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**UK Government Legislation, Policy and Practice on
Female Genital Mutilation**

**Background Briefing and Position Paper
on amendments to 1985 Female Circumcision Act**

Endorsed by:

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Introduction

The Female Genital Mutilation Bill, a Private Member's Bill introduced by Labour MP Ann Clwyd, would amend the current Prohibition of Female Circumcision Act 1985 and make it an offence for parents or relatives to take girls out of the UK to have FGM performed on them, even in countries where FGM is legal. This change in the legislation aims to close a loophole in the law and protect the estimated 6,000 girls under 16 at risk in the UK. Activists working with African communities in the UK believe it is common for people to take their children on 'holidays' or trips back to their countries of origin for the purposes of carrying out the FGM procedure.

While the proposals to amend the 1985 Female Circumcision Act and strengthen legislation banning FGM are welcome, voluntary sector organisations have serious concerns about the extent to which this legislation will in fact protect women and girls and prevent FGM. We feel that legislation must go hand-in-hand with awareness-raising about the changes in law among communities where FGM is practised, and that careful measures must be put in place to ensure that the legislation does not cause further harm to children and break up families.

Our concerns are explained in further detail below, with questions for Members of Parliament to consider in their deliberations.

Contents of Briefing

Questions for Members of Parliament (extracted)

Civil society concerns regarding the proposed amendments to the 1985 FGM Bill and current Government practice on FGM

- 1 Prosecution and implementation of the legislation
- 2 Raising awareness among African communities in the UK
- 3 Providing services for women and girls who have experienced FGM
- 4 Working with civil society
- 5 Monitoring FGM in the UK

UK policy and practice in countries where FGM is prevalent

- 6 UK Department for International Development Policy related to FGM
- 7 Translating DFID policy into practice

Background information, human rights context, and international experience on FGM

- 8 Definitions, causes and consequences of FGM
- 9 Prevalence and incidence of FGM
- 10 International human rights framework on FGM
- 11 International experience on work to eradicate FGM
- 12 European efforts to tackle FGM

Questions for Members of Parliament

Civil society concerns regarding the proposed amendments to the 1985 FGM Bill and current Government practice on FGM

Inter-family power

- 1 In the implementation of this legislation, what attention will be paid to the power dynamics within families and the reality that many women have restricted ability to exercise control over family decisions?

Gender inequality and men's responsibility

- 2 What efforts will be made to ensure that implementation of this legislation considers men's responsibility and influence in decisions about whether their daughters undergo FGM, irrespective of whether fathers are directly involved in FGM taking place?

Implementation

- 3 How will the law be implemented? What guidelines will be drawn up and distributed to relevant Government officials? What will happen to a girl and her family if it is discovered that she has undergone FGM while outside the UK? What mechanism will be used to find this out – assuming that there will not be checks on girls upon arrival from countries with high levels of FGM?

Responsibility and Accountability

- 4 What Government department will be responsible for co-ordination and implementation of Bill? What kind of inter-agency cooperation will take place?

Capacity

- 5 What training will relevant officials (immigration, health care, educators, social services, police) have to undergo in order to understand and implement the amended Act?

Consulting with communities about changes in legislation

- 6 What plans does the Government have to consult widely with communities about the legal prohibition of FGM, the proposed changes in legislation, and the best way to implement them? Will the Government publish translations of the current legislation, the proposed changes, and the resources available to women, in all relevant languages?

Raising awareness among African communities about eradicating FGM

- 7 What plans does the Government have to work with African community organisations and women's groups to carry out awareness-raising campaigns about the need for eradication of the practice and the services available to women and children who have undergone FGM? What effort will be made to ensure that this includes work to influence men's expectations of marrying a woman who has undergone FGM?

Providing information to members of African communities at entry and exit of the UK

- 8 What plans does the Government have to ensure that families leaving the UK for visits to their countries of origin are informed of the changes in legislation (for example, at points of departure from the UK or through information provided by British Embassies, High Commissions, and Consulates in countries with high levels of FGM)?
- 9 What effort will the UK Government make to work with governments of countries with high levels of FGM to ensure that UK residents travelling to those countries are

- informed of the law (for example, by asking immigration officials in those countries to distribute information about changes in British law to people arriving from the UK)?
- 10 How does the Government intend to inform incoming migrants and refugees from countries with high levels of FGM about the prohibition of FGM in the UK and the possibility of claiming asylum on the grounds of risk of FGM?

Providing services for women and girls who have experienced FGM

- 11 What measures will the Government put in place to ensure that the legislation and the use of child protection measures do not increase the stress experienced by young girls and result in the break-up of families?
- 12 What progress have the Government and relevant statutory bodies made in addressing or implementing the recommendations made after the UK Parliamentary Hearings on FGM?
- 13 What action will the Government take to ensure that women and children who have undergone FGM receive adequate social, psychological, and medical support?
- 14 What efforts will the Government make to ensure that African community organisations receive support and funding to continue their outreach work to the community?

Working with civil society

- 15 What commitment can the Government make to institutionalise working with community organisations, particularly African-led organisations, on all work against FGM?

Research on prevalence and impact indicators:

- 16 What plans does the Government have for a national survey of prevalence of FGM and assessment of numbers of girls at risk, looking at all communities where FGM is practised?
- 17 What indicators will the Government use to monitor progress on eradicating FGM in the UK?

UK Policy and Practice in countries where FGM is prevalent

Prosecution

- 18 What action will the UK Government take to encourage governments in countries where FGM is practiced to ensure that FGM is banned either through legislation or integrated in the penal code?

Raising awareness for prevention

- 19 What action will the UK Government take to encourage governments of countries where FGM is practised to implement national awareness-raising campaigns aimed at preventing the practice, in collaboration with civil society organisations?
- 20 What action will the UK Government take to encourage governments in countries where FGM is practiced to inform arrivals from UK that FGM is outlawed in the UK?

Providing support for women and girls

- 21 What action will the UK Government take to encourage governments of countries where FGM is practised to ensure that relevant officials are trained to deal with FGM cases appropriately and sensitively?
- 22 How will the UK Government increase its support to African civil society organisations providing services and support to women and children who have undergone FGM?

Mainstreaming FGM into policy and practice

- 23 During its negotiations and assistance to countries where FGM is practiced, what efforts will the UK Government make to encourage governments to include policies on FGM in their Poverty Reduction Strategy Papers?
- 24 What commitment can the UK Government make to include a statement and action about FGM in the Country Strategy Paper / Country Assistance Plan and programming in all countries where the practice is prevalent?
- 25 What evidence can the UK Government give that UK development aid spent in direct support to relevant government ministries (such as Health, Education, etc.) goes towards anti-FGM work?

Civil society concerns regarding the proposed amendments to the 1985 FGM Bill and current Government practice on FGM

1 Prosecution and implementation of the legislation

There has not been one single prosecution under the 1985 Female Circumcision Act, despite claims by African community organisations that FGM does indeed occur in the UK. A study of Somali young people living in the UK by Black Women Health and Family Support and the London School of Hygiene and Tropical Medicine found that eight girls out of a sample of 62 girls surveyed had been circumcised in the UK in a clinic/hospital, or by a doctor, nurse or midwife.¹

Amending the 1985 FGM Act will serve to raise the profile in the UK of the prohibition of FGM. But further failure to prosecute offences will reinforce the belief that the Government is not fully committed to protecting girls and preventing this practice.

Implementation and enforcement of this Bill are essential for it to mean something among African communities and to reinforce the message that FGM must be abandoned. But community activists and organisations feel that this must be done with care and sensitivity and with their full and equal participation.

Community organisations are concerned that the legislative approach will serve to criminalise parents who may not believe that carrying out FGM harms their children. To the extent that the final recourse may be to separate children from their parents or to imprison the parents, the legislation could result in the break-up of families and an increase in the stress and isolation already experienced by people living in an unfamiliar and sometimes hostile environment. For girls taken away from their families and put into care due to their parents' incarceration, the legislation will punish girls and do nothing to address the fact that FGM has already occurred. The whole process could result in a girl's isolation from her community, stigma, and increasing levels of psychological strain, on top of the physical harm she has suffered.

In addition, as much of the pressure for FGM comes from grandmothers (who argue that they want to be sure their grand-daughters can marry well) and mothers are often in subordinate positions to their mother-in-laws due to complex family structures and power relations within families, many women are left with little choice over the fate of their daughters. Women who return to their country of origin with their children to visit family may have little power to express their will to prevent FGM, let alone enforce it. As a result, they could be coerced by family members to allow the procedure to be carried out on their daughters. On return to the UK, under the proposed legislation, such a woman would then be held responsible and penalised.

The inter-family pressures involved in FGM are highlighted below:

“My wedding night was very difficult, because I bled a lot due to my circumcision ... I was too young and I had no idea that marriage would be so terrible. Young girls are not ready to give birth; I myself nearly died when delivering my first baby. I would like my daughter to escape circumcision, but I can't change this old practice; even if I refused, my mother would never allow her to stay uncut.”

¹ Williams, L., Dirir, S., Warsame, J., et al (1998) “Experiences, Attitudes and Views of Young Single Somalis Living in London on Female Circumcision.” London School of Hygiene and Tropical Medicine and London Black Women's Health Action Project (since renamed Black Women's Health and Family Support)

This legislation is heavily weighted against women, as FGM is an issue which is in the domain of women. Discussions with members of the Somali community reveal that a central reason for the practice is the fear that unless their daughters are circumcised, they will not be able to marry well, as most men prefer circumcised wives. This legislation would penalise women, but it is clear that men have a role in the perpetuation of the practice, both as fathers and husbands. There are concerns among community organisations about the extent to which men would be held responsible or penalised if they organised or condoned the FGM procedure, but did not actually accompany the girl to be circumcised abroad.

Inter-family power

- 1 In the implementation of this legislation, what attention will be paid to the power dynamics within families and the reality that many women have restricted ability to exercise control over family decisions?

Gender inequality and men's responsibility

- 2 What efforts will be made to ensure that implementation of this legislation considers men's responsibility and influence in decisions about whether their daughters undergo FGM, irrespective of whether fathers are directly involved in FGM taking place?

Implementation

- 3 How will the law be implemented? What guidelines will be drawn up and distributed to relevant Government officials? What will happen to a girl and her family if it discovered that she has undergone FGM while outside the UK? What mechanism will be used to find this out – assuming that there will not be checks on girls upon arrival from countries with high levels of FGM?

Responsibility and Accountability

- 4 What Government department will be responsible for co-ordination and implementation of Bill? What kind of inter-agency cooperation will take place?

Capacity

- 5 What training will relevant officials (immigration, health care, educators, social services, police) have to undergo in order to understand and implement the amended Act?

2 Raising awareness among African communities in the UK

The Government must make a commitment to raising awareness among African communities in the UK on two fronts: one, the legal prohibition of FGM and two, the reasons why families and communities should abandon the practice. To date, the Government has failed to put adequate efforts into either aspect of community awareness-raising, leaving this work to small, under-resourced organisations.

At a recent celebration of International Women's Day organised by Black Women's Health and Family Support, members of the Somali community in Tower Hamlets discussed the proposed changes to UK legislation on FGM. One participant exclaimed, "*How can they think about changing the law about us without even telling us?*" It was clear that the proposed legislative changes were not seen as the main tool with which to encourage

² WOMANKIND Worldwide (March 2003) "Communities and Customs: Change for women in the 21st Century? Women speak out about their lives in Egypt, Ethiopia, Kenya, Somalia, Somaliland and Sudan."

people to abandon the practice. As noted in the Parliamentary Hearings in 2000, less than half of civil society groups interviewed knew about the 1985 Female Circumcision Act.³ In order to build its credibility among African communities living in the UK and make a real impact on eradication of FGM, the UK Government must prioritise raising awareness in the community.

The following testimony emphasises the importance of raising awareness at a community level:

“Some women agree already that FGM is harmful, while others are worried about leaving their daughters uncut because of marriage problems. I think that FGM educators should go to public occasions and discuss it with women on a one-to-one level, so that women get to know about the disadvantages such as bleeding, obstructed labour, maternal mortality, pain during intercourse and problems with menstrual periods.”

Taiyba age 23, El Hitana, Sudan⁴

Consulting with communities about changes in legislation

6 What plans does the Government have to consult widely with communities about the legal prohibition of FGM, the proposed changes in legislation, and the best way to implement them? Will the Government publish translations of the current legislation, the proposed changes, and the resources available to women, in all relevant languages?

Raising awareness among African communities about eradicating FGM

7 What plans does the Government have to work with African community organisations and women’s groups to carry out awareness-raising campaigns about the need for eradication of the practice and the services available to women and children who have undergone FGM? What effort will be made to ensure that this includes work to influence men’s expectations of marrying a woman who has undergone FGM?

Providing information to members of African communities at entry and exit of the UK

8 What plans does the Government have to ensure that families leaving the UK for visits to their countries of origin are informed of the changes in legislation (for example, at points of departure from the UK or through information provided by British Embassies, High Commissions, and Consulates in countries with high levels of FGM)?

9 What effort will the UK Government make to work with governments of countries with high levels of FGM to ensure that UK residents travelling to those countries are informed of the law (for example, by asking immigration officials in those countries to distribute information about changes in British law to people arriving from the UK)?

10 How does the Government intend to inform incoming migrants and refugees from countries with high levels of FGM about the prohibition of FGM in the UK and the possibility of claiming asylum on the grounds of risk of FGM?

3 Providing services for women and girls who have experienced FGM

Although the primary aim of the legislation under discussion is punitive, the Government must also address the need for providing services and support to women who have

³ All-Party Parliamentary Group on Population, Development and Reproductive Health. (November 2000) “Female Genital Mutilation: Survey Report and Analysis,” November 2000. p. 13

⁴ WOMANKIND Worldwide (March 2003) “Communities and Customs: Change for women in the 21st Century? Women speak out about their lives in Egypt, Ethiopia, Kenya, Somalia, Somaliland and Sudan.”

undergone FGM. People working at a community level report that women and girls may require counselling, appropriate information about health consequences (including maternal health), information about possibilities for reversal. They should have access to support and advice for choosing not to have FGM performed on their children. Women and children need trained, specialist responses by agencies and organisations with knowledge of the communities with which they are working. As noted in the UK Parliamentary Hearings on FGM, most NGOs working in this area provide free services to women and children. Organisations feel that they have received little recognition and inadequate support from the Government for their contribution in this area.

Working with girls

Current Government practice in responding to cases of FGM in girls relies on the intersection between the legal prohibition of FGM under the 1985 Act and the existing structure of child protection. Those working at a community level have reservations about the use of child protection measures. While it is clear that FGM harms girls, participants in conference held by Black Women Health and Family Support in 1991 argued that FGM was different from child abuse in the sense that from the community's perspective, the practice is undertaken not to harm girls but to help them in securing their status in the community.⁵ Families do not believe or know that they are harming their children: in some cases, families who do not choose to make their girls undergo FGM will pretend that the girls have been circumcised to avoid stigma.

The role of community beliefs and fear of stigma are made clear in the following quote:

"I did circumcise my own daughters because I was afraid of what my neighbours would say about my family if I had not, but now I am convinced that FGM is a harmful practice."

Fatima age 42, El-Doroshab, Sudan⁶

The connections between Britain's immigration and asylum policies and the continuing prevalence of FGM among migrant communities living in the UK is made clear by Shamis Dirir of London Black Women Health and Family Support:

*"Here they are stigmatised, they have to use vouchers for shopping, they have problems with the language. If they see conditions getting better in their country they want to go back ... 'But they fear that if they or their daughters are not circumcised they will be ostracised, they will not be part of the community [when they return]."*⁷

In this context, it is essential for Government agencies and people working with children to respond sensitively and work in partnership with organisations with expertise on FGM issues. Government policies and guidelines for people working with children must be strengthened to provide guidance on appropriate action when dealing with cases of FGM.

Black Women's Health and Family Support has been working with communities to eradicate FGM for nearly 20 years. A recent case illustrates some of the anxieties around the application of child protection procedures and the impact on girls and their parents.⁸

⁵ London Black Women Health Action Project (1991) "Is Female Circumcision Child Abuse?" Report of a one-day conference held on 17th May 1991.

⁶ WOMANKIND Worldwide (March 2003) "Communities and Customs: Change for women in the 21st Century? Women speak out about their lives in Egypt, Ethiopia, Kenya, Somalia, Somaliland and Sudan."

⁷ "Conditions in Britain make many want to return to their homeland".

<http://news.bbc.co.uk/1/low/health/1033674.stm>

⁸ Names and details have been withheld to protect confidentiality.

A young girl and her teenager sister were taken by their mother to Somaliland to be circumcised. The mother used a holiday to do this and then rushed the girls back in order not to miss any school. Because the mother and daughters came back to the UK immediately, the wounds did not heal properly. A distant male relative found out about what had happened and decided to report the case to a number of people including Black Women's Health and Family Support and to the girls' school. The Director of BWHFS went to talk to the headmistress, who despite initially saying she would not call in Social Services, panicked about her own liability and decided to do so.

Social Services took the young girl away but not her older sister who couldn't be forced to leave her family as she was of a legal age to make her own decision. The younger girl was taken into foster care in tears at leaving her family and all the trauma of this. The family were distraught at the separation from their daughter and worried about her safety and her possible abuse in care.

BWHFS subsequently worked with the family and Social Services for four months and the girl was returned to her family. However she is on the 'at-risk' register and Social Services continue to monitor her.

The reason that the youngest daughter could be returned to her family was because under current legislation, it is not illegal for a child to be circumcised abroad. If the proposed legislation passes and it extends to both UK nationals and residents, BWHFS are deeply concerned that it would mean children like this young girl would probably be permanently separated from a family that in their eyes only did what was customary and right for their daughter.

Support and Services for Women and Girls

For many women living in the UK who have already undergone FGM, health services are often women's first point of contact with state agencies. Consequently, it is essential that health care professionals are aware of the issues around FGM and can provide women with the appropriate care and support. Yet research conducted in 1998 found that only 54% of UK healthcare professionals were aware of the UK law banning FGM (compared to 91% of Swedish health care professionals knowing of their country's law against FGM)⁹. It also found that about 50% of healthcare professionals who responded to the survey had seen patients suffering health complications of FGM.

As reported at the UK Parliamentary Hearings in 2000, specialist healthcare providers working in this area, including staff working at specific FGM clinics, report that many women lack even basic knowledge about the primary health care services available to them.¹⁰ There is also a misconception that FGM services in the UK are available solely to expectant mothers, meaning that many young women wait until they are pregnant to seek help. There is a clear need to raise awareness of this issue and the services available to both among women who have undergone FGM and healthcare professionals.

⁹ International Centre for Reproductive Health (1999) Findings presented at Expert Meeting on Female Genital Mutilation, Ghent, 5-7 November 1998, in speech entitled 'The DAPHNE Project on Female Genital Mutilation in Europe', by Els Leye. Available at <http://www.icrh.org/index-f.html>

¹⁰ All-Party Parliamentary Group on Population, Development and Reproductive Health. (November 2000) "Parliamentary Hearings on Female Genital Mutilation" November 2000.

- 11 What measures will the Government put in place to ensure that the legislation and the use of child protection measures do not increase the stress experienced by young girls and result in the break-up of families?
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- 13 What action will the Government take to ensure that women and children who have undergone FGM receive adequate social, psychological, and medical support?
- 14 What efforts will the Government make to ensure that African community organisations receive support and funding to continue their outreach work to the community?

4 Working with Civil Society

Civil society organisations do not feel that the Government is placing sufficient effort on forming partnerships with organisations working with African communities. This is not acceptable given the Government's stated commitment to partnership with voluntary sector organisations. African women should be at the forefront of developing strategies and taking action against FGM in the UK.

This lack of an active partnership approach also means that Government action is not sufficiently informed by the experience of civil society organisations in working with African communities on an issue which is often difficult to discuss. Black Women Health and Family Support has found that it is often best to approach the issue of FGM with members of the Somali community by using indirect methods. Many of their discussions and services for community members focus on health training, family planning, and reproductive health. Through these themes, they introduce discussions about FGM and gradually encourage women to abandon the practice. BWHFS have also found that many new arrivals to the UK know very little about the UK legal system, social services, or state agencies. People coming from rural areas, where FGM is often more prevalent, have little experience in dealing with such government structures.

The experience of a worker at Black Women Health and Family Support illustrates the need for a community-based approach:

"You have to gain the trust of the community first, especially when ... you want to introduce a new concept about things that are precious to them. FGM is something personal, something traditional. When they come here they need advice and many other things, but if you immediately bring up the issue and say 'don't circumcise your daughters' they will wonder who you are, what is happening. They would ask 'have we come here to change our ways of life?' People might question what your motive is. So you work with them on their day-to-day problems, like social services, benefits, immigration problems, finding a school for their children, housing and everything. It is not right to bring up a tradition immediately before settling them emotionally. You must try to help them, be seen as somebody who is helping them, working for them and then after a while you will be able to talk to them on many health issues and FGM can be one of them. But you cannot bring this issue up out of the blue. Some of them don't know about the laws and so on. Some of them want to circumcise their daughters and they ask me what is the alternative? I say that the alternative is to leave them alone because this is wrong and it is very harmful. At the same time it is an old fashioned practice and it is not in the Koran. The most important thing that they need to hear is that it is not in the Koran."

Working with civil society

- 15 What commitment can the Government make to institutionalise working with community organisations, particularly African-led organisations, on all work against FGM?

5 Monitoring FGM in the UK

As there has been no national survey of prevalence or risk of FGM in the UK, the impact of Government and civil society efforts to eradicate FGM in the UK are almost impossible to measure. This makes it difficult for Government departments, local government agencies, and civil society organisations to make policy and take action on the basis of evidence or monitor progress.

Research on prevalence and impact indicators:

- 16 What plans does the Government have for a national survey of prevalence of FGM and assessment of numbers of girls at risk, looking at all communities where FGM is practised?
- 17 What indicators will the Government use to monitor progress on eradicating FGM in the UK?

UK Policy and Practice in countries where FGM is prevalent

The prevalence of FGM in Africa (and some countries in the Middle East) and the fact that many of the women and girls at risk in the UK come from these countries and return there to have FGM performed means that the UK must adopt a joined-up approach between its domestic and international policy.

British international development policy and practice makes some effort to address gender-based violence, such as female genital mutilation, but there is nowhere near enough priority placed on this issue (in terms of political or financial commitment) given the endemic nature of violence against women.

A central theme of the international efforts to improve health is the reduction of maternal mortality by three quarters by 2015. Violence against women, and FGM in particular, severely impact on women's health. A recent World Health Organisation study on violence and health states that violence "accounts for a substantial but largely unrecognized proportion of maternal mortality."¹¹ Although there is little statistical research on the connections between female genital mutilation, other forms of gender-based violence, and maternal mortality, FGM clearly carries the risk of life-threatening complications during childbirth. One of the most common complications of infibulation is obstructed labour due to genital scarring. Half of the ten countries with the highest levels of maternal mortality (based on 1995 WHO statistics) are countries in which FGM is widely practiced. With the exception of Egypt, one in 200 women in all of the countries in which FGM prevalence rates exceed 50% are likely to die due to pregnancy-related complications.

6 UK Department for International Development Policy related to FGM

The Government's lack of attention to violence against women - female genital mutilation in particular - begins at the policy level. To establish a framework for the UK Department for

¹¹ Krug EG et al., eds. (2002) *World report on violence and health*. Geneva, World Health Organization

International Development's (DFID) work towards achievement of the International Development Targets¹², the Department published a series of Target Strategy Papers. According to Clare Short, Secretary of State for International Development, the Target Strategy Papers "spell out actions which could transform the lives of hundreds of millions of poor people ... They say what needs to be done to achieve key targets for international development."

The Target Strategy Papers with the most direct relevance to work against FGM are the papers on *Poverty Eradication on the Empowerment of Women*¹³ and on *Better Health for Poor People*.¹⁴ In the paper on the empowerment of women, DFID commits to work towards "increasing women's personal security and reducing gender-based violence" and notes that gender-based violence, such as female genital mutilation, is an indicator of gender inequality. DFID pledges to take action on violence against women by reforming and strengthening criminal and civil law, raising awareness of among police and judiciary, and supporting public information campaigns and women's organisations.

DFID's paper on the empowerment of women presents a thorough strategy to address violence against women. However the Target Strategy Paper on Health shows nowhere near as significant a recognition of the importance of violence against women, and FGM in particular. It makes almost no mention of violence against women or FGM, simply referring readers to the Target Strategy Paper on Women's Empowerment. The paper mentions that women "are vulnerable to specific abuses with health consequences, notably female genital mutilation" but does not say what will be done to address this. The Health Target Strategy Paper gives rise to fears that the connections between violence against women and maternal mortality are not being recognized in DFID policy and practice.

In the context of the international focus on maternal mortality and the disappointing progress towards achievement of this target, more attention must be placed on the inextricable linkages between violence against women, including FGM, and maternal mortality.

7 Translating DFID Policy into Practice

Looking beyond the level of policy in thematic areas, DFID's strategies at a country level also do not appear to place adequate attention on FGM. A review of Country Strategy Papers and Country Assistance Plans for the East African region, where prevalence of FGM is high, shows that FGM is not mentioned in any of these documents. Given DFID's commitment to gender equality, the reduction of maternal mortality, and the promotion of human development, the Department's work in these countries should take greater account of a harmful practice which affects as many as 90-95% of women.

DFID's report to the Special Rapporteur on Violence against Women (May 2002) mentions seven activities which DFID is undertaking in the area of FGM.¹⁵ Assuming that DFID would use the opportunity of a report to the Special Rapporteur to highlight its achievements in work on FGM, the report suggests that the total spend by DFID on FGM is just over £1.5 million, just 0.1% of total bilateral aid expenditure (£1.5 billion) and just over a tenth over

¹² The International Development Targets, also called the Millennium Development Goals, are internationally agreed targets aimed at reducing poverty and promoting human development. Donor and developing countries have agreed to work together towards achievement of these targets.

¹³ Department for International Development (2000) *Poverty Eradication and Women's Empowerment Strategies for achieving the international development targets*

¹⁴ Department for International Development (2000) *Better Health for Poor People Strategies for achieving the international development targets*

¹⁵ DFID contribution to information request by the Special Rapporteur on Violence against Women., its Causes and Consequences, May 2002, compiled by the Social Development Department

what is spent on roads projects. With the exception of one programme with the World Health Organisation, these activities are funded through non-governmental organisations. According to evidence, it does not appear that DFID invests in work against FGM either through direct support to government or at a direct programme implementation level. Funding for all but two of these activities ended in 2001, suggesting that DFID is funding little new work in this area. In countries where estimates of FGM prevalence are over 50%, only 2.4% of DFID's total expenditure in these countries goes towards FGM.

DFID must invest significant resources to address FGM if it is to make good on its commitment to tackle gender-based violence and achieve progress on the target of reducing maternal mortality.

The following areas of activity require further priority, action and investment, through bilateral and multilateral aid programmes, high-level inter-governmental dialogue, and international parliamentary assemblies and summits.

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Background Information, Human Rights Context, and International Experience on FGM

8 Definitions, Causes and Consequences of FGM

Definitions of FGM

Female genital mutilation, also referred to as female genital cutting or circumcision, involves procedures which include the partial or total removal of the external female genital organs for cultural or any other non-therapeutic reasons.¹⁶ On a global level, the most common type of female genital mutilation is excision of the clitoris and the labia minora, accounting for up to 80% of all cases; the most extreme form is infibulation, which constitutes about 15% of all procedures.

Consequences of FGM

According to the World Health Organisation, female genital mutilation carries immediate and long-term health effects, varying according to the type and severity of the procedure performed. Immediate complications include severe pain, shock, haemorrhage, urine retention, ulceration of the genital region and injury to adjacent tissue. Haemorrhage and infection can cause death. There are also concerns about possible transmission of the human immunodeficiency virus (HIV) due to the use of one instrument in multiple operations. Long-term consequences include cysts and abscesses, keloid scar formation, damage to the urethra resulting in urinary incontinence, dyspareunia (painful sexual intercourse) and sexual dysfunction and difficulties with childbirth. Genital mutilation may leave a lasting mark on the life and mind of the woman who has undergone it.¹⁷

Causes and Context

FGM is usually performed by a traditional practitioner with crude instruments and without anaesthetic. Among the more affluent in society it may be performed in a health care facility by qualified health personnel. The age at which female genital mutilation is performed varies from area to area. It is performed on infants a few days old, female children and adolescents and, occasionally, on mature women.¹⁸ Post-operative care is generally unavailable as the practice usually takes place outside medical facilities.

Inequality between women and men underpins the practice of female genital mutilation. Female genital mutilation occurs in the context of acceptance of the practice on the basis of cultural norms. The reasons given for having FGM performed include:

- control and reduction of women' sexual desire, through reduction or elimination of the sensitive tissue of the outer genitalia, particularly the clitoris;
- maintain chastity and virginity before marriage and fidelity during marriage;
- increase male sexual pleasure;
- initiation of girls into womanhood, social integration and the maintenance of social cohesion;

¹⁶ WHO classification of the four types of FGM are: Type I: Excision of the prepuse, with or without excision of part or all of the clitoris; Type II: excision of the clitoris with partial or total excision of the labia minora (excision); Type III: Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation); Type IV: Unclassified – including pricking, piercing, or incising of the clitoris and/or labia, etc.

¹⁷ WHO Fact Sheet on FGM (June 2000)

¹⁸ WHO Fact Sheet on FGM (June 2000)

- hygiene and aesthetic reasons - the external female genitalia are considered dirty and unsightly and are to be removed to promote hygiene and provide aesthetic appeal;
- myths about the enhancement of fertility and promotion of child survival;
- belief that the practice is required for religious reasons (despite fact that FGM predates Islam and Christianity and is not mentioned in the Koran or the Bible)

9 Prevalence and Incidence of FGM

Most of the girls and women who have undergone genital mutilation live in 28 African countries, although some live in Asia and the Middle East. They are also increasingly found in Europe, Australia, Canada and the USA, primarily among immigrants from these countries. In 2000, the number of girls and women who had undergone female genital mutilation was estimated at between 100 and 140 million. It is estimated that each year, a further 2 million girls are at risk of undergoing FGM.

As noted by the 2000 report of the Parliamentary Hearings on Female Genital Mutilation, there is a severe shortage of data about the prevalence of FGM. Data collated by the WHO in May 2001 reported estimates of prevalence as high as 90-100% in some countries, such as Somalia, Eritrea, Egypt, Sierra Leone, Djibouti, and Mali. In other countries, such as Uganda, only about 5% of women and girls have undergone FGM.

Estimates of incidence of FGM in the UK cited during the 2000 Parliamentary Hearings report that about 6000 girls in the UK are at risk of FGM. Yet there have been no national prevalence or risk studies to confirm these figures. Research conducted in 1998 by the International Centre for Reproductive Health at the University of Ghent found that the UK had the highest number of migrants coming from FGM risk countries, compared to other European countries. Of the 303,454 migrants to the UK from countries in which FGM is practised, the study estimated that 148,291 women had either undergone FGM or were at risk.¹⁹

As the distribution of incidence of FGM in Africa varies from 5% to 95% depending on country, coming from a particular country or ethnic group does not automatically mean that the family practices FGM or the children are at risk. But what is known is that women more likely to be at risk of FGM appear to be concentrated in large cities where some support services might be available and where the main voluntary sector expertise is located. The current Government policy of dispersal of asylum-seekers may affect women's access to these vital services.

10 International human rights framework on FGM

FGM is a violation of the most fundamental human rights – such as the right to life, physical integrity, health, and protection against cruel, inhuman and degrading treatment. In the **Universal Declaration of Human Rights (UDHR)** five articles provide a basis for action against FGM: art.2 on discrimination, art. 3 on security of person, art. 5 on cruel, inhuman and degrading treatment, art.12 on privacy and art. 25 on the right to a minimum standard of living. Article 7 against cruel, inhuman or degrading treatment and article 17 on privacy of the **International Covenant on Civil and Political Rights** complement the articles under the UDHR. In the **International Covenant on Economic, Social and Cultural Rights**, art. 10 is on protection of children and young persons and art. 12 on a healthy development of the child strengthen the claim that FGM is a human rights issue. The **Convention on the Rights of the Child** states in art. 24 paragraph 3 that " States parties shall take all effective

¹⁹ International Centre for Reproductive Health (1999) Findings presented at Expert Meeting on Female Genital Mutilation, Ghent, 5-7 November 1998, in speech entitled 'The DAPHNE Project on Female Genital Mutilation in Europe', by Els Leye. Available at <http://www.icrh.org/index-f.html>

and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children".

The international **Convention on the Elimination of all Forms of Discrimination against Women (CEDAW)** in its art.2, (f) calls for "Appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs or practices. The CEDAW Committee recommends that States Parties take appropriate action discrimination against women." The **General Recommendation No. 14** calls governments to introduce effective measures for the collection of data on FGM, to seek the help of women's organisations, to encourage politicians and professionals at all levels to work for the eradication of the practice, to consider fundamental and adequate forms of education and training, to suggest health policies for the eradication of FGM. It also requires all the States parties to include in their reports to the Committee, under art. 10 and 12 of CEDAW, measures taken against the elimination of FGM. The Beijing Platform for Action (1995), the Programme of Action of the International Conference on Population and Development (1994), the Declaration and Programme of Action of the World Summit on Social Development (1995) urge urgent action to end the practice of FGM.

The 1993 **UN Declaration on Violence against Women** states clearly that: "States should condemn violence against women and should not invoke any custom, tradition or religious consideration to avoid their obligations with respect to its elimination. States should pursue by all appropriate means and without delay a policy of eliminating violence against women."²⁰ The Declaration goes on to say that States should "Exercise due diligence to prevent, investigate and, in accordance with national legislation, punish acts of violence against women, whether those acts are perpetrated by the State or by private persons."²¹



Under the **African Charter on Human and Peoples' Rights**, Article 4 on the integrity of persons, Article 5 on human dignity and protection against degradation of man, such as torture and cruel, inhuman or degrading treatment, Article 16 on the right to health and Article 18 (3) on the protection of the rights of the woman and the child are provide the legal framework for opposing FGM.

In a recent report on harmful practices, the Special Rapporteur on Violence against Women stated that "It is imperative that practices such as female genital mutilation, honour killings, Sati or any other form of cultural practice that brutalizes the female body receive international attention, and international leverage should be used to ensure that these practices are curtailed and eliminated as quickly as possible."²²

Recommendations of the Special Rapporteur for action at a national level against harmful practices:

- States should not invoke any custom, tradition or religious consideration to avoid their obligation to eradicate violence against women and the girl child in the family;
- States should exercise due diligence to prevent, investigate and, in accordance with national legislation, punish acts of violence against women, whether these acts are perpetrated by the State or by private actors;

²⁰ UN Declaration on Violence against Women, Article 4. General Assembly, 1993.

²¹ UN Declaration on Violence against Women, Article 4. General Assembly, 1993. Article 4 (c)

²² Integration of the Human Rights of Women and the Gender Perspective: Violence Against Women. Report of the Special Rapporteur on violence against women, its causes and consequences, Ms. Radhika Coomaraswamy, submitted in accordance with Commission on Human Rights resolution 2001/49. Cultural practices in the family that are violent towards women. 31 January 2002, E/CN.4/2002/83., p. 8

- States should develop penal, civil and administrative sanctions in domestic legislation to punish violence in the family and to provide redress to women victims, even if the violence is associated with a cultural practice. The penal sanction should be strong and effective and not merely on paper;
- States should develop national plans of action to eradicate violence in the family, particularly violence related to cultural practices through health and education programmes at a grass-roots level;
- States should develop social services and provide shelters aimed at helping women victims of violence in the family to escape from human rights violations;
- States should train all public officials in the administration of justice, education, and health sectors to be sensitive and energetic with regard to issues relating to violence against women;
- States should adopt all appropriate measures in the field of education to modify the social and cultural patterns of conduct that foster cultural practices in the family that are violent towards women;
- States should collect data and statistics on the pervasiveness of cultural practices that are violent towards women, so as to ensure the development of appropriate strategies for their eradication;
- States should include the measures they have taken to combat cultural practices that are violent towards women in their reports under relevant human rights instruments;
- States should recognise the important role that women's groups and women's organizations play in the eradication of cultural practices that are violent towards women and give them all necessary support and encouragement.

Civil society has been vocal, both in Africa at an international level, against FGM. At its 1997 conference, the **Inter-African Committee on Traditional Practices**, a regional non-governmental organisation, called on governments to "Adopt clear and consistent national policies for the abolition of female genital mutilation and other harmful practices including the enactment of specific national legislation to prohibit them".

On February 6 2003, the Inter-African Committee for traditional practices launched the first **International Day against FGM**. Carol Bellamy, Executive Director of UNICEF, urged governments and communities to take immediate action to put an end to this practice by 2010. She noted ending all forms of FGM is crucial to the achievement of the Millennium Development Goals on improving maternal health and promoting gender equality.

11 International Experience on work to eradicate FGM

There is a vast body of international experience at a grass-roots and international level of work to eradicate FGM.

The WHO Commissioned study, "FGM Programmes to date: What Works and What Doesn't" suggested that FGM elimination efforts must be built on the following foundation:

- strong and capable institutions implementing anti-FGM programmes at the national, regional and local levels;
- a committed government that supports FGM elimination with positive policies, laws and resources
- mainstreaming of FGM prevention issues into national reproductive women's health and literacy development programmes
- trained staff who can recognise and manage the complications of FGM
- coordination among governmental and non-governmental agencies
- advocacy that fosters a positive policy and legal environment, increased support for programmes and public education

The study made the following recommendations

1. Governments and donors should continue to foster the groundswell of agencies involved in FGM elimination by providing technical and financial support.
2. Governments must enact, and/or use anti-FGM laws to protect girls and education communities about FGM.
3. Governments need to be active in legislation, policy and (crucially) implementation.
4. To sustain programmes and achievements, FGM elimination activities must be institutionalised or mainstreamed, primarily into relevant government ministries programmes.
5. Health care providers at all levels need to receive training to manage FGM complications and to prevent FGM.
6. Governments, donors, and non-governmental organisations must continue coordination with all agencies working on the elimination of FGM.
7. Given the importance of advocacy, international agencies must help non-governmental organisations to develop their advocacy skills.

Who must be involved in work against FGM?

The WHO recommendations capture many of the key points raised by civil society. The strongest message coming from civil society organisations working against FGM is the importance of taking a community-based, bottom-up approach that involves local organisations, particularly women's groups. Participants in a five-day conference held in Somaliland highlighted this issue, concluding that,

“it is local activists and organisations in Somalia/Somaliland, which are based amongst the people and are sensitive to the local community needs, that are best placed to communicate with the majority of the population. Even those Somali people who have left the country and then returned are not always trusted – having, it is believed, been influenced by life in the West.”²³

The Special Rapporteur on violence against women stated that, *“It is only with enthusiastic support from the local community that this practice can eventually be eliminated.”* She also argued that *“The involvement of local women's groups and civil society in the movement to eradicate harmful practices is the only guarantee that the practice will not re-emerge in the future.”²⁴*

Civil society experience also highlights the importance of working with both women and men to eradicate FGM. Dr. Olayinka Koso-Thomas, Anglophone International Vice-President of the Inter-African Committee stressed the need to target both young men and women in her evidence to the UK Parliamentary Hearings in November 2000. Participants in the Somaliland conference concluded that *“The inclusion of men and boys in all areas of the campaign is crucial to effecting lasting behavioural change.”²⁵*

How to go about work against FGM:

²³ Black Women Health and Family Support (2002) “Advancing in Unity – report from a five-day forum to strengthen action against female genital mutilation.” Hargeisa, Somaliland, 29 October – 2 November 2001

²⁴ Integration of the Human Rights of Women and the Gender Perspective: Violence Against Women. Report of the Special Rapporteur on violence against women, its causes and consequences, Ms. Radhika Coomaraswamy, submitted in accordance with Commission on Human Rights resolution 2001/49. Cultural practices in the family that are violent towards women. 31 January 2002, E/CN.4/2002/83., p. 31

²⁵ Black Women Health and Family Support (2002) “Advancing in Unity – report from a five-day forum to strengthen action against female genital mutilation.” Hargeisa, Somaliland, 29 October – 2 November 2001

In evidence given to the UK Parliamentary hearings on female genital mutilation in November 2000, Demba Diawara, a farmer and Imam from Senegal, described a community-based approach that involved dialogue with community members, education and awareness-raising, and making joint declarations at a community level about abandonment of FGM. Participants in the Somaliland conference agreed that,

“The issue of FGM cannot be tackled in isolation. Local communities are more likely to be receptive to strategies that take into account the range of problems they are facing ... In order to further the process of behavioural change and sustain eradication efforts, attention needs to be given to the position of women in society as a whole.”²⁶

Dr. Olayinka Koso-Thomas of the Inter-African Committee emphasised the importance of talking to communities using appropriate language and frames of reference and argued that using international human rights conventions and legal provisions as a means of convincing people to abandon the practice was not sufficient.²⁷

Limits of legislative responses to FGM

Experience from civil society highlights the limits of law the importance of public education and awareness-raising. The Special Rapporteur commented that, “Legal measures are not enough if people are not educated about the social ills of harmful traditional practices.”²⁸

In a statement supported by the first ladies of Burkina Faso, Nigeria, Mali and Guinea, activists called for legal prohibition of FGM and “acknowledged that ending the cutting will only come by educating communities – young girls and boys, their parents, and the local leaders who endorse the practice and carry it out.”

According to the WHO study, anti-FGM legislation provides an official legal platform for project activities, offers legal protection for women, and ultimately discourages excisors and parents fearing prosecution. Its survey of 24 countries where FGM is practised showed that less than half of these countries made strong, clear indications outlawing FGM, either by way of a specific law or provisions in the penal code. In most countries with anti-FGM laws, the practice of FGM continues unabated because laws are not enforced. Furthermore, in FGM practising communities, there is little difference in behaviour between those who know of the legislation and those who do not. The study argued that it was important to present the law as a protective measure for all communities rather than as an instrument of punishment. In most countries, governments stop at legislation and leave the hard work of providing services and support to NGOs.

During the UK Parliamentary hearings, Demba Diawara was clear that law alone would not change people’s behaviour. On the basis of his experiences working in Senegal, he recommended the need for a basic education programme, based on dialogue and including a strong human rights component.²⁹

²⁶ Black Women Health and Family Support (2002) “Advancing in Unity – report from a five-day forum to strengthen action against female genital mutilation.” Hargeisa, Somaliland, 29 October – 2 November 2001

²⁷ All-Party Parliamentary Group on Population, Development and Reproductive Health. (November 2000) “Parliamentary Hearings on Female Genital Mutilation” November 2000, p. 46.

²⁸ Integration of the Human Rights of Women and the Gender Perspective: Violence Against Women. Report of the Special Rapporteur on violence against women, its causes and consequences, Ms. Radhika Coomaraswamy, submitted in accordance with Commission on Human Rights resolution 2001/49. Cultural practices in the family that are violent towards women. 31 January 2002, E/CN.4/2002/83., p. 32.

²⁹ All-Party Parliamentary Group on Population, Development and Reproductive Health. (November 2000) “Parliamentary Hearings on Female Genital Mutilation” November 2000, p. 51

The greatest concern among civil society activists was the risk of driving FGM underground through legal prohibition. “Even those who supported legislation against FGM suggested that it was risky to impose such a law on a community. Clearly, the best approach is that enactment of a law should go hand-in-hand with community education.” (p. 14)³⁰

The experience of WOMANKIND partners working in Ethiopia and the Sudan demonstrate the important linkages between community awareness-raising and legislation:

Case Study: Ethiopia

In Ethiopia, the WOMANKIND supported Kembatta Women’s Self-Help Centre (KWSHC) has established programs that promote the understanding necessary to eradicate FGM. Their most successful tactics have come from a fusion of legislative and awareness-raising efforts. By targeting traditional leaders, KWSHC recognises the existing social structures and works from within them, identifying and supporting young women who are willing to speak out against circumcision. The activism of outspoken youth has had a snowball effect, resulting in a population that is becoming more informed about the consequences of FGM. Until very recently, FGM was not an exception but the rule in the region of KWSHC’s influence.

However, KWSHC acknowledges the need for support by government extension agents and routinely lobbies for a law preventing the harmful tradition. The Centre’s grassroots work has put them at the forefront of the struggle to end FGM and their experience has led them to unquestionably believe that awareness raising by community groups and by statutory authorities must go hand in hand with legal change. Done together, each can reinforce social change and lend to the other’s efforts, but done separately, can lead to negative outcomes, as inconsistent messages and implementation difficulties give room for doubt and the perpetuation of the practice.

Case Study: Sudan

Stories from Sudan attest to the complexity of FGM’s presence in communities. Statistical evidence conveys the damage to women’s health and well being resulting from FGM. 91% of circumcised women suffer from severe and chronic infections and the government has even allowed a monthly day away from work for women because of severe pains. But, the government has hesitated to enact legislation because officials fear that the practice will go underground, leading to another set of problems for Sudanese women.

WK’s partner, the Sudan National Committee on Traditional Practices has initiated training programmes aimed at educating midwives and birth attendants. The Committee acknowledges the income that these women get from their work and provides them with alternative opportunities. SNCTP’s holistic vision guarantees that a community’s stable cultural identity is not threatened with their activism, as doing otherwise will undoubtedly result in an increase in FGM. For the Committee, tackling FGM requires a cooperative and thorough effort by the government, community based organisations and religious leaders. The work of many agencies, guided by a unified vision and aimed at dispelling myths associated with FGM, is the most appropriate means of eradicating the harmful and dangerous practice.

12 European efforts to tackle FGM

³⁰ CITE FIND!

At the 1998 Expert Meeting on FGM, the existing legal approaches to FGM in Europe and their limitations were outlined. Participants argued that the enforcement of law had great limitations, as FGM is being performed secretly, it is difficult to find evidence, and the communities where FGM is widespread (mostly communities of refugees and asylum seekers) often remain closed to government outsiders.³¹

Countries have adopted a range of approaches to deal with FGM – some have adopted a specific law, but most have amended the penal code or argued that FGM is covered under existing law. Regardless of the legal framework, the main challenge rests in effective implementation and a linked-up approach among relevant government agencies and community groups.

A variety of laws are applicable in cases of FGM. They include the criminal law (penal code), administrative law (concerning health centres and health professions), family law, civil law, and migration law (relating to the status of refugees and asylum seekers). The following section highlights experiences in three European countries.

Denmark

FGM is prohibited in Denmark as "grievous bodily harm" under the Penal Code, but there is no specific law. Committing such a crime can be punished with imprisonment of maximum four years (for more severe conditions with imprisonment of maximum eight years). Health personnel and other persons performing or assisting in female circumcision can also be prosecuted. It is also possible to punish persons assisting in the circumcision of girls abroad or sending their daughters to another country for FGM. Danish citizens and persons who are living in Denmark can - under certain circumstances - be held liable, since they have assisted in breaking the law. Doctors assisting in the practice of FGM are also acting in contradiction with the Medical Act.

According to a member of the Danish Working Group on FGM at the Danish National Board of Health, the Danish response to FGM originated among health professionals and the Minister of Health. Guidelines for health professionals were developed. To raise awareness among the 14,000 Somalis in Denmark, videos were produced to make clear that FGM was illegal in Denmark. It was important in this process to involve religious leaders, women's organisations, and men from the Somali community.³²

France³³

France has taken one of the strongest positions in Europe in relation to FGM. With over 180,000 residents in France coming from high risk FGM countries, France is the only country besides Sweden where a case of FGM has gone through the court system. In the 'Code Penal' two new articles were added on mutilation (non-specific genital mutilation) and entered into force in 1994. They carried punishments of prison terms and fines. The French law is applicable to everyone living on national territory (thus not discriminating between residents and citizens).

³¹ Expert Meeting on Female Genital Mutilation, Ghent, 5-7 November 1998. Proceedings available at <http://www.icrh.org/index-f.html>. Organised by the International Centre for Reproductive Health (ICRH), the Royal Tropical Institute (KIT) of Amsterdam, Defence for Children International (DCI), section the Netherlands and the Groupement d'Abolition des Mutilations Sexuelles/ European Section of the Inter-African Committee (GAMS).

³² Jorgensen, Vibeke "Preventive measures against female genital mutilation among Somalian girls in Denmark." http://mwia.regional.org.au/papers/papers/21_jorgensen.htm.

³³ This section based on Meuwese, Stan & Wolthuis, Annemieke. "Legal Aspects of FGM: Legislation on International and National Level in Europe." Defence for Children International, the Netherlands. Paper presented at Expert Meeting on Female Genital Mutilation, Ghent, 5-7 November 1998.

Approximately 10 cases have been brought to court, and more than 25 cases have been investigated in the Paris region alone. In March 1991 a Mali couple was sentenced to 5 suspended years in prison for allowing 6 daughters of the man's first wife to be circumcised. The circumciser was sentenced to 5 years imprisonment for performing excisions on 17 children. In January 1993 a Gambian woman was sentenced to 5 years in prison (of which 4 years suspended) for the genital mutilation of her two baby daughters. In February 1993 two women from Mali admitted in court that they had paid another woman to cut genital parts from their 3-year-old daughters in 1989; both were convicted to 5 years suspended sentence. In May 1994 a Malian man was sentenced to 1 month in prison after his two wives testified in court that he had ordered them to have their daughters excised. A Malian woman has recently been jailed for eight years for circumcising 48 girls. The court also convicted more than two dozen parents who took their girls to the circumciser. The legal prohibition of FGM is enforced and monitored through checks in schools of girls deemed to be at risk of FGM.³⁴

Sweden

In Sweden an act prohibiting the female genital mutilation of women came into force in 1982 and amended in 1998. Penalties for FGM include prison sentences of a maximum of 10 years. In addition to the person performing the genital mutilation, any person/s involved in organising the procedure may also be punished. According to the 1998 amendment in the act, it is punishable to prepare, conspire or neglect to report the crime. Anyone living in Sweden who helps to organise genital mutilation in another country can be punished in Sweden, if genital mutilation is prohibited in the country where it takes place. If, on the other hand, it takes place in a country where genital mutilation is permitted, these persons cannot be punished in Sweden.

Work against FGM at a community level has focused on raising awareness among the African immigrant community, with the aim of starting to break the taboos around FGM. The joint involvement of women's organisations, health authorities, and local government has been essential to this work.³⁵

Conclusion

Specific law exists prohibiting all or some forms of FGM exist in only a few Western countries. The formulation of the law, however, does not seem to be the main problem. Enforcement of the law proves a far greater challenge. The experience in Sweden, France, and Denmark demonstrate the need for a joined-up approach to FGM that includes civil society, central government, health authorities, and other relevant agencies. Working with communities to raise awareness and change attitudes to FGM must go hand-in-hand with legal prohibition in order to achieve changes in behaviour.

³⁴ Female circumcision clampdown call <http://news.bbc.co.uk/1/hi/health/1033732.stm>, 22 November 2000

³⁵ Norway: "Difficult Topic" http://www.afrol.com/Categories/Women/women014_fgm_europe.htm