Female genital mutilation as a social norm: a study of the beliefs and attitudes of women in this diaspora

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Summary

In this article we explore the beliefs, values, and attitudes about female genital mutilation in the diaspora of sub-Saharan women and how the migration process has influenced these beliefs. Our qualitative analysis of the life stories and lifelines of 10 women in the sub-Saharan diaspora in light of the Social Convention Theory indicated that making public statements about the topic is complex and that the taboo permeating the practice remains intact even outside of Africa. Furthermore, we discovered that, in our context, this practice was not a requirement and did not improve the chances of marriage, with female behaviours considered ‘appropriate’ instead gaining value. Any interventions based on this theory must consider the broad networks that help shape marriages in this diaspora. This work opened new lines of research regarding the situation of the diaspora of sub-Saharan women and the relationship of the practice of female genital mutilation with marriage.
Introduction

The World Health Organization (WHO) defines female genital mutilation (FGM) as practices that damage the external female genitalia without any medical justification (World Health Organization, 2020). It further classifies the injury according to the extent and tissues affected, proposing the following taxonomy: type 1 when it affects the clitoris with partial or complete excision, type II which adds excision or complete or partial excision of the inner labia, type III which by reshaping the labia minora or majora generates a narrowing at the opening of the vagina (World Health Organization, 2015). The phenomenon of medicalization is leading to health professionals replacing traditional excisers in the performance of female genital mutilation, it is still unclear how this new dynamic implies in reducing the prevalence or legitimizing the practice (Nina et al., 2020; World Health Organization, 2015b).

This practice is motivated by a mixture of sociocultural factors and is mainly implemented in sub-Saharan Africa, the Middle East, and some parts of Asia (WHO, 2020). According to WHO estimates, more than 200 million women and girls have already been subjected to this practice and, each year, more than 3 million girls are at risk of FGM (WHO, 2020). The United Nations Population Fund (UNFPA) estimated that 4.1 million girls were subjected to FGM in 2019 (UNFPA, 2020) and, in addition, the Covid-19 pandemic has worsened forecasts of the practice for forthcoming decades by disrupting interventions being implemented to eradicate the practice (UNICEF, 2021). In addition, migration has dispersed this practice, making it a problem worldwide (WHO, 2020).

In societies with a high prevalence of FGM, it is considered a universal and dynamic social convention which is strongly resistant to change (Essén & Mosselmans, 2021; Mackie & Le Jeune, 2009; WHO, 2020). Social conventions have been defined as behaviours that help coordinate individual and social expectations when interests coincide (Miller Moya, 2009).
Various theories are based on FGM being a social convention (Brown et al., 2013). According to Mackie’s Social Convention Theory, FGM is a solution to improve the chances of marriage because the practice would consecrate women’s fidelity, purity, and chastity, first among the most powerful social elites and then by anchoring itself as a social norm (Mackie & Le Jeune, 2009). The random choice of social conventions makes it difficult to separate them from the sociocultural conditions in which they were generated, thereby also perpetuating themselves through the formation of roles, imitation, and interpersonal reinforcement (Miller Moya, 2009), explaining why such practices resist change over time, despite the efforts of many different organisations (Al-Amoudi & Latsis, 2014; Miller Moya, 2009). Resistance to the eradication of FGM stems both from male beliefs that a non-mutilated wife would be unfaithful, as well as female beliefs about the requirement of FGM for them to marry (Mackie & Le Jeune, 2009).

FGM requires community interrelationships both for the establishment and perpetuation of marriage agreements, and by extension, also for the eradication of the practice. The Social Convention Theory arose from models of strategy games and by establishing similarities with the Chinese history of foot binding in China (Mackie, 1996). Thus, Mackie proposed addressing the eradication of FGM by following the same successful mechanisms previously used to eliminate the practice of foot binding. According to this theory, to trigger and accelerate eradication of a given practice, first, a proportion of the community—the so-called critical mass—must publicly declare their intention to abandon the procedure (thereby eliminating its ability to configure marriages) and raise awareness in the general population of the repercussions and negative consequences of the practice (Mackie, 1996; Mackie & Le Jeune, 2009).

Studies designed to understand and learn how to approach FGM based on the theory of social convention in the African context have so far obtained positive results that reinforce this aforementioned idea (Bedri et al., 2019; Wander & Shell-Duncan, 2020). Certain interventions
based on these principles have also proven effective and have received support (Cislaghi & Heise, 2018). Good examples of this include the Saleema project in Sudan (Evans et al., 2019), the case of Tostan in Senegal (Cislaghi & Heise, 2018), and the joint UNFPA-UNICEF program (UNFPA-UNICEF, 2018).

However, the main criticisms of this approach are its simplistic nature and the presumption that a small effort will generate a large and consistent result over time, as well as a good knowledge of the community and the mechanisms and agents involved in the decision-making process (Agboli et al., 2020; Efferson et al., 2015, 2019).

It is important to emphasise that the application of the Mackie approach in countries where FGM is a social norm could require adjustments and additional factors may need to be addressed in the diaspora, namely, in those communities that perform the practice in their places of origin and are settled in territories where it does not occur (Johansen & Ahmed, 2021).

To date, research conducted in Europe with the aim of eliminating FGM has started from the theory of shaping interventions (Barrett et al., 2020), or in the case of Somali and Sudanese communities with a high prevalence of type-III FGM or infibulation present in Norway and Sweden, with the study of behavioural changes (Johansen, 2019; Wahlberg et al., 2019). However, in Spain, migratory groups mainly come from West African countries which usually carry out type-I or II FGM (Fundación Wassu-UAB, 2020; WHO, 2020). Furthermore, the study by Agboli et al. (2020) focused exclusively on women who actively oppose FGM within the context of a specific multicultural moment (Author et al., 2020).

Therefore, work was required to investigate the power of social conventions outside the country of origin in order to increase our knowledge and understanding of this practice in the diaspora, as well as its processes of change (Agboli et al., 2020; Johansen, 2019; Johansen & Ahmed, 2021).
2021). Especially when it has been concluded that understanding how social norms operate is a key factor in ensuring that these women are treated with respect (O’Neill & Pallitto, 2021).

The objective of this study was to identify the beliefs, values, and attitudes of women in the sub-Saharan diaspora regarding FGM and to inquire about how the processes involved in migration had influenced these women’s perspectives about FGM.

**Methods**

This research was qualitative and was set within an interpretive paradigm because it was designed to collect the perspectives of migrant women who were subjected to FGM in their countries of origin.

This work was conducted in different cities in the Valencian Community, which has more than 5,700 women and 1,500 girls from countries where FGM is widely implemented. The Valencian community in Spain has the fourth highest population of immigrants originating in countries where FGM occurs—especially those from West Africa from countries including Nigeria, Senegal, Guinea, Mali, and Cameroon (Wassu-UAB Foundation, 2020; *Mapa de la Mutilación Genital Femenina (MGF) en la Comunitat Valenciana* [Map of FGM in the Valencian Community], 2016).

We carried out a convenience sampling through NGOs and by using the authors’ personal networks, followed by snowball sampling (Naderifar et al., 2017), arranging the interviews by telephone. The sample size was determined by the power of the information, as defined by Malterud et al. (2016). The inclusion criteria were (1) having undergone FGM; (2) being of legal age; (3) having resided in Africa for at least 10 years; (4) having resided in Spain for at least 5 years; and (5) possession of the minimum levels of sociolinguistic ability in Spanish, that is, the ability to converse with some ease in the language (Squires, 2008).
For data collection, we used life histories and lifelines. The combined use of visual methods as an adjunct in qualitative research is currently experiencing a boom because of its advantages in the subject of study (Agboli et al., 2020). In our research it also brought benefits both in improving the quality of the data and for the experience of the participants (Author et al. in press).

Life stories are stories created based on interviews that collect both the events and personal evaluations of their protagonists (Pujadas, 2002). The main strengths of this technique are its ability to help researchers understand the different dimensions of a social phenomenon or processes, thereby providing access to deep and detailed information (Bassi Follari, 2014; Caetano & Nico, 2018; Dhunpath, 2000; Moriña, 2016). This technique is also valued for its ability to help make underrepresented communities visible, especially in a challenging world with groups that often become marginalised after migration processes (Lincoln & Lanford, 2018).

To compose the life stories, a guide was designed and used to conduct the interviews. The guide was divided into thematic blocks as follows:

- Origin and experiences of childhood and adolescence.
- Marriage and sex life (FGM, pregnancies, and children).
- Situation at the time of the interview.

The life story was enriched with complementary material by the creation of life lines on which the interviewees pointed out major events that had been turning points in their life trajectories, annotating these with drawings or an explanatory phrase (Agboli et al., 2020). These life lines allowed us to locate events in their chronological order, as shown in the illustration in figure 1.

**Figure 1. Example of a lifeline**
The interviews were carried out in the homes of the participants or at the facilities of one of the associations they used, according to the interviewee’s preferences and accommodating the presence of companions if requested; thus, some interviews were conducted in the presence of friends or children. The researchers recorded the audio and the interviewees’ gestures, or expressions were noted as they narrated events, over three sessions lasting between from an hour to an hour and a half each. Subsequently, the interviews were transcribed verbatim and, to refine the data, returned to the participants with a request for additional information, if necessary, as well as confirmation of the facts.

The analysis was performed using ATLAS.ti qualitative data analysis software to extract and categorise citations. We began by reading the first interview to introduce us to the participant and to identify issues that would require the provision of more detail in the subsequent interviews. The first author coded the data, wrote down possible themes, developed them, and looked for connections. Before beginning an in-depth analysis, the themes were organised based on the theoretical framework and the objective of the research. The Social Convention Theory was chosen based on the fact that the data about FGM we were provided with suggested that the practice is based on a societal norm and as a normative practice related to behaviour and the precepts that lead towards marriage. Thus, our analysis was conducted based on the definition of social convention and knowledge of the so-called "behavior change approach"
that has addressed this and other practices. Finally, the implicit meaning of the text was explained in the inference phase and was supported by the results of the analysis (Peat et al., 2018).

Methodological triangulation was carried out using both life histories and life lines to improve the internal consistency of the data, thus increasing its reliability and validity (Copeland, 2012). The data analysis was audited by the researchers until a consensus was reached, which was also supported by feedback and confirmation of these results by the participants and key informants (Peat et al., 2018). In addition, our understanding of each participant was complemented by observation and participation in informal conversations and social encounters with West African women settled in the community during the time we spent in the field.

This study was approved by the Ethics Committee (File UA-2020-10-15). To ensure adequate understanding of the informed consent document and the research objectives, we read the text aloud, asked whether it had been understood, and resolved any doubts that arose. Likewise, we insisted on the confidentiality and anonymity of the data collected during this work. We aimed to establish a relationship based on empathy, understanding that the narrative included painful events for the participants, not only in relation to female genital mutilation, but also in other events such as the migration process. For example, by substituting the term mutilation by the one used by the participant herself, usually ‘cut’ or ‘seli ji.’ In addition, the life lines were proposed as elements to mediate between the narration and the participants’ own experiences, thus providing them a safe space for reflection (Guenette & Marshall, 2009; Kolar et al., 2015). Likewise, the possible impact of discussing the topic under study was always considered (Johansen & Ahmed, 2021; Sanjari et al., 2014).

Reflexivity
The interviewer, who was conducting her doctoral research, was a woman who did not belong to the African community, nor did they share race or language. However, she was of similar age and personal characteristics to the majority of the sample in terms of marriage and children. Despite the differences, the empathetic attitude and explanation of the objectives and expected impact of the research with respect to ensuring respectful care in accordance with human rights (see O’Neill & Pallitto, 2021), as well as the implementation of lifelines to enhance understanding of the narrative, were key points that favored a smooth, rich, and in-depth data collection (Autor et al., in press). The use of methods that de-emphasize language and aim for a collaborative and participatory approach can ameliorate the power imbalances that often exist between researcher and participant, helping to address the inaccessibility of the participant-researcher relationship of other more traditional methods and creating safe spaces for the evocation of painful emotions; moreover, data that would otherwise have remained hidden may surface (Author et al., in press; Smit et al., 2020). In this line, we consider ourselves close to Eakin and Gladstone (2020) when they state that "everything is data".

**Results**

A total of 15 women were contacted; of these, 2 did not meet the eligibility criteria (one of them had not been mutilated because it was not practiced in her ethnic group and another one only lived a few months in Africa) and 3 declined to participate in the research; thus 10 women participated in the work. They were aged a mean 34 years, with the range being 18 to 61 years. Their origins were Mali, Nigeria, the Republic of Côte d’Ivoire, Gambia, and Sierra Leone and they had lived in Spain an average of 16 years (with the range being 10 to 30 years). Only two of the women were not married and did not have children; the remaining 8 had a total of 25 children. Although most of the participants had only had a basic education, one had received
a higher education, and another had undergone professional training. They were all Muslim and most had come to Spain to reunite their families; one had come for educational purposes, and another had arrived as a refugee. The daughters of the participants who had been born in their country of origin had been subjected to FGM but those born in Spain had not.

The results obtained allowed us to elaborate the following categories intertwined with the central pillars of the Social Convention Theory. The first category consists of data on the necessary public declaration suggested by the theory for the process of change to begin; the second category collects data on marriage and its relationship with FGM, according to the theory this relationship is the main motivation for the practice to take place and, finally, the third category defines the space where decisions about marriages are made, which the theory considers the environment where to exert pressure to modify the relationship between the marriage bond and the practice.

**Enculturation versus public statements of truth**

Whether they remembered their experience or not, all the participants said they did not talk about it. From what they heard and saw on a day-to-day basis, they had known about the procedure since they were children, but this practice was always hidden from them and they were not given clear information about it. In fact, the girls had been tricked with promises and gifts and had been showered with compliments, thus offering them a positive version of the event because of its relation to getting older and/or being brave.

The participants told us that this practice is necessary, even though it had been a physically and psychologically painful experience for them. Thus, they had conformed to the concept of a type of normality wrapped in silence which also crosses borders to establish itself in the diaspora. Several examples of this were related to us during the interviews. Indeed, one participant took advantage of the interviews to talk about the application of this practice in her adolescent
daughter before leaving Africa. Until the time of the interview, she had never discussed the
mutilation with her daughter, thereby further perpetuating the taboo. The interviewee
commented that this silence was because these events are not usually talked about until you get
married and start to be considered as an equal.

One of the participants, conducting the snowball sampling, introduced us to a friend of hers, a
member of the Wolof ethnic group. This new participant preferred to conduct the interview
with her friend present (for reasons of trust), but in the end she was not included in the study
because she did not meet the inclusion criteria; she had not experienced female genital
mutilation although she was aware of the practice. This came as a surprise to her friend who
expressed by way of apology:

But if all women in Africa are like this...

The physical repercussions suffered by these women or their acquaintances, as well as the fact
that the interview had promoted reflection, shaped a dialectical process in some of the
participants. Therefore, without actively intending to be an anti-FGM intervention, we had
inadvertently promoted a change of attitude towards the practice in some cases. In contrast, the
sole reason this practice is not carried out outside of their native regions in Africa is because
of its legal consequences:

When I started talking to you, I thought to myself, ‘why are you asking about that?’ [...] I [thought], ‘this is not important.’ So, I talked to my mother and my aunt, and I saw everything.
I saw that it’s not good, that it doesn’t work, that this isn’t important, it must be stopped.

For our participants, whoever leads and implements the interventions to combat the practice is
key to the achievement of the objectives. Information will be better received if it comes from
peers and will be successful if it manages to convince decision-makers. Moreover, for them,
changes in attitude should not derive from imposing measures. This will also require the involvement of men, who, in a veiled way, play relevant roles in the practice.

*I’ve told them all and my sister understood [*the idea*] well, but her husband didn’t. They all listened to me, but when I came [*back*] they had still done [*the FGM]*.

The migration process had promoted a change in attitude in the women in the diaspora, giving them the ability to observe their past and culture from another perspective. However, making people aware of this enculturation process can be an obstacle to triggering change in other people, which can lead to rejection in the community. This can even lead to threats directed towards people who have changed their attitudes and who try to convince others to do so:

*My father was angry with me and didn’t speak to me. He said that since I’d been in Spain I’d absorbed [*ideas*] from here, from white [*people*] [*…*] My father said, “Listen carefully to the words you say. Here the people are very bad. As long as you keep talking like that, maybe one day someone will hurt you.” Yes, my father told me that… But I don’t care because every day people die.*

**Gender roles versus the requirements of marriage**

Although a combination of factors was mentioned as reasons for performing FGM, our results indicated that most of the explanations consolidated around the fact that the practice has been maintained over time and is interrelated with marriage, polygamy, and sexual control. It seems that FGM intends to impose and maintain the fundamental behaviours of faithfulness, submissive respect, and a lack of decision-making power. Nonetheless, these behaviours cannot be guaranteed, even when female sexuality is limited:

*If you have this cut—because your husband can marry four women, right—if you aren’t cut you always feel like [*sex*]. Women say, if you’re cut, then once a month and that’s it [*…*] The*
cut is so you don't feel like [sex]—that’s what’s said—but [FGM] is useless, not important, nothing good. In my country, a man can [marry] four women. Four. So, he can't manage all of them. He just can’t. Imagine, four. So, women have boyfriends [...] This isn’t good if he finds out...! Oh my! A lot of fighting. But of course, your husband can't really... This happens, this happens a lot in my country. So, they say that the wife shouldn’t ask for more—more from the husband. He says when [sex] has to be, for example, one night, not another, like this [...] They always think that way, [ideas] that get into their heads—that until [their wives] are cut, that you're dirty.

Although in their countries these women associated FGM with marriage, this fact had not remained the same for them outside of their home countries in Africa. This was partly because their marriage possibilities had not improved, even though they had been mutilated during childhood, prior to their process of migration. This situation was because the behaviour acquired by the girls had diverged from the expected one from the point of view of their native communities in Africa. This highlighted the importance of behaviour in female identity and demonstrated the relevance, not only of aesthetics (in other words, ‘looking’ African), but also of ethics as a set of norms and values that guide behaviour:

This has nothing to do with the cutting. That is not a problem. For example, I have a daughter who is cut and another who isn't, but that’s not a problem. The problem is the behaviour. [They think like] white [people], they don’t know about Africa, or women... Yes, yes, there’s the problem. In Mali it doesn’t matter, the women are cut, they haven’t [acquired] white [people’s ideas], and their dads want to marry them off. There’s no problem there [in Africa]. But here, there is.

**International networks versus close African community**
To deal with the challenge resulting from enculturation processes, strategies such as transnational marriages, organised through networks of acquaintances and relatives. This phenomenon makes it possible to maintain the way of life or the values of their societies of origin in Africa also outside Africa. The family, both in the diaspora and in the country of origin, influences marriage and situations related to African traditions, identity, and values, such as in some cases FGM. In this way, the community is not a concept limited only to the environment, but rather, is extended through connections with friends and family members, both in the countries of origin and in the diaspora:

They don't want to [marry] because they [think like people] from here, about things from here. And so, they [the patriarchy] don't like it. That's why they [look] to Africa to [find them wives]. There, if your husband says [something is a certain way], you must also [say it’s that way], even if it isn't.

Their parents look for an African woman from there. Maybe they talk to their friends, or their families and they look for a girl for them, the family is very important to [help you] get married.

Discussion

The assumptions of the Social Convention Theory are that FGM is associated with the possibilities of marriage and that the eradication of FGM will accelerate when certain key figures manifest against it. To evaluate this, we must first define the concept of community (1996). However, to some extent, the results obtained from in this study challenge this approach to the practice of FGM based on this theory and in the context of these women’s diaspora, thereby requiring adaptations (Johansen, 2019).

The assumptions of the Social Convention Theory proposed by Mackie are mainly based on directly relating FGM to the possibilities of marriage within a given community. Thus, the
theory suggests that to eradicate FGM, a public declaration regarding the change will be required, which will then generate a domino effect leading to the acceleration of the eradication (Mackie, 1996). Our results revealed the secrecy that surrounds the practice of FGM, with women only becoming convinced to abandon the practice after a process of intercultural interaction and some time for reflection (Agboli et al., 2020; Author et al., 2020; Wahlberg et al., 2017, 2019). Women sufficiently motivated to talk about the practice, which has been maintained over a very long time, require a small impulse to do so, perhaps leading to the reversal of the taboo and helping to break its relationship with their identity (Al-Amoudi & Latsis, 2014; Efferson et al., 2019). Thus, they become aware of the repercussions of FGM, as well as the fact that its perpetuation over time is unjustified (Agboli et al., 2020; Pastor-Bravo et al., 2020).

Public manifestation of their belief against the practice has not contributed to change in the countries in which it originates. Instead, a negative reaction has been generated because of exposure to the practice and the culture in which it is inserted. In this sense, the enculturation process has functioned as a barrier to continuation of the eradication of FGM (Johansen, 2019; Shahawy et al., 2019). Therefore, our results support the premise that groups of families can express attitudes towards the abandonment of FGM (thereby generating a reflection on this possibility and its repercussions) only if they interact with a culture that does not accept the practice as a social convention and are able to have a dialogue based on a relationship of trust (Gele et al., 2015). In contrast, West African women residing in the diaspora suggest that the best way to approach the practice is to generate a dialogue with the community over time which should be based on trust, knowledge, and culturally competent communication skills (Pastor-Bravo et al., 2020).

Our research objectives did not include the implementation of an awareness-raising intervention against FGM. Nonetheless, through dialogue, this work seemed to result in a
consolidation towards change and the start of questioning of the practice among the participants. This observation aligns with understanding FGM as a social convention which will require changes in group attitudes, both among men and women, for its definitive eradication (Mackie, 1996).

A second element—the link between FGM and marriage—is central to the Social Convention Theory and constitutes the origin of the practice when interpreted as a guarantee of wives’ faithfulness towards their polygamous husbands (Mackie, 1996; Mackie & Le Jeune, 2009). In relation to this idea, our results indicate that both girls from the diaspora who were mutilated before starting the process of migration as well as those born in the diaspora and therefore protected by legislation (Author et al., 2016; Johansen & Ahmed, 2021), seemed to marry at equal rates. It appears that FGM is no longer a requirement for marriage and so the practice has taken a back seat to the ‘proper behaviour’ that women must display in order to enter into marriage. Other research also highlights the importance of exemplary behaviour in non-mutilated women in the diaspora, for example, in the sense that they are expected to be more respectful of their culture of origin through their choices of clothing or social behaviour (Johansen, 2019).

The link between FGM and marriage has lost its relevance in the diaspora because it is no longer a sine qua non condition for the establishment of marriage (Gele et al., 2015; Shell-Duncan et al., 2011; Wahlberg et al., 2019). There is evidence of the importance of FGM in controlling the behaviour of women and maintaining the patriarchal structure with female submission and faithfulness (WHO, 2020) even though the women in our study admitted that women in polygamous marriages do engage in divergent behaviours such as extramarital relationships (Agboli et al., 2020). Similarly, we also found evidence that the deprivation of full sexuality and the exposure to health and life complications endured by sub-Saharan women is underestimated (Ismail et al., 2017; Author et al., 2016; Khosla et al., 2017).
Our results agree with other studies which revealed that strong social norms seem to be related directly or indirectly to FGM (Johansen, 2019; Shell-Duncan et al., 2011). However, the abovementioned Social Convention Theory focuses on FGM itself and undervalues beliefs and other factors that would play a supporting role in its practice (Mackie & Le Jeune, 2009), thus increasing the probability that it will be carried out (Kandala et al., 2019). Of note, this theory claims that a synergy between the interventions could occur (Mackie & Le Jeune, 2009).

When dealing with social conventions, we must understand their dual nature by which they simultaneously regulate behaviour and provide the normative principles that guide these behaviours (Al-Amoudi & Latsis, 2014; Miller Moya, 2009). Therefore, any approach to tackling FGM must be comprehensive and should consider the behaviour of the practice itself and the underlying interrelated factors that maintain this behaviour (Johansen, 2019) as well as revealing the precise laws and complementary measures required to further the goal of the abandonment of FGM (Muthumbi et al., 2015).

Although some authors have stated that achieving attitude changes is more complex when related to sexuality, they also recognise that this situation is infrequent (Mackie & Le Jeune, 2009; Shell-Duncan & Hernlund, 2001). However, the participants in our work provided evidence that FGM plays a significant role in the control of female sexuality as a means to allow polygamy and maintain male power and decision-making (Author et al., 2014; Author et al., 2017; Johansen, 2019; Author et al., 2020). Therefore, marriage, as a motivation for practice, should be understood in a broader sense as an androcentric motivation (Author et al., 2014). This fact would justify the incorporation of men into future interventions (Akweongo et al., 2021; Johansen, 2019; Shell-Duncan et al., 2011). Nonetheless, interventions that only consider matrimonial dichotomies will be simplistic and, by not considering all of the meanings and behaviours related to FGM, will fail to generate deep and sustained attitude changes and, given that it is such a dynamic practice (Essén & Mosselmans, 2021), could even result in its
adaptation to changing circumstances in the diaspora (Graamans et al., 2019; Johansen, 2019). Thus, loss of the relevance of FGM for marriage might cause the start of the adaptation of strategies that maintain the values of African society outside national lines precisely because ritual interventions on female genitalia can “become symbols of African traditions, cultural identity and authenticity” (La Barbera, 2010, p. 479).

The last fundamental pillar in the Social Convention Theory is definition of the concept of community, with this problem representing a challenge in previous work (Johansen, 2019; Johansen & Ahmed, 2021; Shell-Duncan et al., 2011; Wahlberg et al., 2019). For the intervention to generate an attitude of change that triggers a greater effect, it must be applied in a group where FGM forms part of the brokerage of marriages (Mackie & Le Jeune, 2009). However, among migrants, the concept of community, both in relation to marriage and to decisions about FGM, is not limited to a close circle, but rather, family connections and transnational social networks are also relevant in the configuration of marriages within the diaspora (Johansen, 2019). Thus, women born in sub-Saharan Africa, who may or may not have been subjected to FGM, maintain the values of African society (and by extension the practice of FGM) in the diaspora (for at least some time) through arranged and international marriages (Johansen, 2019). Hence, anti-FGM efforts must be targeted towards the diaspora to achieve its abandonment at a global level (Gele et al., 2015; Varol et al., 2017).

The theory of FGM as a social convention, especially when it serves as the basis of anti-FGM interventions in the diaspora, must consider the definition of community and the breadth of its interconnections in order to maximise the effectiveness of these planned actions (Johansen, 2019; Johansen & Ahmed, 2021; Shell-Duncan et al., 2011) and to allow members of this diaspora to express themselves publicly (Mackie, 2018).

**Limitations and strengths**
The main limitation of this work was the small sample size we studied and the composition of the cohort. However, these results may be relevant in the exploration of FGM as a social convention in the diaspora and in terms of the effect of the migratory process. This is because we followed published recommendations regarding the required study power when establishing the necessary sample size (Malterud et al., 2016) and steps required to perform an interpretive phenomenological analysis in this context (Peat et al., 2018). Our use of lifelines in this work was a strength because this technique helped us to obtain deep, co-constructed data through active participation of the interviewees.

**Implications for practice and research**

From the perspective of sub-Saharan women, specifically in the West African subregion, we must implement interventions that generate an environment of intercultural dialogue, and which motivate reflection, thus achieving changes in the individual and community attitudes that have been maintained over time. These actions can benefit from an understanding that the secrecy surrounding the practice of FGM in its countries of origin also extends into the diaspora. In addition, women who may think about questioning the practice can be stigmatised by their community for having assimilated and externalised values of the ‘foreign’ culture in which they reside. These factors must be understood and considered because of their potential roles in the future abandonment of FGM, both in the diaspora and in its countries of origin.

Women in the diaspora, whether mutilated or not, face the same difficulties in terms of marriage, because, in both cases, they may present behaviours different from those expected of sub-Saharan women. Thus, this element opens new lines of study related to the diaspora: interculturality, processes of multiculturalisation, needs of first-generation migrants, and gender perspectives if the undervaluation of women as community members is confirmed. In turn, in countries with high prevalences of FGM, work remains to explore whether the practice
is really a requirement for marriage or if it is in fact an expression that the appropriate values and beliefs have been acquired from the community's point of view. Anti-FGM interventions within the diaspora are still necessary because international marriages arranged through friends or family may become a strategy that maintains the values of the communities of origin in the diaspora and may promote FGM.

Conclusion

The practice of FGM has been transmitted through generations, wrapped in taboos and positive values, leading to its normalisation in African social structure and identity, in some communities. We found that the women in our study believed that the main motivation for FGM was control of female sexuality and its relationship with male polygamy. We also identified emerging concepts related to a marked patriarchy that prevails in the societies they come from and that certain community actors wish to maintain outside their place of origin as well of African society, within the diaspora. In the diaspora, FGM has been relegated to a secondary position in relation to aspirations of marriage, behind showing the behaviour considered correct by the community. Thus, we revealed that the meanings and values upon which the practice is based and that help to perpetuate it, are fundamental to this practice, perhaps even more so than its most apparent and pragmatic ‘justification’—its relationship with marriage. It is important to note that undergoing the processes involved in migration is decisive in bringing about changes in attitudes about FGM. But, nonetheless, these processes also create barriers to the changing the practice of FGM in its countries of origin because the shift in perspective they create in migrants is interpreted in their countries of origin as a rejection of their own culture.
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