

# **Combating Female Genital Mutilation in Europe**

A Comparative Analysis of Legislative and Preventative Tools in the Netherlands, France, the  
United Kingdom, and Austria

Sophie Poldermans, Master of Law

European Master's Degree in Human Rights and Democratisation

Academic year 2005/2006

Every year, 3 million girls and women are subjected to the harmful traditional practice of Female Genital Mutilation (FGM). Worldwide, the number of girls and women who have undergone this practice is estimated to lie between 100 and 150 million. FGM is not only an important issue in Africa, the Middle-East, and Asia where it has been traditionally practised, but due to the arrival of immigrants, refugees, and asylum seekers from these countries to the West, to Europe, North America, and Australia, FGM has also become a Western concern. In this thesis, I would like to explore how FGM can be combated most effectively, by means of legislative and/or preventative tools.

Chapter 1 sets out what the harmful traditional practice of FGM exactly entails, where, by whom and why it is practised, and which medical and social consequences it results in. Chapter 2 addresses the human rights that are applicable to FGM and the various instruments where they are enshrined. Chapter 3, 4, 5, and 6 contain a comparative analysis of legislative and preventative tools regarding FGM in the Netherlands, France, the United Kingdom, and Austria, followed by my Concluding Observations and Recommendations.

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University of Vienna, Austria

Supervisor: Elizabeth McArthur, E.MA

Ludwig Boltzmann Institute for Human Rights



*“If Genital Mutilation were a problem affecting men,  
the matter would long be settled.”*

- Waris Dirie

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## Introduction

Every year, 3 million girls and women are subjected to the harmful traditional practice of Female Genital Mutilation (FGM).<sup>1</sup> Worldwide, the number of girls and women who have undergone this practice is estimated to lie between 100 and 150 million.<sup>2</sup> FGM is not only an important issue in Africa, the Middle-East, and Asia where it has been traditionally practised, but due to the arrival of immigrants, refugees and asylum seekers from these countries to the West, to Europe, North America, and Australia, FGM has also become a Western concern.

It is estimated that in the European Union alone, 500,000 girls and women are affected or threatened by the practice of FGM.<sup>3</sup> The magnitude and serious medical and social consequences of this practice in Europe and, moreover, the human rights that might be violated by it, should not be underestimated.

In this thesis, I would like to shed light on the harmful traditional practice of FGM carried out in Europe, and explore how this practice can be combated most effectively, by means of legislative and/or preventative tools, in order to protect the women and girls concerned in the best possible way.

Chapter 1 of this thesis sets out what the harmful traditional practice of FGM exactly entails; where, by whom and why it is practised, and which medical and social consequences it results in. Chapter 2 addresses the human rights that are applicable to FGM and the various instruments where they are enshrined. Chapter 3, 4, 5, and 6 contain a comparative analysis of legislative and preventative tools regarding FGM in the Netherlands, France, the United Kingdom, and Austria. My Concluding Observations and Recommendations, in terms of the most effective way to combat FGM in Europe, follow these Chapters.

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<sup>1</sup> UNICEF, *Changing a Harmful Social Convention: Female Genital Mutilation/Cutting*, Innocenti Research Centre, Florence, Italy, 2005, p.vii.

<sup>2</sup> World Health Organisation, UNICEF and UNFPA, *FGM Joint Statement*, Geneva, 1997.

<sup>3</sup> Dirie, Waris, *Onze verborgen tranen*, Amsterdam, Sirene, 2005, p. 16.



Beforehand, some introductory annotations should be made, with regard to the Chapters enclosing the comparative analysis of legislative and preventative tools regarding FGM in the four countries concerned. This thesis will mainly concentrate on legislative tools to combat FGM. The Rule of Law, in particular criminal law, plays a crucial role in the prohibition of FGM. In the European Union there exist different approaches vis-à-vis legislative measures prohibiting FGM. Some member states employ already existing general criminal law provisions related to abuse or mutilation (Finland, France, Germany, Greece, Ireland, Italy, Luxemburg, Portugal, and the Netherlands); whereas other member states have introduced specific criminal law provisions prohibiting FGM (Austria, Belgium, Denmark, Spain, Sweden, and the United Kingdom).<sup>4</sup> It goes beyond the scope of this thesis to address all these countries. Consequently, I will narrow its scope, addressing four significant countries: the Netherlands, France, the United Kingdom, and Austria.<sup>5</sup> In spite of this, it should be noted that criminal law should always be the *ultimum remedium* - the last resort - since the health and physical integrity of the girl is the most important issue and is not always best served by criminal law proceedings. Criminal law and actual court cases showing the implementation and effects of the law can be used as a warning and sometimes even as a deterrent to the parent(s), traditional practitioner, or community concerned, due to the fear caused to possibly endure criminal proceedings.

Forms of co-perpetration and assistance (e.g. aiding and abetting a crime and/or providing the necessary means to commit the crime) are also criminally liable. *In casu* of

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<sup>4</sup> To date, only research has been conducted on FGM in the 15 oldest EU member states. For the 10 new member states, it has been estimated that there are only very few countries with specific criminal law provisions prohibiting FGM, due to the fact that not many immigrants from countries where FGM is traditionally practised are living in these countries and thus, FGM is not of such a great concern in these countries, as it is in the other 15 member states. Leye, Els, Deblonde, Jessika, *A comparative analysis of the different legal approaches towards female genital mutilation in the 15 EU Member States, and the respective judicial outcomes in Belgium, France, Spain, Sweden and the United Kingdom*, International Centre for Reproductive Health (ICRH), Publications No. 8, Ghent, The Consultory, April 2004, p.12-13.

<sup>5</sup> I have chosen these four countries because of the following reasons: 1) the Netherlands: due to my Dutch nationality and my training as a Dutch jurist, I have extensive knowledge of the Dutch legal system; 2) France: this is the only European country to date where a systematic practice of court cases related to FGM takes place; 3) the United Kingdom: this country was the first European country to introduce specific criminal law provisions prohibiting FGM; 4) Austria: due to the fact that I'm currently living in Vienna, Austria, to write this thesis, I have easy access to the Austrian laws and organisations tackling the problem. Furthermore, a large number of immigrants from countries where FGM is traditionally practised, live in these four European countries.

FGM, this is applicable to the traditional practitioners, parents, grandparents, other family members and medical professionals.

The majority of girls living in Europe, who are at the age of being subjected to FGM, do not undergo FGM in Europe. Instead, they are sent to their country of origin (mostly in Africa), in order to be subjected to the practice. To avoid the situation that criminal liability can be escaped this way, most European countries employ the principle of extraterritoriality. This means that a person committing a crime outside the territory of a country is still criminally liable, provided that certain criteria are met.

Furthermore, this thesis examines other legislative tools applicable to FGM (e.g. constitutional law, child protection law, medical professional law, and asylum law).

Next to legislative tools, this thesis will set out the different prevention policies of these four European countries, addressing the various tactics to finally eradicate the practice of FGM and providing an overview of the NGOs that operate in this field.

Ultimately, this thesis will stress the importance of the function of the signalling and reporting of cases and threats of FGM at an early stage. Probably the people in the best position to do this are the people that are closest to and in direct contact with the girl or woman concerned, for example family members, neighbours, teachers, medical professionals, key figures from the community, and religious leaders.

After having said this, we now arrive at the main body of this thesis.

## Chapter 1: The Harmful Traditional Practice of Female Genital Mutilation

In order to get a clear picture of the harmful, traditional practice of Female Genital Mutilation (FGM) and the issues and problems related to it, I will give a brief overview of the concept of FGM. In this Chapter, I would like to address: (1) What the concept of Female Genital Mutilation exactly entails; (2) Where it is practised; (3) By whom it is practised; (4) Why it is practised; and (5) What the medical and social consequences of this practice are.

### 1.1. What does the Concept of Female Genital Mutilation Entail?

The World Health Organisation (WHO) defines FGM as *all procedures that involve partial or total removal of the female external genitalia and/or injury to the female genital organs for cultural or any other non therapeutic reasons*.<sup>6</sup> The World Health Organisation classifies four types of FGM (see Annex 1):

- Type 1: Excision of the prepuce with or without excision of part or all of the clitoris. This is also referred to as *Clitoridectomy*, *Sunna* - meaning “the tradition of the Prophet Mohammed”- and as *Sunna Kashfa* - meaning “open *Sunna*” - in Sudan. Type I is mostly practised in West African countries: Burkina Faso, Mali, Nigeria, and Senegal.
- Type 2: Excision of the prepuce and clitoris together with partial or total excision of the *labia minora*. This is also referred to as *Excision*, and as *Sunna Magatia* - meaning “closed *Sunna*,” - in Sudan. Type II is mostly practised in Burkina Faso and Sudan.
- Type 3: Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening. This is also referred to as *Infibulation* or as *Pharaonic* or *Sudanese circumcision*. This type is mostly practised in Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Mali, Somalia, and Sudan.

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<sup>6</sup> World Health Organisation, UNICEF and UNFPA, *FGM Joint Statement*, Geneva, 1997.

- Type 4: Unclassified: pricking, piercing, or incision of the clitoris and/or *labia*; stretching of the clitoris and/or *labia*; cauterisation by burning of the clitoris and surrounding tissues; scraping (*Angurya cuts*) of the vaginal orifice or cutting (*Gishiri cuts*) of the vagina; introduction of corrosive substances into the vagina to cause bleeding or herbs into the vagina with the aim of tightening or narrowing the vagina; and any other procedure that falls under the definition of Female Genital Mutilation given above.

The WHO condemns all forms of FGM, including the medicalisation of it. Medicalisation is the performance of FGM by medical professionals, in sterile conditions with anaesthesia.<sup>7</sup> Yet, the WHO states that FGM should not be practised by health professionals in any setting, including hospitals or other health establishments. The WHO's position rests on the basic ethics of health-care, whereby unnecessary bodily mutilation cannot be condoned by health providers. Medicalisation of the procedure does not eliminate the harm that is done. Moreover, it is inappropriate as it reinforces the continuation of the practice by seeming to legitimise it. In communities where *infibulation* is the norm, it has been noted that many families revert to Type I (*clitoridectomy*) when health education programmes commence. However, the formal policy messages must consistently convey that all forms of Female Genital Mutilation must be stopped.<sup>8</sup>

The most common type of Female Genital Mutilation is excision of the clitoris and the *labia*, which accounts for up to 80% of all cases; the most extreme form is *infibulation*, which constitutes 15% of all procedures.<sup>9</sup>

The age at which FGM is carried out varies from area to area and is related to which form of FGM is practised. FGM is performed on infants less than one year old, on girls between the ages of 6 and 10, in adolescence, and occasionally in adulthood.<sup>10</sup>

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<sup>7</sup> British Medical Association, *Female genital mutilation. Caring for patients and child protection: Guidance from the Ethics Department*, London, February 2004, p. 2.

<sup>8</sup> World Health Organisation, UNICEF and UNFPA, *FGM Joint Statement*, Geneva, 1997, pp. 8-9.

<sup>9</sup> World Health Organisation, *Fact Sheet No. 24*, June 2000.

Today, the number of girls and women who have been subjected to FGM lies between 100 and 150 million. It is estimated that each year, a further 3 million girls become subjected to FGM. It is further estimated that in the European Union alone, 500,000 girls and women are affected or threatened by the practice of FGM.<sup>11</sup>

Regarding the terminology that is used to indicate this harmful traditional practice, I would like to state that, although this practice is known under various names, I will employ the term *Female Genital Mutilation* in this thesis. This term was globally introduced in 1994, originating from the word *mutilation*, meaning “to cut.” This term best reflects the practice, and is now most commonly used. The term FGM stresses the irreversibility of the practice and the life-long effects. The term also clearly differentiates the practice from that of male circumcision, which is not of the same magnitude and has different objectives.<sup>12</sup> It should be noted that according to the WHO’s classification, piercing and tattooing would be qualified as FGM Type IV. Consequently, in countries with specific criminal law provisions prohibiting FGM, problems might arise in terms of clarity of the law regarding the definition of FGM and which forms are exactly prohibited.

### 1.2. Where is FGM Practised?

FGM is practised in around 28 African countries, roughly in a belt across the middle of the continent from the West to the East coast. In East and North Africa it is prevalent in Djibouti, Egypt, Eritrea, Ethiopia, Kenya, Somalia, and Sudan. These countries have a prevalence ration of over 90%. In addition, most of the West African countries: Benin, Burkina Faso, Gambia, Ghana, both Guineas, Ivory Coast, Liberia, Mali, Niger, Nigeria, Senegal, and Sierra Leone, practice FGM. Outside Africa FGM is practised by small, mostly Muslims communities in the Arabian Peninsula: Oman, United Arab Emirates, and Yemen; Asia: India, Indonesia, and Malaysia; Australia; and Latin America: Brazil,

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<sup>10</sup> World Health Organisation, UNICEF and UNFPA, *FGM Joint Statement*, Geneva, 1997, p. 4.

<sup>11</sup> Dirie, Waris, *Onze verborgen tranen*, Amsterdam, Sirene, 2005, p. 16.

<sup>12</sup> Other terms used for the practice are: *Female circumcision*, *Excision*, *Female genital excision*, *Female genital cutting* (used by UNFPA and USAID), *Female genital mutilation/cutting* (introduced by UNICEF as a compromise). African Women’s Organisation, *Training Kit: Prevention and Elimination of Female Genital Mutilation among Immigrants in Europe (EU DAPHNE Project)*, Vienna, 2005, p.12.

Mexico, and Peru. In the predominantly Islamic countries such as Algeria, Iraq, Iran, Kuwait, Pakistan, and Saudi Arabia, FGM is not practised.<sup>13</sup>

### 1.3. By Whom is FGM Practised?

FGM is usually practised by women on women. In the majority of cases, FGM is carried out by a traditional practitioner upon the mother's or parents' request. These traditional practitioners are usually local specialists (cutters or *exciseuses*), traditional birth attendants, and generally, older members of the community (80% are women). In most countries medical professionals are not widely involved, with the exception of Egypt (61%), Sudan (36%), and Kenya (34%).<sup>14</sup> In Egypt and Nigeria barbers (male) often perform this practice.<sup>15</sup> Originally, it began as an initiation rite where a number of young girls were invited at a special site. A feast would be organised where the girls would receive presents and then they would have to undergo FGM one by one. The purpose of an initiation rite seems to have lost its meaning though. More and more girls are being individually subjected to FGM and at a younger age, even as babies. In traditional Africa, FGM is exercised under extremely unhygienic circumstances. The young girl is put on a rock, held-down by a group of women. Usually the mother stands close-by to observe or assist, and then a knife, scissors, a stone, a piece of glass, a razor blade, or another sharp object is used to exercise the practice. In Europe, FGM is usually carried out at home, behind closed doors.

### 1.4. Why is FGM Practised?

The origin of FGM is difficult to trace. Some claim that it has its origin in the Middle East or the Arabian Peninsula and was then spread by Arab traders to parts of Africa. Others claim that it has its origin in East Africa. Herodotus, from the 5<sup>th</sup> Century B.C., places the origin in Egypt or Ethiopia. Other sources indicate that FGM existed in Egypt from around 163 B.C. The form of FGM that we refer to nowadays as Type III

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<sup>13</sup> Rahman, Anika, Toubia, Nahid, *Female Genital Mutilation: A Guide to Laws and Policies Worldwide*, London, Zed Books, 2000, pp. 6-7; Smith, Jacqueline, *Visions and Discussions on Genital Mutilations of Girls*, Defence for Children International, the Netherlands, 1995.

<sup>14</sup> UNICEF, *Changing a Harmful Social Convention: Female Genital Mutilation/Cutting*, Innocenti Research Centre, Florence, Italy, 2005, p. 7.

<sup>15</sup> African Women's Organisation, *Training Kit: Prevention and Elimination of Female Genital Mutilation among Immigrants in Europe (EU DAPHNE Project)*, Vienna, 2005, p. 13.

(*infibulation*), is called *Pharaonic circumcision* in Sudan, derived from the Egyptian Pharaohs.<sup>16</sup> It is known as *Sudanese circumcision* in Egypt.

FGM can be exercised for numerous reasons. It goes beyond the scope of this thesis to address all of them, therefore, I will only address the most important ones.

The reason to carry out FGM that is mentioned most often, is that it is rooted in a cultural tradition. In order for a girl to get married she needs to be “pure.” It is believed that the only way that this can be guaranteed is when she has undergone FGM. This is based on the assumption of gender-identity (FGM is believed to make a woman feminine) or on aesthetic reasons (a woman is believed to be more beautiful when she has undergone FGM). A girl who has not been subjected to FGM will never be able to marry, which is considered to be a shame for the girl and her family. In addition, if the girl doesn’t marry, that would mean a loss of income for the family, since they will not receive the bride dowry.

Another reason that is often mentioned is that FGM is used by men as a tool to exercise power and control over women: “*It is still claimed by men, that female sexuality is dangerous and has to be controlled.*”<sup>17</sup>

Sometimes it is argued that FGM would be prescribed by religion, more specifically by Islam. Conversely, this is not true. FGM is not mentioned in the Koran. Moreover, FGM is not practised in the most radical Islamic countries in the world (e.g. Saudi Arabia or Iran). In addition, FGM is also practised among Christians (Catholics, Orthodox, and Protestants). Slowly but surely more religious leaders have publicly spoken out against FGM, which can be a very effective tool in the prevention of FGM.

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<sup>16</sup> Smith, Jacqueline, *Visions and Discussions on Genital Mutilations of Girls*, Defence for Children International, the Netherlands, 1995; Hosken, Fran P., *The Hosken Report*, WINNEWS, Lexington, M.A., 1993.

<sup>17</sup> Hosken, Fran P. *The Hosken Report*, WINNEWS, Lexington, M.A., 1993.

### 1.5. What are the Medical and Social Consequences of FGM?

First, I would like to address some of the general medical consequences of FGM. There are immediate and long-term health complications, varying according to the type of FGM and the severity of the performance. It is a fact that the practice of FGM is irreversible and the effects are life-long.

The practice of FGM is usually carried out under extremely unhygienic circumstances. These women suffer from severe pain, while often no painkillers are used. In some cases in Africa, herbs or animal excrement are used to alleviate pain; however, no medical proof supports this. Many girls bleed to death. If they are lucky enough to survive, they have a high risk of all sorts of infections, caused by the use of un-sterile instruments. In addition, damage to vital parts of the human body as anus, urethra, and bladder, is done. Usually these girls are kept aside from the rest of the community for a couple of days or weeks to recover. Their legs are tied together and leaves are put into the girl's vagina in order for the wound to heal.

If the wound is healed at first instance, these women remain having severe problems on a daily basis. In the case of Type III (*infibulation*) urination is extremely problematic. It can take up to 20 minutes to urinate, due to the extremely small opening of the vagina that is left. This way, urine can only drip. Furthermore, repeated urinary infections appear.

Menstruation is extremely painful, and due to blood clogging up in the lower belly, numerous types of infections might appear.

Sexual intercourse is extremely painful. Penetration is difficult, due to the extremely small opening of the vagina. Therefore, FGM, *infibulation* in particular, can definitely be considered as a tool of power and control of domination by men over women. Female Genital Mutilation is in this case a fairly safe guarantee for the virginity of the girl or woman, provided that she has not been raped before. On the night of the wedding the husband will cut the wound open in order to have sexual intercourse with his newly



wedded wife. The next morning, the mother-in-law will check the sheets for fresh bloodstains, to check whether the girl had indeed been “pure.” The damaging or removal of the clitoris causes loss of sexual sensitivity for the woman. Sexual feeling is decreased or lost completely, making the achievement of an orgasm by stimulation of the clitoris difficult and in some cases even impossible, simply because the clitoris has been damaged or removed.

Childbirth is extremely complicated and is almost impossible in the case of *infibulation*. In order to give birth to a child, these women need to be cut open. Often the vagina is re-closed after childbirth. This practice is called *re-infibulation*. The wound becomes even more damaged the more children a woman gives birth to, because of the re-cutting and re-sewing of the vagina.

Next to the physical complications, these women usually suffer psychologically from fear, shock, stress, flashbacks, and post-traumatic stress.

Second, I would like to address the social consequences. There is enormous pressure from the family for FGM to be carried out. In a way, these parents have the best intentions for their child, because they want their child to be able to marry and the only way that this is possible for the girl is to be “pure,” which can only be guaranteed once she has undergone FGM. As mentioned above, if the girl does not undergo FGM, she will not be able to marry, which is considered to be a shame for the family. FGM can be seen as a social cohesion among the people of the community concerned, hence a binding force. In addition, it will cause community ostracism, isolation, and discrimination. Furthermore, the family will lose income because they will not receive the bride dowry if the girl does not marry.

From all of the above, we can conclude that FGM is not only an individual matter, but also a matter of the community, even of the entire culture that lies at the basis of this practice.

## **Chapter 2: Which Human Rights are at Stake and which International Human Rights Instruments are Applicable to Female Genital Mutilation?**

In the West, the concept of human rights is considered to be of the utmost importance, lying at the basis of every modern democratic society. Human rights are certain basic, individual rights that apply to all human beings by virtue of their humanity, without distinction on such grounds as race, colour, sex (gender), religion, political opinion language, or national or social origin.<sup>18</sup> These rights are considered to be universal. That means that they are applicable to every human being, at all times, at all places. Therefore, these rights are not only applicable to human beings living in the West or to people of Western descent, but also to immigrants, refugees and asylum seekers coming from all parts of the world.

Originally, human rights were developed to stress individual freedom, protecting the individual from the state (vertical relation). They can be either *negative* or freedoms *from*: guarantees that governments will refrain from behaving badly toward their own people or *positive* as freedoms *to*: the asserted obligations of society to help its members to achieve a better life.<sup>19</sup> Gradually, human rights could also be invoked from one citizen to another (horizontal relation).

From originally only being applicable to the public sphere, the public/private dichotomy was broken open and slowly but surely the applicability of human rights was expanded towards the private sphere. This has been achieved fairly recently and still needs to be developed further.

States are under a *negative* obligation to respect human rights, but also under a *positive* obligation to protect and fulfil these rights, especially with regard to the most vulnerable in society (*in casu* of FGM women and children). Furthermore, the internationally

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<sup>18</sup> Abdullahi, An-Na'im A., *Islam and Human Rights: Beyond the Universality Debate*, in "American Society of International Law," *Proceedings of the 94<sup>th</sup> Annual Meeting*, 5 – 8 April 2000, p. 95.

<sup>19</sup> Barash, D., Webel, C., *Peace and Conflict Studies*, University of California at Berkeley, USA, Sage Publications, 2002, p. 444.

recognised principle of “due diligence” requires states to take all measures - legislative and administrative - to prevent, punish, investigate, and redress violations of human rights.

In this Chapter, I would like to explore which human rights might be violated in cases of FGM and in which international human rights instruments these rights are laid down.

- First, the right to life could be violated. Often the practice of FGM results in the death of the girls who have been subjected to it. For example, they can bleed to death or they could die from infection. This is a clear violation of the right to life, as laid down in: *Universal Declaration of Human Rights* (UDHR) article 6; *International Covenant of Civil and Political Rights* (ICCPR) article 6; *European Convention for the Protection of Human Rights and Fundamental Freedoms* (ECHR) article 2; *African (Banjul) Charter on Human and Peoples’ Rights* article 4; *Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa* article 4.
- Second, the right to health could be violated. It should be noted that the definition of health includes maturity, reproductive, and sexual health. Considering the severe medical consequences as mentioned above, it is clear that the health of the girl or woman can be damaged by the practice of FGM, sometimes even irreversibly, as laid down in: UDHR article 25; *International Covenant on Economic, Social, and Cultural Rights* (ICESCR) article 12; *Convention on the Elimination of all forms of Discrimination Against Women* (CEDAW) article 2; *Declaration on the Elimination of Violence against Women* article 3; *Convention on the Rights of the Child* (CRC) article 24; *African (Banjul) Charter on Human and Peoples’ Rights* article 16; *Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa* article 14; *African Charter on the Rights and the Welfare of the Child* article 14; *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights* article 10, paragraph 1; *Programme of Action of the International*

*Conference on Population and Development* paragraph 7.2; *Platform for Action of the Fourth World Conference on Women* (Beijing 1995) paragraph 89.

- Third, the right to physical integrity could be violated, which includes freedom from violence. A person cannot force somebody to undergo special treatment, *in casu* FGM. Everybody has the right to have disposal over his or her own body, as laid down in: UDHR article 1 and 3; ICCPR article 9, paragraph 1; ICESCR preamble; ECHR article 8; *Charter on the Fundamental Rights of the European Union* articles 1 and 3; *Declaration on the Elimination of Violence against Women* articles 1 and 2(a); CRC article 19, *African (Banjul) Charter on Human and Peoples' Rights* articles 4 and 5; *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa* articles 3, 4, and 5; *American Convention on Human Rights* article 5, paragraph 1; *Inter-American Convention on the Prevention, Punishment, Eradication of Violence against Women* article 1; *Platform for Action of the Fourth World Conference on Women* (Beijing 1995) paragraphs 107(d), 118, and 232(h).
- Fourth, the right not to be subjected to torture or ill treatment could be violated. Considering the serious medical and social consequences, it can be argued that the practice of FGM can be considered to be a form of torture or ill treatment. This is an absolute right that leaves no room for derogation, as laid down in: *Convention Against Torture and other Cruel, Inhuman, or Degrading Treatment or Punishment* (CAT) articles 1 and 16; ICCPR article 7; ECHR article 3; *Charter on the Fundamental Rights of the European Union* article 4; *Declaration on the Elimination of Violence against Women* article 3; CRC article 37, *African (Banjul) Charter on Human and Peoples' Rights* article 5.
- Fifth, the right to non-discrimination could be violated. FGM is a practice that is performed on women and therefore specific women's rights come into play. The most important one is the right not to be subjected to discrimination based on gender. Evidently, FGM is a practice that only concerns women and is rooted in

traditional societies where assigned roles and stereotypes for men and women exist, counter-balancing the equality between men and women. This leads to discrimination of these women merely on the basis of gender, as laid down in:

*United Nations Charter* articles 1 and 55; UDHR articles 2 and 7; ICCPR article 2; ICESCR article 2; ECHR article 14; CEDAW articles 1 and 5(a); *African (Banjul) Charter on Human and Peoples' Rights* articles 18, paragraph 3, and 28; *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa* article 2; *African Charter on the Rights and the Welfare of the Child* article 26; *American Convention on Human Rights* article 1;

To stress non-discrimination against women, I would like to cite CEDAW article 5(a):

*States Parties shall take all appropriate measures:*

*(a) To modify the social and cultural patterns of conduct of men and women with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or superiority of either of the sexes or on stereotyped roles for men and women.*

- Sixth, specific children's rights could be violated. Since FGM is usually performed on children, on babies even, there are specific children's rights that come into play as well. From a human rights approach, these children's rights are of the utmost importance, since children hold an extremely vulnerable position in society. Therefore, extra caution needs to be taken to respect and protect their rights, as laid down in: CRC articles 2, paragraph 1; 3, paragraph 1; 6, paragraph 1 and 2; 16, paragraph 1; 19, paragraph 1; 24, paragraph 1 and 3; and *African Charter on the Rights and the Welfare of the Child* articles 4, paragraph 1; 5 paragraph 2; 10; 14, paragraph 1; 21, paragraph 1(a) and (b).

To stress the importance of the protection of children's rights, I would like to cite CRC article 19, paragraph 1:

*States parties shall take all appropriate legislative, administrative, social, and educational measures to protect the child from all forms of physical or mental violence, injury, or abuse, neglect or negligent treatment, maltreatment or exploitation including sexual abuse while in the care of parent(s), legal guardian(s), or any other person who has the care of the child.*

In addition, I would like to cite CRC article 24, paragraph 3:

*States parties shall take all effective and appropriate measures with the view to abolishing traditional practices prejudicial to the health of children.*

The same intention is laid down in the *African Charter on the Rights and the Welfare of the Child* article 21, paragraph 1(a) and (b).

- FGM as a harmful traditional practice is specifically mentioned in the following instruments: *Council of Europe (CoE) Parliamentary Assembly Resolution 1247 on FGM* of 2001; *European Union (EU) Parliament Resolution on FGM* of 2001; CEDAW article 2(f); *Declaration on the Elimination of Violence against Women* article 2(a); CRC article 24, paragraph 3; *African Charter on the Rights and the Welfare of the Child* article 21, paragraph 1(a) and (b); *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa* article 5; *Platform for Action of the Fourth World Conference on Women* (Beijing 1995) paragraph 232(h);

First, I would to address the European resolutions:

Under *Resolution 1247*, the Council of Europe urges governments, *inter alia*:

- i. *to introduce specific legislation prohibiting genital mutilation and declaring genital mutilation to be a violation of human rights and bodily integrity;*
- ii. *to take steps to inform all people about the legislation banning the practice before they enter Council of Europe member states;*
- iii. *to adopt more flexible measures for granting the right of asylum to mothers and their children who fear being subjected to such practices;*  
(...)
- iv. *to prosecute the perpetrators and their accomplices, including family members and health personnel, on criminal charges of violence leading to mutilation, including cases where such mutilation is committed abroad.*<sup>20</sup>

The report accompanying this resolution asserts that FGM in Europe cannot be justified on the grounds of cultural relativism.<sup>21</sup>

The European Union Parliament Resolution on Female Genital Mutilation of 2001 strongly condemns FGM as a violation of fundamental human rights and *inter alia* calls upon the European Commission to draw up a complete strategy to eliminate the practice of FGM in the European Union, which should *establish both legal and administrative and also preventive, educational and social mechanisms to enable women who are or are likely to be victims to obtain real protection.*<sup>22</sup>

To stress the broad scope of article 5 of the *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa* regarding measures to combat FGM, I would like to cite this article:

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<sup>20</sup> Council of Europe, P.A. Resolution 1247, paragraph 11, 2001.

<sup>21</sup> Miller, Michael, *Responses to Female Genital Mutilation/Cutting in Europe*, UNICEF Innocenti Research Centre, Florence, Italy, 2004, p. 6.

<sup>22</sup> European Union, E.P. Resolution 2001/2035 (INI), paragraph 7; Miller, Michael, *Responses to Female Genital Mutilation/Cutting in Europe*, UNICEF Innocenti Research Centre, Florence, Italy, 2004, p. 5.

*States Parties shall prohibit and condemn all forms of harmful practices which negatively affect the human rights of women and which are contrary to recognized international standards. States Parties shall take all necessary legislative and other measures to eliminate such practices, including:*

- (a) creation of public awareness in all sectors of society regarding harmful practices through information, formal, and informal education and outreach programmes;*
- (b) prohibition, through legislative measures backed by sanctions, of all forms of female genital mutilation, scarification, medicalisation and para-medicalisation of female genital mutilation and all other practices in order to eradicate them;*
- (c) provision of necessary support to victims of harmful practices through basic services such as health services, legal and judicial support, emotional and psychological counselling as well as vocational training to make them self-supporting;*
- (d) protection of women who are at risk of being subjected to harmful practices or all other forms of violence, abuse and intolerance.*

Paragraph 232(h) of the *Platform for Action of the Fourth World Conference on Women* (Beijing 1995) calls for government action. It urges governments to:

*Prohibit female genital mutilation wherever it exists and give vigorous support to efforts among non-governmental and community organizations and religious institutions to eliminate such practices.*



## Chapter 3: The Netherlands

### 3.1. Context

The Netherlands have always been a country with many immigrants, due to its history of tolerance and trade. It is a true melting pot and a vivid example of a multi-cultural society. There are many immigrants from countries where FGM is traditionally practised in Africa: Egypt, Eritrea, Somalia, and Sudan, living in the Netherlands.<sup>23</sup> The majority of immigrants live in the bigger cities of Amsterdam, the Hague, Rotterdam, Utrecht, and Tilburg. It is estimated that 39,000 women who have been subjected to FGM live in the Netherlands and that 14,000 girls are currently at risk.<sup>24</sup>

All types of FGM are present in the Netherlands, however, the type that is most commonly practised is Type III (*infibulation*), which is most often practised among Somali women. The age at which this is commonly practised lies between 6 and 12 years old.

Although the debate surrounding the topic of FGM already started in the seventies of the twentieth century, it was not until the nineties that the topic became a relevant and highly debated issue with the arrival of migrant women in the Netherlands from, in particular, Somalia. Public attention was drawn to the severe health and social consequences of FGM. Under the motto of respecting different cultural backgrounds, “cultural relativism,”<sup>25</sup> possible alternatives to FGM were heavily discussed. For example, in 1992,

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<sup>23</sup> According to the Central Bureau for Statistics (*Centraal Bureau voor Statistiek*) there were 12,786 girls/women from Somalia living in the Netherlands in 2003. It is estimated that 98% of Somali women are subjected to FGM. There were a total of 116,546 immigrants from the following African countries where FGM is practised living in the Netherlands in 2003: Cameroon, The Democratic Republic of Congo, Egypt, Ethiopia, Ghana, Guinea, Kenya, Liberia, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Tanzania, Togo, and Uganda. Of this total, 48,272 were female. Centraal Bureau voor Statistiek <<http://statline.cbs.nl/statweb/start.asp?DM=SLnl&LA=nl&lp=applet&THEME=3600>> (date accessed: 3 March 2006).

<sup>24</sup> PHAROS <<http://www.pharos.nl>> (date accessed: 3 March 2006); Dirie, Waris, *Onze verborgen tranen*, Amsterdam, Sirene, 2005, pp. 77-85.

<sup>25</sup> Cultural relativism is the form of moral relativism that holds that all ethical truth is relative to a specified culture. According to cultural relativism, it is never true to say simply that a certain kind of behaviour is right or wrong; rather, it can only ever be true that a certain kind a behaviour is right or wrong relative to a specified society. Holt, Tim, *Cultural Relativism*, <<http://www.philosophyofreligion.info/culturalrelativism.html>> (date accessed: 3 March 2006).

an alternative form of “symbolic” cutting was proposed.<sup>26</sup> This would be a little hole or cut in the clitoris, which would not mutilate the girl and which should be exercised under medical supervision. Justification for this alternative form of FGM was given by stating that this way the girls concerned would not have to be subjected to other, more damaging forms of FGM.<sup>27</sup> The study was received with confusion and the media reacted emotionally. Many misunderstood the proposal of the study, accusing the authors of being pro-FGM.<sup>28</sup>

After being discussed intensively in the Parliament, legislation was passed, in which FGM was considered to be a criminal offence in all its forms, as a form of abuse, as laid down in articles 300-304 of the Dutch Penal Code (*Wetboek van Strafrecht*).<sup>29</sup>

### 3.2. Criminal Law

In the Netherlands, FGM is prohibited under general criminal law and is applicable to every person. FGM would fall under articles 300-304 of the Dutch Penal Code, title XX and would be qualified as a form of abuse (see Annex 2). Aggravating factors occur when there are serious corporal lesions<sup>30</sup> and when the offence causes death.<sup>31</sup> An additional aggravating factor is the performance of the offence by a parent or person having custody over the child. This is laid down in article 304, paragraph 1.

The primary applicable criminal law provision regarding FGM is article 303:

#### **Article 303**

##### *1. Premeditated aggravated physical abuse is punishable by a term of*

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<sup>26</sup> After a study on the situation of Somali refugee women by the Ministry of Wellbeing, Health and Culture (*Welzijn, Volksgezondheid en Cultuur*).

<sup>27</sup> Kwaak, van der, Anke, et al., *Strategieën ter voorkoming van besnijdenis bij meisjes: Inventarisatie en aanbevelingen*, Vrije Universiteit and VU Medisch Centrum, Amsterdam, October 2003, p. 17.

<sup>28</sup> Kwaak, van der, Anke, et al., *Strategieën ter voorkoming van besnijdenis bij meisjes: Inventarisatie en aanbevelingen*, Vrije Universiteit and VU Medisch Centrum, Amsterdam, October 2003, p. 17.

<sup>29</sup> FGM can also be qualified as the illegal performance of medical practices (*het onbevoegd uitoefenen van de geneeskunst*), as laid down in article 436 of the Dutch Penal Code. However, the main focus lies on articles 300-304 of the Dutch Penal Code.

<sup>30</sup> Dutch Penal Code, articles 301, paragraph 2 and 300.

<sup>31</sup> Dutch Penal Code, articles 303, paragraph 3; 302; and 300.

- imprisonment of not more than twelve years or a fine of the fifth category.*
- 2. Where death ensues as a result of the act, the offender is liable to a term of imprisonment of not more than fifteen years or a fine of the fifth category.*

FGM is almost always a premeditated crime. Aggravated physical abuse must be proven, meaning that the intention of the perpetrator must have been aggravated physical abuse. That holds true for most forms of FGM. However, this can be hard to establish where FGM Type I (*circumcision*) is concerned.<sup>32</sup> When aggravated physical abuse cannot be proven, the perpetrator must be acquitted. To avoid this unsatisfactory outcome, it is recommended that the lighter form of “just” physical abuse can be used as a subsidiary charge.<sup>33</sup>

As a subsidiary criminal provision regarding FGM, article 302 can be used:

***Article 302***

- 1. A person who intentionally inflicts serious bodily harm on another person is guilty of aggravated physical abuse and is liable to a term of imprisonment of not more than eight years or a fine of the fifth category.*
- 2. Where death ensues as a result of the act, the offender is liable to a term of imprisonment of not more than ten years or a fine of the fifth category.*

Here, serious bodily harm caused by FGM must be proven. The purpose or reason for doing so is not relevant.<sup>34</sup>

Regarding aggravated physical abuse, the same can be said as to article 303.

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<sup>32</sup> As classified by the World Health Organisation.

<sup>33</sup> Kool, R.S.B., et al., *Vrouwelijke genitale verminking in juridisch perspectief: (Rechtsvergelijkend) onderzoek naar de juridische mogelijkheden ter voorkoming en bestrijding van vrouwelijke genitale verminking*, Willem Pompe Instituut, sectie Strafrecht, Universiteit Utrecht, Zoetermeer, the Netherlands, 2005, p. 25.

<sup>34</sup> Kool, R.S.B., et al., *Vrouwelijke genitale verminking in juridisch perspectief: (Rechtsvergelijkend) onderzoek naar de juridische mogelijkheden ter voorkoming en bestrijding van vrouwelijke genitale verminking*, Willem Pompe Instituut, sectie Strafrecht, Universiteit Utrecht, Zoetermeer, the Netherlands, 2005, p. 26.

If article 302 is not applicable, then article 301 may be considered, where premeditated physical abuse must be proven:

***Article 301***

- 1. Premeditated physical abuse is punishable by a term of imprisonment of not more than three years or a fine of the fourth category.*
- 2. Where serious bodily harm ensues as a result of the act, the offender is liable to a term of imprisonment of not more than six years or a fine of the fourth category.*
- 3. Where death ensues as a result of the act, the offender is liable to a term of imprisonment of not more than nine years or a fine of the fifth category.*

As a last resort, article 300, which criminalises physical abuse as such, may be considered:

***Article 300***

- 1. Physical abuse is punishable by a term of imprisonment of not more than two years or a fine of the fourth category.*
- 2. Where serious bodily harm ensues as a result of the act, the offender is liable to a term of imprisonment of not more than four years or a fine of the fourth category.*
- 3. Where death ensues as a result of the act, the offender is liable to a term of imprisonment of not more than six years or a fine of the fourth category.*
- 4. Intentionally injuring a person's health is equivalent to physical abuse.*
- 5. An attempt to commit the serious offence of physical abuse is not punishable.*

This article is also applicable to FGM Type I (*circumcision*).

Paragraph 4 of article 300 is of particular importance to FGM. The situation in which a person intentionally injures another person's health, is regarded by the law to be equivalent to physical abuse. This is important since many women performing the

practice of FGM do not see it as a form of physical abuse, but rather as a mere cultural tradition. They employ this reasoning as a cultural defence for the practice. However, criminal liability cannot be avoided, because the harm that FGM causes can not be denied.

As noted above, performance of the offence by a parent or a person having custody over the child is considered to be an aggravating factor. FGM is traditionally practised by the mother or upon the mother's or parents' request; therefore, this criterion is easily fulfilled. This is laid down in article 304, paragraph 1:

***Article 304***

*The terms of imprisonment prescribed in articles 300-303 may be increased by one third in the following cases:*

- 1. where the offender commits the serious offence against his mother, his legal father, his spouse or his child;*
- 2. where the serious offence is committed against a public servant during or in connection with the lawful execution of his duties;*
- 3. where the serious offence is committed by administering substances injurious to life or health.*

**3.3. General Criminal Law Prohibiting FGM**

In 2004, the Dutch Parliament raised the question why there hadn't been any court cases relating to FGM yet, making a comparison with France. The Parliament decided to follow a new, firmer approach with better signalling of FGM cases and a more prominent role for criminal law within the context of FGM.<sup>35</sup> The Council of Health (*Raad voor de Volksgezondheid*) was approached for advice on the topic. A special commission was founded, the Commission Combating Female Genital Mutilation (*Commissie Bestrijding Vrouwelijke Genitale Verminking*), to develop an effective strategy to combat FGM in the

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<sup>35</sup> Kool, R.S.B., et al., *Vrouwelijke genitale verminking in juridisch perspectief: (Rechtsvergelijkend) onderzoek naar de juridische mogelijkheden ter voorkoming en bestrijding van vrouwelijke genitale verminking*, Willem Pompe Instituut, sectie Strafrecht, Universiteit Utrecht, Zoetermeer, the Netherlands, 2005, p. 5; Letter of the Minister of Health, Wellbeing and Sports, BHTK 2003-2004, 29 2000, XVI, nr. 231, p. 4.

Netherlands. In preparation of this advice, the commission consulted the Willem Pompe Criminal Law Institute connected to the University of Utrecht, regarding the legal possibilities. This institute rejected a specific criminal law provision regarding FGM, but was not completely satisfied with the current situation. They proposed to add a paragraph to the articles 300-303 of the Penal Code to address FGM as an aggravated form of abuse with an increased penalty for this form of abuse. This way, FGM would be recognised as specific form of (child) abuse without having to change the entire structure of the Penal Code.<sup>36</sup> The commission followed this advice, however, Mr. Hoogervorst - Minister of Health, Wellbeing and Sports - did not follow it.<sup>37</sup> He stated that there was no need to change the current criminal provisions. A specific criminal law provision regarding FGM wouldn't result in a more effective criminal policy and therefore wouldn't be necessary. The current Penal Code is considered to be sufficient in order to combat FGM prohibiting FGM in all its forms, including the issue of *re-infibulation* (the re-closing of the vagina after childbirth).<sup>38</sup>

The Cabinet decided to follow the commission's proposal that the timeframe, within which a person can press criminal charges regarding FGM, should start running when the victim turns 18 years old, similar to cases regarding sexual abuse of children. This way the girl or woman will have more time to deal psychologically with her having being subjected to FGM and to think about the consequences of pressing criminal charges. This measure is expected to increase the chance of the girl or woman pressing criminal charges.<sup>39</sup>

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<sup>36</sup> Kool, R.S.B., et al., *Vrouwelijke genitale verminking in juridisch perspectief: (Rechtsvergelijkend) onderzoek naar de juridische mogelijkheden ter voorkoming en bestrijding van vrouwelijke genitale verminking*, Willem Pompe Instituut, sectie Strafrecht, Universiteit Utrecht, Zoetermeer, the Netherlands, 2005, pp. 36-38.

<sup>37</sup> Commissie Bestrijding Vrouwelijke Genitale Verminking, *Bestrijding vrouwelijke genitale verminking*, Zoetermeer, the Netherlands, 23 March 2005, pp. 37-40.

<sup>38</sup> Letter from Minister of Health, Wellbeing and Sports, *Kabinetstandpunt RVZ-advies bestrijding vrouwelijke genitale verminking* and attachment to this letter, 26 August 2005, pp. 3-8 and pp. 1-3.

<sup>39</sup> Letter from Minister of Health, Wellbeing and Sports, *Kabinetstandpunt RVZ-advies bestrijding vrouwelijke genitale verminking* and attachment to this letter, 26 August 2005, p. 8 and pp. 4-5.

### 3.4. Extraterritoriality - Double Criminality

Is it possible to hold a person criminally liable in cases where the practice of FGM has been exercised outside the territory of the Netherlands? In other words, does the principle of extraterritoriality apply?

Yes, it does, provided that the person is a Dutch national or a permanent resident of the Netherlands. Until recently, in order for the principle of extraterritoriality to be applicable, two requirements needed to be fulfilled: (1) the person had to be a national; and (2) the principle of double criminality was required.<sup>40</sup> This latter principle entails that, in order for the person to be criminally liable, the act has to be a criminal offence in both the country of nationality or residence and the country where the crime was carried out. Another possibility is that the person had to be liable for preparatory acts in the Netherlands concerning the performance of the act of FGM abroad.<sup>41</sup> This way, many girls had undergone FGM in countries where FGM was not prohibited by (criminal) law. Consequently, the people who performed this practice were able to avoid criminal liability. That outcome was considered to be unsatisfactory and undesirable. Therefore, the principle of double criminality regarding FGM was abandoned in 2004. Currently, this principle is no longer required in cases of FGM and the principle of extraterritoriality is applicable to both nationals and permanent residents without further requirements.<sup>42</sup> This is, in my opinion, a great step forward in the ability to combat FGM and to protect the girls and women concerned. It should be noted that this law is only applicable to cases regarding FGM after this law has entered into force.

### 3.5. Court Cases

It is remarkable that, although FGM has been considered a criminal offence since 1992 and is prohibited by criminal law as a form of abuse, not a single court case regarding FGM has taken place. This deserves attention and should be considered thoroughly. Why

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<sup>40</sup> Dutch Penal Code, article 5, paragraph 1, sub 2.

<sup>41</sup> Kwaak, van der, Anke, et al., *Strategieën ter voorkoming van besnijdenis bij meisjes: Inventarisatie en aanbevelingen*, Vrije Universiteit and VU Medisch Centrum, Amsterdam, October 2003, p. 53.

<sup>42</sup> Letter from Minister of Health, Wellbeing and Sports, *Kabinetsstandpunt RVZ-advies bestrijding vrouwelijke genitale verminking* and attachment to this letter, 26 August 2005, pp. 3-4; Kamerstukken II 2003/04, 29241, nr.1 p. 15; Kamerstukken I 2004/05, 28484, A; Kamerstukken II 2003/04, 28484, nr. 41 and 2004/05, 28484, nr. 48.

has that not happened...yet? Is it the difficulty of finding solid and sustainable evidence? Is it the hidden character of FGM that makes it difficult to trace? Or is it perhaps the Dutch policy of preferring prevention and health-care over criminal proceedings? Evidently, there is no clear-cut answer to these questions, leaving us no option but to speculate.

### 3.6. Other Applicable Laws

Besides criminal law, there are several other laws applicable to cases concerning FGM in the Netherlands:

- First, the Dutch Constitution guarantees the principle of equality (between men and women *in casu* of FGM) and the principle of non-discrimination (based on gender in the case of FGM) in article 1; the right to physical and mental integrity in article 11; and the right to health in article 22. No one can be deprived of this. On the other hand, article 10 of the Constitution states that the private life of individuals should be respected.<sup>43</sup>
- Second, child protection laws exist. In case of a threat of being subjected to FGM, the Dutch Civil Code (*Algemeen Burgerlijk Wetboek*) provides in Book 1, article 254, paragraph 1, for the possibility for the judge to give temporary custody of the child to a special child custody institution. Article 261 provides for the possibility to remove the child from her parental home for a longer period of time, if necessary.<sup>44</sup> This is a preventative action that could be quite effective.
- Third, for the medical profession there is a special law (*Wet Beroepen in de Individuele Gezondheidszorg*) holding liable the person executing, and/or providing assistance to the practice of FGM for damaging somebody's health.<sup>45</sup> In

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<sup>43</sup> Dutch Constitution, articles 1, 10, 11, and 22.

<sup>44</sup> Dutch Civil Code, articles 254, paragraph 1 and 261.

<sup>45</sup> *Wet Beroepen in de Individuele Gezondheidszorg*.



addition, article 436, paragraph 2 of the Penal Code punishes persons crossing the reasonable/moral boundaries of their profession with a fine.<sup>46</sup>

In addition, article 53, paragraph 3 of the Youth Care Act (*Wet op de Jeugdzorg*) states that a doctor or health-care worker with an obligation of professional secrecy has the right (not the duty as has been proposed by the commission) to report a threat of being subjected to FGM to the national child abuse institution (*Advies- en Meldpunt kindermishandeling*).<sup>47</sup>

- Fourth, the threat of being subjected to FGM can, under certain circumstances, be recognised as a reason to grant asylum. In a few cases, asylum has been granted to girls and women from Somalia, for example, to a Somali girl and her family in 2002. The Dutch Cabinet is now researching whether a medical statement accompanying the asylum request should be required.<sup>48</sup> In practice, not many women are granted asylum on the basis of a threat of FGM, due to the fact that during the reporting procedure that has to take place within 48 hours upon arrival in the Netherlands these women do not mention their fear of being subjected to FGM, either out of embarrassment or because they simply don't know about this possibility.<sup>49</sup>

### 3.7. Prevention

Today, the Dutch policy in combating FGM follows a health and human rights approach, with its main focus on prevention rather than on criminal proceedings. Prevention means here to ensure that the practice of FGM won't take place, both in the Netherlands and elsewhere.

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<sup>46</sup> Dutch Penal Code, article 436, paragraph 2.

<sup>47</sup> *Wet op de Jeugdzorg*, article 53, paragraph 3.

<sup>48</sup> Commissie Bestrijding Vrouwelijke Genitale Verminking, *Bestrijding vrouwelijke genitale verminking*, Zoetermeer, the Netherlands, 23 March 2005, p. 8.

<sup>49</sup> Kwaak, van der, Anke, et al., *Strategieën ter voorkoming van besnijdenis bij meisjes: Inventarisatie en aanbevelingen*, Vrije Universiteit and VU Medisch Centrum, Amsterdam, October 2003, pp. 57-58.

The Dutch prevention policy consists of awareness raising, education and training of medical professionals and health-care workers, and the empowerment of women. The main focus is to prevent as much harm to the health of the girls as possible. It is hoped that, by providing the girls concerned with better information, they will be better equipped to seek professional help in cases of complications at an earlier stage.<sup>50</sup>

The key issues of the Dutch prevention policy are to:<sup>51</sup>

- Inform everybody about the fact that FGM is prohibited by law and that people should inform the authorities if they have any suspicion in a particular case (when better informed, people will be more alert). This information should be provided continuously and consistently.<sup>52</sup>
- Convince risk groups and individuals to eradicate the practice of FGM, aimed at the entire social system: women, men, youth, and the elderly (the latter exerting pressure in the majority of cases). Key figures from the community, religious leaders in particular, play an important role here. Inspiring examples of people eradicating and combating FGM could be used (e.g. Ayaan Hirsi Ali - former member of the Dutch Parliament – in the Netherlands, or Waris Dirie - the United Nations goodwill ambassador on FGM - at the international level). Information should be provided about the legal prohibition of FGM, about the damage that FGM might cause to the health of the girl or woman, and about the background of the custom. In addition, information about the position of women in (Dutch) society should be provided and people should be made more aware of the concept of human rights, in particular the right to physical integrity.<sup>53</sup> The above can be achieved by addressing FGM in the media, specifically targeted at the risk groups,

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<sup>50</sup> Commissie Bestrijding Vrouwelijke Genitale Verminking, *Bestrijding vrouwelijke genitale verminking*, Zoetermeer, the Netherlands, 23 March 2005, p. 41.

<sup>51</sup> Commissie Bestrijding Vrouwelijke Genitale Verminking, *Bestrijding vrouwelijke genitale verminking*, Zoetermeer, the Netherlands, 23 March 2005, pp. 41-46.

<sup>52</sup> Commissie Bestrijding Vrouwelijke Genitale Verminking, *Bestrijding vrouwelijke genitale verminking*, Zoetermeer, the Netherlands, 23 March 2005, pp. 41-42.

<sup>53</sup> Commissie Bestrijding Vrouwelijke Genitale Verminking, *Bestrijding vrouwelijke genitale verminking*, Zoetermeer, the Netherlands, 23 March 2005, pp. 42-43.

by providing information on special websites in their mother tongue, by a regional approach, and by projects in the local neighbourhoods. In the United Kingdom, special clinics are set up to provide the girls and women concerned with physical and psychological aid. These clinics could serve as a good example for the Netherlands (see Chapter 5 on the United Kingdom).<sup>54</sup>

- Train and educate concerned professionals: medical professionals (e.g. midwives and gynaecologists), health-care workers, police, judicial authorities, and teachers.<sup>55</sup> For example, the Dutch Organisation of Gynaecologists and the Dutch Medical Inspection Board have issued guidelines how to deal with the medical complications of FMG and the issue of *re-infibulation*.<sup>56</sup>

It should be noted that this policy of prevention is not necessarily the same as overtly acknowledging the negative consequences of FGM and advocating that FGM is not a desirable practice. Often people are moved to desist from the practice because of a threatening prosecution, rather than that they are willing to prevent it and refrain from it out of disapproval of the practice at its roots and because of the negative consequences incurred.<sup>57</sup>

For the purpose of prevention, several organisations exist. The most famous organisation is PHAROS. This Centre for Refugees and Health has a national advisory function and is based in Utrecht. Other organisations are: the *Federation of Somali Associates the Netherlands* (FSAN), *Vluchtelingen-Organisaties Nederland* (Refugee organisations the Netherlands), and *African Sky* (the national foundation for women from the horn of Africa) in Utrecht and organisations dealing with children's issues like *Defence for*

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<sup>54</sup> Commissie Bestrijding Vrouwelijke Genitale Verminking, *Bestrijding vrouwelijke genitale verminking*, Zoetermeer, the Netherlands, 23 March 2005, pp. 43-44.

<sup>55</sup> Commissie Bestrijding Vrouwelijke Genitale Verminking, *Bestrijding vrouwelijke genitale verminking*, Zoetermeer, the Netherlands, 23 March 2005, pp. 44-45.

<sup>56</sup> Remarkable is that the Organisation of Midwives (*Organisatie van Verloskundigen*) states that the wishes of the woman concerned should be respected during childbirth, even if she requests for *re-infibulation*. Geneeskundige Hoofdingspectie van de Volksgezondheid, *GHI Bulletin: Informatie over vrouwenbesnijdenis*, Rijswijk, March 1994.

<sup>57</sup> Kwaak, van der, Anke, et al., *Strategieën ter voorkoming van besnijdenis bij meisjes: Inventarisatie en aanbevelingen*, Vrije Universiteit and VU Medisch Centrum, Amsterdam, October 2003, p. 4.

*Children International Nederland* (DCI) and for child abuse like *Advies- en Meldpunt Kindermishandeling* (AMK), and the *Stichting Tegen Meisjesbesnijdenis* (Foundation against the Circumcision of Girls) in Amsterdam. *Focal Point* is a special organisation founded to facilitate dialogue between all the parties concerned.

According to a survey that was conducted regarding the attitude towards FGM among immigrants from FGM risk countries in the cities of Amsterdam and Tilburg, the majority of women indicated that they were against the practice of *infibulation* and did not want their daughters to be subjected to it. They agreed with the legal prohibition of FGM (although their knowledge concerning this legal prohibition was not asked), however, they considered their own morals and values to be more important than criminal law.<sup>58</sup> As this survey shows, awareness raising and training are of the utmost importance.

### 3.8. Signalling and Reporting

The function of signalling at an early stage has been discussed extensively in the Netherlands.

In order to signal most effectively, former member of the Dutch Parliament Ayaan Hirsi Ali (originally from Somalia) of the conservative VVD party proposed a mandatory physical examination among girls from the risk group. However, this would not be possible *in casu* of FGM, due to the following reasons: (1) it would be considered discriminatory to only let girls and women from specific countries undergo a physical examination;<sup>59</sup> (2) the Dutch law does not provide for the possibility of a mandatory physical examination in FGM cases;<sup>60</sup> (3) a compulsory physical medical examination

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<sup>58</sup> The response of this survey was 55%. Kramer, Merlijn, et al., *Vrouwelijke Genitale Verminking nader bekeken: Een onderzoek naar de aard omvang en attitude onder professionals en risicogroep in Amsterdam en Tilburg*, GG&GD Amsterdam, GGD Hart voor Brabant, March 2005, pp. 43-46.

<sup>59</sup> Hirsi Ali, Ayaan, *Besnijdenis mag niet gedoogd worden*, VVD, 4 March 2004 <<http://www.vvd.nl/index.aspx?Contentid=835&Chapterid=1147&Filterid=974>> (date accessed: 5 March 2006); TweeVandaag (TROS), *Vrouwenbesnijdenis in Nederland*, 29 June 2005; Dirie, Waris, *Onze verborgen tranen*, Amsterdam, Sirene, 2005, pp. 162-163.

<sup>60</sup> In general, the authority to do so only exists in criminal cases, where there is a well-grounded suspicion of the potential commission of a crime and can only be performed on the perpetrator, not on the victim. Kool, R.S.B., et al., *Vrouwelijke genitale verminking in juridisch perspectief: (Rechtsvergelijkend) onderzoek naar de juridische mogelijkheden ter voorkoming en bestrijding van vrouwelijke genitale*

would interfere too much with the private life of a person and would therefore violate article 10 of the Dutch Constitution, article 17 ICCPR, and article 8 ECHR.<sup>61</sup> The Cabinet considered a mandatory physical examination to be too heavy-handed a tool and a too immense interference in the private life of an individual. Obligatory examinations would also bear the risk that children would avoid going to a doctor, which would not be in the best interest of the health of the child.<sup>62</sup> A voluntary physical examination was later proposed for all children, not only for girls from the FGM risk group. It was argued that this way, children could also be generally checked upon signs of other forms of abuse.<sup>63</sup> However, the Cabinet did not follow this proposal, repeating the risk of girls and women avoiding doctor visits and stating that it would be more effective to signal at an early stage and to assess and register the risks properly.<sup>64</sup>

Although no mandatory examination takes place, medical professionals are still in the best position to signal cases and threats of FGM. The earlier mentioned survey conducted among immigrants living in Amsterdam and Tilburg, shows that doctors and health-care workers do not have sufficient knowledge regarding FGM. Gynaecologists, family practitioners and midwives indicated to have some knowledge, however, not detailed enough to act upon. That unmistakably damages the signalling function.<sup>65</sup> Medical professionals, as we have seen above, have the right, not the duty, to report cases and threats of FGM to the national child abuse institution (*Advies- en Meldpunt kindermishandeling*). Reasons for not making the report system mandatory are: (1) the risk of parents and/or their children avoiding doctor visits; (2) the risk that the conduct of parents will be influenced by the fear of criminal proceedings; and (3) a likely increase of

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*verminking*, Willem Pompe Instituut, sectie Strafrecht, Universiteit Utrecht, Zoetermeer, the Netherlands, 2005, pp. 18-21.

<sup>61</sup> Kool, R.S.B., et al., *Vrouwelijke genitale verminking in juridisch perspectief: (Rechtsvergelijkend) onderzoek naar de juridische mogelijkheden ter voorkoming en bestrijding van vrouwelijke genitale verminking*, Willem Pompe Instituut, sectie Strafrecht, Universiteit Utrecht, Zoetermeer, the Netherlands, 2005, pp. 45-47.

<sup>62</sup> Letter of the Minister of Health, Wellbeing and Sports, BHTK 2003-2004, 29 2000, XVI, nr. 231, p. 6.

<sup>63</sup> Commissie Bestrijding Vrouwelijke Genitale Verminking, *Bestrijding vrouwelijke genitale verminking*, Zoetermeer, the Netherlands, 23 March 2005, pp. 23-27.

<sup>64</sup> Letter from Minister of Health, Wellbeing and Sports, *Kabinetsstandpunt RVZ-advies bestrijding vrouwelijke genitale verminking* and attachment to this letter, 26 August 2005, pp. 5, 9 and p. 6.

<sup>65</sup> Kramer, Merlijn, et al., *Vrouwelijke Genitale Verminking nader bekeken: Een onderzoek naar de aard omvang en attitude onder professionals en risicogroep in Amsterdam en Tilburg*, GG&GD Amsterdam, GGD Hart voor Brabant, March 2005, pp. 31-32.

false reports.<sup>66</sup> To make the reporting system as effective as possible, guidelines are provided for medical professionals on how to deal with cases and threats of FGM.<sup>67</sup> When medical professionals do signal cases or threats of FGM, there exist numerous reasons for not reporting them (e.g. to protect the family). Therefore, it is estimated that a high number of cases go unreported.

Teachers are also in a good position to signal. However, they don't see it as their task to discuss FGM with mothers of their pupils and therefore are not likely to signal cases and threats of FGM and report them to the authorities. This is regrettable because they are in close contact with the risk group on a daily basis. It is questionable if family members and neighbours are really willing to signal and report cases and threats of FGM. They are likely to support the girl or woman concerned and to protect her family. Moreover, reporting is often seen as betrayal of the girl or woman, family, and culture. In all probability, the same amounts to key figures from the community and religious leader.

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<sup>66</sup> Letter from Minister of Health, Wellbeing and Sports, *Kabinetsstandpunt RVZ-advies bestrijding vrouwelijke genitale verminking*, 26 August 2005, p. 6.

<sup>67</sup> Letter from Minister of Health, Wellbeing and Sports, *Kabinetsstandpunt RVZ-advies bestrijding vrouwelijke genitale verminking*, 26 August 2005, p. 7.

## Chapter 4: France

### 4.1. Context

France is a European country with a high number of immigrants, partially due to a vivid colonial history in (West) Africa. There are many immigrants from countries where FGM is traditionally practised in Africa: Ivory Coast, Mali, Mauritania, and Senegal, living in France. The majority of immigrants live in Paris and in the other bigger cities of Le Havre, Lille, Lyon, and Marseille.<sup>68</sup> It is estimated that between 40,000 and 65,000 girls and women from FGM risk countries live in France.<sup>69</sup> There are between 13,000 and 27,000 girls/women who have been subjected to FGM<sup>70</sup> and 4,500 girls currently at risk.<sup>71</sup>

The type of FGM that is most commonly practised in France is Type II. The age at which this is commonly practised is before the 1<sup>st</sup> year.<sup>72</sup>

In 1982, the topic of FGM was discussed heavily in the media, after a three months old girl, Bobo Traoré, bled to death as a result of complications incurred during an FGM

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<sup>68</sup> Leye, Els, Deblonde, Jessika, *A comparative analysis of the different legal approaches towards female genital mutilation in the 15 EU Member States, and the respective judicial outcomes in Belgium, France, Spain, Sweden and the United Kingdom*, International Centre for Reproductive Health (ICRH), Publications No. 8, Ghent, The Consultory, April 2004, p. 27.

<sup>69</sup> Leye, Els et al., *Health care in Europe for Women with genital mutilation*, in "Health Care for Women International," vol. 27, nr. 4, April 2006, p. 24, and reference cited in Table 2 to Gallard, C., *Female Genital Mutilation in France*, in "British Medical Journal," no. 310, 1995, pp. 1592-1593; Gillette-Faye, Isabelle, *Répartition géographique en France et dans le monde*, in Académie nationale de médecine (ed.), *Les mutilations sexuelles féminines. Un autre crime contre l'humanité: Connaître, prévenir, agir*, Supplément au *Bulletin de l'Académie nationale de médecine*, vol. 188, no. 6, 10 June 2004, pp. 47-48.

<sup>70</sup> Leye, Els et al., *Health care in Europe for Women with genital mutilation*, in "Health Care for Women International," vol. 27, nr. 4, April 2006, p. 24, and reference cited in Table 2 to Délégation Régionale aux Droits des Femmes, 1998; Gillette, Isabelle, *La polygamie et l'excision dans l'immigration africaine en France, analysées sous l'angle de la souffrance sociale des femmes*, Villeneuve d'Ascq Cédex France: Presses Universitaires du Septentrion, 1997.

<sup>71</sup> Leye, Els et al., *Health care in Europe for Women with genital mutilation*, in "Health Care for Women International," vol. 27, nr. 4, April 2006, p. 24, and reference cited in Table 2 to Délégation Régionale aux Droits des Femmes, 1998.

<sup>72</sup> Mrs. Emmanuelle Piet, director of the PMI centres in France, states that a clear-cut classification as employed by the WHO is not so clear in practice. In France, the most common form of FGM is the form where the clitoris and the *labia minora* are cut and the latter are sewn together. Interview with E. Piet, 5 May 2006.

procedure carried out in France. The parents failed to bring their daughter to the hospital in time and were prosecuted.<sup>73</sup>

In 1983, FGM was recognised as a form of mutilation, as laid down in article 312-3 of the old<sup>74</sup> *Code Pénal* (French Penal Code).<sup>75</sup> FGM was considered to be a *crime*, the most severe category of criminal offences.<sup>76</sup> In France, the definition of *mutilation sexuelle* is employed to stress the broader scope of the term, referring to the psychological, medical, and social context.<sup>77</sup>

It is remarkable that France is the only European country with a systematic practice of criminal court cases dealing with FGM,<sup>78</sup> from as early as 1979 onwards.<sup>79</sup>

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<sup>73</sup> Weil-Curiel, Linda, *Strafrechtliches Vorgehen, eine Anerkennung der Rechte von Kindern*, in Hermann, Conny (Hg.), *Das Recht auf Weiblichkeit: Hoffnung im Kampf gegen die Genitalverstümmelung*, Bonn, Dietz, 2000, p. 153.

<sup>74</sup> The *Code Pénal* was revised on 1 March 1994.

<sup>75</sup> As recognised in the *Richer-Peyrichout* case, *Cour de Cassation*, 20 August 1983. The Court stated: “*L’ablation du clitoris constitue un crime de violence ayant entraîné une mutilation au sens de l’article 312-3 du Code de procédure pénale.*” Kool, R.S.B., et al., *Vrouwelijke genitale verminking in juridisch perspectief: (Rechtsvergelijkend) onderzoek naar de juridische mogelijkheden ter voorkoming en bestrijding van vrouwelijke genitale verminking*, Willem Pompe Instituut, sectie Strafrecht, Universiteit Utrecht, Zoetermeer, the Netherlands, 2005, p. 69; Kwaak, van der, Anke, et al., *Strategieën ter voorkoming van besnijdenis bij meisjes: Inventarisatie en aanbevelingen*, Vrije Universiteit and VU Medisch Centrum, Amsterdam, October 2003, p. 73.

<sup>76</sup> The three types of criminal offences in the *Code Pénal* are, in order of severity: *contravention*, *délit*, *crime*. Crimes are offences with a punishment of a minimum of ten years imprisonment.

<sup>77</sup> Morbois, Catherine, Casalis, Marie-France, *Violences masculines envers les femmes: contexte historique et socio-culturel*, in Académie nationale de médecine (ed.), *Les mutilations sexuelles féminines. Un autre crime contre l’humanité: Connaître, prévenir, agir*, Supplément au *Bulletin de l’Académie nationale de médecine*, vol. 188, no. 6, 10 June 2004, p. 63.

<sup>78</sup> In Sweden, there have been two FGM court cases as well (one in 2000 and one in June of 2006, where in the latter case, the father was sentenced to four years imprisonment and compensation for damages for forcing his daughter to undergo FGM in Somalia). In Italy, there have also been two FGM court cases (one in 1997, where the parents of a Nigerian girl were finally acquitted and one in 1999, where the father was sentenced to two years imprisonment for forcing his daughter to undergo FGM in Menofeia, Egypt). In Sweden and Italy, no systematic practice of criminal court cases takes place. Miller, Michael, *Responses to Female Genital Mutilation/Cutting in Europe*, UNICEF Innocenti Research Centre, Florence, Italy, 2004, p. 3; E-mail from L. Segato (Director of *Ricerche e Studi su Sicurezza e Criminalità*, Zanè, Italy), 4 July 2006; *The Waris Dirie Foundation* <[http://www.waris-dirie-foundation.com/web/e\\_index.htm](http://www.waris-dirie-foundation.com/web/e_index.htm)> (date accessed: 27 June 2006).

<sup>79</sup> Weil-Curiel, Linda, *Combating sexual mutilation in France through the application of the law*, C.A.M.S., 2002.



#### 4.2. Criminal Law

In France, FGM is, just like in the Netherlands, prohibited under general criminal law. These general criminal law provisions are applicable to every person (no distinction is made between children and adults, at the most this would result in a more severe penalty; for the application regarding FGM, however, it is applicable to both girls and women). FGM would fall under articles 222-9 and 222-19 of the *Code Pénal* (French Penal Code) of 1994, title 1, paragraph 2, under *Des actes de violences* (violent acts) and would be qualified as a form of mutilation. An aggravating factor is when the offence is performed against a minor and an additional aggravating factor is when the offence is performed by a parent or person having custody over the child. The latter can be prosecuted as accomplices.<sup>80</sup>

Several specific forms of (child) abuse are mentioned in the *Code Pénal*. The difference with the Netherlands should be noted, where a basic form of abuse is used with additional aggravating factors.<sup>81</sup>

The primary applicable criminal law provision regarding FGM is article 222-9:

##### **Article 222-9**

*Les violences ayant entraîné une **mutilation** ou une **infirmité permanente** sont punies de **dix** ans d'emprisonnement et de 1 000 000 F d'amende.* (emphasis added)

The aggravating factors that might occur are laid down in article 222-10:

##### **Article 222-10**

*L'infraction définie à l'article 222-9 est punie de **quinze** ans de réclusion criminelle*

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<sup>80</sup> Leye, Els, Deblonde, Jessika, *A comparative analysis of the different legal approaches towards female genital mutilation in the 15 EU Member States, and the respective judicial outcomes in Belgium, France, Spain, Sweden and the United Kingdom*, International Centre for Reproductive Health (ICRH), Publications No. 8, Ghent, The Consultory, April 2004, p. 16.

<sup>81</sup> Kool, R.S.B., et al., *Vrouwelijke genitale verminking in juridisch perspectief: (Rechtsvergelijkend) onderzoek naar de juridische mogelijkheden ter voorkoming en bestrijding van vrouwelijke genitale verminking*, Willem Pompe Instituut, sectie Strafrecht, Universiteit Utrecht, Zoetermeer, the Netherlands, 2005, pp. 70-71.

*lorsqu'elle est commise:*

- 1° Sur un **mineur de quinze ans**;*
- 2° Sur une personne dont la **particulière vulnérabilité**, due à son âge, à une maladie, à une infirmité, à une déficience physique ou psychique ou à un état de grossesse, est apparente ou connue de son auteur;*
- 3° Sur un **ascendant légitime ou naturel** ou sur les **père ou mère adoptifs**;*
- 4° Sur un magistrat, un juré, un avocat, un officier public ou ministériel, un militaire de la gendarmerie, un fonctionnaire de la police nationale, des douanes, de l'administration pénitentiaire, un agent d'un exploitant de réseau de transport public de voyageurs ou toute autre personne dépositaire de l'autorité publique ou chargée d'une mission de service public, dans l'exercice ou à l'occasion de l'exercice de ses fonctions ou de sa mission, lorsque la qualité de la victime est apparente ou connue de l'auteur;*
- 5° Sur un témoin, une victime ou une partie civile, soit pour l'empêcher de dénoncer les faits, de porter plainte ou de déposer en justice, soit en raison de sa dénonciation, de sa plainte ou de sa déposition;*
- 6° Par le conjoint ou le concubin de la victime;*
- 7° Par une personne dépositaire de l'autorité publique ou chargée d'une mission de service public dans l'exercice ou à l'occasion de l'exercice de ses fonctions ou de sa mission;*
- 8° Par plusieurs personnes agissant en qualité d'auteur ou de complice;*
- 9° Avec **préméditation**;*
- 10° Avec usage ou menace d'une arme.*

*La peine encourue est portée à **vingt ans** de réclusion criminelle lorsque l'infraction définie à l'article 222-9 est commise **sur un mineur de quinze ans par un ascendant légitime, naturel ou adoptif ou par toute autre personne ayant autorité sur le mineur.***

*Les deux premiers alinéas de l'article 132-23 relatif à la période de sûreté sont applicables aux infractions prévues par le présent article. (emphasis added)*

As we have seen, FGM is almost always a premeditated crime.

In case of unintended death caused by the mutilation, *in casu* the practice of FMG, article 222-7 is applicable:

***Article 222-7***

*Les violences ayant entraîné la mort sans intention de la donner sont punies de quinze ans de réclusion criminelle.*

The same aggravating factors as mentioned above are applicable to this article, increasing the penalty to twenty years of imprisonment.

4.3. General Criminal Law Prohibiting FGM

In 1981, the Minister of Women's Rights appointed a working group to research whether the introduction of a specific criminal law for FGM would be desirable. This working group concluded that the general criminal law provisions that already existed were sufficient and preferred this over a specific criminal law provision. The scope of the latter would have been too narrow, would risk discrimination and stigmatising effects and would merely be symbolic.<sup>82</sup> The general criminal law provisions would combine repression and prevention. Mrs. Weil-Curiel was then a member of this working group.<sup>83</sup> She stresses that general criminal law should be preferred, since it is applicable to everybody and not just to the risk group (mainly people of African descent). According to her, this is the only way that the principle of non-discrimination can be guaranteed.<sup>84</sup> The only thing that is not clear under the French criminal law is if it also covers the prohibition of *re-infibulation*. Most immigrants living in France come from West Africa, where *re-infibulation* is not practised on a big scale. Therefore, it is not a big issue in France and there is no definite standpoint regarding this issue.<sup>85</sup>

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<sup>82</sup> Kool, R.S.B., et al., *Vrouwelijke genitale verminking in juridisch perspectief: (Rechtsvergelijkend) onderzoek naar de juridische mogelijkheden ter voorkoming en bestrijding van vrouwelijke genitale verminking*, Willem Pompe Instituut, sectie Strafrecht, Universiteit Utrecht, Zoetermeer, the Netherlands, 2005, pp. 71-72.

<sup>83</sup> Mrs. Weil-Curiel is currently criminal lawyer, leading the FGM court cases, and president of the *Commission pour l'Abolition des Mutilations Sexuelles* (C.A.M.S.) in Paris.

<sup>84</sup> Interview with L. Weil-Curiel, 5 May 2006.

<sup>85</sup> Interview with L. Weil-Curiel, 5 May 2006.

#### 4.4. Extraterritoriality

Is it possible to hold a person criminally liable in cases where the practice of FGM has been exercised outside the territory of France? In other words, does the principle of extraterritoriality apply?

Yes it does, provided that the person is a French national. The *Code Pénal* acknowledges the principle of passive nationality. This means that the *Code Pénal* is applicable to all criminal cases, in which a French national (not resident as in the United Kingdom) is involved as victim, irrespective of whether the crime has been committed on French soil or elsewhere.<sup>86</sup> France does not require the principle of double criminality, but claims to be competent, independent from criminality in other countries. Several court cases have already taken place based on this competence, where parents living in France were prosecuted as accessories.

Mrs. Weil-Curiel proposed to give a certificate issued by the *Protection Maternelle et Infantile* (PMI) centres (the French infant care centres) accompanying a girl travelling to Africa, in which it is stated that the girls' outer genitalia are still intact and should be intact upon return and furthermore that FGM is prohibited under French criminal law. This can be used as an effective weapon against family living in the country of origin, who are usually socially and economically depending on the immigrants in Europe.<sup>87</sup>

#### 4.5. Court cases

It is remarkable that France is the only country where a systematic practice of criminal court cases related to FGM takes place. Since 1979, between 35 and 40 cases have taken place, all relating to FGM committed on minors (which is an aggravated factor, as we have seen).<sup>88</sup>

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<sup>86</sup> *Code Pénal*, article 113-7.

<sup>87</sup> Interview with L. Weil-Curiel, 5 May 2006.

<sup>88</sup> Weil-Curiel, Linda, *Aspects judiciaires: l'excision et la loi*, in Académie nationale de médecine (ed.), *Les mutilations sexuelles féminines. Un autre crime contre l'humanité: Connaître, prévenir, agir*, Supplément au *Bulletin de l'Académie nationale de médecine*, vol. 188, no. 6, 10 June 2004, p. 115.

#### 4.6. Competent Courts

Now that we have seen that FGM is prohibited by the *Code Pénal* and know that actual court cases have taken place, we can raise the question: which courts are competent to deal with FGM cases?

In the traditional justice system in France the *juge d'instruction* (investigating judge) would refer the case to the *Tribunal de Grande Instance* (county court), which would be the competent court in these cases. Yet, because of the great significance and severity of FGM cases and because it was clear from the start that these cases would set an example, access to the *Cour d'Assises* (highest court at first instance) was desirable.<sup>89</sup>

In 1984, the competence of the *Cour d'Assises* was recognised for the first time.<sup>90</sup> In 1986 a Parisian *Tribunal de Grande Instance* referred to the *Cour d'Assises*, which was confirmed by the *Cour de Cassation* (court of appeals).<sup>91</sup> This paved the way for later cases: for the *Coulibalys-Keita* case in 1986, where the qualification of the *crime* of FGM was confirmed and the competence of the *Cour d'Assises* was recognised, for the *Baradji* case in 1988, for the *Traoré – Fofana* case in 1989, and for the *Soumaré* case in 1990.<sup>92</sup>

The proceedings before the *Cour d'Assises* are adversarial. This means that the *juge d'instruction* drafts the indictment. The parties are questioned at the session, whereafter the hearing of witnesses and experts takes place. The civil party states its arguments, upon which the public prosecutor holds his or her requisitory, followed by the final plea of the defence. All evidence is presented orally before three judges and a jury panel

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<sup>89</sup> Kool, R.S.B., et al., *Vrouwelijke genitale verminking in juridisch perspectief: (Rechtsvergelijkend) onderzoek naar de juridische mogelijkheden ter voorkoming en bestrijding van vrouwelijke genitale verminking*, Willem Pompe Instituut, sectie Strafrecht, Universiteit Utrecht, Zoetermeer, the Netherlands, 2005, p. 73.

<sup>90</sup> In the *Traoré* case the *Tribunale de Grande Instance* referred the case to the *Cour d'Assises* in 1984.

<sup>91</sup> *Richer-Périchout* case, *Cour de Cassation*, 20 August 1983.

<sup>92</sup> Kool, R.S.B., et al., *Vrouwelijke genitale verminking in juridisch perspectief: (Rechtsvergelijkend) onderzoek naar de juridische mogelijkheden ter voorkoming en bestrijding van vrouwelijke genitale verminking*, Willem Pompe Instituut, sectie Strafrecht, Universiteit Utrecht, Zoetermeer, the Netherlands, 2005, pp. 73-74.

consisting of nine members.<sup>93</sup> The prosecution can refuse three members of the jury and the defence can refuse four members.

#### 4.7. Participation of Victim or Interest Group

The French criminal proceedings can be initiated in three ways: (1) by the public prosecutor; (2) by the *juge d'instruction*: the *action publique*; and (3) by the victim. The victim has two possibilities to initiate criminal proceedings: (a) the *action civile*;<sup>94</sup> and (b) the *citation directe*.<sup>95</sup> In addition, interest groups can initiate criminal proceedings, provided that the aim of this group or organisation protects the interest(s) of the victim that is damaged, and that the group has been registered five years before the criminal offence has taken place.<sup>96</sup> Examples are interest groups combating child abuse or sexual or domestic violence. The most famous interest group regarding FGM in France is the *Commission pour l'Abolition des Mutilations Sexuelles* (C.A.M.S.) in Paris. C.A.M.S. acts as *partie civile* on behalf of the girl, charging a symbolic honorarium of € 1. Mrs. Weil-Curiel states that intervention of a civil party is of the utmost importance and should serve as an example for other European countries.<sup>97</sup>

#### 4.8. Analysis of Court Cases

For an overview of French criminal cases regarding FGM, I would like to refer to the list in Annex 3.<sup>98</sup>

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<sup>93</sup> *Code Pénal*, article 309; Kool, R.S.B., et al., *Vrouwelijke genitale verminking in juridisch perspectief: (Rechtsvergelijkend) onderzoek naar de juridische mogelijkheden ter voorkoming en bestrijding van vrouwelijke genitale verminking*, Willem Pompe Instituut, sectie Strafrecht, Universiteit Utrecht, Zoetermeer, the Netherlands, 2005, p. 80.

<sup>94</sup> There are two possibilities: 1) comply as civil party to criminal proceedings initiated by the public prosecutor or *juge d'instruction*: *partie civile ex Code Pénal*, article 3; or 2) request of the *juge d'instruction* directly to start criminal proceedings: *plainte avec constitution de partie civile*. Primary goal is to claim compensation for damages. Note that both victims and interest groups can employ this tool. *Code Pénal*, articles 2 and 3.

<sup>95</sup> This tool is not employed very often, due to the risk of being held liable for involving someone in criminal proceedings in case of acquittal. In addition, this tool is only applicable in cases where the *Tribunaux de Grande Instance* have competence. That is hardly ever the case with the *crime* of FGM. *Code Pénal*, article 86.

<sup>96</sup> *Code de Procédure Pénale* (Code of Criminal Proceedings), articles 2-2 and 2-3.

<sup>97</sup> Interview with L. Weil-Curiel, 5 May 2006.

<sup>98</sup> This table entails the French FGM court cases until 13 January 2004 (data about more recent court cases could not easily be accessed). Kool, R.S.B., et al., *Vrouwelijke genitale verminking in juridisch perspectief: (Rechtsvergelijkend) onderzoek naar de juridische mogelijkheden ter voorkoming en bestrijding van vrouwelijke genitale verminking*, Willem Pompe Instituut, sectie Strafrecht, Universiteit

After analysis of all court cases, there are several issues that draw our attention:

- The first issue that draws our attention concerns the person prosecuted. In only a few cases, the traditional practitioner, most commonly an elderly highly respected woman from the community concerned, is prosecuted. Unfortunately, in many cases, it is not known who the actual practitioner is. The parents of the girl who has undergone FGM often remain silent and therefore it is hard to trace the person who actually carried out the practice. In only 7 of the 35 cases, the practitioner was prosecuted. The majority of accused are the mothers of the girl or the second wives. It is seldom that the father is seen as the accused. This is a confirmation that FGM is considered to be a “women’s issue.” But the countries in which FGM is traditionally practised are often based on a patriarchal society. Thus, it is likely that the father had at least the knowledge that FGM took place and he probably even gave his consent in most cases.<sup>99</sup> He could also have aided and abetted, by for example driving a car to the place where the practice is carried out, or by providing the necessary financial means.
- The second issue that draws our attention is the fact that the passing of time does not prevent a prosecution from taking place. In three cases, the practitioners were accused of exercising FGM on different occasions over a period of several years.<sup>100</sup>
- The third issue that draws our attention is the penalty imposed and the severity of it. In the majority of cases the penalty imposed is totally conditional imprisonment, which is not carried out under certain circumstances: *sursis*. It is

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Utrecht, Zoetermeer, the Netherlands, 2005, pp. 80-82.

<sup>99</sup> Kool, R.S.B., et al., *Vrouwelijke genitale verminking in juridisch perspectief: (Rechtsvergelijkend) onderzoek naar de juridische mogelijkheden ter voorkoming en bestrijding van vrouwelijke genitale verminking*, Willem Pompe Instituut, sectie Strafrecht, Universiteit Utrecht, Zoetermeer, the Netherlands, 2005, pp. 82-83.

<sup>100</sup> Kool, R.S.B., et al., *Vrouwelijke genitale verminking in juridisch perspectief: (Rechtsvergelijkend) onderzoek naar de juridische mogelijkheden ter voorkoming en bestrijding van vrouwelijke genitale verminking*, Willem Pompe Instituut, sectie Strafrecht, Universiteit Utrecht, Zoetermeer, the Netherlands, 2005, p. 83.

remarkable that in most cases regarding totally conditional imprisonment, the maximum penalty is imposed. In only a few cases, probation time is imposed: *sursis avec mise à l'épreuve*. In most cases where partially unconditional imprisonment, *dont une ferme*, is imposed, the period of this unconditional part is relatively short.<sup>101</sup> The penalty of totally conditional imprisonment is seen as proportional in the cases of FGM, even though one would perhaps expect a more severe penalty considering the young age of the victims and the harm caused. Deciding factors for this merely “symbolic” punishment are the relationship between the parents and the girl. It is believed that imprisonment of the parent(s) would not serve the interest of the child. In the last years, an additional indemnification is often imposed as compensation for damages for the victim. In the majority of cases, the parents do not live under great economical conditions. For that reason this indemnification is a heavy burden on the parent(s). When the parent(s) is/are not able to pay this indemnification (usually between € 13,000 and € 25,000), a special fund will provide the money that can recoup the money from the parent(s) later on.<sup>102</sup> According to Mrs. Linda Weil-Curiel the indemnification is a very important tool, which can be used as a weapon against pressure from the family living in the country of origin. The family abroad is in most cases socially and economically depending on the immigrants living in the West, *in casu* France. Consequently, the threat with probable loss of income by possible imprisonment also hits the family abroad.

- The fourth issue that draws our attention is that Mrs. Weil-Curiel is in favour of even harsher punishment. Ideally, she would like to see the parents sent straight to prison. In addition, she would like to see the penalty for the parents to be increased, expressing that parents have a social responsibility towards their child

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<sup>101</sup> Kool, R.S.B., et al., *Vrouwelijke genitale verminking in juridisch perspectief: (Rechtsvergelijkend) onderzoek naar de juridische mogelijkheden ter voorkoming en bestrijding van vrouwelijke genitale verminking*, Willem Pompe Instituut, sectie Strafrecht, Universiteit Utrecht, Zoetermeer, the Netherlands, 2005, p. 83.

<sup>102</sup> Kool, R.S.B., et al., *Vrouwelijke genitale verminking in juridisch perspectief: (Rechtsvergelijkend) onderzoek naar de juridische mogelijkheden ter voorkoming en bestrijding van vrouwelijke genitale verminking*, Willem Pompe Instituut, sectie Strafrecht, Universiteit Utrecht, Zoetermeer, the Netherlands, 2005, p. 84.



and should therefore be punished in the same way as, or even heavier as, the traditional practitioners.<sup>103</sup>

- The last issue that draws our attention is the fact that it is not always clear what exactly can be qualified as mutilation. In the *Soumaré* case of 2006, it was disputed whether a mutilation had taken place.<sup>104</sup> The defence argued that the clitoris was still intact and that therefore one could not speak of a mutilation in this case. C.A.M.S. as *partie civile* on the other hand argued that *in casu* the *labia minora* were cut, which should be qualified as a mutilation, with or without the clitoris still present. The judges ordered a second medical examination on the girl concerned, in order to determine whether a mutilation had taken place or not.

#### 4.9. Defence

After analysis of the French jurisprudence regarding FGM, three types of defences can be detected. The first defensive argument employed is that an error has occurred with regard to the law. This means that, due to the immigrant status, the accused expresses not to be aware of the legal situation in France and thus not of the fact that FGM is prohibited by law. Subsequently, this lack of knowledge would protect the person from being subjected to criminal proceedings. The second defensive argument employed is psychological force majeure, in terms of the accused not being able to resist the pressure from the family in the country of origin.<sup>105</sup> The third defensive argument employed is the so-called “cultural defence,” meaning that the accused claims the right to cultural identity deriving from his or her own traditional norms and values. Nonetheless, none of these three defences have ever been recognised as such in order to acquit a person.<sup>106</sup> On the other hand, these defences might have influence on the severity of the penalty, but the gravity of this impact is unknown.

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<sup>103</sup> Interview with L. Weil-Curiel, 5 May 2006.

<sup>104</sup> *Soumaré* case, *Cour d’Assises* Paris, 5 May 2006.

<sup>105</sup> *Code Pénal*, article 64.

<sup>106</sup> Kool, R.S.B., et al., *Vrouwelijke genitale verminking in juridisch perspectief: (Rechtsvergelijkend) onderzoek naar de juridische mogelijkheden ter voorkoming en bestrijding van vrouwelijke genitale verminking*, Willem Pompe Instituut, sectie Strafrecht, Universiteit Utrecht, Zoetermeer, the Netherlands, 2005, p. 84.

#### 4.10. Success of French Court Cases

From its republican historical roots, France has always stressed the rights and freedoms of the individual.<sup>107</sup> This has two sides. On the one hand, the individual should be protected in all his or her rights; on the other hand, the individual is expected to conform to the French norms and values. That also amounts to immigrants.<sup>108</sup> Only in extreme circumstances can intervention in the private sphere be legitimised. Since the early eighties of the last century, FGM has been recognised as a severe problem that calls for such intervention. Not only its historical roots, but also recent French politics (e.g. the ban on headscarves in 2004) show a clear standpoint regarding secularity and the refusal of the notion of cultural relativism. Mrs. Weil-Curiel emphasises the responsibility to live a “French life,” to respect the French norms and values, and to obey the French law.<sup>109</sup> This reflects the prioritisation of criminal law in the French approach towards FGM. Mrs. Weil-Curiel expresses that, next to the necessity to employ criminal legislative tools and their correct implementation, the advantages of the French court cases are that, due to their publicity, FGM has become known to the public and that the number of girls and women being subjected to FGM has decreased. It is believed that these court cases have an important deterrent factor, due to the fear of possible criminal proceedings.<sup>110</sup> One last observation should be made, namely that the French court cases can only be successful and effective in combination with a clear-cut prevention policy.

#### 4.11. Disadvantages of French Court Cases

The French court cases also show the other side of the coin. There are two major disadvantages that I would like to address:

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<sup>107</sup> French revolution of 1789: *liberté, égalité et fraternité*.

<sup>108</sup> Kool, R.S.B., et al., *Vrouwelijke genitale verminking in juridisch perspectief: (Rechtsvergelijkend) onderzoek naar de juridische mogelijkheden ter voorkoming en bestrijding van vrouwelijke genitale verminking*, Willem Pompe Instituut, sectie Strafrecht, Universiteit Utrecht, Zoetermeer, the Netherlands, 2005, p. 85 and reference to B. Winter, who speaks in her article *Women, the Law, and Cultural Relativism in France: The Case of Excision* in "Journal of Women in Culture and Society," 1994 of “republican universalism.”

<sup>109</sup> Interview with L. Weil-Curiel, 5 May 2006.

<sup>110</sup> Interview with L. Weil-Curiel, 5 May 2006.

- First, it is questionable whether criminal proceedings are effective to combat FGM. Most parents act with good intentions and think that FGM is necessary for their daughter to enable her to marry. Moreover, it remains doubtful whether the imprisonment of the parent(s) would be in the best interest of the child. Then, a penalty like compensation of damages would be more in place. Trials of the traditional practitioner are a different matter, since the link with the child is less direct than that of a parent with his or her child and because the traditional practitioner is often involved in more than one case. It could be argued that imprisonment would be justifiable for them.
- Second, the deterrent effect of these court cases has not been proven. FGM is still practised in France and it cannot be proven that the number of FGM cases has actually gone down. Furthermore, due to the risk of criminal proceedings, the practice of FGM is often postponed, resulting in a decrease of the chance of detection of cases and threats of FGM. That way, the girl or woman concerned is likely to miss out on the provision of physical and psychological aid.

#### 4.12. Other Applicable Laws

Besides criminal law, there are several other laws applicable to cases concerning FGM in France:

- First, the Preamble to the French Constitution of 1958 confirms the provisions of the Preamble of the French Constitution of 1946 that guarantees women equal rights to those of men in all spheres. In addition, it guarantees, notably to children, protection of the right to health.<sup>111</sup>
- Second, France has a comprehensive system of child protection laws. In case of a threat of being subjected to FGM, the *Code Civil* (French Civil Code) provides for the possibility to take preventive measures. Article 375 provides for the possibility for the judge to take preventive measure in case the health, security or

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<sup>111</sup> Preamble to the 27 October 1946 Constitution.

morals of the child are endangered. As a last resort, the judge can decide to remove the child from its parental home.<sup>112</sup>

- Third, for the medical profession, *Le Conseil National de l'Ordre des Médecins* (the French Medical Disciplinary Board) issued a decision prohibiting doctors to exercise mutilating operations when there is no serious medical necessity for that.<sup>113</sup>

In January 2004, a phrase was added to article 226-14 of the *Code Pénal* to ensure that medical professionals would not be subjected to disciplinary rulings or punishment in case they would violate their professional secrecy.<sup>114</sup> On the contrary, medical professionals have the same duty as everyone else to report cases and threats of FGM to the social services and the police.<sup>115</sup> In cases of abuse (including FGM) of a child younger than fifteen years old, medical professionals are relieved from their professional secrecy.<sup>116</sup>

- Fourth, the threat of being subjected to FGM has been recognised as a reason to grant asylum in a few cases. For example, the cases of a couple from Mali and a woman from Somalia, who refused to let their daughters undergo FGM in their country of origin, were granted asylum in 2001.<sup>117</sup>

#### 4.13. Prevention

Today, the French policy in combating FGM has its main focus on criminal proceedings. However, FGM can only be combated effectively when a combination of tactics is used: a combination of prevention (awareness raising, education and training of professionals dealing with FGM, and empowerment of women) together with criminal proceedings.

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<sup>112</sup> *Code Civil* (Civil Code), article 375-3.

<sup>113</sup> Décret n. 95-1000, 6 September 1995, article 41 *portant code de déontologie médicale*.

<sup>114</sup> “*Le signalement aux autorités compétences effectuée dans les conditions prévues au présent article ne peut faire l’objet d’aucune sanction disciplinaire*” (emphasis added).

<sup>115</sup> *Code Pénal*, article 434-3.

<sup>116</sup> *Code Pénal*, article 226-14.

<sup>117</sup> Kwaak, van der, Anke, et al., *Strategieën ter voorkoming van besnijdenis bij meisjes: Inventarisatie en aanbevelingen*, Vrije Universiteit and VU Medisch Centrum, Amsterdam, October 2003, p. 71.

For the purpose of prevention, several organisations exist.

The most famous organisation is the *Groupe femmes pour l'Abolition des Mutilations Sexuelles et autres pratiques affectant la santé des femmes et des enfants* (G.A.M.S.), which is based in Paris. G.A.M.S. is recognised as the French section of the “Inter-African Committee” (IAC) and was established in Paris in 1982. The organisation is a cooperation of both French and immigrant women. The main aims are the provision of information and education on FGM and other harmful traditional practices at schools and at the *Protection Maternelle et Infantile* (PMI) centres (the French infant care centres), the facilitation of dialogue, and to train doctors and midwives. They set up international projects in both Europe and Africa (in cooperation with the IAC and the EU; and with NGOs like Amnesty International). To achieve this, Isabelle Gillette-Faye, sociologist and director of G.A.M.S., emphasises the importance of providing information to immigrant women and doing everything possible to prevent and signal threats of FGM at an early stage. When asked about a mandatory medical examination of girls as proposed by former member of the Dutch Parliament Ayaan Hirshi Ali, she agreed with the opponents that that would be discriminatory.<sup>118</sup> Although G.A.M.S. initially strongly opposed criminal proceedings, causing a split of C.A.M.S. from the G.A.M.S. group, Mrs. Gillette-Faye now stresses that a combination of prevention and criminal proceedings is desired to combat FGM most effectively. To do justice in individual cases and to avoid harm being done to other girls in a family is very important. On the other hand, Mrs. Gillette-Faye remains sceptical about the penalties imposed in criminal proceedings. She considers the penalty for traditional practitioners to be too high and does not consider imprisonment to be the right penalty for parents. Furthermore, she is not convinced that these court cases will change the way people think about FGM.<sup>119</sup> Mrs. Gillette-Faye welcomes and encourages European initiatives with regard to the prevention of FGM.<sup>120</sup> An initiative on the European level launched by G.A.M.S. is EURONET, a European network to combat FGM, supported by the EU DAPHNE

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<sup>118</sup> Interview with I. Gillette-Faye, 4 May 2006.

<sup>119</sup> Interview with I. Gillette-Faye, 4 May 2006.

<sup>120</sup> Interview with I. Gillette-Faye, 4 May 2006.

Programme.<sup>121</sup> Khady Koïta, president of EURONET, stresses the importance of the education and empowerment of women. Another European coordinated programme that I would like to mention in this regard is the *No Peace Without Justice* project from the *Stop FGM* group.<sup>122</sup>

Although there are no special clinics related to prevention or treatment of FGM like there are in the United Kingdom, there is one surgeon (Pierre Foldès - surgeon-urologist of the Saint-Germain-en-Laye hospital), who offers, next to the already existing operation of *de-infibulation* (the opening of the vagina after *infibulation*), the possibility of excision repair, with in some cases even the possibility to increase or normalise the sexual sensitivity. He is the first and only surgeon in Europe who offers this kind of operation. Approximately 2000 women have been operated successfully.<sup>123</sup>

#### 4.14. Signalling and Reporting

Medical professionals are in the best position to signal cases and threats of FGM. In France, the detection by medical professionals takes place during medical examinations. The *Académie Nationale de Médecine*, (the National Academy of Physicians) has issued recommendations to routinely check the sexual organs of girls and to register the status of these organs in medical files.<sup>124</sup> This academy also issued recommendations regarding prevention in June 2004, calling for awareness raising and better information and education.<sup>125</sup> Systematic check ups on all childrens' outer sexual organs are also

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<sup>121</sup> The DAPHNE Programme is set up by the EU and supports initiatives to combat violence against women, youth, and children. DAPHNE Programme <[http://ec.europa.eu/justice\\_home/funding/daphne/funding\\_daphne\\_en.htm](http://ec.europa.eu/justice_home/funding/daphne/funding_daphne_en.htm)> (date accessed: 3 April 2006); EURONET <[www.euronetfgm.org](http://www.euronetfgm.org)> (date accessed: 3 April 2006).

<sup>122</sup> Koïta, Khady, *Contexte historique et socio-culturel des violences infligées aux femmes*, in Académie nationale de médecine (ed.), *Les mutilations sexuelles féminines. Un autre crime contre l'humanité: Connaître, prévenir, agir*, Supplément au Bulletin de l'Académie nationale de médecine, vol. 188, no. 6, 10 June 2004, pp. 74-76.

<sup>123</sup> Foldès, Pierre, *Mutilations sexuelles: prise en charge des séquelles*, in Académie nationale de médecine (ed.), *Les mutilations sexuelles féminines. Un autre crime contre l'humanité: Connaître, prévenir, agir*, Supplément au Bulletin de l'Académie nationale de médecine, vol. 188, no. 6, 10 June 2004, pp. 83-95.

<sup>124</sup> Kool, R.S.B., et al., *Vrouwelijke genitale verminking in juridisch perspectief: (Rechtsvergelijkend) onderzoek naar de juridische mogelijkheden ter voorkoming en bestrijding van vrouwelijke genitale verminking*, Willem Pompe Instituut, sectie Strafrecht, Universiteit Utrecht, Zoetermeer, the Netherlands, 2005, p. 75 note 166 and reference to B. Winter.

<sup>125</sup> Académie nationale de médecine (ed.), *Les mutilations sexuelles féminines. Un autre crime contre l'humanité: Connaître, prévenir, agir*, Supplément au Bulletin de l'Académie nationale de médecine,

performed by the *Protection Maternelle et Infantile (PMI)* centres (the French infant care centres). Visits to these PMI centres are not obligatory, in spite of this, immigrants often go there because the services that are provided are free. At the four major PMI centres in Seine-Saint-Denis in 1994, there had been, out of every eighty-four girls who visited these centres, seven subjected to FGM. Four girls out of these seven had undergone FGM during a special journey to Africa, two had undergone FGM in France, and one arrived in France already being subjected to the practice.<sup>126</sup> Special guidelines for PMI personnel are issued and registration is prescribed. When there is a well-founded suspicion of a threat of FGM, this has to be reported to *le brigade des mineurs* (the juvenile police). The doctor will announce his or her findings to the parents of the girl concerned and will ask them why they let their daughter undergo FGM. The doctor will explain that FGM is prohibited by law in France (and in many other countries) and he or she will inform the parents about his or her duty to report the case to the head of the PMI centre and to the public prosecutor. The doctor needs to be sure that the parents fully understand the information. He or she then draws a medical certificate stating what kind of damage was caused by FGM, which can be used as evidence in criminal proceedings. In court, the person who has reported the case plus the accused are heard. The child will be examined in a hospital and the *juge d'instruction* will start the criminal proceedings.<sup>127</sup>

Everyone who signals a case or threat of FGM is obliged to report this to the social services and the police. According to article 434-3 of the *Code Pénal*, everyone who detects a mutilation performed on a person who is not able to defend himself or herself (e.g. due to his or her age) is obliged to report this, on penalty of three years imprisonment.<sup>128</sup> In cases of FGM, medical professionals are released from their

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vol. 188, no. 6, 10 June 2004.

<sup>126</sup> Piet, Emmanuelle, *Les mutilations sexuelles féminines et leur prévention*, in Académie nationale de médecine (ed.), *Les mutilations sexuelles féminines. Un autre crime contre l'humanité: Connaître, prévenir, agir*, Supplément au *Bulletin de l'Académie nationale de médecine*, vol. 188, no. 6, 10 June 2004, pp. 100-101.

<sup>127</sup> Kool, R.S.B., et al., *Vrouwelijke genitale verminking in juridisch perspectief: (Rechtsvergelijkend) onderzoek naar de juridische mogelijkheden ter voorkoming en bestrijding van vrouwelijke genitale verminking*, Willem Pompe Instituut, sectie Strafrecht, Universiteit Utrecht, Zoetermeer, the Netherlands, 2005, pp. 75-76.

<sup>128</sup> *Code Pénal*, article 434-3 states: “*Le fait pour quiconque ayant eu connaissance de privations, de mauvais traitements ou d’atentes sexuelles infligés à une personne qui n’est pas en mesure de se*

professional secrecy and thus the same legal duty to report threats and cases of FGM exists for them as for everyone else. In consequence, they have a duty and not just the right to report (like in the Netherlands).

Many medical professionals do not report cases and threats of FGM to the authorities as they are supposed to, due to numerous reasons (e.g. to protect the family or to avoid hurting them).<sup>129</sup>

One issue that is mentioned often is that, due to the risk of criminal proceedings, immigrant women often postpone the performance of FGM on their daughters until a later age. In the majority of cases, the performance of FGM will be postponed until the girl is older than six years. That way the PMI centres will not be able to detect and signal a mutilation. Yet, when the girl becomes older, the chances of her speaking about FGM with people in her surroundings will increase. Parents often decide to postpone it until after the age of fifteen or sixteen. At that age, the girl is not obliged to go to school anymore and the girl will be sent to the country of origin (mostly in Africa) during the holidays to undergo FGM there. This way the chance of detection is minimised.<sup>130</sup>

Teachers, family members, neighbours, key figures from the community, and religious leaders also have the duty to report. But, it is questionable if they are willing to do this. Although they are under an obligation to report, it is likely that, in order to protect the family concerned, they will try to avoid reporting and perhaps even turn a blind eye on their surroundings.

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*protéger en raison de son âge, d'une maladie, d'une infirmité, d'une déficience physique ou psychique ou d'un état de grossesse, de ne pas en informer les autorités judiciaires ou administratives est puni de trois ans d'emprisonnement et de 45.000 euros d'amende."*

<sup>129</sup> Weil-Curiel, Linda, *Strafrechtliches Vorgehen, eine Anerkennung der Rechte von Kindern*, in Hermann, Conny (Hgh.), *Das Recht auf Weiblichkeit: Hoffnung im Kampf gegen die Genitalverstümmelung*, Bonn, Dietz, 2000, p. 154.

<sup>130</sup> Kool, R.S.B., et al., *Vrouwelijke genitale verminking in juridisch perspectief: (Rechtsvergelijkend) onderzoek naar de juridische mogelijkheden ter voorkoming en bestrijding van vrouwelijke genitale verminking*, Willem Pompe Instituut, sectie Strafrecht, Universiteit Utrecht, Zoetermeer, the Netherlands, 2005, p. 74.



## Chapter 5: The United Kingdom

### 5.1. Context

The United Kingdom is a country with a high number of immigrants, who already started to arrive 40 years ago. There are immigrants from countries where FGM is traditionally practised in Africa: Eritrea, Ethiopia, Somalia, and Yemen living in the United Kingdom.<sup>131</sup> The majority of immigrants live in London. However, the practice of FGM is especially a matter of concern in Manchester, Liverpool, Cardiff, and Sheffield.<sup>132</sup>

In November 2000, the All Party Parliamentary Group on Population, Development and Reproductive Health acknowledged that there was a severe shortage of data on the practice of FGM in the United Kingdom. One estimate says that 10,000 girls and young women are at risk of FGM, another estimate shows that there are between 3,000 and 4,000 new cases each year in this country.<sup>133</sup> The International Centre for Reproductive Health (ICRH) in Ghent, Belgium, states that it is impossible to ascertain the numbers of black communities living in the United Kingdom because the census information does not categorise communities by country of origin. It refers to the 1999 labour force survey that indicates that possibly 5,444 girls under 16 years are at risk of FGM and 69,875 women have already been affected. If one extrapolates further to include the remaining countries known to practise FGM, one could assume that nearly 22,000 girls are at risk and some 279,500 women have already been affected. Here it is stated that most of the women at risk come from Egypt, Kenya, and Somalia.<sup>134</sup>

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<sup>131</sup> British Medical Association, *Female genital mutilation. Caring for patients and child protection: Guidance from the Ethics Department*, London, February 2004, p. 3.

<sup>132</sup> Dirie, Waris, *Onze verborgen tranen*, Amsterdam, Sirene, 2005, p. 76.

<sup>133</sup> British Medical Association, *Female genital mutilation. Caring for patients and child protection: Guidance from the Ethics Department*, London, February 2004, p. 3.

<sup>134</sup> Leye, Els, Deblonde, Jessika, *A comparative analysis of the different legal approaches towards female genital mutilation in the 15 EU Member States, and the respective judicial outcomes in Belgium, France, Spain, Sweden and the United Kingdom*, International Centre for Reproductive Health (ICRH), Publications No. 8, Ghent, The Consultory, April 2004, pp. 23-24.

The types of FGM that are most commonly practised in the United Kingdom are Type II and Type III (Eritrea, Ethiopia, and Somalia). The age at which this is commonly practised lies between 7 and 9 years old.<sup>135</sup>

The British were already aware of the phenomenon of FGM taking place in their colonies as early as in the 1940s, when they proclaimed FGM to be an illegal act in Sudan.<sup>136</sup>

The United Kingdom is the first country to introduce a specific law prohibiting FGM in Europe, namely the *Female Circumcision Act* of 1985. In 2003, this was expanded and changed into the *Female Genital Mutilation Act* for England, Wales, and Northern Ireland and into the *Female Genital Mutilation Act (Scotland)* of 2005 for Scotland.<sup>137</sup> These Acts prohibit all forms of Female Genital Mutilation.

## 5.2 Criminal Law

In the United Kingdom, FGM is prohibited under specific criminal law. The prohibition of *Female Genital Mutilation Act* of 2003 entered into force in March 2004. The three major changes of this Act are:

- Applicability of the principle of extraterritoriality, meaning that FGM committed outside the territory of the United Kingdom is still prohibited.
- The name of the Act has been changed from *Female Circumcision Act* to *Female Genital Mutilation Act*, because it is believed that the term mutilation does reflect the practice better. On the other hand, the Royal College of Midwives points out that the term mutilation can also be offensive to the girls and women concerned.

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<sup>135</sup> British Medical Association, *Female genital mutilation. Caring for patients and child protection: Guidance from the Ethics Department*, London, February 2004, p. 3.

<sup>136</sup> Afrikanische Frauenorganisation in Wien, *Bewußtseinsbildung und Information über WEIBLICHE GENITALVERSTÜMMELUNG in Österreich*, Vienna, October 2000, p. 5.

<sup>137</sup> The content of the *Female Genital Mutilation Act (Scotland)* of 2005 is similar to that of the *Female Genital Mutilation Act* of 2003 for England, Wales, and Northern Ireland. This thesis will only further focus on and refer to the latter Act.

- The penalty was increased from 5 years imprisonment to 14 years imprisonment.

It should be noted that at present the penalty is almost triple as high as before. The main argument for this is that it is believed that the *Female Genital Mutilation Act* has a deterrent effect.<sup>138</sup>

The Female Genital Mutilation Act of 2003 states:

***Article 1 Offence of female genital mutilation***

1. *A person is guilty of an offence if he excises, infibulates or otherwise mutilates the whole or any part of a girl's labia majora, labia minora or clitoris.*
2. *But no offence is committed by an approved person who performs-*
  - (a) *a surgical operation on a girl which is necessary for her physical or mental health, or*
  - (b) *a surgical operation on a girl who is in any stage of labour, or has just given birth, for purposes connected with the labour or birth.*
3. *The following are approved persons-*
  - (a) *in relation to an operation falling within subsection (2)(a), a registered medical practitioner,*
  - (b) *in relation to an operation falling within subsection (2)(b), a registered medical practitioner, a registered midwife or a person undergoing a course of training with a view to becoming such a practitioner or midwife.*
4. *There is also no offence committed by a person who-*
  - (a) *performs a surgical operation falling within subsection (2)(a) or (b) outside the United Kingdom, and*
  - (b) *in relation to such an operation exercises functions corresponding to those of an approved person.*

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<sup>138</sup> Kool, R.S.B., et al., *Vrouwelijke genitale verminking in juridisch perspectief: (Rechtsvergelijkend) onderzoek naar de juridische mogelijkheden ter voorkoming en bestrijding van vrouwelijke genitale verminking*, Willem Pompe Instituut, sectie Strafrecht, Universiteit Utrecht, Zoetermeer, the Netherlands, 2005, p. 102.

5. *For the purpose of determining whether an operation is necessary for the mental health of a girl it is immaterial whether she or any other person believes that the operation is required as a matter of custom or ritual.*

***Article 2 Offence of assisting a girl to mutilate her own genitalia***

*A person is guilty of an offence if he aids, abets, counsels or procures a girl to excise, infibulate or otherwise mutilate the whole or any part of her own labia majora, labia minora or clitoris.*

***Article 3 Offence of assisting a non-UK person to mutilate overseas a girl's genitalia***

1. *A person is guilty of an offence if he aids, abets, counsels or procures a person who is not a United Kingdom national or permanent United Kingdom resident to do a relevant act of female genital mutilation outside the United Kingdom.*
2. *An act is a relevant act of female genital mutilation if-*
  - (a) *it is done in relation to a United Kingdom national or permanent United Kingdom resident, and*
  - (b) *it would, if done by such a person, constitute an offence under section 1.*
3. *But no offence is committed if the relevant act of female genital mutilation-*
  - (a) *is a surgical operation falling within section 1(2)(a) or (b), and*
  - (b) *is performed by a person who, in relation to such an operation, is an approved person or exercises functions corresponding to those of an approved person.*

***Article 4 Extension of sections 1 to 3 to extra-territorial acts***

1. *Sections 1 to 3 extend to any act done outside the United Kingdom by a United Kingdom national or permanent United Kingdom resident.*
2. *If an offence under this Act is committed outside the United Kingdom-*
  - (a) *proceedings may be taken, and*
  - (b) *the offence may for incidental purposes be treated as having been committed, in any place in England and Wales or Northern Ireland.*

### **Article 5 Penalties for offences**

*A person guilty of an offence under this Act is liable-*

- (a) on conviction on indictment, to imprisonment for a term not exceeding 14 years or a fine (or both),*
- (b) on summary conviction, to imprisonment for a term not exceeding six months or a fine not exceeding the statutory maximum (or both).*

### **Article 6 Definitions**

- 1. Girl includes woman.*
- 2. A United Kingdom national is an individual who is-*
  - (a) a British citizen, a British overseas territories citizen, a British National (Overseas) or a British Overseas citizen,*
  - (b) a person who under the British Nationality Act 1981 (c. 61) is a British subject, or*
  - (c) a British protected person within the meaning of that Act.*
- 3. A permanent United Kingdom resident is an individual who is settled in the United Kingdom (within the meaning of the Immigration Act 1971 (c. 77)).*
- 4. This section has effect for the purposes of this Act.*

### 5.3. Specific Criminal Law Prohibiting FGM

The United Kingdom is the first European country to introduce a specific criminal law prohibiting FGM. Although article 1 of the *Female Genital Mutilation Act* prohibits all forms of FGM, some problems arise with regard to the clarity of the law. This seems to be true for all countries employing specific criminal law provisions with regard to FGM. The main problems that arise for the United Kingdom are:

- First, the issue of *re-infibulation* is not mentioned in the *Female Genital Mutilation Act* of 2003. The question we can pose here is: what would be the difference between *re-infibulation* (the re-closing of the vagina after childbirth) and the performance of Female Genital Mutilation in first instance? Although the procedure of *re-infibulation* is not specifically mentioned in the *Female Genital*

*Mutilation Act*, it is not specifically excluded either. Consequently, it could be argued that this procedure would implicitly fall under the scope of all forms of Female Genital Mutilation and would therefore be prohibited. In this case, the law itself remains unclear.

- Second, there is the issue of piercing and tattooing. According to the WHO's classification, piercing and tattooing would fall under FGM Type IV and would therefore be prohibited, although that might not have been the intention of the law makers. In the United Kingdom, piercing and tattooing are not explicitly included in the *Female Genital Mutilation Act* and would thus be prohibited. On the other hand, it could be argued that they would implicitly be excluded by virtue of the fact that they are not included in the definition of offensives constituting FGM, as foreseen in the *Female Genital Mutilation Act*.<sup>139</sup>
- Third, there is the issue of cosmetic genital surgery. This is an increasing phenomenon in the West, covering vaginal tightening, lifting of the *labia*, and trimming of the *labia minora*. This type of surgery is performed for non-therapeutic reasons, usually on aesthetic grounds. The results, however, do often not differ from those usually associated with FGM. Therefore, the question arises if some non-African women in the United Kingdom would be allowed to purchase these so-called "designer vaginas," why and how would adult African women be prevented from doing the same?<sup>140</sup> It could be argued that these women are adults and should be able to act with their own consent, to have disposal over their own body, and to have the right to cultural self-determination. Nonetheless, the United Kingdom government argues that the practice of Female Genital Mutilation is such a severe act that all forms, even with consent, should be prohibited.

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<sup>139</sup> Leye, Els, Deblonde, Jessika, *A comparative analysis of the different legal approaches towards female genital mutilation in the 15 EU Member States, and the respective judicial outcomes in Belgium, France, Spain, Sweden and the United Kingdom*, International Centre for Reproductive Health (ICRH), Publications No. 8, Ghent, The Consultory, April 2004, p. 14.

<sup>140</sup> Leye, Els, Deblonde, Jessika, *A comparative analysis of the different legal approaches towards female genital mutilation in the 15 EU Member States, and the respective judicial outcomes in Belgium, France, Spain, Sweden and the United Kingdom*, International Centre for Reproductive Health (ICRH), Publications No. 8, Ghent, The Consultory, April 2004, p. 14.

Accumulative, the government questions whether the performance of FGM can ever be voluntarily (due to the pressure from family and community) and therefore questions the consent.<sup>141</sup>

It should be noted that according to the *Female Genital Mutilation Act* of 2003, no offence is committed by an approved person who performs a surgical operation on a girl, which is necessary for her physical or mental health. This is laid down in Article 1, paragraph 2, which aims to refer to plastic surgery. At this juncture, it is unclear what is meant by the mental health of the girl, especially since it is stated in paragraph 5 that it is considered immaterial whether the girl or any other person believes that the operation is required as a matter of custom, in order to qualify the operation necessary for the mental health of the girl.

#### 5.4. Extraterritoriality

Is it possible to hold a person criminally liable in cases where the practice of FGM has been exercised outside the territory of the United Kingdom? In other words, does the principle of extraterritoriality apply?

Yes, it does, provided that the person is a United Kingdom national or permanent resident. Article 3 and article 4 of the *Female Mutilation Act* of 2003 set out in detail the principle of extraterritoriality and the requirements for its applicability. The most important requirement is that the person involved has to be a United Kingdom national or permanent resident. The difference with the French legislation should be noted here, where the principle of extraterritoriality only applies to nationals and not to permanent residents. Nevertheless, this condition has still been intensively criticised, questioning why British children are more protected than non-British children, especially since newly-arriving immigrants cannot gain the status of national or permanent resident immediately.

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<sup>141</sup> Kool, R.S.B., et al., *Vrouwelijke genitale verminking in juridisch perspectief: (Rechtsvergelijkend) onderzoek naar de juridische mogelijkheden ter voorkoming en bestrijding van vrouwelijke genitale verminking*, Willem Pompe Instituut, sectie Strafrecht, Universiteit Utrecht, Zoetermeer, the Netherlands, 2005, pp. 102-103.

### 5.5. Court Cases

It is remarkable that, although the United Kingdom is the first country with a specific law prohibiting FGM in Europe, not a single court case regarding FGM has taken place (yet). In spite of this, two doctors have been found guilty of serious professional misconduct before the general medical council. The first case was in 1993 and involved a doctor who had performed Female Genital Mutilation, while knowing that it was illegal. This doctor of Arabic origin was struck off the medical register, but the police did not prosecute him. In 2000, another doctor of Indian origin was struck off the medical register for offering to carry out Female Genital Mutilation. This offer for £ 50 was filmed by a hidden camera and broadcasted on Channel 4 titled: *Cutting the rose*.<sup>142</sup>

### 5.6. Other Applicable Laws.

Besides criminal law, there are several other laws applicable to cases concerning FGM in the United Kingdom:

- First, although the United Kingdom does not have a written Constitution like France and the Netherlands have, there are several laws protecting children's rights. Next to these laws, there is jurisprudence, in which children's rights are guaranteed.<sup>143</sup>
- Second, a special child protection law exists: the *Children Act* of 1989. Part 5 of this *Children Act* deals with the protection of children against abuse. Although citizens generally do not have the legal duty to report knowledge concerning a suspicion of a future crime to the statutory sector, any professional identifying a child at risk of suffering significant harm, is obliged to share that information with the social services to ensure that the child will be protected. This is in accordance with the policy document *Working Together to Safeguard Children*, issued by the Department of Health, and endorsed by professional guidelines. FGM child

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<sup>142</sup> British Medical Association, *Female genital mutilation. Caring for patients and child protection: Guidance from the Ethics Department*, London, February 2004, p. 3; Dirie, Waris, *Onze verborgen tranen*, Amsterdam, Sirene, 2005, p. 92.

<sup>143</sup> Kwaak, van der, Anke, et al., *Strategieën ter voorkoming van besnijdenis bij meisjes: Inventarisatie en aanbevelingen*, Vrije Universiteit and VU Medisch Centrum, Amsterdam, October 2003, p. 64.



protection guidelines are mentioned in the chapter entitled *Child Protection in Specific Circumstances*.<sup>144</sup> In case of a threat of being subjected to FGM, article 47 of the *Children Act* of 1989 requires to initiate a child protection investigation.

Next to voluntary child protection measures, like counselling and providing information, there are compulsory child protection measures, as laid down in article 8 of the *Children Act* of 1989. Parents are, for example, prohibited to travel to another country with their child in order to perform FGM in that particular country. Sometimes removal of the child from the family or suspension of the parental authority is necessary to protect the child.

- Third, the government issued guidelines intended for the medical profession: *Working Together to Safeguard Children*, applicable to health professionals, social workers, police, and educational staff.<sup>145</sup> A number of medical profession groups have issued their own guidelines on advice and policy regarding Female Genital Mutilation (e.g. the British Medical Association, the Royal College of Obstetricians and Gynaecologists, the Royal College of Nurses, and the Royal College of Midwives).<sup>146</sup> The British Medical Association, the Royal College of Midwives, and the General Medical College are very clear in their standpoint prohibiting FGM, including the prohibition of the medicalisation of it. The Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists also state that a request of *re-infibulation* after childbirth has to be refused.<sup>147</sup> The

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<sup>144</sup> The Department of Health 1999; Leye, Els, Deblonde, Jessika, *A comparative analysis of the different legal approaches towards female genital mutilation in the 15 EU Member States, and the respective judicial outcomes in Belgium, France, Spain, Sweden and the United Kingdom*, International Centre of Reproductive Rights (ICRH), Publications No. 8, Ghent, The Consultory, April 2004, p. 32.

<sup>145</sup> Doctors should cooperate with local initiatives providing information and advice. They have to work closely with appropriate statutory and other organisations, in order to signal and combat FGM most effectively. This is also referred to as an inter-agency approach. British Medical Association, *Female genital mutilation. Caring for patients and child protection: Guidance from the Ethics Department*, London, February 2004, pp. 3-5.

<sup>146</sup> Department of Health, Home Office, Department for Education and Employment, *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children*, London, The Stationary Office, 1999.

<sup>147</sup> Kwaak, van der, Anke, et al., *Strategieën ter voorkoming van besnijdenis bij meisjes: Inventarisatie en aanbevelingen*, Vrije Universiteit and VU Medisch Centrum, Amsterdam, October 2003, p. 67; British Medical Association, *Female genital mutilation. Caring for patients and child protection, Guidance*

British Medical Association goes even further regarding the task of medical professionals, stating that when a girl has undergone FGM or when there is a fear that she may be taken abroad to get subjected to FGM there, that the medical professional should counsel the parents and explain the health and legal issues surrounding the topic of FGM, trying to persuade them to eradicate the practice.<sup>148</sup> As we have seen above, according to these government guidelines, any professional identifying a child at risk of suffering significant harm, *in casu* FGM, is obliged to report that to the social services (but not also to the police as in France).

- Fourth, the threat of being subjected to FGM has been recognised as a reason to grant asylum in a few cases. The United Kingdom's Immigration Appellate Authority states that social, cultural and religious behavioural requirements, traditions and norms may consider gender-related harm to be acceptable practice.<sup>149</sup> No statistics are available for the United Kingdom, but the home office reports that there have been successful asylum claims in the United Kingdom based on a threat of Female Genital Mutilation, where removing the applicant could be contrary to Article 3 of the *European Convention on Human Rights* that protects the right not to be subjected to torture, inhuman, or degrading treatment.<sup>150</sup> Unfortunately, there is a great lack of information provided to the newly arrived asylum seekers and refugees regarding the legal prohibition of FGM in the United Kingdom and about the possible recognition of FGM as a reason to grant asylum.

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*from the Ethics Department*, London, February 2004, p. 3.

<sup>148</sup> British Medical Association, *Female genital mutilation. Caring for patients and child protection: Guidance from the Ethics Department*, London, February 2004, p. 4.

<sup>149</sup> Immigration Appellate Authority, *Asylum gender guidelines*, London, 2000; Asylum Appellate Authority, 2000.

<sup>150</sup> British Medical Association, *Female genital mutilation. Caring for patients and child protection: Guidance from the Ethics Department*, London, February 2004, p. 5; Powell, Richard A., et al., *Female genital mutilation, asylum seekers and refugees: the need for an integrated European Union agenda*, in "Health Policy," no. 70, 2004, pp. 153-156.

### 5.7. Prevention.

Today, the United Kingdom policy in combating FGM has its main focus, just like the Netherlands, on prevention rather than on criminal proceedings. It consists of awareness raising, education, training of medical professionals and health-care workers, and the empowerment of women.

For the purpose of prevention, several organisations exist. The most famous organisation in the United Kingdom is the *Foundation for Women's Health, Research and Development* (FORWARD), based in London. Their main aim is to promote well-being and human dignity. FORWARD was founded by Efua Dorkenoo in 1993 as a working group within the human rights organisation the *Minority Rights Group*. FORWARD was later established as an independent organisation to undertake field work related to women's health. The primary objective of FORWARD is the eradication of FGM worldwide. It does this through sponsorship of local and international health programmes, in the countries directly concerned. It advocates remedial policies to be adopted in those countries where harmful traditional practices such as FGM have a strongly negative impact on health, including child mortality and reproductive morbidity. FORWARD focuses on awareness raising and training and education of medical professionals. Central to this is the development of protocols and guidelines. Internationally, FORWARD's activities are primarily concentrated on programmes in Africa, working in partnership with local grass root organisations supporting African women's health and economic development.<sup>151</sup>

According to a survey conducted by FORWARD, the majority of women who were questioned were in favour of the eradication of the practice of FGM: 84.5% of the respondents said that FGM should be stopped and 15.5% said it should continue. In addition, to the question whether these women would let their daughters undergo FGM, 77.6% answered that they would not, as opposed to 20.7%, that said they would.<sup>152</sup> The

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<sup>151</sup> FORWARD <[www.forwarduk.org.uk](http://www.forwarduk.org.uk)> (date accessed: 15 April 2006).

<sup>152</sup> The study was conducted by Eunice Munanie among 70 women from four communities, Eritrea, Ethiopia, Somalia, and Sudan, living in the Royal Borough of Kensington & Chelsea and Westminster. FORWARD, *Female Genital Mutilation: Knowledge Attitudes & Responses Amongst Communities &*

outcome of this questionnaire shows that when information is provided and awareness is raised, the girls, women, and communities concerned, are more likely to oppose FGM. They will consider the severe medical consequences and human rights violations and are more likely to signal and report cases and threats of FGM to the social services.

Other organisations are: the *Research, Action and Information Network for the Bodily Integrity of Women* (RAINBO), aiming to stimulate self-assurance of African women; the *Black Women's Health and Family Organisation*, issuing prevention policies on FGM and *Women Living under Muslim Law*, an international network for women who live under the rules and laws of Islam. All organisations are based in London.

Another aspect of the prevention policy in the United Kingdom is to set up several clinics, where the girls and women concerned can go with their physical and psychological problems related to FGM. An example of one of these clinics is the *African Well Women Clinic* in London, which was set up in cooperation with FORWARD. In this clinic, Harry Gordon was the first surgeon to offer *de-infibulation* operations. This is not the reparation of the clitoris like what Pierre Foldès offers in France, but this is the mere opening of the vagina after the practice of *infibulation*. This operation is *de facto* a simple surgery, however, the psychological burden is very heavy, since these women suffer from flashbacks and post-traumatic stress. The treatment that is provided is free of charge and therefore easily accessible to the women and girls concerned. Another issue is that the operations remain secret, which encourages women and girls to actually visit such a clinic. Usually these women visit the clinic accompanied by a friend, or sometimes even by their husbands. They come in right before marriage, to enable them to have normal sexual intercourse, or right before childbirth. Information about these kind of clinics is spread by word of mouth, which seems to work quite well. Next to the medical aid that is provided, medical scientific research is performed on the issue of FGM. Other major clinics that I would like to mention are: the *African Women's Clinic/Women and Health* by Sarah Craighton and the *Harry Gordon Antenatal Clinic* in London, the *Susan*

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*Health Professionals: A case study among African communities and health professionals in the health authority of Kensington & Chelsea and Westminster, 2001.*

*Dolman Antenatal Clinic* in Harrow, Middlesex, and the *Lydia Moore Multi-Cultural Antenatal Clinic* in Liverpool.<sup>153</sup>

### 5.8. Signalling and Reporting

Medical professionals are in the best position to signal. In the case of the United Kingdom, the special clinics play an important role in the detection of FGM. Another survey conducted by FORWARD among health professionals shows that medical professionals are not ethically prepared and not sufficiently informed about what FGM exactly entails, what types of FGM exist, what exact medical consequences it is accompanied by, and how they should respond to the signalling of such a case or threat. Of the professionals interviewed, 93.8% had heard of FGM, but their more detailed knowledge regarding FGM was shockingly low. Regarding knowledge concerning the medical complications associated with FGM, 78.1% of the interviewed health professionals did not consider themselves adequately equipped. In addition, these health professionals were not well informed about the legal prohibition of all types of FGM. Some of them even expressed to be in favour of the medicalisation of FGM, in fear of performance of FGM under unhygienic circumstances. However, the United Kingdom law prohibits this as well. The percentage of people willing to perform FGM under medical conditions was 33.3%. This shows that there is a lack of clarity regarding the legal position on FGM.<sup>154</sup>

The last item of this survey that I would like to address, is that apparently access to information regarding FGM is extremely problematic. The majority of respondents, 64.5% of the health professionals, had no access to FGM information or material. Only

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<sup>153</sup> Dirie, Waris, *Onze verborgen tranen*, Amsterdam, Sirene, 2005, pp. 77-85; British Medical Association, *Female genital mutilation. Caring for patients and child protection: Guidance from the Ethics Department*, London, February 2004, p. 4.

<sup>154</sup> The study was conducted by Eunice Munanie among 32 health professionals practicing in the Royal Borough of Kensington & Chelsea and Westminster. FORWARD, *Female Genital Mutilation: Knowledge Attitudes & Responses Amongst Communities & Health Professionals: A case study among African communities and health professionals in the health authority of Kensington & Chelsea and Westminster*, 2001.

35.5% did, mostly through NGOs (e.g. due to materials and books of FORWARD and the specially set up clinics).<sup>155</sup>

As seen before, medical professionals have the duty to report threats and cases of FGM to the social services. Unfortunately, this signalling function is damaged by the lack of knowledge of medical professionals regarding FGM.

It is not clear if suspected cases or threats of FGM are systematically reported to the statutory sector. There is an expressed concern that a number of cases go unreported. FORWARD has been involved in only five cases of children at risk in the past two years.<sup>156</sup> It is also mentioned that several medical professionals have been unwilling to report cases because of fear being labelled to be a racist.<sup>157</sup>

Regarding signalling by teachers, family members, neighbours, key figures from the community, and religious leaders, the same can be said as with regard to the Netherlands and France, that it is not very likely that these people are willing to signal and report threats and cases of FGM.

As mentioned above, the few cases that do reach the social service departments are followed up by the so-called inter-agency approach, being a child protection investigation with a multi-disciplinary strategy meeting involving police, child protection, and health and educational staff.

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<sup>155</sup> FORWARD, *Female Genital Mutilation: Knowledge Attitudes & Responses Amongst Communities & Health Professionals: A case study among African communities and health professionals in the health authority of Kensington & Chelsea and Westminster*, 2001.

<sup>156</sup> Leye, Els, Deblonde, Jessika, *A comparative analysis of the different legal approaches towards female genital mutilation in the 15 EU Member States, and the respective judicial outcomes in Belgium, France, Spain, Sweden and the United Kingdom*, International Centre for Reproductive Health (ICRH), Publications No. 8, Ghent, The Consultory, April 2004, p. 45.

<sup>157</sup> Leye, Els, Deblonde, Jessika, *A comparative analysis of the different legal approaches towards female genital mutilation in the 15 EU Member States, and the respective judicial outcomes in Belgium, France, Spain, Sweden and the United Kingdom*, International Centre for Reproductive Health (ICRH), Publications No. 8, Ghent, The Consultory, April 2004, p. 14.

## Chapter 6: Austria

### 6.1. Context

Although Austria does not have a colonial history, due to the arrival of foreign workers, asylum seekers and refugees, it is estimated that around 13,380 (legal) African immigrants live in Austria.<sup>158</sup> There are many immigrants from countries where FGM is traditionally practised in Africa: Egypt, Ethiopia, Ghana, and Nigeria, living in Austria.<sup>159</sup> The majority of immigrants live in Vienna and in the other bigger cities of Graz and Linz. It is estimated that around 8,197 girls and women from FGM risk countries live in Austria, of which half come from Egypt.

The type of FGM that is most commonly practised in Austria is Type II. The age at which this is commonly practised is before the 1<sup>st</sup> year for 62% of the girls and lies between 6 and 13 years old for 27.8% of the girls.

As a result of the World Conference on Human Rights, held in Vienna on 25 June 1993, condemning violence against women, including Female Genital Mutilation, FGM became an issue. Later, in 1998, when Waris Dirie was present in Vienna to sign her book *Desert Flower* in bookstores together with Etenesh Hadis of the African Women's Organisation in Vienna (*Afrikanische Frauenorganisation in Wien*), FGM became known by the public at large, not only in Austria, but all around the globe. It became an issue again, when in 2001 the newsmagazine *Profil* published an undercover research revealing that Austrian doctors exercised FGM.<sup>160</sup> This result was very shocking and opened up the issue to public debate.

In the same year, a specific law was designed to prohibit FGM. Article 90, paragraph 3 of the Austrian Penal Code (*Strafgesetzbuch*) was introduced to prohibit FGM, entering into force in 2002. It emphasises the irreversible damage that is done to the sexual sensitivity

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<sup>158</sup> Afrikanische Frauenorganisation in Wien, *Die Anwendung der FEMALE GENITAL MUTILATION (FGM) bei MigrantInnen in Österreich*, Vienna, October 2000, p. 18.

<sup>159</sup> Afrikanische Frauenorganisation in Wien, *Die Anwendung der FEMALE GENITAL MUTILATION (FGM) bei MigrantInnen in Österreich*, Vienna, October 2000, p. 8.

<sup>160</sup> Dirie, Waris, *Onze verborgen tranen*, Amsterdam, Sirene, 2005, p. 23.

of a woman when FGM is performed. It is specifically stated that consent to undergo FGM is not permitted as a defence.

## 6.2. Criminal Law

In Austria, FGM is, just like in the United Kingdom, prohibited under specific criminal law. As a basis, FGM would fall under articles 84-87 of the Austrian Penal Code and would be qualified as a form of serious bodily injury. Austria introduced a specific law prohibiting FGM in their existing Penal Code in 2001: article 90, paragraph 3 (see Annex 4). Aggravating factors occur when there is loss of essential parts of the body, which is laid down in Article 84, and when there are permanent and incurable corporal lesions and/or permanent loss of functional capacity, which is laid down in article 85. Another aggravating factor is when the offence causes death, which is laid down in article 86.

The primary applicable criminal law provision regarding FGM is article 90:

### ***§ 90 Consent of the injured***

- 1. Bodily injury or endangering one's bodily safety is not illegal, if the injured or endangered person has consented to it and the injury or endangering as such does not violate good morals.*
- 2. A sterilisation performed by a physician and with the consent of the sterilised person is not illegal if either the person is already 25 years old or the operation does not violate good morals for other reasons.*
- 3. It is not possible to consent to a mutilation or other injury of the genitals that may cause a lasting impairment of the sexual sensitivity.*

Article 90, paragraph 3 deals specifically with genital mutilation, stressing the irreversible damage that is done to sexual sensitivity. In addition, no consent regarding genital mutilation is permitted here, meaning that a voluntary request to the performance of circumcision or mutilation has to be refused because it is prohibited under Article 90, paragraph 3.



Article 90 should be read in accordance with articles 84-87.

Premeditated bodily injury is laid down in article 87, which is most likely to be applicable. This states:

***§ 87 Intentional serious bodily injury***

- 1. Whoever inflicts upon another person a serious bodily injury (§84 (1)) intentionally, is punished with imprisonment of one to five years.*
- 2. If the offence causes serious, lasting consequences (§85), the offender is punished with imprisonment of one to ten years, if it causes the death of the injured person, with imprisonment of five to fifteen years.*

FGM is almost always a premeditated crime.

As a subsidiary criminal provision regarding FGM, article 84 - serious bodily injury - or article 85 - bodily injury with long-lasting effects - can be used. These state:

***§ 84 Serious bodily injury***

- 1. If the offence has caused impairment to the injured person's health lasting more than 24 days, or if the injury or impairment to one's health is serious in itself the offender is punished with imprisonment up to three years.*
- 2. The offender is punished likewise if the offence has been committed:*
  - (a) with such means and in such a way , with which danger to life is involved as a rule,*
  - (b) by at least three persons acting in conspiracy,*
  - (c) with the infliction of particular agonies or*
  - (d) against a public official, a witness or an expert during or because of the exercise of his functions or the performance of his duties.*
- 3. The offender is punished likewise if he has committed three separate offences without understandable reason and using considerable violence.*

**§ 85 Bodily injury with serious, lasting consequences**

*If the offence has caused*

- 1. loss or serious impairment of the injured person's speech, sight, hearing or reproductive ability,*
- 2. a considerable mutilation or a striking deformation or*
- 3. a serious suffering, lingering illness or professional inability forever or for a long period of time, the offender is punished with imprisonment of six months to five years.*

When death occurs, article 86 is applicable. This states:

**§ 86 Bodily injury resulting in death**

*If the offence has caused the death of the injured person, the offender is punished with imprisonment of one to ten years.*

As a last resort, article 83, which criminalises bodily injury as such, may be considered:

**§ 83 Bodily injury**

- 1. Whoever inflicts a bodily injury or an impairment of one's health upon another person is punished with imprisonment up to one year or with a fine of up to 360 day's rates.*
- 2. Likewise is punished who insults another person bodily and thereby negligently inflicts a bodily injury or an impairment of one's health upon the insulted person.*

**6.3. Specific Criminal Law Prohibiting FGM**

After the United Kingdom prohibited FGM under specific criminal law, Austria followed its example. The specific referral to genital mutilation is captured in article 90, paragraph 3 of the Austrian Penal Code, and is therefore absorbed in the existing Penal Code. The Austrian specific criminal law provision prohibiting FGM was designed in 2001 and entered into force in 2002.

The same problems arise in Austria as in other countries employing specific criminal law provisions prohibiting FGM, with regard to which forms of FGM are prohibited:

- First, there is the issue of *re-infibulation*. Although the procedure of *re-infibulation* is not specifically mentioned in article 90 of the Austrian Penal Code, it is not specifically excluded either, and therefore, it could be argued that it would implicitly fall under the scope of genital mutilation in general and would therefore be prohibited. However, the law itself remains unclear.
- Second, there is the issue of piercing and tattooing. Article 90 of the Austrian Penal Code is not clear about this issue. The law is not detailed enough and therefore it remains questionable if piercing and tattooing would be covered by the prohibition.
- Third, there is the issue of cosmetic genital surgery. The Austrian government argues that the practice of Female Genital Mutilation is such a severe act that all forms should be prohibited. Consent is never honoured with regard to genital mutilation. This is specifically laid down in paragraph 3 of article 90.
- Next to these general problems regarding the lack of clarity of these laws, there is an additional problem that occurs in Austria: the issue of male circumcision. Article 90, paragraph 3 of the Austrian Penal Code speaks of genital mutilation and not of Female Genital Mutilation. This would also imply the prohibition of male circumcision. Nonetheless, it is questionable if this was the intention of the lawmakers. On the other hand, it could be argued that this article is not applicable to male circumcision, because the latter does not cause irreversible damage to the sexual sensitivity of men, which is most often the case with Female Genital Mutilation.

On 23 February 2006, the Austrian Cabinet passed legislation to change, just like in the Netherlands, the statute of limitation for FGM as criminal offence, entering into force on

1 July 2006.<sup>161</sup> Now this starts running when the victim turns 18 years old (before the statute of limitation was three years, starting at the date of the commission of the crime of FGM). This way, the girl or woman will have more time to deal with the psychological effects of FGM and gives her more time to press criminal charges. This will probably increase the chance of the girl or woman pressing criminal charges.<sup>162</sup>

#### 6.4. Extraterritoriality - Double Criminality

Is it possible to hold a person criminally liable in cases where the practice of FGM has been exercised outside the territory of Austria? In other words, does the principle of extraterritoriality apply?

Yes it does, provided that two requirements are fulfilled: (1) The principle of double criminality is required, unless both the victim and the offender are Austrians;<sup>163</sup> and (2) the offender must be found on the territory of Austria if he or she is a foreigner.<sup>164</sup> When both requirements are met, the principle of extraterritoriality is applicable.

#### 6.5. Court Cases

It is remarkable that, although FGM has been considered a criminal offence since 2002 and is prohibited under specific criminal law, not a single court case regarding FGM has taken place, just like in the Netherlands and the United Kingdom. Although the specific criminal law provision dealing with FGM has been introduced fairly recently in 2002, one would expect at least one or a few court cases regarding FGM, considering the high number of women and girls who have been subjected to FGM or who are at risk.

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<sup>161</sup> The statute of limitation is the time-frame within which a person can press criminal charges.

<sup>162</sup> *Änderung des Strafrechts bei Genitalverstümmelung und Zwangsheirat*, in "Die Presse," 23 February 2006; Österreichische Plattform gegen weibliche Genitalverstümmelung, *RechtSinformatiOnsblatt zum Informationsabend über FGM für ÄrZInnen und Hebammen*, 28 June 2006.

<sup>163</sup> This principle entails that in order for the person to be criminally liable, the act has to be a criminal offence in both the country of nationality or residence and the country where the crime was carried out.

<sup>164</sup> Leye, Els, Deblonde, Jessika, *A comparative analysis of the different legal approaches towards female genital mutilation in the 15 EU Member States, and the respective judicial outcomes in Belgium, France, Spain, Sweden and the United Kingdom*, International Centre for Reproductive Health (ICRH), Publications No. 8, Ghent, The Consultory, April 2004, p. 19.

## 6.6. Other Applicable Laws

Besides criminal law, there are several other laws applicable to cases concerning FGM in Austria:

- First, although the Austrian Constitution does not mention human rights apart from a few civil and political rights, the old part of the Constitution (*Staatsgrundgesetz*) states that the *European Convention for the Protection of Human Rights and Fundamental Freedoms* (ECHR) has the rank of constitutional law in Austria. Therefore, the provisions in the ECHR that are applicable to FGM can be invoked here: the right to life as guaranteed in article 2 ECHR, the right not to be subjected to torture or ill-treatment as guaranteed in article 3 ECHR, and the right to non-discrimination, as guaranteed in article 14 ECHR.
- Second, child protection laws exist. The Austrian Civil Code (*Allgemeines Bürgerliches Gesetzbuch*) requires in article 146 that parents guarantee the physical wellbeing and health of their child.<sup>165</sup> Article 176 of the Austrian Civil Code provides for the possibility for the judge to withdraw custody of the child in part or in total, if the wellbeing and/or health of the child is endangered by the parental behaviour, when it is absolutely necessary and in the best interest of the child.<sup>166</sup> In addition, the Austrian Civil Code provides for the possibility to claim for damages for causing bodily harm.<sup>167</sup>
- Third, for the medical profession there is a special law (*Ärztegesetz*), stating in article 1, paragraph 54 (4) that if a doctor has a suspicion that by an illegal act bodily harm or the death of a person was caused, he or she has to immediately inform the police. Article 1, paragraph 54 (5) states that if the doctor has the suspicion that a minor was maltreated, tormented, neglected or sexually abused, he or she has to inform the police. He or she has therefore the duty to report cases of FGM to the police, as opposed to a right to report (as in the Netherlands).

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<sup>165</sup> Austrian Civil Code, articles 146-146d (*Obsorge*).

<sup>166</sup> Austrian Civil Code, articles 176-176b (*Entziehung oder Einschränkung der Obsorge*).

<sup>167</sup> Austrian Civil Code, article 1325.

However, if there is a suspicion that the maltreatment was caused by a close relative, which is often the case with FGM (e.g. when the mother performs FGM instead of the traditional practitioner), the doctor can wait with this if the wellbeing of the minor depends on that. Here, the duty of the medical professional to report remarkably changes into a right to report.<sup>168</sup>

- Fourth, the threat of being subjected to FGM has been recognised as a reason to grant asylum in a few cases. The first asylum precedent was set in March 2002, when the Independent Federal Asylum Senate granted asylum to a woman from Cameroon, because she was threatened to undergo *infibulation* in order to be able to marry. It should be noted that asylum has been granted regarding FGM in very few cases, not even in ten cases.<sup>169</sup>

#### 6.7. Prevention

Today, the Austrian policy in combating FGM has its main focus, just like the Netherlands and the United Kingdom, on prevention rather than on criminal proceedings. For the purpose of prevention, several organisations exist. The most famous organisation is the African Women's Organisation in Vienna (*Afrikanische Frauenorganisation in Wien*), established in 1996, as sector of the Inter-African Committee (IAC). The main aim is to address various political, economical, social, and traditional problems women face in different societies. One of their biggest activities is a campaign for the eradication of FGM. The organisation raises awareness, provides information among the communities and at schools, provides consultation to FGM victims and offers training for medical professionals and Muslim and Christian religious leaders, since FGM is not only performed among Muslims but also under Christians (Catholics, Orthodox, and Protestants). This organisation plays a leading role in the EU DAPHNE Programme.

Since June 2005, the African Women's Organisation has officially been an advisory centre (*Beratungsstelle*) on women's health, reproductive health, and FGM. Mrs. Etenesh

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<sup>168</sup> *Ärztegesetz*, article 1, paragraph 54 (4) and (5).

<sup>169</sup> Dirie, Waris, *Onze verborgen tranen*, Amsterdam, Sirene, 2005, p. 30.

Hadis, director of the African Women's Organisation, is of Ethiopian origin. She stresses the importance of facilitating dialogue. She considers FGM to be a bad tradition, which can only be changed from within the community. There is no role for outsiders here. What is needed is the taboo to be broken. Communication goes through different interpreters that are provided by the organisation.<sup>170</sup> In addition, Mrs. Hadis emphasises the importance of an interdisciplinary approach, where medical experts, psychologists, lawyers, social workers, and politicians combine their efforts.<sup>171</sup>

It is noteworthy that Mrs. Hadis opposes court cases as they are held in France. She shares this opinion with Isabelle Gillette-Faye of G.A.M.S. in France. Mrs. Hadis sees no use in sending parents to jail. She is of the opinion that the mother or the parents believe that they are acting in the best interest of their child and it will not help to send them to jail. According to Mrs. Hadis, it is positive that in Austria there is legislation prohibiting FGM, which should be obeyed by everyone living in Austria. Therefore, it contributes to combating FGM, however, the main focus should be on prevention rather than on criminal proceedings.<sup>172</sup>

According to a study conducted by the African Women's Organisation in Vienna on FGM practised among immigrants in Austria, the majority of the people questioned, 76%, opposed the traditional practice of FGM. It is remarkable that at the same time, 30.5% of the people questioned, indicated that they would like their daughters to be subjected to FGM.<sup>173</sup> This can be explained by numerous reasons (e.g. because the parents are afraid that their daughter will not be able to marry otherwise).<sup>174</sup> This is a significantly high number and shows that a lot remains to be done regarding prevention in Austria. The

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<sup>170</sup> Interview with E. Hadis, 31 May 2006.

<sup>171</sup> Interview with E. Hadis, 31 May 2006.

<sup>172</sup> Interview with E. Hadis, 31 May 2006.

<sup>173</sup> The study was conducted among 250 men and women, originally from African countries where FGM is traditionally practised. Of these people, 130 were women, 120 were men, 75% living in Vienna. The majority of people questioned came from Egypt (59%), from Nigeria (11%), Ethiopia and Ghana. Of the people questioned, 59.2% were Muslim and 34.8% were Christian (Catholics, Orthodox and Protestants). Afrikanische Frauenorganisation in Wien, *Die Anwendung der FEMALE GENITAL MUTILATION (FGM) bei MigrantInnen in Österreich*, Vienna, October 2000.

<sup>174</sup> Interview with E. Hadis, 31 May 2006.

decision to let the daughters undergo FGM comes from both parents in 64% of the cases.<sup>175</sup>

The majority of people indicated that they would prefer that FGM be exercised in hospitals or at least under hygienic medical circumstances. The African Women's Organisation however, supports the view of the WHO that all forms of FGM should be prohibited, including the medicalisation of it. The performance of FGM takes place in the majority of cases in the country of origin, usually in Africa (88.5%). The rest of the FGM operations are performed in Europe (11.5%, of which 1.9% in Austria and 9.6% in Germany or the Netherlands). It is interesting to see that apparently Germany and the Netherlands are mentioned as hot spots for FGM. In these countries other countries are mentioned likewise (e.g. in the Netherlands, Italy is mentioned as a hotspot; in Italy, the United Kingdom is mentioned etc.). Of course this is not easily verifiable.<sup>176</sup>

Regarding legislation, the majority of people questioned, agreed with the legislation in Austria prohibiting FGM (60.4%). More than a third considered it to be “complete nonsense” to have legislation prohibiting FGM (35.6%) and a very small percentage thought it to be absolutely necessary to have legislation prohibiting FGM (1.2%). Education was considered to be of much more importance than legislation. It was seen as the task of governments and of the EU to provide this education and information and to raise awareness.<sup>177</sup>

The second organisation in Austria with regard to the prevention of FGM that I would like to mention, is the *Waris Dirie Foundation*. Waris Dirie is a woman originally from Somalia, Africa, where she lived a nomadic life. She underwent FGM herself, at the age of five she was subjected to *infibulation*. When she was forced to marry, she fled to Europe. In London she was discovered as a supermodel and she soon moved to New

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<sup>175</sup> Afrikanische Frauenorganisation in Wien, Die Anwendung der *FEMALE GENITAL MUTILATION (FGM) bei MigrantInnen in Österreich*, Vienna, October 2000, p. 14.

<sup>176</sup> Afrikanische Frauenorganisation in Wien, Die Anwendung der *FEMALE GENITAL MUTILATION (FGM) bei MigrantInnen in Österreich*, Vienna, October 2000, pp. 17, 19; Dirie, Waris, *Onze verborgen tranen*, Amsterdam, Sirene, 2005, p. 151.

<sup>177</sup> Afrikanische Frauenorganisation in Wien, Die Anwendung der *FEMALE GENITAL MUTILATION (FGM) bei MigrantInnen in Österreich*, Vienna, October 2000, p. 27.



York City, USA, to expand her modelling career. She first mentioned that she had undergone FGM herself in an interview with the fashion magazine *Marie Claire* in 1997. That was the first step to inform the public at large about her personal experience with FGM. In the same year, she was appointed by the United Nations as goodwill ambassador to combat the traditional practice of FGM. She has published several books on FGM: *Desert Flower* (1997), *Desert Dawn* (2002) and *Desert Children* (2005). In 2002, the *Waris Dirie Foundation* was founded in Vienna, where she currently lives. The organisation supports projects in Senegal, Somalia, and Sudan, helping individual cases of girls with severe health problems as a result of a FGM. In addition, campaigns against FGM are launched in African schools. In her last book, *Desert Children* (2005), Waris Dirie addresses the fact that FGM also takes place in Europe on a large scale. At this moment, there are plans to set up a research centre regarding FGM in Europe, to collect data on the number of cases and threats of FGM in Europe and to develop a strategy to combat FGM in Europe most effectively.<sup>178</sup>

Another important Austrian organisation is the *Österreichische Plattform gegen weibliche Genitalverstümmelung*, a platform uniting all important organisations dealing with the topic of FGM in Austria. It has set up an internet forum, in which different national and international NGOs take part: *StopFGM*.<sup>179</sup>

Other organisations that deal with the topic of FGM are: *Orient Express*, providing general information to immigrant women, *Care*, *Menschen für Menschen*, *SOS Mitmensch*, *Women Against Violence Europe* (WAVE), and *Pro Frau*.

### 6.8. Signalling and Reporting

Medical professionals are in the best position to signal FGM. A survey conducted among Viennese medical professionals shows that the majority of medical professionals had some knowledge with regard to the existence of the traditional practice of FGM: 95.2%, or had at least heard about it: 4.8%. However, this knowledge was not detailed enough to

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<sup>178</sup> Interview with W. Lutschinger (Managing Director of the *Waris Dirie Foundation*), 20 April 2006.

<sup>179</sup> *StopFGM* <<http://www.stopfgm.net>> (date accessed: 8 May 2006).

combat and prevent FGM effectively: 12.5% of the medical professionals questioned, indicated that they had no detailed knowledge on FGM, 34.6% stated they had, and 52.9% that they had partial knowledge. Gynaecologists knew most, paediatricians least about FGM.<sup>180</sup>

From these medical professionals, only 17% indicated that the topic of FGM was covered in their studies and only 15% indicated that FGM was covered in their higher education. In addition, 54.4% indicated that they had dealt with FGM in practice, 45.6% had not. Of all questioned, 80.8% stated that they were aware of the legal prohibition of FGM in Austria. That means that 19.2% had not, which is a fairly high percentage. When they were questioned about what they did after signalling a case or threat of FGM, the reaction of the majority, of 26.2%, was to share the experience with a colleague and of one-fourth, 25.2%, was not to do anything.<sup>181</sup> This shows that training is really necessary. The main problems that were signalled were language barriers and other communication problems. Most African immigrant women are very isolated and do not understand or speak German. This could be solved by providing information in the form of posters, leaflets, and meetings regarding the issue of FGM in their mother tongue, provided by NGOs, in hospitals, and in other medical institutions. In some cases, interpreters will be needed.

It is very clear that the knowledge of Austrian medical professionals regarding the topic of FGM is not sufficient at all. Therefore, they should be trained and educated in more detail concerning what the issue of Female Genital Mutilation exactly entails, that FGM is also practised in Austria, and that it is prohibited by (criminal) law.

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<sup>180</sup> This research was conducted by the *Österreichische Plattform gegen weibliche Genitalverstümmelung*, the *Wiener Programm für Frauengesundheit*, the *Renner Institut*, the *Institut für Kinderrechte & Elternbildung* and the *Waris Dirie Foundation*, among 803 medical professionals (covering paediatricians, gynaecologists, and midwives) in the city of Vienna in February 2006. The study was conducted by distributing questionnaires, however, only 13% of the questionnaires was returned. Therefore, it is questionable how reliable this study is. For the moment it is a good indication and the only one we have. *Österreichische Plattform gegen weibliche Genitalverstümmelung et al., Weibliche Genitalverstümmelung: Was weiß die Medizin?*, Vienna, 2006.

<sup>181</sup> *Österreichische Plattform gegen weibliche Genitalverstümmelung et al., Weibliche Genitalverstümmelung: Was weiß die Medizin?*, Vienna, 2006, pp. 6-7.

As we have seen above, medical professionals are obliged to inform the police when they have a suspicion that by an illegal act bodily harm or the death of a person was caused, especially when a minor has been maltreated. However, if there is suspicion that the maltreatment was caused by a close relative, which is often the case with FGM, the medical professional can wait with this, if the wellbeing of the minor depends on that. Here, the duty to report turns into a right to report, prioritising the best interest of the child.

Regarding signalling by teachers, family members, neighbours, key figures from the community, and religious leaders, the same can be said as to the Netherlands, France and the United Kingdom, that it is not very likely that these people are willing to signal and report cases and threats of FGM. One last remark regarding religious leaders should be made. They have a great influence on the communities concerned, and therefore the fact that the African Women's Organisation approaches these leaders and uses them in their prevention policy is already a step in the right direction.

## Chapter 7: Concluding Observations

This thesis tries to find an answer to the question how the harmful traditional practice of Female Genital Mutilation, practised among immigrants in Europe, can be combated most effectively. Next to the obligation to respect human rights on the international level, as laid down in various human rights instruments, there are different ways to combat FGM on the national level. Some countries have their main focus on criminal proceedings, other countries give priority to prevention strategies.

After a comparative analysis of the national legislation and the prevention policies in the Netherlands, France, the United Kingdom, and Austria, of criminal law, constitutional law, child protection law, medical professional law, and asylum law, we have detected some major differences in approach on how to combat FGM and we have come across several initial problems regarding these legislative and preventative tools. As concluding observations, I would like to address and answer the following questions:

- A) Which type of criminal law is preferable?
- B) Implementation of criminal law: What are the obstructing and favourable factors?
- C) How do the legislative tools relate to the preventative tools?
- D) Is a European policy desirable and feasible?

### **Ad A)**

Although all sorts of laws are applicable to FGM cases, the main focus of my thesis lies in criminal law, for this is probably the strongest legislative tool that can be used to combat FGM most effectively. As we have seen, the Netherlands and France employ general criminal law provisions prohibiting FGM, respectively as abuse and mutilation. The United Kingdom and Austria employ specific criminal law provisions prohibiting FGM, respectively the Prohibition of *Female Genital Mutilation Act* of 2003 and article 90 of the Austrian Penal Code of 2001.

The question arises which type of law is preferable to combat FGM: general criminal law or specific criminal law? At first sight, a specific criminal law seems to be very advantageous, in that it stresses the importance of the need to combat FGM. After a closer analysis, however, it appears that several problems might occur inherent to these specific criminal law provisions. In the United Kingdom, Austria, and in countries with similar provisions, it is generally not clear which forms of FGM are prohibited, leaving us to rely on creative interpretations:

- First, there is the issue of *re-infibulation* (the re-closing of the vagina after childbirth). *Re-infibulation* is not mentioned in the specific criminal law provisions of the United Kingdom nor Austria, and therefore it is unclear whether this practice is prohibited or not. A strict interpretation of the law would read that *re-infibulation* is not prohibited, whereas a more creative interpretation would read that since *re-infibulation* is not explicitly excluded either, it could implicitly fall under “all forms of FGM,” which are prohibited. Because there is technically no difference between the result of *infibulation* and *re-infibulation*, I would strongly plead for the prohibition of *re-infibulation* as well. When medical professionals are currently confronted with a request of *re-infibulation*, they are often unsure how to respond, especially when they are not instructed on the issue (e.g. in guidelines). Therefore, there is a need for a clear-cut definition of *re-infibulation* and a call for countries with specific criminal law provisions prohibiting FGM to clarify their laws.
- Second, there is the issue of piercing and tattooing. According to the WHO’s classification, piercing and tattooing would fall under Type IV of FGM. Although piercing and tattooing are not considered to be criminal offences in countries employing general criminal law, in countries with specific criminal law, this is not clear. Belgium is an exception, where piercing and tattooing are explicitly excluded from the law.<sup>182</sup> It could be argued that the United Kingdom has

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<sup>182</sup> Leye, Els, Deblonde, Jessika, *A comparative analysis of the different legal approaches towards female genital mutilation in the 15 EU Member States, and the respective judicial outcomes in Belgium*,

implicitly excluded piercing and tattooing from the United Kingdom *Female Genital Mutilation Act* of 2003. However, Austria has not clarified this under its law.

- Third, there is the issue of cosmetic genital surgery. The question arises here, if you can allow Western women to “design” their vagina and at the same time prohibit women of African descent from doing so in the form of FGM. Although both cosmetic general surgery and FGM involve cutting of the woman’s outer genitalia, there is, in my opinion, still a difference between the two. With cosmetic genital surgery, the *labia* are merely “adjusted,” whereas with FGM they are usually cut more severely and, in addition, the clitoris is cut or removed completely. The latter causes irreversible damage to the sexual sensitivity of a woman, as opposed to cosmetic genital surgery, where this is not the case. Another difference lies in the issue of consent. It could be argued that both practices of cosmetic genital surgery and FGM performed on adult women are exercised with the consent of these women, invoking the right to have disposal over one’s own body. Nevertheless, I personally question the consent in the case of FGM. I have strong doubts that consent to undergo FGM can ever be voluntarily. As we have seen above, the social pressure from family, community, and culture are enormous and should not be underestimated. It leaves women with basically no choice but to undergo FGM. In cases of cosmetic genital surgery, the consent is much more convincing. Although it could be argued that “designer vagina” operations are carried out for esthetical reasons as derived from a beauty ideal imposed by men and therefore under social pressure from the Western “picture perfect” society, this social pressure is in my opinion in no way comparable with the pressure from communities where FGM is traditionally practised.<sup>183</sup> A woman in societies where FGM is traditionally practised risks being abandoned and repudiated if she does not conform, whereas this is less

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*France, Spain, Sweden and the United Kingdom*, International Centre for Reproductive Health (ICRH), Publications No. 8, Ghent, The Consultory, April 2004, p. 14.

<sup>183</sup> The same argument applies to piercing and tattooing and other forms of cosmetic surgery, where ethics play an additional important role. It goes beyond the scope of this thesis, however, to elaborate in more detail on this issue.

likely in Western societies. Although the United Kingdom *Female Genital Mutilation Act* of 2003 does not elaborate on the issue of consent, the United Kingdom government considers FGM to be such a severe act that it should always be prohibited. Article 90, paragraph 3 of the Austrian Penal Code states explicitly that a request for FGM can never be granted.

- Fourth, the specific criminal law provisions do not always clearly specify that the law is specifically related to Female Genital Mutilation. Consequently, this law could also be applicable to the genital mutilation of boys, although it is questionable whether this would have been the intention of the lawmakers. As we have seen, this is the case in Austria.<sup>184</sup> On the other hand, it could be argued that the sexual sensitivity of men are not irreversibly damaged by genital mutilation of boys and therefore male circumcision would not likely fall under this provision.

Next to the problems regarding the clarity of specific criminal law provisions, it could be argued that: (1) the scope of specific criminal law provisions would be too narrow; (2) specific criminal law provisions would be discriminatory, because they would only be applicable to (mostly) black African immigrants, causing stigmatising effects; and (3) it would be merely symbolic.

From the comparative analysis, I can conclude that general criminal law provisions are sufficient. They offer enough solid ground to combat FGM and their scope is wide enough. In addition, problems in terms of clarity of the law can be avoided and perhaps most importantly, to employ general criminal law provisions is the only possibility to guarantee the principle of non-discrimination. Altogether, general criminal law provisions should be preferred over specific criminal law provisions.

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<sup>184</sup> And in Spain. Leye, Els, Deblonde, Jessika, *A comparative analysis of the different legal approaches towards female genital mutilation in the 15 EU Member States, and the respective judicial outcomes in Belgium, France, Spain, Sweden and the United Kingdom*, International Centre for Reproductive Health (ICRH), Publications No. 8, Ghent, The Consultory, April 2004, p. 51.

A few last remarks regarding criminal law should be made here. In order for criminal law provisions, whether general or specific, to be most effective, all obstructing elements should be removed. For the principle of extraterritoriality, the requirement of double criminality should be abandoned in countries where this principle is still in force (e.g. in Austria). The case of the Netherlands can serve as an example here. In addition, the principle of extraterritoriality should be extended from being applicable to only nationals (France) to residents as well (the United Kingdom and the Netherlands) or even wider: to any person on the territory of a country (Austria). However, this remains problematic, since refugees and asylum seekers do not obtain residency immediately, let alone the status of national. Another obstructing factor that needs to be removed, is that when countries have a statute of limitation for FGM as a criminal offence (the timeframe within which a person can press criminal charges) that this should be widened to starting to run at the age of 18 years old, like it has recently been changed in the Netherlands and Austria. This is important, because the chance that the girl or woman concerned would press criminal charges is likely to increase when she has had more time to deal with the psychological and physical effects of FGM and to think the process of pressing criminal charges over more thoroughly.

**Ad B)**

It seems that the theoretical basis of the laws is sufficient, however, the practical implementation of these laws is still problematic.

Regarding court cases, we have seen that France is the only country where a systematic practice of criminal court cases related to FGM takes place, employing general criminal law provisions. There have been a few FGM court cases in Italy and Sweden, however, this cannot be considered to be a systematic practice.

Personally, I agree with criminal proceedings regarding FGM as such. FGM in all its forms is, in my opinion, a horrific practice, which can not be justified in any circumstances. It is a practice that grossly violates core human rights (e.g. the right to life, the right to health, the right to physical integrity - including freedom from violence,



the right not to be subjected to torture or ill treatment, the right to non-discrimination, and additionally, specific children's rights). On the international level, there are several human rights instruments that can be invoked. On the national level, criminal law would be the best instrument to deal with FGM, qualifying FGM as mutilation or abuse. Criminal proceedings raise public awareness, due to the publicity surrounding it, provide a warning signal to the families and communities concerned, and help to do justice in individual cases.

There are still a few issues concerning criminal proceedings that I remain sceptical about:

- My first issue of concern is the severity of the penalties. I doubt that the imprisonment of the parent(s) or legal guardian(s) of the child would be in the best interest of the child.<sup>185</sup> Since most parents act with good intentions and think that FGM is necessary for their daughter to enable her to marry, the penalty of unconditional imprisonment would in my opinion too harsh. Conditional imprisonment, however, would contribute to prevention, if for example the condition is imposed that no other girls should be subjected to FGM. That way, other girls in the family (e.g. younger sisters) would be protected, where conditional imprisonment could serve as a weapon to achieve this. Compensation for damages is another penalty for parents and legal guardians that I would be in favour of, either alone or in combination with conditional imprisonment (depending on the circumstances of the case). This form of penalty hits both the parents and the family abroad, who are usually socially and economically depending on the immigrants in Europe. This threat can therefore be used as a strategic preventative weapon against the pressure from the family or community concerned. The height of the fine (compensation for damages) should be dependent on the parents' income, so that a minimum standard of living is guaranteed. I agree with more severe penalties for the traditional practitioner. They are in a more distant position from the girl who undergoes FGM and are often involved in more cases of FGM. Depending on the severity of the case,

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<sup>185</sup> It should be noted that this argument can be used regarding any criminal case.

unconditional imprisonment could be justified here, for example when the traditional practitioner operates systematically and on a large scale (see Annex 3).

- My second issue of concern is the deterrent effect of the court cases. Personally, I am not very convinced of the deterrent effect, since it has never been proven. FGM is still practised in France and it has not been proven that the number of FGM cases has actually gone down. In addition, it should be noted that within 27 years, only between 35 and 40 court cases have taken place. That is a relatively low number for such a long period of time, considering the high number of girls and women subjected to FGM in France. That leads to the following question: how many people do you really reach with these court cases, in terms of doing justice and as a warning signal?

It is remarkable that no systematic practice of criminal court cases regarding FGM have taken place in other countries than France. That could be caused by numerous reasons. For example, these countries face problems regarding the gathering of evidence, which is extremely hard to collect, due to the hidden character of FGM (in France, the certificates issued by the PMI centres are considered to be sufficient evidence). Another reason might be that these countries deliberately prefer prevention over criminal proceedings. In addition, cases and threats of FGM are hard to trace, due to the inability and unwillingness of people to signal and report these cases to the social and/or the judicial authorities.

Several people are in a good position to signal a case or threat of FGM at an early stage, of which medical professionals are probably in the best position. However, their signalling function can be damaged by their insufficient knowledge regarding what FGM entails, and what forms and types of FGM exist. As has been shown by surveys conducted in all four countries, medical professionals often do not know how to respond and therefore undertake nothing. In the Netherlands, it has been shown that no mandatory physical examination is possible on girls from the risk group. This would be discriminatory, and moreover, the law does generally not provide for a possibility to

conduct such a mandatory physical examination, since that would interfere with the private life of a person too much. To solve this problem and to repair the signalling function, we need consequent and frequent signalling, like is happening in France by the PMI centres. In addition, specific professional guidelines should be provided and special clinics focused on FGM and reproductive health should be set up, the United Kingdom serving as a good example. Furthermore, it is of the utmost importance to educate and train medical professionals and to avoid communication problems, like was indicated in the case of Austria (e.g. by providing information in the mother tongue and by providing interpreters). Family members, neighbours, key figures from the community, and religious leaders are often not willing to report because of shame, taboo, or to protect the family concerned; and teachers often do not see it as their task to signal and report cases and threats of FGM. This is even the case in France, where everyone is under a legal obligation to report.

In the Netherlands, medical professionals have the right to report. In France, everybody has the duty to report. In the United Kingdom, medical professionals have the duty to report. The same amounts to Austria, where medical professionals have, in principle, the duty to report, unless the interest of the child requires a different strategy. In the latter situation, the duty turns into a right to report. Nonetheless, there is an expressed concern that a number of cases go unreported, most often because of unwillingness to report (e.g. to protect the girl or women and family concerned).

Altogether, the implementation of criminal law is not sufficient at all, as can be concluded from the lack of signalling and reporting and from the fact that criminal proceedings are only systematically taking place in France and not in any of the other countries.

#### **Ad C)**

While France focuses primarily on criminal proceedings, the Netherlands, the United Kingdom, and Austria give priority to prevention. This can be considered to be a human rights approach, covering a wider scope, stressing the equality of men and women, the

principle of non-discrimination, and the protection of the most vulnerable in society (*in casu* of FGM: women and children). This human rights approach is supported by the other laws that are applicable to FGM (e.g. constitutional law, child protection law, medical professional law, and asylum law). The prevention policies of these countries (including France) consist of awareness raising, providing information to the members of the communities concerned and the public at large, education and training of medical professionals and health-care workers, education and training of teachers, and the empowerment of women. Discussion sessions are held among the risk communities in their mother tongue or with interpreters to convince the people concerned of the importance to eradicate the traditional practice of FGM. Key figures from the community and religious leaders play a very important role. It is possible to change perspectives on this tradition, but it will go very slowly and has to come from within the community itself. Outsiders can only play a minor role. It is the task of governments to tackle these problems (e.g. through public campaigning), to facilitate dialogue, and to create space for civil society, where grass root organisations are able to operate in an atmosphere of trust. In practice, it is NGOs like PHAROS, G.A.M.S., FORWARD, and the African Women's Organisation in Vienna that organise these discussion sessions, approach religious leaders and other key figures from the community, and raise awareness among the public at large.

Legislative tools in the form of criminal law or any other legislative measures and prevention policies will not be able to exist distinctively from one another. They have to go hand in hand. From all of the above, we can conclude that FGM can only be combated effectively when a combination of tactics is used of both legislative and preventative tools.

**Ad D)**

From my analysis of national legislation in these four European countries, I can conclude that there is no need for harmonised (criminal) legislation prohibiting FGM on the European level. The national legislation is sufficient to combat FGM, at least in theory. The implementation of this legislation is problematic, but that is a different concern.

Nevertheless, several initiatives have taken place on the European level. Both the Council of Europe (Parliamentary Assembly) and the European Union (Parliament) have issued a resolution in 2001 condemning the harmful traditional practice of FGM.<sup>186</sup> Unfortunately, these resolutions are recommendations and therefore not legally binding. Because of the inability to enforce these “soft” law resolutions, it can be questioned whether they are really effective or perhaps merely symbolic. Several supplementary European initiatives have been undertaken regarding prevention. Programmes have been set up or supported by the EU to combat FGM. One example is the DAPHNE Initiative (1997-1999), the DAPHNE Programme (2000-2003), and its follow up DAPHNE II (2004-2008), a multiple year programme supporting initiatives to combat violence against women, youth, and children. Another example is EURONET, a European platform combining all organisations dealing with the prevention of FGM. Unfortunately, there have only been very few European initiatives to combat FGM, due to lack of political will and funding.<sup>187</sup>

In my opinion, more attention should be awarded to the development of a prevention policy regarding FGM on the European level, with a more prominent role for a human rights approach. International and regional human rights instruments can be employed as a guide (e.g. the *European Convention for the Protection of Human Rights and Fundamental Freedoms*).

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<sup>186</sup> Council of Europe, P.A. Resolution 1247, 2001; European Union, E.P. Resolution 2001/2035 (INI).

<sup>187</sup> Interview with E. Leye, 30 May 2006.

## Chapter 8: Recommendations

The traditional practice of Female Genital Mutilation is, as we have seen, not only an African issue. Due to the arrival of immigrants, asylum seekers, and refugees from countries where FGM is traditionally practised, it has also become a European concern. Considering the large number of girls and women who have been subjected to FGM and who are still at risk, the serious medical and social consequences of FGM, and the core human rights that might be violated, FGM should not be underestimated.

This thesis shows that several steps still need to be taken, in order to combat FGM in Europe most effectively:

- All European governments should publicly recognise the problem of FGM in Europe and bring it up as an issue in both national and international fora; An excellent occasion to do this would be on the “International Zero Tolerance to FGM day,” that was introduced by the IAC in 2003, taking place annually on 6 February.
- There is an urgent need to map the scope and magnitude of the problem. All governments should collect and compile statistical data on FGM: on the number of immigrants from countries where FGM is traditionally practised in a specific country (there are statistics regarding legal immigrants, however, statistics regarding refugees and asylum seekers are hard to detect), on the number of cases and threats of FGM in a specific country (the fact that FGM is hidden from the surface is no excuse for not conducting research regarding this matter), on the type of FGM that is most commonly practised in a specific country, and on the age at which FGM is most commonly practised in a specific country.
- National plans of action should be developed, which include the following elements. Clear-cut criminal legislation prohibiting FGM is needed. It is not necessary to design specific criminal law provisions against FGM. General

criminal law provisions are sufficient to combat FGM and at the same time, problems regarding the clarity of the law, a too narrow scope, and the infringement of the principle of non-discrimination would be avoided. Countries with specific criminal law provisions prohibiting FGM should clarify their laws with regard to which forms of FGM are prohibited and should ensure that discriminatory and stigmatising effects will not occur.

- At the same time, laws in themselves are not enough unless their enforcement and implementation is ensured. All obstructing elements should be removed (e.g. the principle of double criminality and an overly restrictive statute of limitation). More countries need to be convinced of the importance of criminal proceedings and employ this means (with conditional imprisonment and compensation for damages as appropriate penalties). In addition, problems regarding the gathering of evidence for these criminal proceedings should be tackled (e.g. by the introduction of the French model, where certificates issued by the PMI centres are employed as evidence).
- The implementation of other legislation applicable to FGM (e.g. constitutional law, child protection law, medical professional law, and asylum law) should be equally safeguarded.
- Monitoring of cases and threats of FGM is important; in addition, signalling and reporting should be improved. People in the best position to signal and report (e.g. medical professionals, family members, neighbours, teachers, key figures from the community, and religious leaders) need to be convinced of the importance of their task.
- All governments should set up prevention policies consisting of: awareness raising among the communities concerned and the public at large, education and training of medical professionals and teachers, encouragement of key figures from the community and religious leaders to contribute to the eradication of the

practice of FGM, and the stimulation of the empowerment of women (e.g. through national education campaigns). FGM could be put in a broader perspective of reproductive health and could be addressed in relation to other forms of gender-based abuse (e.g. incest and forced marriages).

- Governments should create a strategy on the European level to tackle the problem: by measuring the magnitude and scope of the problem, by monitoring cases and threats of FGM, by safeguarding enforcement and implementation of legislation (both national legislation and international human rights instruments), and by setting up, financing, and supporting prevention policies (e.g. the EU DAPHNE Programme and EURONET). As we have seen, there is no need for harmonised legislation on the European level; the national legislation is sufficient, provided that it is well implemented.
- An evaluation should be conducted on the (criminal) legislation and prevention policies of the different EU member states; Best-practice models should be developed.
- Coordination and cooperation of the different national and European initiatives are absolutely necessary. At this moment, all organisations dealing with the problem seem to focus on their own interest and field of expertise separately, instead of combining their efforts to combat FGM. In national action plans, governments should coordinate, and cooperate with, national NGOs. In addition, there is a need for better coordination and cooperation of European NGOs. Furthermore, cooperation with governments where FGM is traditionally practised (mostly in Africa) and the NGOs operating in these countries should be encouraged.

Taking into account all of the above, we can conclude that a lot remains to be done...

In order to combat FGM in Europe most effectively, I would plead for an integrated, human rights based, approach, where legislative and preventative tools are combined.



There is a strong need for a complete examination of the state of affairs regarding FGM in Europe. In order to accomplish this, it would be desirable to set up one central research centre. Consequently, it is of the utmost importance for the European governments to find the political will and the necessary financial means to achieve this.

## Bibliography

### Articles

- Abdullahi, An-Na'im A., *Islam and Human Rights: Beyond the Universality Debate*, in "American Society of International Law," *Proceedings of the 94<sup>th</sup> Annual Meeting*, 5 – 8 April 2000.
- Barash, D., Webel, C., *Peace and Conflict Studies*, University of California at Berkeley, USA, Sage Publications, 2002.
- Foldès, Pierre, *Mutilations sexuelles: prise en charge des séquelles*, in Académie nationale de médecine (ed.), *Les mutilations sexuelles féminines. Un autre crime contre l'humanité: Connaître, prévenir, agir*, Supplément au *Bulletin de l'Académie nationale de médecine*, vol.188, no. 6, 10 June 2004.
- Gallard, C., *Female Genital Mutilation in France*, in "British Medical Journal," no. 310, 1995.
- Geneeskundige Hoofinspectie van de Volksgezondheid, *GHI Bulletin: Informatie over vrouwenbesnijdenis*, Rijswijk, March 1994.
- British Medical Association, *Female genital mutilation. Caring for patients and child protection: Guidance from the Ethics Department*, London, February 2004.
- Gillette-Faye, Isabelle, *Répartition géographique en France et dans le monde*, in Académie nationale de médecine (ed.), *Les mutilations sexuelles féminines. Un autre crime contre l'humanité: Connaître, prévenir, agir*, Supplément au *Bulletin de l'Académie nationale de médecine*, vol. 188, no. 6, 10 June 2004.
- Harrison, Sarah, *Backing the ban*, in "Nursing Standard," vol. 19, no. 27, March 2005.
- Henkin, Louis, *International law: politics, values and functions*, in Steiner, Henry J., Alston, Philip, *International Human Rights in Context: Law, Politics, Morals*, New York, Oxford University Press, 2000 (2<sup>nd</sup> ed.).
- Ignatieff, Michael, *Human Rights as Idolatry*, in *Human Rights as Politics and Idolatry*, Princeton University Press, 2003.
- International Women's Rights Action Watch, *FGM in Court and in Culture: An Advocacy Lesson from Egyptian Women*, in "The Women's Watch," vol. 11, no. 2, December 1997.
- Kelly, Elizabeth, Adams Hillard, Paula J., *Female genital mutilation*, in "Obstetrics & Gynecology," vol. 17, 2005.
- Koïta, Khady, *Contexte historique et socio-culturel des violences infligées aux femmes*, in Académie nationale de médecine (ed.), *Les mutilations sexuelles féminines. Un autre crime contre l'humanité: Connaître, prévenir, agir*, Supplément au *Bulletin de l'Académie nationale de médecine*, vol. 188, no. 6, 10 June 2004.
- Leye, Els et al., *Vrouwenbesnijdenis in Europa. Enkele knelpunten in de aanpak van de gezondheidszorg, wetgeving en preventie*, in "Ethiek & Maatschappij," vol. 7, no. 4, 2005.
- Leye, Els et al., *Health care in Europe for Women with genital mutilation*, in "Health Care for Women International," vol. 27, nr. 4, April 2006.
- Miller, Michael, *Responses to Female Genital Mutilation/Cutting in Europe*, UNICEF Innocenti Research Centre, Florence, Italy, 2004.
- Momoh, Comfort, *Female genital mutilation*, in "Obstetrics & Gynecology," vol. 16, 2004.

- Morbois, Catherine, Casalis, Marie-France, *Violences masculines envers les femmes: contexte historique et socio-culturel*, in Académie nationale de médecine (ed.), *Les mutilations sexuelles féminines. Un autre crime contre l'humanité: Connaître, prévenir, agir*, Supplément au *Bulletin de l'Académie nationale de médecine*, vol. 188, no. 6, 10 June 2004.
- Mwangi, Rosmary, Smith-Stoner, Marilyn, *Caring for the patient who has undergone female circumcision*, in "Home Healthcare Nurse," vol. 20, no. 1, January 2002.
- Nour, Nawal, M., *Female Genital Cutting: A Need for Reform*, in "Obstetrics & Gynecology," vol. 101, no. 5, part 2, May 2003.
- Piet, Emmanuelle, *Les mutilations sexuelles féminines et leur prévention*, in Académie nationale de médecine (ed.), *Les mutilations sexuelles féminines. Un autre crime contre l'humanité: Connaître, prévenir, agir*, Supplément au *Bulletin de l'Académie nationale de médecine*, vol. 188, no. 6, 10 June 2004.
- Powell, Richard A. et al., *Female genital mutilation, asylum seekers and refugees: the need for an integrated European Union agenda*, in "Health Policy," no. 70, 2004.
- Prasad, Divya, *Universality and Cultural Practice with respect to Female Genital Mutilation*, in "Indian Journal of International Law," vol. 41, no. 3, July-September 2001.
- Simonsen, Jorgen Boek, *Redefining rights: Islamic perspectives and the Cairo Declaration*, in Hastrup, K., *Legal Cultures and Human Rights, The Challenge of Diversity*, the Hague, Kluwer Law International, 2001.
- Wallis, Lynne, *When rites are wrong*, in "Nursing Standard," vol. 20, no. 4, October 2005.
- Weil-Curiel, Linda, *Aspects judiciaires: l'excision et la loi*, in Académie nationale de médecine (ed.), *Les mutilations sexuelles féminines. Un autre crime contre l'humanité: Connaître, prévenir, agir*, Supplément au *Bulletin de l'Académie nationale de médecine*, vol.188, no. 6,10 June 2004.
- Weil-Curiel, Linda, *Combating sexual mutilation in France through the application of the law*, C.A.M.S., 2002.
- Winter, B., *Women, the Law, and Cultural Relativism in France: The Case of Excision* in "Journal of Women in Culture and Society," 1994.

## **Books**

- Benedek, Wolfgang, (ed.), et al., *Human rights of women: international instruments and African experiences*, London, Zed books, 2002.
- Cassese, Antonio, *Human Rights in a Changing World*, Philadelphia, Temple University Press, 1990.
- Commissie Bestrijding Vrouwelijke Genitale Verminking, *Bestrijding vrouwelijke genitale verminking*, Zoetermeer, the Netherlands, 23 March 2005.
- Cook, Rebecca J., *Human Rights of Women: National and International Perspectives*, University of Pennsylvania Press, 1994.
- Dirie, Waris, *Mijn Woestijn*, Amsterdam, Arena, 1997.
- Dirie, Waris, *Desert Dawn*, London, Virago, 2002.
- Dirie, Waris, *Onze verborgen tranen*, Amsterdam, Sirene, 2005.
- Donnelly, Jack, *Universal Human Rights in Theory and Practice*, New York, Cornell University Press, 2003.

- Forsythe, David P., *Human rights and World Politics*, University of Nebraska Press, 1989.
- Forsythe, David P., *Human rights in International Relations*, Cambridge University Press, 2000.
- Gruenbaum, Ellen, *The Female Circumcision Controversy: An Anthropological Perspective*, Philadelphia, University Pennsylvania Press, 2001.
- Hermann, Conny (Hg.), *Das Recht auf Weiblichkeit: Hoffnung im Kampf gegen die Genitalverstümmelung*, Bonn, Dietz, 2000.
- Hosken, Fran P., *The Hosken Report*, WINNEWS, Lexington, M.A., 1993.
- Kool, R.S.B., et al., *Vrouwelijke genitale verminking in juridisch perspectief: (Rechtsvergelijkend) onderzoek naar de juridische mogelijkheden ter voorkoming en bestrijding van vrouwelijke genitale verminking*, Willem Pompe Instituut, sectie Strafrecht, Universiteit Utrecht, Zoetermeer, the Netherlands, 2005.
- Kramer, Merlijn, et al., *Vrouwelijke Genitale Verminking nader bekeken: Een onderzoek naar de aard omvang en attitude onder professionals en risicogroep in Amsterdam en Tilburg*, GG&GD Amsterdam, GGD Hart voor Brabant, March 2005.
- Kwaak, van der, Anke, et al., *Strategieën ter voorkoming van besnijdenis bij meisjes: Inventarisatie en aanbevelingen*, Vrije Universiteit and VU Medisch Centrum, Amsterdam, October 2003.
- Leye, Els, Deblonde, Jessika, *A comparative analysis of the different legal approaches towards female genital mutilation in the 15 EU Member States, and the respective judicial outcomes in Belgium, France, Spain, Sweden and the United Kingdom*, International Centre for Reproductive Health (ICRH), Publications No. 8, Ghent, The Consultory, April 2004.
- Nowak, Manfred, *Introduction to the International Human Rights regime*, Leiden, Martinus Nijhoff Publishers, March 2004.
- Okroi, Eiman, *Weibliche Genitalverstümmelung im Sudan*, Hamburg, Akademos-Wissenschaftliche Verlag (Medizin), 2001.
- Rahman, Anika, Toubia, Nahid, *Female Genital Mutilation: A Guide to Laws and Policies Worldwide*, London, Zed Books, 2000.
- Roald, Anne Sofie, *Women in Islam: the Western experience*, London, Routledge, 2001.
- Schnüll, Petra, TERRE DES FEMMES (Hrsg.), *Weibliche Genitalverstümmelung: Eine fundamentale Menschenrechtsverletzung*, Göttingen, Pachnicke-Druck, 1999.
- Shasheen, Ali Sardar, *Gender and Human Rights in Islam and International Law: Equal Before Allah, Unequal Before Man?*, the Hague, Kluwer Law International, 2000.
- Smith, Jacqueline, *Visions and Discussions on Genital Mutilations of Girls*, Defence for Children International, the Netherlands, 1995.
- Steiner, Henry J., Alston, Philip, *International Human Rights in Context: Law, Politics, Morals*, New York, Oxford University Press, 2000 (2<sup>nd</sup> ed.).
- Weil-Curiel, Linda, *Strafrechtliches Vorgehen, eine Anerkennung der Rechte von Kindern*, in Hermann, Conny (Hg.), *Das Recht auf Weiblichkeit: Hoffnung im Kampf gegen die Genitalverstümmelung*, Bonn, Dietz, 2000.
- Yazbeck Y., Haddad & Esposito J.L., *Islam, Gender and Social Change*, New York, Oxford University Press, 1998.

## **CD**

Kul, Bafing (C.A.M.S.), *Africa Paris*, June 2004.

## **Documentaries/Films**

- Bakker, Jacqueline, *De Engel komt terug*, the Netherlands/Somalia, 2002.
- C.A.M.S., *Le Pari de Bintou*, 1994.
- Goch, van, Theo, *Submission*, the Netherlands, 2004.
- Longinotto, Kim, *The Day I Will Never Forget*, United Kingdom, 2002.
- Pomeroy, Gerry, *A Nomad in New York*, BBC, United Kingdom, 1995.
- Sembene Ousmane, *Moolaadé*, Senegal/France 2004 (Contributor: Isabelle Gillette-Faye, G.A.M.S.).
- TweeVandaag (TROS), *Vrouwenbesnijdenis in Nederland*, 29 June 2005.

## **EU Documents**

- European Commission, *Commission Final Report to the European Parliament and the Council on The Daphne Programme (2000-2003)*, March 2004.
- European Parliament, *Report on female genital mutilation*, 17 July 2001.

## **Interviews**

- Interview with I. Gillette-Faye, 4 May 2006.
- Interview with E. Hadis, 31 May 2006.
- Interview with E. Leye, 30 May 2006.
- Interview with W. Lutschinger, 20 April 2006.
- Interview with E. Piet, 5 May 2006.
- Interview with L. Weil-Curiel, 5 May 2006.

## **Jurisprudence**

- *Richer-Peyrichout case*, *Cour de Cassation*, 20 August 1983.
- *Soumaré case*, *Cour d'Assises Paris*, 5 May 2006.
- See Annex 3.

## **Legislation**

### **Domestic**

#### *Austria*

- Ärztegesetz* (1998).
- Austrian Civil Code (*Allgemeines Bürgerliches Gesetzbuch*) (2005).
- Austrian Constitution (*Staatsgrundgesetz*) (1988).

#### *France*

- Code Civil* (2001).
- Code Pénal* (1994).
- Code de Procédure Pénale* (2001).
- Decrét n. 95-1000* (6 September 1995).
- Preamble to the 27 October 1946 Constitution.

### *The Netherlands*

- Dutch Civil Code (*Algemeen Burgerlijk Wetboek*) (1986).
- Dutch Constitution (*Grondwet*) (1983).
- Dutch Penal Code (*Wetboek van Strafrecht*) (2001).
- Wet Beroepen in de Individuele Gezondheidszorg* (1993).
- Wet op de Jeugdzorg* (2004).

### *The United Kingdom*

- The Female Circumcision Act* (1985).
- The Children Act* (1989).
- The Female Genital Mutilation Act* (2003).
- The Female Genital Mutilation Act (Scotland)* (2005).

### **International**

- *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights* (1988).
- *African (Banjul) Charter on Human and Peoples' Rights* (1982).
- *African Charter on the Rights and the Welfare of the Child* (1990).
- *American Convention on Human Rights* (1969).
- *Charter on the Fundamental Rights of the European Union* (2000).
- *Convention Against Torture and other Cruel, Inhuman, or Degrading Treatment or Punishment* (CAT) (1984).
- *Convention on the Elimination of all forms of Discrimination Against Women* (CEDAW) (1979).
- *Convention on the Rights of the Child* (CRC) (1989).
- *Council of Europe, P.A. Resolution 1247* (2001).
- *Declaration on the Elimination of Violence against Women* (1993).
- *EU, E.P. Resolution 2001/2035* (INI).
- *European Convention for the Protection of Human Rights and Fundamental Freedoms* (ECHR) (1950).
- *Inter-American Convention on the Prevention, Punishment, Eradication of Violence against Women* (1994).
- *International Covenant of Civil and Political Rights* (ICCPR) (1966).
- *International Covenant on Economic, Social, and Cultural Rights* (ICESCR) (1966).
- *Platform for Action of the Fourth World Conference on Women* (Beijing 1995).
- *Programme of Action of the International Conference on Population and Development* (Cairo 1994).
- *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa* (2000).
- *Universal Declaration of Human Rights* (UDHR) (1948).

### **NGO Reports**

- African Women's Organisation, *Training Kit: Prevention and Elimination of Female Genital Mutilation among Immigrants in Europe* (EU DAPHNE Project), Vienna, 2005.
- Afrikanische Frauenorganisation in Wien, *Bewußtseinsbildung und Information über WEIBLICHE GENITALVERSTÜMMELUNG in Österreich*, Vienna, October 2000.

- Afrikanische Frauenorganisation in Wien, *Die Anwendung der FEMALE GENITAL MUTILATION (FGM) bei MigrantInnen in Österreich*, Vienna, October 2000.
- Afrikanische Frauenorganisation in Wien, *Bewußtseinsbildung und Information über WEIBLICHE GENITALVERSTÜMMELUNG in Österreich*, Vienna, October 2000.
- Afrikanische Frauenorganisation in Wien, *FEMALE GENITAL MUTILATION (Genitale Verstümmelung an Frauen) Hintergrundinformationen*, Vienna, October 2000.
- Amnesty International, *Female Genital Mutilation: A Human Rights Information Pack*, London, 1997.
- Amnesty International, *Amnesty International Special Project on Female Genital Mutilation and Human Rights*, in "Amnesty International Newsletter," no. 1, April 2003.
- FORWARD, *Female Genital Mutilation: Knowledge Attitudes & Responses Amongst Communities & Health Professionals: A case study among African communities and health professionals in the health authority of Kensington & Chelsea and Westminster*, 2001.
- Österreichische Plattform gegen weibliche Genitalverstümmelung et al., *Weibliche Genitalverstümmelung: Was weiß die Medizin?*, Vienna, 2006.
- Österreichische Plattform gegen weibliche Genitalverstümmelung, *Rechtsinformationsblatt zum Informationsabend über FGM für ÄrztInnen und Hebammen*, 28 June 2006.
- The Minority Rights Group report no. 47 (*Female Circumcision*), London, 1985.
- World Health Organisation, UNICEF and UNFPA, *FGM Joint Statement*, Geneva, 1997.
- World Health Organisation, *Female Genital Mutilation. Policy Guidelines for nurses and midwives*, Department of Women's Health, Health Systems and Community Health, Geneva, 1999.
- World Health Organisation, *Female Genital Mutilation. Programmes to Date: What Works and What Doesn't? A Review*, Department of Women's Health, Health Systems and Community Health, Geneva, 1999.
- World Health Organisation, *Fact Sheet No. 24*, June 2000.

#### **Press Articles**

- *Änderung des Strafrechts bei Genitalverstümmelung und Zwangsheirat*, in "Die Presse," 23 February 2006.
- Boyer, Elisabeth, *Arzt wollte Frau "beschneiden"*, in "Der Standard," 7 November 2000.
- Male, Eva, *Es ist Folter, ich weiß es aus Erfahrung*, in "Die Presse," 20 March 1999.

#### **Theses/Dissertations**

- Charvat, Katharina, *"African Problem Means Global Problem:" Die aktuellen Entwicklungen im Diskurs um Female Genital Mutilation (FGM), dargestellt anhand ausgewählter Österreichischer Printmedien*, Magister Philosophie Thesis, University of Vienna, 2001.
- Edwards, Alice, *Age and gender dimensions in international refugee law*, 2005 [unpublished].
- Edwards, Alice, *The Feminising of torture under international human rights law*, 2005 [unpublished].

- Gillette, Isabelle, *La polygamie et l'excision dans l'immigration africaine en France, analysées sous l'angle de la souffrance sociale des femmes*, Villeneuve d'Ascq Cédex France: Presses Universitaires du Septentrion, 1997.
- Karacsonyi, Claudia, *Weibliche Genitalverstümmelung in Afrika: Eine tief verwurzelte Tradition und Möglichkeiten ihrer Überwindung*, Magister Sozial- und Wirtschaftswissenschaften Thesis, University of Vienna, October 2005.
- Martin, Boris, *Les droits culturels comme mode d'interprétation et de mise en oeuvre des droits de l'homme. Etude à partir du conflit opposant l'excision à l'ordre public français*, Dea Etudes Africaines, Option Droit Thesis, University Pantheon-Sorbonne, Paris, October 1996 [unpublished].

### **United Nations**

- OHCHR Commission on Human Rights, *Plan of action for the Elimination of Harmful Traditional Practices Affecting the Health of Women and Children*, Economic and Social Council, UN Doc. E/CN.4/Sub.2/1994/10/Add.1, 22 July 1994.
- OHCHR Commission on Human Rights, *Integration of the Human Rights of Women and the Gender Perspective: Violence Against Women*, Economic and Social Council, UN Doc.E/CN.4/2000/68, 29 February 2000.
- OHCHR Commission on Human Rights, *Integration of the Human Rights of Women and the Gender Perspective: Violence Against Women*, Economic and Social Council, UN Doc. E/CN.4/2002/83, 31 January 2002.
- OHCHR Commission on Human Rights, *Economic, Social and Cultural Rights: The right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Economic and Social Council, UN Doc. E/CN.4/2004/49, 16 February 2004.
- Office of the High Commissioner for Human Rights (OHCHR), *Fact Sheet no. 23: Harmful Traditional Practices Affecting the Health of Women and Children*, 1997.
- The Committee on the Elimination of Discrimination against Women, *General Recommendation no. 14*, 1990.
- The Committee on the Elimination of Discrimination against Women, *General Recommendation no. 24*, 1999.
- UNICEF, *Changing a Harmful Social Convention: Female Genital Mutilation/Cutting*, Innocenti Research Centre, Florence, Italy, 2005.
- UNICEF, *Council of Europe Actions to Promote Children's Rights to Protection from All Forms of Violence*, Innocenti Research Centre, Florence, Italy, 2005.
- UNICEF, *UN Human Rights Standards and Mechanisms to Combat Violence Against Children*, Innocenti Research Centre, Florence, Italy, 2005.

### **Varia**

- Délégation Régionale aux Droits des Femmes, 1998.
- Department of Health, Home Office, Department for Education and Employment, *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children*, London, The Stationary Office, 1999.
- Kamerstukken I 2004/05, 28484, A.
- Kamerstukken II 2003/04, 28484, nr. 41 and 2004/05, 28484, nr. 48.
- Kamerstukken II 2003/04, 29241, nr.1.



- E-mail from L. Segato (Director of *Ricerche e Studi su Sicurezza e Criminalità*, Zanè, Italy), 4 July 2006.
- Letter from Minister of Health, Wellbeing and Sports, *Kabinetsstandpunt RVZ-advies bestrijding vrouwelijke genitale verminking* and attachment to this letter, 26 August 2005.
- Letter of the Minister of Health, Wellbeing and Sports, BHTK 2003-2004, 29 2000, XVI, nr. 231.

### Web Sources

- *Advies- en Meldpunt Kindermishandeling* <<http://www.amk-nederland.nl>>.
- *African Sky* <<http://www.vrouwendomein.info/african-sky/>>.
- *Afrikanische Frauenorganisation in Wien* <<http://www.african-women.org>>.
- Ahmed, Sahro Mohamed, *Recaps of a 'Sealed' Woman* <<http://www.globalmedicine.nl/article?id=20060111>>.
- *Amnesty International* <<http://www.amnesty.org/ailib/intcam/femgen/fgm1.htm>>.
- *Black Women's Health and Family Organisation (Black Women's Health & Family Support)* <<http://www.bwhafs.co.uk>>.
- C.A.M.S. <<http://www.cams-fgm.org>>.
- *Care* <<http://www.care.at>>.
- *Center for Reproductive Rights, New York, USA* <[http://www.crlp.org/ww\\_iss\\_fgm.html](http://www.crlp.org/ww_iss_fgm.html)>.
- *Commissie Bestrijding Vrouwelijke Genitale Verminking* <<http://www.commissie-fgm.nl>>.
- DAPHNE Programme <[http://ec.europa.eu/justice\\_home/funding/daphne/funding\\_daphne\\_en.htm](http://ec.europa.eu/justice_home/funding/daphne/funding_daphne_en.htm)>.
- *Defence for Children International Nederland* <<http://www.defenceforchildren.nl>>.
- *Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)* <<http://www.gtz.de/fgm>>.
- EURONET <[www.euronetfgm.org](http://www.euronetfgm.org)>.
- *Focal Point* <<http://www.meisjesbesnijdenis.nl>>.
- FORWARD <[www.forwarduk.org.uk](http://www.forwarduk.org.uk)>.
- FSAN <<http://www.fsan.nl>>.
- G.A.M.S. <<http://perso.orange.fr/.associationgams/pages/presgams.html>>.
- Hirsi Ali, Ayaan, *Besnijdenis mag niet gedoogd worden*, VVD, 4 March 2004 <<http://www.vvd.nl/index.aspx?Contentid=835&Chapterid=1147&Filterid=974>>.
- Holt, Tim, *Cultural Relativism* <<http://www.philosophyofreligion.info/culturalrelativism.html>>.
- ICRH <<http://www.icrh.org>>.
- *Koninklijk Instituut voor de Tropen* <<http://www.kit.nl>>.
- *Menschen für Menschen* <<http://www.menschenfuermenschen.org/at/index.php?AT>>.
- *No Peace Without Justice* <[http://www.npwj.org/?q=taxonomy\\_menu/1/13](http://www.npwj.org/?q=taxonomy_menu/1/13)>.
- *Office of the High Commissioner for Human Rights* <<http://www.unhchr.ch/women/focus-tradpract.html>>.
- *Orient Express* <<http://www.orientexpress-wien.com>>.
- PHAROS <<http://www.pharos.nl>>.
- *Pro Frau* <<http://www.profrau.at/index.htm>>.

- RAINBO <<http://www.rainbo.org>>.
- SOS Mitmensch <<http://www.sosmitmensch.at>>.
- *StopFGM* <<http://www.stopfgm.net>>.
- *Vluchtelingen-Organisaties Nederland* <<http://www.vluchtelingenorganisaties.nl>>.
- WAVE <<http://www.wave-network.org/start.asp?b=6>>.
- *Waris Dirie Foundation* <[http://www.waris-dirie-foundation.com/web/e\\_index.htm](http://www.waris-dirie-foundation.com/web/e_index.htm)>.
- *Women Living under Muslim Law* <<http://www.wluml.org>>.



**Annex 1: Types of FGM as Classified by the WHO**



## **Annex 2: Dutch Penal Code (Wetboek van Strafrecht)**

### **Artikel 303**

- 1. Zware mishandeling gepleegd met voorbedachten rade wordt gestraft met gevangenisstraf van ten hoogste twaalf jaren of geldboete van de vijfde categorie.*
- 2. Indien het feit de dood ten gevolge heeft, wordt de schuldige gestraft met gevangenisstraf van ten hoogste vijftien jaren of geldboete van de vijfde categorie.*

### **Artikel 302**

- 1. Hij die aan een ander opzettelijk zwaar lichamelijk letsel toebrengt, wordt, als schuldig aan zware mishandeling, gestraft met gevangenisstraf van ten hoogste acht jaren of geldboete van de vijfde categorie.*
- 2. Indien het feit de dood ten gevolge heeft, wordt de schuldige gestraft met gevangenisstraf van ten hoogste tien jaren of geldboete van de vijfde categorie.*

### **Artikel 301**

- 1. Mishandeling gepleegd met voorbedachten rade wordt gestraft met gevangenisstraf van ten hoogste drie jaren of geldboete van de vierde categorie.*
- 2. Indien het feit zwaar lichamelijk letsel ten gevolge heeft, wordt de schuldige gestraft met gevangenisstraf van ten hoogste zes jaren of geldboete van de vierde categorie.*
- 3. Indien het feit de dood ten gevolge heeft, wordt hij gestraft met gevangenisstraf van ten hoogste negen jaren of geldboete van de vijfde categorie.*

### **Artikel 300**

- 1. Mishandeling wordt gestraft met gevangenisstraf van ten hoogste twee jaren of geldboete van de vierde categorie.*
- 2. Indien het feit zwaar lichamelijk letsel ten gevolge heeft, wordt de schuldige gestraft met gevangenisstraf van ten hoogste vier jaren of geldboete van de vierde categorie.*
- 3. Indien het feit de dood ten gevolge heeft, wordt hij gestraft met gevangenisstraf van ten hoogste zes jaren of geldboete van de vierde categorie.*
- 4. Met mishandeling wordt gelijkgesteld opzettelijke benadeling van de gezondheid.*

*5. Poging tot dit misdrijf is niet strafbaar.*

**Artikel 304**

*De in de artikelen 300-303 bepaalde gevangenisstraffen kunnen met een derde worden verhoogd:*

- 1°. ten aanzien van de schuldige die het misdrijf begaat tegen zijn moeder, zijn vader tot wie hij in familierechtelijke betrekking staat, zijn echtgenoot of zijn kind;*
- 2°. indien het misdrijf wordt gepleegd tegen een ambtenaar gedurende of ter zake van de rechtmatige uitoefening van zijn bediening;*
- 3°. indien het misdrijf wordt gepleegd door toediening van voor het leven of de gezondheid schadelijke stoffen.*

### Annex 3: Synopsis French Criminal Cases regarding FGM

Case	Year	Accusation	Accused	Penalty	Commentary
1	1979	221-6	Traditional practitioner	1 year CI	-
2	1984	222-3	Traditional practitioner	1 year CI	-
3	1984	121-3 jo 221-6 jo 221-7	Parents	6 months CI	Competent court: <i>Cour d'Assises</i> (Traoré)
4	1986/ 1991	121-7 jo 222-9 jo 10	Parents	5 year CICC, probation of 2 year	<i>Coulabilys-Keita</i> ; judicial competency dispute
			Traditional practitioner	5 year UI	
5	1988	222-6	Parents	3 year CI	Father + 2 wives
6	1989	121-7 jo 222-9 jo 10	Mother	3 year CI	
7	1990	121-8 jo 222-9 jo 10	Father	5 year CI	Against wish of the mother
8	1991	222-6  121-7 jo 222-6 or 222-9 jo 10	Traditional practitioner	4 year CI/UI, whereof 1 year unconditional	Megacase, the same traditional practitioner as in case 4 ( <i>Keita</i> )
			Parents (15)	1 year CI	3 Fathers: acquittal  <i>Partie civile</i> was not entitled against advice of Public Prosecutor  Dismissal in a number of cases
9	1993	222-9 jo 10	Mother	5 year CI/UI, whereof 1 year unconditional	-
10	1993	222-9 jo 10	Mother	5 year CI	-
11	1993	222-9 jo 10	Father	4 year CI/UI, whereof 1 month unconditional	
			Mother (2)	3 year CI	-
12	1993	222-9 jo 10	Mother (2)	5 year CI	



Case	Year	Accusation	Accused	Penalty	Commentary
13	1993	121-7 jo 222-9 jo 10	Husband of traditional practitioner	5 year CI/UI, whereof 6 months unconditional	
14	1993	222-9 jo 10	Mother	3 year CI/UI, whereof 6 months unconditional	
15	1993	222-9 jo 10	Parents	1 year CI	
16	1993	222-9 jo 10	Mother	5 year CI	
17	1993	222-9 jo 10	Father	1 year CI	
18	1994	222-9 jo 10	Father	2 year CI	
19	1994	222-9 jo 10	Parents	4 year CI	
20	1994	222-9 jo 10	Parents	Acquittal	
			Traditional practitioner	1 year CI	
21	1995	222-9 jo 10	Father	15 months UI	Mutilation abroad, in co-operation with agreements guardian
22	1996	222-9 jo 10	Father	1 year CI	
23	1996	222-9 jo 10	Traditional practitioner	3 year CI/UI, whereof 1 year unconditional	
24	1997	222-9 jo 10	Father	5 year CI/UI, whereof 1 year unconditional	
			Mother	5 year CI	
25	1997	222-9 jo 10	Mother	5 year CI	
26	1997	222-9 jo 10	Parents	3 year CI	Compensation for damages 10,000 French Francs
27	1997	222-9 jo 10	Parents	3 year CI	

Case	Year	Accusation	Accused	Penalty	Commentary
28	1998	222-9 jo 10	Father	1 year CI	
			Wives (2)	1 year CI	
29	1999	222-9 jo 10	Traditional practitioner	8 year UI	<i>Gréou Case</i> , first time the victim asks for prosecution. Difference in penalty between the parents involved. Compensation for damages of 13,000 French Francs for each of the 48 victims.
			Mother of complainant	2 year UI	
			Other parents (25)	5 year CI (22 parents) respectively 3 year CI (3 parents)	
30	1999	222-9 jo 10	Mother (2)	5 year CI	
31	2002	222-9 jo 10	Parents	2 year CI	Compensation for damages 762 Euro per accused inflicted. Compensation for damages 762 Euro per accused.
			Parents	3 year CI	
32	2003	222-9 jo 10	Mother	5 year CI, whereof 3 year with probation	Compensation for damages 12,000 Euro.
33	2003	222-9 jo 10	Mother	3 year CI	Compensation for damages 15,000 Euro.
34	2004	222-9 jo 10	Mother	5 year CI, whereof 3 year probation	Compensation for damages 15,000 Euro.
35	2004	222-9 jo 10	Mother	5 year CI	Compensation for damages 25,000 Euro.

*Legend:*

- CI = totally conditional imprisonment (under certain conditions not carried out: *sursis*)  
CICC = totally conditional imprisonment under the condition of not committing a crime within a probation period (*sursis avec mise à l'épreuve*)  
CI/UI = the unconditional part of a combined partially conditional, partially unconditional imprisonment (*dont une ferme*)  
UI = totally unconditional imprisonment

#### **Annex 4: Austrian Penal Code (Strafgesetzbuch)**

##### **§ 90 Einwilligung des Verletzten**

- (1) Eine Körperverletzung oder Gefährdung der körperlichen Sicherheit ist nicht rechtswidrig, wenn der Verletzte oder Gefährdete in sie einwilligt und die Verletzung oder Gefährdung als solche nicht gegen die guten Sitten verstößt.
- (2) Die von einem Arzt an einer Person mit deren Einwilligung vorgenommene Sterilisation ist nicht rechtswidrig, wenn entweder die Person bereits das fünfundzwanzigste Lebensjahr vollendet hat oder der Eingriff aus anderen Gründen nicht gegen die guten Sitten verstößt.
- (3) In eine Verstümmelung oder sonstige Verletzung der Genitalien, die geeignet ist, eine nachhaltige Beeinträchtigung des sexuellen Empfindens herbeizuführen, kann nicht eingewilligt werden. (emphasis added).

##### **§ 87 Absichtliche schwere Körperverletzung**

- (1) Wer einem anderen eine schwere Körperverletzung (§ 84 Abs. 1) absichtlich zufügt, ist mit Freiheitsstrafe von einem bis zu fünf Jahren zu bestrafen.
- (2) Zieht die Tat eine schwere Dauerfolge (§ 85) nach sich, so ist der Täter mit Freiheitsstrafe von einem bis zu zehn Jahren, hat die Tat den Tod des Geschädigten zur Folge, mit Freiheitsstrafe von fünf bis zu zehn Jahren zu bestrafen.

##### **§ 84 Schwere Körperverletzung**

- (1) Hat die Tat eine länger als vierundzwanzig Tage dauernde Gesundheitsschädigung oder Berufsunfähigkeit zur Folge oder ist die Verletzung oder Gesundheitsschädigung an sich schwer, so ist der Täter mit Freiheitsstrafe bis zu drei Jahren zu bestrafen.
- (2) Ebenso ist der Täter zu bestrafen, wenn die Tat begangen worden ist
  1. mit einem solchen Mittel und auf solche Weise, womit in der Regel Lebensgefahr verbunden ist,
  2. von mindestens drei Personen in verabredeter Verbindung,
  3. unter Zufügung besonderer Qualen oder

4. an einem Beamten, Zeugen oder Sachverständigen während oder wegen der Vollziehung seiner Aufgaben oder der Erfüllung seiner Pflichten.
- (3) Ebenso ist der Täter zu bestrafen, wenn er mindestens drei selbständige Taten ohne begreiflichen Anlaß und unter Anwendung erheblicher Gewalt begangen hat.

#### **§ 85 Körperverletzung mit schweren Dauerfolgen**

*Hat die Tat für immer oder für lange Zeit*

1. den Verlust oder eine schwere Schädigung der Sprache, des Sehvermögens, des Gehörs oder der Fortpflanzungsfähigkeit,
2. eine erhebliche Verstümmelung oder eine auffallende Verunstaltung oder
3. ein schweres Leiden, Siechtum oder Berufsunfähigkeit des Geschädigten zur Folge, so ist der Täter mit Freiheitsstrafe von sechs Monaten bis zu fünf Jahren zu bestrafen.

#### **§ 86 Körperverletzung mit tödlichem Ausgang**

*Hat die Tat den Tod des Geschädigten zur Folge, so ist der Täter mit Freiheitsstrafe von einem bis zu zehn Jahren zu bestrafen.*

#### **§ 83 Körperverletzung**

- (1) *Wer einen anderen am Körper verletzt oder an der Gesundheit schädigt, ist mit Freiheitsstrafe bis zu einem Jahr oder mit Geldstrafe bis zu 360 Tagessätzen zu bestrafen.*
- (2) *Ebenso ist zu bestrafen, wer einen anderen am Körper mißhandelt und dadurch fahrlässig verletzt oder an der Gesundheit schädigt.*