding work life and increase their bargaining power in the employment market (Arends-Kuenning and Amin 2001). The materialization of empowerment and freedom at the time of the interviews was the hope of holding a refugee status document in their hands. The refugee status would give the women the right to vote, to seek employment, get more education and expand their life choices. One woman particularly concerned about her asylum application during the interview stated:

...getting the papers will allow me to look for a proper job, go to school to become a nurse as I always dreamed. Because I will have the same rights as Belgians. You know, if I want to become a nurse to care for children and build an orphanage and I know that dream will come true if I become a citizen one day...

Discussion

In this study, the women's awareness of their basic rights constitutes the first step towards empowerment. These women also gained empowerment through the individual support they received at GAMS in addition to participating in the workshops. Their acknowledgement of their right to be protected and being granted refugee status was important to them in the reinforcement of their capabilities. The practice of FGM/C within the definition of gender-based violence, is understood to be a form of discrimination and a violation of the fundamental freedoms of women by the Council of Europe (Middleburg and Balta 2016). Women with FGM/C require special protection that must be acknowledged and fulfilled as they are survivors of the practice (Middleburg and Balta 2016). The refugee status is a form of freedom, a political right, and a claim for justice, since FGM/C is understood as a form of torture and a violation of women's bodily integrity (WHO 2008). Freedom is a valuable empowerment concept that can be used to identify one's robust level of participation and what one can control directly. The migrant women in this study valued and wanted their refugee status documents, therefore they wanted to take control of their lives in order to exercise what they value as "effective freedom". In this case, this will give them more power and more freedom to lead the lives they will choose to lead (Sen 1999). Furthermore, Keleher (2014) stresses that effective freedom is linked to our objectives being achieved as well as the ability to control how these objectives are achieved. The freedom of these migrant women relies on an implicit and social background of habits (Zimmerman 2006). In our study, these habits (for example, how the women saw themselves in their country of origin) play a necessary and paradoxical function of enabling the conditions of freedom to transform a socially constructed vulnerability (FGM/C) into a desire for emancipation and thus social empowerment (Zimmerman 2006). In this case, the women's claim of effective freedom would be for their country of residence to grant them full citizenship, since this is in line with their choice. If these women were granted refugee status, their newly acquired rights in the host country would reinforce their capability to exert *Control over their Environment* and this would contribute to their empowerment as well as improving their quality of life (Woodward and Barbour 2009). For the migrant women with FGM/C their empowerment does not conform with the policies of immigration in Belgium. Thus, despite participating in health promoting activities that aim to empower them, these women feel that actually obtaining

legal status and full rights would be even more empowering to them. Despite not feeling fully empowered themselves, women felt that they were in a better environment for their daughters, an environment where the practice of FGM/C is frowned upon and illegal and where they are protected from this practice. However, when it comes to freedom and empowerment, the women's understanding of their experience of disempowerment/ empowerment goes beyond what GAMS-Belgium can offer them. The important difference here between the concepts of freedom and empowerment is that the capabilities approach addresses the range of possibilities that these women can achieve on arrival in Belgium. These possibilities include knowing their rights, as well as the actors they need to address when in need of help and support.

Nussbaum's (2005) list of central human capabilities was also applied in a study among migrant women from a subaltern region into the city of Istanbul to explore their desired capabilities in their own terms (Uyan-Semerci 2007). These women, just like the migrant women in this study, understood empowerment in their own way and they verbalized their sense of empowerment in relation to what they were able to give to their children rather than in terms of their individual freedom (Uyan-Semerci 2007).

Conclusion

This paper uses the central human capabilities to explore the empowerment experienced by migrant women with FGM/C in relation to the activities organized by GAMS-Belgium. The activities of psycho-corporal and group discussion workshops organized by GAMS in Belgium appeared to reinforce four central human capabilities:

Practical Reason; Affiliation; Emotions; and Play among migrant women who had undergone FGM/C in their home countries. However, how women defined empowerment in their own terms differed in this context, since it was their *Control over their Environment* achieved by receiving their papers which emerged as an even more important element of the women's freedom, making this the priority to be resolved. For the women, the capabilities to function, the opportunities available for them in the host country to engage in decisions and actions of their choice and to be whom they want to be, just like other citizens, constitutes what would make their lives more valuable. We argue that it is important to understand how women view their own empowerment. Though the sample is small, the article provides important insights into how empowerment can be linked to citizenship. From a theoretical perspective the gender

violence dimension may be perceived as more important; however, this research shows that in fact, rather than intact genitals, women feel that full citizenship would be truly empowering. In our study, not all the capabilities on Nussbaum's list were reinforced through the activities. However, the central human capabilities framework used in our analysis appeared to be a helpful instrument to capture what is at stake for women with FGM/C in creating a turning point from vulnerability into power in their pursuit of freedom through the refugee status in their Western host country. Indeed, for these women in exile, their capabilities involve above all, the recognition of FGM/C through which they can obtain refugee status. However, the capabilities approach may turn the vulnerability into power for the women, since it emphasises the importance that these women set their own priorities. This study shed light on the influence of the context in the development of capabilities as stressed by Robeyns (2003). The women in our study drew their own list in terms of priorities and what emerged was the importance of *Control over their Environment*, gained through their refugee status. Gaining this status was an absolute priority and it came before everything else. Their refugee status is meant to contribute the most to their *Control over their Environment*, and thus reveals their empowerment.

In our study, as we have identified that different capabilities were reinforced by different activities, there is a need to develop more activities and resources in the perspective of health promotion and empowerment. The support GAMS now offers has expanded from 2 social workers (at the time of the study) to five social workers, expanding the potential to give individual support and helping women with asylum procedures. In addition, in 2017 GAMS developed a tool of Trajectory FGM & Asylum and also trained two staff at each reception centre (Fedasil and Red Cross Belgium). Although GAMS cannot give papers to the women as far as their framework of competencies are concerned, GAMS rather takes into account the need for security and recognizes the role of empowerment given by refugee status.

Further research is needed to explore the applicability of the capabilities approach with FGM/C and empowerment in other situations, where women with FGM/C in the diaspora are not asylum seekers or are no longer in the asylum process because they have been granted their refugee status.

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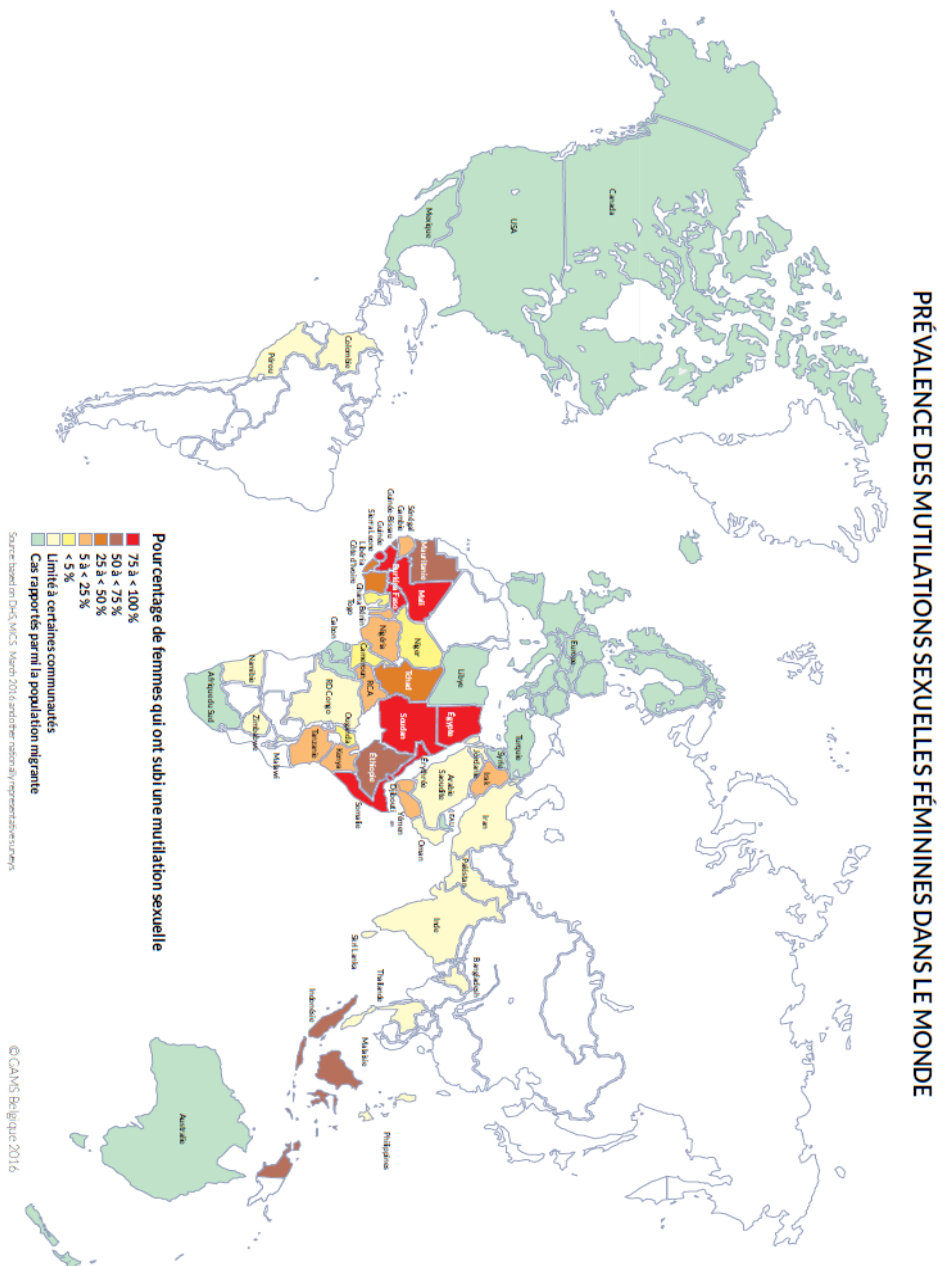
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Appendix 2



Appendix 3: vignette

A fictive vignette of a typical reconstructed story from different participants after the 1st and 2nd interviews.

All names and some identifying details have been changed to protect the anonymity and confidentiality of the migrant women.

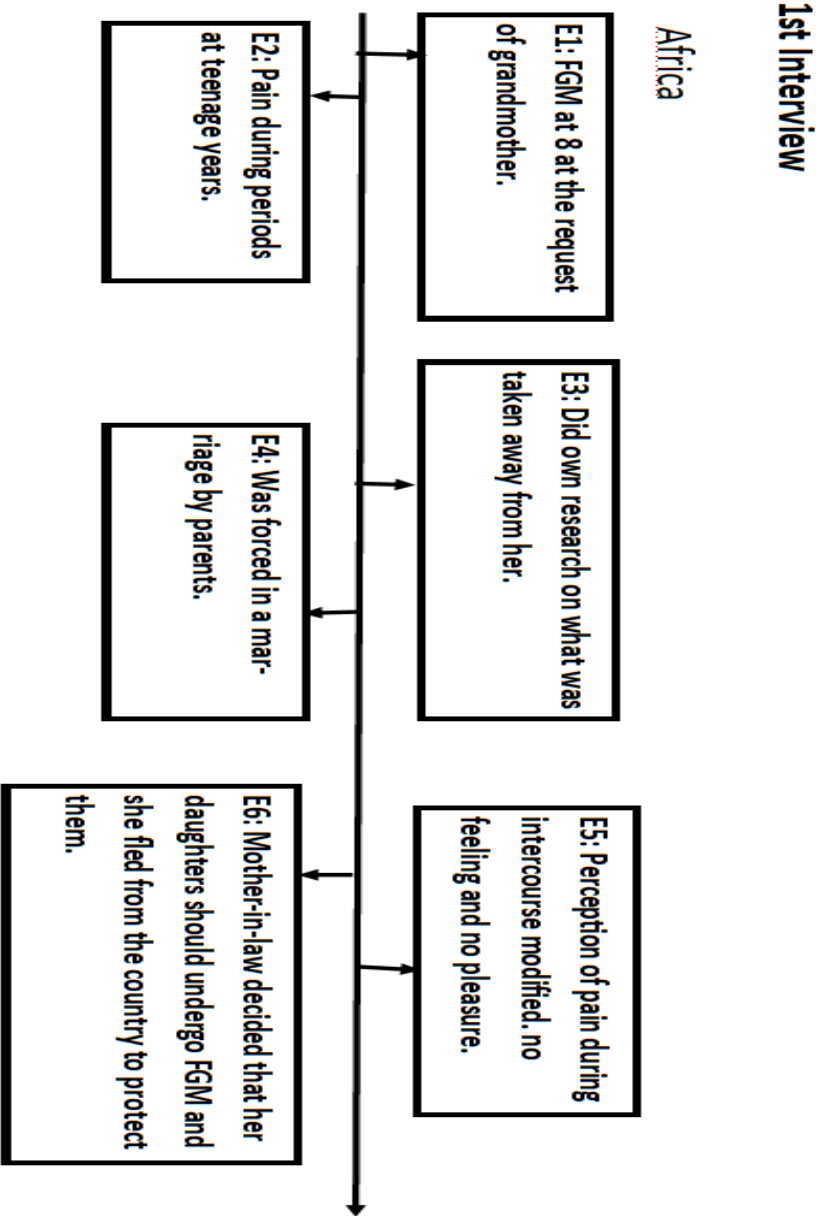
1st interview: Sarah (fictive name) was 42 years old at the time of the interview and came from a high prevalence FGM-practicing country. She has been living in Belgium for nine years after her refugee status has been granted. She has two girls and two boys all born in her home country and fled from there because her mother-in-law put pressure on her and had arranged for the girls to undergo the practice of FGM. She remembered her own experience of the procedure and felt the pain for her daughters.

She had to hide and contacted a smuggler who helped her through until she got into the country. Her stay in the asylum seekers centre after her arrival in Belgium made her to be confronted with the noise of urine in the bathrooms from other women from other ethnic backgrounds. She realised she was different, and she cried.

Her own experience of FGM was back to when she was eight years old, and she underwent FGM at the request of her grandmother who told her that she would become clean and important in the community. The feeling afterwards was extreme pain, hatred and loss of something instead of gaining something even though she received lots of presents. She suffered a lot of period pain during her teenage years. She went through forced marriage and described the sexual intercourse as nightmares as it was very painful to the point, she does not have any desire for it at such. Her child delivery came along with painful labour too, and she understood the link with FGM.

2nd interview: Sarah expanded more about her sexual experiences for not being fulfilled. She saw it as part of herself as a woman and mentioned that she was taught otherwise to endure pain as part of her fate, but thought she was entitled to pleasure and desire, not pain. She also reported the urgency she felt to protect her daughters and reflected on her own trauma experiences. Thus, she wanted to be a good mother for them. So, she took action to flee from the country and later became an activist to fight and protect her daughters until they become adults.

Lifeline for the 1st interview with few events: E represents events



2nd interview: More events - confirmation of TP- new TP

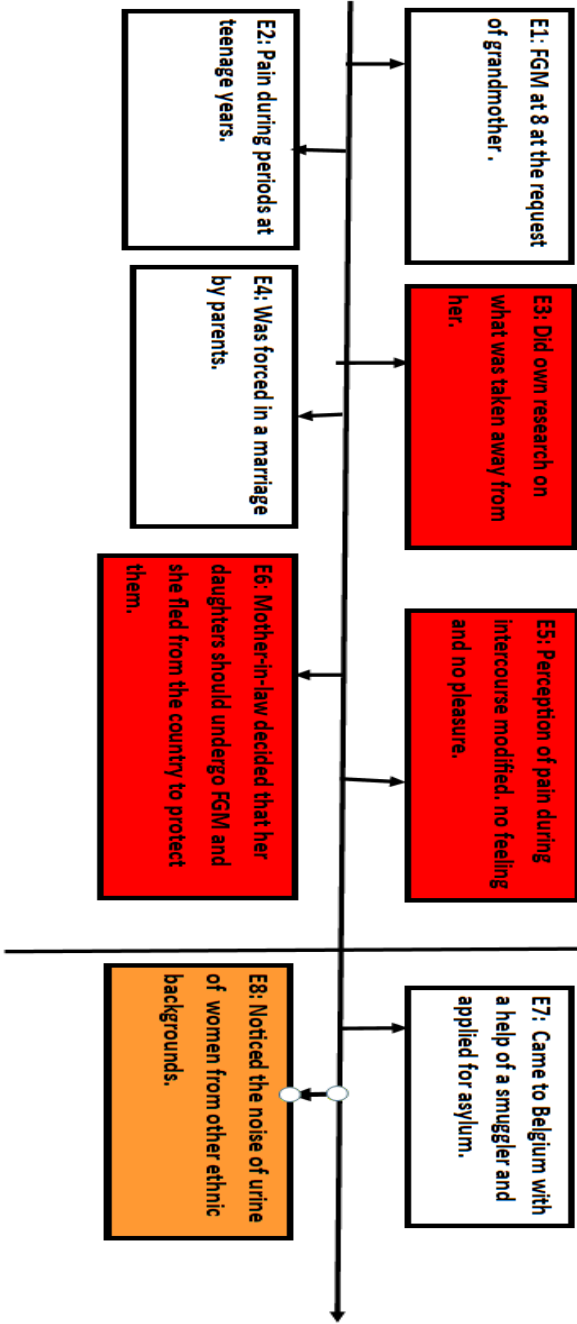
 TP in the home country (confirmation of TP)

 TP in Belgium (new TP)

2nd Interview: Confirmation of TPs and new TP

Africa (high prevalence FGM country)

Belgium



Appendix 4: Interview guide with general questions

Interview guide

Thank you for your time and participation in this interview. It should last about 1 hour. The aim of the interview is to identify in the life stories the significant events that influenced the change of attitudes towards the practice of FGM.

First interview

Could you tell me about your life experiences, and in doing so, include any story in your life that you think important? You can start wherever you want.

Second interview

The purpose of the second interview is for the women to confirm the hypotheses of turning points, to narrate more events, to identify other relevant turning points and to complete the lifelines together with the women. The second interview was guided by semi-structured questions that were unique to each woman according to their initial narratives.

-Please could you confirm the hypotheses of *turning points* raised after the first interview?

-Could you tell me more of any event you think that has contributed to any awareness towards the change?

Based each woman's life story

- What led you to question excision?

-Growing up, what do you think the reason was?

-How do you position yourself regarding FGM now?

-How do you feel about it now?