Competing loyalties
The case of female genital mutilation

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In this paper we will demonstrate that access to, or being part of a group or culture is not by definition beneficial to an individuals’ health. We will do so by considering the findings of a study into the psychological, social and relational consequences of female genital mutilation (FGM), which was conducted in 2008-2009 among women of African descent now living in The Netherlands (Vloeberghs et al., 2010). The authors, working for Pharos (the Dutch Focal Point for the eradication of FGM), promote the idea that belonging to a group can have both a positive and a negative outcome and that the relationship between an individual and a group is as dynamic as culture. Sometimes stigmatization causes feelings of not being fully part of a group. Or the group may expect loyalty to a cause which the individual has abandoned following to migration and because they now have additional knowledge about that cause. Immigrants, or their offspring, living in the Netherlands may tend to choose other loyalties or reference groups. With regard to Female Genital Mutilation, belonging to the group that is in favour of abolishing the practice may invoke the disapproval of family members and more traditional persons within the ethnic community to which one belongs, and vice versa. When a woman from the Sudan, or from Somalia or Sierra Leone visits family in her country of origin, she may experience conflicting loyalties.

Female Genital Mutilation

Female Genital Mutilation (FGM) is a harmful traditional practice involving the external genital organs for which there is no medical necessity. FGM currently occurs in large parts of Africa (i.e. within the triangle delineated by Guinea, Egypt and Kenya), and in East Africa in particular. In Somalia as many as 98% of women aged between 15 and 49 appear to have been circumcised. In addition, FGM occurs in parts of Asia (Indonesia) and the Middle East (Kurdistan, Yemen) and has recently also been found to occur among groups of immigrants in Australia, North America and Europe.
There is a higher incidence among Muslims, but the custom itself is not Islamic, as victims of FGM may also be found among Coptic Christians (De Lucas, 2004). According to estimates by the World Health Organization, at present some 100 to 140 million women and girls worldwide have undergone a circumcision. In Africa some 3 million girls annually are at risk of being circumcised – which comes down to 6,000 to 8,000 girls per day.

Parents have their daughters circumcised assuming this will secure their daughter’s future, because they fear uncircumcised girls may not be able to find a partner in marriage. Being eligible to marry is very important as is collective pressure; because everyone has their daughters circumcised, everyone has to conform. Research has shown that those who adhere to the custom gave the following reasons for doing so:

- It will increase a woman’s chances of getting married (Fokkema & Huisman, 2004).
- It will protect a girl’s virginity and marital fidelity (Johnsdotter, 2003; Rahman & Toubia, 2000).
- It contributes to the marking of both female and male identity (Bartels, 1993; Van der Kwaak, 1992).
- It gives women a certain status within the community (Van der Kwaak et al., 2003)
- Infibulated women are beautiful and sophisticated (Lightfoot-Klein, 1989).
- It is (supposedly) a religious precept (Johnsdotter, 2003, 2007; Lightfoot-Klein, 1989; Van der Kwaak, 1992).

The circumcision is usually carried out before the girl has reached puberty, but may also be done at a later stage. On a societal level FGM may mark a transition (rite de passage), one’s identity (to become a woman) and a guarantee of belonging to an ethnic group, including social control over fertility and often a duty of confidentiality (taboo). Control over women’s sexuality by men is often the underlying reason. Within a community in which FGM is practiced not being circumcised may have significant (psycho)social consequences for a girl. She may be considered unclean or she may be suspected of being sexually promiscuous. An uncircumcised woman will bring dishonour to the family, risks being expelled and has reduced chances of getting married.

It is becoming increasingly evident that women and girls living in the Netherlands are also circumcised (Van der Kwaak et al., 2003). In total there are about 31,000 adult women from at-risk countries living in the
Netherlands who are either at risk of being circumcised or who have already been circumcised (CBS, 2009). Estimates vary, but it is thought that annually about fifty girls become the victims of circumcision.²

In the Netherlands and many other countries FGM is forbidden and considered hidden violence against girls and women. FGM can cause a range of problems: health-problems, sexual and psychological impairments and relationship problems. Since 1990 the struggle for the elimination of FGM has intensified. To this end Western countries are strengthening their penal codes while at the same time informing the at-risk ethnic communities and taking preventive measures. Things have also changed in the countries of origin: these days FGM is forbidden in most countries on the national level as well as by international law. All this has met with varying rates of success, since FGM is a deep-rooted practice. An Eritrean respondent recalling her latest visit to her country of origin said:

My sisters and brothers are now against FGM. But the older family members, uncles and aunts ... are still in favour. But the government campaign is heading in the right direction in Eritrea. Now, whether we like it or not, FGM is prohibited. No turning back ...

All in all, in twenty years’ time what once was considered normal, not even negotiable, has now become abnormal, something deviant, unhealthy, morally reprehensible and punishable (Johnsdotter, 2009). This raises questions such as: what impact does this change have on the relations between members of their ethnic community in the Diaspora, and on their loyalties? What about women’s relationships given that they are part of Dutch groups? Do these immigrant women now feel more accepted and part of Dutch societal life? How do they cope with the conflicting views and demands when they visit family in the country of origin? In short, how beneficial is membership of these distinct groups to a circumcised woman after migration?

Veiled pain

In 2008-2009 a study was conducted involving a sample of 66 women, aged 18 to 60 years who had migrated from Somalia, Sudan, Eritrea, Ethiopia or Sierra Leone to live in the Netherlands. The study used a mixed method to explore the psychological, social and relational consequences of female genital mutilation. Four standardized questionnaires (HTQ, HSLC-25, LAS and
Competing loyalties and a topic list interview were administered by female interviewers from the same ethnic group who had been selected and trained by a team of researchers from Pharos, Foundation Centrum '45 and the Royal Tropical Institute. The semi-structured interview contained items such as: the woman’s own experiences, the influence of migration on the meaning and experience of FGM, sexual conduct and their relations with Dutch women, care providers and others. A number of Focus Group Discussions were held with members of the target population. Coaching and monitoring of the interviewers was undertaken in close cooperation with the Federation Somali Associations Netherlands (FSAN) and other community women organizations.

According to the quantitative datasets, sixteen per cent of the respondents may suffer from PTSD while one-third reported symptoms related to depression or anxiety. The qualitative data provide useful information about the women’s feelings of doubt, shame, guilt, anger and isolation and how they deal with these feelings. The study included questions about being part of certain ‘groups’ in relation to being genitally mutilated. The researchers asked about their relationships with women in the Netherlands who have not been circumcised. We questioned the women about the influence changing views on FGM due to their migration had on relationships at home, and with the members of the extended family. In addition, the study conveyed information about the women’s relationships with other immigrant women in the Netherlands, including those from the same ethnic background.

In the context of this paper we will separately examine three different reference groups to which a mutilated immigrant women belong or which they have access to: as members of a group of immigrant women with a common ethnic background; as women belonging to different groups in the Netherlands; and as members of an extended family, some of which are still living in the country of origin.

Relationships within the ethnic community

It is common knowledge that migrants often attach more strongly to traditions than people living in the country of origin. With regards to FGM that does not seem to be the case. Migration to the Netherlands has led to a major shift in how FGM is regarded. Very few respondents had a daughter who had undergone mutilation since their arrival in the Netherlands. The stream of information provided by the media as well as awareness
campaigns and meetings among members of the communities has made the women more knowledgeable about the consequences of FGM. To many, learning that it does not say anywhere in the Quran, Hadith or Bible that women should be genitally mutilated, has fuelled the resistance.

As Pharos is involved in the fight towards the elimination of FGM and as it has close relations with many (key) individuals within the various communities, it often participates in focus group discussions, meetings and events. Time and time again women are heard to say how much they feel supported when they are together. They rejoice in taking part in cultural events, being amongst themselves, celebrating the ‘good things’ of their culture – as one respondent called it. The ethnic women’s organizations offer emotional support to their members. The women share experiences, break through taboos and help make the decision to counter pressures from family. During interviews, respondents from all ethnic groups unequivocally said: ‘I have learned to talk about it.’ Some report they did not allow their daughters to undergo FGM because of the information they received during meetings with other women from their own community. Later on in her interview, one of them said: ‘you feel more free here. I’m not afraid to say what I think about FGM.’ Being part of such a group empowers the women.

But it is also clear from our research that the topic of FGM may divide the ethnic community as a group into opponents and proponents of the practice. Two respondents indicated it would be unwise to advocate too strongly for the abandonment of FGM and that it would be better to keep low profile. Key informants from within the community who are very active in promoting the total eradication of every type of female genital mutilation, may encounter problems with fellow community members. One of them, a Sudanese woman, replied to the question as to how she was regarded by her companions, since she talked so openly against FGM: ‘They see me as a renegade. I have given up the traditions. And some people think I am very emancipated, and they very much disapprove of that.’ Crossing the line and committing yourself too much to a Western, liberated reference group can result in a woman being excluded from her own ethnic group.

Relationships with Dutch groups

In general, most women experienced being part of Dutch society as beneficial; overall, they are glad to be in the Netherlands (and safe) and claim not to feel homesick very often. As is apparent from our study, women who are in a job or who participate in groups in the Netherlands (as volunteers or
while studying) report less depression and anxiety. Moreover, the younger the women are when migrating to the Netherlands, the less psychological problems were reported. Being involved with Dutch (or mixed) groups and doing all kinds of activities is beneficial to their health. Still, some respondents would rather remain among themselves and not mingle with Dutch groups due to the language barrier.

Quite a number of the respondents appeared to be opponents of FGM. Most women felt supported and safe when talking about FGM in company of Dutch people who showed respect for the women and who talked about the practice with knowledge and understanding. Positive stories were told about general practitioners as well as neighbours or Dutch friends who took the time to listen to the women’s stories. However, on many occasions the respondents also reported feeling outsiders and being stereotyped.

When in contact with Dutch women, some respondents said they felt confronted with their own impairments. Dutch women speak out openly about relationships and sexual pleasures, which was strange to respondents and alienated them, since their experiences are so different. In company of Dutch women and girl friends who talked about sex saying how much they enjoyed it, young respondents found it hard to share their experiences. These situations created feelings of isolation and otherness despite being member of that occasional group. Hence some women simply deny that they have been genitally mutilated when questioned by somebody from outside their own communities. One respondent admitted she denied being mutilated from the moment she heard from her Iraqi roommates, at the asylum seeker centre, that not all Muslims practise FGM. It felt like a major blow since she had been told that FGM was a religious precept.

The isolation can be twofold: women may isolate themselves, staying home, not willing or not feeling mentally capable to continue having contact with Dutch women. This is an active choice on their part. Or they may be excluded from the group they are in by other members of that group. The latter is an act forced upon them by others. A young respondent, still studying, answers the question of whether she talked about FGM during her programme of studies as follows: ‘They all hung on my lips, and then all the questions they asked … It was terrible. Some said it is gruesome, some found it disgusting and others found it inhumane. That was the only time I talked about it with anyone outside of my culture.’ The isolation resulted in the woman (temporarily) not sharing her views and feelings with the members of the group. Also, as is known from research by social psychologists, if people are not addressed at as a person but as a member of a group about which there exist negative expectations – as is the case – this kind of
subtle discrimination has a negative influence on the motivation and performances of the person. It may lead to ‘stereotype threat’ (the risk of confirming a negative stereotype about one’s group as self characteristic) and when directed to oneself, to avoidance behaviour, anxiety and depression (Steele & Aronson, 1995; Knipscheer & Kleber, 2008; Stroessne, Good & Matheson, 2011; Inzlicht, Tullett, & Gutsell, 2011).

**Within the family**

Most respondents maintain contact with their family back home by telephone. Some go on holiday to meet up with family. Women from all groups of respondents indicated that the situation within their own nuclear families was quite different now compared to living with the extended family in the country of origin. One respondent recalling her mother visiting the Netherlands answered the question about how important FGM was to her mother as follows:

**Eri 12:** She still approves of circumcision. When she saw the girls in our street trot around and act out in front of boys, she said ‘those girls need to be circumcised, that will calm them down a bit.’

**Interviewer:** Is it important what she thinks about it?

**Eri 12:** Well, no. She was brought up with that mentality. They (i.e. the family back home E.V.) don’t know any better.

Some of the Sudanese, Somalian and Eritrean respondents said that the fact they were genitally mutilated made them feel angry with their family. They found it particularly difficult to understand why they had been submitted to this harmful practice for no valid reason at all. Most of the times however, immediately after expressing their grievances about this, feelings of loyalty to their family would prevail, and they would say: they did what was supposed to happen, it was done with good intentions, they couldn’t act differently. Nevertheless those haunting memories would cast a shadow over the visit, and relations may be under some pressure if a respondent visits her family.

A few times trouble was reported by respondents when they visited family back home accompanied by a daughter, or when family members coerced their daughters into being circumcised during their stay in the home country. All respondents, except one, explicitly stated that they were opposed to having this done to their daughters, knowing it may cause dismay among family members in the home-country. In two cases such a situation led to
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seriously escalating conflicts while in another situation it caused a break with the family back home, and a long-term breakdown of a woman’s relationship with her daughter.

In two other cases the visiting mother had been kept in the dark about the fact that their mothers-in-law (and their own husbands) were trying their utmost to have the respondents’ daughters circumcised during a visit to the home-country. A Somalian respondent indicated feeling sad because her daughter underwent a circumcision in the country of origin at a time when she was not present. It was done ‘against her wishes’. Another respondent from the same group recalled: ‘I was away on a trip when my mother had her [my daughter] circumcised. But I didn’t want that.’

Typically, it is often the mother-in-law who has a say in these matters. They have a crucial role to play when it comes to their grandchildren being circumcised. Sometimes they are very strict in that the girls need to be circumcised and that ‘is a big problem, because nobody can say No to her.’ A Sudanese respondent had the following experience:

**Sud 4:** I told my mother-in-law that I did not want to allow my daughters to be circumcised. She did not agree with me at all. She said my daughters were her daughters – and that she didn’t care what I thought about it. So I kept my mouth shut, because you have to listen to your mother-in-law, otherwise your marriage will be hell and you might even get divorced. She said I’d only be allowed to organize the party, buy my daughter clothes and gold, because she was going to be circumcised. I tried to postpone the circumcision as long as possible and in the meantime I went to see my family to discuss this with them. But my mother also felt that my daughters should be circumcised. So I met opposition from both sides ...

She eventually managed to persuade her husband and saved her daughter from submission to the ritual. To this respondent: ‘fear because of the girls being circumcised was one of the reasons we fled from Sudan.’

But it was also clear from the interviews that changes are taking place in the country of origin. According to all respondents these days most girls will undergo a less severe type of circumcision than before. The latter has much to do with the efforts taking place in the countries of origin. Through different media channels and as a consequence of information meetings in the villages the message is spread that FGM is unnecessary and forbidden.

In three cases it was reported during the interviews that a circumcision of a daughter (2) and a niece had been cancelled. In those cases the mothers
were backed up by other family members or the husband agreed to oppose his mother’s wishes. These women talk with much pride about these victories. One of them, an Eritrean woman, said: ‘I learned to say no. And I saved my girl from being mutilated because of my knowledge about FGM.’

Conclusions
There is no univocal relation between improved health and having access to or being part of a group. Having access to or being part of a group has advantages but may also cause problems. The impact on the women of the three different groups to which the respondents belong, proved to be negative at times, positive at other times. The process within these groups is dynamic and can be full of contradictions, competing loyalties, and can even be confusing for its members, depending of the different contexts, power positions and interests people have. Being part of a group can be supportive as well as oppressive, with all the consequences for health and well being. People’s loyalties may change depending on the context. People act in a strategic way, trying to deal with what they feel is right and what they feel should be done with the relationships within and dependencies of the groups to which they belong.

The women we interviewed had undergone genital mutilation. In the Netherlands as in many other countries in the world, including countries of origin, people are now trying to eradicate this harmful practice. It mutilates girls and women and breaches their fundamental rights. The question may be asked which lessons can be learnt from the above analysis that can be useful in the struggle against FGM? We consider three aspects regarding group-influence and group dynamics: firstly, (and we also know this from good practices in Africa): a ‘critical mass’ of group-members who oppose FGM is very important to persuade the other members to denounce the practice and to feel safe enough to do so; secondly: in order to have a successful impact, the rejection of FGM by this ‘critical mass’ should be done explicitly, in the public arena; thirdly: the respectful and sensitive support from people in the receiving society of which immigrants become members, can mean a lot to those women and men in the at-risk groups who refuse to continue FGM or who have undergone it and who suffer the consequences of.
Notes
1 Female genitalia can be cut in a number of different ways. Variations occur depending on which part of the genitalia is mutilated and the extent to which this is done. The World Health Organization distinguishes the following four types [2]. Type I: Partial or total removal of the clitoris, and/or the clitoral hood. This type is known as clitoridectomy. Type II: Partial or total removal of the clitoris, and the labia minora, with or without excision of the labia majora. This is also known as excision. Type III: Narrowing of the vaginal orifice by cutting and closing the labia minora and/or the labia majora, with or without excision of the clitoris. This is also known as infibulation. Type IV: All other harmful procedures to the female genitalia for non-medical purposes, such as, pricking, piercing, incising, scraping and cauterization. Sometimes the word sunna is used to refer to this type.
2 Information about the origins and incidence of FGM around the world may be found on www.meisjesbesnijdenis.nl.

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