Female Genital Mutilation

A study of health services and legislation in some countries of the European Union

Elis LEYE

2008

Thesis submitted to fulfil the requirements for the degree of Doctor in Comparative Sciences of Culture

Promotor: Prof Dr Marleen Temmerman, Dept of Obstetrics and Gynaecology, Ghent University

Co-promotor: Prof Dr Hendrik Pinxten, Dept of Comparative Sciences of Culture, Ghent University

Ghent University
Faculty of Arts and Philosophy
Female Genital Mutilation – A study of health services and legislation in some countries of the European Union
Els Leye

Promotor: Prof. Dr. Marleen Temmerman
Dept of Obstetrics and Gynaecology, Ghent University

Deze publicatie is verschenen binnen de reeks “ICRH Monografieën”/ This title has been published in the series “ICRH Monographs”

International Centre for Reproductive Health Ghent (ICRH)
Ghent University (UGent)
De Pintelaan 185 P3
B- 9000 Ghent (Belgium)
www.icrh.org
Promotor: Prof Dr Marleen Temmerman
Department of Uro- and Gynaecology
Ghent University

Co-promotor: Prof Dr Hendrik Pinxten
Department of Comparative Sciences of Culture
Ghent University

Members of the jury: Prof Dr Raymond Detrez
Department of Slavic and East European Studies
Ghent University

Anke van der Kwaak
Development, Policy and Practice, Department Health
Royal Tropical Institute Amsterdam

Prof Dr Eva Brems
Human Rights Centre
Department of Public Law
Ghent University

Prof Dr Patricia Claeys
International Centre for Reproductive Health
Ghent University

Dr Chia Longman
Centre for Intercultural Communication and Interaction
Department of Comparative Sciences of Culture
Ghent University

This work was supported by the European Commission, Daphne Programme

Photo credit: Griet Quartier
For Patricia...
### CONTENTS

**ACKNOWLEDGEMENTS** ........................................................................................................... 15

**LIST OF ABBREVIATIONS** ....................................................................................................... 19

**CHAPTER 1: INTRODUCTION** .................................................................................................. 21

1.1. Definition and classification ................................................................................................... 21

1.2. Terminology .......................................................................................................................... 22

1.3. Magnitude of FGM .................................................................................................................. 22

1.4. Reasons for performing FGM .................................................................................................. 24
   1.4.1. Religion ............................................................................................................................. 24
   1.4.2. Health ................................................................................................................................. 25
   1.4.3. Socio-economic reasons .................................................................................................... 25
   1.4.4. Tradition and ethnic reasons ............................................................................................. 26
   1.4.5. Gender-related factors ....................................................................................................... 26

1.5. Origins of female genital mutilation .......................................................................................... 27

1.6. Reproductive, sexual and other health consequences of FGM .................................................. 27
   1.6.1. Factors contributing to FGM-related morbidity .................................................................. 27
   1.6.2. FGM related morbidity and mortality ................................................................................ 28
   1.6.3. Issues in assessing reproductive, sexual and other health consequences of FGM .................. 33

1.7. Strategies for the prevention of FGM ....................................................................................... 34
   1.7.1. Legal approach .................................................................................................................. 35
   1.7.2. Health (risk) approach ....................................................................................................... 36
   1.7.3. Human rights approach ..................................................................................................... 37
   1.7.4. Religious approach ........................................................................................................... 38
   1.7.5. Reconversion of excisors ................................................................................................... 38
   1.7.6. Alternative rites of passage / coming of age programmes ................................................. 39
   1.7.7. Integrated or comprehensive social development approach .............................................. 39
   1.7.8. Positive deviance approach ............................................................................................... 40
   1.7.9. Research based approach ................................................................................................ 40

1.8. Community based interventions .............................................................................................. 41
   1.8.1. Alternative rites of passage, Maendaleo Ya Wanawake, Kenya ........................................... 43
   1.8.2. Village Education Programme, Tostan Senegal ................................................................ 43
   1.8.3. Monitoring of Girls at Risk by Positive Deviants, CEDPA, Egypt ...................................... 44
   1.8.4. The Intergenerational Dialogue, GTZ, Guinea-Conakry ..................................................... 45

1.9. Female genital mutilation in the European Union ..................................................................... 45
   1.9.1. Magnitude of the problem of FGM in some countries of the European Union .................... 45
   1.9.2. Initiatives at the level of the European Community ............................................................... 49
   1.9.3. National legislation prohibiting FGM ................................................................................ 51
CHAPTER 2: CONTEXT, AIMS, APPROACH AND LIMITATIONS ..........57

2.1. Context 57

2.2. Aims of the study 58

2.3. Limitations 59

2.4. Approach 60

2.5. Data collection 61

2.5.1. Objective 1: To examine the legal provisions in Europe applicable to FGM and to identify and analyse determinants of the implementation of the laws in some countries in the EU .................................................................61

2.5.2. Objective 2: To explore the health services available in some EU countries for women with FGM .................................................................62

2.5.3. Objective 3: To assess the FGM-related knowledge, attitudes and practices of Flemish gynaecologists .................................................................63

2.5.4. Objective 4: To obtain knowledge on key issues to be addressed in an integrated European agenda .................................................................63

2.6. Publications 64

2.7. Dissemination of results 65

CHAPTER 3: FINDINGS AND DISCUSSION........................................67

3.1. An analysis of the implementation of laws with regard to female genital mutilation in Europe 67

3.2. Health care in Europe for women with genital mutilation 99

3.3. Female genital mutilation: Knowledge, attitudes and practices of Flemish gynaecologists 117

3.4. Female genital mutilation, asylum seekers and refugees: the need for an integrated European Union agenda 141

CHAPTER 4: CONCLUSIONS ................................................................153

4.1. Summary of the results 153

4.2. Recent dynamics 155

4.2.1. Legal responses ..............................................................................155

4.2.2. Response of the health sector ...........................................................156

4.2.3. Operational cohesion in EU countries .............................................158
4.2.4. Response of religious leaders ................................................................. 159

4.3. Overall conclusion .................................................................................. 160

CHAPTER 5: REFERENCES ......................................................................... 163

EXECUTIVE SUMMARY .......................................................................... 173

SAMENVATTING ....................................................................................... 179
WOORD VAN DANK

Het is met een immens gevoel van opluchting en dankbaarheid dat ik dit dankwoord schrijf. Opluchting omdat het werk af is en omdat de vele obstakels er niet in geslaagd zijn om het hele project te kelderen, en dankbaarheid voor een groot aantal personen die mij gedurende deze lange weg hebben geholpen en ondersteund.

Eerst en vooral, wil ik mijn erkentelijkheid betuigen aan mijn promotor en mijn co-promotor. Professor Temmerman ben ik ontzettend dankbaar voor de kansen die ze gaf om mee te werken aan de uitbouw van het International Centre for Reproductive Health (ICRH). Haar constante aanmoediging om te publiceren en om een onderzoeks“niche” uit te bouwen hebben uiteindelijk geleid tot dit doctoraat. Ik ben ondertussen één van de veteranen geworden, en ben heel fier deel uit te maken van het team van bevlogen en kundige onderzoekers. Ik ben haar ook zeer erkentelijk voor de niet aflatende steun tijdens het schrijven van mijn doctoraat, in het bijzonder tijdens de incidenten de eindsprint. Hierbij gaat mijn oprechte dank en erkentelijkheid ook uit naar Prof Pinxten, voor de kans die hij mij bood om te doctoreren aan de Vakgroep Vergelijkende Cultuurwetenschappen. Het is voor mij een eer om in deze faculteit te kunnen doctoreren. Prof Brems en Dr Thierfelder, wil ik hierbij uitdrukkelijk bedanken voor hun wijze woorden en goede suggesties tijdens het schrijven van het doctoraat. Ik hoop in de toekomst nog vaak met jullie te kunnen samenwerken.

En dan zijn er nog de collega’s op het ICRH! De steun die jullie gaven was van onschatbare waarde, zeker tijdens de laatste maanden. Op die momenten dat de eindmeet verder leek dan ooit, was er altijd wel een collega die mij aanspoorde om het vooral niet op te geven. Heel in het bijzonder wil ik Prof Patricia Claeys bedanken. Niet alleen voor haar hulp tijdens het doctoraat, maar vooral omwille van de fijne, collegiale samenwerking tijdens de vele jaren dat we samenwerkten op het ICRH. Jouw doorzicht en capaciteiten om naar oplossingen te zoeken hebben mij in vele opzichten verder geholpen. Je lach is legendarisch geworden en heeft menig maal gezorgd voor het vrijwaren van de goede sfeer op het werk.

Khady Koita, Gerda Nienhuis en ik worden soms de drie musketiers genoemd! Samen hebben we het Europees Netwerk voor de Preventie van Vrouwelijke Genitale
Verminking uit de grond gestampt. Het was, en is, een helse klus, om het Netwerk operationeel te houden, maar met jullie hulp komen we er zeker. Ik heb jullie leren kennen als hardwerkende en integere collega’s, en heb jullie allebei als vriendinnen in mijn hart gesloten. Ik zou hier graag ook twee personen in het bijzonder willen bedanken: Dr Ruud Mak en Marijke Van Hemeldonck. Zij zijn sleutelpersonen geweest die mijn leven een andere wending hebben gegeven. Ruud is voor mij een mentor geweest toen ik met hem samenwerkte in EUROPAP, en ik heb van hem heel wat opgestoken over project management en netwerking. Marijke Van Hemeldonck heeft mij op de weg gezet die leidde naar dit doctoraat: zij signaleerde ons de noodzaak om vrouwelijke genitale verminking in Europa aan te pakken, en mijn gesprekken met haar waren altijd zeer inspirerend.


Het laatste woord van dank heb ik bewaard voor mijn familie en vrienden. Mijn ouders, Louis en Cécile, ben ik dankbaar voor de inspanningen die zij hebben geleverd om hun vier kinderen te laten studeren. Ik hoop dat dit doctoraat een kleine compensatie is voor de zaken die jullie je hebben moeten ontzeggen toen wij allen studeerden in Gent.
En dan zijn er nog mijn “maatjes”, die altijd voor de nodige mogelijkheden hebben gezorgd om lichaam en geest te ontspannen, heel in het bijzonder: Lieve, Hartwig en Axana, bedankt voor jullie gastvrijheid, familiewarmte en steun; Lieven en Nadine, bedankt om er altijd te zijn en jullie luisterend oor; Niels, onze geesten aanscherpen blijft één van mijn favoriete bezigheden, waarvoor dank; Eef en Geert, ik wil jullie bedanken voor de “family nights” maar vooral om de steun en de knuffels toen het heel hard nodig was; en Johan, je zin voor relativering hebben mij vaak terug met de voeten op de grond gebracht, waarvoor eveneens mijn oprechte dank!

Ik draag dit proefschrift op aan de vele slachtoffers van vrouwelijke genitale verminking. Ik hoop dat de onderzoeken die ik heb uitgevoerd, een bescheiden bijdrage kunnen leveren tot het uitbouwen van betere dienstverlening voor de slachtoffers.
ACKNOWLEDGEMENTS

With huge feelings of gratitude and relief, I’m writing this word of thanks. Relief because the work is finally finished and the many obstacles did not succeed in sinking the whole project; and gratitude towards many individuals who have helped and supported me during this long journey.

First of all, I would like to express my gratitude towards my promoter and co-promoter. I would like to thank Professor Temmerman for the opportunities she gave me to contribute to the implementation of the International Centre for Reproductive Health (ICRH). Her continuous encouragements to find a research “niche” and to publish have finally led to this doctoral manuscript. Meanwhile, I’ve become a veteran, or an old-timer, and am very proud to be member of a team of inspired, committed and knowledgeable researchers at ICRH. I’m also very grateful to her for her consistent support for writing up the manuscript, especially in the eventful final sprint. I’m equally very grateful to Professor Pinxten, for providing the opportunity to obtain a PhD within the Department of Comparative Cultural Sciences. It’s a great honour to receive my doctor’s degree within the faculty of Arts and Philosophy. I would also like to thank Professor Brems and Dr Thierfelder for their wise words and good suggestions while I was writing this document. I hope to be able to work with you again in the future.

Secondly, I’d like to thank my colleagues at ICRH! The support that all of you provided was invaluable, especially during these last months. At times when the end seemed further away than ever, there was always a colleague to prompt me to not give up. I’d like to express my gratitude especially to Professor Patricia Claeys, not only for her help during my PhD, but also because she has been a good colleague during all the years we have worked together at ICRH. Her insights and capacities to find solutions have helped me in many ways. Her laugh is legendary, and more than once her laughter preserved the good atmosphere at work.

Khady Koita, Gerda Nienhuis and I are sometimes called “the three musketeers”. Together we have created the European Network for the Prevention of Female Genital
Mutilation. It has been, and still is, a hell of a job to keep the network operational, but with your help I know we can succeed. I have got to know you as hard-working and honourable colleagues, but I have equally taken you into my heart as friends.

In particular, I also would like to thank Dr Ruud Mak and Mrs Marijke Van Hemeldonck. They were key people who helped in changing the course of my life. Ruud was my mentor while I was working with him in the EUROPAP project, and I learned a lot about project management and networking. Marijke Van Hemeldonck put me on the track that led to this manuscript: she was the one who pointed out the importance of taking up the issue of female genital mutilation in Europe, and my conversations with her have always been very inspiring.

Over the years I have been privileged to work with a wide variety of people and organisations, while doing the research or during workshops, meetings and conferences. In particular, I would like to mention: Adwoa Kwateng-Kluitse from Forward in London, Linda Weil-Curiel from CAMS in France, Sara Johnsdotter from Malmö University, José Garcia Añón (Pepe) from the University of Valencia, Zahra Said Naleie and Shamsa Said from the Federation of Somali Associations in the Netherlands, Ambara Hashi Nur from the Somali Women’s Organisation in Denmark, Fana Habteab from Sweden, Comfort Momoh from London, Berhane Ras-Work from the Inter-African Committee on Harmful Traditional Practices in Geneva, Etenish Hadis from the Afrikanische Frauenorganisation in Vienna, Isabelle Gillette-Faye from GAMS in Paris, Jamila Said Musse and Piret Esken from Göteborg, Stan Meuwese from Defence for Children International, Maria de Bruyn and Anke van der Kwaak from the Royal Tropical Institute in Amsterdam.

My final word of gratitude goes to my family and friends. Last, but certainly not least. I’m ever so grateful to my parents, Louis and Cécile, for their efforts to give their four children the opportunity to study. I hope that this PhD can be a small compensation for the many hardships you’ve endured while we were studying in Ghent.

And then there are my “buddies”, my friends, who were always ready to provide the much-needed opportunities to relax my body and mind. In particular, I’m ever so thankful to: Lieve, Hartwig and Axana for their hospitality, warm-heartedness and
support; Lieven and Nadine for listening to me and just for being there; Niels for our vivid discussions that sharpen our minds; Eef and Geert for the family nights, but especially I thank Eef for her being there on the important days and the big hugs when it was so very needed; and finally Johan for putting things in perspective!

I dedicate this manuscript to the many victims of female genital mutilation. I hope that my research could make a small contribution to a better service delivery for them.
**LIST OF ABBREVIATIONS**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACP</td>
<td>African, Caribbean, Pacific</td>
</tr>
<tr>
<td>AD</td>
<td>Ante Deus</td>
</tr>
<tr>
<td>AIDOS</td>
<td>Associazone Italiana Donne per lo Sviluppo</td>
</tr>
<tr>
<td>ARP</td>
<td>Alternative Rite of Passage</td>
</tr>
<tr>
<td>AWWC</td>
<td>African Well Women Clinic</td>
</tr>
<tr>
<td>BBC</td>
<td>British Broadcasting Corporation</td>
</tr>
<tr>
<td>CAMS</td>
<td>Commission pour l’Abolition des Mutilations Sexuelles</td>
</tr>
<tr>
<td>CBO</td>
<td>Community-based Organization</td>
</tr>
<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of All Forms of Discrimination Against Women</td>
</tr>
<tr>
<td>CEDPA</td>
<td>Centre for Development and Population Activities</td>
</tr>
<tr>
<td>CRC</td>
<td>Convention on the Rights of the Child</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic Health Survey</td>
</tr>
<tr>
<td>EC</td>
<td>European Commission</td>
</tr>
<tr>
<td>EP</td>
<td>European Parliament</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>EURNET-FGM</td>
<td>European Network for the Prevention of Harmful Traditional Practices, in particular Female Genital Mutilation</td>
</tr>
<tr>
<td>FGC</td>
<td>Female Genital Cutting</td>
</tr>
<tr>
<td>FGM</td>
<td>Female Genital Mutilation</td>
</tr>
<tr>
<td>FGM/C</td>
<td>Female Genital Mutilation/Cutting</td>
</tr>
<tr>
<td>FOKO</td>
<td>Nordic Network for Research on Female Circumcision</td>
</tr>
<tr>
<td>FORWARD</td>
<td>Foundation for Women’s Health, Research and Development</td>
</tr>
<tr>
<td>GAMS</td>
<td>Groupement pour l’Abolition des Mutilations Sexuelles</td>
</tr>
<tr>
<td>GTZ</td>
<td>Gesellschaft für Technische Zusammenarbeit</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HV</td>
<td>Health Visitor</td>
</tr>
<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
</tr>
<tr>
<td>ICRH</td>
<td>International Centre for Reproductive Health</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education, Communication</td>
</tr>
<tr>
<td>IRCP</td>
<td>International Centre for Research on Criminal Policy</td>
</tr>
<tr>
<td>IUD</td>
<td>Intrauterine Device</td>
</tr>
<tr>
<td>KAP</td>
<td>Knowledge, Attitude and Practices</td>
</tr>
<tr>
<td>MICS</td>
<td>Multiple Indicator Cluster Surveys</td>
</tr>
<tr>
<td>MYWO</td>
<td>Maendaleo Ya Wanawake</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental Organization</td>
</tr>
<tr>
<td>NPWJ</td>
<td>No Peace Without Justice</td>
</tr>
<tr>
<td>PATH</td>
<td>Programme for Appropriate Technology in Health</td>
</tr>
<tr>
<td>PDA</td>
<td>Positive Deviance Approach</td>
</tr>
<tr>
<td>PFCA</td>
<td>Prohibition of Female Circumcision Act</td>
</tr>
<tr>
<td>PID</td>
<td>Pelvic Inflammatory Disease</td>
</tr>
<tr>
<td>PMI</td>
<td>Protection Maternelle Infantile</td>
</tr>
<tr>
<td>PROWID</td>
<td>Promoting Women in Development</td>
</tr>
<tr>
<td>RISK</td>
<td>Riksföreningen Stoppa Kvinnlig Könsstypning</td>
</tr>
<tr>
<td>SSD</td>
<td>Social Services Department</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>SW</td>
<td>Social Worker</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Name</td>
</tr>
<tr>
<td>---------</td>
<td>-----------</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children Fund</td>
</tr>
<tr>
<td>UNIFEM</td>
<td>United Nations Development Fund for Women</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
CHAPTER 1: INTRODUCTION

1.1. Definition and classification

Female genital mutilation (FGM) comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons (2). Since 1997, the World Health Organization (WHO) has classified the various forms of FGM into four categories (3):

- Type I – excision of the prepuce, 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;
- Type III – excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation);
- Type IV – pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it; and any other procedure that falls under the definition given above (2).

The most common type of FGM 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 (2).

This widely used classification is currently being reviewed by WHO in collaboration with United Nations (UN) bodies, and a proposal has been made to include a Type V which refers to symbolic practices that involve the nicking or pricking of the clitoris to release a few drops of blood (4).
1.2. Terminology

The terms most widely used are “female genital mutilation” and “female circumcision”. A wide range of stakeholders have used the term “female genital mutilation” because they believe it acknowledges the damage caused by the practice. The term FGM has been “a very effective advocacy and policy tool and has been used in several UN conference documents”(5). Female circumcision and any other local terminology are often used by fieldworkers and researchers, as it is believed to be less offensive and judgmental towards practising communities than the term “female genital mutilation”. Opposition to this term focuses on the similarities with male circumcision, although the cutting involved in male circumcision is nowhere near as invasive as most forms of FGM.

Recently the term “female genital mutilation/cutting (FGM/C)” or even “female genital cutting (FGC)” has emerged in publications, and there is a tendency to use these terms in public discourse and at political level, once again because it is believed to be more neutral than “female genital mutilation”. At a UN consultation meeting on the new Joint Statement on Female Genital Mutilation (Geneva, 4–5 October 2006), the draft of the new joint statement included a discussion on the proposed switch to FGM/C. This meeting did not render a decisive conclusion to change the terminology, and discussion is ongoing between UN agencies, researchers and activists. Until further notice, the official terminology used by WHO is still “female genital mutilation”.

In accordance with the terminology used in the first joint statement of WHO, the United Nations Children’s Fund (UNICEF) and the United Nations Population Fund (UNFPA), the term “female genital mutilation” is used throughout this thesis (3).

1.3. Magnitude of female genital mutilation

WHO estimates that between 100 and 140 million women and girls in the world have undergone FGM, and about three million girls and women are being cut each year (6). Ethnic groups in about 28 African countries practise it, with prevalence rates varying
between 20% in Senegal to 5% in the Democratic Republic of Congo and 98% in Somalia. It is not practised in northern (with the exception of Egypt) and southern African countries, but it is also found in regions of the Arabian peninsula, for example in Yemen, and in some communities in Asia, although to a much lesser extent (7). According to WHO, the most common type of FGM is excision (Type II), accounting for up to 80% of all cases, while infibulation constitutes about 15% of all procedures (2).

A significant decline in the prevalence rates of FGM is the “ultimate quantitative measure” to show that interventions towards the abandonment of FGM have been successful. However, the most recent statistical report, based on Demographic Health Survey (DHS) and Multiple Indicator Cluster Surveys (MICS)¹ data, states that there is still no overall global drop in prevalence, but only a slow decline in prevalence in some countries (8).

Assessing differences in prevalence is only possible over the long term, since the population is followed from childhood to adulthood. Measuring the incidence might be more accurate but is more difficult, time-consuming and expensive. A cumulative incidence could be assessed in young girls and children, e.g. at one year, five years and adolescence, to follow any changes in the practice over time.

¹ DHS and MICS are nationally representative household surveys designed to measure the health and nutritional status of women and children in the developing world (8).
1.4. Reasons for performing female genital mutilation

The reasons why FGM is performed can be summarized as follows: religious or health reasons, hygienic grounds, for the sake of tradition or ethnic interests, and for socio-economic or gender-related reasons. This categorization is somewhat artificial: in reality FGM might be performed for a number of reasons at the same time. The reasons also vary between regions, ethnic groups or communities (9).

1.4.1. Religion
Religion plays an important role in the persistence of FGM. It is predominant among Muslims, but also occurs among Christians (Coptic, Catholic and Protestant), animists and Jews (the Falashas in Egypt) (9). Research showed that the incidence of FGM in
the Central African Republic, Ivory Coast, Egypt, Eritrea, Mali, Sudan and Yemen is higher among Muslim women than among Christian women (10). However, the majority (80%) of Muslims worldwide do not practise FGM (11).

Among different ethnic groups in Africa there is a persistent belief that FGM is an Islamic rule. Until recently, there has been an ongoing discussion between advocates and opponents of FGM as to whether the practice is recommended in the Koran or not. At present, there is a general understanding that FGM is not recommended in any religious text. The persistence of the practice, especially among Muslim women, is partly because many women do not have access to religious texts or because they are illiterate, and partly because many religious leaders do not openly oppose all forms of FGM.

1.4.2. Health
In some ethnic groups FGM is related to fertility, male potency and the health of babies. Some ethnic groups believe that women who have undergone FGM have higher fertility. Women in Ghana and Nigeria are excised to cure infertility. The Mossi in Burkina Faso and the Bambara in Mali believe that the clitoris can make men impotent or can even kill them during sexual intercourse. The Wala in Ghana believe that the clitoris neutralizes the erection and hence prevents conception. It is also believed that the clitoris can kill a baby during birth (Mossi in Burkina Faso, Bambara and Dogon in Mali, some Nigerian groups), and in Sudan people believe that FGM can cure some infant diseases (9).

1.4.3. Socio-economic reasons
In many regions women need to undergo FGM to get married. In those communities where women are economically dependent on men, the questioning of FGM is not a possibility. The economic disadvantages of FGM, such as medical costs or the loss of productivity because of illness, are often not recognized as being caused by FGM. Excisors themselves also gain a living through the performance of the “operations” and enjoy a certain status as guardians of tradition, two factors that have an influence on the resistance to abandon FGM (9).
1.4.4. Tradition and ethnic reasons

FGM may be seen as a ritual that strengthens community cohesion, since it is thought to promote identification with a culture or lineage group. Girls and women who have not been genitally cut may be prohibited from activities within their communities such as participating in funeral rites or preparing food for men and genitally cut women. Their condition could also affect other family members. Among the Samburu in Kenya boys with uncut older sisters may not be initiated as warriors. Bartels has speculated that FGM may be seen as a demarcation ritual in some cases: it serves as a characteristic that helps to distinguish ethnic groups from one another. When an uncut woman from one ethnic group marries into another that practises FGM, she may be pressured by her female in-laws to undergo the procedure so that it becomes obvious she has joined the new ethnic group (9).

1.4.5. Gender-related factors

Gender-based ideas related to concepts and norms regarding "proper" womanhood, femininity and female sexuality play a major role in the propagation of FGM. Some authors characterize FGM as a rite of passage in which a girl accepts her female identity and is prepared for later marriage; others state that it is a demarcation ritual in which a distinction is made between gender-ambiguous children and adults and/or between males and females. Among the Dogon and Bambara ethnic groups in Mali it is believed that people possess both male and female souls at birth: the boy's female soul is in the prepuce and the girl's male soul in the clitoris. An evil spirit resides in the prepuce and clitoris that prevents the hosts from uniting with members of the opposite sex and entering adulthood. A child is neither male nor female until he/she has been genitally cut. The immense value placed on female virginity and control of female sexual desire and practice is expressed through making virginity a prerequisite for marriage eligibility and/or payment of bride price. Women of some groups refer to FGM when speaking of a girl's honour. It is often in this context of honour that FGM is defended: it is assumed to reduce a women's sexual desire and lessen temptations to have extramarital sex (thus also reducing chances of children being born outside the patriarchal lineage) and preserving a girl’s virginity (9). A study from New York City revealed that African parents are in favour of FGM because they fear “promiscuity in their daughters in a society that has no sexual limits” (12).
1.5. Origins of female genital mutilation

There is no univocal answer to the question of where FGM has its origins. Several publications and researchers are inconsistent in explaining where FGM originates. Lightfoot-Klein claims that it can be traced back to ancient Egypt (3000 AD–332 AD); others state that it occurred with the rise of Islam (579 AD) or that it originated independently within some ethnic groups in Black Africa as part of initiation rites (1;13;14).

1.6. Reproductive, sexual and other health consequences of female genital mutilation

1.6.1. Factors contributing to FGM-related morbidity

Most evidence on obstetric and other reproductive and sexual health consequences comes from surveys based on self-reported consequences, case reports and hospital-based epidemiological studies that use clinical examinations to determine complications (15;16). Community-based studies on the frequency of complications of FGM do not exist, as further discussed in Section 1.6.3 (16).

FGM is performed by traditional health practitioners, women and men who have inherited the position of excisor, male barbers, herbalists, members of secret (religious) societies and of certain castes or families, traditional birth attendants, midwives, nurses and physicians (9). Many of these traditional “circumcisers” have no or limited medical training and/or knowledge of anatomy and surgical techniques (9;17). In some areas in Africa there is a tendency to medicalize the practice by, for example, replacing the traditional practitioners with skilled health personnel or by providing sterile instruments to diminish the negative health implications of the procedure (18). The medicalization of FGM is subject to extensive debate (see Chapter 3).

The instruments used (such as knives, razor blades, pieces of glass, sharp stones or scissors), the conditions under which the procedure is performed (the (non)-use of sterile instruments and anaesthesia), the condition of the girl (e.g. health of the child,
the degree of struggling at the time of cutting) and the availability of medical support (e.g. availability of injections against tetanus, medicines for wound care and haemostasis and proximity of post-operative care services) are factors that might have an influence on the health implications of the cutting.

1.6.2. FGM-related morbidity and mortality
The morbidity and mortality associated with FGM is difficult to measure, as is explained in detail in Section 1.6.3. In the literature a wide range of FGM-related health consequences are described and most commonly classified based on the time at which they appear (short-term or long-term complications), on the nature of the consequences (e.g. obstetric, psychological, sexual and social consequences) or both (19-21). A major shortcoming when describing FGM-related sequelae is that the type and frequency of complications are not systematically attributed to the type of FGM (15;18).

○ Immediate complications
According to Elchalal, approximately 25% of infibulated women suffer from one or more of the immediate complications of FGM (22). A study among Somali women showed that acute complications occur in 39% of the procedures (23). Immediate complications that have been documented include:

- **Severe pain** (24);
- **Haemorrhage**: amputation of the clitoris involves cutting across the clitoral artery which has a strong flow and a high pressure. Cutting across the internal pudendal artery can cause serious bleeding. Haemorrhage may also occur after the first week because of sloughing of the clot over the artery, usually because of infection. If bleeding is very severe and uncontrolled it can result in death (24);
- **Shock**: because of the sudden blood loss and/or the unexpected and agonising pain (17);
- **Acute urinary retention** occurs nearly always because of 1) the pain and burning sensation of urine on the raw wound; 2) damage to the urethra and its surrounding tissue; 3) labial adhesion or nearly complete closure of the vaginal orifice as in infibulation (15;17);
- **Urinary infection**: due to urine retention, the use of non-sterilized equipment and the application of local dressings of animal faeces and ashes. The infecting
organisms may ascend through the short urethra into the bladder and the kidneys (15);

- **Wound infection and fever** (23;25;26);
- **Septicaemia** (23);
- Group excisors using the same unclean cutting instruments are still common and can spread **HIV infection** (27);
- Eventually **death** can occur due to haemorrhagic or septic shock, tetanus and a lack of availability of medical services or a delay in seeking help (17).

According to WHO, immediate complications associated with all four types of FGM include infection, urinary retention, severe pain, shock, haemorrhage and death (17).

° **Long-term complications**

Late complications are more often associated with infibulation than with clitoridectomy alone because of the interference with the drainage of urine and menstrual blood, although Shell-Duncan states that this link has been poorly researched (18).

- **Pelvic inflammatory disease (PID)**: this has been shown to be three times more common in women who have undergone infibulation than in those who have had a clitoridectomy (26;28;29). PID is a risk factor for infertility;
- **Problems with menstruation**: irregular bleeding and vaginal discharge, dysmenorrhea due to pelvic infection or due to the obstruction of the vaginal orifice (as in infibulation) (20);
- **Cysts and abscesses**: resulting from the edges of the incision being turned inwards and inclusion of the epithelium. Damage to the Bartholin’s duct can also lead to cysts and abscesses (15;20;24);
- Formation of **a keloid scar**: coloured people have an increased tendency to develop keloids, and this is exacerbated by the slow and incomplete healing of the wound and infection (20;25);
- **Dyspareunia**: due to the tight vaginal opening, to pelvic infection or to vaginismus (25);
Haematocolpos is estimated at 2–3.5% in Sudan and Somalia due to closure of the vaginal opening by scar tissue. Menstrual blood accumulates over many months in the vagina and uterus (23); Primary infertility: an association between severe forms of FGM and primary infertility has been described in Sudan. Infections that arise after FGM in childhood might ascend to the internal genitalia, causing inflammation and scarring and subsequent tubal-factor infertility (28); Formation of rectovaginal and vesico-vaginal fistula: vesico-vaginal and recto-vaginal fistula results in a distressing condition of urinary and faecal incontinence, respectively, for which women are often ostracized by their community (30); Recurrent or chronic urinary tract infections: due to stasis of urine in the bladder and behind the scar tissue (16;20;28;29); Urinary problems: 1) Difficulty in urinating because of a damaged urethral opening or scarring over the urethral opening or inability to completely evacuate the bladder when urinating; 2) Urinary incontinence as a complication of an over-distended bladder and recurrent urinary infections. Scar neuroma: on the dorsal nerve of the clitoris (20); Anal incontinence and anal fissures: due to rectal intercourse when vaginal intercourse is not possible; Transmission of HIV, Hepatitis B, and other blood borne diseases: possible modes of infection are 1) sexual intercourse before the wound is healed; 2) easy bruising of the genital mucosa after FGM enhancing susceptibility to HIV infection; 3) tears and cuts during intercourse in the case of scar tissue and a small vaginal opening; and 4) anal intercourse due to difficulties with vaginal intercourse (17;19;20;27).

Obstetric complications
Although few reliable data exist, it is likely that the risk of maternal death and stillbirth is increased, particularly in the absence of skilled health personnel and appropriate facilities.

A recent study by WHO among women attending obstetric centres in six African countries for singleton deliveries showed that deliveries in women who have
undergone FGM are significantly more likely to be complicated by caesarean section, postpartum haemorrhage, episiotomy, extended maternal hospital stay, resuscitation of the infant, and inpatient perinatal death than deliveries to women who have not undergone FGM. These higher risks of obstetric complications in women with FGM are likely to be more widely applicable. However, the frequency and effect of these complications among women giving birth in hospital might differ from those in women giving birth elsewhere (31). Other obstetric complications that have been documented are:

- **Prolongation of the second stage of labour** (a major obstetric problem) because of vulval scarring or soft tissue dystocia (25;32;33). Prolonged, obstructed labour and lack of oxygen during the second phase of labour can result in foetal death (stillbirth and early neonatal death) (33-35;35;36);
- **Perineal lacerations** because of loss of natural compliance of the tissues (33;35;37;38);
- **Perineal wound infections** and **postpartum sepsis** (35);
- **Postpartum haemorrhage** due to tearing of the scar tissue (33);
- **Fistulae formation**: obstructed labour can cause necrosis of the vaginal wall because of the constant pressure of the baby’s head on the posterior wall of the urinary bladder and the anterior wall of the rectum (35);
- **Repetition of deinfibulation and reinfibulation** leaves extensive scarring which is often unstable (17);
- **Unnecessary caesarean sections** in cases where doctors are not familiar with FGM. Resorting to caesarean section for fear of handling the infibulation scar adds the risks of general anaesthesia and major surgery (39).
- **Increased risk of HIV transmission** in infibulated women: excessive blood loss at delivery in infibulated women might expose the child (and staff) to HIV infection.

* **Other gynaecological problems**
  - A proper bimanual and vaginal speculum examination (including Papanicolaou smear taking, sexually transmitted infection (STI) screening and intrauterine device (IUD) insertion) might be hampered by FGM (37);
Difficulty in performing a good pelvic examination in infibulated women may result in the inability to effectively monitor the progress of labour (40).

Psychological and sexual problems
Little scientific evidence is available on the psychosexual effects of the practice, and findings are inconclusive. Some of the psychosexual problems that have been documented include:

- **Sexual problems**: 1) Frigidity due to dyspareunia, injuries sustained during early intercourse, pelvic infection; 2) Lack of orgasm due to the amputation of the glans clitoris (41;42). A study conducted on 651 circumcised Egyptian women showed that their sexual desire was not affected by the procedures, but the ability to achieve an orgasm was dependant on the severity of the operation and the extent to which social messages inhibiting sexual expression were internalized (43); 3) coital difficulty or inability to have vaginal intercourse at all because of stenosis of the vagina may affect up to 35% of infibulated women (44); 4) marital conflicts.

- **Psychological problems** such as post-traumatic stress disorder, behavioural disturbances, psychosomatic illnesses, anxiety, nightmares, depression, psychosis, neurosis and suicide due to the painful FGM procedures may occur. Also subsequent painful menstruation, painful intercourse, recurring episodes of frigidity, formation of dermoid cysts and urine incontinence might also cause psychological problems (5;41;45).

A syndrome of ‘genitally focused anxiety depression’, characterized by a constant worry over the state of their genitals, intolerable dysmenorrhea and fear of infertility has been described in Sudan among infibulated women (30).

In communities where FGM has a high social value, girls and women who are not mutilated may be ostracized by their communities. Genitally mutilated women in migrant communities may face problems concerning their sexual identity when confronted with non-mutilated Western girls and women and the strong opposition to FGM in their host country.
1.6.3. Issues in assessing reproductive, sexual and other health consequences of FGM

Although FGM is widely recognized as a procedure causing physical and psychological suffering, the extent of FGM-related morbidity and mortality is poorly understood. The prevalence of FGM-related morbidity has been mainly assessed through hospital-based studies. No population-based surveys have been done to document the adverse outcomes of FGM according to the severity of cutting. Few studies have been designed that measure the frequency and nature of the health consequences by type of FGM (17;18;31;36). Consequently, many authors have reported the inconclusiveness of documented health consequences of FGM, especially of obstetric outcomes (15;16;19;27;31;36;46-48). The lack of scientific evidence is most apparent for types I and II of FGM (49). With regard to mortality rates due to FGM, there are no data but only case reports available (15).

According to Obermeyer, obtaining evidence on the complications of FGM is complicated because of the limits of logistics as well as the ethical issues involved in epidemiological studies that would follow individuals who undergo the cutting to observe complications over time (15). Medical examinations to assess the FGM status are problematic because they are costly and almost always performed on subgroups of hospital-based populations (50).

In 2003, Obermeyer performed a review of the health effects of FGM based on studies published between 1997 and 2002. She concluded that the fundamental problems in studies measuring health and other effects of FGM are the lack of precise definitions of the types of FGM, the lack of control groups, and difficulties in study design. Studies on sexuality and FGM fail to take contextual factors into consideration, and data collection methods are not careful with terminology, phrasing of questions, circumstances of the interview and quality of the conversation with the interviewer (47).

Self-reporting of sequelae is often not reliable, as women have difficulties in defining the relation between sequelae and the procedure (e.g. do they relate the pain they have to an infection caused by FGM, or do they qualify their bleeding as haemorrhage due to FGM), and there might be a recall bias if women have to report an event that
happened in childhood (31;15). This might lead to an under-measurement of sequelae (51). Another attributing factor is that women perceive the effects of FGM as normal because all women within a given population suffer the same consequences. Even if they acknowledge it as abnormal, the causal relationship between their excision and the effect is difficult to establish (15;18;51). Self-reported retrospective survey data also suffer from selection bias in that they are limited to women who survived FGM (18).

As stated before, information about the medical complications of FGM is based on hospital and clinic records (18). However, it is likely that only a limited number of complications ever come to the attention of medical personnel due to the unavailability or inaccessibility of health care, ignorance or fear of legal retribution. Most operators take care of the complications themselves, sometimes with devastating results. Only the more serious complications are referred to the health sector (22;25).

In some studies, self- or parental reporting of FGM status (excised or not) has proven to be fairly accurate when followed by a clinical examination, while self-reporting on non-excision status\(^2\) was less accurate (36;50;52;53). In a hospital-based study in Sudan, self-reporting of the type of FGM has also proven to be less reliable in that there is considerable under-reporting of the extent of the cutting (53). These inconsistencies might be due to a number of reasons such as difficulties experienced by clinicians in assessing minor forms of FGM, local terms used for FGM that do not correspond to anatomical terms and to WHO typology, as well as social pressure to report being cut since this is the socially accepted norm (27;53).

### 1.7. Strategies for the prevention of female genital mutilation

This section is an overview of most commonly used strategies that are or have been used to prevent FGM, evaluated and/or discussed by the WHO, the Population Reference Bureau, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) and Toubia and Sharief (54).

---

\(^2\) In communities where FGM is common, women tend to report being cut even if they are not, to comply with the social norm.
It should be noted here that within these approaches, different levels of discourse can be outlined and have led to heated debates among researchers, policymakers, feminists and activists. For example, advocates of cultural relativism consider FGM as a cultural tradition that should be respected and cannot be criticized by outsiders, while universalists consider FGM as an act of violence and a violation of the human rights of women. Another debate demonstrates the controversy between the pragmatic and the ideological approach to FGM. Health care workers prefer to limit the negative health effects of FGM, by providing sterile instruments to traditional excisors or by performing limited forms of FGM to avoid serious mutilations. Activists, on the other hand, focus on the abandonment of all forms of FGM and frame FGM within the human rights context. Feminists see FGM as a form of male dominance and sexual oppression of women, which might be contradictory to the pragmatic approach of health professionals.

The importance given to some attitudes has also shifted over time. In the 1960s and early 1970s, FGM was considered a traditional practice in which Westerners should not interfere. In a later phase, the human rights violations of FGM were denounced at international level, but field interventions focused on the negative health effects of FGM, trying to reduce FGM in the communities. Consequently, medicalization has increased in many countries in Africa in the past decades. More recently, the human rights perspective has gained more and more momentum in the setting up of interventions to curb the practice.

1.7.1. Legal approach
Many African and European countries have passed laws declaring FGM illegal. The advantages of FGM legislation are that it provides an official legal platform for action, it offers legal protection for women and it discourages excisors and families for fear of prosecution (55). It can also offer health professionals a legal framework to oppose requests for performing FGM.

However, FGM legislation alone cannot motivate communities and families to stop the practice if it is not accompanied by targeted efforts for prevention, training and behaviour change interventions (56). It is also known that criminal laws can lead to
the performance of FGM in an illegal setting, whereby complications are not taken to health services because of fear of prosecution (55;57). Indeed, one of our studies on the implementation of FGM laws in Europe indicates that sufficient time, means and commitment are paramount to implementing existing laws successfully (56). The findings of this study are discussed in Chapter 3.

1.7.2. Health (risk) approach
The health (risk) approach has been the most widely used motivator in efforts to eliminate FGM for the past 20 years (54). Interventions using a health-related strategy emphasize the harmful effects of FGM on women’s health. Health professionals deliver messages about the physical complications of FGM such as bleeding, infection and the risk to both mother and child during delivery. Although this approach had an important impact on breaking the taboo surrounding FGM, it has also led to a greater medicalization of FGM: trained health professionals such as doctors, nurses and midwives perform FGM. Milder forms of FGM performed by medically trained personnel have emerged and/or have been promoted (55). A discussion on medicalization is included in Chapter 3.

Health workers remain, however, important stakeholders for sensitizing and training communities on FGM, due to the significant role they can play in addressing the health consequences of the practice. There are various ways in which health workers are confronted with FGM, as they (55):

- have a unique relationship with the community;
- play an important role in medicalization and may be asked to reinfibulate women after delivery;
- have to deal with the complications of FGM;
- are in a position to play an important role in counselling women and couples to prevent them from excising their daughters; and
- are sometimes opinion leaders.

Consequently, training and sensitization of health workers is considered to be a priority strategy in the global abandonment of FGM.
1.7.3. Human rights approach

FGM is internationally seen as a violation of human rights (55). The human rights involved include the right to life, the right to the highest attainable standard of health and the right to freedom from violence (4). Milestones that put FGM on the human rights agenda include the UN World Conference on Human Rights in Vienna in 1993, the International Conference on Population and Development (ICPD) in Cairo in 1994, the Beijing Fourth World Conference on Women in 1995 and their follow-up events, Beijing +5 (2000) and Beijing +10 (2005).

The International Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted in 1979, and the Convention on the Rights of the Child (CRC), adopted in 1989, are two legally binding international human rights instruments that address “customary” or “traditional” practices. Article 5 of CEDAW addresses cultural practices (which may include FGM) in the context of unequal gender relations, while CRC addresses harmful traditional practices (with an explicit reference) in the context of the child’s right to the highest attainable standard of health (article 19) (4).

Most intervention programmes link FGM to human rights and use international conventions as lobbying and advocacy tools. However, when human rights are used as a central and isolated focus of discussion, such efforts show little effect and may present a concept far too abstract for many people involved if not ‘translated to fit their realities’ (55). A successful example of adapting the human rights framework to the local context is the Tostan education programme in Senegal, which has included teaching on human rights and democracy as an important topic in its integrated learning programmes to reinforce the abandonment of FGM (55). Human rights were integrated as part of a larger package of information on health, hygiene and other topics which were used in the women’s classes. The material was adapted and delivered in a sensitive and culturally acceptable manner (55). As a result, the community did not oppose the human rights approach.
1.7.4. Religious approach
In areas where the population is predominantly Muslim, religion is one of the strongest reasons given by parents for continuing the practice of FGM (55). Although the Koran does not require FGM, there is discussion among some Islamic religious leaders about hadiths\(^3\) which are supposed to claim that excision is recommended for women. Another main point of discussion is the so-called “sunna” type of FGM, which is believed to be a less invasive form and is, therefore, still recommended by some religious leaders (for further discussion, see Chapter 3).

Consequently, one of the approaches to the prevention of FGM focuses on involving Islamic religious leaders in strategies to change the community’s FGM behaviour. In many African countries, Islamic religious leaders have already openly supported the campaign against all forms of FGM (e.g. in Senegal), while in other countries religious leaders have spoken out against FGM but still claim that the sunna type of FGM is recommendable (e.g. in Djibouti).

1.7.5 Education of excisors
This approach, in which traditional excisors are educated about the health risks of FGM and/or alternative sources of income are provided for them, has been tried in many countries. It usually includes three phases:

- Identifying excisors and informing them about various issues related to FGM;
- Training excisors as change agents and motivating them to inform the community and families who request FGM about its harmful effects;
- Orienting them towards alternative sources of income and giving them resources, equipment and skills with which to earn a living (55).

The success of this approach has been questioned because of the following potentially negative effects:

- It does not deal with the demand and, where such strategies are not accompanied by extensive awareness campaigns addressing the community as a whole, families seek other providers;
- Traditional excisors return to cutting within a short period of time, as excision is a lucrative business;

\(^3\) Hadith is the second highest (after the Koran) text of Sunni Muslims (58). A hadith is a saying or action ascribed to the Prophet or an act approved by the Prophet (59).
In Ethiopia, income-generating projects for excisors attracted women who later said they had never excised girls;

- Focusing on the excisors sometimes actually boosts their importance instead of exposing the profession as one that is harmful and needs to be stopped (55).

### 1.7.6. Alternative rites of passage/coming of age programmes

This approach is described as “developing alternative rituals to substitute for the traditional cutting ceremonies”. The aim of this approach is to allow community-based organizations (CBOs) to consult with family and community members, such as tribal and religious leaders, to create coming of age celebrations that exclude cutting but that embrace other aspects of the ritual, including seclusion, information sharing, and celebration (60). This approach seems only applicable when there is a culturally meaningful coming of age ceremony or ritual (54;60). The success of this approach lies in its involvement of family and community members, including men, in designing the project (61). The progress is initially slow, but raising public awareness may have a snowballing effect that increases over time. It has been successful when implemented in close collaboration with the communities concerned and as part of a larger strategy i.e. it provides an entry point for the promotion of dialogue among family members about family, life education and sexuality issues (55;60). Initial evidence indicates that alternative ceremonies are well received and reduce the number of girls in their adolescent years who are cut as part of initiation. Evaluation of the types of rituals which work best and their sustainability over time is needed (55). An example of this approach is discussed in Section 1.8.1.

### 1.7.7. Integrated or comprehensive social development approach

FGM requires a comprehensive approach addressing aspects of gender and development as well as the social, political, legal, health and economic development of a community (55). The “integrated learning” approach is one such comprehensive approach and integrates the issue of FGM into a wider learning package.

The Tostan programme in Senegal, for example, which targets mainly women, includes modules on problem identification and problem-solving skills, women’s empowerment, hygiene, health and other subjects which are relevant to the community. After completion of the programme, whole villages speak out against
FGM in a public declaration. Until now, more than 1360 villages have delivered such a public declaration.

An example of this approach is discussed in Section 1.8.2. Although this approach is very promising, the success of such an intervention requires a large input of human resources as well as concise and systematic monitoring and evaluation. The results need to be quantified in terms of population numbers or the number of girls protected rather than the number of villages. Long-term follow-up is essential to ensure public declarations are followed by a widespread and sustainable stop to FGM (55). However, WHO and UNICEF consider this approach as a “model programme for other nations” (62).

1.7.8. Positive deviance approach
The positive deviance approach (PDA) identifies individuals who oppose FGM in communities and promotes them as role models in the community, the so-called “positive deviants”. Role models may include families, teachers, religious leaders, and others who have opposed the practice, urged others to reject it, or publicly declared their opposition to it. The strategy’s effectiveness is enhanced by efforts to document the stories of individuals who rejected FGM and how they dealt with confusion, opposition, and taking a stand against the majority. These individuals then recount their experiences at community forums (60). An in-depth analysis of the effect of this approach has not been conducted because of the lack of reliable descriptive or analytical reports (54). An example of this approach is discussed in Section 1.8.3.

1.7.9. Research-based approach
This approach encourages the design of an intervention or activity based on a thorough understanding of the local context. The activity needs to have monitoring and evaluation as key elements in its design (55). Programmes have sometimes failed because their approach was perceived as being imported or top-down, or they were criticized because they did not have monitoring and evaluation as key elements in their activities (55). A successful programme based on this approach has four essential elements:

- Conduct baseline research (quantitative and qualitative) to gain an understanding of the local context;
1.8. Community-based interventions

The first anti-FGM programmes, which started in the mid 1970s, focused on promoting, informing, motivating and teaching on the adverse health effects of FGM to break the taboo surrounding this harmful traditional practice. Therefore, efforts to stop the practice of FGM relied on information, education and communication (IEC) materials such as leaflets, booklets, training manuals and guidebooks for professionals. These IEC activities were often conducted with a focus on raising awareness rather than behaviour change and thus focused on short-term results, since behaviour change takes time. Moreover, these messages were neither research-based nor adapted for a specific context. The messages of the IEC tools were often developed without the involvement of the target population, and messages were seen as imposing (e.g. “Stop excising”), demoralizing (e.g. “Plan your family or you will be poor”) or were hard to understand. Research showed that while IEC activities are essential steps to raising awareness of the harmful effects of FGM, these activities (by themselves) did not change behaviour towards an abandonment of all forms of FGM (57). Information campaigns have increased knowledge among the target groups and are a necessary first step in sensitizing communities, but they need to be followed by community-based interventions targeting behaviour change.

In communities where IEC activities took place, there was a gap between what people knew and what people did – the so-called KAP⁴ gap. There was indeed a greater awareness (knowledge) of the adverse effects of FGM among the communities that practised it, and people changed their attitudes towards it (e.g. “I am not going to circumcise my daughter”), but only a minority of the people actually changed their behaviour, i.e. abandoned the practice of FGM (63). Consequently, a shift was made in the early 1990s from traditional IEC strategies to communication strategies that aimed at changing behaviour. However, IEC activities remain an important and

---

⁴ KAP means knowledge, attitudes and practice
crucial first step in the process of behaviour change in terms of informing people and raising awareness.

Over the past five years, in-depth reviews and evaluations have been conducted to ascertain the effectiveness of FGM programmes and approaches\(^5\). They concluded that most of the intervention programmes which aim to bring about FGM abandonment have been pilot in nature, thus reaching small numbers of at-risk communities. These programmes have not been tested in settings other than the ones in which they were initiated and have not been scaled-up (65). Most of these programmes have not been properly monitored, evaluated and documented and have not been sustainable over a long period of time (57). FGM interventions have not been designed with reference to a theoretical model but were developed in response to a particular situation, a specific setting (e.g. uncut girls needing an alternative ritual), programmatic experience (a functional literacy programme) or simply intuition (converting traditional practitioners) (65). Those interventions identified as successful were all designed and implemented in close relationship with the community and have more than one outreach component.

Some of the effective community-based abandonment programmes/approaches targeting behaviour change that have recently been used include the alternative rites of passage (e.g. MYWO in Kenya), community education and consensus building (e.g. Tostan in Senegal), the positive deviance approach (e.g. CEDPA in Egypt) and the Intergenerational Dialogue (Guinea-Conakry). These interventions are briefly discussed below.

\(^5\) In 1999, WHO reviewed and evaluated different interventions aiming at behaviour change (57). In 2000, Masterson and Swanson published the results from the evaluation of the Promoting Women in Development (PROWID) grants programme (64). In 2001, the Population Reference Bureau published a report presenting an overview and recent statistics about the practice of FGM, a summary of FGM abandonment approaches, and a brief discussion of projects in four countries identified as promising by the WHO and the Programme for Appropriate Technology (PATH) (60). In 2003, Toubia and Sharief assessed progress in FGM interventions, using reviews, secondary reports and evaluation studies from various sources (54).
1.8.1. Alternative rite of passage, Maendaleo Ya Wanawake, Kenya (66)

In 1996 MYWO and PATH developed the alternative rite of passage approach in close consultation with women leaders from families who had decided to stop excising their girls. The idea to develop an alternative rite of passage arose because those who decided not to excise their girls were faced with the dilemma of what to do about the traditional rite of passage that included FGM. The cultural significance associated with the practice of FGM makes it a very sensitive subject to address, and families and communities who are simply not ready to confront age-old tradition opt to continue with the practice even if they understand that it is harmful. The alternative rite of passage was designed to retain the best elements of the rite of passage and to discard the cut.

The first alternative rite of passage ceremony was celebrated in 1996 in Tharaka Nithi District where 28 girls were initiated into adulthood. Based on the success of the first ceremony, MYWO replicated the ceremony in nine other districts of Kenya. Since then, over 10,000 girls have been initiated through the alternative rite of passage, and other organizations have replicated the MYWO programme.

1.8.2. Village Education Programme, Tostan, Senegal (60;67)

Tostan, which means “breakthrough” in the Senegalese language of Wolof, empowers people through education and knowledge to enhance their personal and community development. This basic education programme consists of four modules: hygiene, problem solving, women’s health, and human rights. Through these four themes, emphasis is placed on enabling participants, mostly women, to analyse their own situation more effectively and find the best solutions for themselves. Tostan’s approach is based on peaceful social change through a basic community education programme and a process of social mobilization. The programme has been implemented in 90 villages in the Kolda region. The first public declaration to stop performing FGM took place in 1996 in Malicounda Bambara. Because of the activities of this community, neighbouring villages also began to speak out against FGM. The imam from the Bambara village of Keur Simbara, who was highly committed to ending FGM, visited all of the Bambara villages over a three-month period. His efforts and the consensus of religious, health, and government
representatives culminated in the Diabougou Declaration, which pledged the Bambara community’s commitment to end the practice of FGM.

Since 1997, 1367 communities in Senegal have abandoned FGM through 17 public declarations, which represents 28% of the 5000 communities that practised FGM in 1997. The social convention, which states that non-excised daughters are not respected and not marriageable, is beginning to change on a large scale. As intra-marrying groups declare abandonment, momentum builds, and others are influenced in the ethnic group, in the country and in other neighbouring countries. Mass abandonment occurs as a critical mass is formed and the social convention changes. Publicity and press coverage have aided the movement in encouraging dialogue on FGM and helped in the dissemination of anti-FGM messages beyond the initial villages.

1.8.3. Monitoring of Girls at Risk by Positive Deviants, CEDPA, Egypt (68)
In 1998–1999, the Centre for Development and Population Activities (CEDPA) in Egypt initiated a project to understand why some families do not excise their daughters. The project is based on the Positive Deviance Approach (PDA), a methodology that focuses on individuals who have “deviated” from conventional societal expectations and adopted – though perhaps not openly – successful alternatives to cultural norms, beliefs or perceptions in their communities. These individuals, whom CEDPA calls the “positive deviants”, have decided that they are against FGM and refuse to practise the procedure on their daughters.

The central approach used for raising awareness in the CEDPA project is community mobilization, which uses participatory processes to involve local institutions, local leaders, community groups, and members of the community to organize a collective action toward a common purpose. The focus of these community mobilization activities is outreach by positive deviants to community members through small group activities and larger public meetings. The strengths of this approach lie in understanding that solutions to problems already exist within communities and that, by taking part in a process of self-discovery, community members have the capacity to identify and implement them.
1.8.4. The Intergenerational Dialogue, GTZ, Guinea-Conakry (69)
The “listening and dialogue” method creates a two-way dialogue between the community and programme implementers. Young and old women participate in a guided dialogue on themes such as gender roles, sexuality, traditional values and practices. During this intergenerational dialogue, both generations reflect on their own values, traditions and aspirations, and decide when and how changes should take place. It encourages discussion on the ambivalences and dilemmas which accompany the process of adapting attitudes and behaviours. This method provides important information about the knowledge, attitudes and behaviour of a community.

1.8.5. Pilot intervention, Burkina Faso and Sudan
In collaboration with WHO, the International Centre for Reproductive Health (ICRH) is currently implementing an innovative pilot intervention in Burkina Faso and Sudan that combines activities of the four successful interventions mentioned above and which is adapted to the local context in these countries. The pilot intervention is research- and community-based, and has a participatory approach. The project will run for two years and is scheduled to be finalized by the end of 2008.

1.9. Female genital mutilation in the European Union

FGM has become an issue in Europe due to the migration of people from communities in Africa where FGM is common to host countries in the West.

1.9.1. Magnitude of the problem of FGM in some countries of the European Union
To date, there are no actual data available on the practice of FGM in Europe, either on the total number of women and girls that have undergone the practice, nor on the number of girls that might be at risk. However, establishing the magnitude of the problem of FGM in Europe is paramount to substantiate the claim for funds, to measure changes in behaviour (56) and to monitor any increase or decrease in the number of women with FGM and girls at risk (5).

Anecdotal evidence on the prevalence of FGM in some European countries can be retrieved from literature. In France, estimates vary from 4500 to 7000 girls at risk, and from 13,000 to 30,000 women with FGM (70;71). Approximately 21,000 women with
FGM live in Germany, and an estimated 5500 girls might be at risk (72). Data for 1994 from the Ministry of Interior estimate that 28,000 (73) women with FGM live in Italy, while there are at least 4000 to 5000 girls with FGM in the country (74). Jäger et al estimate that there were approximately 6700 girls at risk of FGM and women who have undergone the procedure in Switzerland (75). In the UK there are 86,000 first-generation immigrant refugees or asylum-seeking women and girls who have undergone FGM (76). In some European countries, such as France, plans exist to assess the magnitude of FGM.

In the framework of research on current legal provisions in Europe with regard to FGM, estimates were calculated for Belgium, Spain, Sweden and the UK (see the boxes below) (56;77-80). The data on Italy are derived from a research report by Nosotras, an Italian NGO based in Florence (81).

**Belgium**

Based on census data of 1 January 2002, the total number of female foreigners in Belgium from African FGM risk countries is estimated at 12,415, excluding asylum seekers and illegal migrants. Based on the extrapolation of country of origin prevalence data (1), the number of women with FGM in this population is estimated at 2745. In this group, a total of 534 girls are from African countries where FGM is practised and are in the age group at risk of FGM (0–14 years). Most of these women and girls are from Ghana (30% prevalence) and the Democratic Republic of Congo (5% prevalence).

**Spain**

About 3000 migrant girls under the age of 16 come from countries where FGM is practised (census 2001). Most of the women and girls come from Senegal (20% prevalence), the Gambia (80% prevalence) and Ghana. The Gambian girls are the major risk group, both due to their number (1265 girls under 16 years of age in November 2001) and to the prevalence of FGM in their country of origin.
**Sweden**

In Sweden the largest groups of Africans from an FGM-practising country are Somalis (98% prevalence), followed by Ethiopians (80% prevalence). Based on census data of 2002, 1138 Somali and 308 Ethiopian girls are in the age group at risk of FGM (0–15 years). Somalis live primarily in Sweden’s three biggest cities: Stockholm, Gothenburg and Malmö.

**United Kingdom**

Estimating the prevalence for the UK means dealing with a particular problem: census information does not categorize communities by country of origin and, as such, it is impossible to ascertain the numbers of practising communities living in the UK. Based on statistics from the 1999 Labour Force Survey (covering only six African risk countries and only those immigrant populations that exceed 6000 people), the extrapolation indicates that possibly 5444 girls under 16 years of age might be at risk of FGM and 69,875 women are already affected. Further extrapolation – including the remaining countries known to practise FGM – gives an estimate of 22,000 girls at risk and 279,500 women already affected. Most of the women at risk come from Kenya (38% prevalence), Somalia and Egypt (97% prevalence).

**Italy**

The estimated number of women with FGM in Italy, based on census data from 2000, is 32,881. Most of these women come from Somalia (7422), Nigeria (5966; 25% prevalence in country of origin), Egypt (5266) and Ethiopia (4180).
Another way of establishing the magnitude of the problem is estimating the number of women with and the number of girls at risk of FGM, based on census data and by extrapolation from country of origin prevalence data. This method gives an indication of the scale of the problem in Europe, but it is important to note that it also meets several critical problems (82-84):

- The estimates of prevalence are based on census data, and these census data are based on the nationality of women (country of birth or citizenship) but do not take into account the ethnic groups to which these women belong, although ethnicity or the region where women come from would give a much more accurate picture of the prevalence of FGM than nationality.
- Country of origin prevalence data are often imprecise because they too are based on estimates ranging from “most reliable” to “questionable” estimates (1).
- Estimates derived from census data do not take into account asylum seekers and illegal migrant women. However, asylum applications need to be taken into account to assess the effect that including asylum seekers might have on the actual number of the population affected by FGM in each Western country. Methods of reaching illegal migrants should be examined to take this population into account.
- Second-generation immigrants are difficult to trace; girls of this category might still be at risk of FGM.
- Census data are not flexible enough to take into account migration flows that influence the foreign population of a country.
- Comparisons between countries are problematic. The main sources of information on migration vary between countries, which makes comparison of figures difficult if not impossible.

Johnsdotter claims that a number of parameters need to be considered for risk estimates, which include both quantitative (e.g. number of immigrants from FGM risk countries, size and composition of ethnic communities, time of residence in a host country) and qualitative factors, such as the socio-cultural logic of FGM (why is it performed, does it change with migration) and the level of social pressure (85). To avoid exaggerations in risk estimates, Johnsdotter describes the need for well-founded and accurate figures regarding the number of women with and girls at risk of FGM.
Powell suggests refining existing methods for estimating the number of women who belong to groups practising FGM using census, immigration and asylum data by desegregation according to gender, and to develop or explore specific methods to study populations that are difficult to count (82).

**1.9.2. Initiatives at European Community level**

At European Community level, several initiatives have been taken. Just some of the milestones that have been of particular importance in putting the issue of FGM on the European agenda are highlighted below.

*European Commission*

The European Commission’s Daphne programme was established to combat violence against women and children in Europe. To date, it has co-financed 14 projects on FGM in Europe costing €2.4 million, some of which are still running\(^6\) (86). In 1997, the Daphne programme funded the first project to focus on FGM in Europe: a study undertaken by ICRH. The overall goal of the study was to gather available resources with the intention of examining problems surrounding FGM in the European Union (EU) and to formulate recommendations on several aspects of FGM to prepare a European strategy for combating FGM. Recommendations focused on guidelines for three groups of professionals who deal with FGM: community outreach workers, health care professionals and the judiciary. The project was carried out in close cooperation with two partners: the Dutch section of Defence for Children International, and the Royal Tropical Institute of Amsterdam (the Netherlands). The report published as the outcome of this study gave input into the Valenciano report and the subsequent European Resolution on FGM.

*European Parliament*

At the initiative of the Swedish National Board of Health and Welfare and the Swedish non-governmental organization (NGO) Riksföreningen Stoppa Kvinnlig Könsstypning (RISK), a group of experts gathered at the European Parliament in Strasbourg (France) in April 2001 to develop a Joint Agenda for Preventing and Eliminating FGM, to be presented to the European Commission, European Parliament

\(^6\) A review of these projects can be found at the Daphne Toolkit website (http://www.daphne-toolkit.org).
and to relevant United Nations agencies. The Agenda was developed by drawing on
declarations, recommendations and statements and on the experiences of those
working towards the elimination of FGM in Africa and Europe. The agenda was used
by the Committee on Women’s Rights and Equal Opportunities of the European
Parliament, to draw a report on FGM (Rapporteur: Elena Valenciano, Report n° A5-
0285/2001), which includes a resolution on FGM. The European Parliament adopted
this resolution on 20 September 2001.

Main issues related to FGM in Europe in the Resolution on Female Genital Mutilation
of the European Parliament (2001/2035(INI))

[...] The European Parliament
- Calls upon Member States to harmonise existing legislation;
- Opposes any form of medicalisation;
- Involves communities when adopting measures;
- Rejects any scientific or religious basis for justifying the practice;
- Condemns FGM as a violation of human rights;
- Calls upon the European Union and the Member States to apply an integrated
  strategy, which takes into account the legislative, health and social dimensions
  and the integration of the immigrant population;
- Calls on the Commission to draw up a complete strategy in order to eliminate
  FGM in the EU, establishing legal and administrative, preventive, educational
  and social mechanisms to enable women who are at risk to obtain protection;
- Asks the Commission to carry out an awareness campaign directed at
  legislators/parliaments in the countries of origin to maximise the impact of
  legislation or to facilitate the formulation and adoption of such legislation;
- Calls on the Council, Commission and Member States to carry out an in-
  depth enquiry to ascertain the extent of FGM in the Member States;
[...]

° Study conferences
In 1992, a First Study Conference on FGM in Europe was held in London (UK),
organized by the Foundation for Women’s Health, Research and Development
(FORWARD). The conference was called to respond to the need for action against the
practice of FGM in Europe and other Western countries. The conference aimed at developing a coordinated, unified approach to the abolition of the practice in Europe and other Western countries (London Declaration, 6–8 July 1992).

A Second Study Conference on FGM in Europe was held in Gothenburg (Sweden) in July 1998. The conference was organized by the Committee of the Regions of the European Union and the City of Gothenburg, with the technical cooperation of WHO, Geneva. The conference came up with recommendations for an Action Plan for Europe (Gothenburg Declaration, 1–3 July 1998).

1.9.3. National legislation prohibiting FGM
An increasing number of countries in Europe have adopted specific legislation with regard to FGM. Issues with regard to these legal provisions, as well as with regard to implementing these laws, are discussed in detail in Chapter 3, Paper 1.

1.9.4. Health care for women with FGM
There is a growing body of evidence in peer-reviewed journals and other literature that indicates that health services in Europe are confronted with women with FGM (37;73;75;87-91). Issues with regard to health service delivery are discussed further in Chapter 3, Paper 2 of this manuscript.

1.9.5. Prevention of FGM by (non-)governmental organizations and community-based organizations
In 2000, 2004 and 2005, ICRH organized four consultative meetings with representatives of NGOs and CBOs7, during which the methodologies of prevention work were discussed and experiences shared. The basic assumption of the workshops and meetings has been to include members of the communities affected by FGM in a participatory process, rather than by a top–down method. The workshops and meetings aimed at defining priorities for action and research and, at a later stage, at assisting in and/or implementing the subsequent interventions. A participatory approach has proven to be successful in creating ownership of the actions and to design bottom–up actions.

7 The workshops in 2000 were organized in the framework of the European Network for the Prevention of FGM project and financed by the European Commission’s Daphne programme. The 2004–2005 workshops were organized in the framework of the Daphne programme’s Strengthening the European Network for the Prevention of FGM by Building on Experiences from the Past project.
The first two meetings were held in 2000, in collaboration with the Immigration Services of the City of Gothenburg in Sweden. Fieldworkers from 11 European countries shared experiences and information with regard to the prevention of FGM in their countries. Topics that were discussed included: use of terminology during prevention work; communication with the different target groups; communication with the media; collaboration with African organizations and at national and European level; the use of educational materials; training of fieldworkers; involvement of religious leaders; and working towards behaviour change.

These consultative meetings revealed the following problems:

- lack of baseline studies to support the activities of NGOs;
- failing communication with the media;
- poor cooperation at national and European level;
- lack of evaluation of educational materials used in Europe; and
- the need to collaborate with religious leaders, young people, and men (92).

In 2004–2005, another two meetings were organized with 12 NGOs and CBOs from nine European countries. The first meeting (June 2004) examined the quantity and quality of existing educational materials developed by earlier Daphne projects (from 1998 to 2004) as well as their effectiveness. The second consultation took place in May 2005 and focused on the community-based dimensions of the Daphne FGM projects. Presentations and discussions analysed the extent to which behaviour change had been factored into the design of these projects. Participants in both workshops acknowledged that, as the focus of the projects had been awareness raising and advocacy, resources (human, time and financial) had been spent on producing IEC materials and not on behaviour change interventions.

The educational materials produced included manuals for health professionals, leaflets, TV spots, websites, posters, comics for youngsters, research reports and an FGM teaching kit. Participants concluded that these materials have increased the knowledge base of FGM in Europe significantly, have also helped to underpin actions to fight FGM in Europe and have succeeded in raising awareness regarding FGM.
However, the participants at the meeting also concluded that there is now a sufficient amount of IEC material available in Europe. Participants were concerned about the lack of knowledge and understanding with regard to behaviour change interventions and the manner in which to implement them in Europe. They also established the need to move from raising awareness on FGM towards the development of activities designed to bring about sustainable behaviour change in Europe. These meetings resulted in the publication of the book *Behaviour change towards female genital mutilation: lessons learned from Africa and Europe* (93). The publication was translated into Somali and will be used in the training of professionals in Somalia on behaviour change towards FGM.

NGOs working towards the eradication of FGM in Europe emerged in the early 1990s, such as Terre Des Femmes in Germany (founded in 1981) and the Groupement pour l’Abolition des Mutilations Sexuelles in France (founded in 1982). In Europe, the bulk of activities of the NGOs working for the prevention of FGM focuses on IEC activities, outreach, lobbying and advocacy. NGOs and CBOs have either focused their work solely on FGM or adopted a holistic approach by incorporating the issue in their work on women’s issues, health issues or migrant/refugee issues (92). Some organizations also conduct research and give support to organizations in Africa, such as the Associazone Italiana Donne per lo Sviluppo (AIDOS) in Italy and FORWARD in the UK.

Activities are targeted at various groups of professionals who come into contact with FGM. One of the most important target groups has been (para)medical professionals, who have been informed about the socio-cultural background and consequences of FGM and who have been trained in, amongst others, the medical aspects of FGM and the clinical management of it. Other important target groups for training include the police and teachers who receive information about FGM, and training includes referral procedures when a girl is at risk. NGOs also target the public as well as the authorities, by the development of sensitization campaigns on the issue of FGM. The most important target group however, is the practising communities. “Outreach” is an important communication tool used by the NGOs and CBOs in Europe for collecting

---

8 Project financed by the National Lottery in Belgium in the framework of Reaching the Millennium Goals; the project runs in partnership with local NGOs.
and spreading information from and to the community. This approach establishes networks within these communities to build trust within them.

The consultative meetings organized by ICRH promoted the exchange of experiences and ideas on some key issues with regard to FGM in Europe, and helped to improve the capacities of the participants and to establish networking and the development of partnerships. The meetings with NGOs and CBOs resulted in identifying priority areas for action: the need for behaviour change interventions, for research-based interventions, and for more coordination between NGOs at both national and international level.

1.9.6. Research on FGM in Europe

More research on FGM in Europe is needed, because it has become an issue in Europe and considerable gaps in information still exist. Research can also help in local capacity building and in improving the implementation of anti-FGM programmes, e.g. by designing and implementing programmes based on research, by providing expertise in performing baseline studies before any intervention takes place, and in evaluation of the interventions (17). To define the research gaps, a consultative meeting was organized with the aim of setting a research agenda with priorities for research on FGM in Europe⁹. At that time, few academics had taken up the issue of FGM in Europe. During the workshop four main research areas, focusing specifically on the European setting, were identified (94):

1. **Assessing magnitude and mapping of FGM in Europe**, including a prevalence study to assess the number of women with FGM and the number of girls at risk, as well as an inventory of existing European interventions and an analysis of their impact (legislative interventions, community-based interventions and health and social care interventions).

2. **Behavioural research**, including research on male involvement (changing male attitudes towards and knowledge of FGM in a migration context); on the health-seeking behaviour of African communities living in Europe; on attitudes of children (5–12 years) and teenagers (12–20 years) living in Europe; on protection mechanisms for girls and women travelling between

---

⁹ The workshop was organized in the framework of the European Network for the Prevention of FGM project in Ghent in June 2000 and financed by the European Community Daphne programme.
Europe and Africa; on the influence of the migration context on attitudes and behaviour towards FGM; on the changing attitudes and behaviour of first- and second-generation migrants; and on the attitudes of religious leaders and their role and influence in the European context.

3. **KAP studies among professionals** in Europe dealing with FGM, to identify the gaps in knowledge and to assess their attitudes and practices.

4. **Role of the media** in the dissemination of information to the public and policymakers. The sometimes overwhelming attention FGM is paid by Western media might be seen as exaggerated by the communities concerned. Newly arrived asylum seekers or refugees have priorities to deal with other than FGM, such as housing or finding a job. Moreover, it has been reported that the open discussion about the “private parts” of women with total disregard for notions of privacy has led to complaints by women concerned and to the assumption that all Black African women have had FGM (95). When little is known about the context of FGM, there is also a risk that Africans are pictured as barbarians, as one aspect of their culture is equated with their whole personality.

Since the time of the workshop, some issues have already been tackled (such as impact analysis of legislation and the inventory of health care interventions), but many of the other issues remain, as discussed in Chapter 4.

1.9.7. *Coordination*

At the EU policy level, interest in FGM is increasing steadily, but as yet general strategies applicable in all Member States are not available (82;96). According to Powell et al, one of the major problems is the degree of operational cohesion between health and social care services and other agencies (e.g. police, immigration officials, lawyers) in addressing FGM needs. Services often develop their own codes of practice in isolation from the numerous other agencies, and this problem is compounded by the relative lack of operational cohesion between these agencies, policymakers and grassroots organizations. Such deficiencies in addressing FGM are present at national and international level (82).
One instrument that has been put in place to deal with the issue of operational cohesion is the European Network for the Prevention and Eradication of Harmful Traditional Practices Affecting the Health of Women and Children, in Particular Female Genital Mutilation (EuroNet-FGM). This network, established with European Commission Daphne funds in March 2000 by organizations from nine EU countries (Belgium, France, Denmark, Italy, UK, Germany, Spain, Sweden and the Netherlands), aims at enhancing the health of immigrant women in Europe, in particular to fight FGM in Europe through establishing cooperation at European level, to avoid duplication of efforts, and to exchange experiences, information and good practices. EuroNet-FGM is considered as a model of good practice with regard to ownership, as it was created by and for NGOs and CBOs.

The European Resolution on FGM made some useful suggestions for developing a European policy and can guide the design and implementation of a common approach to address FGM. The (lack of) operational cohesion in Europe is further discussed in Chapters 3 and 4.
CHAPTER 2: CONTEXT, AIMS, APPROACH AND LIMITATIONS

2.1. Context

FGM is a harmful traditional practice that can lead to reproductive ill-health. However, it is also recognized as being more than a health problem and is considered as a form of gender-based violence and a violation of the sexual and reproductive health rights of women. The society and culture in which it takes place – of major importance for any action or intervention to bring about change – is one of the main domains of reproductive health research (97). Elements of the society or culture that shape reproductive health include values, beliefs, socio-economic conditions, underserved groups, laws and services (97).

This manuscript focuses on FGM in the EU, and more particularly on two aspects pertaining to the socio-cultural context of FGM: health services and laws. The choice of these two areas stems from pragmatic considerations, i.e. the need to provide input to the European Commission on legal and medical issues. In 1997 the European Commission requested information on how to deal with FGM in Europe, and more specifically:

- to provide practical recommendations for policymakers in the European Commission, European Parliament and EU Member States, in particular to determine whether specific legislation is needed to prohibit FGM, and
- to prepare codes of conduct for professionals in the health sector, among others (84).

Answers to these questions were pushed forward because many women with FGM – and more specifically with infibulation – needed specialized clinical care, which in many EU countries was not readily available. In addition to this, discussion was ongoing about whether specific criminal laws on FGM were necessary. Thus it was paramount to determine whether specific laws on FGM are effective and, more particularly, what the possibilities and difficulties of implementing such laws might be.
Following these requests, ICRH initiated research on FGM in the EU. The research consisted of several studies that took place within the framework of the European Commission-funded Daphne programme on the prevention of violence against women and children. The main questions were the state of practices related to FGM in the health care sector, and the legal situation in some European countries (see Sections 2.5.1 and 2.5.2 below). These studies were descriptive and exploratory and aimed at improving existing health care service delivery towards women with FGM in the EU and improving the implementation of legislation regarding FGM in the EU.

The third study, undertaken among gynaecologists in the Flanders region of Belgium, combines both legal aspects and health care issues, by studying the tensions between the attitudes and practices of gynaecologists regarding some issues related to FGM within the boundaries of Belgian law.

### 2.2. Aims of the study

The overall aim of this study is to assess the responses at legislative and health care level to the problem of FGM in some countries of the EU.

The specific objectives are:

1. to examine the legal provisions applicable to FGM and to identify and analyse determinants of the implementation of the laws in some countries of the EU;
2. to explore the health services available in some EU countries for women with FGM;
3. to assess the FGM-related knowledge, attitudes and practices of Flemish gynaecologists; and
4. to obtain knowledge on key issues to be addressed in an integrated European agenda.
2.3. Limitations

This manuscript looks at FGM from a health and medico-legal perspective only, for pragmatic reasons as explained above. The human rights framework, although of major importance and an important tool in the global abandonment of FGM, has not been the focus of research.

This manuscript does not address male circumcision. FGM in general is a serious (reproductive) health problem and has been widely accepted as a violation of the reproductive health and sexual rights of women. The extent of cutting in women, even in type I when only part of the clitoris is cut, is far more invasive to the sexual organ than the circumcision of the penis. Although health problems caused by the symbolic pricking of the clitoris are minimal, there are risks associated with promoting this type of female “circumcision”, which are further discussed in Chapter 3 of this manuscript (Papers 2 and 3). An in-depth analysis of the parallels and differences between male circumcision and FGM (e.g. people persisting with circumcision in both cases so as not to be excluded from the community, both types being performed for religious reasons, violation of the human right to bodily integrity in both cases) is beyond the scope of this manuscript.

This research focused on service delivery, from both the health care perspective and from the legal perspective, and did not analyse the needs of the populations that practice FGM. The perspectives of those who adhere to the practice are, however, of major importance to help design and implement effective interventions, and could be complementary to findings from our research. However, given the limited resources available for research on FGM – which is even more so for research on FGM in a European context – we were not able to include comprehensive research into the needs and demands of women living with FGM and girls at risk.

Countries for the studies were selected to fit the requirements of the European Commission Daphne programme. The studies do not pretend to be representative of the whole EU: the study on the health sector only gives an overview of the health care
provisions in some EU Member States; the review of laws was done for the first 15 Member States, but the in-depth analysis was done in five countries only.

2.4. Approach

The research was conducted in close consultation with intermediaries. These are the people who work with the communities that adhere to FGM, such as health professionals, NGOs and CBOs. The intermediaries were closely involved, from the formulation of gaps in knowledge and services and defining the priorities for future interventions and research, to formulating recommendations for the abandonment of FGM in Europe. Results have been shared with the intermediaries by means of report distribution, the creation of EuroNet-FGM, the publication of scientific papers, and the presentation of results at conferences and other public events.

The research is also interdisciplinary, i.e. it tackles the issue of FGM in EU countries from two angles where a lack of operational knowledge was detected – the legal aspects of FGM and the health care responses to FGM – and tried to integrate findings from both disciplines into a more comprehensive understanding of care delivery for women with FGM in EU countries. Such an interdisciplinary approach was advisable to address the complex and multifaceted problem of FGM, and to provide suggestions for an integrated European agenda.

The research on legal aspects of FGM has been carried out in collaboration with several partners, joined in an interdisciplinary steering group of experts from various (scientific) disciplines including anthropology, (philosophy of) law, applied social sciences and community prevention work. The research on the health services in Europe was also performed by a multidisciplinary team consisting of a gynaecologist/obstetrician, an applied social scientist, an anthropologist, lawyers, a (community-based) prevention worker, and a midwife, among others.
2.5. Data collection

We performed four studies described in four papers. Not all papers can be exclusively attributed to one study (Paper 2 results from Study 2a and 2b), and not all papers deal exclusively with one specific objective (Papers 1, 2 and 4 contribute to Objective 4).

2.5.1. Objective 1: To examine the legal provisions in Europe applicable to FGM and to identify and analyse determinants of the implementation of the laws in some countries in the EU

Study 1: Evaluating the impact of existing legislation in Europe with regard to FGM (2003–2004) – Paper 1

The research consisted of a questionnaire-based survey and a comparative analysis. The questionnaire was sent to key informants in the first 15 EU Member States, to compile a review of legal provisions applicable to already performed acts of FGM (penal laws) or laws applicable in the case of a girl at risk of FGM (child protection laws).

An in-depth comparative analysis was performed on the implementation of laws in five European countries – Belgium, France, Spain, Sweden and the UK – and consisted of:

- a case study to investigate the different legal approaches and respective judicial outcomes in each country;
- an analysis of factors inhibiting the implementation of legislation applicable to FGM in each country; and
- a comparative analysis of the implementation of laws across the five countries.

The results are discussed in Chapter 3, Paper 1.
2.5.2. Objective 2: To explore the health services available in some EU countries for women with FGM


The research consisted of a KAP study among gynaecologists in some EU countries, a review of the guidelines of hospitals and professional organizations, and a rapid appraisal of FGM as an issue for health professionals.

Study 2a was a research project undertaken by ICRH in 1998, aiming at providing the European Commission with a strategy to address FGM in the EU. Central to the proposed strategy was the formulation of recommendations on medical aspects of FGM in the EU. These recommendations were based on a questionnaire which assessed prevailing knowledge, attitudes and practices of health care professionals in the EU, and a discussion paper that reviewed the medical complications of FGM and its medico-ethical aspects (e.g. medicalization of FGM and reinfibulation).

Study 2b was carried out in 2000 and aimed at creating a multidisciplinary network for preventing FGM in the EU. One part of the project focused on providing health care professionals with frameworks for the prevention of FGM and care for women with FGM. The development of these frameworks was based on the recommendation of medical experts at the FGM Expert Meeting in Ghent (November 1998, Study 2a) that suggested reviewing existing guidelines and using the findings as a basis for developing frameworks for the care for women with FGM, the prevention of FGM by health care professionals, and training for health care professionals. Following this recommendation, the “network project” mentioned above organized a workshop with experts from six European countries (Belgium, Denmark, Germany, the Netherlands, Sweden and the UK) that had previous experience in developing guidelines or specific expertise on the topic (FGM-specialist midwives). Prior to the workshop, the experts were invited to prepare an overview of the existing guidelines in their country. Following the workshop, two frameworks were suggested: one to develop guidelines
for caring for women with FGM and the prevention of FGM, and one to develop guidelines concerning training of health care professionals on the issue of FGM.

These results are discussed in Chapter 3, Papers 2 and 4.

2.5.3. Objective 3: To assess the FGM-related knowledge, attitudes and practices of Flemish gynaecologists

The questionnaire-based survey was addressed to Flemish gynaecologists and included questions regarding their knowledge of FGM in general and the law related to FGM in Belgium. It also enquired about attitudes and practices of gynaecologists towards some issues regarding FGM that have proven to be controversial in other European countries, such as pricking, reinfibulation and cosmetic vaginal surgery. The study was a collaborative effort between Ghent University and the University Hospital of Antwerp, and was carried out by Ilse Ysebaert as part of her master’s thesis on Criminological Sciences (98), under the leadership of Prof G Vermeulen.

Data are discussed in Chapter 3, Paper 3.

2.5.4. Objective 4: To obtain knowledge on key issues to be addressed in an integrated European agenda

The above-mentioned studies indicated deficiencies in the way FGM is currently addressed at legislative and health care level. Paper 4 explored a number of key elements for an integrated agenda to be developed by the EU and implemented by Member States and relevant NGOs, taking these deficiencies into account.
2.6. Publications

Data in this manuscript have been published or accepted for publication in the following journals:

   A1

   A2

   A1 publication

   A1 publication; first and second author equally contributed to the paper.
2.7. Dissemination of results

Results of the studies have been used at both EU and national policy level as well as at advocacy level:

- Studies 2a and 2b resulted in the creation of the European Network for the Prevention of Harmful Traditional Practices (established in 2002), in particular FGM (EuroNet-FGM). The network was initiated by organizing workshops (in 2000) and aimed at:
  1) sharing information and experiences and disseminating models of good practice at community level;
  2) harmonizing various training and management guidelines for the care of circumcised/infibulated women currently available for health professionals; and
  3) harmonizing research efforts in Europe.
Topics discussed during the workshops were drawn from the issues brought up by the experts who participated in the meeting in 1998. Representatives of organizations from the following countries were present at the workshops: Austria, Belgium, Denmark, France, Germany, the Netherlands, Italy, Spain, Sweden, the UK, and the Inter-African Committee on Harmful Traditional Practices.
- The two studies both resulted in a series of recommendations used to draw up a report on FGM by the Committee on Women’s Rights and Equal Opportunities of the European Parliament, including the European Parliament Resolution on FGM (2001).
- Data from Study 3 have been presented to the expert group of the Belgian Secretary of State for the Family and Disabled People, which developed a national action plan to prevent FGM in Belgium (December 2006–March 2007).
CHAPTER 3: FINDINGS AND DISCUSSION

3.1. An analysis of the implementation of laws with regard to female genital mutilation in Europe

An analysis of the implementation of laws with regard to female genital mutilation in Europe

Els Leye · Jessika Deblonde · José García-Añón · Sara Johnsdotter · Adwoa Kwateng-Kluvitse · Linda Weil-Curiel · Marleen Temmerman

Published online: 4 April 2007
© Springer Science + Business Media B.V. 2007

Abstract This paper presents results of a survey on legislation regarding female genital mutilation in 15 European member states, as well as the results of a comparative analysis of the implementation of these laws in Belgium, France, Spain, Sweden and the UK. The research showed that although both criminal laws and child protection laws are implemented a number of difficulties with the implementation of these laws remain. The article suggests that efforts should primarily focus on child protection measures, but also on developing implementation strategies for criminal laws, and concludes with suggestions to overcome the obstructing factors to implement laws applicable to FGM in Europe.

Introduction

The terms most widely used are “female genital mutilation” (FGM) and “female circumcision.” A wide range of stakeholders has used “female genital mutilation” because they believe it acknowledges the damage caused by the practice. The term FGM

E. Leye (✉) · J. Deblonde · M. Temmerman
International Centre for Reproductive Health, Ghent University, De Pintelaan 185 P3, Ghent, Oost-Vlaanderen 9000, Belgium
e-mail: els.leye@ugent.be

J. García-Añón
Human Rights Institute of the University of Valencia, Valencia, Spain

S. Johnsdotter
Department of Sociology, Lund University, Lund, Sweden

A. Kwateng-Kluvitse
Foundation for Women’s Health, Research and Development (FORWARD), London, UK

L. Weil-Curiel
Commission pour l’Abolition des Mutilations Sexuelles (CAMS), Paris, France
has been “a very effective advocacy and policy tool and has been used in several United Nations (UN) conference documents” [17]. Female circumcision and any other local terminology is often used by fieldworkers and researchers, as it is believed to be less offensive and judgmental towards practicing communities, than the term female genital mutilation. Opposition to this term focuses on the similarities it evokes with male circumcision, although the cutting with male circumcision is by far not as evasive as with female circumcision.

Recently “female genital mutilation/cutting” or even “female genital cutting” is emerging in publications and there is a tendency to use these terms in public discourse and at political level, once again because it is believed to be more neutral than “female genital mutilation.” At a UN consultation meeting on the new Joint Statement on Female Genital Mutilation (Geneva, 4–5 October 2006), the draft of the new joint statement discussed – amongst others – the proposed switch to FGM/C. The meeting did not come up with a decisive conclusion to change the terminology, and discussion is ongoing between UN agencies, researchers and activists. Until further notice, the official terminology used by WHO is still female genital mutilation.

In accordance with the terminology used in the first joint statement of WHO, the United Nations Children’s Fund (UNICEF) and the United Nations Development Fund (UNFPA), the term “female genital mutilation” is used throughout this thesis [39].

The World Health Organisation defines female genital mutilation (FGM) as all procedures involving partial or complete removal of the external female genitalia or other injury to the female genital organs, whether for cultural or any other non-therapeutic reasons [40]. These procedures are classified into four types ranging from pricking, piercing, stretching or incision of the clitoris and/or labia (Type IV), to the excision of the prepuce and clitoris (Type I), excision of clitoris and part or all of the labia minora (Type II) and to the stitching/narrowing of the vaginal opening (infibulation or Type III) [40]. WHO is currently reviewing this classification, to include a Type V: the symbolic practices that involve the nicking or pricking of the clitoris to release little drops of blood [33].

FGM affects between 100–140 million women and girls worldwide [40] and it is estimated that more than 3 million girls a year are at risk of mutilation [33]. Even though primarily practised in 28 African countries, ranging from parts of central, eastern and western Africa to the Horn of Africa, international migration has extended the practice outside the African continent, so that it has become a worldwide concern [28].

Female genital mutilation is predominant among Muslims, but also occurs among Christians (Coptic, Catholic and Protestant), animist and Jews (the Falashas in Ethiopia) [9]. However, the majority of Muslims worldwide, this is 80%, do not practice FGM [25].

Among different ethnic groups in Africa, there is a persistent belief that female genital mutilation is an Islamic rule. Until recently, there was an ongoing discussion between advocates and opponents of FGM if the practice was recommended in the Koran or not. At present, there is a general understanding that FGM is not recommended in any religious text. The persistence of the practice, especially among Muslim women is partly due to the fact that many women do not have access to religious texts or because they are illiterate, and partly because a lot of religious leaders do not openly oppose FGM. Because these religious leaders are highly respected in communities and have considerable influence, they are one of the target groups for prevention of FGM.

Both in Africa and Europe, the criminalisation of FGM is considered to be and is used as one of the mechanisms that could strengthen the global fight against FGM. In Europe, legal provisions pertaining to FGM are found in a variety of domains, including criminal laws and child protection laws.
Research methodology

Questionnaires were sent to key informants (1 per country) in the former fifteen Member States of the European Union, in order to compile a review on legal provisions applicable to already performed acts of FGM (penal laws) or laws applicable in case of a girl at risk of FGM (child protection laws). The questionnaire assessed criminal law provisions (specific laws dealing with FGM or the general criminal law) with regard to FGM, child protection provisions with regard to child abuse and FGM (if any) and professional secrecy laws with regard to reporting cases of child abuse/FGM. The questionnaire also enquired about the respective enforcement of these laws. All key informants returned the questionnaires, including texts of laws of their countries.

An in-depth comparative analysis was performed on five European countries, i.e. Belgium, France, Spain, Sweden and the United Kingdom. A pilot study investigated the different legal approaches and respective judicial outcomes in these countries, and was followed by an analysis of factors inhibiting implementation of legislation applicable to FGM. Afterwards a comparative cross-country analysis of the implementation of the laws was performed.

The fieldwork for the pilot studies was done at three levels – police, prosecution offices and courts – and consisted of two main parts: the search for and an analysis of (classified) documents (if any) with regard to jurisprudence related to FGM, followed by a case study. The case study collected and analysed empirical evidence concerning the implementation of legislation applicable to FGM, such as cases reported, investigations done and cases brought to court, in a particular geographic jurisdiction of the five countries, through semi-structured interviews with key-informants. The case study also identified factors impeding the implementation of legislation. The main issues addressed by the interviews were knowledge about FGM and related laws, possible (dis)advantages of a specific law and difficulties of implementing legislation. In each country, the interviews were taped, transcribed and analysed, using the same analytical framework for the five countries, defined before the interviews were conducted.

In order to identify and analyse factors inhibiting the implementation of FGM legislation, the following research questions emerged:

1. Is legislation applicable to FGM being implemented in Belgium, France, Spain, Sweden and the UK?
2. What are the inhibiting factors concerning implementation of legislation applicable to FGM in Belgium, France, Spain, Sweden and the UK?

The underlying assumptions to these questions are (1) that FGM is still being performed in Africa and consequently also among immigrants and refugees from countries where the practice is prevalent and (2) that in the five selected countries, legislation on FGM is not applied.

To assess whether or not legislation is being implemented, fieldwork has been performed based upon a two-folded strategy – an analysis of documents and a case study in a defined geographical area in each of the five countries, as described above.

Factors inhibiting the implementation of laws were analysed according to four categories: (1) knowledge about the practice of FGM; (2) knowledge about the legal aspects of FGM; (3) perceptions and attitudes towards the legal intervention and (4) practices and procedures followed in case of a legal intervention.

The study resulted in an inventory of existing laws in 15 member states of the European Union with regard to FGM, a review of judicial outcomes in five EU countries and a review of factors that impede the implementation of existing legislation in these five countries.
Results

Legal provisions applicable to FGM

*General criminal law in cases of performed FGM*

FGM is forbidden under general criminal law provisions in the following European Member States: Finland (Chapter 21, sections 5&6 of the Penal Code: assault of serious assault), France (Articles 222-9 and 222-10 of the Penal Code: mutilation), Germany (Sections 224 and 226 of the Penal Code: serious and grave bodily harm), Greece (Articles 308–315 of the Penal Code: bodily injury), (Southern) Ireland (Criminal Justice Act 2000: bodily injury), Luxemburg (Article 392 of the Penal Code: voluntary corporal lesion), Portugal (Articles 143–149 of the Penal Code: bodily injury or serious bodily injury) and the Netherlands (Articles 300-304 of the Penal Code: bodily injury or serious bodily injury). All criminal law provisions in these countries consider FGM as “(serious) bodily injury.” Aggravating circumstances increasing the penalties include, amongst others: the offence causes death (Finland, Greece, Ireland, Luxemburg, Portugal, the Netherlands), the offence is committed against a minor (France, Greece, Ireland, Luxemburg, Portugal) or the offence is committed by the parents or person(s) having custody.\(^1\)

In France, Germany and the Netherlands, the principle of extraterritoriality is applicable in the context of this general criminal law provision. This principle makes FGM punishable, even if it is committed outside the borders of that country. For example, parents can be prosecuted if they take their daughter(s) on holiday to the home country where they are cut. In the countries where this principle is applicable, additional conditions or restrictions may be attached. In France for example, an act of FGM committed outside France is punishable if the victim has French nationality. In Germany, an act of FGM outside Germany will only be considered as a criminal offence if the perpetrator is a German and he/she has not been extradited to the country where the crime was committed, or if the victim is a German national and with the prerequisite of double incrimination. Extraterritoriality, with the prerequisite of the principle of double incrimination makes FGM punishable only when it is committed outside the frontiers of Germany, but on the condition that FGM is also an offence in the country where it was committed. As by February 1, 2006, the principle of double incrimination has been removed from the Dutch Penal Code (art. 300–304). Consequently, perpetrators with the Dutch nationality or persons with another nationality but residing in the Netherlands are now liable, even for preparatory acts or requesting to perform an act [10] (Table 1).

*Specific criminal law provisions in case of performed FGM*

Other European countries have chosen to make FGM prosecutable under a specific legal provision, by developing legal provisions specifically dealing with FGM, or by adding clauses dealing with FGM to the Penal Codes.

Such specific criminal law provisions have been developed in six of the European Member States, included in the survey: Austria, Belgium, Denmark, Italy, Spain, Sweden and the UK. Sweden and the UK were the first countries to develop specific criminal law provisions, in 1982 and 1985, respectively. Sweden, being the first western country to

---

\(^1\) For example in France, parents or persons having custody can be and have been prosecuted as accomplices.

\(^2\) Springer
legislate against the practice [14], changed the *Act prohibiting genital mutilation in women* (1982:316, 1/7/1982) in 1998 and 1999. In 1998 the law was revised to change terminology, from “female circumcision” to “female genital mutilation,” and more severe penalties for breaking the law were imposed, while the revision in 1999 removed the principle of double incrimination [18]. The *Prohibition of Female Circumcision Act* of 1985 of the UK was amended to the ‘Female Genital Mutilation Act 2003’ in March 2004, and also changed the terminology: the term ‘female genital mutilation’ is now used in stead of ‘female circumcision.’ More importantly, penalties have been increased and the concept of extraterritoriality was introduced.

Laws in the other countries have all been developed recently: in Belgium in 2001 (Article 409 of Penal Code, 27/03/2001), in Austria in 2002 (Section 90 of the Penal Code, 1/1/2002), in Denmark in 2003 (Articles 245–246 of the Penal Code, 1/6/2003), in Spain in 2003 (Article 149 of the Penal Code, 1/10/2003) and in Italy in 2005 (Article 583bis of the Penal Code, 23/12/2005).

At the moment, discussion is ongoing in Portugal and Ireland with regard to the inclusion of a specific criminal law provision for FGM in the Penal Code. In Portugal, the parliament is discussing a resolution to add the issue of FGM to Article 144 of the Penal Code, as Article 144a. In 2001, a Private Members Bill, namely the Prohibition of FGM Bill 2001, was unsuccessfully introduced in Ireland. In 2003, an Irish coalition of organisations, the Irish Family Planning Association, Akidwa (Network of African Women) and the Labour Party Women, called on the Irish Government to introduce legislation to prohibit FGM taking place in Ireland.

In general, the criminal offence of FGM exists in all countries, consisting of the performance of or participation in an act of FGM. Facilitating an act of FGM is also prosecuteable in Belgium, Spain, Sweden and the UK, and the attempts to do so in all countries but the UK. In the UK, once an act is defined as an offence, any attempt to carry out that act is also an offence under the Criminal Attempts Act (1981). Sweden is the only country with a specific law provision where failure to report knowledge of a crime is also a criminal offence. To ‘procure FGM’ is punishable in Sweden and the UK only. The Spanish and Austrian legal provisions regarding FGM do not clearly specify that the law is related to ‘female’ genital mutilation, which implies that the law is applicable to male circumcision, although it’s questionable if this was the intent when the law was developed. For example, the current Spanish legislation (Article 149 of the Penal Code) reads as follows: “Any person performing whatever form of genital mutilation shall be punished with a sentence of imprisonment of between 6 and 12 years. [...]” [11].

Clitoridectomy (Type I), excision (Type II) and infibulation (Type III) are forbidden in all seven countries that have specific law provisions. Type IV of FGM (all other forms of FGM performed for cultural or non-therapeutic reasons), is also forbidden by law in all countries, except for Denmark that only mentions the first three types. In Belgium, piercing and tattooing are explicitly mentioned in the preparatory works of the law as being excluded from the law. In the UK, these two forms are implicitly excluded as they are not included in the definition of offences constituting FGM, as per the UK FGM Act 2003 [20]. The new Italian law excludes “any other practice that causes effects of the same kind” as Type I, II and III [11].

Specific laws applicable to FGM fail to deal with the issue of re-infibulation, which is the frequently requested process of ‘re-closing’ the vagina following childbirth. They also

---

2This procedure is common after every childbirth (and between childbirths, after divorce, a.o.) among Sudense women [12, 34] as cited in [4], but is rarely requested by Somali women [4]. The commonly requested re-tightening after delivery by most Somali women is closing until a narrowed vaginal opening, but not to the primary infibulated state that needs a de-infibulation [4].
<table>
<thead>
<tr>
<th>Country</th>
<th>Criminal law provision</th>
<th>Aggravating circumstances increasing penalty</th>
<th>Extraterritoriality</th>
<th>Criminal prosecutions for FGM</th>
<th>Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finland</td>
<td>Chapter 21, sections 5 &amp; 6 of the Penal Code: assault or serious assault</td>
<td>Bodily injury; serious bodily injury; illness; unconsciousness</td>
<td>Loss of essential parts of the body; offence endangers life of the victim; offence causes death</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>France</td>
<td>Article 222-9/10</td>
<td>Mutilation</td>
<td>Offence against minor; offence performed by parent/person having custody (prosecuted as accomplice)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Germany</td>
<td>Sections 224 and 226 of the Penal Code: serious and grave bodily harm</td>
<td>Bodily injury; serious bodily injury; voluntary corporal lesions; mutilation</td>
<td>Loss of essential parts of the body; permanent and incurable corporal lesions</td>
<td>Yes, if victim is German national and exigency of double incrimination or; if offender is German and (s)he has not been extradited to country where crime was committed</td>
<td>No</td>
</tr>
<tr>
<td>Greece</td>
<td>Articles 306-315 of the Penal Code: bodily injury</td>
<td>Bodily injury; serious bodily injury</td>
<td>Offence against minor; Offence performed by parent/person having custody; loss of essential parts of the body; permanent and incurable corporal lesions; offence endangers life; offence causes death</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Ireland</td>
<td>Criminal Justice Act 2006: bodily injury</td>
<td>Bodily injury; serious bodily injury; mutilation</td>
<td>Offence against minor; loss of essential parts of the body; permanent loss of working capacity; offence endangers life</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Country</td>
<td>Article(s) from the Penal Code</td>
<td>Voluntary corporal lesions</td>
<td>Offence against minor; offence performed by parent/person having custody; loss of essential parts of the body; permanent and incurable corporal lesions; permanent loss of working capacity; offence causes death; offence causes serious mutilation; offence carried out with premeditation</td>
<td>Voluntary corporal lesions</td>
<td>8 days to 6 months imprisonment and fine to 251 to 1,000 euros; with premeditation: 1 month to 1 year, fine of 500 to 2,000 euros</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------------------------</td>
<td>-----------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>-----------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Luxemburg</td>
<td>Article 392 of the Penal Code; voluntary corporal lesions</td>
<td>Voluntary corporal lesions</td>
<td>Offence causes death</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Portugal</td>
<td>Articles 143–149 of the Penal Code</td>
<td>Bodily injury; serious bodily injury</td>
<td>Offence against minor; offence performed by parent/person having custody; loss of essential parts of the body; permanent and incurable corporal lesions; permanent loss of working capacity; offence causes death</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Bodily injury; up to 3 years; serious bodily injury: 2 to 10 years</td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td>Articles 300–304 penal Code</td>
<td>Bodily injury; serious bodily injury</td>
<td>Offence performed by parent/person having custody; serious corporal lesions; offence causes death</td>
<td>Yes, on the condition that the offender is a national or liability for preparatory acts in the Netherlands concerning a FGM operation abroad</td>
<td>Bodily injury; 2 years imprisonment or fine Serious bodily injury with premeditation; imprisonment of 12 years max or fine</td>
</tr>
</tbody>
</table>
do not take into consideration cosmetic genital surgery, such as vaginal tightening or lifting/reduction of labia that are performed for non-therapeutic reasons. For example, Swedish law does not mention age or ethnic background in its content, and considers consent irrelevant [18]. Consequently, the Swedish Act on FGM technically outlaws genital changes also in non-African women, and all gynaecologists or plastic surgeons performing such alterations to the genitalia for non-medical reasons could be prosecuted.

Specific criminal laws in the seven countries included in the survey, have included the principle of extraterritoriality. Additional conditions for the applicability of the principle of extraterritoriality are present in all seven countries, and include double incrimination (Austria, Denmark), nationality/residency of the victim (Austria, Italy, Denmark, UK), or the prerequisite that the perpetrator must be found on the territory, which is the case for Austria and Belgium. In Belgium, an additional condition is that the victim has to be a minor. The only condition attached in Sweden is that "the perpetrator should be in some way connected to Sweden." In the UK, the principle of extraterritoriality first came into effect when the law was changed in March 2003.

The principle of double incrimination was removed from Swedish law in 1999. This consequently resulted in the fact that all forms of FGM performed outside Sweden on girls residing in Sweden (citizens, refugees, residents, etc.) before 1999, could not be classified as illegal, as long as they had been performed in a country where such acts were not considered criminal [18]. Spain adopted a law recently (July 9, 2005), which abolishes the double incrimination from the FGM criminal law. The only condition that remains is that the offender has to be found on Spanish territory in order to be punishable.

In all seven countries with a specific criminal law provision dealing with FGM, the consent of the victim is not considered to be taken into account. Consequently, anyone performing FGM can be prosecuted even if the victim is an adult who "consented" to have it done (Table 2).

Legal provisions applicable in case of a girl at risk of FGM: child protection laws

Female genital mutilation is considered as a form of child abuse. In situations when the act is not yet committed but a girl is at risk, laws dealing with the protection of children from abuse can be applied. Child protection laws exist in all Member States studied, and have been examined more closely in the five countries of the in-depth analysis.

As is the case in all EU countries, child protection laws pertaining to child abuse exist in Belgium (Child Protection Law of 1965), France (Article 375 of the Civil Code), Sweden (Social Services Act; Care of Young Persons Act (1990) and the Act regarding Special Representative for a child of 1999) and the UK (Children Act of 1989). In Spain, the following child protection provisions are applicable: Civil Code Articles 9.6, 92, 93, 156, 158, 216.2, 217; the Parliamentary Law of Judiciary Power Articles 223 and 5; and the following national child protection laws: Parliamentary Law (Ley Organon 21/1987 de 11/11) and the Parliamentary Law for the Legal Protection of Minors, enacted 15th January 1996 (Ley Organica 1/1996 de 15/01, de Protección Jurídica del Menor). Furthermore, autonomous communities in Spain have their own child protection laws that are applicable in case of child abuse. In none of the above-mentioned countries does separate child protection legislation with regard to FGM exist.

In the case of girls at risk of FGM, either voluntary child protection measures are undertaken, such as hearings with the family, providing information, counselling and warnings to the family; or compulsory child protection measures, such as removing a child from the family or suspending parental authority. Certain compulsory child protection measures are subject to court permission, e.g. suspension of parental authority, removal from the home and withdrawal of travel permission.
<table>
<thead>
<tr>
<th>Specific criminal law provision</th>
<th>Austria</th>
<th>Belgium</th>
<th>Denmark</th>
<th>Italy</th>
<th>Spain</th>
<th>Sweden</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of entering into force</td>
<td>01/01/2002</td>
<td>27/03/2001</td>
<td>10/05/2003</td>
<td>23/12/2005</td>
<td>1/10/2003</td>
<td>1/1/1982</td>
<td>30/04/2004 (FGM Act)</td>
</tr>
<tr>
<td>Applicable on genital mutilation of boys</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Which forms of FGM are forbidden</td>
<td>Clitoridectomy</td>
<td>Excision</td>
<td>Excision</td>
<td>Excision</td>
<td>Excision</td>
<td>Excision</td>
<td>Excision</td>
</tr>
<tr>
<td></td>
<td>Excision</td>
<td>Inflation</td>
<td>Inflation</td>
<td>Inflation</td>
<td>Inflation</td>
<td>Inflation</td>
<td>Inflation</td>
</tr>
<tr>
<td></td>
<td>All other forms, except piercings and tattoos</td>
<td>All other forms</td>
<td>Reinforced not stipulated as illegal</td>
<td>All other forms, except any other practice that causes effects of the same kind</td>
<td>All other forms</td>
<td>All other forms, except piercings, tattoos and stretching of labia</td>
<td></td>
</tr>
<tr>
<td>Criminal offence consists of</td>
<td>Reinforced not specifically specified as illegal</td>
<td>Reinforced not specifically stipulated as illegal</td>
<td>Reinforced not specifically mentioned</td>
<td>Reinforced not specifically stipulated as illegal</td>
<td>Reinforced not specifically stipulated as illegal</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Performance</td>
<td>Performance</td>
<td>Performance</td>
<td>Performance</td>
<td>Performance</td>
<td>Performance</td>
<td>Performance</td>
</tr>
<tr>
<td></td>
<td>Participation</td>
<td>Participation</td>
<td>Participation</td>
<td>Participation</td>
<td>Participation</td>
<td>Participation</td>
<td>Participation</td>
</tr>
<tr>
<td></td>
<td>Attempt to</td>
<td>Attempt to</td>
<td>Attempt to</td>
<td>Attempt to</td>
<td>Attempt to</td>
<td>Attempt to</td>
<td>Attempt to</td>
</tr>
<tr>
<td>Aggravating circumstances</td>
<td>Loss of essential parts of the body, permanent and irreversible corporal lesions; permanent loss of working capacity; offence</td>
<td>Offence committed against minor; offence performed by parent/person having custody; permanent and irreversible corporal lesions; offence</td>
<td>Loss of essential parts of the body; permanent and irreversible corporal lesions; offence</td>
<td>No details received</td>
<td>Offence is committed against a minor; offence is performed by a parent/person having custody</td>
<td>Offence endangers life of the victim; crime involved particularly reckless behaviour</td>
<td>Not mentioned in 1945 FGM Act</td>
</tr>
</tbody>
</table>
Table 2 (continued)

<table>
<thead>
<tr>
<th></th>
<th>Austria</th>
<th>Belgium</th>
<th>Denmark</th>
<th>Italy</th>
<th>Spain</th>
<th>Sweden</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Does the consent of the victim affect the legal qualification of the act?</strong></td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Applicability of extraterritoriality</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Not in 1915, but in 2003 Act</td>
</tr>
<tr>
<td><strong>Conditions for applicability of extraterritoriality</strong></td>
<td>Double incitement, unless both the victim and offender are Austrians; offender must be found on the territory if he/she is a foreigner</td>
<td>Victim is a minor; offender must be found on the territory</td>
<td>Double incitement; victim is a resident</td>
<td>Victim is a resident</td>
<td>Double incitement; complainant of the victim; offender has not been judged, absolved, condemned or exonerated in a foreign country for the same charges</td>
<td>Offender is in some way connected to Sweden</td>
<td>Victim is a national or permanent resident or offender is a national or permanent resident</td>
</tr>
<tr>
<td><strong>Criminal prosecutions for FGM?</strong></td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Penalty</strong></td>
<td>Depends on the seriousness of the injury (up to 15 years of imprisonment if victim dies)</td>
<td>Performance: imprisonment from 3 to 5 years; attempted performance: imprisonment from 4 days to 1 year</td>
<td>Up to 6 years if the act does not have severe consequences. If the practice implies “severe consequences” the penalty can be up to 10 years</td>
<td>Imprisonment for max 4 years; imprisonment for min 2 years and max 10 years</td>
<td>From conviction or indictment, to imprisonment for a term not exceeding 14 years, or a fine or both (FGM Act 2003); from summary conviction to imprisonment for a term not exceeding 6 months, or a fine not exceeding the statutory minimum or both (PCFA 1985)</td>
<td>From conviction or indictment, to imprisonment for a term not exceeding 14 years, or a fine or both (FGM Act 2003); from summary conviction to imprisonment for a term not exceeding 6 months, or a fine not exceeding the statutory minimum or both (PCFA 1985)</td>
<td>From conviction or indictment, to imprisonment for a term not exceeding 14 years, or a fine or both (FGM Act 2003); from summary conviction to imprisonment for a term not exceeding 6 months, or a fine not exceeding the statutory minimum or both (PCFA 1985)</td>
</tr>
</tbody>
</table>
However, all five countries – with the exception of Belgium – have developed specific child protection guidelines or protocols on the protection of a girl at risk of FGM. In the UK for example, the policy document “Working together to safeguard children,” issued by the Department of Health, contains guidelines on how professionals should work together to promote children’s welfare. In this document, a specific reference is made to the practice of FGM. The new London Child Protection Procedures (introduced in November 2003 and replacing the local Area Child Protection Procedures) provide the statutory sector\textsuperscript{3} with a specific framework within which to work effectively to protect children from FGM.

In Paris, France, the ‘Conduite à tenir face à l’excision des petites filles’\textsuperscript{4} has been issued by the ‘Protection Maternelle Infantile (PMI),’\textsuperscript{5} and is a guideline to protect girls at risk. In the autonomous Spanish regions of Gerona and Catalonia, protocols for the prevention of FGM have also been developed: ‘Protocol de prevenció de la mutilació genital femenina a la demarcació de Girona’\textsuperscript{6} developed in June 2002 and modified in October 2003 [6]; and the ‘Protocol d’actuacions per a prevenir la mutilació genital femenina,’\textsuperscript{7} developed by the area of Catalonina in 2002 [7]. The Swedish Board of Health and Welfare issued guidelines regarding the prevention of FGM that have been elaborated at national level ‘Kvinnläg könssynspråk: Ett utbildningsmaterial för skola, socialtjänst och hälso- och sjukvård,’ 2002.\textsuperscript{8}

It should be noted that the new Italian law sets forth not only repressive measures, but also preventive measures regarding FGM, such as promotion and coordination activities, information campaigns, training of health care personnel, the creation of a toll-free telephone number to report cases and to provide information, dealing with FGM in international cooperation programmes of Italy [1] (Table 3).

Legal provisions regarding professionals’ confidentiality

Social workers and health professionals have an important role in reporting actual cases or suspicion of cases of FGM, or situations of girls at risk of FGM. Many of these professionals can be bound by their professional confidentiality not to reveal private information about their patients/clients or people they work with. Hence it is critical for professionals to be knowledgeable about the laws regarding FGM in their respective countries, and more specifically whether the law considers reporting (suspected) cases of FGM as being mandatory or optional. Consequently, our in-depth analysis also focused on legal provisions pertaining to professionals’ confidentiality.

The five countries that were under consideration in the research analysis all have legal provisions regarding professionals’ confidentiality. In Belgium, this is Article 458 and 458bis of the Penal Code; in France Article 226-13 and 226-14 of the Penal Code, and Article 434-3 of the Penal Code; in Spain Article 263 of the Criminal Procedure Law and in Sweden the Secrecy

\textsuperscript{3}The ‘statutory sector’ comprises the departments and services provided by the government, including the Department of Social Services, the Department of Health, Local Government Authorities, the Police and Education services [20].

\textsuperscript{4}Guideline regarding excision of girls.

\textsuperscript{5}Mother and Child Health Care service, a public service provided in each of the French departments.

\textsuperscript{6}Protocol for the Prevention of Female Genital Mutilation in the area of Gerona.

\textsuperscript{7}Protocol of Proceedings to prevent female genital mutilation.

\textsuperscript{8}Female genital mutilation: An educational material for schools, social authorities and the health sector.
<table>
<thead>
<tr>
<th></th>
<th>Belgium</th>
<th>France</th>
<th>Spain</th>
<th>Sweden</th>
<th>United Kingdom</th>
</tr>
</thead>
<tbody>
<tr>
<td>FGM is specifically mentioned</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>A specific FGM child protection guideline is provided</td>
<td>No</td>
<td>Yes; regional guideline applicable in Paris; information brochures disseminated nationally</td>
<td>Yes; Geneva Protocol (only applicable in Catalonia); Interdisciplinary Commission on FGM was constituted on 14/11/2005 to discuss and approve the &quot;Angom Protocol&quot;</td>
<td>Yes, elaborated by the Swedish Board of Health (2002)</td>
<td>Yes, in the sense that FGM is mentioned in the chapter entitled &quot;Child protection in specific circumstances&quot; by Department of Health (1999)</td>
</tr>
<tr>
<td>Voluntary child protection measures</td>
<td>Hearing with the family; informing, counselling and warning</td>
<td>Hearing with the family; informing counselling, warning</td>
<td>Hearing with the family; informing counselling, warning</td>
<td>Hearing with the family; informing counselling, warning</td>
<td>Hearing with the family; informing counselling, warning</td>
</tr>
<tr>
<td>Compulsory child protection measures</td>
<td>Certain acts are subject to court permission, e.g. travel permission; removing the child from the family; suspending parental authority</td>
<td>Certain acts are subject to court permission, e.g. travel permission; periodic medical (genital) examination of a child; removing the child from the family; suspending parental authority</td>
<td>Certain acts are subject to court permission, e.g. travel permission; periodic medical (genital) examination of a child; removing the child from the family; suspending parental authority</td>
<td>Medical (genital) examination of a child; removing the child from the family; suspending parental authority</td>
<td>Certain acts are subject to court permission, e.g. travel permission; removing the child from the family; suspending parental authority</td>
</tr>
<tr>
<td>Child protection interventions</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Act. The UK has the Human Rights Act and the Data Protection Act, but has also developed several policy documents relating to confidentiality and child protection. For example, the document "Working Together to Safeguard Children," states that personal information about children and families held by professionals should not generally be disclosed without the consent of the subject except where there is a need to protect the child's welfare [20].

In France, Spain, Sweden and the UK, professionals have a duty to report child abuse, either to social authorities (Sweden, France and the UK) or to judicial authorities (France, Spain). Only in Belgium is FGM specifically mentioned in the legal provision (Article 458bis) relating to confidentiality of professionals. Belgium is also the only country where reporting is optional. Moreover, several conditions have to be fulfilled before Belgian professionals can reveal information to prosecution authorities: (1) the crime of FGM should already be committed against a minor, and (2) the victim should be in danger and the professional should be sure that the integrity of the minor cannot otherwise be secured. In Sweden, the duty to report knowledge of FGM is integrated in the Swedish FGM act. Furthermore, the health and school sectors as well as the police, have a duty to report any case of child abuse to the social authorities, while the social authorities only have a right to report to the police under certain circumstances, i.e. information can be revealed in case of any crime that may lead to a minimum of 2 years imprisonment or if the purpose of revealing the information is to prevent a crime. However, at the time of the research, a commission was reviewing the Secrecy Act, and confusion within the police and social authorities on reporting procedures is likely to disappear in the future. In France, information has to be disclosed by health professionals when the law imposes or authorises such disclosure, e.g. in case of deprivation or abuse of a minor (Table 4).

Implementation of laws

In order to put these legal provisions into practice, a succession of actions should be performed by a wide range of public officials, along the lines of several prescribed formalities. Referral procedures describe this process and, as such, are a tool for translating legal provisions into practice. Referral procedures differ according to if FGM has already been performed, or if a girl is at risk of FGM. Once the crime has been committed, criminal procedures can be started with the aim to prosecute perpetrators of FGM, parents, guardians and/or other accomplices. When the main concern is to prevent harm and to protect the child's well-being and physical health, child protection provisions can be initiated. Both procedures, emphasising, respectively, the dimension of punishment or prevention, contain an established set of steps — ranging from reporting of a case or a suspicion of FGM, over an investigation phase to deciding to take a case to court — and involve a variety of public officials and professionals in each phase of this referral process. The number of prosecutions is only one outcome of the law enforcement process and is not the sole indicator of the legal response to FGM by a country.

The implementation of legislation constitutes the totality of actions that are undertaken de facto, to give effect to the legal provisions at distinct levels of interaction by a number of different agents, who make use of multiple strategies. While the referral procedures describe an ideal scenario to be followed, the reality of implementation is informed by the actions of the different stakeholders involved.

The next section of this paper describes the implementation of the legal provisions regarding FGM, in Belgium, France, Spain, Sweden and the UK, by looking at the reporting of cases of FGM and child protection procedures, at investigations and possible court cases, as well as at the obstacles for an effective implementation of the law, as expressed by the key informants during the interviews.
Table 4 Professional secrecy provisions in the EU

<table>
<thead>
<tr>
<th>Professional secrecy provisions</th>
<th>Belgium</th>
<th>France</th>
<th>Spain</th>
<th>Sweden</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Article 458 and 458bis of the Penal Code</td>
<td>Article 226-13 and 226-14 of the Penal Code; Article 436-3 of the Penal Code</td>
<td>Article 263 of the Criminal Procedure Law</td>
<td>No, specific guidelines elaborated by the Swedish Board of Health and Welfare (2002)</td>
<td>Working Together to Safeguard Children documents; professional guidelines</td>
<td>Yes</td>
</tr>
<tr>
<td>FGM is specifically mentioned</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Which professionals are envisaged?</td>
<td>Health professionals; &quot;other professionals bound to secrecy&quot; such as education staff and social workers</td>
<td>Health professionals</td>
<td>Lawyers; priests</td>
<td>Health professionals, social authorities</td>
<td>Health professionals, social workers, police, education staff</td>
</tr>
<tr>
<td>Conditions for disclosing information</td>
<td>Art. 458bis: crime of FGM is committed against a minor AND the victim is in danger AND her/his cannot assure the integrity of the minor</td>
<td>When the law imposes or authorizes disclosure, e.g. in case of deprivation or abuse, incl. sexual harm or assault committed against a minor or any person unable to protect herself</td>
<td>Not specified</td>
<td>In case of any crime which may lead to a minimum of 2 years imprisonment if the purpose is to prevent a crime</td>
<td>When there is a need to protect the child’s welfare and safety</td>
</tr>
<tr>
<td>Duty or right to report</td>
<td>Right to report to prosecution authorities</td>
<td>Duty to report to administrative or judicial authorities</td>
<td>Health professionals and teachers have a duty to report to police or judicial authorities; citizens have an obligation to denounce to prosecutor, competent court instruction judge or police</td>
<td>Duty to report any suspicion of child abuse to the social authorities; social authorities may report a crime involving a child to the police</td>
<td>Duty to report to social services</td>
</tr>
</tbody>
</table>

© Springer
Belgium

The research in Belgium found no evidence at any level of past implementation of the law, i.e. there have been no police, prosecution, child protection or criminal court interventions with regard to FGM. This indicates that no reports have been recorded by the public, health sector, child and family care, (pre-)school sector or social sector, either concerning a case of performed FGM or concerning a girl at risk [22]. In Belgium, six key informants have been interviewed including an activist, examining magistrate, prosecutor, child protection officer, gynaecologist and an officer at Child and Family Care.

During the fieldwork, the issue of re-infibulation came up, and one key informant reported that gynaecologists are unaware that re-infibulations might be considered as FGM:

"Many professionals will not see it as bodily injury, but as an operation, and they are not aware that doing it is illegal" (Officer at Child and Family Care) [22].

Possible obstructing factors to implementing the law in Belgium were assessed by all key informants. They assessed a scarce knowledge of FGM among professionals who could be confronted with FGM, such as police, police physicians, health professionals and teachers, as well as a lack of knowledge about the legal aspects of FGM and referral procedures, in case a girl is at risk of FGM.

Some key informants reported that the lack of reported cases was also linked to the fact that FGM is something performed within the secrecy of the family and community. Communities tend to solve problems within their own communities and there might be a resistance to report to the police or prosecution authorities. Two key informants also mentioned that there is a general lack of knowledge about the judicial structures and procedures of Belgium, among the migrant communities.

"Because FGM happens in migrant communities, where the lack of knowledge about the Belgian structures is high and initial resistance exists, I think that they do not consider it necessary to report cases to the police. Moreover, cases of FGM will most probably only be known within the family, so there should already be high disagreements within a family before any member of the family would go to report to the police. FGM is surrounded by secrecy, it's a family matter, and happens in a world that does not know our judicial world. Therefore, the chance that anyone will take the initiative to report is very small" (Prosecution officer in Leye) [22].

Another obstructing factor defined by the key informants was the difficulty in finding evidence, both in case of performed FGM as well as in cases of girls at risk. Some interviewees mentioned that gynaecological examinations of girls are the only possibility to find evidence, although at the moment, there is no systematic and compulsory gynaecological examination of girls within Child and Family Care, nor is it integrated in medical check-ups at school.

"Children up to 3 years are checked by Child and Family Care, after that by school doctors. However, it is not the norm to examine girls' genitals, and there are so many other things to check. Moreover, we are also not talking about the average population. So it would be very difficult to systematically check and monitor this" (Officer at Child and Family Care) [22].

One key informant stated that evidence gathering is even more complex in extraterritorial cases. Two key informants stressed the lack of coordinated action at
European judiciary level and arbitrary cooperation between African and European fieldworkers to protect girls that travel abroad, which further exacerbates an inadequate follow up of excisors travelling around Europe and girls that travel to Africa.

One key informant mentioned the fact that reporting to prosecution officers is contrary to the normal way of working:

"In case you are informing a family of the illegality of the practice of FGM, then you show to the family that in case something happens to the girl, you will report. And this is contrary to our normal way of working... Confidentiality is the key in our way of working (to try to stop abuse and to limit the damage), and you have to be very careful with this. You can only destroy the relation of confidentiality with the family if you are absolutely sure that you do not have a grip on the situation, in case there is a permanent danger for the child that we cannot control..." (Child protection officer) [22].

Most of the key informants also assumed some positive aspects of having a specific law in Belgium, such as the warning function it might have towards practicing communities, the fact that it gives gynecologists a legal way of refusing to perform reinfiltrations. They also believed that the principle of extraterritoriality avoids girls of being taken abroad. The key informants specifically stressed that such a law is a strong argument against the 'cultural argument' used both by perpetrators and lawyers, that justifies FGM as a ritual or tradition of another culture that needs to be respected and in which westerners cannot interfere. Some key informants believed that a specific law helps in countering this cultural argument and avoids discussions in court about the liability of FGM under general criminal law.

France

The case study in France focused on the Paris region, where a number of cases have been reported. Within the PMI services of the Paris region, health professionals received instructions to perform inspections of the external genitalia of all girls during medical follow-up and monitoring of the child until she is 6 years old, and to note and date the state of the (normal) genitalia in the so-called Carnet de Santé⁹ [31]. In case the girl comes from a community that practices FGM, it is also advised to write down and date when the parents have been informed about the potential dangers related to FGM and the illegality of the practice. However, it is important to note that medical follow-up of newborns and children up to 6 years is not compulsory in France.

Since 1988, at least 33 cases have been brought to the Assize court in France, involving 120 children and 99 parents, and prison sentences for the imprisonment of parents and traditional excisors have been pronounced. An illustrative case in France, which attained extensive media coverage in Europe, is the case of an excisor who appeared in the Assize Court in 1999, together with 25 parents (see box 1). The case resulted in penalties for the excisor and the parents, and compensation for the 48 child victims. In 2004, five new cases were tried leading to penalties for the parents who had sent their children abroad in order to have them excised [36].

⁹This is a small booklet given to the parents at birth of the child. It is to be presented at each medical consultation, either preventive or curative, and contains medical surveillance data on the child from birth until 6 years [26].

© Springer
Box 1: Court case of Awa Greco, Assize Court of Paris, 1999

Following a reported case of FGM by a young woman, a criminal case was opened. The victim reported that she and her three younger sisters were excised in the eighties, and that she was afraid her younger sisters would be forced to marry. She also revealed the name of the excisor who performed FGM on her and her sister. After investigating the whereabouts of the excisor, the excisor was arrested in 1994 and put to trial in February 1999. During the investigation, the electronic address book of the excisor was seized, after which two investigations in all Île-de-France regions were initiated. The police questioned some 70 families, and examined their daughters in hospital. Besides the mother of the victim, 25 other parents involving 48 child victims acknowledged the excisor as the perpetrator, and were equally put to trial. The excisor was sentenced to 8 years and the victim’s mother to 2 years of stiff imprisonment. The other parents had suspended prison penalties: 5 years for twenty of them and 3 years for three of them. The court granted compensation to the 48 victims: 13,000 € each. Since a court decree in 1999, compensations in France for the child victim may be up to 25,000 € [36].

When a girl is at risk of FGM in France, child protection measures are taken with family consent or if this is not possible, the juvenile judge is informed. Several child protection interventions have taken place in France. The illustrative case of a child protection intervention, as described in Box 2, concerns a girl who was going on holiday to Africa and who needed to be protected from FGM. It demonstrates that several actions were undertaken at different levels, such as health care, judicial level and the Ministry of Health, involving a number of persons, both in Europe and Africa, in order to protect the girl.

Box 2: Child protection intervention, Paris, 1994

In a PMI centre located near Paris, medical doctors organized meetings with African women relating to FGM, its health risks and legal provisions. At one of these meetings in 1994, a mother from Mauritania bragged that she was entitled to decide for her child and she added that she would soon leave for vacations in her country where her daughter would be done. The doctor called the Juvenile Judge who summoned the father to his office. He explained that the baby, being born in France, was under the protection of the French law even abroad, and that if she came back excised, the parents would be prosecuted. Meanwhile the information on the planned trip was forwarded to an officer from the Health Ministry in Nouakchott, capital of Mauritania. She offered her help and sent a civil servant to the airport to escort the mother and child to the village. The civil servant gathered the villagers to explain that the government was not in favour of the practice. In the meantime, the father had sent a message saying that he did not want his daughter to be excised. The child returned to France untouched [36].

Five key informants were interviewed in spring 2004, including a medical doctor from PMI, the prosecutor of Paris, the lawyer who has taken several cases to court, police officers at Bobigny where several cases of FGM have been reported, and a retired prosecutor who followed up the reported cases at Bobigny.

Although France has succeeded in bringing more than 30 cases to court, the key informants interviewed identified several obstacles to the implementation of the law in France.

All key informants mentioned that identifying cases was one of the main barriers to implementing the law, caused by a number of reasons: doctors and other service providers who do not want to betray the trust that families put in them; service providers who want to
avoid the nuisance of reporting FGM to the authorities; and certain population groups that are very hard to reach.

"I confirm that today we have entire families who escape not only from education but also from every social control. [...] There have been a lot of illegal entries in the country in the last couple of years. [...] You cannot trace them, not even by the circuit of the PMI because going to the PMI is not compulsory" (Prosecutor, Paris) [36].

"[...] Those very young girls who arrive in Paris with their old husband. [...] those are women who live in total distress and who we don’t see" (PMI officer) [36].

Identifying cases is further exacerbated by the fact that, according to some key informants, not all health professionals follow the instructions of the PMI regarding systematic screening [36]. Some key informants expressed concern about the occasional lack of follow-up by prosecutors and another mentioned the lack of guidelines for professionals who are confronted with a girl at risk of FGM that might have an impact on the implementation of the law [36].

Another difficulty mentioned was that because FGM is committed within the family and within the community, individuals remain silent when they are interrogated, making it difficult to find sufficient evidence to proceed against the performer, though parents are always prosecuted as accomplices [36].

The lack of cooperation at international level was seen as an obstructing factor, since the procedure to prevent that a girl being mutilated when she is on holiday is very complicated and expensive.

"The problem is that you have to go and search for them [...] You have to pay for the trip back home in case parents decide to stay there [...] and you have to find the girl(s) because they might not be in the village where they said they were taken to. So it is very complicated and that is why we have to prevent the departure from France" (Lawyer) [36].

And finally, all key informants mentioned that the perceptions of doctors and others about FGM are a factor that might influence a good implementation of the law. For example, the fact that parents claim that they meant no harm and acted with respect to their religion and tradition was a good enough excuse not to inform the police or prosecutor [36]. Although France has no specific law on FGM, the lawyer who brought the many cases to court states that French jurisprudence can take the background of the parents into consideration as extenuating circumstance, but never as an element that removes the criminal dimension of the act [36].

Key informants in France considered that activism, the many court cases and the subsequent media attention they attained, as positive contributing factors to the fact that the majority of the population involved considers FGM as illegal and thus refrain from committing FGM.

Spain

The case study in Spain focused on two autonomous regions – Catalonia and Valencia, where a number of interviews have been done with judges, public prosecutors, lawyers,
police officers, medical doctors, social workers and immigrants. Five interviews have been translated from Spanish to English, of which excerpts are included below.

In Catalonia, a number of cases have been reported to the authorities by the health sector, social services and citizens. Key informants in Valencia had no knowledge about cases, neither of performed FGM nor of girls at risk of FGM. The reported cases in Catalonia have been followed by a preliminary police investigation, but no sufficient evidence has been found to open a criminal procedure. Some of the cases in Catalonia [11], describe successful interventions to protect a girl from FGM, by informing the parents about the legal consequences if they proceed with the act, but also by adopting compulsory measures such as prohibiting the child leaving the country and withholding the passport. One illustrative case of such a child protection intervention is described in Box 3.

**Box 3: Child protection intervention in Girona, in 2001: Committal Proceedings (Diligencias previas) 75/1, Court of First Instance and Investigation number 2 of Santa Coloma de Farners in Girona**

Neighbours informed the social services of the intention of the Senegalese parents of a girl to travel to their home country to have FGM performed on the child. The social services informed the prosecuting authorities, who solicited the initiation of the committal proceedings and the adoption of urgent preventive measures: prohibition for the child of leaving the country, and if advisable, withholding the passport, and taking the statements of the parents as well as informing them of the penal consequences of the act to the parents.

After that, the parents assured that although they had planned to have FGM performed, they would no longer do it. The Court handed down a ruling in which it was formally agreed to request the parents to abstain from promoting any action that impaired the integrity of their children, warning them of the penal consequences, and they were requested to inform the authorities about their return to Spain for a medical examination of the girl. Upon their return from Africa, a gynaecological examination was performed, that found no sign of FGM. Afterwards, the case was dismissed without prejudice, since evidence of an offence was not found [11].

With regard to implementing child protection measures, the main difficulty mentioned in Spain is the conflict between acting in the interest of the child and respecting the autonomy of the parents. For example, measures are taken to avoid risky situations for a girl, such as withholding her passport so that she cannot travel with her parents to the home country, but at the same time, such a measure is also considered to be a serious intrusion into the privacy of a family [11].

Another obstacle identified in Spain is the scarce and/or imprecise knowledge about FGM and the details of the applicable legislation, although in general the interviewees know that FGM is considered to be a crime under Spanish law.

"I do not have much knowledge about legislation; I only know that it is punished as serious bodily injury offence, with penalty of imprisonment [...] The truth is that I do not have a deep knowledge of this legislation" (Nurse) [11].

The lack of knowledge about the procedures to follow when a case is reported is also another obstacle, although an important difference was noted between professionals interviewed in Valencia and in the Catalan area. The existence of the protocol for the prevention of FGM in Catalonia, and the fact that it is known locally, are considered to be the main causes of the different levels of knowledge between Catalonia and Valencia...
where no protocols for professionals are provided [11]. There was also a difference noted between the professionals' own perception of their knowledge about FGM and the actual reality of that knowledge, as well as a lack of interest in the matter.

Another obstacle identified was the secrecy surrounding the practice and the fact that FGM is performed in specific groups of the population:

"I consider that the main obstacle for the implementation of the legislation would be the lack of reporting; taking into account that it is practiced in closed familial and religious circles [...]. Therefore the first step to take on the way to eradication would not be the application of the law – which would be necessary once it has happened – but the education of people that are susceptible of this practice [...]" (Police inspector) [11].

The difficulty in finding sufficient evidence is also an obstructing factor, especially to prove if the practice has been carried out, where it happened and who did it. Some cases mention that girls are taken outside Spain to the countries of origin to have FGM performed. However, in these cases, the investigations have not led to court cases. At that time the principle of extraterritoriality was applicable under the condition of double incrimination. The verification of FGM in the country of origin, more specifically outside Spanish jurisdiction, is considered to be main problem for law enforcement in relation to FGM, as demonstrated in the case Cervera (box 4).

Box 4: Case Cervera (Lérida), 2002

A social assistant reported to the police and judicial authorities the intention of the father of three girls, expressed in public, of practicing the mutilation from the clitoris to his daughters between 6 and 9 years. The prosecutor opened an investigation. Months later the doctors verified in an ordinary inspection that FGM had been performed, and it had been done in Gambia. The prosecutor re-opened previous judicial proceedings and accused the parents of facilitation for a crime of mutilation. The parents stated that the grandparents and the girls' uncles carried out the practice when they (the parents) were in another town in Gambia. They assured that they acted in the conviction that they did not perform something bad, since the practice is usual in the Gambia. The case was dismissed because the facts were committed outside the country by some relatives who did not act with the intention to do harm. FGM has been performed on the three girls.


**Sweden**

The Swedish case study documented all cases reported to the police in the 21 police districts of Sweden. Six in-depth interviews have been done with a prosecutor, social worker, social nurse, gynaecologist/obstetrician, midwife and a detective superintendent of the police.

In Sweden, most reported cases come from the school and pre-school sector, some originate from the health sector, and are reported to the social authorities [18]. Several cases have been reported to the police by the social authorities [18].

Only a few cases have led to reliable conclusions that FGM had actually been performed (unclear if performed before or after migration to Sweden). Many of these cases were about fear of future performance of FGM or turned out to be unfounded [18]. Although some cases have reached the prosecution authorities, Sweden has never had any court case on
FGM. This was due to the following facts: after investigations it turned out that no crime was committed; it was impossible to prove that FGM was performed or it was impossible to prove that the performance of FGM was illegal [18].

Box 5: Case of suspicion of illegally performed FGM, 1999, Göteborg, Sweden

January. A 5-month-old baby girl is hospitalised due to an infection. An experienced nurse discovers that the genitals of the girl have been excised. Her interference is supported by two experienced colleagues [she states later, during the police investigation]. She is convinced that this has been discovered earlier – as the changes of the genitals were so “striking” – so she restricts her actions to writing a note in the medical case record.

17 February. One and a half months later a chief physician discovers the note in the case record. He writes a report to the social welfare office of the district where the girl’s family lives. The social welfare office reports the case to the district police office (26 February).

5 May. A detective inspector makes the decision to act in this case.

17 May. Police, social authorities, and a physician make a house call. The parents are informed that they are under suspicion of plotting regarding severe genital mutilation. The girl, at the time, 10 months old is taken to a clinic for genital examination. The other children of the family are taken into custody. The parents are taken separately to police headquarters where they are further informed about the serious charges. Both parents deny these insincerely and indignantly, and cannot understand why anyone could think they would harm their own child in this way. Later the same day, the two physicians declare the girl’s genitals to be completely normal. Neither of them could find signs of any kind of violence or of an operation.

Status: Suspicion of performed illegal circumcision, suspicions unfounded.

Source: A newspaper article (GP, 26 May 1999) referring to the police investigation in detail.

One of the obstacles to the implementation of the law, as identified by interviewees in Sweden, was the difficulty in assessing if FGM had been performed, especially to assess the divergence between normally shaped genitals of young girls and type I or II of FGM (see box 5).

"Extremely few physicians know what a young girl looks like in her genital area, and what divergence there may also be in normally shaped genitals. This requires specialist qualifications." (Prosecutor) [18].

Another difficulty reported in Sweden, was the problem in police investigations to prove that an act of FGM was performed after 1999, the time when the principle of double incrimination was removed from the law. The case study showed that in some cases FGM has been admitted by a parent, but alleged to have been performed abroad before the change of law in 1999 in a country where FGM is not penalised, and thus not illegal [18].

Key informants in Sweden also mentioned that identifying cases remains difficult. The possibility of a medical screening of girls was suggested by some of the key informants as a means of identifying cases, although other key informants were critical about this.

"I’d say that such an examination of girls of this age would be too intrusive. It’s a very sensitive age. And there are girls who have certain experiences... no, I really don’t recommend that" (School nurse) [18].

Springer
Another impediment to the implementation of the law concerns the general difficulties associated with crimes committed within the family:

"Investigation of this crime is associated with great difficulties, since victim and perpetrator(s) belong to the same family, and their relation is characterised by a position of dependence. There is a weakness in our ability to protect the victim, in that it is seldom possible to use compulsion toward the person injured with the purpose of finding evidence or bringing about an interrogation. This means that the perpetrator is always one step ahead of the judicial system, and, in addition, in a position where he or she can strongly influence the person injured" (Police officer) [18].

Swedish key informants also identified some contributing factors to effective implementation of the law including: the consensus in Swedish society that FGM is punishable; the consensus that children cannot be abused (not even a slap against the head is allowed according to Swedish law); the high level of awareness and good knowledge about FGM and the existence of guidelines on how to act practically when a girl is at risk or a case of FGM is detected, as well as the existing good cooperation between authorities [18].

UK

In the case study in the UK, five key informants were identified and interviewed: a FGM specialist midwife, a gender and youth advisor, a solicitor, a project manager and the head of the child protection section in the social services department.

In the UK, several child protection cases, of which one is described in box 6, have been reported to Social Services Department. These cases are followed by a child protection investigation process as described in Section 47 of the Children Act, which includes the organisation of a multidisciplinary strategy meeting, involving police, child protection officers, health professionals, social/educational staff and NGOs working in the field of FGM [20]. Since the law was enacted in 1985, no evidence has been found to initiate a criminal prosecution, although two medical practitioners in the UK received administrative sanctions imposed by the Medical Council for offering to perform FGM. Key informants from the UK also expressed their concern that a number of cases go unreported [20].

Box 6: Voluntary child protection measure taken in the UK [20]

"Following a training day on FGM in the city concerned, a health visitor (HV) visited a young mother from a practising community who had a child of under 5 years (for a routine developmental check). The young mother (F) lived with her younger relative (aged 13) as her mother was out of the UK. During the visit, this younger relative (Z) mentioned to the HV that she was going home to visit her mother during the holidays. The HV asked if her mother had mentioned FGM to her, and the young girl said that the topic had been raised the previous year. The HV was concerned and referred the matter to Social Services. Social Services allocated a social worker (SW) to go and talk to the young mother about the concerns expressed. The SW made a home visit and raised the fear that Z might be subjected to FGM when she went home, and asked if F would agree to give her their passports until the discussions were complete as the travel date was very soon. F agreed to

[20] The project manager is responsible for a project in Nigeria that works with women and girls who have suffered Vesico Vaginal Fistula and Recto Vaginal Fistula as a result of FGM (Type 4) and early pregnancy and obstructed labour [21].
that and arrangements were made for further home visits to continue the discussions. F contacted an advocacy organisation and informed them of what had happened as well as several members of her extended family. The advocate, who was not from a practising community, did not seem to know enough about FGM and was very critical of the actions of the SW. At this point, the UK-based NGO, FORWARD, was contacted to give advice and guidance in respect of Social Services involvement. F attended a meeting with several members of her extended family, her solicitor, a teacher in a supplementary school and her advocate. The SW, her manager and another social services manager represented the Social Services Department. FORWARD attended in an independent advisory capacity. The meeting was quite fraught as there were several issues that were of concern to F and her representatives. Firstly, that the HV had acted outside her role – as she was there to see the baby, she had no business talking to her younger sister about issues like FGM, that the SW had ‘taken’ the passports and that because of the actions of Social Services, Z might not be able to go and see her mother. FORWARD took the position of using the meeting to explain why the concerns of the HV were valid, why Social Services had a responsibility under child protection legislation to investigate any concerns. F assured the meeting that the mother had changed her views on FGM, that Z was now too old to undergo FGM as the age for having it done was younger and that the mother no longer lived in the home country and times were different from when her older sisters had had FGM done. F promised that when Z returned she was willing for the SW to see her, interview her alone and even have a medical examination if that would reassure the SW. Based on the assurances the Social Services Department (SSD) [with FORWARD’s agreement] agreed that it would be safe to allow the Z to go and visit her mother. Z and the supplementary schoolteacher (who was also going on holiday) were provided with information on the law and the health and human rights dimension of FGM to take with them on the journey for the mother. Unfortunately, Z never returned from the ‘holiday’ and it’s assumed that despite all the assurances the young girl was subjected to FGM and therefore is unable to return to the UK”.

UK key informants mentioned several obstacles to an effective implementation of the law in the UK. Primarily, the lack of reliable nationwide baseline data was seen as an obstacle, as it means that legislators and activists are working in a vacuum – laws and amendments to laws are being drafted and passed without an accurate knowledge of the countrywide prevalence [20].

Furthermore, key informants reported a lack of knowledge in practising communities about the existing law. Laws have not been translated and presented to communities in an accessible form, and not all communities have not been sensitised about the need for an FGM law. Ensuring work with all practising communities has been left up to small, poorly resourced NGOs who are unable to access all the communities in England, Ireland, Wales and Scotland. Consequently communities will not always appreciate the reasoning behind the need for such legislation and will disregard it and/or perceive it as a direct attack on their traditions and beliefs [20].

“Where laws are made without them necessarily understanding the laws of a country, it becomes very difficult for practising communities not to feel that they are being discriminated against...that is where implementation of the law without careful preparation of the community becomes problematic. As you are aware, it is easier to make a law than to implement it. Implementation of the law actually requires adequate
preparation, it involves resources, and involves testing the ground and I think this is where it may become very, very difficult" (Gender and youth advisor) [20].

This lack of knowledge about the FGM law among various professionals such as police, legal officers, teachers, school nurses and health visitors, was also apparent and perceived as a main obstacle to an effective implementation [20].

Key informants also mentioned that several professionals are paralysed into inaction because of fear being labelled 'racist' [20], and such attitudes were thought to obstruct the implementation of the law.

“The attitudes of people who are going to implement the law, sometimes I feel it’s like... there is this complacency about the fact that it is a Black people’s thing and don’t push too hard or go softly, softly... To me this is a discriminatory attitude it is a sort of complacency when it is something, an issue that concerns the black children and this should stop” (Project manager) [20].

Since the UK never had any cases brought to court, there is no experience about how to monitor such a law and concerns were raised about how this will be done:

“Now, this will have some ethical implications and its implementation can also be very controversial -how is this going to be done? Who is going to be involved in it? Are people going to be stopped arbitrarily at the airport and examined? On what grounds are you going to stop one person and not stop the other?” [20].

Finally, some key informants considered the law in the UK as an asset because it provides a clear operational framework, a message of the government’s commitment to protect children as well as support to organisations working in the field of FGM and it makes it possible to punish those who may be caught [20].

Discussion

FGM is considered to be a violation of the human rights of women and an act of violence, as described in the 1979 Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). It is considered to be a form of child abuse, as described in the 1989 Convention of the Rights of the Child (CRC). CEDAW and CRC are two of the most important, legally binding human rights instruments that are used as a tool to prevent FGM. States that ratified these documents have the legal obligation to implement these instruments. Both documents make specific reference to harmful traditional practices and/or FGM, and call upon State Parties to introduce legislation to deal with FGM [33], or to ensure that laws are enacted and enforced to prohibit FGM [33]. The cross-country analysis has shown that all former member states of the EU have criminal laws that can be used in order to define FGM as an offence, either as a specific criminal act or as an act of bodily harm/injury, and have child protection laws that protect minors from abuse, which could be used to protect girls from FGM. No child protection legislation exists that deal specifically with FGM, but some countries have guidelines and protocols that are applicable at local level.

With regard to FGM legislation and its enforcement, this research provides a number of insights in the implementation of laws regarding FGM in Europe. The research clearly showed that both criminal laws and child protection laws are being implemented in four of
the five countries (except Belgium); cases are reported and investigations have been initiated, although the number of cases brought to criminal court is limited to France only. No evidence was found to state that specific criminal law provisions are necessary to guarantee the punishment of FGM, or that they are more successful in their implementation than general criminal law provisions.

However, the survey also showed that a number of issues remain, both regarding the types of FGM that are liable under specific laws on FGM as well as regarding the implementation of criminal laws and child protection laws.

Specific FGM legislation is problematic when it comes to Type IV, and more specifically regarding piercing or cosmetic surgery to the external genitalia. Clearly, the context in which genital alterations are performed differs considerably between, e.g. an adult Swedish woman requesting lifting of the labia for aesthetic reasons, and a Senegalese woman who has the labia minora of her daughter removed for cultural/religious reasons. However, specific criminal laws on FGM do not distinguish between ethnicity, age or if the victim gives consent or not. It is therefore questionable if legislators have taken into consideration cosmetic vaginal surgeries when drafting the law. Although the survey did not come across any reported cases of labia piercing and cosmetic genital surgeries as a form of FGM, concerns were raised about the applicability of the law on cosmetic surgeries, and more specifically about whom the law would apply to: the whole female population or African women only? [18, 20] These concerns are consistent with questions raised by other scholars, who claim that specific legislation on FGM perpetuate double standards, with stigmatisation of a minority population and uncertainty for those operating in this field as a consequence [2, 16].

The recurrent demands made to health care professionals for re-infibulation a woman after childbirth, is another issue that is not adequately covered by existing specific criminal laws. Although several key informants in this research assumed that the specific law regarding FGM dealt with the issue of re-infibulation, the analysis showed that existing legislation is not clear about it, and it remains unclear how the law would be interpreted should a case of re-infibulation be taken to court. This leaves health care providers in a vacuum, in which they have to decide whether or not to provide this type of surgery, and more specifically whether to provide a perineal repair as to the pre-delivery state i.e. back to Type 3 FGM, or to perform a normal perineal repair [23, 32]. The need for guidance in this matter was demonstrated in a Swedish study of Swedish midwives’ encounters with infibulated African women in Sweden, where midwives – in the absence of guidelines – refer to the law when women request re-infibulations [38], although the Swedish law itself is not clear about this [19]. This obscurity in Sweden seems to be exacerbated by a recent statement of the Swedish Board of Health and Welfare about cosmetic operations to the genitals, which are considered to be equal to operations on the nose and breast [19], which has led Johndottor and Essen [19] to pose the question whether re-infibulation can be said to be condoned as well in Sweden. To clarify these ambiguities in the law, it is advisable that the commonly used typology of FGM by the World Health Organisation – which is currently being revised – also takes the issues of cosmetic surgeries, re-infibulation and piercings into consideration.

Furthermore, the research identified a number of a number of factors that obstruct an effective implementation of both criminal laws and child protection laws, when it comes to FGM. These factors are related to the knowledge and attitudes of those confronted with FGM – both professionals and practicing communities – that have an influence on the process of law enforcement, including the reporting of cases, finding evidence and protecting girls at risk.
Knowledge and attitudes

The study showed that in Belgium, Spain and the UK those health professionals, authorities and police officers who need to be alert to the problem of FGM, lack knowledge about the practice in general and about the legal provisions and procedures to follow in particular. Key informants believed that due to this lack of knowledge cases are not being detected, reported or followed up. It has also been described in other sectors, such as the health sector, that a deficient knowledge about FGM [5, 23] and personal emotions and feelings of professionals [29, 30] might hamper the provision of adequate care for women with FGM. Key informants in this research have suggested that the lack of knowledge about laws and the legal system of the host country is apparent among practicing communities too. This was shown by the case study in the UK where not all communities have not been sensitised regarding the legislation and laws have not been translated in local languages, which has led to communities not respecting the law on FGM [20]. Other research among the Somali community in the UK is consistent with this as it indicated that knowledge about the FGM Act among the Somali community was not accurate [27]. Whether or not the law has an influence on behaviour of practicing communities regarding FGM, was not the subject of this research, but further research on this subject would definitely contribute to a better understanding of the decision making process of communities concerning FGM.

In the process of implementing the law, a number of actors play a role at various levels: health professionals who report cases, police officers and prosecutors who investigate cases, and judges and lawyers in the court room. The research showed that in some cases, the attitudes of these actors might obstruct an effective implementation of the law, e.g. the fear of being labelled as a racist or the respect for other cultures that might lead to not reporting cases to the authorities. France has countered the “respect for other cultures”-argument in the numerous cases that have been brought to court. French law views that every person living in France is subject to the law, making no difference between origin and nationality. Consequently all children enjoy the same rights, including the right on protection from abuse, and FGM should not be considered differently than any other form of child abuse (Weil-Curiel in [3, 22]. Weil-Curiel also argues that, should the court take into consideration this cultural argument, some children within French jurisdiction would be discriminated against as only children of African descent are victims of the practice [35].

These findings indicate how individual attitudes might influence the implementation process of a criminal law and underscore the need for targeted training and information sessions for those actors involved.

Reporting cases

The identification of cases has proven to be a major impediment to successful implementation of laws. Problems are related to the fact that FGM is an act committed within the family, where perpetrator (parents) and victim belong to the same family. In most cases the girl is dependent from the parents, which jeopardises the possibility of cases being reported. Communities also need to be knowledgeable about the law on FGM, and about the fact that, by having their daughters cut, they have committed a crime, which is contrary to their intention of doing well for the girl. Furthermore, FGM is performed in communities that are sometimes hard to reach by health and social services, making the detection of cases even more difficult.

Several key informants suggested genital examinations of girls as a method to increase the number of cases reported or to find evidence of performance of FGM. The example of
Paris showed that, although there are guidelines available and sensitisation of health professionals has been done, such examinations are not performed systematically within maternal/child health services or during medical check-ups in schools, if performed at all. Introducing compulsory gynaecological screening for girls as a means of enforcing the law on FGM is highly controversial and will create critical problems to put in practice, as was demonstrated in the Netherlands. After an investigation of a special commission,\textsuperscript{11} the Dutch Minister of Public Health, Welfare and Sports, concluded that the Dutch government does not have the legal power to oblige citizens to cooperate with gynaecological examinations of under-aged girls of a specific population group \cite{8}. The main arguments are that it is against the individual's right to freedom and only perpetrators – not the victims – can be obliged to undergo such examinations, and only when the public health is in danger, which is clearly not the case in this instance. Furthermore, the Commission states that imposing such a measure on a specific population group is against the principle of non-discrimination \cite{8}. One can also ask why compulsory gynaecological examinations have not been suggested to detect cases of child sexual abuse among the whole population, which once again suggests that double standards are in operation. Compulsory screening of primarily African girls, is not feasible, is discriminatory and is too repressive in nature, to be suggested as a way of increasing the number of cases reported. The focus should rather be on increased training of professionals who are likely to come in contact with FGM practising communities.

Finding evidence

Another main impediment to the implementation of laws is the difficulties in finding evidence. These difficulties are similar to those related to reporting cases: a lack of knowledge about FGM and the attitudes of actors involved, and the fact that the acts of FGM are performed within the family and as such are surrounded by secrecy. Parents, grandparents, and suspected executors remain silent and in general there is no written material to prove the circumstances of the fact. If FGM is committed abroad, the process of evidence gathering is even more complicated, since this cross-border investigation requires international co-ordinated actions at judiciary level, not only among EU countries, but also between Europe and Africa. A further impediment to finding sufficient evidence is the difficulty of assessing if FGM has been carried out, particularly the case of Type I and IV FGM. Another obstructing factor to prosecution is the difficulty of assessing when FGM was performed, as shown by the research in Sweden, where the principle of double incrimination was only removed in 1999, making it difficult to prove that acts of FGM done before 1999 were illegal if performed in a country where it is not a criminal offence. Furthermore, providing evidence that FGM was performed in any particular country is problematic, especially where there are no medical records of the procedure, and when FGM is performed in remote areas of a country where it is not policed as a criminal offence. Finally, communities do not easily reveal names of executors, which do not facilitate finding the perpetrator of the action. The case of the excisor who was arrested in France, and whose address book resulted in numerous court cases against parents who had had their daughters excised, is much more an exception than the rule.

\textsuperscript{11}Commission Fight Against Female Genital Mutilation ("Commissie Bestrijding Vrouwelijke Genitale Verminking").
Protection of girls at risk of FGM

This research showed that compulsory child protection measures to protect a girl at risk of FGM, such as withholding the passports of girls or withdrawing the girl from parental authority, are only implemented when counselling, hearings and partnership working with the family did not succeed [11, 20]. In the UK for example, a Prohibitive Steps Order\textsuperscript{12} is only considered after advice and counselling have been unsuccessful [15] and removal from home is considered only as a last resort [16, 24]. Clearly, a measure such as seizing the passport of a girl can be seen as an intrusion into the privacy of a family, and concerns about how the enforcement of laws will be monitored – as expressed in the UK case study – are legitimate. On the other hand, the lack of protective mechanisms for girls who are travelling to Africa, has resulted in an unknown number of girls that do not return from holidays, as was shown by the case study in Sweden and the UK, and who are thought to be cut while on visit in the native country [13]. Protocols and guidelines to protect girls from FGM are valuable instruments to enhance the protection of girls from FGM, but are not available at country and European wide level, which was thought to increase the risk of cases going unreported. There is an urgent need to further investigate how measures to protect girls from FGM can be implemented successfully, and how protective mechanisms in European countries as well as existing African traditional protection systems should be further developed.

Conclusions and recommendations

This paper discussed criminal laws and child protection laws applicable to FGM in a number of European countries. It showed that specific criminal laws that have been developed have not resulted in more prosecutions than general criminal laws. On the contrary, specific criminal laws have proven to be incomplete to cover emerging issues such as piercing or cosmetic vaginal surgeries, and to deal with the issue of re-infibulation, leaving those professionals who perform these actions, with a lack of clarity about how to proceed.

FGM has received considerable attention by legislators and other actors and in many European countries they have responded by enacting specific legislation regarding FGM. However, the number of cases brought to court has been limited because of issues around conditions attached to extraterritoriality, the secrecy of the communities, the reluctance of girls to formally implicate parents and the reluctance of professionals to follow through on all complaints and concerns. There is also discussion about finding ways to increase the numbers of cases (or identify the numbers of victims) through compulsory gynaecological screenings and thereby identifying girls who have been subjected to FGM despite being born in Europe. The research suggests that many of these laws have been developed without having a clear strategic plan on the implementation mechanisms and the consequences. Therefore, this paper concludes that the attention should primarily be targeted to protection measures for girls at risk and prevention of FGM in the practicing communities. However, this does not exclude the possibility of having recourse to criminal laws, and more attention should also be paid to the implementation strategies of the existing laws.

\textsuperscript{12}Such an order can prevent girls of being taken out of the country.

\textsuperscript{13}Springer
Taking into consideration the following suggestions could enhance the implementation of FGM laws.

1. Where specific law provisions exist, they should be very clear about the forms of FGM that are prohibited, especially with regard to the emerging practice of piercing of the genitals and cosmetic vaginal surgery vis-à-vis FGM.

2. In the event that specific legislation is developed, or that there are amendments made to existing legislation, the government must ensure that community NGOs working towards the prevention of FGM are brought on board to ensure that they are able to inform their community members. These NGOs have been highly proactive in seeking to protect girls and to prevent FGM from taking place in the first instance, and a legal framework has been very helpful. Consequently, these NGOs need to be adequately provided with resources to advocate for the implementation of the law.

3. To avoid confusion, there should be a clear description of what re-infibulation entails, and what is permissible under the law so that medical professionals are fully informed.

4. Professional organisations should develop clear operational guidelines regarding re-infibulation.

5. The limits of applicability of extraterritoriality, and more specifically the exigency of double incrimination in the context of FGM, should be carefully analysed.

Effective implementation of laws with regard to FGM is closely linked to knowledge and attitudes of professionals about particular population groups that practice FGM, the practice itself, its different types, as well as to their knowledge of the laws and child protection procedures to follow in case a girl is at risk.

6.a Therefore, targeted training and information campaigns about FGM issues, legislation and child protection procedures are necessary for all stakeholders, in order to effectively ensure that legislation is implemented to protect children from FGM.

All professionals likely to come into contact with FGM practising communities must receive general information about FGM-related issues, e.g. by including the issue in their mainstream curricula.

6.b Key persons among doctors, paediatricians and child protection authorities should be identified as experts, and should receive specialised training.

7. Practicing communities should be informed about the judicial system in the host country and about the laws regarding FGM in particular.

The international dimension of the problem of FGM also needs attention.

8. At EU level, co-operation is necessary between judiciaries to facilitate the provision of evidence and at national level between various authorities in a country (child protection, police, health sector, schools, migration officials etc.).

9. Co-ordination between fieldworkers (state agencies, NGOs, etc.) in Europe and Africa is necessary to protect girls who travel between Africa and Europe.

10. Countrywide and European wide agreed protection protocols need to be developed to ensure that no cases go unreported.
Acknowledgements. The authors kindly acknowledge the Daphne Programme of the European Commission for funding the research and Prof Eva Brem of Ghent University for reading an earlier version of this paper and her valuable input in the research.

References


© Springer


3.2. Health care in Europe for women with genital mutilation

Leye E, Powell RA, Nienhuis G, Claeys P, Temmerman M.

Health Care in Europe for Women with Genital Mutilation

ELS LEYE
International Centre for Reproductive Health, Ghent University, Belgium

RICHARD A. POWELL
London, England

GERDA NIENHUIS
Pharos Knowledge Centre Refugees and Health, the Netherlands

PATRICIA CLAEYS and MARLEEN TEMMERMAN
International Centre for Reproductive Health, Ghent University, Belgium

The increasing number of immigrants from African countries practicing female genital mutilation (FGM) has raised concern in Europe. Health care professionals have developed three main responses: (1) technical guidelines for clinical management; (2) codes of conduct on quality of care; and (3) specialised health services for medical and psychological care and counselling. Much remains to be done, however, to ensure adequate care in Europe: (1) medico-legal/ethical discussions; (2) development of protocols to assist in making informed decisions; and (3) development of guidelines on counselling, communication strategies, and referral procedures. All agencies working in the field of FGM should be interlinked at the national level, in which members of the affected communities should be included. At the European level, a coordinated approach between all agencies should be developed.

Female genital mutilation (FGM), or female circumcision, includes all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or other
nontherapeutic reasons (World Health Organisation [WHO], 1998). The WHO classifies four types of FGM (Table 1; WHO, 2001).

The effects of FGM can range from immediate complications (e.g., severe pain, haemorrhage, shock, and infections) to longer-term consequences (e.g., vulvar dermoid cysts, chronic pelvic infections, and with heightened risk of rectovaginal fistulae, among others). In general, the effects of FGM depend on the type performed, the expertise of the circumciser, the hygienic conditions under which the practice is conducted, and the cooperation of the girl at the time of the mutilation (Koso-Thomas, 1987). These effects are more frequent, tend to be more serious, and last longer with infibulations (WHO, 1998).

Worldwide, between 100 and 140 million girls and women have experienced FGM; it is estimated that at least 2 million girls are at risk from FGM every year (WHO, 2001). Type I and II are the most common forms of FGM, accounting for approximately 80% of cases, while infibulation is found in around 15% of cases. Most women and girls with FGM live in 28 sub-Saharan African countries, with some living in Asia and the Middle East (WHO, 2001). Due to the migration of people who follow this tradition, however, FGM is today evident in Australia, Canada, the United States, and the European Union (WHO, 2001).

Estimating the number of girls at risk from, and the number of women with, FGM in the European Union is not easily inferred from existing data on migrant populations (Powell, Leye, Jayakody, Mwangi-Powell, & Morison, 2004). First, although figures on the number of immigrants can be obtained from National Offices of Statistics in each country within the European Union, these rudimentary statistics do not take into account variations in FGM practice within ethnic groups or their differential prevalence within a country's constituent regions. For example, the overall prevalence rate of FGM in Sudan is estimated at 89% (WHO, 2001); yet in the Darfur region and Eastern region, women are less likely to be genitally mutilated (65% and 87%, respectively) as compared with other parts of the country (Carr, 1997).
Second, official statistics do not enumerate illegal immigrants, refugees, and asylum seekers, thereby potentially underestimating its prevalence. Third, statistics also may not be gender specific, further hindering any assessment of the number of girls at risk of being genitaly mutilated. Fourth, methodologies for determining the numbers of immigrants, refugees, and asylum seekers vary between countries within the European Union, thereby making intercountry comparisons problematic (Leye, 2001). Fifth, statistics are not updated regularly and might not reflect changes in migration and mobility (Leye, 2001). Table 2 shows estimates of FGM-related figures in eight European countries.

Although reliable national prevalence data and systematic epidemiological data for FGM and its related health problems are unavailable in Europe (Leye, 2001), and the magnitude of the problem in the European Union is difficult to assess, FGM has raised concern in several countries within the European Union and various services (such as health care, social services, and the police) have been confronted with FGM-related issues. In health care, for example, pregnant infibulated women often will present at health services at the time of delivery.

It also has been established that African communities living in European countries continue the practice of FGM, by sending their girls to Africa (Leye & Deblonde, 2004b), by inviting circumcisers to the West, or by requesting Western health professionals to perform the procedure. There is evidence that FGM has been performed illegally in at least three European countries, including the United Kingdom, Italy, and Switzerland, by medically qualified personnel or by traditional circumcisers (Black & Debelle, 1995; Grassivaro Gallo et al., 1998; Irujo, 2003; Jäger et al., 2002; Reyners, 1993; Sala & Manara, 2001). Girls are suspected of being circumcised in other European countries, including Denmark (Johnsdotter, 2002), Spain (Irujo, 2003), and Belgium (Leye & Deblonde, 2004a). Whether health care professionals in Europe perform the operations for financial motives, because of lack of knowledge about the practice, or because they respect the decision of an adult woman who requests the operation, remains unclear. On the other hand, there is evidence that communities can more easily resist social pressure to have their daughter(s) “circumcised” in Europe than they can in Africa (Johnsdotter, 2002), although this process of cultural reassessment of the practice cannot be generalised and should be interpreted with caution (Johnsdotter, 2002; Powell et al., 2004).

Currently, there is a paucity of literature on the responses to FGM across the European Union. Using data from two projects on FGM among sub-Saharan African immigrants in the European Union, we will highlight some ethical problems European health care professionals can face, review existing health care provisions across the European Union, identify gaps that exist in the care for women with FGM, and suggest possible solutions.
<table>
<thead>
<tr>
<th>Country</th>
<th>Number of girls at risk</th>
<th>Annual new cases</th>
<th>Number of girls/women with FGM</th>
<th>Number of girls/women from FGM risk countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>France</td>
<td>4,500 (Délegation Régionale aux Droits des Femmes, 1998)</td>
<td>13,000 (Délegation Régionale aux Droits des Femmes, 1998–2000)</td>
<td>27,000 (Grassivaro Gallo et al., 1995)</td>
<td>40,000 (Gallard, 1995)</td>
</tr>
<tr>
<td>Germany</td>
<td>5,500 (Utz, 2000)</td>
<td>21,000 (Glessner, 2002; Utz, 2000)</td>
<td>36,000 (Bosch, 2001)</td>
<td></td>
</tr>
<tr>
<td>Italy</td>
<td>4,000–5,000 (girls with FGM) (Grassivaro Gallo et al., 1998)</td>
<td>27,000 (Grassivaro Gallo et al., 1995)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sweden</td>
<td></td>
<td></td>
<td>27,000 (Andersson, 2001; Widmark et al., 2002)</td>
<td></td>
</tr>
<tr>
<td>Switzerland</td>
<td></td>
<td>(incl. of girls at risk) 6,711</td>
<td></td>
<td>13,315 (Somali women) (Central Bureau voor Statistiek, The Netherlands, 2003; Jäger et al., 2002)</td>
</tr>
<tr>
<td>Netherlands</td>
<td></td>
<td></td>
<td>10,000–20,000 (Momoh et al., 2001)</td>
<td></td>
</tr>
<tr>
<td>UK</td>
<td>10,000 (British Medical Association, 2004; Jäger et al., 2002)</td>
<td>3,000–4,000 (British Medical Association, 2004; Levin, 2001)</td>
<td>10,000–20,000 (Momoh et al., 2001)</td>
<td></td>
</tr>
</tbody>
</table>
METHODS

The primarily qualitative data arise from two sources: the first source is a research project undertaken by the International Centre for Reproductive Health in 1998 (Leye et al., 1998), aiming at providing the European Commission with a strategy to address the problem of FGM in the European Union. Central to the proposed strategy was the formulation of recommendations on medical aspects of FGM in the European Union. These recommendations were based on a questionnaire that assessed current knowledge, attitudes, and practices of health care professionals in the European Union, and a discussion paper that reviewed the medical complications of FGM and its medico-ethical aspects (e.g., medicalisation of FGM and resuturing after delivery; Leye et al., 2003). More than 1,880 questionnaires with both open-ended and closed questions were sent to gynaecology/obstetric departments of hospitals in major cities (i.e., from 250,000 to >1,000,000 inhabitants) within the 15 European Union Member States. Although the response rate was disappointing (i.e., 15%), the data provided insight into the opinions of health care professionals on FGM, and gathered valuable information about existing guidelines and codes of conduct for health care providers in the European Union. Prior to submission to the European Commission, the recommendations were discussed at an expert meeting in Ghent, Belgium (1998), attended by 50 African and European FGM experts.

The second data source is a project that was carried out in 2000 again by the International Centre for Reproductive Health, aiming at the creation of a multidisciplinary network for preventing FGM in the European Union. One part of the project (Leye & Githaiga, 2000) focused on providing health care professionals with a framework for the care for women with FGM, to be implemented by each European Union Member State. A review of existing guidelines for health care professionals on the care for women with FGM and the resulting framework subsequently were discussed in a workshop (in Belgium, 2000) with participants from six countries within the European Union (i.e., Belgium, Denmark, Germany, Sweden, the Netherlands, and the United Kingdom).

RESULTS AND DISCUSSION

This section highlights the key findings that arose from both projects and discusses their implications. The key areas follow: ethical problems for Western health care professionals; the responses of European health care providers; and issues of service delivery.
Ethical Problems for Western Health Care Providers

Health care professionals are facing multiple questions regarding women and girls who have FGM-related problems (Grassi-Winter, Gallo & Viviani, 1995; McCaffrey, Jankowska, & Gordon, 1995; Momoh, Ladhani, Lochrie, & Rymer, 2001; Nienhuis & Haaijer, 1995), not only with regard to the clinical management of infibulated women, but also over ethico-legal questions about reinfibulation after delivery, the pricking or incision of the clitoris, and the issue of the cosmetic surgery of female genitalia. Although health care professionals in Europe are increasingly becoming aware of the correct clinical management of FGM, the lack of clear guidelines and legislation leaves them facing these ethical problems.

The WHO and other organisations advise consistently that health care providers in any setting should refrain from any form of FGM. One of the main ethical debating points concerns performing FGM under hygienic and controlled conditions, often referred to as the “medicalisation of FGM.” The WHO’s position rests on the basic underlying ethics of health care: health care providers cannot condone unnecessary bodily mutilation given it conflicts with the Hippocratic Oath (i.e., to act in the interest of the patient; primum non nocere). The International Federation of Gynaecology and Obstetrics, the International Council of Nurses, the Royal Colleges of Obstetrics and Gynaecology in the United Kingdom and Canada, the Council on Scientific Affairs of the American Medical Association, and many others have published similar position statements; the Ghent expert meeting also adopted this position. Despite the adoption of these positions by international and professional organisations, however, the issue of medicalisation is repeatedly emerging in the European Union.

In 1992, two researchers in the Netherlands submitted a report to the Dutch Ministry of Health in which they proposed that as a step toward the total eradication of the practice, incisions of the clitoris be allowed in cases where the parents or family wanted to circumcise a girl (Bartels & Haaijer, 1992). This kind of incision was considered as a nonmutilating form of “female circumcision,” as FGM is commonly referred to in the Netherlands. This report’s recommendation provoked a public debate about the issue that resulted in the total rejection of any form of FGM and, moreover, the rejection of any attempts to differentiate between mutilating and nonmutilating forms of “female circumcision” (Reyners, 1993).

In Germany in 1999, Dr. Groh suggested a “new” technique, “Incision Praeputii”—an incision in the clitoral hood without cutting—as a solution to the problem of FGM (Groh, 1999). He argued that this technique is the only promising strategy to eradicate the practice; given the ritual itself will not change, it is contended that it is better to perform a less invasive type of FGM (Baumgarten & Gahn, 2002). Again, opposition came from nongovernmental organisations (NGOs, i.e., Terre Des Femmes [Richter,
2(2002)) and the German organisation for development cooperation, GTZ (Baumgarten & Gahn, 2002).

In November 2003, a Somali gynaecologist at Careggi Hospital in Florence, Italy, proposed to practice a "sunna"\(^1\) version of FGM on African women at this public hospital (Turone, 2004), by using a local anaesthetic cream and performing a small cut in the clitoris. The health care service then would provide a certificate to the family to prove that the rite had been performed. The objective of this "sunna" version of FGM was reportedly to prevent illegal infibulations conducted during school holidays. This proposition provoked controversy in Italy and all over the European Union, and was condemned by Italian and European NGOs at an international conference in Florence in February 2004.

The medicalisation of FGM as a harm-reduction strategy also is supported by Shell-Duncan (2001). Arguing that many international associations' and activists' opposition to FGM is based on its adverse health outcomes, she contends that medicalisation would protect the health of individual women by having the procedure performed by medically skilled personnel under hygienic circumstances with anaesthetics (Shell-Duncan, 2001).

The main arguments against this proposed medicalisation of FGM follow: (1) it is difficult to avoid damaging the clitoris when performing an incision, especially in genitalia that are not fully developed; (2) complications (such as shock, infections, sepsis, and bleeding) are difficult to avoid, even with an incision; (3) such an incision is performed for cultural/traditional and not for medical reasons; any form of FGM performed is against medical deontology;\(^2\) (4) an incision remains a violation of the human rights of girls and women (the right to bodily integrity); (5) in some communities, traditional circumcisers will "redo" girls if they notice that only an incision has been made (Baumgarten & Gahn, 2002); (6) promotion of a "light" version promotes the message that FGM is acceptable and thus legitimises the practice (Baumgarten & Gahn, 2002; Richter, 2002); (7) culture is not static, but dynamic, and as such a ritual can be changed over time through, for example, alternative rites of passage; and (8) "sunna" can imply various degrees of cutting, including infibulation, and the terminology "sunna" also means tradition in a religious sense, giving it a religious connotation and suggesting that the practice is accepted as normal and positive (Leye, 2000; Sarkis, 2003).

Another medico-ethical issue that health care providers need to resolve concerns requests for reinfiltration or resuturing of the infibulation after

\(^{1}\) "Sunna": practices undertaken or approved by the Prophet and established as legally binding precedents (Al-Sabbagh, 1996).

\(^{2}\) Medical deontology refers to the complex of principles, codes of conduct, and practices that every medical doctor must respect and use as a guiding principle in carrying out his or her profession (Nationale Raad van de Orde der Geneesheren, 1998).
delivery, by consenting adult women. Specific criminal law provisions in countries of the European Union (including Austria, Belgium, Denmark, Spain, Sweden, and the United Kingdom) do not mention reinfibulation. In those countries where it is not illegal, tension exists among the attitudes of the health care professionals, his or her practice, his or her own ethical point of view, and the law.

Health care providers need to decide whether they are willing to provide this type of surgery. Moreover, they need to decide the extent of the perineal repair. For example, should it be as tight as the woman requests, or returned to its pre-delivery state, or repaired as in a normal perineal repair? According to Toubia (1994), a thorough medico-legal debate also must be generated about the similarities and differences between circumcision and other nonessential surgery in adults. Are requests for reinfibulation comparable with requests for female genital cosmetic surgery—such as vaginal tightening, lifting of the labia, hymen reconstructions, and labiaplasty (trimming of the labia minora)—practices that are on the rise in the United States, Canada, and Europe (Jenda, 2001)? In both cases, there are no medical reasons that legitimate these operations. The question remains, why in some cases women can “design” their vagina in the way they want them to look, while others cannot receive resutures after deliveries as they are considered to be “female genital mutilation” and prohibited because there are no medical reasons to justify the procedure.

Obviously, differences exist between the more pragmatic approach of health care professionals and the more ideological discourse of activists at international forums. Nevertheless, medico-legal and medico-ethical discussions should be held in European Union countries, and in collaboration with members of the affected communities, to help health care professionals make informed decisions, especially in those cases where the law remains unclear about what is illegal and what is not. The outcome of such discussions could be guidelines from the European Ministries of Health. If such are not yet present at the national level, protocols from medical associations or guidance from ethics committees in hospitals could help health care professionals make informed decisions.

The Response of Health Care Professionals in the European Union
Following the migratory flow of immigrants and refugees from FGM-practicing countries in sub-Saharan Africa to Europe, an increasing number of health care professionals have been confronted with the health consequences of FGM. The responses of health care providers in the European Union (in Belgium, Denmark, Sweden, the Netherlands, and the United Kingdom) to women with FGM reviewed in the second project are presented below.
BELGIUM

The experience of health care professionals with FGM is relatively new in Belgium, with only a few cases being reported or documented (Richard, 2000). Since June 2000, technical guidelines on delivery procedures for infibulated women have existed (Richard, Daniel, Ostyn, Colpaert, & Amy, 2000), available in French and Dutch and distributed through the Belgian Ministry of Health. These guidelines consist of a brief practical manual for health care providers who are confronted with infibulation during prenatal consultations, delivery, and postpartum care. For each of these phases, the manual offers clinical advice; background information on the practice, counselling guidelines, preventative methods, and training advice are not included.

DENMARK

FGM became of public interest during the 1980s when the first Somali refugees came to Denmark (Danish Board of Health, 1999); in 2000 there were an estimated 14,500 Somalis living in the country (Sørensen Hoff, Aden, & Nybro, 2000). In 1981, the National Board of Health informed Danish medical professionals not to perform FGM. Fifteen years later, at the instigation of the Ministry of Health, an information campaign concerning the circumcision of girls resident in Denmark was initiated (Danish Board of Health, 1999). In 1999, the National Board of Health in Denmark published a reference book for local governments and health professionals, informing them about FGM and the means by which they could address the practice in a culturally sensitive way (Danish Board of Health, 1999).

Currently, a specialist FGM midwife works at the antenatal care clinic of the Frederiksborg hospital, near Copenhagen. This is one of the health care centres in Denmark that deals specifically with infibulated women, and to which various general practitioners in Denmark refer pregnant infibulated Somali women (Sørensen Hoff et al., 2000).

SWEDEN

Somalis began to arrive in Sweden in 1990; today an estimated 19,000 live there, with the largest groups living in Gothenburg and Stockholm (Johnsdotter, 2002). In 1996 the Immigration Services Administration of the City of Gothenburg started a pilot project for both the community and for concerned professionals, and developed several guidelines for medical and health care staff. These guidelines tackled various issues, including the management of genitally mutilated women in antenatal care, the performance of gynaecological examination, and delivery among genitally mutilated women. Some guidelines for paediatricians on the prevention of genital
mutilation among girls and the role of the school health care system in dealing with FGM were also produced (Esken & Aronsson, 2000).

Many Swedish hospitals have their own guidelines concerning care for women with FGM (Leye et al., 1998).

THE NETHERLANDS

Interest in FGM in the Netherlands started in the 1960s as a result of the influx of Somali refugees. Research on FGM within this community revealed that questions regarding FGM and its subsequent sequelae seldom reached health care professionals and that the health care sector was ill prepared to deal with the problems of infibulated women (Bartels & Haaijer, 1992). In 1992, following a vigorous public debate, the Dutch government prohibited all forms of FGM in accordance with the guidelines of the WHO.

One year later, the Dutch Society of Gynaecology & Obstetrics developed a position paper (1993) that rejected requests for infibulation. It also stated that, in those cases where a general practitioner/gynaecologist is confronted with a request for an FGM operation, the request should be rejected. Should this refusal be unsuccessful, the general practitioner/gynaecologist is advised to contact a commission of experts of FGM (established by the Ministry of Health) to find an acceptable solution to each individual case. In 1994, the Chief Medical Inspector of the Department of Public Health developed guidelines concerning the actions to be undertaken when a girl has been genitaly mutilated or where there is an assumption that a girl is at risk (Geneeskundige Hoofdinspectie van de Volksgezondheid, 1994).

Several centres for refugees and asylum seekers exist in the Netherlands. PHAROS is a national institute, established to contribute to the health and well-being of this client group. Their main objective is to improve the accessibility of Dutch health services to refugees (including girls and women with FGM) by supporting regular health care services in the development of care, prevention, education, and training programs (Geneeskundige Hoofdinspectie van de Volksgezondheid, 1994).

UNITED KINGDOM

FGM came to prominence in the United Kingdom in the early 1980s, with stories of women and girls arriving from overseas to have FGM performed in private clinics in London (FORWARD, 1998). The main ethnic groups in the United Kingdom that practice FGM are from Eritrea, Ethiopia, Somalia, and the Yemen (British Medical Association, 2004).

In the United Kingdom, codes of conduct exist for medical doctors, nurses, midwives, gynaecologists, and obstetricians issued by professional organisations, such as the British Medical Association (2004) and the Royal
College of Midwives of England (The Royal College of Midwives, 1998). These codes of conduct outline advice on how to provide ethically sensitive care, from an ethical-legal point of view, which goes far beyond technical advice on the management of women with FGM.

Information provided to UK hospitals on FGM-related issues usually concerns the extent of the problem and the monitoring of FGM-related health outcomes. The Female Circumcision Prohibition Act in the United Kingdom (1985) was found to be useful for health care professionals as a supportive tool to refuse any FGM requests (Momoh, 2000).

Due to the increasing number of pregnant and nonpregnant women with FGM presenting at delivery suites, and gynaecology and family planning clinics, African Well Women Clinics (AWWC) have been established in the United Kingdom. Examples are located at Northwick Park Hospital in Middlesex established in 1993, and at Guy’s and St. Thomas’s in London (1997; McCaffrey et al., 1995; Momoh et al., 2001). These AWWCs provide appropriate medical care for women with FGM and care for any attendant psychiatric disorders related to FGM. These services also include support, information, advice, and counselling to women and their partners, as well as offering deinfibulation where appropriate to both pregnant and nonpregnant women, and training for health care professionals. These AWWCs work with specialist midwives, often members of the affected African communities themselves (Leye et al., 1998; McCaffrey et al., 1995; Momoh et al., 2001).

Issues in Service Delivery

Experiences from the five countries of the European Union mentioned above show responses to FGM are based primarily on three health interventions: (1) technical guidelines for the clinical management of women with FGM; (2) codes of conduct for health care professionals, published by professional associations, on quality of care issues (e.g., culturally appropriate care); and (3) specialised health services that provide medical care, psychological care, and counselling.

There are several factors that may hamper the provision of adequate clinical care for women with FGM, however, including the unfamiliarity of health care professionals with FGM and their deficient knowledge. In northern Somalia, women are deinfibulated immediately after marriage, but they may have difficulties obtaining such a facility in Western countries and remain "closed," thus requiring this care in pregnancy and labour (McCaffrey et al., 1995). This situation can result in unnecessary caesarean sections (Elchallal, Ben-Ani, Gillis, & Brzezinski, 1997), or in women not seeking appropriate care during pregnancy, at the time of delivery, or for any FGM-related health problem.
The personal emotions and feelings of health care professionals can play an important role. Some health care providers are reluctant to address the subject out of respect for, or ignorance of, different cultures. Feelings of powerlessness (FGM procedures are irreversible) or anger (cutting genitals is alien to Western practice) may all hamper adequate care for women with FGM (Nienhuis & Haahter, 1995). Moreover, a qualitative study among a limited number of midwives in three hospitals and two antenatal clinics in Sweden revealed that both obstetric and psychosocial care for women with FGM may be suboptimal, due to communication difficulties among midwives, circumcised women, and their families (Widmark et al., 2002).

A lack of technical guidance for caring for women with FGM hampers the provision of optimal care (Widmark et al., 2002). A similar study in Canada found that Somali women perceived a lack of knowledge and ability by health care professionals to care appropriately for women with FGM during birth (Chalmers & Hashi, 2000). The Swedish study among midwives revealed that the absence of guidelines on what to do in case of a specific request for reinfibulation after delivery forces midwives to refer to the law. They preferred to have supportive guidelines advising them what they could do however, rather than a law instructing them on what they could not do (Widmark et al., 2002).

A lack of knowledge about the health care expectations and needs of affected communities is another issue in delivering appropriate care. In the Netherlands, a small study among Somali women revealed that obstetric care is insufficiently focused on their expectations and needs, and education about obstetric procedures in the Netherlands toward Somali women is necessary (Nienhuis, 1998).

In addition to deficiencies within existing health services, the lack of operational coherence among health and social services, other agencies (such as education, judiciary, police, immigration officials), policymakers and grassroots organisations, further hamper adequate care for those affected by FGM. Powell and colleagues (2004) argue that services develop their own codes of practice in isolation from the multiple other agencies and that the care for women with FGM must be provided collaboratively as part of an integrated approach if it is to be effective. Moreover, until now there has been no coordinated European approach at the health care, legislative, and grassroots levels.

CONCLUSIONS

Ideally, adequate care for women with FGM should focus not only on appropriate clinical care, but also should include culturally sensitive professional counselling.
Because affected communities can be deterred from contact with health care services that are unable to give appropriate and sensitive treatment, it is paramount to assess their health-seeking behaviour and their needs for adequate care with regard to FGM. Those health care providers who take medical care of pregnant infibulated women/girls, or who are in direct contact with girls at risk, need to be identified and provided with adequate and detailed guidelines on how to deliver antenatal care, care at the time of delivery, and postpartum care. They also need to be informed of how to perform gynaecological examinations for the different types of FGM. Health care professionals also need to be informed of how to deal with the provision of counselling services concerning deinfibulation, reversal operations, caesarean sections, and prevention of FGM in newborn girls, and guidance on successful communication strategies. Ethical issues, such as medicalisation and reinfibulation, need to be discussed at a national level, and health care providers need clear guidelines on these issues.

Health care professionals also should receive clear guidelines about referrals when they do not have the adequate skills or time to give appropriate care for a woman with health problems due to FGM, or where to report or refer a girl at risk.

Last but not least, the training needs of health care professionals must be assessed. Training should take into account various levels: clinical care, the prevention of FGM; counselling, communication and attitudes (e.g., open communication skills), and ethical issues (e.g., medicalisation, reinfibulation). In addition, FGM should be included in the curricula of medical students, nurses, and midwives.

In order to establish these guidelines, all agencies working in the field of FGM should be interlinked at the national level, at which members of the affected communities should be included. At the European level, a coordinated approach between all agencies should be developed.

REFERENCES


Nienhuis, G. (1999). Somali women tell: It's like you have to do the delivery here by yourself. Tijdschrift voor Verloskundigen.


3.3. Female genital mutilation: Knowledge, attitudes and practices of Flemish gynaecologists

Leye E, Ysebaert I, Deblonde J, Claeys P, Vermeulen G, Jacquemyn Y, Temmerman M. 

*European Journal of Contraception and Reproductive Health Care*, Accepted for publication, 2007.
Title Page

Female genital mutilation: Knowledge, attitudes and practices of Flemish gynaecologists

Els Leys*, Ilse Ysebaert*, Jezulla Deblonde*, Patricia Clinck*, Gert Vermeulen*,
Yves Jacquemyn†, Marleen Temmerman‡

* International Centre for Reproductive Health (ICRH), Ghent University
* Institute for International Research on Criminal Policy (IRCP), Ghent University
† University of Antwerp, Department of Obstetrics and Gynaecology

Short title: Views of Flemish gynaecologists on female genital mutilation

Key words: female genital mutilation, gynaecologists, Flanders, knowledge, attitudes, practices

Address for correspondence: Els Leys, els.leys@ugen.be, ICRH, De Pinteelman 185, P3, 9000 Gent, Belgium, tel +32-9-2403564, fax +32-9-2403867
Abstract:

Objective: To assess the knowledge, attitudes and practices with regard to female genital mutilation (FGM) among gynaecologists in Flanders, Belgium.

Methods: A questionnaire-based survey was sent to 724 Flemish gynaecologists and trainees.

Results:

Three hundred thirty four questionnaires have been returned. This survey revealed gaps in the knowledge of FGM and the provision of care by Flemish gynaecologists to women suffering from this mutilation. Lack of information on FGM in the basic and specialized medical training in Flanders, ill knowledge about or the absence of codes of conduct issued by the hospitals as well as a naivety regarding the legislation concerning FGM have to be addressed. There is confusion whether re-infibulation is authorized, and what its legal status is. Few respondents consider cosmetic vaginal surgery as a form of FGM and many are in favour of the medicalization of FGM. It also appears that gynaecologists are most commonly confronted with complaints related to sexual problems occurring as a consequence of FGM. Finally, the study also showed that only about a third of gynaecologists are discouraging women from having their daughters excised.

Conclusion

There is clearly a need for a thorough ethical-legal consultation process with all those concerned on the issues of re-infibulation, medicalisation of FGM and cosmetic vaginal surgery.
Introduction

Female genital mutilation (FGM) comprises all procedures involving the partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons. Since 1997, the World Health Organization (WHO) has classified the various forms of FGM into four categories:

- **Type I** - excision of the prepuce, 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;
- **Type III** - excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation);
- **Type IV** - pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cautery of the clitoris and the surrounding tissue; scraping of tissue surrounding the vaginal orifice (angunya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it, and any other procedure that falls under the aforementioned definition.

The most common type of FGM 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.
This widely used classification is currently being reviewed by WHO, in collaboration with other United Nations bodies.

WHO estimates that between 100 and 140 million girls and women in the world have undergone FGM, and about three million girls and women are being cut each year. Various groups in about 28 African countries carry out such mutilations, with prevalence rates varying from 5% in the Democratic Republic of Congo to 98% in Somalia. FGM are not practised in northern (with the exception of Egypt) and southern African countries; but they are performed in regions of the Arabian peninsula, and in some communities in Asia, although to a much lesser extent.

FGM has increasingly become an issue in Western countries, including Belgium, due to migration flows. The total number of girls and women from African “FGM countries” registered in the population and in the foreigners’ registers in Belgium is estimated at 12,415 (census data of January 2002). Based upon an extrapolation from the country of origin prevalence data, and the census data of January 2002 of the population and the foreigners’ registers, the total number of women residing in Belgium who could have had an FGM was around 2,700, with some 500 girls in the age group 0 to 14 years who might have been at risk of FGM. Most of these women and girls were from Ghana and the Democratic Republic of Congo (former Zaire).

Estimations based on such extrapolations should be interpreted with caution, as mentioned elsewhere. It should also be noted that the persons concerned represent only a small sub-group of the Belgian and foreign populations, as most non-European immigrants are from Morocco and Turkey where FGM are not practised. The share of foreigners in the total population is the biggest in the cities of Brussels, Liège, Charleroi, Antwerp and Ghent.
In Belgium, FGM is since April 2001 explicitly forbidden under article 409 of the Belgian Penal Code, which reads as follows:

**Art. 409 Code of Criminal Law**

§ 1. Anyone who performs, facilitates or promotes any form of mutilation of the genitalia of a person of the female sex, with or without her consent, will be punished by a term of imprisonment of three to five years. Attempted mutilation will be punished by a term of imprisonment of eight days to one year.

§ 2. If the mutilation is undertaken on a minor or in pursuit of profit, the punishment is confinement of five to seven years.

§ 3. If the mutilation has caused an apparently incurable illness or a lasting incapacity for work, the punishment is confinement of five to ten years.

§ 4. If the mutilation results in death, even though there was no intent to kill, the punishment is confinement of ten to fifteen years.

§ 5. If the mutilation referred to in § 1 is undertaken on a minor or a person who, by reason of their physical or mental state, is not in a position to provide for themselves, by their father, mother or another blood relation in the ascending line, or by any other person who has authority over the minor or the legally disqualified person, or by a person who has them in their care, or by a person who occasionally or usually lives with the victim, then the minimum punishment as referred to in §§ 1 to 4 is doubled in the case of a term of imprisonment and increased by two years in the case of confinement.

Article 409 of the Code of Criminal Law prohibits all forms of mutilation of the female genitalia. The criminal offence consists of the performance of FGM, the
participation in and the facilitation of the performance of FGM, as well as the attempt to carry it out.

Mutilation is defined as the complete or partial removal of female genital organs. According to the preparatory works of the law, piercing and tattoos are excluded, as well as transsexual operations. The latter are considered as lawful acts of medical care. The practice of re-infibulation is not explicitly mentioned in this context. This practice does not remove an organ but stitches the vulva after childbirth to make it resemble the former state of infibulation. Hence, it is not clear whether the legislator considers it as an illegal mutilation or rather as a re-storing of the pre-delivery state.

Research performed in 2004 on the implementation of this law showed that there were no reports of FGM performed in Belgium, no cases of girls at risk being reported to the police or social services, and no cases that were brought to court. In Belgium, FGM has been the object of little public debate (except in parliament), and it receives little media coverage. Since 2000, there are guidelines available on the clinical management of infibulated women at the time of delivery. This technical advice discourages the practice of re-infibulation.

We wished to assess the knowledge of FGM and of its legal regulation among Flemish gynaecologists as well as their attitudes and practices with regard to some issues that have proven to be controversial in other European countries, such as piercing, re-infibulation and cosmetic vaginal surgery. Hopefully, our findings will assist in the formulation of recommendations for the training of health professionals.

Methods
The study was a collaborative effort between Ghent University and the University Hospital of Antwerp, and has been carried out by Ilse Yseboert as the framework of her masters' thesis Criminological Sciences, under the leadership of Prof G Vermeulen. The questionnaire used was based on that of a survey conducted in Switzerland among midwives, gynaecologists, paediatricians and social services, and was further developed at the International Centre for Reproductive Health (ICRH) – Ghent University, in collaboration with the International Centre for Research on Criminal Policy (ICRP) and the University Hospital of Antwerp. The survey was sent to 724 gynaecologists and trainees in Flanders, through the Flemish Society of Obstetricians and Gynaecologists. After one month, a reminder was sent, and when closing the study in April 2006, 334 questionnaires had been returned (response rate of 46.05%).

The survey was conducted between February and April 2006. It included questions regarding the knowledge of FGM in general and the law penalizing FGM in Belgium, as well as questions concerning the attitudes and practices of gynaecologists when confronted with patients with FGM. Respondents were assured of confidentiality. Data-entry and analysis were done by ICRH using SPSS for Windows. Chi-square tests were used to analyse differences in categorical variables. Ethical clearance has been obtained from the ethical committee of the Antwerp University Hospital.
Results

Characteristics of the respondents

One hundred and forty two respondents (42.5%) were 25 to 40 years old, and 191 (57.2%) were older than 40; 184 of the respondents (53.1%) were male and 150 (44.9%) were female. One hundred and ninety two respondents (58.2%) worked in a private hospital, 71 (21.5%) in a university hospital, 65 (19.7%) in a public hospital, and 2 (0.6%) in a combination of these.

Knowledge and attitudes

Only 25 (7.5%) respondents had heard about FGM during basic medical training, and 69 (20.7%) during postgraduate training. Younger respondents were significantly more likely to have been taught about FGM: 16 out of 142 respondents (11.3%) younger than 40 had heard about FGM in their undergraduate medical training as compared to nine out of 142 (6.3%) among those over 40 years of age (p=0.01). During specialty training, 40 (28.4%) of the younger respondents had received information on FGM, compared to 29 (15.3%) of the older respondents (p=0.004).

Only four respondents (1.2%) were aware of guidelines or information concerning FGM in their hospital. One hundred and fifty two respondents (45.5%) knew that FGM was illegal in Belgium, but only 36 (23.7%) of them knew exactly what types of FGM were included and excluded under the specific criminal law provision. The other respondents had varying ideas regarding what was prohibited: nine (5.9%) thought that all forms were forbidden including re-infibulation. 54 (35.6%) believed that all forms of FGM were illegal and 46 (30.3%) did not know what types were
prohibited. Six respondents (3.9%) thought that FGM was not prohibited if the woman consented and three (2.0%) considered it legal if the woman was an adult.
One respondent (0.5%) thought it was allowed if it was performed by a doctor.

Of all respondents, 285 (83.6%) considered FGM a form of violence against women and 203 respondents (60.8%) saw it as a violation of the human rights of women.
Seven respondents thought FGM deserved respect because of its cultural and religious connotation.

Of 316 respondents, 249 (77.6%) considered re-infibulation as a form of FGM, yet 60 (19%) would have performed it and restored the original infibulated state after delivery if an infibulated woman would have requested to be “closed”. When asked what exactly they would have done, only 12 gynaecologists (3.8%) responded that they would have restored the original infibulations, 28 (8.9%) would have partially restored it and would have left a bigger opening, while the remainder would either have done an episiotomy repair or were unsure as to what they would have done.
Ninety seven respondents (30.7%) would have explained to the patient that they could not perform a re-infibulation due to its illegality, and 157 (49.7%) would have expressed their unwillingness to carry out the procedure.

Genital piercing and cosmetic vaginal surgery were considered to be some kind of FGM by 30 (15.2%) and 13 (4%) of 328 respondents, respectively. Out of 306 respondents, 155 (50.7%) rejected a symbolic incision as an alternative to FGM, 144 (47.1%) were in favour of such a strategy and seven (2.3%) were unsure. However, of 317 respondents, 243 (76.7%) thought it was unacceptable for medical personnel to
carry out a FGM in order to avoid complications, while 67 (21.1%) approved such a
harm reducing strategy and 7 (2.2%) were unsure.

When asked about the need for information, 205 gynaecologists (61.4%) wanted more
information regarding the Belgian legislation on FGM, 172 (51.3%) requested
technical guidelines on the clinical management of complications and 161 (48.2%)
wanted more clarity on the codes of conduct applying in ethical-legal issues of FGM
such as re-infibulation and symbolic incision. Forty gynaecologists (12 %) required
no further information.

Practices
Six out of 328 (1.8%) gynaecologists had been requested to perform a FGM. Thirteen
(4.0%) had been asked whether FGM could be performed in Belgium and 31
gynaecologists (9.5%) had already heard that FGM had been done in Belgium.

Of all the respondents, 195 (58.4%) had seen women or girls with genital mutilation
in their consultations. Of these, 104 (53.3%) had seen one or two women with FGM
in the past year while 54 (17.4%) had seen three or more such patients. Fifty seven
(29.2%) of the respondents had not seen any patient with FGM in the past 12 months.

When asked with what kind of FGM related problems they were confronted, two
respondents (1.0% of those who had seen women with FGM) were consulted for acute
complications, three (1.5%) for fertility problems, four (2.1%) for psychological
problems and seven (3.6%) for fistulae. Furthermore, 29 gynaecologists (14.9%) were
consulted for problems associated with pregnancy and delivery, 35 (17.9%) for
chronic pain, 35 (18.5%) for urinary tract infections and 79 (40.5%) for sexual problems.

The type of FGM most encountered by the respondents was infibulation (56) followed by excision (40), sunna (3) and all of these types (76). Sunna was defined as the removal of the hood of the clitoris. In 20 cases, the respondents were unaware of the type of FGM that they had encountered. Seven patients were less than 14 years old, 23 were 15-18 years old, and 233 were aged 19 to 34 years. Twenty seven women were 35-44 years old and six women were still older. Patients were mostly from Somalia (101/233) and Ethiopia (69/265) while the rest of the patients came mainly from Nigeria, Egypt, Mali and Senegal.

Of the 168 respondents who had cared for an infibulated patient, 52 (41.6%) were asked to perform a defibulation and 34 (27.2%) were asked to perform a re-infibulation. Eighteen gynaecologists reported to have done the re-infibulation, but only seven actually carried out a total re-infibulation, another seven left a larger vaginal opening then before the delivery whereas four performed a normal episiotomy repair.

After having been confronted with a patient with FGM, 84 of the 185 gynaecologists concerned (45.2%) undertook to learn more about FGM. This included consultation of literature, seeking the advice of colleagues and attending conferences and training on the subject.
Of 120 respondents who were consulted by a pregnant woman with a FGM, only 42 (35%) attempted to persuade the mother not to have a FGM performed on the child to be born, in case it would be a daughter. Preventive actions were more likely to be undertaken by older respondents. Of 54 respondents, 24 (44.4%) aged 40 years or older indicated that they would initiate a preventive action, as compared to only 15 (27.7%) among those younger than 40. The main initiatives that were taken included providing information on health complications and the legal implications, as well as counselling. Most respondents (65%) indicated that they would not do anything in the form of prevention. The main reasons given for the lack of preventive interventions were communication problems, the language barrier, or out of respect for the culture of the woman.

Discussion

Limitations of the study

Of the gynaecologists in Flanders who had been contacted, 46% responded. There might be a response bias as it is possible that those who had already been confronted with FGM were more likely to respond. Consequently, results cannot be generalised and we cannot exclude that the group of non-respondents might have other views. The low response rate does also not allow to estimate how often gynaecologists are confronted with FGM and the issues discussed above. However, the gynaecologists that did respond give an indication of some of the obstacles they face.

Occurrence of FGM in Flanders
An interesting finding of this study is that – in Flanders – gynaecologists seem to be confronted with a demand for FGM, either to perform it themselves or to refer to someone who is doing it. One finding from an earlier study on the implementation of the law in Belgium, seems to be confirmed here, i.e. FGM is being done in Belgium, although no hard evidence is available to confirm this “rumour”. This is exacerbated by the fact that two gynaecologists have been consulted for acute complications. This finding from Flanders, contributes to the existing evidence that FGM is performed illegally in Europe, as has been described elsewhere11-15.

Although the majority of women and girls in Belgium that come from “FGM risk countries” are from Ghana and DRC, women who presented to gynaecologists were mainly from Somalia and Ethiopia. This might be due to the fact that women of type III of FGM – most common in Somalia and Ethiopia – present more often to gynaecologists with health complications, or that gynaecologists have failed to recognise less severe forms of FGM as practices in Ghana and DRC.

**Training, guidelines and legal provisions with regard to FGM**

Little attention is given to FGM in either basic or specialty medical training as reflected by the small number of practitioners who had heard about FGM during training. Awareness of hospital guidelines was very low, either because the gynaecologists were unaware that such guidelines existed or because the hospital had indeed not issued a circular with regard to FGM. Nearly half of the respondents assumed that FGM was illegal in Belgium, but less than a quarter knew the exact content of the law. If we assume that those who were already knowledgeable about FGM participated in the survey, the proportion of those who are not aware of the law...
on FGM is high. This corroborates earlier observations on the implementation of the law on FGM in Belgium. That study showed that health professionals know little about FGM, about the criminal law provisions with regard to FGM, and, in particular, about the procedures which should be implemented in the event of confinement with a victim of FGM. It also showed that attitudes of health professionals—such as the fear of being labelled a racist or the respect for other cultures—might obstruct an effective application of the law. In other studies it has been shown that a deficient knowledge of FGM as well as personal emotions and feelings might hamper the provision of adequate care. The apparent lack of training on FGM in basic and specialized medical training in Flanders and the deficient knowledge about or the absence of codes of conduct issued by the hospitals are further aggravated by the unsatisfactory knowledge of the legislation concerning FGM. This highlights the urgent need to inform health professionals about FGM, especially since more than half of the respondents had already been confronted with a woman with FGM in their practice.

Respondents themselves were desirous of receiving more information on the legal context, the technical guidelines of clinical management and guidance on the ethical-legal issues.

Ethical-legal issues

Research of health care services for women with FGM in Europe showed that, due to a lack of clear legislation and/or guidelines regarding FGM, a number of issues confront gynaecologists, especially with regard to piercing or incision of the clitoris (type IV FGM), cosmetic surgery to the external genitalia and re-infibulation. In addition, research on the implementation of specific criminal laws in five Western
European countries, including Belgium, demonstrated that such legislation is problematic when it comes to these issues.

Although re-infibulation does not remove an organ but consists of re-stitching of the vulva after childbirth to restore the former state of infibulation, it is not clear whether the Belgian legislator considers it as an illegal mutilation or rather as the restitution of the pre-delivery state. Specific laws applicable to FGM fail to deal with the issue of re-infibulation. Thus health care providers are left out in the cold, unsure as to whether or not to reconstruct the pre-delivery state of infibulation. According to Article 409 of the Belgian Penal Code, the consent of the victim does not affect the legal status of the act and no mention is given of an age limit. As it remains unclear whether re-infibulation falls under article 409, adult women who request a re-infibulation and the doctors performing it might be convicted of an illegal act if the court interprets re-infibulation as such.

The problem of re-infubulation also exists in other European countries. A study showed that partial re-infibulation was carried out in the obstetric services of all Swiss university hospitals that had no relevant guidelines. Swedish midwives—in the absence of guidelines—referred to the law when women requested re-infibulations, although the Swedish law itself is not clear about this. In Denmark, the law does not explicitly ban re-infibulation, but national guidelines have been established by the National Board of Health clarifying the extent and conditions of re-infibulation.

Although more than 75% of the respondents considered re-infibulation as a form of FGM, one out of five would have restored the original infibulation. Of those who had
actually seen infibulated patients and who reported to have done a re-infibulation, some had performed a complete restoration whereas others had created a larger opening than was the case earlier on. Some respondents claimed to have done a re-infibulation, but only performed a normal episiotomy repair. One third of the respondents considered re-infibulation to be illegal. This demonstrates the lack of knowledge among Flemish gynaecologists about the legal status of re-infibulation and the confusion on the extent of re-suturing. Clear national guidelines on the degree and conditions of re-infibulation are needed.

As the law does not mention ethnic background, and as consent does not affect the legal status of the act, article 409 of the Code of Criminal Law could also apply to the performance of genital mutilation on non-African women as well as to cosmetic vaginal surgery. This practice consists of reducing the labia and narrowing the vaginal orifice, as in some types of FGM performed on African women. It is not clear whether this specific legislation bans this kind of genital changes. Cosmetic vaginal surgery in adult women raises the question why adult African women cannot request a FGM or re-infibulation while it is not considered a crime to carry out, also for non-therapeutic reasons, a wide range of operations on the genitals of western women. In neither case do medical reasons justify these procedures. In our survey, few respondents considered cosmetic vaginal surgery as a form of FGM, and Flemish gynaecologists do not seem to question possible similarities between FGM and cosmetic vaginal surgeries.

With regard to Type IV FGM, problems arise when it comes to piercing and symbolic pricking. The Belgian law on FGM explicitly excludes piercing and tattooing.
However, 15% of the respondents considered piercing to be a form of FGM. The so-called “light” version of FGM (symbolic pricking or incision of the clitoris), a recurrent issue in western countries, is often proposed as an alternative to more radical forms of FGM and as a harm reducing strategy. Such form of medicalisation of FGM has been rejected by WHO and professional organisations (e.g., the International Federation of Gynaecology and Obstetrics) which have taken a clear stance against it. Article 409 of the Penal Code does not mention pricking and incision of the clitoris. As the law is unclear about this, gynaecologists should decide whether or not they will provide this type of surgery. The survey demonstrates much confusion around the medicalisation of FGM. Nearly half of the respondents were in favour of an incision and one out of five was in favour of the performance of FGM by medical personnel. It is remarkable that so many Flemish gynaecologists supported such harm reducing strategies. Pricking is retained and described as either a traditional form of FGM or as a replacement of more severe forms.

Arguments against medicalisation have been discussed elsewhere. Incisions carry a risk of damaging the clitoris and are not devoid of immediate complications. Furthermore, they are incompatible with the medical deontology. They violate the right to bodily integrity. People who speak out in defence of such less radical and less dangerous procedures are counterproductive with regard to the abolishment of FGM and legitimise the practice. Our study demonstrates a clear need for informing gynaecologists in Flanders on this issue and for providing guidelines. This need for information and guidance is underlined by the respondents themselves.
Sexual problems due to FGM

A remarkable finding of this survey is that sexual problems are the most prominent ones affecting women with FGM with which gynaecologists are confronted. The survey did not allow for in-depth questioning as to the nature of these sexual problems. In general, there is little scientific evidence available on the psychosexual effects of the practice and findings are inconclusive. Some of the sexual problems that have been documented include frigidity due to dyspareunia, injuries sustained during early intercourse, pelvic infection, orgasmic failure due to the amputation of the glans clitoridis37, and social difficulty or inability to have vaginal intercourse at all (pareunia) because of stenosis of the vagina38.

The high percentage of sexual problems in women with FGM which Finnish gynaecologists were confronted with in this study, suggests that the consequences of FGM should not be underestimated. More in-depth studies are needed to identify the nature of these sexual problems and to care adequately for women with such problems.

Prevention of FGM by gynaecologists

Health workers, who address the health consequences of this practice, are well placed to counsel women and couples and to sensitize the community on FGM. To this end, knowledge about clinical management of women with FGM, about the legal status of FGM and about the reasons behind the practice is paramount. Consequently, training of health workers is a priority strategy in the global abolition of FGM39.
The proportion of respondents in this study who took the opportunity during their consultations to discourage the women from having their daughters excised amounts to only 25%. The main reasons cited by the respondents for not initiating preventive measures were problems that could quite easily have been solved by providing intermediaries to obviate communication problems and to overcome the language barrier.

Conclusion

This survey revealed a number of shortcomings in the knowledge of FGM and in the provision of care among Flemish gynaecologists. Lack of training on FGM in basic and specialized medical training in Flanders, a lack of knowledge of or the absence of codes of conduct issued by the hospitals as well as a naivety regarding the legislation concerning FGM have to be addressed. There is also a clear need to train gynaecologists and to provide guidelines with regard to harm reducing strategies, such as the performance of symbolic incisions or the medicalisation of FGM. There is confusion regarding re-infibulation, and its legal status. Few gynaecologists consider cosmetic vaginal surgery as a form of FGM and many are in favour of medicalisation. This underlines the need for a thorough ethical/legal consultation process with all stakeholders on the topics of re-infibulation, medicalisation of FGM and cosmetic vaginal surgery.

Because sexual problems are the most prominent problem with which gynaecologists are confronted, more in-depth studies are needed to identify the nature of these problems. Finally, the study also showed that gynaecologists should be more assertive in dissuading women who had a FGM from having their daughters mutilated.
This study demonstrated considerable gaps in knowledge of FGM among the Flemish gynaecologists, and the possibility of developing a tool that could provide useful information, e.g. a CD-Rom, should be considered.

Acknowledgements

The authors wish to acknowledge Sherron Fergus for reviewing this paper.

References:


(4) Yoder S, Abderrahim N, Zhunzhu Z. Female genital cutting in the Demographic and Health Surveys: a critical and comparative analysis. DHS Comparative Reports No. 7. Calvert, Maryland, USA: ORC Macro 2004.


(19) Nienhuis G. Sonansi women tell: It’s like you have to do the delivery here by yourself. *Tijdschrift voor Verpleegkunde* 1998; (March):183-6.


3.4. Female genital mutilation, asylum seekers and refugees: the need for an integrated European Union agenda

Powell RA, Leye E, Jayakody A, Mwangi-Powell F, Morison L.  
Female genital mutilation, asylum seekers and refugees: the need for an integrated European Union agenda

Richard A. Powell a,⁎, Els Leye b, Amanda Jayakody c, Faith N. Mwangi-Powell a, Linda Morison d

a 90 Kew Green Road, Surbiton, Surrey KT6 4JR, UK
b International Centre for Reproductive Health, Ghent University, De Paterstraat 185 P3, 9000 Ghent, Belgium
c Université Libre de Bruxelles, 1050 Brussels, Belgium
d Infectious Disease Epidemiology Unit, Department of Infectious and Tropical Diseases, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK

Abstract

Asylum seekers and refugees (ASRs) are a heterogeneous population with distinct physical and psychological needs. ASRs with additional health needs are girls and women who have undergone, or are at risk of undergoing, female genital mutilation (FGM). Across the European Union (EU), variation exists in Member States' anti-FGM and asylum legislation, the rigour of existing research programmes, and the operational coherence of the multiple agencies combating the practice. ASRs' needs are, consequently, not being addressed satisfactorily. This paper proposes an integrated future agenda, applicable in all EU countries, capable of meeting these girls' and women's needs.

© 2004 Elsevier Ireland Ltd. All rights reserved.

Asylum seekers and refugees (ASRs) are a heterogeneous population with distinct physical and psychological needs [1,2]. Whether arising from war, political persecution, torture, or massacres experienced at home [3,4], or from social dislocation, financial hardship and discrimination encountered in their country of asylum [5] or residence, ASRs can have multiple health problems [6,7].

In the European Union (EU), such problems can be exacerbated by the inadequate or culturally insensitive care ASRs receive from statutory health services (e.g. the National Health Service (NHS) in the United Kingdom (UK)) [8–10]. ASRs' problems can also be compounded by their unwillingness and inability when detained to engage with health authorities until their health status is severely impaired [11]. Moreover, some EU states have legislation that can exacerbate these problems further. In the UK, for example, the Immigration and Asylum Act (1999) enables authorities to dispense ASRs to largely monocultural and ethnically homogeneous areas outside London [12], where sensitivity to minority group issues is limited [13,14].

One group of ASRs with additional health needs are girls and women who have undergone, or are at risk of undergoing, female genital mutilation (FGM). Despite commendable work, unacceptable variation exists in EU Member States' anti- FGM and asylum legislation, the rigour of existing research programmes and the

⁎ Corresponding author.

0168-8910/ - see front matter © 2004 Elsevier Ireland Ltd. All rights reserved.
doi:10.1016/j.healthpol.2004.02.010

142
operational coherence of the multiple agencies combating the practice. ASEPs' needs are, consequently, not being addressed satisfactorily. This paper outlines the nature, prevalence and practice of FGM across the EU, and the current legislative environment, identifying areas of deficiency before proposing an integrated European agenda capable of meeting these girls' and women's needs.

1. FGM and its health consequences

The World Health Organisation (WHO) defines FGM as the partial or complete removal of female genital organs performed for cultural rather than therapeutic reasons [15]. FGM is classified into four types ranging from reduction operations (the excision of part or all of the clitoris [Type I] and/or the labia [Type II]), to closure operations that consist of Type II FGM along with the stretching/narrowing of the vaginal opening (Type III, or infibulation). Other procedures, such as piercing or pricking the clitoris, are classified as Type IV [16].

Infibulation (i.e. Type III FGM) accounts for approximately 15% of all cutting procedures, being performed on as many as 90% of women in Somalia, Djibouti and northern Sudan [17]. Types I–III are thought to affect between 100 and 140 million women and girls worldwide [15]. Estimates suggest that approximately 2 million girls annually are at risk of FGM—nearly 6000 per day [17]. Even though practised primarily in 28 African countries from the Horn of Africa, to parts of central, eastern and western Africa, international migration has extended the practice outside the African continent. Existing evidence suggests FGM is increasingly an issue of European concern [18].

The health consequences of FGM have been documented by WHO [19]. Immediate effects can include pain, injury to adjacent tissue, shock, infection, urinary retention, and haemorrhaging resulting in death. Long-term morbidity consequences, particularly of infibulation, can be severe and include: urinary incontinence, recurrent urinary tract infection, pelvic infections resulting in infertility, menstrual difficulties, obstetric complications, fistulae of the bladder or rectum, and sexual dysfunction. While there is no doubt that these health problems can be caused by FGM, the frequency of such problems and how this relates to the different types of FGM operation is not well established and has led to some controversy among researchers [20–23].

FGM is also considered by many to embody gender inequalities, representing discrimination against women and girls, the torture, cruel, inhumane or degrading treatment of children and women and the abuse of the physical, psychological and sexual health of women and children [16].

2. FGM in Europe

2.1. Prevalence and practice

With increasing migration over the past few decades, the EU has been confronted with an increasing number of women and girls from sub-Saharan African countries where FGM is practised [26–29].

In the UK, FORWARD, a non-governmental organisation (NGO) working against FGM, estimates there are 86,000 first generation immigrant refugee/asylum-seeking women and girls—mostly residing in London, Manchester, Liverpool, Sheffield, Birmingham and Cardiff—who have undergone FGM in their countries of abode [30]. These numbers are increasing with the influx of asylum seekers from Somalia, Sudan and Sierra Leone. For example, asylum applications from Somalia accounted for 9% of all applications to the Home Office in 2001, rising by 29% on the previous year from 5020 to 6455 [31]. Hedley and Dorkenoo [32] estimated 10,000 UK-based children were at risk of FGM, while Booth [33] suggested there are 3000–4000 new FGM cases in this country per annum.

In Italy, based on 1994 Ministry of Interior data, it is estimated there were 'not less than 28,800 immigrant African women who have undergone FGM' [26], and at least 4000–5000 young excised girls based in Italy [34]. Around 25,000 Somalis have settled in The Netherlands, with an additional small number requesting political asylum and an increasing number of unaccompanied minors arriving in the country [35]. It is estimated there are approximately 21,000 genital mutilated women living in Germany; this number could potentially be doubled if non-registered migrants are included [36]; the same
source estimates the number of girls at risk of FGM at 5500. Across the Nordic countries (including Sweden, Denmark, Norway, Finland and Iceland), FGM is increasingly seen as a health issue requiring attention, though enumeration of the extent of the problem is absent [37], while in Switzerland Jüger et al. [38] estimated there were approximately 6700 girls at risk of FGM and women who have undergone the procedure.

As for the practise of FGM, in several EU countries concern exists that FGM is being performed within the host country. Since the 1980s, it has been believed that FGM is being practised in the UK by various trained practitioners (e.g. doctors) and that children are being sent on “holidays” to be mutilated abroad [39]. Hedley and Darkenroo’s national survey [40] across social services departments (SSDs) found FGM is more widespread than believed. Ten of 65 SSDs canvassed reported centrifugal intervention because of suspected FGM; a further 18 were concerned about communities possibly practising it.

In Italy, as in Spain, similar reports have been recorded of FGM being performed. A 1993 inquiry among obstetricians in Italy revealed FGM was being carried out in the country, either by medical staff or by traditional birth attendants [41]. Indeed, one Somali doctor has proposed a “harmless and symbolic” ritual alternative (i.e. a puncturing of the clitoris under local anaesthesia) to FGM for African women at a Florence public hospital [42]. In Spain, six cases of illegal circumcision of immigrant African girls were subject to an inquiry; in one case, paediatricians from a Zaragoza hospital suspected that at least one operation was undertaken recently [43]. In France in 1984, several excisions were performed in the 18th district of Paris; in the following year, 500 excisions were performed in a Paris suburb [44].

The problem inherent in these prevalence figures is that they are all too often risk estimates and not derived from rigorous primary social research, extrapolations from (often imprecise) country-of-origin prevalence data that are unsubstantiated by empirical findings (e.g. from court cases or social services documentation). Consequently, quantifying their degree of precision is problematic. Of course, verifying the occurrence of what in some countries is an illegal and secretive activity practised by relatively small sub-populations of the population is problematic in itself.

a fact exacerbated when that activity is seen as both beneficial to the individual and intrinsic to the cultural identify of an exiled group. More generally, reliable cross-national comparative prevalence data on the epidemiology and practice of FGM in Europe and its health-related consequences are largely unavailable [45,46], a limitation that in part constitutes the raison d’être for this paper.

However, some authors contend that not only are these estimates erroneous, but that there is a mistaken public discourse on the prevalence of FGM that obscures the fact that the practice is slowly disappearing among exiled communities. For example, Johnsdotter [45,46] has claimed that the exiled Somali community in Sweden have engaged in an internal discourse in which the religious imperative to undertake FGM has been reassessed, re-evaluated and re-interpreted as a violation of fundamental Islamic teachings, resulting in an abandonment of infibulation (Type III FGM) and a belief that the stinmah type of FGM is unnecessary.

Whilst offering useful insights into the potential process of cultural abandonment, Johnsdotter’s work is wholly anthropological in nature, gathering data from a non-probabilistic sample of only thirty respondents (15 from each gender) from one Swedish city. Caution has to be exercised, as Johnsdotter acknowledges, when making any generalised conclusions to the wider Swedish Somali community (not to mention the experiences of other Somali and non-Somali African communities in exile elsewhere in Europe) given the “representativeness” of the interviewees.

Caution has to also be demonstrated when interpreting similar tendencies in cultural change that have been reported elsewhere in Europe. For example, though Morrison et al. [47] found a tendency for abandonment of FGM and the beliefs in sexuality, marriage and religion that underpin it among young (i.e. aged 16–22 years) Somalis living in London, the process of cultural reassessment is neither necessarily inevitable nor linear:

The process involved in any change of values or behaviours of members of minority ethnic groups is complex. Assimilation can occur whereby members of ethnic minority groups gradually take on the values and behaviour of the majority culture. However, there is heterogeneity within the culture of the
receiving country so assimilation may occur into some subgroup(s) of it. It is difficult to make generalisations about assimilation of a particular ethnic group because assimilation might occur to different extents in different parts of the minority group (for example, it might occur more in younger and less in older members) and might occur in some aspects of life (for example, socialising at work) but not others (for example, marriage) [47].

Moreover, as the authors note, since the study was conducted there has been a substantial increase in the number of Somalis in exile in the UK, which has increased the size of the Somali community. This increase could potentially have altered the dynamics within which cultural change is expected to occur, possibly increasing the pressures for cultural adherence and reducing the opportunities for cultural abandonment by reawakening the fear of social criticism and competition.

Lastly, where research has been conducted with the aim of estimating the prevalence of FGM, there is relatively convincing evidence that the practice remains a problem. For example, based upon postal questionnaires among Swiss gynaecologists, canton health representatives and five medical schools, Jäger et al. [38] found 20% of the former had been confronted with patients presenting with FGM, while 40% had been asked about infibulation. Similarly, Kangouru et al. [48] found that among African women resident in the Swedish county of Örebro, 58% reported being generally mutilated, a fact corroborated in part by clinical examination.

2.2. Legislation in Europe

On 20 September 2001, the European Parliament (EP) adopted a Resolution on FGM which, although not legally binding, has the potential to prepare the ground for a EU-wide FGM policy. The resolution calls upon Member States to collaborate to harmonise existing FGM legislation. If existing legislation is inappropriate, however, it requests that specific legislation should be enacted [49]. The same Resolution requests the European Commission to undertake an awareness campaign directed at legislators/parliamentarians in all EU Member States affected by FGM with a view to maximising the impact of existing legislation and, where legislation does not exist, to assist in the formulation and adoption of such legislation [49].

National legislation across the EU States leaves many questions unanswered. In some countries, an ongoing discussion exists over whether or not specific FGM legislation should be adopted. Unsurprisingly, in the absence of EU legislation, there is variation in Member States' national laws. Specific anti-FGM legislation exists in some European countries, such as Austria (enacted in 2002), Belgium (2001), Sweden (1982), Switzerland (1982), the UK (1985, amended in 2002), and Norway (1986) [50]. Other national laws applicable to FGM are criminal laws (under the penal code), administrative laws (concerning health centres and health professions), family law/child protection laws (relating to the role of the parents, possible suspension of parental authority and the removal of the child considered at risk of FGM), civil law (on financial compensation), and migration law (relating to the status of refugees and asylum seekers) [51]. In Finland, France, Germany, Greece, Italy, Luxembourg, Portugal and The Netherlands, FGM is punishable under general criminal law (penal code), whereas in Ireland, it is punishable under the Criminal Justice Act 2000 [50, 52].

In those European countries that have a specific FGM law, however, no cases have reached the courtrooms [53, 50]. In contrast, one country with no specific legislation (i.e. France) has taken several FGM cases to court. However, although FGM has been punished in France since the early 1980s, convictions are still being practised there [54].

Clearly, the enforcement of laws prohibiting FGM has a number of limitations. For example, more than 30 lawsuits filed by doctors against parents and practitioners of FGM allegedly performed in Spain were dropped because prosecutors could not prove that the procedures were undertaken in the country [41].

Another factor contributing to the non-enforcement of the law/international human rights law is 'cultural relativism,' with no action undertaken against FGM out of respect for the customs and traditions of different cultures [55]. Moreover, FGM is a historically and socially deeply embedded tradition; severe punishments based on the penal code or on specific legislation do not appear a sufficient deterrent to continuing the tradition [56]. Another factor is ASR's unfaul-
146

The growing number of ASRs from FGM-affected countries means European health and social care professionals, educational staff, the judiciary, police and immigration officials increasingly face the problem of caring for those affected by the practice. One of the major problems is the degree of operational coherence between health and social care services and other agencies (e.g. police, immigration officials, lawyers) in addressing ASRs' FGM needs. Services often develop their own codes of practice in isolation from the multiple agencies that could, and should, be involved in a suspected FGM case. This problem is compounded by the relative lack of operational coherence between these agencies, policy makers and grassroots organisations.

In countries such as the UK, Sweden, The Netherlands and Denmark, which have a large number of African immigrants from countries where infibulation is common, professionals have been confronted with the need to pay attention to the practice's potentially severe health complications. However, operational disarray between services is exacerbated by deficiencies within those services. For example, the care for women with FGM must be provided collaboratively as part of an integrated approach if it is to be effective. Professionals' ability to deal with FGM currently (not least in a collaborative manner) is, however, questionable. Mwangi-Powell [61] found women who have undergone FGM cited lack of FGM knowledge among health professionals as a major problem, identifying the need for increased awareness among

such professionals. Similarly, Lawrence's [62] study among professionals in health, education, social services and the police in three major UK cities found nearly four-fifths felt ill-equipped to deal with cases. Moreover, Levy et al. [43] showed that an addition to a lack of clinical knowledge of FGM procedures and its complications, knowledge about the underlying socio-cultural beliefs and traditions is deficient. Niemelä and Hakkarainen [25] suggest that offering adequate care may become difficult for care providers as a result of their own feelings of powerlessness and anger towards FGM, thus resulting in inadequate care for women with FGM.

Police and immigration officers also need to be aware of the problem of FGM and the relevant international conventions in order adequately to provide information on a country's legislation and to respond to cases of girls at risk of being circumcised reported to them. They will have to receive systematised information on groups that still perform FGM and on NGOs that provide services to deal with FGM [43]. Immigration officials need to inform newly arrived ASRs about the legislation, ensuring that the law is explained positively, that is, as a protector of girls and women, not a weapon for use against their culture. In these encounters, families should be informed about the consequences of breaking the law. Examples of good practice do exist. For example, the Belgian NGO Groupement pour l'Abolition des mutilations Sexuelles (GAMS) is planning to organise training sessions for the police to sensitise them to the problem of FGM among African migrants. However, more work across EU States that addresses operational inadequacies between, as well as within, professions needs to be initiated.

3. FGM: an integrated European agenda

The above discussion indicates national and international deficiencies in the way FGM is currently addressed. The EU needs to develop an agenda (to be implemented by Member States and relevant NGOs) that must be multi-faceted and integrated if it is to be effective. To this end, national interagency groups should be established comprised of members of at-risk communities, health and social services, police and legislators, researchers and schools' representatives [63,64].

In addition to the need for greater legislative harmony regarding FGM, there are four priority areas that such interagency groups need to address across all EU Member States: research; professionals' training; community education; and the development of culturally sensitive health services. It is contended that while the specific socio-cultural, political and legislative context of each EU Member State differs, these four areas have generic relevance and applicability.

3.1. Research

Any EU Member States' FGM policy initiatives must be premised upon rigorous evidence-based research if they are to be effective. Priority research areas include:

(a) Prevalence: The National Offices of Statistics across Europe provide limited information regarding the number of ethnic minority women from FGM risk countries. For example, non-disaggregated data do not permit analysis by ethnicity or by sub-regions of a country (e.g. in Sudan, the regional prevalence of FGM varies between 5 and 89%), nor do they provide information about the considerable number of illegal immigrants. Moreover, methodologies for determining the number of ASRs vary between EU countries, thereby making inter-country comparisons problematic. Furthermore, statistics are not updated regularly and might not reflect changes in migration and mobility [66].

Methods for estimating the number of ethnic minority women from practising groups using census, immigration and asylum data (where they exist) need to be refined, including their disaggregation by gender. Survey methods for smaller areas (such as local authorities) need to be developed to overcome the lack of available sampling frames and ASRs' suspicion regarding research into this sensitive issue. Additionally, the use of capture-recapture methods (used successfully with other populations that have proven difficult to count, for example the homeless and lesbians) [65,66], should be explored.

(b) An inventory of existing interventions and their impact analysis: Interventions developed at legislative, community and health and social sector
level need to be inventoried across Europe, and
an evaluation of their activities undertaken to
determine their relative effectiveness.

- Legislation: European countries address the
  practice of FGM as a violation of women's
  rights and consider such violation under no cir-
  cumstances justified by cultural heritage. How-
  ever, in many countries, there is still an ongoing
discussion about whether or not specific legis-
lation is an effective tool to combat FGM. A
coherent strategy throughout Europe concern-
ing legislative measures and their implemen-
tation will reinforce the fight against FGM. In
this context, an impact analysis of existing laws
throughout Europe needs to be undertaken. For
example, research is needed to examine reasons
why legal prosecution of FGM practitioners is
rarely attempted and the extent to which ASRs
are aware of existing legislation.

- Evaluation of interventions: Community-based
  programme interventions intended to change
  people’s attitudes to, and practice of, FGM
  among ASRs in the ‘West’ have never been
  prospectively evaluated for their impact. Rigi-
  dous evaluation, ideally using a quasi-exper-
  imental research design, will enable the repli-
cation of effective programmes across Europe
  (see [67]).

- Health and social sector: Research should be
  initiated on the effectiveness of health and
  social care for ASRs, in combination with re-
  search on the health- and social care-seeking
  behaviour of ASRs. KAP (i.e. knowledge, atti-
  tude and practice) studies among health profes-
sionals and social workers in relation to FGM
  could be a first step in developing efficient in-
  terventions for women with FGM [44]. To en-
sure FGM policies meet affected communities’
  needs, research investigating the attitudes and
  experiences of women and girls is necessary.
  While the physical effects of FGM have been
documented in sub-Saharan Africa, there is a
paucity of research on the specific problems
faced by circumcised women in Europe, where
the practice is widely misunderstood. The psy-
chological consequences of FGM also require
investigation; it is likely they will be worse
for girls and women living in a society that
regards circumcision as an abnormality rather
than a legitimate means of enhancing social
status [64,54]. It is also vital that the opinions
and attitudes of FGM-practicing communities
are heard and understood. Not only do pro-
essionals need to appreciate why the practice
continues, but also the obstacles encountered
accessing appropriate health and social care.

(c) Behaviour change research: Living in a coun-
try where such practices are rejected might create
circumstances in which it is easier to abandon
the practice of FGM. Some researchers have found
that acculturation and abandonment of the prac-
tice appears to be associated with age on arrival
in the country of abode [47]. However, with a
few notable exceptions [45], there is minimal re-
search investigating those who have abandoned
the practice. Such research could help deconstruct
the behavioural change process that leads to that
decision. For example, how are gender dynam-
ics among exiled communities affected and what
impact does that exert upon the continuation of
the practice? What is the impact of generational
differences among the exiled community, espe-
cially the perspective of the younger generation
who may find traditional discourse regarding
FGM an alien phenomenon? Future qualitative
studies investigating the wider diversity of expe-
riences, attitudes and beliefs of men and women
of varying ages from diverse cultures who could
play a major role in advancing our understand-
ing of such behavioural processes [68]. Research
on the influence of migration context on FGM
behavioural changes could also provide an im-
portant contribution to the development of more
effective interventions [69].

3.2 Training of professionals

Professionals working with ASRs face multiple
challenges, including linguistic differences; pressures
of finite time; inadequate cultural awareness; and de-
ficient expertise. Co-ordinated inter-agency training
is key for all professionals working with affected
communities, enabling them to provide effective and
culturally sensitive support to those affected and to
protect children by being sensitised to warning signs. Underlying this training gap is the fact that many local agencies are unaware of FGM and do not have FGM-specific procedures to serve affected women. An estimated 65% of local authorities in the UK, for example, have no FGM-specific policies or procedures in place [30].

3.2.1. More specific professional needs include

(a) Professionals receiving ASRs (e.g. immigration officials): In some countries, the fear of FGM is sufficient grounds for women to seek political asylum (e.g. [69]). To evaluate these claims compassionately and equally, immigration officials, barristers and solicitors need to receive adequate and appropriate FGM education to make informed judgements and represent their clients effectively.

(b) Professionals working with ASRs

- Child protection workers: General practitioners (GPs), social services, police and teachers [32] in the UK suggested specially trained advisers should be available to provide support and advice to professionals in contact with families affected by FGM. Specific child protection guidance should be made available to all professionals potentially involved in identifying the risk of FGM. This guidance should include the early indicators of FGM and the referral process, such as the advice released for UK GPs by the British Medical Association [70]. Although the likelihood of FGM occurring is difficult to detect, it is possible a child may confide their fears that this has happened, or may occur, to a teacher, social worker, medical professional or trusted friend. All referrals should be treated seriously irrespective of how meagre the substance of the suspicion or allegation appears. Professionals will become aware of the practice through multiple indicators (e.g. a teacher noticing a pupil is suffering with bladder or severe menstrual problems causing frequent school absence). It is also important that referral procedures are made known to all service-providing professionals, as a referral of suspected or actual FGM could arise from a variety of sources, including nurses, health visitors, doctors, midwives, school nurses, community workers, social services, friends and families. This highlights the importance of interagency collaboration and dissemination of information.

- Health professionals: All health professionals have a significant role to play in eliminating FGM and providing an effective service for women who have undergone the practice. Training of health professionals will depend on the particularities of the health sector and training modalities in each European country. However, training could be provided to the following target groups: GPs, gynaecologists and obstetricians, midwives, nurses, medical practitioners, paediatricians, psychologists, and cultural mediators [63].

Training should be undertaken at different levels, using varied methodologies and materials. For example, local hospitals and primary care services (for GPs and school health services) could develop guidelines, organise in-service training, or provide information through hospital and university libraries. At an academic level, FGM should be included in all curricula for medical and para-medical courses, as well as in set journals and textbooks. Nationally, guidelines for health care professionals should be developed discussing the socio-cultural, medical and legal aspects of FGM [43].

Training modalities could be organised in the following way: there could be a FGM specialist in every health authority with susceptible ethnic populations who is able to organise FGM training for nurses, midwives, GPs, gynaecologists, paediatricians, health visitors and health link workers. FGM policies and referral systems could be installed in each health authority. Lastly, a networking link and information exchange could be formed with the local practising communities, and statutory and voluntary organisations.

3.3. Community education

The Gent Expert Meeting [43], the UK Parliamentary Hearings on FGM [71] and the EP Resolution on FGM [49] recommended more support be given to NGOs and local community organisations, both of which are crucial to community education. This education will vary depending on the status of the ASR.
(a) **For those in transit:** Information available in multiple relevant languages needs to be given to newly arrived ASRs. This information should discuss FGM, the services available for help and relevant orientation information (including legislation on FGM) on living in a specific European country.

(b) **For those established in a EU country on a longer-term basis:** This could take the form of the training of peer educators in the community to educate on FGM, holding health and capacity-building seminars or using active community groups (including men and religious leaders) to implement FGM education among the community.

### 3.4 Culturally sensitive health services

In Europe, specialised health services for women who have undergone FGM are more the exception than the rule. Most general health services in Europe are unfamiliar with the consequences of FGM; this can result in inadequate care. Moreover, it discourages women from seeking appropriate care for their FGM-related problems [60]. There is a variety of means to overcome the lack of such culturally sensitive health services.

(a) **Information workshops:** Information workshops on the health consequences of FGM, UK FGM legislation, and the services available to women affected by the practice can help to raise awareness, improve women’s health and help eliminate FGM among ASRs in Europe.

(b) **Language:** Given European languages are not the first languages of most FGM-practising communities, it is likely women accessing health services will be unable to articulate their problems adequately (e.g. [72]). Interpreters, who are crucial to overcoming these linguistic barriers, should be female, not known socially to the women, and able to translate medical terms in an understandable form. It is important to consider the personal view of each interpreter towards FGM; those in favour of the practice must not, of course, be employed.

(c) **Specialist clinical services:** In the UK, there are now eight clinics (including African Well Women Clinics) offering FGM services. Since 1993, FORWARD, Northwick Park Hospital, Guy's & St. Thomas’ Hospital and others have helped establish five African Well Women Clinics across London offering women affected by FGM advice and medical help [27]. It is certain, however, that the growing number, and national dispersal in the UK, of women who have undergone FGM will render these capital-focused clinics insufficient to cater to existing needs. These initiatives should be duplicated across the EU and the lessons learnt. Moreover, not only must Member States be encouraged to provide similar services, but affected communities need to be informed of these specialist clinics through surgeries and grassroots community groups.

### 4. Conclusions

At the request of the European Parliament, ‘1999’ was designated the ‘European Year against Violence Towards Women.’ Five years later, the challenge facing the EU remains. The increased numbers of ASRs from FGM-practising countries arriving in the EU mean the practice will at best be abandoned by affected populations over time (potentially several generations), and at worst will not disappear through a gradual process of adaptation and acculturation, as some anticipated [73]. Existing evidence suggests FGM will increasingly become an issue of EU-wide rather than localised concern.

Existing variation in anti-FGM and asylum legislation across EU Member States, as well as the inadequacies of existing research and the operational coherence of the multiple agencies involved, mean ASRs’ FGM needs are not being met. The above discussion has outlined the need to harmonise legislation, improve the rigour of research programmes and strengthen the partnership working of agencies. It is only by initiating such an integrated agenda that the needs of women and girls affected by FGM can be addressed satisfactorily.

### Acknowledgements

The authors thank Elaine Davies, Ben Osunde, Nana Otoo-Oyeyi and Marleen Tenman for reading earlier drafts of this work. Views expressed are those of the authors only.
CHAPTER 4: CONCLUSIONS

This chapter includes a summary of the main results of the studies, by addressing each of the specific objectives as defined in Chapter 2. In addition, some recent dynamics in the fields of legislation, health care provision and operational cohesion in the EU are presented, as a supplement to the findings of the research. Finally, a critical appraisal is given of some of the recent trends, and prospects for future action are provided.

4.1. Summary of the results

The aim of this dissertation was to assess the responses given at legislative and health care level to FGM in some countries of the EU. To meet this aim, several studies have been described:

- a questionnaire-based survey that identified legal provisions applicable to FGM and an in-depth comparative analysis of the implementation of laws in five EU countries;
- a KAP survey among gynaecologists in some EU countries and a rapid appraisal of FGM as an issue for health professionals;
- a questionnaire-based survey among Flemish gynaecologists in Belgium to assess the tensions between the clinical practice, attitudes of health care professionals and the legal provisions regarding FGM, reinfibulation, symbolic incision, medicalization and cosmetic vulvar and vaginal surgery; and
- an exploration of a number of key issues to be addressed in an integrated European agenda.

Specific objective 1: To examine the legal provisions applicable to FGM and to identify and analyse determinants of the implementation of the laws in some countries in the EU (Paper 1)

The research showed that both criminal and child protection laws are being implemented in a number of EU countries. An increasing number of EU countries
have developed specific criminal law provisions to prohibit FGM. Specific criminal laws have not resulted in more prosecutions than general criminal laws, and have proven to be incomplete when addressing emerging issues such as symbolic incisions, cosmetic vaginal surgeries and reinfibulation. Indeed, they leave the professionals who perform these actions with a lack of clarity on how to proceed. A number of factors hinder an effective implementation of both criminal and child protection laws, in particular with regard to case reporting, finding evidence and protecting girls at risk.

This study demonstrated that an effective implementation of laws with regard to FGM is closely linked to the knowledge and attitudes of professionals regarding population groups where FGM is common, the practice of FGM itself and its different types, as well as knowledge of the laws and child protection procedures to follow if a girl is at risk. The study contended that current legislation needs a clear strategic plan for implementation mechanisms.

Specific objective 2: To explore the health services available in some EU countries for women with FGM (Papers 2 and 4)

Our research into health care responses in EU countries showed that three main services have been established: technical guidelines for the clinical management of women with FGM, codes of conduct for health care professionals, and specialized health services that provide medical care, psychological care and counselling for women from practising communities. The main factor hampering the provision of adequate care for women with FGM is the deficient knowledge of health care professionals about FGM.

Specific objective 3: To assess the FGM-related knowledge, attitudes and practices of Flemish gynaecologists (Paper 3)

This survey revealed a number of shortcomings in the knowledge of FGM and in the provision of care among Flemish gynaecologists. Confusion exists regarding reinfibulation and its legal status, and a clear support for medicalization and symbolic incisions was demonstrated. Few gynaecologists consider cosmetic vaginal surgery as a form of FGM. The study indicated a need for a thorough ethical-legal consultation
process with all stakeholders on the topics of reinfiltration, medicalization of FGM, symbolic incisions and cosmetic vulvar and vaginal surgeries.

Specific objective 4: To obtain knowledge on key issues to be addressed in an integrated European agenda (Paper 4)

The above-mentioned research indicated deficiencies in the way FGM is currently addressed at legislative and health care level. Paper 4 explored a number of key elements for an integrated agenda to be developed by the EU and implemented by Member States and relevant NGOs, taking these deficiencies into account. It contended that existing variations in anti-FGM legislation across EU Member States, as well as the inadequacies of existing research and the operational cohesion of the multiple agencies involved, result in the needs of women or girls who undergo FGM not being met. In addition to the need for greater legislative harmony regarding FGM, the paper identified four priority areas to be addressed by national interagency groups across all EU member states: research on FGM (prevalence, inventory of existing interventions and analysis of their impact, behaviour change research); training of professionals; community education; and the development of culturally sensitive health services. The paper outlined the need to harmonize legislation, improve the rigour of research programmes and strengthen the working partnerships of agencies.

4.2. Recent dynamics

4.2.1. Legal responses

Legal responses to FGM change rapidly in Europe. New laws or changes to existing laws have emerged in Scotland (new law, 2005), France (change, April 2006) and Italy (new law, 2005).

The Scottish Parliament passed the Prohibition of Female Genital Mutilation Act 2005 on 26 May 2005. FGM has been a specific criminal offence in the UK since the passage of the Prohibition of Female Circumcision Act 1985 (“the 1985 Act”). In England, Wales and Northern Ireland, the Female Genital Mutilation Act 2003 repealed and re-enacted the provisions of the 1985 Act, gave them extra-territorial effect and increased the maximum penalty for FGM. Like the Female Genital
Mutilation Act 2003, the 2005 Act repeals and re-enacts for Scotland the provisions of the 1985 Act, gives extra-territorial effect to those provisions and increases the maximum penalty for FGM in Scotland from five to 14 years’ imprisonment (99).

In France, repression of FGM committed abroad has been reinforced by introducing the new article 222-16-2 of the penal code. This article extends the implementation of the French law on mutilation and punishes practices committed on minors of foreign nationality who normally reside on French territory and who are victims of FGM abroad (100).

In Italy, the new law combines preventive measures with punitive measures. A total of €5 million is foreseen every year for prevention campaigns and training of health care professionals (101).

Our research discussed in Paper 1 studied laws regarding FGM in the first 15 EU Member States and resulted in a review of these laws. Knowledge of the legal situation in the new EU Member States is currently lacking. ICRH obtained funding from the European Commission Daphne programme to update the existing review, as well as to study the laws in the 10 new EU Member States. This study is timely and will keep the current knowledge on laws regarding FGM in the EU up to date. The new review will equally document new court cases, such as Sweden’s first ever court case since the law banning FGM came into effect in 1982.

4.2.2. Response of the health sector
Since the research carried out in 1998 and 2000, health sector services for women with FGM in many European countries have increasingly been (or will be) improved and expanded. In France, for example, the Ministry of Health announced that a manual will be developed and training will be organized for health care professionals (104). One country that has caught up on developing strategies for health care services is Switzerland. Guidelines for obstetricians and gynaecologists have been developed

\[\text{\textsuperscript{1}}\text{ A man of Somali origin went to trial in 2006 for forcing his 13-year-old daughter to undergo genital mutilation (102). The man was sentenced to four years in prison (103).}\]
and have been used as a basis to develop similar guidelines in Germany (105). Swiss midwives have developed guidelines for childbirth instructors and teachers. In Switzerland, FGM is included in curricula for medical students, and a national working group has been established to examine the issue. Expert consultations are being organized on medico-legal issues such as reinfibulation, and training of health professionals has been substantially increased. In Belgium, some curricula for medical students include FGM.

Reversal operations for infibulated women are increasingly being requested and offered. Special attention needs to be drawn here to reconstructive surgery of the clitoris, which is an emerging surgical technique developed primarily in France and the UK. In a first stage, the surgical technique is currently being developed and debated and, in a second phase, the population for whom this type of surgery is beneficial needs to be determined (106). Until now, this type of genital surgery has not yet been evaluated in “any properly conceived, controlled, prospective study, nor has it led to peer-reviewed articles in international journals” (107). However, some testimonies of women who have undergone this type of reconstructive surgery show that, even if the physical functions of the clitoris are not reconstructed, it has enabled them to feel like a “whole woman” (108). More research is needed to reach conclusive guidelines on how to proceed with reconstructions of the clitoris (106).

A number of qualitative studies among women from communities that practise FGM have emerged in recent years. These studies provide valuable insights for the development of appropriate health care services for women with FGM living in Europe, and seem to underline that specialized care for women with FGM during pregnancy, childbirth and the postpartum period is sub-optimal (109-111). Some studies also suggested that FGM continues in Europe (112;113). Given the new services that have been put in place in many countries and the insights into the opinions and needs of the women concerned, a new assessment of health care services in EU countries is necessary to reduce the gaps in service delivery.
4.2.3. Operational cohesion in EU countries

A number of initiatives to enhance cooperation and collaboration between different stakeholders have been established in recent years.

At national level, the coordination between different stakeholders is being put into place in some countries in the EU. National action plans to prevent FGM have been or are being developed in, among others, Sweden (national action plan against FGM, 2005), Belgium (national action plan to prevent FGM, 2007) and Spain (2005–2008 national plan to prevent violence against women in the home). The European Network for the Prevention of FGM has obtained funding from the European Commission Daphne programme to assist in the development and/or implementation of national action plans to prevent FGM in 15 European countries, and the project will run from 2007 to 2009.

Following advice on effective strategies to abandon FGM in the Netherlands (issued in 2005), the Dutch Government has piloted a common approach in six Dutch cities (Amsterdam, Rotterdam, The Hague, Utrecht, Eindhoven and Tilburg). This approach includes outreach to at-risk groups, training of professionals, and the introduction of a guiding protocol for professionals. This policy not only focuses on prevention but also on reporting, detecting and registration by doctors, nurses, youth health care practitioners, gynaecologists and obstetricians, general practitioners and those doctors responsible for abused children. Regional CBOs are a major partner in the implementation of the policy. This pilot project will be evaluated in 2008 with the possibility of implementing it at national level (114).

In 2001 a Nordic network was created to optimize research undertaken in Scandinavian countries. Since then, the Nordic Network for Research on Female Circumcision (FOKO) has convened a conference every second year to share findings and questions related to research projects on FGM.

The Donor’s Working Group on FGM is a network of public and private agencies from around the world which includes the provision of funding for efforts to end FGM in its strategy. Its members approach this strategic initiative with a wide range of concerns, priorities and strategies, yet they share the common desire to enhance
their effectiveness as donors (115). The group was initiated by the US Agency for International Development (USAID), the Wallace Global Fund, WHO and the World Bank in December 2001. It meets every year to explore and discuss funding and technical assistance possibilities to improve support for FGM prevention activities (116).

On the initiative of ICRH and the World Bank, two meetings were organized to develop a common strategy to abandon FGM. The meetings brought together the departments within the European Commission that have been funding FGM projects (the Directorate General (DG) for External Relations; DG for Justice, Freedom and Security; DG for Health and Consumer Affairs, and the Europe Aid Cooperation Office) and representatives of the World Bank, (World Bank Europe Office and Washington Headquarters), Austria (Ministry for Health and Women), Finland (Ministry of Development) and civil society (No Peace Without Justice (NPWJ), ICRH and GTZ). The meetings were convened to discuss the lack of an integrated approach and to discuss a possible long-term strategy among the different European Commission agencies involved. ICRH made a series of suggestions to enhance operational cohesion.

4.2.4. Response of religious leaders

Religious leaders are finally, increasingly speaking out against FGM. An important statement was made when esteemed Muslim clerics at an international conference on FGM in Cairo in November 2006 dissociated Islam from FGM. At this conference the Grand Sheikh of al-Azhar, the highest Sunni Islamic institution in the world, Sheikh Mohammed Sayyid Tantawi, stated that FGM is not mentioned in the Koran nor in the Sunnah. This statement was reaffirmed by the senior official cleric and Grand Mufti in Egypt, Sheikh Ali Gomma, as well as by other prominent Islamic figures at the conference (117).

Vigilance is, however, still required because, despite the rejection of FGM by many religious leaders, the main point of discussion that still remains is the support of religious leaders for the “sunna” type of FGM. This was clearly demonstrated at the sub-regional conference on FGM, Towards a Political and Religious Consensus on the
Elimination of FGM, which convened in Djibouti on 2–3 February 2005. Religious leaders from the sub-region (Yemen, Sudan, Djibouti and Egypt) discussed the issue and, in their final declaration, spoke out against FGM but supported the “sunna” type of FGM. After strong rejection of this declaration by the audience, the spokesperson withdrew this statement, but it remains to be seen if religious leaders will speak out against all forms of FGM in practice.

4.3. Overall conclusion

FGM in the EU has gained considerable attention in recent years. Exact prevalence data are lacking, but FGM does not constitute a public health priority in EU countries. The prevention of FGM should rather be framed in enhancing the sexual and reproductive health and rights of women in general, and of migrant women in particular.

However, health care providers’ lack of knowledge about FGM and deficiencies in providing adequate clinical care and counselling have urged national authorities and professional organizations to find answers to this issue. Another trend being seen in European countries is the increasing number of countries that have developed a specific criminal law on FGM. This has, however, not led to more court cases, and the question has emerged as to whether these laws are implemented and/or whether they are necessary.

The research described in this dissertation explored the above-mentioned issues at legislative and health care level. The studies showed that, despite the existence of specialized health care services and guidelines, the lack of knowledge about FGM and deficiencies in care delivery remain. Moreover, recent developments show that other priorities need to be addressed: a lack of clarity about reinfibulation, medicalization, cosmetic vulvar and vaginal surgery, and performing less severe cuts. The research on legislation and the study among Flemish gynaecologists clearly showed that specific laws do not provide any guidance on these issues.
It is, however, important to deal with these issues, given the increasing trends towards medicalization of the practice and performing less severe forms of FGM rather than the total abandonment of FGM. Although the health benefits of these strategies are obvious, they do not address the human rights violations of FGM performed on a non-consenting adult and are against medical deontology, as discussed in this manuscript. The increasing trend of performing FGM on young girls to avoid complaints to law enforcement agencies makes it even more important to address these issues. The tendency to medicalize FGM is because, in the past, campaigns have focused solely on the negative health effects of FGM. More effective strategies now focus on the human rights violations of FGM and frame their prevention efforts in basic education packages (see, for example, the successful NGO Tostan in Senegal). Such community-based interventions that frame the prevention of FGM within basic education and poverty reduction activities require time and sufficient means. Given the number of girls at risk worldwide (3 million each year), a substantial increase of funds is necessary to scale up initiatives such as Tostan’s. The recent launch of the UNFPA/UNICEF Joint Initiative, that will set up a $44 million programme to decrease FGM by 40% by 2015 in 16 countries in Africa with the highest prevalence, might be a first step in that direction.

The increasing trend of cosmetic genitoplasty also challenges the arguments against medicalization (118). Criminal laws on FGM, where the woman or girl’s consent does not play a role – as in Belgium – might equally challenge the implementation of the law when it comes to vaginal and vulvar cosmetic surgery.

The research on the implementation of laws in Europe demonstrated that specific laws do not need to be developed. It is more important to see that cases are being reported and that sufficient evidence is found to bring cases to court. To achieve this, those individuals and agencies that are able to detect cases (such as health professionals, teachers, police and social workers) need to be informed and trained to be able to identify a girl at risk or to be able to detect whether a girl has been cut, even when it concerns type I. The practical organization of such a detection system needs to be thoroughly discussed, and priorities have to be set. Of paramount importance is also an inventory and impact analysis of interventions at community level. This is complementary to the service delivery and legislation that have been described in this
manuscript. Neither a law nor health care workers will be sufficient to change behaviour towards the abandonment of all forms of FGM, and the focus should switch towards such behaviour change strategies.

Consultations on several aspects of FGM are needed at national level, taking into account the national laws and existing guidelines. At European level, such consultations are equally important. Within Europe, considerable expertise is available to prevent FGM, but given the lack of cohesion between the actors and given that FGM is not a public health priority, we would like to suggest creating a focal point on harmful traditional practices at European level – to enhance collaboration and strengthen partnerships between all agencies involved. This focal point could bring together the expertise available in the EU, disseminate good practice and experiences, centralize research, enhance the operational cohesion between agencies, develop and implement protection protocols for girls at risk, lobby and advocate towards various institutions, and identify needs regarding harmful traditional practices that might include FGM, early and forced marriage and honour-related violence.

A model on care for women with FGM and the prevention of FGM within the health sector should be developed. This model should include the research findings, especially with regard to the ethical-legal issues (medicalization, reinfibulation and cosmetic vaginal surgery), should take into account new developments in the health care sector (such as reconstructive surgery) and needs further expert discussion.

Research is needed to gain better insights into the problem of FGM in Europe, but an increased operational cohesion is equally important to reach a global abandonment of FGM.
CHAPTER 5: REFERENCES


(86) Bellander-Todino I. The Daphne Programme's experiences concerning FGM/C. Presented at the International Conference on Female Genital Mutilation and Forced/Early Marriages, Brussels, February 8-11, 2007:91-95.


(89) Nienhuis G. Somali women tell: It's like you have to do the delivery here by yourself. Tijdschr Verlosk 1998;(March):160-6.


(101) Scoppa C. *New law on FGM approved by the Italian Parliament*. Personal Communication [December 20 2005]


(109) Vangen S, Johansen E RB, Sundby J, Traen B, Stray-Pedersen B. Qualitative study of perinatal care experiences among Somali women and


(117) FORWARD. *FGM is not an Islamic Requirement*. Personal communication [24-11-2006]

EXECUTIVE SUMMARY

1. Context and objectives

1.1. Problem definition
An estimated 100 to 140 million women and girls have undergone female genital mutilation (FGM), and at least 3 million girls are excised annually. Most of these women and girls live in 28 African countries; migration by populations that practice FGM has brought it to Europe, but clear statistical data on FGM in Europe are unavailable.

FGM is a harmful traditional practice that can lead to reproductive ill-health. However, it is also recognised as being more than a health problem, and is considered as a form of gender-based violence and a violation of the sexual and reproductive health rights of women. This manuscript focuses on FGM in the European Union (EU), and more particularly on two aspects pertaining to the socio-cultural context of FGM: health services and laws.

1.2. Objectives
The overall aim of this dissertation is to assess the responses at legislative and health care level to FGM in some countries of the EU.

We were particularly interested in:
- Examining legal provisions applicable to FGM and identifying and analysing determinants of the implementation of the laws in some EU countries;
- Exploring health services available in some EU countries for women with FGM;
- Assessing the FGM-related knowledge, attitudes and practices of Flemish gynaecologists; and
- Obtaining knowledge on key issues to be addressed in an integrated European agenda.
1.3. Data collection

To meet the overall aim, several studies have been performed:

- A questionnaire-based survey that identified legal provisions applicable to FGM and an in-depth comparative analysis of the implementation of laws in five EU countries;
- A KAP survey among gynaecologists in some EU countries and a rapid appraisal of FGM as an issue for health professionals;
- A questionnaire-based survey among Flemish gynaecologists in Belgium to assess the tensions between the clinical practice, attitudes of health care professionals and the legal provisions regarding FGM, reinfibulation, symbolic incision, medicalisation and cosmetic vulvar and vaginal surgery.

2. Results

2.1. Examining the legal provisions applicable to FGM and identifying and analysing determinants of the implementation of the laws in some countries in the EU

The research showed that both criminal and child protection laws are being implemented in a number of EU countries. An increasing number of EU countries have developed specific criminal law provisions to prohibit FGM. Specific criminal laws have not resulted in more prosecutions than general criminal laws, and have proven to be incomplete when addressing emerging issues such as symbolic incisions, cosmetic vaginal surgeries and reinfibulation, leaving the professionals who perform these actions with a lack of clarity on how to proceed. A number of factors hinder an effective implementation of both criminal and child protection laws, in particular with regard to case-reporting, finding evidence and protecting girls at risk.

This study demonstrated that an effective implementation of laws with regard to FGM is closely linked to the knowledge and attitudes of professionals regarding population groups where FGM is common, the practice of FGM itself, and the different types as well as knowledge of the laws and child protection procedures to follow if a girl is at risk. The study contended that current legislation needs a clear strategic plan for implementation mechanisms.
2.2. Exploring the health services available in some EU countries for women with FGM

Our research into health care responses in EU countries showed that three main services have been established: technical guidelines for the clinical management of women with FGM, codes of conduct for health care professionals, and specialised health services that provide medical care, psychological care and counselling for women from practising communities. Factors hampering the provision of adequate care for women with FGM are mainly the unfamiliarity of health care professionals with FGM and their deficient knowledge about FGM.

2.3. Assessing the FGM-related knowledge, attitudes and practices of Flemish gynaecologists

This survey revealed a number of shortcomings in the knowledge of FGM and in the provision of care among Flemish gynaecologists. Confusion exists regarding reinfibulation and its legal status, and a clear support for medicalisation and symbolic incisions was demonstrated. Few gynaecologists consider cosmetic vaginal surgery as a form of FGM. The study indicated a need for a thorough ethical-legal consultation process with all stakeholders on the topics of reinfibulation, medicalisation of FGM, symbolic incisions and cosmetic vulvar and vaginal surgeries.

2.4. Obtaining knowledge on key issues to be addressed in an integrated European agenda

The above-mentioned research indicated deficiencies in the way FGM is currently addressed at legislative and health care level. A number of key elements were explored, to be addressed in an integrated agenda for the EU, taking these deficiencies into account. It contended that existing variations in anti-FGM legislation across EU Member States, as well as the inadequacies of existing research and the operational cohesion of the multiple agencies involved, result in the needs of women or girls who undergo FGM not being met.

In addition to the need for greater legislative harmony on FGM, four priority areas to be addressed by national interagency groups across all EU Member States were identified:
- Research on FGM (prevalence, inventory of existing interventions and their impact analysis, behaviour change research);
- Training of professionals;
- Community education; and
- The development of culturally sensitive health services.

The need to harmonise legislation, improve the rigour of research programmes and strengthen the working partnerships of agencies were equally outlined.

3. Conclusions

The lack of knowledge of health care providers about FGM and deficiencies in providing adequate clinical care and counselling have urged national authorities and professional organisations to find answers to this issue. An increasing number of European countries have developed a specific criminal law on FGM; however, this has not led to more court cases, and the question has emerged as to whether these laws are implemented and/or whether they are necessary.

The research described in this dissertation explored the above-mentioned issues at legislative and health care level. The studies showed that, despite the existence of specialised health care services and guidelines, the lack of knowledge about FGM and deficiencies in care delivery remain. Moreover, recent developments show that other priorities need to be addressed: a lack of clarity about reinfibulation, medicalisation, cosmetic vulvar and vaginal surgery, and performing less severe cuts. The research on the legislation and the study among the Flemish gynaecologists clearly showed that specific laws do not provide any guidance on these issues. Criminal laws on FGM, where the woman or girl’s consent does not play a role – as in Belgium – might equally challenge the implementation of the law when it comes to vaginal and vulvar cosmetic surgery.

The research on the implementation of the laws in Europe demonstrated that specific laws do not need to be developed. It is more important to see that cases are being reported and that sufficient evidence is found to bring cases to court. To achieve this, those individuals and agencies that are able to detect cases (such as health
professionals, teachers, police and social workers) need to be informed and trained to be able to identify a girl at risk or to be able to detect whether a girl has been cut, even when it concerns type I. The practical organisation of such a detection system needs to be thoroughly discussed, and priorities need to be set. Of paramount importance is also an inventory and impact analysis of interventions for the prevention of FGM at community level. This is complementary to the service delivery and legislation that have been described in this manuscript, as neither a law nor health care workers will be sufficient to change behaviour towards the abandonment of all forms of FGM.

Consultations on several aspects of FGM are needed at national level, taking into account the national laws and existing guidelines. At European level, such consultations are equally important. Within Europe, considerable expertise is available to prevent FGM, but given the lack of cohesion between the different actors, we would like to suggest creating a focal point on harmful traditional practices at European level – to enhance collaboration and strengthen partnerships between all agencies involved.
SAMENVATTING

1. Achtergrond en objectieven

1.1. Definitie van het probleem
Volgens een ruwe schatting zijn 100 tot 140 miljoen vrouwen en meisjes het slachtoffer van vrouwelijke genitale verminking (VGV), en worden minstens 3 miljoen meisjes per jaar besneden. Het grootste aantal van deze vrouwen en meisjes leeft in Afrika; door migratie van bevolkingsgroepen waar VGV courant is, werd het geïmporteerd naar Europa, maar duidelijke statistische data over de omvang van VGV in Europa ontbreken.

VGV is een schadelijke traditionele praktijk met negatieve gevolgen op de reproductieve gezondheid. Tevens wordt het beschouwd als een vorm van geweld tegen vrouwen en meisjes én als een schending van de seksuele en reproductieve rechten van vrouwen. Dit proefschrift belicht VGV in de Europese Unie (EU), en meer bepaald twee aspecten van de socio-culturele context van VGV: de gezondheidszorg en de wetgeving.

1.2. Objectieven
De algemene doelstelling van dit proefschrift is na te gaan welke de antwoorden zijn die geformuleerd werden op wettelijk vlak én in de gezondheidszorg ten aanzien van de problemen die VGV stelt binnen enkele landen van de Europese Unie.

In het bijzonder hebben we 1) de wettelijke voorzieningen onderzocht van toepassing op VGV en de determinanten voor het uitvoeren van deze wetten in enkele EU-landen geïdentificeerd en geanalyseerd; 2) de aanwezige gezondheidszorgvoorzieningen voor vrouwen met VGV onderzocht in enkele EU-landen; 3) de kennis, houdingen en handelingen van Vlaamse gynaecologen ten aanzien van VGV vastgesteld; en 4) enkele sleutelelementen gedefinieerd om een samenhangende, Europese agenda op te stellen om VGV aan te pakken.
Om de algemene doelstelling te bereiken werden diverse studies uitgevoerd:
- een onderzoek gebaseerd op een vragenlijst, dat diverse wettelijke voorzieningen ten aanzien van VGV definieerde, en een vergelijkende diepteanalyse van de toepassing van de wetgeving in vijf landen van de EU;
- een onderzoek naar de kennis, attitudes en handelingen van gynaecologen in enkele EU-landen en een rapid appraisal van VGV bij Europese experts in de gezondheidszorg;
- een onderzoek gebaseerd op een vragenlijst onder Vlaamse gynaecologen om het spanningsveld te determineren tussen de klinische praktijk en de houdingen van de gynaecologen ten aanzien van VGV en het wettelijk kader waarin ze opereren, vooral met betrekking tot reinfibulatie, symbolische incisies, medicalisatie en cosmetische vaginale chirurgie.

2. Resultaten

2.1. Wettelijke voorzieningen van toepassing op VGV en identificatie en analyse van de determinanten voor het uitvoeren van deze wetten in enkele EU-landen
Het onderzoek toonde aan dat zowel strafwetten als wetten ter bescherming van het kind in een aantal landen van de EU worden toegepast. Een toenemend aantal landen van de EU hebben specifieke strafwetvoorzieningen ontwikkeld t.a.v. VGV. In vergelijking met de algemene strafwetten resulteerden deze specifieke strafbaarstellingen niet in meer vervolgingen dan de algemene strafwetbepalingen. De specifieke strafwetten waren ook onvoldoende om bepaalde VGV-gerelateerde kwesties zoals symbolische incisies, cosmetische vaginale chirurgie en reinfibulatie aan te pakken, zodat gynaecologen en andere dokters deze ingrepen uitvoeren in onduidelijkheid over de wettelijke toelaatbaarheid ervan. De studie verschafte tevens inzicht in een aantal elementen die een effectieve toepassing van de strafwet en de wet op kinderbescherming verhinderen, meer bepaald met betrekking tot het rapporteren, vinden van afdoende bewijslast en de bescherming van meisjes die het risico op VGV lopen. De studie toonde dat de kennis en attitudes (betreffende Afrikaanse bevolkingsgroepen, praktijk van VGV, kennis van wet en kinderbeschermingsprocedures) van diegenen die beroepshalve met VGV worden geconfronteerd, het toepassen van de wet beïnvloeden. De studie dringt aan om bij de
bestaande wetgeving een strategisch plan ter implementatie van de wetgeving te ontwikkelen.

2.2. Aanwezige gezondheidszorgvoorzieningen voor vrouwen met VGV in enkele EU-landen
Het onderzoek toonde aan dat er voornamelijk drie interventies zijn opgezet: 1. technische richtlijnen voor de klinische behandeling van vrouwen met VGV; 2. gedragscodes van professionele organisaties over de kwaliteit van de zorgverlening; en 3) gespecialiseerde voorzieningen die medische zorg, psychologische behandelingen en adviesverlening combineren. De studie bewees verder dat de gezondheidszorgvoorziening voor vrouwen met VGV voornamelijk wordt bemoeilijkt door een gebrekkige kennis over VGV en het formuleren van een adequaat antwoord op VGV.

2.3. Kennis, houding en handelingen van Vlaamse gynaecologen met betrekking tot VGV
De studie toonde een aantal tekortkomingen aan in de kennis ten aanzien van VGV en in de zorgvoorziening. Er heerst onduidelijkheid over reinfibuulatie en de wettelijke status van deze ingreep, een groot aantal Vlaamse gynaecologen zijn vóór een medicalisatie van VGV en symbolische incisies. Weinig gynaecologen zien cosmetische vaginale chirurgie als een vorm van VGV. De studie toonde aan dat er een diepgaand debat nodig is met alle belanghebbenden over de ethisch-legale kwesties (reinfibusulatie, medicalisatie, symbolische incisies en cosmetische vaginale chirurgie).

2.4. Belangrijke elementen voor een samenhangende Europese agenda om VGV aan te pakken
Een aantal elementen werden gedefinieerd om een samenhangende, Europese agenda op te stellen om het probleem van VGV aan te pakken, rekening houdend met enkele van de tekortkomingen zoals in de hierboven vermelde onderzoeken werden vastgesteld. Bestaande variaties in anti-VGV wetgevingen in de EU-landen, het ontoreikend onderzoek en de gebrekkige samenhang tussen diverse actoren, zorgen ervoor dat aan de noden van de vrouwen en meisjes met VGV slechts gedeeltelijk wordt tegemoetgekomen. De nood om wetgevingen te harmoniseren, nauwkeurigheid
van onderzoeken te verbeteren en samenwerkingsverbanden tussen actoren te verbeteren, werden eveneens aangekaart. Er werden vier prioriteiten geïdentificeerd die door nationale overlegorganen in de landen van de EU zouden moeten worden aangepakt:

- Onderzoek naar VGV (prevalentie, inventaris van bestaande interventies en een analyse van hun impact, onderzoek naar gedragsveranderingen ten aanzien van VGV);
- Training van professionelen;
- Educatie van de gemeenschappen;
- Ontwikkelen van aangepaste gezondheidszorg.

3. Conclusies

Het gebrek aan kennis over VGV binnen de gezondheidszorg en de ontoereikende klinische hulpverlening en advisering, hebben nationale overheden en beroepsorganisaties genoegd tot het zoeken van antwoorden op deze kwesties. Een toenemend aantal EU-landen hebben een specifieke strafwet ten aanzien van VGV ontwikkeld. Deze hebben echter niet tot meer rechtszaken geleid, en de vraag stelde zich of de wet wel werd toegepast en/of dergelijke specifieke strafbaarstelling noodzakelijk is.

Het onderzoek in dit proefschrift heeft dit probleem onderzocht, op wetgevend vlak en op het niveau van de gezondheidszorg. De studies toonden aan dat, ondanks het bestaan van gespecialiseerde gezondheidszorg en richtlijnen, er nog altijd een gebrekkige kennis over VGV en zorg voor vrouwen met VGV bestaat. Daarenboven tonen recente ontwikkelingen aan dat er nog andere prioriteiten zijn die een antwoord verlangen: onduidelijkheid over reinfibrulatie, medicalisatie, cosmetische vaginale chirurgie en het uitvoeren van symbolische incisies. Het onderzoek naar de wetgeving en de studie bij de Vlaamse gynaecologen toonden duidelijk aan dat specifieke wetgevingen op dit vlak geen richting aangeven. Strafwetten t.o.v VGV, waarbij de toestemming van het meisje of de vrouw niet relevant is – zoals in België – kunnen eveneens een uitdaging betekenen voor het toepassen van de wet wanneer het gaat over vaginale cosmetische chirurgie.
Het onderzoek naar de wetgeving toonde aan dat er geen specifieke strafbaarstelling van VGV nodig is. Belangrijker is om er op toe te zien hoe de rapportering van gevallen kan worden verbeterd, en hoe voldoende bewijsmateriaal kan worden gevonden om tot een rechtsvervolging te kunnen overgaan. Daartoe dienen diegenen die gevallen kunnen detecteren (gezondheidszorg, onderwijzers, politie) voldoende geïnformeerd en getraind te worden om risicogevallen te kunnen vaststellen en vaststellingen te kunnen doen betreffende type I. Hoe dergelijke screening van meisjes moet gebeuren dient met een expertengroep te worden overlegd. Het opstellen van een inventaris en een analyse van de impact van de initiatieven ter preventie van VGV bij de betrokken gemeenschappen, als aanvulling op de gezondheidszorg en wetgeving zoals omschreven in deze dissertatie, zijn noodzakelijk omdat noch een wet, noch de gezondheidszorg de beoogde gedragsveranderingen tav VGV kunnen teweeg brengen.

Overleg over diverse aspecten van VGV op nationaal niveau dient in overweging te worden genomen, rekening houdend met de bestaande wetgeving en richtlijnen. Op Europees niveau zijn dergelijke overlegstructuren eveneens van belang. In Europa is reeds voldoende expertise aanwezig, maar gezien het gebrek aan samenhang tussen de diverse actoren stellen wij voor om een Europees kenniscentrum voor schadelijke traditionele praktijken op te richten, om samenwerking tussen alle actoren te bevorderen.