



**Dealing with Female Genital Mutilation/Cutting in
Western Europe:
Challenges of Achieving Zero Tolerance**

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Kisanet Abraha Seare
(Eritrea)

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Members of the examining committee:

Dr John Cameron
Dr Wendy Harcourt

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Inquiries:

Postal address: Institute of Social Studies
 P.O. Box 29776
 2502 LT The Hague
 The Netherlands

Location: Kortenaerkade 12
 2518 AX The Hague
 The Netherlands

Telephone: +31 70 426 0460

Fax: +31 70 426 0799

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List of Acronyms

FC	Female Circumcision
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation or Cutting
FORWARD	Foundation for Women's Research and Development
FSAN	The Federation of Somali Association in the Netherlands
IAC	Inter African Committee on Traditional Practices affecting the Health of Women and Children
INGO	International Non-Governmental Organizations
NGO	Non-Governmental Organizations
OHCHR	Office of the High Commissioner of Human Rights
UN	United Nations
UNFPA	United Nations Population Fund
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNECA	United Nations Economic Commission for Africa
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
WHO	World Health Organization

Abstract

This paper explores the potential challenges that could have contributed to the difficulty of achieving ‘Zero tolerance’ to FGM/C. In an attempt to answer the question the research looked at the language and representation of the initial campaigning, production of FGM/C and the reactions to the issue at a global level. Debates about the medicalization and criminalization of FGM/C are discussed in order to show the underlying contradictions and complexities of dealing with FGM/C. It also looked at the role and position of Anti-FGM/C NGO’s and their challenges regarding the practice. Information from a semi-structured interview with key informants working on anti-FGM/C organization is used to complement the analysis of selected secondary data. The research argues that the issue of FGM/C is caught in debates of polarized positions loaded with abstract meanings and has moved its focus from the ‘woman’ or the ‘girl’ in the practicing communities. It shows the tendency of the issue to be driven by the international community and hence its limitation in reaching the very communities it intends to change. It also highlights the lack of accuracy in basic the knowledge about prevalence of FGM/C.

Relevance to Development Studies

FGM/C had proven to be one of the highly difficult and controversial issues in development work. It is an issue situated within the universal human rights goal and included as one of the MDG’s (millennium development goals). Efforts to achieve ‘zero tolerance’ to FGM/C had proven difficult and understanding the reasons problem is half way to the solution. This research is a search for potential sources of challenges to the current efforts in an attempt to inform a better intervention in the future.

Keywords

Female Genital Mutilation/Cutting, Culture, Human rights, Medicalization, Criminalization, Action (Civil Movement)

Chapter 1 Introduction

1.1 What is FGM/C? Why is it important?

Female genital mutilation/cutting (FGM/C) is sometimes referred to as female genital cutting (FGC), female genital mutilation (FGM) or female circumcision (FC) (Population Reference Bureau, 2008). According to the joint WHO, UNICEF, UNFPA 1997 definition, FGM/C is a procedure involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons (WHO 2008). In 2008 a joint statement by WHO, OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNHCR, UNICEF and UNIFEM classified FGM/C into four broad categories:

1. **Clitoridectomy:** partial or total cutting of the clitoris
2. **Excision:** removal of the clitoris and partial or total cutting of the inner lip or labia minora
3. **Infibulation:** this type involves two of the above types as well as cutting of the labia majora. The lips are tied together so that the incisions would heal sealing and completely covering the urethra and narrowing the vaginal opening. Only a small opening is left for discharge of urine and menstrual blood.
4. **Unclassified:** this type involves different kinds of practices such as piercing, incising or even burning the clitoris, scraping or using harsh herbs to the vagina.

As a practice that affects between 100–140 million women and girls worldwide and an estimated more than 3 million girls at risk each year Female Genital Mutilation/ Cutting has gained increasing attention in the past three or four decades. It is a name given to the traditional practices pertaining the cutting, trimming, nicking, stitching etc. of the Female genitalia for various context and community specific reasons. FGM/C is practiced not only in Africa, some countries in the Middle East and communities in Asia and Latin America but also it has spread to and is being practiced in Europe among communities originating from countries where FGM/C practiced (Leye et al. 2007; Ending Female Genital Mutilation: 7)

Medical experts show that FGM/C as a practice is not only harmful to the health of young girls and women but could be fatal. It can result in both long term and short term negative physical and mental health problems. Since the tools used for performing the cutting are usually poorly sterilized there is a higher risk of infection and other health complications. Mental health issues among the girls who have undergone FGM/C may be the result of psychological terror, shock or extreme pain (Darr 1997). Moreover, writers on the issue believe that FGM/C has an impact in the girl's or woman's sexuality in some extremes presented as sexual castration or blinding (Bell, K. 2005: 130)

According to UNICEF (2005), the legally binding international human rights instruments-the 1979 Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the 1989 Convention on the Rights of the Child (CRC) especially urge state parties to take all appropriate and effective measure to end practices that jeopardize the wellbeing of women and children through articles 5 and 24 of both conventions respectively. FGM/C became a global development concern (UNFPA 2008) as it is impossible to achieve Millennium Development Goals (MDGs) which is a global commitment, especially goals 4 and 5 that are aimed at child mortality and improving maternal health, without addressing and abandoning FGM/C (UNICEF 2005). In 1994, Ghana became the first independent African nation to prohibit female genital mutilation. Many countries then followed Ghana's example and legislated laws banning female genital mutilation.

FGM/C in Western Europe

The practice of FGM/C found its way to Europe, with the influx of immigrants from practicing communities. There is no actual data about the prevalence of the practice of FGM/C in Europe (Leye 2005: 73). But estimates on the bases of National census data in Europe and extrapolation prevalence data from the country of origin, has been made. The European Parliament Estimates that there are around 500,000 women who have undergone FGM/C in Europe with another 180,000 women and girls at risk of being subjected to the practice each year (Leye et al. 2007; Ending Female Genital Mutilation: 7). This could give an indication of the prevalence but it is problematic in many ways. To say the very least it is an estimate built up on another estimate.

Unified actions and EU resolutions were conducted to combat the practice on the EU level. A unified action against the practice of FGM/C in Europe was first attempted in 1992, in a study conference conducted in the UK which was organized by FORWARD. This was followed by another conference in Sweden in 1998. In 2001, the European parliamentary committee on women's rights and equal opportunities developed a report on female genital mutilation including a resolution on FGM/C of the European parliament which was later approved by the European Parliament. The European parliament also included the issue of FGM/C in its international relations agenda regarding population and family planning (Leye 2005: 74-79)

FGM/C and "Culture"

Before discussing about "the cultural context" of FGM/C it is important to note "culture" in this research is defined as 'a relational phenomenon of individuals with in groups, among groups and within ideas and perspectives'. (Rao and Sanyal 2009: 7-8) The notion of culture is closely related with identity aspiration, symbolic change, communication, and structures and practices that serve relational ends (ibid). Language and context plays an integral part in understanding the communication, symbols, rituals, values and norms of a given culture. This section highlights the use of language to name the practice of FGM/C in selected communities, examples to highlight the difference in age under which the practice is performed, difference of meanings given to

FGM/C and the limitation of generalizing about a heterogeneous practice and the heterogeneous communities that give respective meanings and values to it.

Despite the presentation of FGM/C as a practice that falls in to four clear categories, FGM/C is in fact a practice that is highly heterogeneous. It is difficult to agree on a single cultural name for FGM/C given that it is practiced by at least twenty eight countries in Africa (more in the Middle East and parts of Asia) with in which different ethnicities and groups give different meaning and reasons for practicing FGM/C. The term "female genital mutilation" ("FGM") has been adopted by human rights activists in the West and, more recently, in Africa, both to emphasize the physical pain caused by the practices and to stress what some construe as the intentional infliction of harm' (Lewis 1995:7) In doing so it implies a deliberate act taken by the family to hurt or disable another member.

The name of the practice in the local language is not always circumcision but another name that indicates the significance and meaning of the practice in its context. Wairimũ Ngaruiya Njambi, a scholar who has undergone FGM/C as coming of age, stated that the phrase 'female circumcision' as a troubling western construct that erases the unique histories and meanings of the genital modifications in Africa to what is already understood as circumcision in the context of male circumcision(2004: 282). According to Zabuz 'words like excision, circumcision and infibulation are derived from Latin' hence not the name given to the actions in the societies within which it is taking place (2007: 10). In Sudan excision is called '*taour*' from Arabic word '*tabara*' meaning 'to purify' (Toubia 1999), in Igbo it is called '*Isa aru or Iwu aru*' meaning 'having a bath', in Bambara '*bolo koli*' meaning 'washing of one's hands' and in Sarakole '*salinde*' meaning 'the washing of one's hands to access prayer' (Zabuz 2007: 10).

Some of the practices usually categorized under FGM/C are performed on boys and girls at the same time and the same justification is given for practicing. For example as presented in the article by Lewis 'Jomo Kenyatta a pan-Africanist leader and anthropologist, introduced Western readers to the Kikuyu term "irua," which refers to the initiation of both boys and girls into adulthood. *Irua* rituals involved surgery as well as educational and socialization rites aimed at strengthening ethnic and sub-group identity' (1995:5). A chapter published under the title 'Kenyan Reactance' indicates that boys and girls of the same age range undergo a festival to indicate 'the coming of age' or a transition from childhood to adulthood. These rituals took weeks of preparation and are followed with about four months of rest, during which the participants of the ritual (boys and girls) transition to adulthood by shedding the behaviors related to childhood. The author further discusses how little the difference the two circumcisions had and how the interpretation of the missionaries had led not only to violence, for it posed a threat to the structure of the culture and the identity of what Kenyatta called 'the tribe' but also singled out FGM/C and problematized it (Zabuz 2007: 35-58).

To add more the WHO classification of the types of FGM/C categorizes a practice that doesn't involve cutting or 'mutilation', labia elongation, where a girl once she shows signs of puberty is encouraged by elder girls or a paternal aunt, who plays the role of a tutor to young girls and women in a wide range of

sexual matters, including pre-menarche practices, pre-marriage preparation, erotic instruction, to pull her labia minora using some herbs (Mwenda 2006: 346). Labia elongation is practiced in Uganda, Zimbabwe and South Africa (ibid) and it is believed to enhance sexual pleasure for both the men and the women.

It is difficult to speak of FGM/C and “culture” as it is more relevant to speak about FGM/C in the specific communities, to address the issue accurately and situate the right type of FGM/C in the right context. Since the congregation of diverse practices in one word (acronym) in combination with the absence of a functional and instrumental conceptualization of “culture” make it almost impossible to make a meaningful statement without generalizing. As many feminists of color have argued ‘cultural practices are a lot more complex than they originally appear to those outside the culture, and often need to be evaluated within the context of their own cultural and moral framework (Kalev 2004: 247).’ However, these cultures are composed of individuals who are situated within their own fluid notions of identity and not cultural beings frozen in time and space.

FGM/C and the identity of bodies on the move

The notion of Identity is a fluid concept and it can be given a range of meanings in the words of Brubaker, R. and F. Cooper (2000) ‘identity’ has become an overburdened term, riddled with ambiguity and riven by contradictory meanings. One way of looking at identity is in terms of belongingness to a group hence identity as a culture rooted on traditions and customs. Culture is not a monolithic and ahistorical phenomenon but is subject to change and negotiated with change in time and space. After recognizing culture as the best predictor of FGM/C prevalence, type and context is not nationality but ethnicity or membership in a culture, Hernlund and Shell-Duncan, go on to indicate that ‘national frontiers have indeed come to play an important role in whether and how FGM/C is practiced and with what consequences’(2007: 3).

Moreover there are more negotiations when communities are ‘uprooted’ and ‘transplanted’ in the process of transnational migration as ‘it often remains equally significant how you are positioned with the nation state - in urban or rural areas in a marriage with someone from the same or different ethnic group as yours surrounded by neighbors who do or do not practice FGC, in communities that have varying degrees of exposure to Anti-FGC campaigns, out-(and perhaps return-) migration, biomedical health care services, and contact with agents of the nation-state (ibid)’.

When bodies move through these different domains, they are subjected to regimes that intersect in varied and sometimes contradictory ways and negotiate their positions. Michelle Johnson cautions against falling in to the trap of assuming that values “at home” as “traditional” and values “in exile” with “change” (2007: 4) Immigrants with a strong value of chastity and virginity might be ‘surprised by what they perceive to be the flagrant sexual behavior’ and moral decay of the society may react with concern of their

children being influenced and look at FGM/C being more important as a reaction of the perceived “other”.

1.2 Research Problem and Research Question

The ‘Zero tolerance to FGM’ was declared on February 6 2003 by the Inter African Committee on Traditional Practices affecting the Health of Women and Children (IAC). The date was later adopted as UN-sponsored awareness day. Despite the efforts made to control and prevent FGM/C and criminalization of FGM/C for a decades the practice still persists. This research attempts to look at the aspects of the current approaches employed in Western Europe and the efforts made to reach the goal of ‘Zero tolerance to FGM’. This has been done in an effort to understand why the practice of FGM/C has proven difficult to eliminate. The study in particular addressed the following specific questions:

1. How has the global campaigns portrayed the practice of FGM/C?
2. Has medicalization of FGM/C been a practical option?
3. Is criminalization the best solution? Why not legalization? (discussing the French court cases)
4. What roles do NGO’s play and what the potential challenges are faced by the NGOs in balancing the demands of the practicing communities and the policies of laws regarding FGM/C?

1.3 Methodology

This research has used two methodological tools namely literature review and semi-structured interviews of key informants to collect the data used. The methodology of this research is more skewed towards secondary data analysis, but it also draws examples from the interviews. Different literatures including policy papers, research papers, journal articles and books written on the subject of FGM/C, majority of which were in English, but articles in French and Dutch were included as sources of secondary data. As the title indicates the scope of the research is limited to Western Europe, hence examples of approaches and debates pertinent to Western Europe selected, based on availability of information and it’s accessibility in terms of language barrier.

Even though the research refers to certain events from the earliest stage of advocacy against FGM/C is mainly focused on the time span between mid-1970s up to present. In order to find the needed information purposive, snowball sampling was used to recognize the informants for the second method, interviewing of key informants. This was done mainly to discover the network of bodies working on advocacy against FGM/C and how they work with each other. The informants were members of NGOs, a knowledge center for FGM in the Netherlands as well as foundation (*Stichting*) of (Eritrean)

immigrant women in Amsterdam namely, FORWARD¹, FSAN², No Game³ under Pharos and Ade a foundation in Amsterdam.

The research initially planned to include the voices of immigrant women who come from practicing communities through interviews and focus group discussions. This was not possible because the NGO that was meant to be used as an entry to the community had minimized its activities for lack of funding and most of the communities went home for the summer during which the fieldwork was planned.

This paper is an analysis of selected secondary documents and deconstruction of written texts. Interviews with selected organizations working with FGM/C among immigrants in Europe will be used as examples in an attempt to shed light in potential sources of challenges regarding the work of NGOs while dealing with FGM/C as an alien practice and is by no means representative and the full picture of the situation in Western Europe regarding the practice.

¹ FORWARD, Foundation for Women's Research and Development is an organization established in 1983 in the UK and has since been working for three decades in the issue of FGM/C and other harmful practices. It is an African diaspora women's charity that works with communities and organizations in the third world. FORWARD has been actively engaged in campaigning and lobbying against FGM/C in the UK and in the international arena. The key informant from the organization is the current Executive Director of FORWARD Ms Naana Otoo-Oyortey.

² The Federation of the Somali Associations in the Netherlands (FSAN) is a non-profit, non-political organization founded in the Netherlands in 1994 that aims to support and advises local Somali refugee organizations as well as Dutch institutions that work closely with Somali community in the Netherlands. FSAN has been working with African organizations in Sierra Leone, Ethiopia, Eritrea, and Sudan. FSAN was the national coordinator of the National Action Plan against FGM in the Netherlands, which is funded by the European Commission. Mrs Zahra Naleie a Program manager who has been working on the issue of FGM/C since 1994 and Mrs Abeba Gebremedhin, activist working in Rotterdam are among the key informants to the research.

³ PHAROs, Dutch National Knowledge and Advisory, is an independent organization that works to ensure the quality and effectiveness of health care for all citizens in the Netherlands. It serves as a knowledge center to improve the quality of health care for migrants and people with limited health literacy. Apart from complementing interventions and quality tools, PHAROs also works on promoting knowledge and awareness among professionals. No Game is an initiative of Pharos which has been co-financed by Kinderpostzegels (Children's Welfare Foundation). It is a group of young people who fight FGM by educating the youth. No Game works through peer education of young people (12 – 21 years old) in the Netherlands through interactive educational methods and websites that are frequented by youth. Jessica Hendriks, project coordinator of No Game is one of the Key informants to this research.

Reflexivity

As a young activist on the issue of FGM/C I wondered why it was hard to convince participants of a conference on the disadvantages of the practice. Being a graduate with formal education it is easier for me to understand the health problems, sexual deprivation and the rights of women and children than to put myself in the life of a woman whose perception of wholeness and maturity is tied to the excision of a body part and whose life is embedded in a culture that rewards and/or punishes her actions. While writing this paper it has become evident to me how the body of a woman has become the discursive battle ground of the “modern” and “the traditional”.

My first intention was to study the voice of this woman who is caught in between two mega bodies who claim to speak on her behalf while she is the one who is going through the day to day pressures of dealing with the practice. I had planned internship with FSAN (The Federation of Somali Association in the Netherlands), an organization in awareness creation among immigrants from Eritrea, Ethiopia, Sudan, and Somalia, as an entry to the practicing community. However, activities of the NGO have ended by the time my field work for the lack of funding. Since it is difficult if not impossible to gain trust of the practicing communities with the criminalization of FGM/C in the Netherlands and in their country of origin and there is little time to create rapport along with the language barrier. Hence the research has shifted more towards analysis of secondary data and interview of NGOs and foundations concerned and working with FGM/C. Even though many say that FGM/C has become a discussable subject, it appears as if people are saying what they think is appropriate to say but acting on what they believe should be done.

Writing this research was a struggle between two viewpoints where, as a woman a professional positioned from a western perspective and gazing at the practice I share the concern of the physical, emotional and sexual wellbeing of the women to endure the pain of being cut anywhere unless it is needed for survival (which in my opinion includes breast implants and augmentation, plastic surgeries). At the same time as a member of the practicing community, born and raised in a country with 89% practice of FGM/C for more than 25 years, despite being positioned as the educated elite, the global discourse about FGM is difficult to relate to the reality I know. Since the discourse of FGM/C has a tendency of categorizing opinions in to conservative and liberal, cultural relativist and Euro centric human rights and other dualisms, I found my own opinions switching from side to side. In this sense, my personal reflexivity is mirrored in the conclusions revealed by this research.

It is always easier to sit on the sidelines and find problems in what work is being done than to engage in the actual work, but it is a necessary evil to often take time and evaluate what has been going wrong. I may come out as someone who is finding faults in this work, but that doesn't mean that I don't acknowledge the work that has been done on eradicating FGM/C so far.

1.4 Organization of the paper

This paper is organized in such a way that it shows a bird's eye view of the decades of activism and the knowledge base upon which the issue of FGM/C is situated. This will be introduced through chapter two in which the global reactions, debates, and power struggles have been presented in a summary. Chapters three and four raise two of the major approaches, namely medicalization and criminalization of FGM/C and discuss in detail about their pros and cons within a Western European setting. Last but not least, chapter five discusses about the role of NGOs and civil society in dealing with the issue of FGM/C. Chapter six draws the findings and the previous chapters together into an overall conclusion. The concepts that are relevant to the discussion are developed within each chapter.

Chapter 2 Global Reactions to the practice of FGM/C

This chapter looks at the rough picture of how the issue of FGM/C has become an international issue and how it is situated within a contested ground in the international arena. It presents a general idea from the literature about the beginning of advocacy against FGM/C, who the first advocates were, how they acquired the knowledge about FGM/C, what reactions it brought in the latter years and how that influences the current knowledge about FGM/C. It also attempted to shed light on the major debates on the issue of FGM/C and the implications of the way they have been resolved. It finally shows how the international approach and understanding about FGM/C is communicated to the national policies.

2.1 Historical background of advocating against FGM/C and the role of NGOs

According to Tubia and Rahman the advocacy against the practice of FGM/C goes back to the early 1900 when missionaries attempted to stop the practice in countries such as Burkina Faso, Kenya and Sudan only to provoke anger from the communities (2000:9). Apart from anthropological accounts on practices involving the cutting of the female genitalia, the arrival of the European missionaries in the early 20th century was the earliest contestations between the missionaries and African leaders over the rite and FGM/C was at the core of the contestation (Joshua 2009). The missionaries perceived the practice as brutal, oppressive, barbaric and primitive. It was medically and hygienically undesirable.

Assuming that the church is responsible for intervening, the missionaries along with other influential European Agencies, pro-African bodies and government Educational and medical authorities attacked the practice. The African leaders hit back strongly thinking that this attack was cultural imperialism (ibid). The laws passed by the Egyptian and Sudanese government in the 1940s and 50s were faced by a similar fate since they were based on little information and there was inadequate campaigns and outreach. As an example passing laws and attempting to enforce them was faced with serious backlashes from the practicing communities. Giuliani states some examples of reactions towards the passing of a law against FGM/C namely mass circumcision of girls, circumcising girls at younger age, driving the practice underground and limited change in attitude towards the practice of FGM/C. (2006: 42-43)

Although the UN has a strong stand against the practice of FGM/C now it was slow to come to that stage the reason being lack of adequate awareness about the gravity of the issue at the beginning. FGM/C first appeared on the agenda of the United Nations in 1948 with in the context of the universal declaration of Human rights and was regarded as a harmful traditional practice in the 1970s and 1980s. Once it was recognized however, FGM/C was considered a major human rights abuse and conferences were held and

discussions were open to the topic. Despite the contradiction with the cultural, minority and religious rights the practice was banned at the international and national level. (Giuliani 2006: 17) In 1981 Article 5 of the United Nations Convention on the Elimination of all forms of Discrimination against women (CEDAW), requiring States to work toward the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the supremacy of either of the sexes came force. (Giuliani 2006: 19) The representatives, mainly European, did not understand the deep cultural roots of the practice and were hence unprepared for the resistance they got from the African countries with the exception of Somalia and other east African countries.⁴

The resistance to the abolition of the practice was still alive, as expressed in Toubia and Rahman's words, 'Despite [the] historical triumphs of women's advocates to stop all forms of FC/FGM, their efforts are still repeatedly undermined by the attempts of the medical community in Africa and the west to medicalize the practice' (2000: 10). In 1979 the first, WHO sponsored seminar on Harmful Traditional Practices Affecting the Health of Women and Children, was held in Khartoum (Sudan). During this seminar the proposal by the medical sector to replace FGM/C with a milder form of cutting under the supervision of medical experts and the hygienic medical setting was rejected.

In 1980 four African women activists attended the UN Mid-Decade conference on Women and the NGO Forum in Copenhagen to present a panel discussion on female circumcision. In that conference, the conflict between the approaches of indigenous African women to stop the practice and those of outsiders was apparent (Toubia and Rahman 2000: 10). After these first rounds of the conferences it was clear that discussing the topic was sensitive and that immediate abolition was impossible. Up to this point it was addressed as Female Circumcision rather than Female genital Mutilation and the efforts of dealing with the practice shifted to funding local efforts to train health professionals and educate the general public.

There has been considerations on the effectiveness of criminalizing FGM/C that was trapped between providing backing for those who decided to stop the practice and creating deterrent of practicing FGM/C; and driving the practice underground and creating backlashes. 'Efforts to criminalize such a cultural practice have proven to be largely unenforceable since they run against a social more and the majority of the population would qualify as a "criminal" under such a law (Giuliani 2006: 41)'. In fact most African countries were hesitant to criminalize the practice for their own particular reasons, until the push from the international community could not be resisted.

The United Nations passed a legislation linking foreign aid to anti-FGC policies in the mid-1990s and developing countries were expected to develop policies to eliminate the practice or face reductions in foreign aid from the International Monetary Fund and World Bank (Boyle 2005: 42). Since the 1990s, a number of African countries have passed legislation banning FGM/C, among

⁴ <http://www.ednahospital.org/hospital-mission/female-genital-mutilation/>

them Egypt (2008), Ethiopia (2004), Burkina Faso (1996), Côte D'Ivoire (1998), Eritrea (2007), Djibouti (1995), Ghana (1994), Guinea (2000), Kenya (2001), Senegal (1999), South Africa (2005) and Tanzania (1998), Togo (1998) and Central African Republic (1996). Accordingly, violations in these countries are punishable by law (Ministry for Economic Cooperation and Development: Sectorial and Supra-regional Project Ending Female Genital mutilation 2009). This could be correlated with the linking of aid to reform efforts by the IMF and World Bank (with impetus from the United States) in the mid-1990s (Boyle 2005: 4).

As a result of the Copenhagen conference an informal African network was established to address the FGM/C which became one of the oldest grassroots NGOs in the field is the Inter African committee on traditional practices (AIC) it was founded in 1984⁵ after a group of women organized a meeting of African NGOs in Dakar, Senegal (Toubia and Rahman 2000: 10). Governments were lobbied to place policies to tackle the practice and implement them.

NGOs and women's organization from the North namely FORWARD (Foundation for Women's Health, Research and Development) have played a major role in bringing the issue to international agenda even during times when it was still sensitive and highly politicized⁶. 'As a direct outcome of FORWARD's intervention, the UNHRC appointed a Special Rapporteur on FGM/C and Harmful Traditional Practices that led to increased international recognition of FGM/C as a human rights issue. Another important outcome from the intervention at the UNHRC was that for the first time the World Health Organization issued a statement against the medicalization of FGM/C (ibid)'.

FGM/C is now directly related to the Millennium Development Goals namely gender equality, reducing child mortality and improve maternal health. It is tied to the aid conditionality from US where African countries are required to report status of FGM/C activities beginning 1994 (Hernlund and Shell-Duncan 2007: 40). The United Nations General Assembly Special Session's outcome document in 2002 explicitly calls for ending FGM/C by 2010 (Giuliani 2006: 26)

2.2 Universal human rights versus cultural relativism: The war of the Titans

In the debate, as termed in Chantal Zabus's book between rites and rights the clash of Titans, between the Universal human rights and the Cultural relativist (2007: 3, 198) FGM/C is considered by many scholars as the test case on the limits of the Cultural relativism and it is placed along with groups such as

⁵ <http://www.global-alliance-fgm.org/Partners.aspx>
http://www.iac-ciaf.net/index.php?option=com_content&view=article&id=25&Itemid=28

⁶ <http://www.forwarduk.org.uk/about/achievements>

political execution, genocide and honor killings as situations that cultural relativism cannot defend (Hernlund and Shell Duncan 2007: 7).

Universal human rights advocates locate FGM/C as a more universal patriarchal oppression of women and they view the arguments presented by the cultural relativists that the practice is deeply embedded in the cultures where they are found as an apologetic approach to the issue (Frazer 1997). Cultural relativists on the other hand argue that feminism and human rights are all from the metropolis and universal human rights are not as universal as they are argued to be but rather means import imperialist and western concepts and values. Hence, according to Frazer those who condemned FGM/C are seen as Eurocentric and perpetuating colonial culture in disguise (1997: 319). Frazer then goes on to give his own opinion by criticizing both approaches for seeing culture as something that is ahistorical and as a static social structure which can be 'encapsulated, recapitulated and circumscribed in an equally static and non-contingent discourse' (Frazer 1997: 320).

According to Lewis with in the human rights approach to the practice there is tension between the individual rights hence the wellbeing of the woman or child and community rights (1995:41). A human rights, women's rights or child rights approach to FGM/C is a purely individualistic approach to the issue. The practice of FGM/C on the other hand is deeply rooted in most of the practicing societies and has a strong meaning attached to it, hence efforts to eliminate or discourage the practice has been faced with challenges and reactions from the society. The classification of FGM/C as an international human rights violation has been a subject of ongoing debate. Despite the claim made on the side of those who see it as a violation of the universal human rights as a clear violation of human rights, leading legal scholars have reported that application of UN conventions to the case of FGM/C has been found to be problematic (Shell-Duncan and Hernlund 2007: 11-12).

As an example '[s]imply referring to the assertion in the UNDRC that every child has the right to "develop ... in a normal Manner" becomes challenging to in cultural contexts in which being circumcised is to develop in a "normal" manner' (Shell-Duncan and Hernlund 2007: 26). To add more 'according the convention on the rights of the child, children have the right to practice their culture under the article 30 as well as a right against traditions prejudicial to their health under article 24(3)', which makes it difficult to decide 'when parents right the exercise their culture over weighs the child's right to protection from the culture' (Renteln 2002: 5 as cited in Shell-Duncan and Hernlund 2007:27)

2.3 WHO and Medicalization

The WHO was first asked to study FGM/C by UNESCO and African women attending a U.N. Seminar in Addis Ababa in 1958 and 1961 respectively but WHO refused for the reason that FGM/C is outside the scope of the organization because it is a social and cultural issue rather than a medical issue (Boyle 2005: 41). In her analysis of changing institutional principles Boyle, looks at '[s]witchbacks and reversals' in the story of addressing FGM/C in the

international arena and shows how 'key arguments that were rejected at one period had reappeared and persuaded in the later periods' (ibid)

The descriptions and arguments presented by Anthropologists and western women's organizations despite their good intentions to help the African women who opposed the practice and bring the issue in to the attention of the INGOs, had offended many women from the practicing communities. This was most explicit when African women in the international women's conference in Copenhagen in 1980 reacted to the anti-FGM/C calling it ethnocentric and insensitive to African women (Kouba and Muasher 1985 in Boyle 2005: 47). Despite the criticisms the feminist discourse on FGM/C caught the attention of the global community but when the INGOs intervened they did not use the feminists arguments explicitly. Instead it was clustered under the category of 'Traditional Practices Affecting the Health of Women and Children' and became a health issue for medicine was seen as neutral and apolitical (Boyle 2005: 49). This has helped to break the impasse between the "African women" and the "Western women" in the Copenhagen conference and became universal interventions that leaks though national autonomy.

According to Boyle medicalization of FGM/C has been successful in creating awareness about the health problems related to the practice and in many places it had become a practice that is done in a medical setting and in many other places the use of antiseptics became common while performing the ritual of circumcision. Despite the relative success of medicalization in terms of response from many practicing communities, the mobilization about the issue of FGM/C had increased and eventually shifted in to a human rights perspective. (Boyle 2005: 49 - 54) In 1995 a joint statement of WHO, UNICEF, UNFPA, and UNDP labeled the medical basis for anti-FGC policies inappropriate since medical information was far too exaggerated and hence not credible on the local settings. The statement also added that medicalization was counterproductive because in reducing the health problems resulting from FGM/C it has also the tendency to reduce the urgency of eliminating the practice (Shell-Duncan 2000: 111; Boyle 2005: 55).

2.4 FGM/C the United Nations (UN) and the European Union (EU)

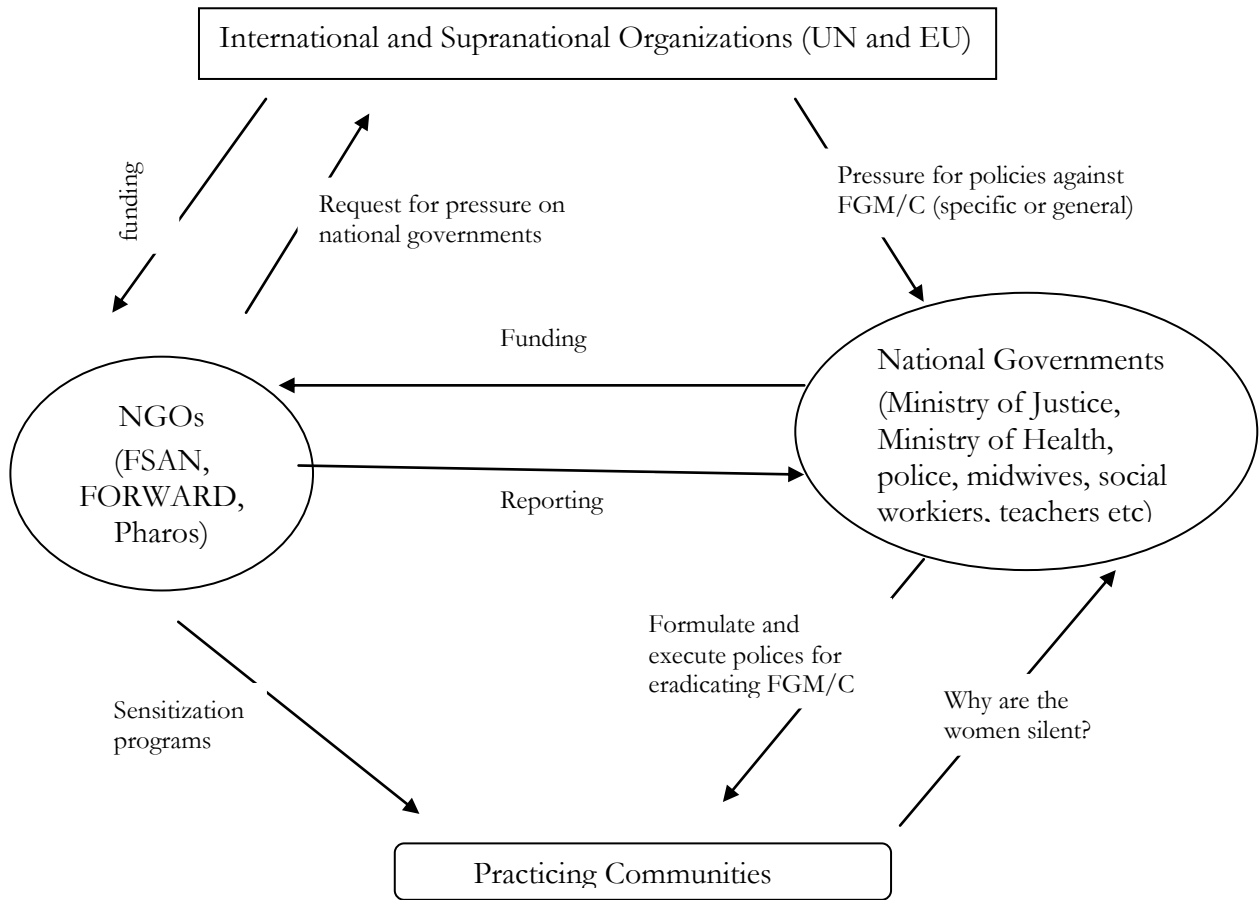


Fig. 2.1 Overview of relationships between different bodies while dealing with FGM/C

The above diagram shows how the bodies responsible for FGM/C in Western Europe work and interact with each other. From the above image one can clearly see that there is a strong interaction between the national and international governmental and non-governmental institutions. It can be observed that the international organizations tend to be strong actors in addressing the issue of FGM/C especially in exerting pressure on local governments where they fail to comply with the procedures and approaches on local governments where they fail to comply. Leye and Sabbe observed a similar pattern on how Western European countries were urged to introduce specific laws addressing FGM/C by the European Council in the resolution of 2001 and 2008 (2009: 7) and majority of the countries that introduced specific legal provisions in Europe have done so between 2001 and 2008 (ibid). Moreover, as discussed above a similar pattern is indicated by Boyle (2005: 77-79) on a global level where many African governments who were hesitating to introduce policies against FGM/C had introduced them following the US legislation that tied FGM/C with aid from IMF and World Bank.

In an attempt to find the responses of the practicing communities to the campaigning, legislations and discourses, I have discovered that the practicing communities appear to have been silent listeners especially in the context of Western Europe. In the Netherlands the discussion appears to resonate around the technicalities of the legislation and the medical interventions than on understanding the view point and perspective of the practicing communities.

2.5 Reflections

The issue of FGM/C had been generalized in a manner that has detached the practice from the original cultural and social meaning of the practice making it prone to different interpretations and meanings that have little relation to the practicing communities. After the impasse of the debate between the cultural relativists and universal human rights perspectives on FGM/C the issue of FGM/C appears to have conveniently shifted to the 'neutral' health perspective avoiding the arguments of the cultural relativist and hence a middle ground to the debate. The health approach was important for legitimizing intervention since nobody dares to counter the argument presented in a medical language. Yet this could not be sustained for long since practicing communities are well aware of the health hazards of the practice and still think it is worth risking it in the light of the social and cultural importance of the practice (Boyle 2005: 13). The interesting switch back from WHO after calling the medical intervention a 'mistake' and shifting back to the Universal human rights perspective or women's rights as human rights as 'the right' way to address the issue of FGM/C seems to have systematically avoided the cultural relativistic perspectives while dealing with FGM/C on a global level and hence the cultural and social aspect.

Chapter 3 Medicalization: Is it helpful?

In 1992 in a refugee camp in Alkmaar in the Netherlands a group of Somali refugees asked an honest question to the medical personnel in the refugee camp saying “where can we take our girls to be circumcised?” A doctor and a nurse by the name Bartels and Haaijer⁷ made a research about the meaning and effects of female circumcision and proposed the medicalization of the practice. In other words, they proposed for an approach that allows and provides a non-mutilating symbolic practice in a safe and clean environment for circumcision (Bartels 2004 as cited by Hendriks 2010: 24). This had provoked one of the first public debates⁸ about FGM/C in the Netherlands, with a reaction that voiced against medicalization. Followed by a second debate in 2008, when an article in a medical magazine was published, in which a Dutch physician highlighted the advantages of medicalization the practice (Mulder 2008 as cited by Hendriks 2010: 24).

3.1 What do we mean by medicalization?

There is an increasing tendency to define areas of life in terms of health illness to mention alcoholism, sexual dysfunction, obesity, anorexia and other eating disorders have shifted from being social or behavioral problems to being defined using medical terms. Among the earliest attempts to define medicalization is one given by Conrad (Davis 2006; Halfmann 2011) whose definition has become fairly standard in the medicalization literature (Davis 2006: 53). He explained medicalization as ‘defining behavior as medical problem or illness and mandating or licensing the medical profession to provide some sort of treatment for it.’(1975: 12 as quoted in Halfmann 2011: 201).

According to Conrad medicalization can occur at least in three levels namely conceptual, institutional and interactional level where a given social problem or behavior is defined using medical vocabulary or model; a medical approach is adopted for the treatment of the medically defined problem and where doctors diagnose the problem and gives a medical form of treatment respectively (Davis 2006: 53; Halfmann 2011: 187).

Critics of the increasing medicalization were inspired by the work of Talcott Parsons and labeling theory who was one of the first to conceptualize

⁷ This information is drawn from one on my interviews with Zahra Naleie program coordinator of FSAN and has been cross checked against a Master Thesis (in English) and some publications from the public debates of that time and translated by my discussant Hedda Van Heijzen who is a native speaker of the Dutch language.

⁸ FORWARD an organization working with FGM/C in the UK which will be discussed in detail later in this paper has taken the position against medicalization and participated in the debate in the Netherlands.

<http://www.forwarduk.org.uk/about/achievements>

medicine as an institution of social control. The medical institution possesses a strong legitimating power and as Zola and Freidson, and ‘many others before them saw medicine as a moral enterprise whose judgments of desirable and undesirable behavior lay behind a scientist facade of objectiveness that makes those judgments invisible and difficult to challenge’(Conrad 1992: 210). Hence if medicalization has extended the jurisdiction of the medicine beyond what is its original position (legitimate mandate) of ordinary organic disease and established successful methods of treatment (Davis 2006: 52) it has extended the exercise of its power to justify intervention in other spheres of life.

3.2 Defining FGM/C as health problem using medical words

As discussed in the first chapter, when answering the question ‘what is FGM/C?’ the first account that follows the description of the four types of FGM/C according to WHO’s classification is the explanation about the physical, social and psychological health effects of the practice. The initial reaction to the issue of FGM/C has been looking at it as a source of a number of health problems before it was raised as a human rights problem. Hence the practice is defined in medical terms.

Despite the justifications given on the bases of medical arguments about the effects of FGM/C, the justification given about FGM/C as a practice against the right to health appears to be in a questionable place. Many writers (Shell-Duncan and Hernlund 2000; Obermeyer 1999; van der Kwaak 1992) agree that, the knowledge production about FGM/C has been ‘polemical, preachy advocacy driven and endlessly self-referential’ with little or no critique (Boddy 2007:53). To add more, unlike what is commonly stated, an attempt to synthesize data on the nature and frequency of complications caused by the practice, it was discovered that the complications. This finding had ignited public outrage (Carla Obermeyer 1999: 91-2 in Shell-Duncan 2001: 1016).

3.3 FGM/C and attempts of including it in the medical institution

Medicalization is heavily debated between abolitionists, those who categorically oppose all kinds of FGM/C and advocates of medicalization. The former argues that medicalization would counteract to efforts to completely eliminate the practice whereas advocates of medicalization claim that there is no empirical link shown between medicalization and its negative effect on elimination of the practice. Abolitionists in turn point out a weakness of the medicalization approach since there is no empirical evidence that medicalization would have a positive effect on the elimination of FGM/C either (Shell-Duncan 2001; Leye et al 2006: 367-8). Moreover abolitionists argue saying that it is unethical for a medical practitioner to harm a healthy tissue in accordance to one of the most important professional health ethics, but this argument contradicts with many practices of plastic surgery and the practice of male circumcision (ibid).

The medicalization of FGM/C was first raised with the intention of protecting the health of girls and women by providing a cleaner and safe environment to undergo the practice and at the same time reduce the intensity or severity of the cutting. This can be done through the provision of the least harmful type of FGM/C in hospitals by trained personnel, using sterile razors, anesthesia and disinfectants. Despite the fact that health consequences of FGM/C are the main reason the practice is resisted measures to improve the health risks of the women are strongly opposed. As Duncan rightly argued the impact of these interventions in improving the health of women has been given little attention instead it was met with strong criticisms (Shell-Duncan 2001: 1014).

Studies also show that medicalization by training traditional birth attendants about the impacts of severe forms (Type II, III, and IV) of FGM/C and providing them with medical provisions such as antibiotics, anesthesia to perform the least harmful form of FGM/C has given different results in different places. Medicalization has been attempted in Sudan and Somalia and it resulted in the replacement of more radical forms of FGM/C in Somalia whereas in Sudan it only led to the renaming of the practice rather than the shift to milder forms of FGM/C (Gruenbaum, 1982 in Shell-Duncan 2001:1019). According to Shell-Duncan it has become common during the late 1990's in many African countries including Djibuti, Nigeria, Mali, and Kenya to see medical personnel performing the cutting with or without the government adopting medicalization as an intervention against FGM/C (ibid). In the western countries, in the Netherlands, in a hospital in Seattle⁹ (Coleman1998) Germany and Italy attempts to adopt medicalization of FGM/C has been proposed only to be met by public protest and disapproval (Leye et al 2006: 367-8). It can be observed that medicalization is resisted less in societies where FGM/C is practiced among the majority (African countries) as compared to countries where it is practiced among the minority (immigrants).

⁹ Sometimes called the 'Seattle compromise' by some authors where a group of immigrants in Seattle were to be allowed to have their daughters symbolically circumcised by a state hospital with a procedure that would have no tissue removal or scarring which according to advocates of the cause would have prevented immigrants from seeking their daughters from being cut in the traditional way. This was met with surprising reactions from feminists, assimilationist and others. However some scholars say that it was one of the most successful compromises of the collision of cultural values.

http://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=1024&context=dlj&seir edir=1&referer=http%3A%2F%2Fwww.google.co.uk%2Fsearch%3Fclient%3Dsafari%26rls%3Den%26q%3D%2522seattle%2Bcompromise%2522%26ie%3DUTF-8%26oe%3DUTF-8%26redir_esc%3D%26ei%3DtuyxT97_A46p8QO-m6GICQ#search=%22seattle%20compromise%22

3.4 Providing services for already circumcised

Medical institutions are also challenged by the question of how to treat the needs of women, who have already been affected by FGM/C. Among these issues are subjects as controversial as reinfibulation and equipping medical personnel with skills in handling these women with sensitivity and care. Personal emotions and feelings, fear or ignorance or in more general terms attitude to and knowledge about other cultures of health care professionals has an important impact on the quality of services they provide to affected individuals, especially for women with FGM/C (Nienhuis and Haaijer 1995 in Leye et al 2006: 373). Many European countries have introduced guidelines and procedures of pre and post natal care and treatment as well as safe delivery of women who have undergone FGM/C especially the more severe types (Thierfelder 2005; Leye et al 2006). They are also working or increasing the awareness of medical practitioners who have close relations with immigrant women affected with FGM/C.

A study conducted in Switzerland in 2005 has shown that due to lack of specific guidelines regulating the practice of FGM/C, medical providers Switzerland, unlike other countries who have established guidelines namely UK, Germany, Denmark, Netherlands, Belgium and Sweden, are faced with difficult decisions that they have to solve based on their own personal judgments. These include decisions of how to respond when requested for reinfibulation by a woman who has been defibulated for delivery or even what to do when cases of women who have been infibulated come to the hospital in order to react in a culturally sensitive and understanding manner (Thierfelder 2005).

To make matters more complicated for the medical personnel there seems to be a tendency to single out FGM/C as an oppressive practice while allowing similar practices to be done in the hospital. Female genital plastic surgery, a practice that includes procedures such as labia reduction, vaginal tightening, clitoral unhooding, G-spot' collagen injections for purposes of beautifying the vulva and increasing sexual responsiveness (Tiefer 2008: 467) is technically the same practice as FGM/C only done in a medical setting with some seemingly medical justification. Even though feminist scholars have taken a stand against oppressive sexual beauty standards their position to surgery on beauty has been divided as their positions are about pornography and sex work. Some saying it is a choice and women have the right to choose whatever they want to do with their bodies, hence a form of agency while others say that it is a choice with in a context of 'prevailing commercial conditions' (Tiefer 2008: 474), thus a suspicious if not a critical view of promoting surgeries and other medical interventions justified under the rhetoric of "women deserve the choice" (ibid).

3.5 Reflections

In an attempt to look at the issue of FGM/C and its medicalization from the view point view of the levels of medicalization according to the work of Conrad, FGM/C seems to have been partially medicalized at conceptual level since it is consequences and health impacts are defined in medical terms and as an issue it is addressed by the WHO. Hence at the discursive level FGM/C has

been medicalized. However, attempts to include FGM/C under the treatment of medical institutions has been resisted on the bases that it is not an issue of an illness for organic causes but an impact of human behavior and culture which can be changed otherwise. This resistance despite its contradiction with inclusion of problems resulting from human behavior and way of life such as alcoholism, conceptions of beauty and eating disorders has been successful in excluding FGM/C from being medicalized at the institutional level and WHO has announced that any forms of FGM/C should not be practiced in medical institutions.

At the interactional level of medicalization, medical personnel are to be given training on how to understand women and girls who have undergone the practice and what kinds of special treatments should be given to them. This becomes problematic when the one moves from the theoretical debates to the day to day practices of the laws and guidelines concerning FGM/C in a medical setting. It becomes especially difficult in the west to draw the line on where the practice of FGM/C and genital cosmetic surgeries are different if it involves un-hooding the clitoris or tightening the vagina and the distinguishing factor falls to the race of the woman. As Essen and Johnsdotter rightly pointed out, while genital alterations in a 'non-African women' are widely accepted in Scandinavia, African women are seen as the potential perpetrators of the practice or trapped in a primitive culture and hence the need for a clear guidelines for gynecologists and plastic surgeons avoid discrimination (2004 as cited in Hendriks 2010: 25).

Medicalization appears to be a less judgmental and hence less polarized approach to eliminating FGM/C. Even if the proposition to medicalize FGM/C had a promising aspect in terms of finding a common ground between two major rivals in the issues. Studies about the outcomes of medicalizing FGM/C made contradicting claims, some saying it was helpful to minimize the harm on the 'victims' without provoking reactions from communities where as others saying it had not changed anything. Despite the different opinions the medicalization of FGM/C remains to be the proposal for the intervention of FGM/C with the least reaction from practicing communities.

Chapter 4 Criminalization of FGM/C

This chapter discusses the legal procedures that are in place in the Western countries and the complication of criminalizing FGM/C. Furthermore, including FGM/C under the child protection laws and the contradiction of reporting and the professional secrecy provisions is also discussed in brief. It also attempts to highlight the elements that make reporting conducive and potential impediments to effective reporting of FGM/C.

4.1 What are the legal procedures available to combat FGM/C?

In Europe the Practice of FGM/C has been punishable by law since as early as 1985. Vast majority of the European countries have general criminal law under which FGM/C is punished while some have specific laws to punish the practice. Lately European countries were urged by the European parliament to adopt specific rules that make FGM/C punishable by law. By 2009 ten of the EU countries namely Austria, Belgium, Cyprus, Denmark, Italy, Norway, Portugal, Spain, Sweden and the UK have adopted specific criminal provisions to deal with FGM/C (Leye and Sabbe 2009: 3).

Moreover, to avoid girls from being taken abroad during their summer holiday and being circumcised many European countries with the exception of Ireland, Luxemburg and Greece have introduced a principle of extraterritoriality in to the law which makes it possible to persecute the practice of FGM/C when it is committed outside the country. Extraterritoriality can differ in application based on the nationality or residence of the victim or the perpetrator or the legalization of the practice in the county where it was committed. 'Often, either the offender or victim - or both - must be a citizen or at least a resident of the European country, and sometimes FGM/C must also be considered an offence in the country where the crime was committed (double incrimination)' (Leye and Sabbe 2009: 3).

4.2 Child protection laws and professional secrecy provisions

Child protection laws exist in all member states and FGM/C is considered as a form of child abuse. Hence in situations where a girl child is at risk of FGM/C then the child protection laws are applicable for the protection of the child. These laws can range from voluntary such as hearings with the family, providing information, counseling and warning to the family; or compulsory measures namely removing the child from the family or suspending parental authority which are subject to court permission.

In the UK there is specific child protection procedure for the practice of FGM/C on how professionals could work together to protect a child at risk of FGM/C (Leye and Sabbe 2009: 4; Leye et al 2007:8). A protocol for discussing FGM/C (Gesperksprotocol) was also developed in 2005, in the Netherlands to prevent the practice. As part of the Youth Health Service, children until they

are 19 years old have regular checkups and screening monitoring their development. Giving necessary information and advice is one of the services offered by the Youth Health Service. The above mentioned 'protocol is a guideline for health workers in the Youth Health Service to raise the subject and hold a structured conversation with the parents of the girl and the girl as well' in an attempt to bring behavioral change through regular conversations and discussion (Leye and Sabbe 2009: 4).

Child protection can also be enhanced through creating awareness about the signs of child abuse in general and FGM/C in particular among the professionals who have direct contact with those at risk namely teachers, social workers and medical personnel. This can help better reporting possibilities. However, European countries are divided when it comes to deciding on whether to make reporting an obligation or an option for professionals who have direct contact with the practicing communities. Some countries including Belgium Ireland, Germany and The Netherlands have said that it is an option for doctors, teachers and social workers to report with the justification that a professional especially a medical professional have the responsibility to not disclose the personal information of his/her clients. In other countries however at least one of the three type professionals have an obligation to report to authorities in others even citizens have an obligation to report it to them (Leye et al 2007: 15).

4.3 Cases of FGM/C taken to court in France

Case 1

In July 1982 a three month old baby born on French soil, Bobo Traore, had died of severe hemorrhage following her clitoridectomy. Her parents hesitated to bring her to hospital for they were fully aware that the practice was illegal and not a drop of blood was on the baby's body by the time she got to the hospital. Following this incident doctors were required to report and evidences that indicated a possibility of 'mutilation' as they would any other form of abuse. The professional secrecy has been absolved. (Weil-Curiel 2001: 191)

Case 2

An article at the website of an organization by the name ¹⁰*MGF Toscana: Progetto per the mgf nella Prevenzione delle Rgione Toscana* indicated that a family of four girls who have imposed on their daughters to undergo female circumcision has been convicted in the tribunal of Nevers, central France. It first came to the attention of the French authorities after a doctor noticed that the eldest daughter of the couple has undergone excision during an appendicitis operation in September 2005 and reported it. During the

¹⁰ <http://www.mgftoscana.it/2012/06/03/in-francia-condannati-i-genitori-di-4-figlie-per-aver-praticato-su-di-loro-mgf/?lang=fr>

investigation for the first report it was discovered the second daughter of the family has also suffered the same fate while the two youngest had been spared. The couple was sentenced for 18 – 24 months in prison. However, three and a half years later, the couple came back to the hospital emergency room with their seven year old child, in January 8, 2009, with significant vaginal bleeding which was reported by the doctors as an attempt of excision. The two eldest girls who said that they do not recall anything about the cutting of their genitals in 2005 and these girls who were 18 and 20 years old at that time decided to publicly defend the actions of their parents in 2009.

Case 3

A young woman reported that her three younger sisters and she were excised and that she feared that her younger sisters would be forced to marry. Moreover she also revealed the name of the excisor that cut her and her sisters. After investigation the excisor was arrested in 1994 and was brought to court in February 1999. After seizing the electronic address book of the excisor 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 €' (Leye et al 2007: 17).

Incidents of contact along with overall efforts of creating awareness and including FGM/C as a crime has brought the cases to the attention of the court in France. Even though cases were brought to court and punished there were cases of parents repeating 'crime' on their younger daughters as in case two. To add more on the observation of the three cases presented above, none of the cases brought in to the attention of authorities were initially brought with the intention reporting FGM/C. Could this be pointing to an aspect of the issue that has not been addressed properly or not addressed at all?

4.4 Reporting of FGM/C cases

The reporting of FGM/C cases varies from country to another in Europe ranging from those who did not have any cases reported namely Belgium, Cyprus and Italy to those countries such as France which has 37 cases reported and persecuted in the court. Some of the patterns could be observed about which approach is more likely to be better in bringing about effective implementation and number of reporting. There are however additional variables that could impede the implementation of the law.

According to Leye and Sabbe, the amount of reports FGM/C does not necessarily depend on the type of criminal law, whether general or specific, of a country only but also on factors such as efforts to raise awareness among the general population and the professionals that have direct contact with communities from risk countries (2009:7). European Parliament Resolution of

March 24th 2009 on combating FGM/C in EU emphasized the importance of creating awareness as a factor for successful reporting of the practice. Leye and Sabbe conclude that it is not whether the laws is general or specific but more related to the action plans adopted by the Governments and the manner of implementation of any legal provision. And therefore the focusing on professionals who are directly related with risk communities and the population groups to which the law applies. 'This entails more interventions among the practicing communities to change behavior and attitudes towards FGM/C. Equally so, interventions among professionals are vital for properly dealing with FGM/C' (Leye and Sabbe 2009:14).

There is a human factor in the chain of reporting beginning from the health officials, teachers, social workers and other citizens who report the cases to the prosecutors and police responsible for investigating the cases. Despite the requirement or option in some cases of reporting case of FGM/C the knowledge about the subject or willingness to be involved with the issue have a role in the implementation of the Law against the practice of FGM/C. In France the notion of respect for other cultures or fear of being labeled racist where mentions as an issue in the reporting of FGM/C cases (Leye and Sabbe 2009: 8). Hendriks (2010) has also noted similar fear of racism among Dutch midwives in their willingness to discuss the issue with their patients who have undergone FGM/C.

The belief on the importance of female circumcision as a practice that is integral for the development of a child could be strong in the practicing communities. In an example given by Elisabeth Boyle, 'until recently a majority of the Muslim and Coptic Christian communities in Egypt perceive a woman who neglected something as important as Female Circumcision in the preparation of a child to womanhood' (2005:2-3) as a child neglect. Many of the practicing communities believe that the 'normal' way of raising a child is to give it all it needs including circumcision. To add more for some communities despite the absence of texts in the Christian or Islamic scriptures to require of allow female circumcision might not depend as much on the scripture as other Christians or Muslims and have a strong belief that their religion requires female Circumcision on the basis of word of mouth or opinion of religious leaders.

Moreover, the spirit of the law as formulated in the 'west' is mainly individualistic but it applies to a practice that is part of to a relatively communal identity. As Leye et al. has argued FGM/C is practiced with in the family where the 'victim' is totally dependent on her parents and those who are expected to report have close blood ties with the perpetrator or even have convictions that the practice on the best interest of the girl. Thus the likelihood of reporting becomes smaller (2007: 15). As Leye has rightly stated 'FGM/C is performed in communities that are sometimes hard to reach by health and social services, making the detection of cases even more difficult'(Leye and Sabbe 2009: 9).

Furthermore, comparable to rape (especially marital rape), battering and other forms domestic violence the issue of FGM/C is prone to the contradiction between the private and the public, hence the level of intervention in the family by the state, the law. 'FGM/C 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' (Leye et al 2004 in Leye et al 2007:15).

Another impediment to the implementation of the law is the fact that evidence gathering could be even more complicated when it comes detecting if FGM/C has been done abroad when the child is supposedly on a holiday. There are cases where young girls never came back home after a holiday in Africa in fear of being detected. It demands a coordinated action between the home country and the host country. Even more, it is not only challenging to find out if FGM/C has been done especially type I and IV but it is also difficult to determine when FGM/C has been performed.

Compulsory gynecological screening for girls as a means of detecting the practice of FGM/C has been highly controversial in many EU countries. In France there has been standard gynecological screening for all children till age 6 as part of PMI¹¹ (Protection Maternelle et infantile) with the intention of preventing or detecting disability among children and checking of FGM/C in little girls is part of the procedure. However, as the special commission that was created by the Dutch Minister of Public health, Welfare and Sports has rightly said the government has no legal power to make it a duty for citizens to cooperate with gynecological examinations of young girls, imposing compulsory checkup is against the principle of non-discrimination and too repressive instead the focus should be on training professionals who have direct contact with practicing communities.

4.5 Reflections

As discussed in the previous chapter the cosmetic plastic surgery and FGM/C have a lot in common. The dilemma of distinguishing FGM/C and cosmetic surgeries without referring to the race of the person is not the dilemma of the medical institution only. Particularly in the UK this has been a major issue regarding the law (See Dustin 2010). Moreover, the child protection law regarding FGM/C is placed in a difficult position in terms of the professional secrecy, where the professional is either required or given the option to report suspicious incidents to the respective authorities concerned with the issue. The professionals play the double role of gaining trust and reporting incidents, hence compromising the trust. A compromise of the trust of professionals after placing them in such a position is inevitable. Girls who have undergone FGM/C are likely to be kept away from medical attention in fear of being detected and punished and such cases have resulted in the death of some girls.

It becomes clear that despite the achievements that the current efforts have had, there is still a clear need to include the aspect that considers the cultural and social aspect of the practice. As could be observed in the court

¹¹ The Maternal and Child Health, is a system of protection of mother and child created in France in 1945 by the health minister of that time.

cases in France there is a practice of FGM/C in Europe that is hidden from the eyes of the law and it appears that criminalization does not seem to be able to deal with the cultural and social setting regarding the issue. On top of the efforts of many NGOs and other awareness creating bodies that have been working on creating a change in the attitude of the practicing communities, legalizing the practice instead criminalizing it would have given the legal system more room to discover more understanding and negotiate as well as influence change in the communities.

In the Netherlands the issues of narcotics, abortion and prostitution that are usually criminalized in many countries have been regulated and legalized as opposed to the issue of FGM/C that provokes public debates every time a proposal or a discussion on medicalizing and regulating is raised. It makes a curious mind wonder how a society that has been able to tolerate differences on many issues has not been able to tolerate. What had led to the criminalization of FGM/C in the Netherlands despite the tolerant approach to other controversial issues?

Chapter 5

Where do NGOs come in to the picture?

Civil society according to Hegel is seen as an intermediate institution between the family on one end and the political relations of the state on the other, ranging from the church, schools to trade unions, citizen rights groups, social protest groups and other non-governmental organizations. However it is not simple to clearly distinguish which characteristics define parts of society as civil society. In explaining the difficulty of defining the meaning of civil society Ottoway says that 'the term is laden with theoretical assumptions, unsolved problems and value judgments.' (2008:167). Bierkart and Fowler also noted the same idea stating that Civil society discourse is simply too 'plural' and its context-specific expressions often too diverse to offer an adequate understanding for how and why people's energy and innovation bring about social change' (2010: 183).

Many practitioners and theorists alike have given different meaning to the term civil society. The aid agencies define civil society as registered NGOs simply because they cannot provide funding to an NGO that is not registered and cannot be held accountable. Civil society tends to be seen as an apolitical organization and the involvement of civil society in politics is less to the pursuit of power but to indirectly influence decision making whereas in reality some civil society organizations are more political than others (Ottoway 2008:169). The civil society can be seen not only as a virtuously dedicated body determined to give citizens a voice and work to the promotion of public interest as opposed to the political society that is more likely to be on the opposite side of the continuum or inattentive to the public interest but it can also be seen as the so called 'uncivil' part of civil society that also drives and acts as protagonists in socio-political processes' (Ottoway 2008:169).

In the globalizing world the notion of civil society has expanded beyond national borders to international level along with its continuum from 'civil' to the 'uncivil' aspects. The nation-state is challenged with the growth of civil society actors and NGOs across the national borders in the pursuit of common ends. One of the most visible global civil activities is the UN thematic conferences on women's rights and the environment from the UN conference on women in Mexico City in 1975 to the UN Decade for women in Copenhagen where there was dramatic increase in the global information. 'The development of transnational women's networking extends beyond, but has been reinforced by, the conference-based moments of 'collective reaction in truly international settings' (Basu 1995: 18 in Friedman 1999: 360).

5.1 Two NGOs advocating against FGM/C

According to Panda, strategies employed by NGOs in tackling issues can be broadly categorized as bottom up and top down approach. The bottom up approach emphasizes community participation, grassroots movements and local decision making where as the top down focuses on lobbying and bargaining with decision making authorities at different platforms, gaining

support from government(s), building up pressures through various campaign mechanisms (Panda 2007: 261).

Moreover, Panda, concludes that despite the perception that grassroots and smaller National NGOs mostly follow a bottom up approach as opposed to bigger national and international NGOs use top-down approach in their activities, no grassroots NGO practices either a top-down or bottom-up approach exclusively, though they are inclined to follow bottom-up strategies (ibid). One of the major differences observed in the role of FORWARD (Foundation for Women's Research and Development) and FSAN (The Federation of Somali Association in the Netherlands) is that the former appears to have an international influence and more involved in the influence of policies and lobbying to government whereas the later operates more as a bridge between the government policies and the law and the communities.

NGOs and social movements alike create Transnational Advocacy Networks to boost their energy by systematically and strategically forming liaisons and bringing issues to the attention of bodies that are in position to deal and at times to pressurize national or local government or hold them responsible for implementing policies (Zippel 2004: 63). According to one of the key informants the appointment of founder and then Executive Director of FORWARD, Efua Dorkenoo as a part of the Global campaign at the WHO, was a strategic move that made FGM/C to become a strong global issue. FORWARD as an influential NGO had made liaisons and brought the issue to the attention of both authorities at the national and international community level.

5.2 The challenges of NGOs working with FGM/C

The informants have named some challenges they faced while working with FGM/C. Some of these challenges are summarized under four themes namely, complexity and over sensitivity of the issue, playing double and contradicting roles and finding the right balance, diversity of opinions and lack of evaluation.

The complexity and over sensitivity of the issue

One of the informants mentioned that among the challenges she faced in the project of working with the issue of FGM/C is that the individuals that are meant to work with the youth community are also expected to, even if not demanded to disclose information they have shared with the participants of their campaign. The volunteers that work with the NGOs are advised to discuss with the program coordinator if they find some information that they believe they should bring to the attention of the authorities. In the same way as the professionals discussed in the previous chapter, this puts the activists and the organization in a difficult position to gain the trust of the communities they work with.

One of the respondents also explained the amount of stigma that she had to endure to advocate against the practice of FGM/C and openly refuse the circumcision of young girls in her family. She said that she was accused of

betraying the community's tradition and the requirement of the 'sunna' of the prophet Mohammed (pbuh) and becoming westernized. In other words she has become one of 'them' instead of becoming one of 'us'.

Diverse and often contradicting opinions of FGM/C

The other challenge on their pursuit to reach out to Islamic communities is where the religious leaders have contradicting stand on the issue with each other despite the fact that there is no evidence of written Islamic scripture.

An Islamic religious leader (sheik) was asked about the stand of Islam on FGM/C agreed that there is no scripture in Islam to support female circumcision however the same leader (Sheik) was encouraging the practice of FGM/C in face to face interactions with other believers. Until a woman went to ask this leader if she should circumcise her daughter with a hidden tape recorder and exposed the advice that she was given (from the interview with Zahra Naleie).¹²

According to the above example given by one of the respondents in a recorded interview, religious leaders and other influential figures often contradict their stand with each other and even with themselves in public and private. This poses a challenge on the credibility of the information that is given to the individuals with in the communities the organizations are working with.

Finding the balance

The NGOs working on the anti-FGM/C advocacy deal with both gaining trust and acceptance a constituency that resents the very cause that the NGO is advocating for and policy making bodies as well as the funding organization to fund the cause of elimination FGM/C. Being an organization that is based on suspicious constituency, because it is assisting the punitive intervention on the practice, and at the same time it has to look at the government for funding, support and resources poses a major challenge of maintaining the right balance.

One of the major challenges as mentioned by one of the interviewees is the lack of political will of their respective national governments. She has said that extent of actions taken to deal with the issue is far too small as compared to the amount of publicity made about the issue. She then went on to appreciate the Dutch government's involvement and action regarding the preparation of ¹³'The Dutch health passport'. This document is an important step that

¹² The same story can be found in the link below

<http://www.dailymail.co.uk/news/article-2136907/Genital-mutilation-British-muslim-leader-caught-camera-advocating-female-circumcision.html>

¹³ The Dutch health passport is a document with the declaration of the Ministry of Health and Ministry of Justice in the Netherlands that an immigrant from risk countries is meant to carry with them when visiting their home countries. This document is evidence that the immigrant is aware about the consequences of exposing

shows cooperation between the various bodies that deal with FGM/C in the Netherlands namely the Ministry of Justice, Ministry of Health and the NGOs with their constituency.

The effort taken to accommodate the legalization to the needs of the immigrants can also be seen in the provision of 'The Africa Well Woman Clinic'¹⁴ in the UK, where the women who have undergone FGM/C receive special treatment by personnel that are familiar with the issue. A woman who has undergone FGM/C but has moved from the support and advice of the community needs a supportive, not only medically but also socially and emotionally conducive environment free from ethnocentric judgments and maltreatment. NGOs working on the issue of FGM/C seem to be walking on a thin line between the practicing communities and the national and international authorities through constant struggle.

Lack of evaluation

FORWARD has proposed an estimation of the number of girls at risk of being circumcised based on the prevalence at home countries while this approach has been contested about its accuracy. The executive director of FORWARD has pointed out that one of the main challenges of advocating against FGM/C in Western Europe is lack of reliable data on the prevalence of the practice. She went on to discuss the estimates that are given about the number of girls at risk of being circumcised are only estimates and not the real empirical amount of risk. This becomes compounded with the criminalization of FGM/C and trust of the practicing communities to give honest responses to questions asked about the practice in fear of being charged.

their daughters for FGM/C as well as evidence to show the families back home that the practice is punishable by law in the Netherlands. The document is prepared by the major native languages that are used in the practicing communities in the horn of Africa. see appendices

¹⁴ There was a clear need for a community based medical services when circumcised Somali women were arriving at hospital in labor. The first African Well Woman Clinic was set up in the Northwick Park Hospital in London in 1992. This has now developed in to Acton African Well Woman Centre, a community project based in west London with unique expertise in helping women who have arrived in the UK, having been through the trauma of FGM/C. It was set up with the intention of helping women before they get pregnant and it has been helpful in providing women access to information and services that accommodates their situation as a circumcised and often infibulated woman.

<http://www.guardian.co.uk/publicservicesawards/no-more-suffering-in-silence>
<http://www.genitalautonomy.eu/#/ga-conference-2011/4552998052>

5.3 Reflections

Advocating against FGM/C in the context of a complex contradicting global discourse is primarily dealing an issue that has meanings on individual, social, cultural, political and religious issues and joining a battle ground of discourses and meanings. Even though NGOs and women's organizations have played a great role in bringing the issue of FGM/C in to the attention of International community and have succeeded in placing laws and policy interventions about the practice they appear to have been trapped between the governments and policy makers and the constituency they claim to represent i.e. the practicing communities.

Chapter 6 Conclusive Reflections

Despite the start of the issue of FGM/C as an issue of saving the ‘woman’ in the practicing communities from the harmful practice, the main cause of the issue appears to have been put aside when the attention has been diverted to discussion on which procedure to follow achieve the goal. As indicated in the discussion of the preceding chapters each step that was taken in eliminating FGM/C as a practice has been contested. The human rights perspective has been accused of being individualistic, Eurocentric, and imperialistic as its major opponent has been accused of being apologetic to a painful, inhumane, barbaric practice. Medicalization has been blamed for being a threat to the weight and urgency of the elimination of the practice of FGM/C. Not only has FGM/C specific meanings within the different societies that it is practiced in but even worse it has been defined and redefined to mean ‘patriarchy’s ultimate oppression on women’, ‘western individualism and imperialism’s excuse to interfere’, ‘practicing communities’ resistance to modernization’ etc.

In the face of the controversy to the view of FGM/C as a violation of human rights, women’s rights and children’s rights, the right’s perspective became the dominant mainstream discourse regarding the issue. Nevertheless, the contest over the issue is still alive even with in the discourse of FGM/C as a harmful practice that violates the basic human rights of women and children. The rights discourse is confronted with issues of agency, double standards of medicalization and plastic surgery, culture and identity, interactions between and influences of the international organizations etc. Hence, FGM/C as an issue is situated in a complex system of contradicting and often quarrelling debates and structures.

It is almost impossible to tackle the issue of FGM/C without knowing what exactly the issue is about. The knowledge about the issue has been based on the accounts of missionaries, anthropologists and feminists and later on the assessment of the WHO’s accounts of the medical consequences of the practice which the organization its self has admitted that it has been to exaggerated and inappropriate to the local understanding. There was and has been lack of sufficient empirical and systematically organized data and knowledge base regarding the subject prior to or after the anti-FGM/C policies and legalization. This is equally true for the home countries of the practicing communities and the Western European countries to which the members of the communities have migrated. One of the major challenges of achieving zero tolerance to FGM/C is that the interventions could not be evaluated against a previous data nor have the debate, legislations and confusions created an environment to gain trust on the pursuit of further research endeavors.

It is thought-provoking to see FGM/C excluded from medicalization in a time in history where issues ranging from weight to self-esteem are included under the scope the medical treatment. To add more, banning medicalization when the whole concern around FGM/C has been revolving around concerns about the health consequences of the practice and when some practicing communities were willing to introduce medicalization contradicts its own argument. Addressing the issue of FGM/C with regard to medicalization also

comes to a closer physical range to and handled within the same legal system with practices such as plastic surgeries on the genitals done within the medical setting but free from the stigma and criminalization attached to FGM/C. Hence, another dimension added to dealing with FGM/C within the European setting.

The criminalization has also provoked the debates along the lines of agency and the choice of the woman over her body even if that meant re-infibulation. It also provoked debates on the mandatory gynecological checking at airports upon return from home countries and regular gynecological check-up for children from risk countries, since it could take racist meanings. It is noteworthy that the parents in the Seattle compromise were willing to comply with a symbolic non-mutilating act of circumcision in hospitals deal with the cultural and social aspects of the issue could be accommodated.

In the process of addressing FGM/C within the setting of Western Europe the national situation and governments has not been immune of the influences of the background and the pressures of the International perspective as well as environment. Some of the decisions appear to have been influenced more by the international community more than the actual situations in the local environment; this can be seen on the ways many European countries adopted laws criminalizing the practice before knowing the prevalence and severity of FGM/C in their National settings. This seems to put NGOs advocating against FGM/C in a go-between position and constant struggle to balance both sides.

Dealing with FGM/C as an issue situated in a chain of debates and competitions has been a difficult issue and attempts to eliminate the practice a complex process. The language and perspective that was chosen to portray the issue of FGM/C has been loaded with different meanings. Consequently, it played a role in the polarization of opinions and positions. Elements of contradicting opinions can be traced from the intervention that was attempted by the missionaries in Africa and the reaction it had provoked to the human rights and cultural relativist debate, up until the debates over medicalization and criminalization. The issue of FGM/C appears to have become more about an issue of institutional, political and intellectual battle grounds between the 'West' and the 'South' than an issue of women and their bodies or a harmful practice. Moreover, lack of reliable and accurate body of knowledge has contributed to the complexity of the emotional debates over the issues.

Reading through the back ground of the issue of FGM/C and the possible implication it has to the present methods of advocating against the practice provokes questions such as: Has there been suppression of opinions and understandings in the process of advocating the practice? Could listening to these attempts to explain the roots of the practice make a difference? Can FGM/C be untangled from the political, cultural and social knots that it has been entangled to?

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Mrs M. L. Veldhuizen van Zanten-Hijnen
18. APRIL 1947 12.31 PM

MR. W. OSTERMAN
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